



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

**State Narrative for
Alabama**

**Application for 2009
Annual Report for 2007**



Document Generation Date: Sunday, September 21, 2008

Table of Contents

I. General Requirements	4
A. Letter of Transmittal.....	4
B. Face Sheet	4
C. Assurances and Certifications.....	4
D. Table of Contents	4
E. Public Input.....	4
II. Needs Assessment.....	6
C. Needs Assessment Summary	6
III. State Overview	8
A. Overview.....	8
B. Agency Capacity.....	22
C. Organizational Structure.....	31
D. Other MCH Capacity	35
E. State Agency Coordination.....	39
F. Health Systems Capacity Indicators	45
Health Systems Capacity Indicator 01:	46
Health Systems Capacity Indicator 02:	48
Health Systems Capacity Indicator 03:	50
Health Systems Capacity Indicator 04:	52
Health Systems Capacity Indicator 07A:	53
Health Systems Capacity Indicator 07B:	55
Health Systems Capacity Indicator 08:	56
Health Systems Capacity Indicator 05A:	57
Health Systems Capacity Indicator 05B:	59
Health Systems Capacity Indicator 05C:	60
Health Systems Capacity Indicator 05D:	61
Health Systems Capacity Indicator 06A:	62
Health Systems Capacity Indicator 06B:	63
Health Systems Capacity Indicator 06C:	64
Health Systems Capacity Indicator 09A:	65
Health Systems Capacity Indicator 09B:	67
IV. Priorities, Performance and Program Activities	69
A. Background and Overview	69
B. State Priorities	71
C. National Performance Measures.....	75
Performance Measure 01:	75
Performance Measure 02:	79
Performance Measure 03:	82
Performance Measure 04:	85
Performance Measure 05:	89
Performance Measure 06:	93
Performance Measure 07:	97
Performance Measure 08:	101
Performance Measure 09:	104
Performance Measure 10:	106
Performance Measure 11:	109
Performance Measure 12:	113
Performance Measure 13:	116
Performance Measure 14:	120
Performance Measure 15:	124
Performance Measure 16:	127
Performance Measure 17:	130
Performance Measure 18:	133

D. State Performance Measures.....	137
State Performance Measure 1:	137
State Performance Measure 2:	141
State Performance Measure 3:	143
State Performance Measure 4:	147
State Performance Measure 5:	149
State Performance Measure 6:	153
State Performance Measure 7:	157
E. Health Status Indicators	160
F. Other Program Activities	170
G. Technical Assistance	172
V. Budget Narrative	177
A. Expenditures.....	177
B. Budget	181
VI. Reporting Forms-General Information	185
VII. Performance and Outcome Measure Detail Sheets	185
VIII. Glossary	185
IX. Technical Note	185
X. Appendices and State Supporting documents.....	185
A. Needs Assessment.....	185
B. All Reporting Forms.....	185
C. Organizational Charts and All Other State Supporting Documents	185
D. Annual Report Data.....	185

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

Assurances and certifications are included in Appendix A. Appendices are not submitted electronically but are on file in the Bureau of Family Health Services, Alabama Department of Public Health. Any appendix, including Appendix A, can be obtained upon request by calling, e-mailing, or faxing the Bureau of Family Health Services' Maternal and Child Health Epidemiology Unit (phone: 334.206.5943; e-mail: acowden@adph.state.al.us; fax: 334.206.2914).

D. Table of Contents

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

E. Public Input

The Bureau of Family Health Services (FHS, or Bureau), Alabama Department of Public Health (ADPH, or Department), seeks public input via 5-year maternal and child health (MCH) needs assessments: through mailed surveys of primary care providers and non-medical organizations serving Title V populations, community discussion groups, and an advisory group convened for MCH needs assessment.

//2008/FHS seeks input by convening several State of Alabama (State) advisory groups that have consumer representation for persons affected by particular health issues. These groups respectively advise FHS on the following programs: Newborn Screening, Universal Newborn Hearing Screening, Early Childhood Comprehensive Systems Planning Grant, and Child Death Review. Some members of these groups are selected by FHS and some by the State's Governor. Members of the advisory groups are paid stipends and travel expenses for meetings they attend.

The State Family Planning Advisory Committee provides community input on FHS's Family Planning Program and the program's materials. The program has 2 toll-free phone lines: 1 for women seeking resources offered through PLAN First (the Family Planning Medicaid Waiver discussed in Section III.A.), and 1 for teens and others who want information on family planning. Two ADPH Web pages seek input on family planning.

Further, 3 key ways that FHS seeks input on MCH issues are through collaboration with the State Perinatal Advisory Council (SPAC) and Regional Perinatal Advisory Councils (RPACs), maintenance of a State Title V MCH Web page, and distribution of promotional items (for example [e.g.], pens, key chains, plastic cups, and a few knapsacks) seeking input on Title V MCH issues. Collaboration with SPAC and RPACs is discussed in multiple places in this document (e.g., under Health Systems Indicator #2A in Section II.E.)//2008//

//2009/Most of the Title V MCH promotional items have been distributed. In FY 2007 the State Title V MCH Web page was accessed on 859 occasions. Some, but conjecturally fewer than 100, of these usages were by FHS staff.//2009//

Children's Rehabilitation Service (CRS), Alabama Department of Rehabilitation Services (ADRS), administers services to children and youth with special health care needs and seeks input from this population and their families. The CRS 2004-05 needs assessment process included open family and youth forums, county-level provider surveys, youth surveys, and an inter-agency advisory group.

/2007/CRS requested input on current activities and plans at the State Parent Advisory Committee meeting. Families rated Form 13 characteristics during local parent advisory committee meetings, and the State Youth Consultant used a modified Form 13 to provide youth feedback.//2007//

/2008/CRS requested input on activities and plans at State Parent and Youth Advisory Committee meetings. Local Parent Consultants (LPCs) rated the agency on Form 13 characteristics, and Youth Advisory Committee members used a modified Form 13 to provide input.//2008//

/2009/CRS's advisory committees offer opportunities for public input. LPCs and the State Parent Consultant participate year round. Form 13 was rated as above. Draft CRS portions of the Block Grant were reviewed by LPCs and were made available to families.//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

The 2004-05 MCH Needs Assessment Report (reference #1) is posted on the Title V Information System Web site (<https://perfddata.hrsa.gov/mchb/mchreports/>). Updates to this report mainly consist of 3 elements:

- 1) Comparison of Alabama "Black Belt" counties to other Alabama counties for selected indicators.
- 2) Preparation of a report on deaths due to drug-related and alcohol-induced causes, focusing on the 15-44 year-old age group.
- 3) Preparation of a background paper on State Outcome Measure #2: the ratio of the infant mortality rate for Alabama to the infant mortality rate for the United States (U.S.).

The attachment to this section consists of the first and third reports listed above and the executive summary of the second report. The reports are ordered as listed above (based on the date they were first produced). The following discussion focuses on key elements of the 3 reports.

BLACK BELT COUNTIES VERSUS REMAINING COUNTIES

This report was prepared by CRS in FY 2006 and attached to the MCH 2005 Report/2007 Application. As stated in the report, the "Black Belt" is a crescent-shaped region reaching from Texas to Virginia and is named for its rich, dark-colored soil. Nineteen of Alabama's counties, mainly located in the southwestern part of the State, are located in the Black Belt. The background to CRS's update is that the initial 2004-05 MCH Needs Assessment Report compares 3 geographic categories--designated as Rural North, Rural South, and Urban county groupings--on selected indicators. Per this comparison, the 3 geographic regions differed significantly on several indicators, and the Rural South counties scored significantly worse for the socioeconomic indicators studied. In their update, CRS reports findings based on reanalysis of data they collected for the FY 2004-05 MCH needs assessment, taking the Black Belt into account. Per this reanalysis, the Rural South counties that are NOT located in the Black Belt were NOT at a socioeconomic disadvantage relative to the Rural North. However, as shown in Table 1 of CRS's report, compared to remaining counties, Black Belt counties were at a clear disadvantage for all the socioeconomic indicators studied.

DEATHS DUE TO DRUG-RELATED AND ALCOHOL-INDUCED CAUSES

In the FY 2004-05 MCH Needs Assessment report, FHS reported that the rate of deaths attributed to unintentional poisoning of 20-24 year-old White youth had more than doubled: from 4.0 deaths per 100,000 20-24 year-old White youth in 1998-2000, to 8.5 deaths per 100,000 in 2001-03. To solicit input for following up on this issue, in March 2006 FHS's Maternal and Child Health Epidemiology (MCH Epi) Unit convened an internal work group. This group, the Drug Overdose Work Group, included persons from the following units or programs, which are collectively located in 4 ADPH bureaus or offices, including FHS: the Center for Health Statistics, the Injury Prevention Division, the Pharmacy Unit, and the State Perinatal Program. Following the group's deliberations, the MCH Epi Unit prepared the report, "Deaths Due to Drug-Related and Alcohol-Induced Causes--Alabama, 1999-2005, With a Focus on the 15-44 Year-Old Age Group." Findings in the report are based on 2 databases. The first consists of computerized death certificate files for Alabama residents who died from 1999-2005, and the second of information

from paper copies of death certificates for 20-24 year-old Alabama residents who died in 1999-2005 from unintentional poisoning. Comparing 2003-05 to 1999-2001, findings from the first database include the following:

1) For 15-44 year-old Alabama residents, the number of deaths due to unintentional drug overdose increased by 56%: from an average of 84 deaths per year to an average of 131 deaths per year.

2) Among 15-44 year-old White males, deaths increased by 72%: from an average of 46 deaths per year to an average of 79 deaths per year. In a more restricted age group of White males--15-24 years of age--the number of these deaths more than doubled: from an average of 11 deaths per year to an average of 27 deaths per year.

3) Among 15-44 year-old White females, deaths due to unintentional drug overdose increased by 47%: from an average of 26 deaths per year to an average of 38 deaths per year.

4) Among 15-44 year-old Black individuals, deaths due to unintentional drug overdose did not change notably. This finding combines Black males and Black females because of the relatively small number of deaths due to this cause among Blacks (from 2003-05, an average of 13 deaths per year among Black males and females combined).

Only the title page, acknowledgements, and executive summary of the aforesaid report are in the attachment to this section. The full report is in Appendix B, which can be obtained by e-mailing acowden@adph.state.al.us. Recommendations in the report are being considered by the Director and Deputy Directors of FHS and the Director of ADPH's Pharmacy Unit.

BACKGROUND PAPER ON STATE OUTCOME MEASURE #2

The full report of this paper, which concerns the ratio of the infant mortality rate for Alabama to the infant mortality rate for the U.S., comprises the third component of the attachment. The paper compares Alabama and the U.S. regarding racial distribution of live births, the proportion of children living in low-income households, the distribution of live births to adolescents, the prevalence of very low birthweight, and the race-specific infant, neonatal, and postneonatal mortality rates: for the years 2002-2004. Findings include the following. White Alabama newborns were from about 14-21% more likely to die before their first birthday than White U.S. newborns were, but the infant mortality rate for Black Alabama newborns was similar to that for Black U.S. newborns. For each group studied (total group, White infants, and Black infants), postneonatal mortality was higher for Alabama infants than for U.S. infants. The full report discusses implications of these findings.

//2009/MATERNAL AND INFANT PROFILES

Maternal and infant profiles for the State and each of its 5 perinatal regions were prepared in early FY 2008. In December 2007 a slide presentation showing key findings from the profiles was made to State Perinatal Program staff and, per request, emailed to them for their use. The profile for the State has been added to the attachment to this section. Corresponding profiles for each of the State's 5 perinatal regions can be requested at the following email address: acowden@adph.state.al.us. The profiles are further discussed, though briefly, under State Performance Measure (SPM) #7.//2009// An attachment is included in this section.

III. State Overview

A. Overview

Acronyms or shortened terms are listed in Appendix C, obtainable by calling 334.206.5943 or e-mailing acowden@adph.state.al.us. Further, Appendix C is included in the attachment to III.A. Other appendices are not included in this Web-based submission but are obtainable through the above phone number and e-mail address.

//2007//Key issues important to understanding health needs of the State's population include the health care environment, selected changes in the State's population, the number of State Title-V served individuals, strategic and funding issues, and special challenges in delivery of services to children and youth with special health care needs (CYSHCN)--all of which are discussed in this section. Also key to understanding the health needs of the State's Title V populations are salient findings reported in the State's FY 2004-05 MCH Needs Assessment Report (sometimes termed "Needs Assessment Report") and priority MCH needs based on these findings. The full report is listed as reference #1 in Appendix D, which lists all references cited.

The process used by the State Title V Director to assess the importance and magnitude of factors impacting the delivery of health services and the priority of addressing these factors, including current and emerging issues, is multifaceted. This process includes collaboration with FHS staff, with other ADPH staff, and with a variety of organizations concerned with the well-being of the State's Title V populations. The process also includes support of ongoing MCH needs assessment and consideration of findings from and priority needs identified via such assessment. Further, the process includes consideration of public input and readily available evidence on the cost/benefit ratio of certain potential public health services. Multiple collaborations are discussed in Sections 1 and 2 of the Needs Assessment Report and throughout this Alabama MCH Services Block Grant FY 2006 Annual Report/FY 2008 Application (MCH 2006 Report/2008 Application), especially in Section III.E.

Included in FHS's considerations are racial, ethnic, and geographic disparities in health status or access to care. Special challenges regarding CYSHCN who reside in rural areas are described later in Section III.A, as are indicators concerning geographic living area and poverty. Certain socioeconomic disparities in MCH indicators, using source of payment for delivery as a surrogate for socioeconomic status, are discussed in Section III.F. Further, poverty, geographic distribution, urbanization, and socioeconomic, racial, and ethnic disparities in MCH indicators are discussed in Section 3 of the Needs Assessment Report.//2007//

The Alabama Title V Program is administered by ADPH, through FHS. FHS does not directly administer aspects focusing on CYSHCN but contracts with CRS, within ADRS, which administers services to this population. In addition to the Title V Program, FHS administers the Title X Family Planning Grant; the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); the State Perinatal Program (SPP); the Alabama Child Death Review System; and the State Dental Program. The Title V Program, as well as these other programs, serves all of the State's 67 counties.

THE HEALTH CARE ENVIRONMENT

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

summarized here.

Medicaid Managed Care Programs

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

Medicaid Maternity Care Program

Under the Alabama Medicaid Agency's (Medicaid's, or Alabama Medicaid's) Maternity Waiver Program that had been implemented in 1988, ADPH had been the primary provider of prenatal care for 23 of the State's 67 counties and subcontractor for care in many other counties. Under this plan, many women eligible for Medicaid-funded services under the Sixth Omnibus Budget Reconciliation Act (SOBRA) received their prenatal clinical health care and care coordination services mainly through CHDs. The care coordinator informed the pregnant patient about pertinent services, helped her access needed services, followed her through the first postpartum visit, and assured that she could access family planning options following the pregnancy. Home visits were made for high-risk patients: that is (i.e.), if the mother was less than 16 years of age or tested positive for human immunodeficiency virus (HIV); if there were indications of substance abuse or domestic violence; or if the baby was premature, low birth weight, or had special needs.

The Department's role in directly providing prenatal care has markedly declined with Medicaid's current State Plan for Maternity Care, which was begun in June 1999 and fully implemented by October 1999. This current State Plan for Maternity Care divides the State into 14 Medicaid maternity districts. Under this plan, ADPH no longer provides maternity services via a direct contract with Medicaid. Instead, with implementation of Medicaid's current State Plan for Maternity Care, ADPH began providing prenatal care and/or case management in certain counties, via subcontracts with groups who assumed responsibility for provision of prenatal care under a direct contract with Medicaid. However, even the number of counties in which ADPH subcontracts to provide prenatal care or case management for pregnant women has substantially declined. Specifically, the number of counties in which ADPH provides prenatal care as a subcontractor has declined from 14 circa FY 2000, to 10 by FY 2003, to 9 as of July 2004. The latter decline occurred because, in May 2004, prenatal care that had previously been provided by the Jefferson County Department of Health (JCDH) was transferred to the University of Alabama at Birmingham (UAB). Further, the number of counties in which ADPH provides case management as a subcontractor declined from 54 circa FY 2000 to 28 in FY 2002. As a corollary, as detailed later in this section, the number of patients receiving prenatal care in ADPH clinics has declined markedly.

By March 2005 it was determined that the private sector had the desire and capacity to provide all the prenatal care required under the SOBRA Medicaid program. For this reason and because of financial and liability-related issues, ADPH decided to completely withdraw from providing prenatal care. Most CHDs made a parallel decision to no longer provide care coordination for pregnant patients, though a few CHDs may continue to work with private providers in the provision of care coordination services only.

//2007/By July 2005 Medicaid Maternity Care Program contracts had been awarded in all 14 Medicaid Districts, to a total of 10 Medicaid Primary Contractors. Eight of these contractors are private-sector groups and 1 is a university. The contractors for specific Medicaid Districts are as follows: Health Group of Alabama for Districts 1 and 2, Viva Health Administration for Districts 3 and 9, Greater Alabama Health for District 4, Alabama Maternity Incorporated for District 5, Gift of Life for Districts 6 and 10, Tombigbee Healthcare for Districts 7 and 8, Maternity Care Services for District 11, Southwest Alabama Maternity Care for Districts 12 and 13, and the University of South Alabama (USA) for District 14. Some of the Medicaid Primary Contractors subcontract with physicians or hospitals to provide prenatal care. As well, some subcontract with physicians, hospitals, or ADPH to provide care coordination for pregnant women and/or postpartum home visits.

ADPH's role in maternity care has continued to decline. By early FY 2006, ADPH was no longer providing direct prenatal care. Further, as of April 2006, ADPH provides care coordination via subcontract with a Medicaid Primary Contractor in only 7 counties (down from 54 circa FY 2000 and 28 in FY 2002): Cullman, Houston, Dale, Henry, Geneva, Coffee, and Mobile Counties. Via these same subcontracts, in these 7 counties ADPH also provides postpartum home visits by a nurse.//2007//

/2008/The Medicaid Maternity Care Program continues to contract with private Primary Contractors to provide prenatal care, care coordination, and postpartum care. Contractors for the Medicaid Districts remain as before, except that Southeast Maternity Care, rather than Southwest Alabama Maternity Care, now provides care for District 13. Southwest Alabama Maternity Care continues to serve as the Medicaid Primary Contractor in District 12.

ADPH continues to provide maternity care coordination in 7 counties. The Health Department subcontracts for nurse postpartum visits in all but 1 of these counties, with Mobile County being the exception.

Though enrollment in the Medicaid Maternity Care Program is limited to U.S. citizens and others legally residing in the U.S., Medicaid provides limited funding to hospitals and doctors for emergency deliveries of women whose residence in the U.S. is not legally documented.//2008//

/2009/The Medicaid contract with the Primary Contractors has been extended through September 2008. A major change that Medicaid plans to implement in October 2008 under the new contract is the addition of "Application Assistors," who are trained to help patients complete applications for the maternity program so that eligible applicants are enrolled in Medicaid in a timely manner. Currently some applicants--especially in Jefferson County--are not being awarded Medicaid coverage until after delivery, and many physicians are unwilling to provide maternity care until the patient is covered by Medicaid.//2009//

Patient 1st and Case Management/Care Coordination

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

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

/2009/Patient 1st care coordination grew rapidly in FY 2007, when 103 ADPH care coordinators provided this service. FHS implemented an electronic Care Coordination Referral System (CCRS) in May 2007. This system is used for referrals received from the Children's Health Division for children with elevated lead levels and for newborns who need care coordination services with respect to hearing screening or metabolic screening.

As well, the system is used for infants referred by Medicaid for care coordination. Since implementation of CCRS, several thousand referrals have gone through the system to the PHAs or counties. Care coordination is further discussed under HSCI #1 in Section III.F and under SPM #1 in Section IV.D.//2009//

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

In early FY 2004 the State's governor (Governor) appointed a new Medicaid Commissioner. Medicaid then discontinued Patient 1st, effective March 1, 2004, because of financial constraints and waiver expiration. When Patient 1st ended, Medicaid-enrolled patients were no longer assigned to a primary care provider and could receive services from any physician who provided services under the Medicaid Program, but Medicaid no longer reimbursed for provision of care coordination services to adults. Further, because the MAR Case Management Program was closely tied to the originally implemented Patient 1st, MAR Case Management also ended effective March 1, 2004. However, through an agreement with Medicaid, ADPH continued to provide care coordination to children and adolescents (through 20 years of age) under EPSDT guidelines. Under EPSDT care coordination, children and youth through 20 years of age who had full Medicaid coverage could receive care coordination at CHDs. Though Patient 1st was no longer in force, ADPH's policy was to perform EPSDT screenings in CHDs only for children and youth who could not access such screenings through private providers. Medicaid, ADPH, and CRS continued to support the concept of a medical home for patients.

Many rural medical providers had depended heavily on the Patient 1st case management fees paid by Medicaid. For this and other reasons, primary medical providers in the State petitioned Medicaid to restart the managed care program. A task force, which included persons from CRS and ADPH, was established to create a new waiver for a revised managed care program for Medicaid enrollees. The Patient 1st Program was redesigned and reinstated in increments, beginning December 1, 2004. Counties were slowly added back into the program, with all counties being a part of Patient 1st by February 1, 2005. The reinstated Patient 1st Program has a similar structure to that of the previous program and provides financial incentives for physicians to provide a true medical home and perform EPSDT screenings. Medicaid pays the provider graduated case management fees, determined by the components of care (e.g., providers' availability after office hours) that the provider agrees to incorporate. The reinstated program includes increased quality assurance efforts, performance-based goals, and a greater focus on affecting behavior through providers being more active in patient education.

One change in Patient 1st that had a major impact on ADPH is that Medicaid no longer requires a referral from the patient's primary medical provider in order to provide care coordination services to children and adults. The removal of this barrier has allowed ADPH care coordinators to receive referrals from a variety of sources, including schools, hospitals, and self-referrals by patients and families. Further, ADPH Central-Office staff can now refer children with elevated lead levels, infants who fail their newborn hearing screenings, and infants identified with certain conditions at birth through the newborn hematologic screening program for care coordination by trained CHD

staff. Moreover, CHD care coordinators can now provide information and counseling on birth control methods and sexually transmitted diseases (STDs), including HIV infection, to Medicaid-enrolled teens who present for family planning services. Reimbursement by Medicaid for these services has been especially valuable in light of the recent loss of funding from the State Department of Human Resources (DHR) for teen care coordination (discussed later in this section).

/2007/Because the reinstated Patient 1st does not require referral from the patient's primary medical provider for ADPH staff to provide care coordination, the Department's provision of care coordination under Patient 1st increased notably in FYs 2005 and 2006. As of January 2006, 68 full-time equivalents (FTEs) of staff were working in ADPH's Patient 1st Care Coordination Program (up from about 45 FTEs working in MAR care coordination in early FY 2004). Of the 68 FTEs, 57 were providing care coordination for children.//2007//

/2008/ADPH's involvement in Patient 1st care coordination continued to grow, with 74 FTEs providing care coordination by the end of FY 2006. Care coordination is further discussed under Health Systems Capacity Indicator (HSCI) #1 in Section III.F and under SPM #1 in Section IV.D.//2008//

Collaboration Between CRS and Medicaid

The Medicaid Commissioner has emphasized children's issues as an agency priority. To this end, CRS has specific Medicaid staff members assigned to work with CRS's programs. Meetings between Medicaid and CRS are conducted quarterly, which has led to greater coordination and communication between these 2 entities. This enhanced partnership has facilitated collaboration such that CRS has established procedures to bill for therapy services provided by vendors, thus increasing access of Medicaid-covered CYSHCN to small therapy-provider groups. CRS credentials its staff and vendor physical, occupational, and speech therapists, and licensed physical therapist assistants and certified occupational therapist assistants according to the Medicaid Administrative Code to provide services to clients in CRS-sponsored early-intervention programs and/or the CRS program. A list of approved multidisciplinary clinics within the Children's Specialty Clinic Program, with required minimum staff, has been negotiated with Medicaid to ensure consistent quality, statewide standards of care, and access for Medicaid-enrolled children to community-based medical specialty clinics. CRS has an ongoing collaboration with Medicaid to meet Health Insurance Portability and Accountability Act (HIPAA) standards for privacy and billing. CRS has become a direct provider with Medicaid for audiological services, hearing aids, and related supplies, thereby providing better coordination of these services for Medicaid-eligible CRS clients. CRS also serves as the reviewer of all requests for Medicaid funding for augmentative communication devices and power wheelchairs.

/2007/Above CRS activities continue. CRS has negotiated with Medicaid to provide specialty eye clinics staffed by optometrists. This will increase access to basic eye care and, when needed, to specialists. The Alabama Early Intervention System (EIS) has been approved to begin billing Medicaid for services. CRS will offer support to the programs it sponsors as they implement the new billing mechanism.//2007//

/2008/Previous activities continue. CRS has worked with Medicaid to pilot a specialty Pediatric Evaluation Clinic to provide comprehensive assessment and treatment planning for children with complex medical issues. Negotiations are ongoing to provide an evaluation clinic to determine eligibility for Part C Early Intervention programs. As a part of newborn screening initiatives, CRS is negotiating to develop a follow-up clinic for infants who screen positively for cystic fibrosis. A data-sharing agreement has been re-established to match CRS and Medicaid data to confirm coverage and to determine receipt of Supplemental Security Income (SSI). CRS is providing input to Medicaid on issues likely to impact CYSHCN and their families.//2008//

/2009/Previous activities continue with the following changes. CRS established new clinics for specialized evaluation of complex orthopedic conditions, limb deficiencies, and follow

up for infants who test positive for cystic fibrosis on Alabama's expanded newborn screening panel. CRS staff, including the State Parent Consultant (SPC), participate on advisory committees and work groups associated with 2 Medicaid-led grants: Together for Quality (an effort to build a statewide health information system; see Section IV.C, NPM #5 for more information) and Alabama Assuring Better Child Health and Development (an effort to enhance well-child physician visits to include standardized developmental screening and referral as needed; see Section IV.C, NPM #3 for more information). Power wheelchair reviews are now contracted out of state, but CRS continues to review augmentative communication device requests.//2009//

Medicaid Family Planning Waiver and Related Issues

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

In June 2001 DHR funded a Teen Family Planning Care Coordination program at ADPH, with the goal of reducing the frequency of pregnancies and abortions among teens in Alabama. Under this program, all teens 18 years old and younger who came to any CHD for family planning services were eligible for care coordination. Because of the cuts in federal Temporary Assistance to Needy Families (TANF) funds to the State, this program began being phased out around March 2004 and was terminated by September 30, 2004. However, half of the teens being served in the program as its termination approached were enrolled in Medicaid, so were eligible to receive the same services via the previously referenced EPSDT Care Coordination Program.

/2008/Teens eligible for Medicaid under Patient 1st continue to be followed by Patient 1st care coordinators for ADPH's Family Planning Program. Psychosocial worksheet, assessment, and case plan forms have been developed specifically for teens who are sexually active. These forms are used by Patient 1st care coordinators for sexually active teens who accept care coordination.//2008//

The State Children's Health Insurance Program

With the creation of Alabama's Children's Health Insurance Commission in August 1997, the State Legislature appropriated funds and designated ADPH as the lead agency for this program. SCHIP was planned and implemented in Alabama using a broad-based work group, formed in September 1997, to research and recommend how services for the uninsured could best be developed. The work group included other State agencies (Medicaid, DHR, ADRS, Alabama Department of Mental Health and Mental Retardation [MHMR], State Department of Education [SDE], and the State Employees' Insurance Board), advocacy groups (AL Arise, Family Voices of Alabama, and VOICES for Alabama's Children), hospitals, community health centers, and various professional associations. Phase 1, a limited Medicaid expansion, was begun in February 1998. Phase 2 (the ALL Kids Program), a private-like insurance package for children between 100% (133% for children under 6 years of age) and 200% of the FPL, began on October 1, 1998.

Alabama SCHIP is administered through the Department's Office of Children's Health Insurance. Title V (FHS and CRS) staff have been heavily involved in the program's efforts, serving on work groups to develop enhancement packages and recommendations on how the program should work. Alabama was the first state in the nation to have a federally approved SCHIP State Plan as well as the first to have a major plan expansion.

/2007/The Office of Children's Health Insurance is now named the Bureau of Children's Health Insurance.//2007//

/2009/Since the inception of ALL Kids, Medicaid and SCHIP have used a joint application form for SOBRA Medicaid and ALL Kids. In 1999 the Alabama Child Caring Foundation's program was added to the application; in 2000 applicant information for Medicaid services for family planning was added; and in 2003 applicant information for the Medicaid for Low Income Families Program was added.//2009//

The joint application has made applying for these programs much simpler and referrals among the programs more automated and streamlined, and many children were added to SOBRA Medicaid rolls over the years. ADPH believes that many of these children were added because of intensive SCHIP outreach and collaboration between Medicaid and SCHIP on the application process. Due to incremental, federally mandated Medicaid coverage of persons from 6-19 years of age with household incomes below 100% of FPL, ALL Kids became the sole component of SCHIP in FY 2004. (For this reason, in this document "SCHIP" and "ALL Kids" are used interchangeably to refer to Alabama's State Children's Health Insurance Program.) Medicaid and SCHIP continue collaborating on the application process, however. Additional activities designed to inform the public about SCHIP and to promote enrollment of eligible children in ALL Kids, Medicaid, or the Alabama Child Caring Foundation's insurance plan are described under National Performance Measure (NPM) #13.

/2008/The Alabama Child Caring Foundation is a charitable organization of Blue Cross and Blue Shield of Alabama (BCBS), an Independent Licensee of the Blue Cross and Blue Shield Association. The foundation was established in 1987; through 2005, more than 50,000 children had received assistance from the foundation's program.//2008//

Further, FHS staff and SCHIP staff are collaborating on the feasibility of expanding SCHIP coverage to include the unborn child.

/2009/Discussions continued regarding the feasibility of expanding SCHIP coverage to include the unborn child, and projections were developed. However, this discussion has been tabled due to budget uncertainties.//2009//

Governor's Task Force on Children's Health Insurance

The previous Governor, through the State Health Officer, convened the Governor's Task Force on Children's Health Insurance (CHI Task Force) in July 2000 and designated a local pediatrician as this group's chair. The Department of Children's Affairs (DCA) Commissioner served as the vice-chair and the DCA Deputy Commissioner as the secretary. The CHI Task Force membership, appointed by the previous Governor, included State agency directors, child health advocates, and pediatric health care providers, including the chief executive officer of the Children's Hospital of Alabama.

The CHI Task Force was charged with coordinating existing funds to determine how to provide health insurance to children not otherwise eligible for Medicaid, developing a comprehensive strategy to expand Medicaid eligibility, and developing a comprehensive strategy to reduce the percentage of Alabama's children without health insurance. The final report of the CHI Task Force contained 29 recommendations and was presented to the Governor in January 2001. Recommendations on outreach included: 1) simplifying and coordinating the enrollment process for the 4 children's health insurance programs (Medicaid for Low-Income Families, SOBRA Medicaid, ALL Kids, and the Alabama Child Caring Foundation); and 2) developing public awareness strategies about eligibility for the 4 programs, with the strategies targeted to hospital staff, primary care physicians, child care providers, and public school staff. Recommendations about enrollment and eligibility included assuring an efficient, adequately staffed enrollment system for ALL Kids and Medicaid, and streamlining the annual renewal processes. Further, establishment of an adjunct "eligibility" for Medicaid based on income eligibility for other means-based programs, such as Food Stamps and subsidized child care, was suggested. Recommendations concerning providers, reimbursement, and financing included: 1) increasing Medicaid reimbursement rates to match Medicare rates for physician office visits and to match BCBS rates for dental procedures, 2) creating a fully automated, Web-enabled enrollment system

for ALL Kids and Medicaid, 3) describing the demographics for uninsured children at the county level, and 4) addressing long-term financing strategies for Medicaid. The CHI Task Force further recommended that an ADPH and Medicaid joint committee be formed to monitor progress on implementing recommendations.

/2008/Per review of discussion under NPM #13, many of the CHI Task Force's recommendations have been implemented.//2008//

Several developments occurred while the CHI Task Force was active. Medicaid convened a dental task force to look at issues affecting access to dental services for children who are Medicaid recipients, and collaborated with the Alabama Dental Association to survey dentists on what might encourage them to become Medicaid providers. As well, Medicaid increased its rates for dental procedures effective October 1, 2000. CRS also increased rates to at least match the new Medicaid rates. Further, Medicaid developed a plan for a functional assessment of orthodontic needs in order to expand its coverage of orthodontic treatment beyond children with craniofacial conditions to include other children with severe disabilities.

Department of Children's Affairs

DCA was created in 1999 through legislation endorsed by the Governor. Per their Web site (www.dca.state.al.us), the DCA's mission is "to provide state leadership to identify, analyze, streamline, and coordinate services for the 1.2 million children ages 0-19 throughout Alabama." This mission is accomplished through 4 divisions within the DCA: 1) Service Information and Evaluation; 2) Service Funding and Training; 3) Early Learning, in which the Head Start State Collaboration Office and the Office of School Readiness are administratively located; and 4) Service Coordination and Support, in which the State Children's Policy Council (CPC) and CPC Field Directors are administratively located. Per the State CPC's County Needs Assessment 2004-2005, "DCA is mandated to advise and educate the Governor, Legislature, and citizens of Alabama on all matters relating to children (reference #2). DCA was instrumental in convening the Children's Summit meeting in November 2000, which led to the creation of Alabama's 5-Year Strategic Plan for Children. Through the State CPC, DCA prepares and submits for approval and adoption legislation required to meet the unmet needs of children. DCA submits annual reports to the Governor and the State Legislature on activities and expenditures of State and local agencies related to children. The Governor continues his support for the DCA and CPCs.

Over their most recent reporting period (March 2004 to November 2005), the State CPC's activities, some of which had also been carried out in prior years, included the following: managing the growth and development of 67 local CPCs across the State; organizing and sponsoring the annual statewide CPC conference, which is attended by persons from each of the State's counties; managing and providing oversight for the budgeting of Children First Fund dollars (discussed in Section III.B); publishing the State CPC's Annual Needs Assessment from 67 counties; maintaining the work of Alabama's Head Start Program; cosponsoring (along with ADPH and others) the Oral Health Summit to identify barriers and strategies to promote oral health in Alabama; cosponsoring the Black Belt Health Summit; organizing a statewide Hispanic Coalition; and cosponsoring Alabama's first statewide fatherhood conference.

/2007/From February through early March 2006, DCA provided 7 CPC Regional Trainings across Alabama. The trainings included a session on the Alabama Early Childhood Comprehensive Systems Plan's "Blueprint for Zero to Five," which is about school readiness.//2007//

/2008/The development of the Alabama Resource Management System (ARMS) was initiated by DCA and the U.S. Space and Rocket Center. Through ARMS, State agencies and local communities will interact and garner input on how to build tools and present data in a way that is easy for users to understand and use. ARMS has 2 main components:

1) Resource List--Via an interactive management system, users can review, edit, and/or provide information on statewide social services resources: including government offices, public programs, nonprofit service providers, faith-based social services, and for-profit providers. This information will provide a base for part of the Internet mapping application, as well as be available for users to access and download for use in creating their own local resource directories.

2) Internet Mapping Application--Through an interactive process, users will be able to select criteria from State and national data and have the ability to print out a map and/or download the data within the map as a spreadsheet. The ability to turn data into information through mapping brings a new perspective that is becoming a standardized means for communicating data.

In addition to the resource data, statistical and funding data will be made available through the mapping application.//2008//

/2009/Additional funding was included in the DCA's Office of School Readiness FY 2008 budget to expand "First Class," Alabama's pre-kindergarten program. The program's mission is to provide Alabama's pre-kindergarten children with early childhood experiences that prepare them for school. This model allows Alabama to build on its existing preschool infrastructure and recognize quality that already exists, while providing affordable access to voluntary, high-quality pre-kindergarten for a much greater number of Alabama's 4-year-olds. First Class will consist of 2 components: 1) pre-kindergarten excellence grants of up to \$45,000 awarded to public school systems, Head Start centers, private childcare centers, and other community-based early learning programs to help them meet the "Alabama High Quality Pre-K Standards"; and 2) pre-kindergarten State-supported slots that will provide varying levels of funding to pre-kindergarten classrooms based on the number of low- and middle-income children they serve.//2009//

ADRS, including CRS, EIS, and Vocational Rehabilitation Service (VRS), is active at the State and local levels with the CPCs, as a voice for children and youth with disabilities. A staff member from ADRS sits on local CPCs in all counties. CRS staff and LPCs attended the CPC's statewide conference in March 2005, which included workshops on substance abuse prevention, family resource centers, rural health, planning and development, early childhood, and emerging topics. Training was provided on needs assessment and strategic planning at the county level, grant writing, resource directory development, and creation of children's advocacy in communities.

/2007/ADRS remains active with the State and local CPCs. CRS staff and LPCs attended the CPC's regional conferences.//2007//

/2008/ADRS participation continues as above.//2008//

/2009/ADRS continues participation in CPC activities.//2009//

Service to Certain Medicare Enrollees

Through expansions under the Medicare Program, various health plan options are available for clients with certain disabilities. This allows Medicare recipients to choose a benefit package that best meets their individual needs, which may challenge CRS clients in the selection of the most appropriate plan. CRS serves about 30 clients with Medicare benefits, most of whom are adults with bleeding disorders. Enrolling in the most beneficial option initially is preferable due to disenrollment penalties. CRS provides assistance to clients with Medicare coverage to select plans that address their needs.

/2007/CRS continues to help Medicare-covered clients choose the plans that best meet their needs. With the implementation of Medicare Part D, CRS administrators identified those Medicare recipients that had dual eligibility with Medicaid. CRS care coordinators then helped these recipients research the most appropriate prescription drug benefit plan. Although factor treatment for bleeding disorders is considered major medical and therefore is not impacted by Medicare Part D prescription drug plans, many clients have co-morbid conditions that require medications. Enrolling in a plan that best meets their needs is preferable to choosing or being assigned to a plan that does not cover all necessary medications.//2007//

/2008/CRS continues to help Medicare-covered clients as described above.//2008//

/2009/CRS continues to serve Medicare clients via clinics and care coordination and assists in locating Medicare pharmacies for factor and other drugs.//2009//

SELECTED CHANGES IN ALABAMA'S POPULATION

Increase in Hispanic/Latino Births

Comparing 2003 to 1999, the number of live births to Latino females living in Alabama increased by 86%, or by 1,377 infants. (In this document, "Latino" refers to Hispanic and/or Latino persons.) This increase occurred for each maternal age group, as well as for all ages combined. The increase began over a decade ago. Specifically, the number of live births to Latino Alabama residents increased from 344 in 1990, to 1,595 in 1999: a 4.6-fold increase (or an increase of 364%). This number further increased to 2,972 in 2003, or 86% above the number in 1999. In 2003, 5.0% of live births were to Latino females, compared to 0.54% in 1990 and 2.5% in 1999. This increase in live births to Latino females is further discussed in Section 3 of the MCH Needs Assessment Report (reference #1).

/2008/The number of live births to Latino females living in Alabama increased to 4,050 births in 2005, which was a 36% increase over the 2,972 Latino live births in 2003. Therefore, in 2005, Latino live births comprised 6.7% of all live births to Alabama residents (up from 5.0% of all live births in 2003.) Comparing 2005 to 2004, the number of Latino live births to Alabama residents increased by 20% (from 3,375 infants in 2004 to 4,050 infants in 2005).

/2009/The number of live births to Latino females living in Alabama increased to 4,709 births in 2006, which was a 16% increase over the 4,050 Latino live births in 2005. In 2006, Latino live births comprised 7.5% of all live births to Alabama residents./2009//

Trends in the number of Latino persons residing in Alabama, as reported in Health Status Indicator (HSI) #6B, are discussed in the Needs Assessment Report (reference #1). A salient element of this discussion is that projected numbers of 15-24 year-old Latino individuals for 2004 were much higher than projections for 1999 had been. Specifically, per population projections, Alabama had 16,955 15-24 year-old Latino residents in 2004, versus 8,119 such residents in 1999: a 2.1-fold increase. The higher projected number of 15-24 year-old Latino youth in 2004 relative to 1999 reinforces the need to assure that the Latino population can access family planning services and obtain health insurance coverage for prenatal and perinatal care. Further, comparing projected numbers for 2004 to the 2000 U.S. Census, the number of 10-14 Latino youth increased by 35% (from 5,601 in 2000 to 7,567 in 2004). As 10-14 year-old Latino youth age, access to health care for young adult Latino individuals will increase in importance./2008//

FHS's Division of Women's and Children's Health implemented the Uncompensated Maternity Care Project in CY 2000, to better understand the needs of and to better serve pregnant women without private insurance or Medicaid coverage. Counties with relatively high proportions of Latino live births were targeted. In FY 2002 MCH Block Grant funds supported uncompensated maternity care in 21 counties (up from 20 counties in FY 2001): with over 250 patients receiving services for which providers would otherwise have been unreimbursed (up from about 170 patients in FY 2001). However, due to funding reductions discussed in Section III.B, the Uncompensated Maternity Care Project was discontinued in early FY 2004.

Poverty Levels

Poverty levels are also discussed in Section 3 of the Needs Assessment Report (reference #1). The Current Population Survey cited there reports that, in 2003, 22.3% of Alabama residents under the age of 18 years were below 100% of the FPL, compared to 17.6% of U.S. residents under 18 years of age (reference #3). Considering the margin of statistical error, the estimated percentage of Alabama children and youth under 19 years of age whose household income is at or below 200% of FPL (42.9% in 2001-03, versus 38.2% for the U.S.) has not notably changed, as reported in on-line U.S. Census Bureau (or Census) health insurance reports (reference #1).

/2008/Compared to the U.S., Alabama children and youth continue to be more likely to live in low-income households. In 2003-05, 43.2% of Alabama children and youth under 19 years of age, versus 38.9% of U.S. residents in this age group, were living at or below 200% of the FPL (reference #13). Household income distribution in Alabama versus the U.S. is further discussed in the background paper on State Outcome Measure (SOM) #2, the ratio of the infant mortality rate for Alabama to the infant mortality rate for the U.S., which is included in the attachment to Section II.C.

TRENDS IN NUMBERS OF ALABAMA TITLE V-SERVED INDIVIDUALS

All numbers in this discussion pertain to numbers of individuals served by the State Title V program and to FYs.

Trends in these numbers for the period 1997-2006 were analyzed, using corresponding forms from previous State MCH Services Block Grant reports/applications (MCH reports/applications). The baseline of 1997 was selected in order to note the dramatic decline in the number of pregnant women annually served by the Title V program. This discussion is organized according to class of individuals, and typically compares numbers served in 2006 to, respectively, 1997, 2001, and 2005.

Page 4 in the attachment to this section graphically depicts numbers of infants, pregnant women, and "others" served, and page 5 depicts numbers of children and youth and numbers of CYSHCN served. The "children and youth" class was served by ADPH and presumably includes some CYSHCN. The "CYSHCN" class was served by CRS.

Pregnant Women--Numbers of pregnant women served under Title V ranged from 2,156 in 2006 to 28,989 in 1997. The number served in 2006 was 93% lower than in 1997, 78% lower than in 2001, and 49% lower than in 2005.

Infants--The surveillance period for infants excludes 1997, since the method for estimating these numbers changed in 1998. Numbers of infants served, from 1998-2006, under Title V ranged from 54,841 in 2004 to 59,747 in 2000, with 57,510 infants being served in 2006. The number served in 2006 was 2.1% higher than in 2001 and 3.1% higher than in 2005. Since 1998, the estimated number of persons receiving Title V services has typically been more stable for infants than for Title V populations served in CHDs, since all infants who receive newborn screening are considered to be Title V served.

Children and Youth--Numbers of children and youth served under Title V ranged from 31,847 in 2006 to 76,357 in 1997. The number served in 2006 was 58% lower than in 1997, 5.6% lower than in 2001, and 3.2% lower than in 2005.

CYSHCN--Numbers of CYSHCN served under Title V ranged from 17,284 in 2006 to 24,545 in 2000. The number served in 2006 was 26% lower than in 1997, 29% lower than in 2001, and 6.2% lower than in 2005.

Others--The "others" class consists of males and females served in CHD Family Planning Program clinics. Numbers of these clients ranged from 87,030 in 2000 to 98,577 in 2002, with 96,719 being served in 2006. The number served in 2006 was 6.0% higher than in 1997, 6.0% higher than in 2001, and 0.7% higher than in 2005.

Per the above review, the most striking declines in numbers served have been for children and youth and pregnant women served at CHDs. Though not as striking, the numbers of CYSHCN served have also declined somewhat. As detailed earlier in this section, changes in the health care environment, especially changes in Medicaid's managed care plans, have caused a shift in the provision of direct medical services from CHDs to private providers, which has impacted the numbers of children and youth and pregnant women served at CHDs. With respect to CYSHCN, the reported decline may be attributed to the following factors: the elimination of eligibility for purchased services for certain diagnoses, a change in the CRS case closure policy, increased access to care in the private sector due to physicians more widely accepting Medicaid, and service cuts due to budget constraints (discussed later in this section) which may have led some families to dis-enroll.//2008//

/2009/The following discussion pertains to number of individuals served by Title V in FY 2007, compared to FY 2006.

The number of pregnant women served declined to 1,389: a 35.6% decline from the 2,156 pregnant women served in 2006. The number of children and youth increased to 34,235, a 7.5% increase over the 31,847 children and youth served in 2006. The number of family planning clients increased to 102,692, a 6.2% increase over the 96,719 family planning clients served in 2006, and the highest number served during any year of the surveillance period.

In FY 2007 CRS served 16,346 CYSHCN, a 5.4% decrease from FY 2006. This figure is for CYSHCN enrolled in the CRS program who receive direct and enabling services or families that receive information and referral services directly from CRS staff. It is difficult to capture the number of CYSHCN who benefit from population-based or infrastructure-building services but are not enrolled in the program. FY 2007 efforts to increase numbers served included an increased public awareness campaign and a focus on onsite screenings for scoliosis and hearing loss through partnerships with schools, Head Start centers, and daycares in underserved areas.//2009//

STRATEGIC AND FUNDING ISSUES

ADPH's Strategic Direction Project and Work Group

Recognizing that recent changes in the health care environment will fundamentally change the way ADPH works to improve the public's health in Alabama, the Department formed a Strategic Direction Project in late summer of FY 1998. FHS's Director was heavily involved in this process, as a member of the project's work group. The work group had representation from the State, public health area (PHA, or Area), and local levels, as well as many public health disciplines. The work group's report was distributed to key State and PHA staff in February 1999. Three of the 5 overarching themes emerging from the work group's deliberations remain especially pertinent to FHS's strategies to promote the health of Title V populations. These 3 themes are:

- 1) Acknowledgment of the trend away from provision of direct patient services in CHDs toward more of a community focus, where public health workers assume new leadership roles to create healthy Alabama communities.
- 2) The increasing importance of an assurance role (going beyond provision of direct services, which is itself part of assurance) for public health within the community-wide focus.
- 3) The importance of maintaining a close association between the Department's mission and its programs, services, and grant pursuits.

Family Health Services' Mission and Vision

The mission of FHS is to protect and promote the health and safety of women, infants, children, youth, and their families through assessment of community status, development of health policy, and assurance that quality health services are available. The vision of FHS is that Alabama's families and the communities in which they live will be HEALTHY and SAFE. Recognizing that we cannot achieve our mission or bring about our vision alone, FHS engages in many collaborative relationships, some of which are described in numerous places in this document. Using the conceptual model of the 3 core public health functions--assessment, policy development, and assurance--FHS continues seeking to foster a paradigm shift around family health at all levels (State, PHA, and county) of ADPH. Simply stated, this shift involves a move from direct health care services to enabling, community-based, or systems development services where appropriate. While seeking to foster this shift, FHS recognizes that some CHDs will need to provide some personal health care services in the future as true "safety net" activities, under the function of assurance. A simple way to conceptualize the shift, however, is to envision the movement of county staff out of the building, across the threshold of the health department, and into the community.

Movement into the community has been hindered to some degree by budgetary constraints discussed in Section III.B. Nonetheless, notable interaction occurred through community discussion groups convened as part of the FY 2004-05 MCH needs assessment process (reference #1). As well as seeking to promote interaction with the community, FHS seeks to foster an increased emphasis on enabling services (e.g., case management or care coordination, described earlier in this section and under State Performance Measure [SPM] #1), population-based services (e.g., newborn screening, discussed under NPMs #1 and #12), and infrastructure-building services (e.g., capacity to collect, manage, and utilize data, discussed under SPM #7 and HSCI #9A). Specific funding constraints on FHS are discussed in Section III.B.

Special Challenges in Delivery of Services to CYSHCN

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

Due to consistent reductions and/or level funding from federal MCH Block Grant monies and State appropriations, significant budget shortfalls have faced the State Children with Special Health Care Needs (CSHCN) Program. As CRS is also responsible for adults and children with hemophilia and other bleeding disorders, the increased manufacturing costs for the production of clotting factor products and the increased utilization in response to a shift in standard of care towards prophylactic treatment have caused concerns about the long-term sustainability of the program at current funding levels. For the first time since 1991, CRS was forced to implement significant budget reductions resulting in cuts to services provided to CYSHCN and their families. Of necessity, the agency sought to reduce its budget for purchasing services for families by 1.5 million dollars in FY 2005. The incontinence supply (diaper) program was suspended effective October 1, 2004. Effective December 1, 2004, CRS suspended purchasing services for children whose family annual taxable income exceeds 250% of the FPL. These children may still attend clinics and receive services, including care coordination, through CRS staff in their local district office. CRS eliminated the purchase of all services for children with heart diagnoses and the purchase of all replacement hearing aid batteries, standers, ramps, and patient lifts. Guidelines were established on the purchase of therapy services, which emphasized that therapy should be specific (goal-oriented), time-limited, and focused. CRS reduced transportation reimbursement for families from 25 cents per mile to the Medicaid rate of 11 cents per mile. Funding to the medical genetics programs at UAB and USA was eliminated after the first quarter of the year. These

decisions, although difficult, were made by a work group consisting of State Office administrators, field supervisors, CRS medical consultants, and family representatives. Further reductions may be necessary if sufficient cost savings are not realized through these measures.

CRS has directed much effort toward informing families about changes in health-related resources and helping them to access alternative resources to meet needs. Family Voices of Alabama (FVA) sponsored a statewide letter-writing campaign to lawmakers, providing families an opportunity to discuss the specialized needs of CYSHCN and to express concerns to their local legislators over the potential impact of budget cuts. Also, the ADRS Commissioner led the agency in educating State legislators about the crucial role of ADRS, including all divisions, in meeting the needs of the State's CYSHCN. Through the services provided by ADRS, CYSHCN are better able to reach their maximum potential in educational, vocational, and community pursuits. By communicating this benefit to legislators, CRS is hopeful in seeking additional funding.

/2007/Continued budget shortfalls resulted in further service cuts. On July 1, 2005 CRS suspended purchasing services through its Associated Clinical Medical Programs with Children's Health System and the USA Children's and Women's Hospital. This program had allowed children to see specialists at those institutions without attending a CRS clinic, but CRS found it difficult to coordinate care, track the services received, and pre-authorize expenditures. CRS suspended purchasing medical and related services for children whose family annual taxable income exceeds 200% of the FPL. Due to budgetary restraints, CRS is filling only essential vacancies.

FVA again initiated a letter-writing campaign. The ADRS Commissioner and CRS Assistant Commissioner led an effort to inform legislators of the crucial role CRS plays in the system of care for Alabama's CYSHCN and the dire fiscal situation faced by CRS. CRS is seeking a 56% increase in its State funding to prevent the closure of offices and an accompanying staff reduction, which would decrease community-based access to care and reduce the number of children who are served by the program. If the effort is successful, CRS will restore some suspended services. ADRS has received positive feedback from its partners and local legislators and is hopeful for a favorable funding outcome.//2007//

/2008/Efforts made by the ADRS Commissioner, CRS Assistant Commissioner, and FVA were successful in securing a significant increase in legislative appropriations to CRS. Though the request for a 56% increase was not entirely granted, additional State dollars were allocated and provided enough stability to CRS's budget to avoid office closures, staff reductions, and further cuts in services to families. With the increased appropriations, CRS is again able to purchase services for families with taxable incomes up to 250% of the FPL. CRS is requesting another increase in State funding, in order to continue restoring services and to support growth of the program, for the purpose of increasing access to care for more of Alabama's CYSHCN.//2008//

/2009/CRS received its FY 2008 State Legislative budget request, allowing restoration of purchased services to families up to 300% of the FPL. Due to difficult economic times, the State has experienced a budget shortfall. A budget cut has been recommended for ADRS. The cut for CRS would make expansion of services unlikely and may create difficulty in maintaining current levels. Guided by the ADRS Commissioner and CRS Assistant Commissioner, local CRS offices and parent consultants engaged in public awareness efforts and a letter-writing campaign to local legislators, again in partnership with FVA. ADRS is hopeful for increased funding levels when the final FY 2009 budget is approved.//2009//

/2008/EMERGENCY PREPAREDNESS

Recent years have brought a focus on emergency preparedness. Alabama has achieved 8 of the 10 possible key indicators for health disaster preparedness, according to the non-profit Trust for

America's Health. Per the "Ready or Not?" report on disaster preparedness, of all 50 states and the District of Columbia, only Oklahoma and Kansas scored higher than Alabama. ADPH and CRS have been among the many partners in this achievement. ADPH's and CRS's roles in emergency preparedness are discussed on pages 6-10 of the attachment to this section.//2008//
/2009/Content on CRS's role in emergency preparedness has been added to the attachment.//2009//
An attachment is included in this section.

B. Agency Capacity

ADPH PROGRAM CAPACITY

ADPH: Fiscal Issues and Capacity

The Title V Program has substantial capacity to provide services to--and promote and protect the health of--mothers, infants, children and youth, and pregnant women. To maintain capacity, ADPH, including FHS, must periodically adapt to budgetary constraints imposed by factors beyond the Department's control. Such factors, as well as the Department's adaptation to resultant budgetary constraints, have been chronicled in previous MCH reports/applications. For example, notable reductions in ADPH funding had occurred by FY 1999. These reductions were largely due to changes in the federal Home Health Care Program and an increase in the State costs of insurance coverage for State employees. This reduction in funding resulted in many layoffs (about 1,400) in CHDs from October 1998 to September 1999 and a reduction in State funding provided by the State Health Officer to other FHS programs. The Area FHS Coordinator positions were eliminated in January 1999, and the Area Nursing Directors assumed many of the FHS Coordinator responsibilities. Though not at previous levels, ADPH funding stabilized by late FY 1999, and further massive layoffs have not occurred.

However, late in FY 2003, projected shortfalls in State revenue for FY 2004 caused the Department to critically review all funding sources, prioritize budget expenditures, and aggressively cut expenditures. As part of this process, the State Health Officer asked FHS to reduce FY 2004 projected expenditures of MCH Services Block Grant funds (MCH Title V funds) on FHS programs by \$1,600,000, compared to FY 2003. One purpose of these reductions was to increase MCH Title V support of CHDs, who faced inadequate local support and decreased availability of State funds. Such use of MCH Title V dollars supported local infrastructure, so that CHDs could continue serving the State's low-income maternal and child population.

Another, overlapping, purpose was to set aside funds to sustain MCH services provided by State, PHA, and CHD staff--should State funds available to ADPH be further reduced. Such further reductions were quite conceivable, given the State's acute financial shortfall and uncertainty over measures that might be taken by the State Legislature. In addition to being asked to reduce projected expenditures of MCH Title V funds allocated for FHS programs, FHS was informed that State dollars previously available to support the SPP and the State Dental Program would no longer be available. Accordingly, FHS's Director and Division Directors scrutinized projected expenditures for contracts, purchase orders, vacant positions, recently funded projects, and grants to other entities. Though the resultant decisions on cuts in projected expenditures were necessary and appropriate, the capacity of certain FHS programs was unavoidably diminished to varying degrees. A list of FHS programs or contracts notably impacted by this \$1,600,000 reduction in FY 2004 projected (as of late FY 2003) expenditures of MCH Title V funds follows:

- 1) Community Development Specialist Program--This program, which had been implemented in FY 2003 to support involvement of county-level staff in promotion of community-based MCH initiatives, was terminated.
- 2) Abolishment of certain positions in 2 programs--FHS abolished the following 3 positions--the Oral Health Branch's (OHB's) position for a fluoridation specialist and the Women's and Children's Health Division's 2 positions for nurses to perform quality assurance functions.

3) Programs with unfilled vacant positions--Due to resignations or promotions to positions outside FHS, the following positions became vacant before or during the FY 2004 budget reductions: 1 epidemiologist and 1 public health research analyst in FHS's Epidemiology and Data Management (Epi/Data) Branch, 1 account clerk in the Administration Division, and 1 nurse in the Women's and Children's Health Division. Because funds previously allocated for these positions in FY 2004 were needed to sustain other programs, FHS decided not to fill these positions. Consequently, directors of the involved units must clearly prioritize tasks, leaving some very important, though perhaps less urgent, tasks undone.

/2007/Funds were set aside to again fill the vacant epidemiologist position located in the MCH Epi Unit, formerly the Epi/Data Branch, but efforts to recruit an epidemiologist were unsuccessful. Instead, in FY 2006 the MCH Epi Unit created and filled a Health Services Administrator I position.//2007//

/2008/The MCH Epi Unit's responsibility for coordinating, contributing to, and editing all narrative for the MCH reports/applications limits the time that the unit can devote to public health surveillance and needs assessment. In FY 2007, therefore, the unit requested that a position be created in the unit for a Health Services Administrator II, whose duties would have included serving as coordinator and contributing editor for the program-related portions of the MCH reports/applications narrative that do not require quantitative analysis. The request was not granted due to budgetary constraints.//2008//

/2009/As discussed under SPM #7, ADPH has asked to replace the MCH Epi Unit's newly vacant research analyst position with a Health Services Administrator II position and fill the new position with an experienced grant writer, and is awaiting a reply from the State.//2009//

4) Uncompensated Maternity Care Project--Through this program, implemented in CY 2004 and discussed in Section III.A, MCH Title V funds had been used to help local communities design and maintain systems of care for maternity patients who could not pay for services. These patients were mainly Latino clients. The program was discontinued in FY 2004 due to budgetary constraints. This termination diminishes the Department's ability to promote systems of care for maternity patients who cannot pay for services.

5) Contract with ADRS--Through FHS, ADPH continues to contract with ADRS to administer services to CYSHCN, through CRS. As part of this contract, prior to FY 2004 ADPH had transferred about 35% of MCH Title V funds to ADRS. Fiscal constraints necessitated that, effective FY 2004, ADPH transfer only about 30% of MCH Title V funds to ADRS.

6) Contract with Monsky Developmental Clinic--The Monsky Developmental Clinic serves CSHCN in the Montgomery, Alabama area. In FY 2003 FHS channeled \$173,000 in MCH Title V funds to this clinic. This amount was reduced by half in FY 2004, diminishing the capacity of Monsky Clinic to serve CSHCN.

/2007/The Monsky Clinic has been renamed the Center for Child and Adolescent Development.//2007//

Some of the savings from the preceding measures were redirected in FY 2004 to sustain the SPP and the State Dental Program, the latter of which is administered through FHS's OHB. Even so, these programs could not be sustained at previous levels. For instance, with the exception of the Monsky Developmental Clinic, FHS no longer channels funds toward clinics that follow infants discharged from neonatal intensive care units (NICUs). (The consequences of discontinuing support for such clinics, from one clinician's viewpoint, are described later in this section.) Additionally, as previously mentioned, OHB's ability to promote water fluoridation and monitor existing water systems has been diminished. However, the SPP and the State Dental Program continue to provide crucial MCH services described elsewhere in this document. As previously explained, some of the savings in projected (as of late FY 2003) FY 2004 MCH Title V expenditures were reserved to cover unforeseen changes in the State's uncertain fiscal situation.

Accordingly, as of early May 2004, senior-level FHS administrators began consulting with the State Health Officer and ADPH's Public Health Administrative Officer on potential uses of unspent FY 2004 MCH Title V funds. One consequence of this consultation was that, by early FY 2005, ADPH began transferring 32% of MCH Title V funds to ADRS, which is still below the 35% that had been transferred prior to the FY 2004 budgetary constraints.

/2007/ADPH funding stabilized by FY 2005 and is expected to remain stable or increase slightly in FY 2007. Therefore, FHS was able to add several new positions. The position of Medical Director for Women's Health, now located in the Consultants Adjunct, was added in early FY 2005 and filled in May 2005. Key positions added and filled in FY 2006 include the following. In the Consultants Adjunct, a Senior Environmentalist was added to the Oral Health Unit (OHU, formerly the OHB), and (as previously mentioned) a Health Services Administrator I to the MCH Epi Unit. In the Women's Health Division, a Public Health Research Analyst II was added to the Family Planning Branch, and a Social Worker III to the Social Work Branch. In the Children's Health Division, a Nurse Coordinator was added to the Lead Branch, and a Nurse Supervisor to the School/Adolescent Health Branch. Compared to early FY 2005, the addition of these positions has increased FHS's capacity with respect to provision of medical consultation to CHDs, promotion of oral health, analysis of and reporting on MCH indicators, tracking provision of care coordination by CHD staff, prevention of lead poisoning in children, and promotion of the health and well-being of adolescents. Specific discussion of FHS's budget is located in Section V.//2007//

/2008/When submitting the MCH 2005 Report/2007 Application, we assumed funding would be stable through FY 2007. However, Title V MCH funding for Alabama decreased from \$12,348,388 for FY 2006 to \$11,873,256 for FY 2007: a decrease of \$475,132, or 3.85%. ADPH was able to use Title V MCH carryover funds to supplement the reduction in funds. However, any further reduction would diminish ADPH's capacity to provide MCH services.//2008//

/2009/Alabama has received notice that FY 2008 Title V MCH funding will be reduced by about \$191,474. Since 2006, funding has decreased from \$12,348,388 to about \$11,683,733: a decrease of \$664,655, or 5.383%. ADPH has been fortunate that it has been able use Title V MCH carryover funds to offset these reductions. It is expected that FY 2009 will see a downturn in the State and national economy. The Governor has submitted his 2009 General Fund budget, which reduces ADPH funding by about \$11 million, to the State legislature. These reductions will impact ADPH's ability to provide services.//2009//

In June 2004 FHS sought input from SPAC and the RPACs. This process entailed distribution of a summary of key activities pertaining to the National and State Performance Measures to members of these groups, along with an invitation to provide comments. A neonatologist (subsequently termed "respondent") from the northwest part of the State expressed concern about the impact of budget cuts on "High Risk Clinics," which follow high-risk graduates of NICUs. (In this context, "high risk" refers to an infant who is discharged from an NICU, whose birth weight was less than 1,500 grams, and/or who is at risk of physical, social, or neurodevelopmental problems.) Since budget cuts, most of these clinics have closed their doors. From the perspective of the respondent (who is neither employed by nor receiving financial benefit from such clinics), the closure of High Risk Clinics entails a high cost in terms of dollars and in terms of medical homes. In the environment in which the respondent works, a graduate of an NICU who was referred to a High Risk Clinic could be seen by at least 6 specialists during a single visit. Without such clinics, such an infant now requires from 3 to 8 appointments to receive the same evaluations that could have been done in a single appointment at a High Risk Clinic. Further, families "have to visit many offices and hospitals and radiology centers to continue the care of these fragile infants." Moreover, the respondent expects that the lack of a medical home, which would have been provided by a High Risk Clinic, will increase use of emergency rooms by the affected population. In sum, he anticipates that the closure of these clinics will increase the cost incurred by Medicaid in funding care for some of these infants and, as well, deprive many infants of a medical home.

Culturally Competent Care

ADPH seeks to provide culturally competent care that is appropriate for populations receiving the particular service being provided. For example, a component of ADPH's Pediatric Physical Assessment Course covers cultural factors and how these factors influence patient and family responses and the care provided. This training is required by Medicaid for non-baccalaureate nurses who perform EPSDT assessments. The pediatric assessment pocket guide that is given to the nurses at the training has a section on cultural variations in family and health practices (reference #4). Further, ADPH provides a refresher course for baccalaureate-prepared nurses who have not recently performed assessments. Though these nurses do not receive the aforesaid pocket guide, they receive a lecture and didactic information on cultural factors. Moreover, FHS's Newborn Hearing Screening Program's brochure, which is distributed by birthing facilities to all new mothers, has been translated into Spanish. With respect to public input, community discussion groups convened by FHS during the FY 2004-05 MCH needs assessment included 2 groups comprised of Latino individuals and 1 group comprised largely of Native Americans.

/2008/In 2002 a team assembled by the U.S. Health Resources and Services Administration (HRSA) developed an in-progress assessment profile for cultural competence. The profile had 7 domains: 1) organizational values, 2) governance, 3) planning and monitoring/evaluation, 4) communication, 5) staff development, 6) organizational structure, and 7) services/interventions. By early FY 2008 FHS's Bureau Management Team (BMT) will jointly consider the degree to which Bureau infrastructure and activities promote cultural competence in each of these domains, and produce a brief internal report on their conclusions. In the interim, though not comprehensive in nature, discussion of some elements of ADPH's and CRS's activities addressing cultural competence follows./2008/

/2009/The BMT has not considered the aforesaid 7 domains per se. Instead, 5 Bureau staff members are members of the ADPH Health Disparities Advisory Council, which seeks to address health disparities and culturally competent care. The advisory council was formed in CY 2007 and has been charged with tasks including, but not limited to, the following: 1) identify service delivery problems, 2) analyze data and develop solutions to address program planning issues concerning health disparities, and 3) measure patient and staff satisfaction with health care services provided in CHDs.

The advisory council's recommendations include, but are not limited to, development of: 1) an interactive methodology to obtain immediate feedback on service delivery at the points of service and at all ADPH sites, and 2) training modules for ADPH staff on communicating effectively with diverse population groups, to include crosscultural and multicultural care./2009//

/2008/New care coordinators for ADPH receive an hour of training, provided by ADPH's Office of Minority Health, on working with Latino individuals. Satellite presentations on cultural competence are broadcast to all CHDs and are available for viewing at the time of presentation or at a later date. Several FHS programs provide Spanish-translated materials. For example, the Healthy Child Care Alabama Program provides Spanish-translated health, safety, developmental, and support services information materials to child care providers and the families of children in child care. As well, the Alabama Child Death Review System, the Alabama Child Lead Poisoning Prevention Program, and FHS's Newborn Screening Program provide educational and/or outreach brochures in Spanish. Further, for National Public Health Week, the Children's Health Division partnered with KPI Latino, a Spanish radio station in Birmingham, and the International Program Manager with JCDH to educate the Latino community (especially mothers with children still living in the household) about the importance of planning for public health threats.

CRS promotes the provision of culturally competent care to all CYSHCN and families. As a part of the FY 2004-05 needs assessment, CRS conducted a family forum in Spanish. Public awareness

materials, clinic brochures, and the HIPAA Privacy Notice are translated into Spanish. Staff use the AT&T language line and/or interpreters to communicate with linguistically diverse families in clinics and/or for service planning. ADRS's staff conference includes sessions on cultural competence. CRS seeks to provide services that are individualized based on need and are respectful of cultural diversity and family tradition, including but not limited to language, race, ethnicity, spiritual beliefs, and generation.//2008//

CRS PROGRAM CAPACITY

CRS has taken an active role in ensuring a statewide system of services that is comprehensive, community-based, coordinated, culturally competent, and family-centered.

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

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

CRS also coordinates health services for CYSHCN within community-based systems. CRS offices are co-located with EIS and VRS in most locations, facilitating service coordination and smoother transitions for CYSHCN. CRS district offices function as powerful resource networks in local communities, responding to requests for information on CYSHCN. CRS has MOUs with the State's 2 tertiary-level pediatric hospitals to provide community-based care coordination, family support activities, and financial assistance to CRS-eligible children receiving care at these institutions. These agreements ensure that children are referred and receive appropriate services from both providers. Medicaid's Patient 1st Waiver has enhanced the flow of information between primary and specialty care at the community level, through the assignment of all children, including CYSHCN, to a medical home.

CRS is 1 of 3 agencies responsible for early intervention services through the sponsorship of 16 EIS programs statewide. These programs provide a more coordinated, team approach to early intervention as opposed to a previous model in which the CRS districts provided case management services directly to eligible infants and toddlers and purchased related services (physical therapy, occupational therapy, speech therapy) via a vendor system. CRS State Office staff participate in annual Provider Appraisal Reviews for these programs to ensure consistent quality and fiscal responsibility, provide technical assistance, and inform program coordinators of the benefits of referral to CRS for eligible infants and toddlers with special health care needs.

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

/2007/CRS program capacity is virtually the same. CRS continues collaboration at all levels to address systems development for CYSHCN. CRS increases access to appropriate care, serves

an advisory role related to the unique needs of CYSHCN and their families, and provides leadership in policy making and service provision. These efforts occur at the CRS State Office and in 15 local offices in the now 8 CRS districts. Due to budget issues, CRS now sponsors 13 EIS programs.//2007//

/2008/CRS program capacity continues, as above, to enhance the system of care for Alabama's CYSHCN via collaborations and partnerships. Efforts are coordinated through the CRS State Office and in 15 local offices across 8 districts.//2008//

/2009/CRS continues to advocate for and develop comprehensive, community-based, coordinated, culturally competent, and family-centered systems of care for Alabama's CYSHCN and their families. Through its program capacity as described above and partnerships with families and other State and local agencies, CRS is influential in policy-making and service provision for this population.//2009//

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

The State is divided into 7 service districts for CYSHCN, each led by a supervisor responsible for personnel, service implementation, and office operations. Fifteen local offices around the State provide community-based services to children and families through outpatient specialty medical clinics; care coordination activities; home, school, and community visits; and agency consultations. Specialty medical staff are recruited from the public and private sector and are credentialed by the CRS medical consultant. They may provide services in their home community or travel to CRS clinic sites in rural areas where specialty services are not otherwise available. Care coordinators, typically nurses or social workers, travel within their assigned counties to meet families, arrange services, and maintain working relationships with other service programs and providers. They also work to develop the State's system of care by identifying local providers with expertise related to CYSHCN and working with community groups on planning issues concerning CYSHCN. Care coordinators have access to a team of CRS specialists to deliver community-based care, education, consultation, or therapy. CRS staff members are mobile and not restricted by district boundaries in the delivery of services. Families are similarly unrestricted and may access services in any CRS office. Any State resident from birth to 21 years of age who has a special health care need is eligible for CRS services. Financial assistance and family participation are determined by the program's sliding fee scale. Families with incomes below FPL and Medicaid-enrolled children receive full assistance. SSI beneficiaries less than 16 years old are eligible for CRS services. Referrals for children evaluated for SSI are received in the State Office from the State Disability Determination Units (DDUs) in Birmingham and Mobile and are directed to the appropriate local office. Families are then contacted to offer CRS services, including care coordination. Flyers with the State toll-free number and a listing of CRS services are distributed through the local offices of the Social Security Administration (SSA), and a CRS staff member provides an annual in-service on the CRS program for each local SSA office.

CRS operates 7 service programs to serve CYSHCN and their families. Services provided in

each of these programs are paid for in full or in part by Title V funds. The 7 programs are:

- 1) Information and Referral--provision of information on resources available in the community, in the form of educational materials related to pediatric specialty health care, community resources, etc.
- 2) Specialty Clinical Services/Clinical Medical--clinics directed by physicians and staffed by multidisciplinary teams for provision of diagnosis, evaluation, treatment, and related services.
- 3) Specialty Clinical Services/Clinical Evaluation--physician-supervised clinics to provide functional evaluation and planning services by multidisciplinary teams.
- 4) Client/Family Education--provision of information to clients and their families that is necessary for carrying out prescribed treatment regimens and making informed choices about services that best meet their needs.
- 5) Care Coordination--arrangement of services to assist clients and families in identifying, accessing, and utilizing health and related resources to effectively meet their needs.
- 6) Parent Connection--provision of family-to-family support and information through State and LPCs, a parent-to-parent network, family resource centers, sibling support activities, and publication of the Parent Connection Newsletter.
- 7) Youth Connection--facilitates youth-to-youth connections, supports youth involvement in policy development and decision making, and promotes transition services for youth with special health care needs to all aspects of adult life. The Youth Connection Program consists of the Youth Advisory Committee (YAC), the State Youth Consultant, Teen Transition clinics, linkages to VRS, and a Youth News insert in the quarterly Parent Connection newsletter.

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

/2007/The following organizational changes have occurred in the CRS program:

CRS divided its Birmingham District, with 1 office located in a community setting and the other housed in the tertiary pediatric hospital. Generally, medical clinics occur in the hospital-based office and specialty evaluation clinics are held in the community-based site. This division provides increased access to care and allows for closer collaboration with pediatric sub-specialists. With this change, there are now 8 CRS service districts statewide.

Due to budget issues, CRS no longer employs a State Youth Coordinator. All duties for this position were assumed by other State Office staff. The State Youth Consultant continues to provide leadership to YAC. The Youth Connection program is now coordinated by the SPC. The State Hemophilia Coordinator is now responsible for transition activities.

State residents from birth to 21 years with special health care needs are eligible for the CRS program. Families at or below 200% of FPL and children who are insured through Medicaid, ALL Kids, or the Alabama Child Caring Foundation are eligible for full financial assistance.//2007//

/2008/The pediatric medical consultant retired in June 2006. The specialty medical consultant provides medical advice in all program and policy decisions. CRS continues to provide full financial assistance to children who are insured through Medicaid, ALL Kids, or the Alabama Child Caring Foundation. All State residents from birth to 21 with a special health care need are

eligible to participate in the program. Purchased services are provided according to a sliding fee scale. CRS has increased eligibility for full financial assistance to families at or below 250% of FPL.//2008//

/2009/CRS has increased eligibility for purchased services to families at or below 300% of the FPL. Other eligibility criteria continue as above. A Care Coordination Specialist has been added to the State Office to spearhead an enhanced care coordination program for enrolled CSHCN.//2009//

SOME STATUTES RELATED TO THE TITLE V PROGRAM

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

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

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

/2008/"Neonatal testing for certain diseases; rules and regulations for treatment thereof..." (Reference: Public Health Laws of Alabama, 1993 Edition, Section 22-20-3)--This legislation created the requirement and established the responsibility for the hospital, physician and/or guardian, who may be attending a newborn infant of 28 days old or less, unless declined by parents, to administer a reliable set of newborn screening tests as designated by the State Board of Health. The law also requires that infants who have positive test results be provided care and treatment, in accordance with established State Board of Health rules and regulations, for a reasonable fee.//2008//

/2009/Through the efforts of the Alabama Newborn Screening Division, the Alabama State Board of Health Administrative Code, Chapter 420-10-1 has been amended to include hearing loss and cystic fibrosis. This amendment adds the disorders to Alabama's mandated list of Newborn Screening Program tests. Now screenings for all of the 29 disorders recommended by the American College of Medical Genetics are mandated by Alabama rule or law.//2009//

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

disbursed through the Children First legislation described later in this section.

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

5) School Nurse Law Act 98-672--This act, passed by the Alabama Legislature in 1998, mandated a school nurse for each school district in FY 1999, a school nurse for every 2,000 students by 2010, and a School Nurse Consultant at SDE.
/2008/In 1999, due to proration, the original law was amended to call for the phase-in of school nurses to be complete by the year 2018. In 2006, \$26.6 million were allocated in the SDE budget for school nurse funding. The allocation was distributed to school districts in relation to student enrollment. As of early FY 2007, during the 2007 legislative session, \$31.1 million are in the SDE budget for school nurse funding. The requested funding for school nurses is being debated, but it appears that the funds will be provided.//2008//

/2009/Proposed legislation has been introduced to fund 1 school nurse for every 500 students and allow for licensed practical nurses to be hired as school nurses under registered nurses' supervision. The bill has the support of SDE, the Alabama Education Association, the Alabama Association of School Nurses, and the Alabama Board of Nursing, and is expected to pass during the current legislative session.//2009//

6) SCHIP--See "Changes in the Health Care Environment," in Section III.A.

7) Children First--A major legislative event was the passage by the Alabama Legislature of the Children First Bill (in April 1999), which allocated some of the money the State would receive from the national settlement with the tobacco industry to various programs to improve the welfare of Alabama children. When tobacco settlement dollars come to Alabama they are deposited into the 21st Century Fund (\$95.8 million in FY 2001), where about 12% are used first for debt service on economic development bonds. Remaining tobacco dollars are then split between Children First (about 53%), Medicaid (about 35%), and Senior Services Trust Fund (1%). Money that comes to Children First is divided among 12 agencies for specific programs as instructed by law (Section 41-15B-2.2). Agencies collectively receiving the bulk (about 79%) of Children First funds are SDE (22%), DHR (20%), the Department of Youth Services (17%), the Administrative Office of Courts, for use in provision of juvenile probation services (10%), and ADPH (10%). ADPH uses its portion of Children First funds (about \$6.2 million in FY 2003) to help provide health insurance to uninsured children (reference #5, Appendix D).

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

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

/2009/Several bills to strengthen the current graduated licensure bill were introduced to include prohibition of the use of electronic devices for persons 17 years or younger while operating a motor vehicle, a requirement for the use of belt restraints for all occupants, and creation of a 3-stage graduated driver's license system.//2009//

10) Woman's Right to Know Act--The State Legislature passed the Woman's Right to Know Act in 2002, and the law went into effect in October 2002. Its purpose is "to ensure that every woman considering an abortion receives complete information on the procedure, risks and her alternatives." The act requires that ADPH create a printed informational booklet as well as an informational video tape. Accordingly, ADPH's Bureau of Health Provider Standards drafted a pamphlet for distribution to abortion centers. A group of health care facilities and physicians who provide abortion services in the State challenged the constitutionality of the act and sought "a preliminary injunction or a temporary restraining order against its enforcement." The preliminary injunction or temporary restraining order requested in the aforesaid challenge was not granted, and the Woman's Right to Know Act remains in effect.

11) State's Office of Women's Health--This office was created with passage of State legislation in 2002 to educate the public regarding women's health; to assist the State Health Officer with identification and prioritization of women's health issues and concerns relating to the reproductive, menopausal, and postmenopausal phases of a woman's life; to assist the State Health Officer in coordination of services to address these issues and concerns; to serve as a clearinghouse and resource for information on women's health data, strategies, services, and programs; and to collect, classify, and analyze relevant research information and data concerning women's health. This office is located in ADPH's Office of Professional and Support Services. /2007/As of April 2006, the Office of Professional and Support Services has been renamed the Bureau of Professional and Support Services.//2007//

C. Organizational Structure

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

ADPH'S ORGANIZATIONAL STRUCTURE

FHS has reorganized several times to accommodate staffing changes and enable the Bureau to efficiently respond to public health challenges and opportunities. Four divisions have comprised the main units of FHS: Administration, WIC, Professional Support, and Women's and Children's Health. FHS is administered by the Bureau Director and, under his oversight, the Bureau Deputy Director, with input from the BMT. The BMT consists of the Bureau Director, Bureau Deputy Director, each Division Director, and each Assistant Division Director.

A description of each division, as organized from April 2005 through May 2005, follows. The Administration Division consists of the Financial Management, Contract Management, and Personnel Management Branches. The WIC Division consists of the Vendor Management, Data Management, and Nutrition Services Branches. The Professional Support Division consists of the

Consultant Branch, which includes the Social Work Program and the Nursing Program; the Epi/Data Branch; and the OHB. The Women's and Children's Health Division consists of the Women's Health Branch and the Children's Health Branch. The Women's Health Branch includes the Family Planning Program, through which ADPH activities concerning Medicaid's PLAN First Program are administered, the SPP/Maternity Program, the Smoking Cessation Program, and the Breast and Cervical Cancer Program. The Children's Health Branch includes the Newborn Screening Program, Newborn Hearing Screening Program, Lead Program, Healthy Childcare Alabama Project, Child Death Review, Abstinence Program, and Adolescent and School Health Program. Ten percent of the Director of the Healthy Childcare Alabama Project's time is allocated to Adolescent and School Health. FHS's Administration Division performs the major financial functions for all 4 of the Bureau divisions, and WIC pays for 2.18 FTEs in the Administration Division.

A major addition to FHS occurred in March 2005. At this time the Alabama Breast and Cervical Cancer Screening Program (BCCP), previously located in the Bureau of Health Promotion and Chronic Disease (HPCD), was administratively relocated to FHS, where it is in the Women's Health Branch. The relocation of this program brought 4 additional Central-Office positions to FHS, 11 PHA Screening Coordinator positions (1 for each PHA), and 2 out-stationed staff positions.

/2007/BCCP is now in the 4th year of a 5-year grant and was recently approved to continue through the 5th year. This program provides breast and cervical cancer screenings for women 40 through 64 years of age who are of low economic means, and staff expect that over 9,000 women will be screened in the program's current FY (which runs from July through June). The program has 7 Central-Office employees and 9 out-stationed screening coordinators.//2007//

/2008/BCCP is completing the 5th year of a 5-year grant and anticipates screening 12,000 women in FY 2007. The Centers for Disease Control and Prevention (CDC) has announced a new 5-year competitive grant for which BCCP has applied. Upon receiving the grant, in the next 5-year period BCCP will focus on 17 counties in Alabama's Black Belt to identify populations of women who have been rarely or never screened, and who are mainly over the age of 50 years. As part of the 5-year strategy, BCCP will partner with the Deep South Network and Reach 2010 to enhance the local community coalitions and utilize trained volunteers to recruit women to BCCP. BCCP will target primary providers and mammogram facilities to enhance the provider network to provide more timely access to services. Grants, to the BCCP, from the Susan G. Komen for the Cure North Central Alabama Affiliate (Alabama Komen Affiliate) and the Joy of Life Foundation will be continued. These organizations provide funding for screening mammograms in select Alabama counties. For the first time, the Alabama Komen Affiliate is also funding selected breast diagnostic procedures. In the upcoming anticipated 5-year grant period, BCCP hopes to attain and sustain an annual screening rate of 15,000 women.//2008//

/2009/BCCP is completing the 1st year of the new 5-year grant and anticipates screening 8,500 women in FY 2008. Due to federal funding cuts, the anticipated focused effort in 17 Black Belt counties was not implemented. The program continues to receive grants from the Komen for the Cure Foundation and the Joy to Life Foundation. This year the program has also received funding from the National Breast Cancer Foundation.//2009//

One temporary variation in the aforesaid organizational structure is that FHS's Deputy Director is Acting Director of the Personnel Management Branch, though that branch is located in the Administration Division. Oversight of personnel transactions will be returned to the Director of the Administration Division when feasible.

/2007/In October 2005 FHS again reorganized. The key change brought about by this reorganization was the splitting of the Women's and Children's Health Division into 2 divisions: Women's Health and Children's Health. With this reorganization the Children's Health Division had 5 branches: Newborn Screening, Lead, Healthy Childcare Alabama, Child Death Review, and School/Adolescent Health. The Women's Health Division had 4 branches: Family Planning,

Perinatal, Breast and Cervical Cancer, and Social Work, which included the Abstinence Program. The former Professional Support Division was dissolved and replaced with a Consultants adjunct to FHS's Deputy Director. The Consultants adjunct included the Epi/Data, Medical, and Oral Health Units. The structure of the remaining 2 divisions, Administration and WIC, has not changed. With this organizational restructuring, the composition of the BMT included FHS's Director, FHS's Deputy Director, the director and assistant director of each of FHS's 4 divisions, and the Medical Director for Women's Health. In March 2006 the BMT expanded to include the OHU Director, the Epi/Data Unit Director, and the Administrative Support Assistant (ASA) to the Bureau Deputy Director. In April 2006 the Foster/Adoptive Parenting Child Health Training Branch was added to the Children's Health Division. Also in April 2006, the name of the Epi/Data Unit was changed to the MCH Epi Unit, in order to better distinguish it from the Division of Epidemiology (located in ADPH's Bureau of Disease Control) and from WIC's Data Management Branch, as well as to indicate the unit's focus on MCH indicators. The responsibilities of the MCH Epi Unit remain as before: surveillance of MCH indicators, including but not limited to most measures included in the MCH reports/applications; overall coordination and editing of the MCH reports/applications; 5-year and ongoing MCH needs assessments; and the State Systems Development Initiative (SSDI.)//2007//

/2008/At ADPH's request, in October 2006 a review of ADPH's newborn screening laboratory was performed by invited experts, and a report of this review was provided by the National Newborn Screening and Genetics Resource Center, located in Austin, Texas. The State Health Officer, in consultation with other ADPH staff, determined that consolidation of key staff involved in newborn screening into 1 division, under the supervision of 1 director, would enable the Department to better address issues raised in the report. He then advised that the Division of Newborn Screening be created and administratively located in FHS. This Division, created in January 2007, includes staff comprising FHS's former Newborn Screening Program, which had been located in the Children's Health Division, certain staff from the Bureau of Clinical Laboratories (BCL), and a director and an ASA who transferred from other FHS positions.

Therefore, FHS now has 5 divisions (1 more than previously)--all depicted in FHS's organizational chart, located in Appendix E. Key changes in the Bureau's current chart, compared to that for April 2006, are:

1) Addition of the Newborn Screening Division, which has 2 branches--the Follow-up Branch and the Laboratory Branch. The Follow-up Branch consists of staff who had comprised the former Newborn Screening Branch. The Follow-up Branch has 5 positions, 1 more than the former Newborn Screening Branch had in April 2006. The Laboratory Branch includes a data-entry unit (the first 7 positions listed in the "Laboratory" box) and 2 technical laboratory units. The Laboratory Branch has 21 positions--all of which were formerly located in BCL. Formation of the Newborn Screening Division, therefore, has notably increased the number of FHS staff.

2) Omission of the Children's Health Division's former Newborn Screening Branch, because staff in this branch have moved to the aforesaid Follow-up Branch.

3) Addition of the Preventive Health Education Branch to the Children's Health Division. This branch has 2 positions, 1 filled by the Director of the Children's Health Division and the other by that division's ASA II. Creation of this branch did not add staff.

Another organizational issue addressed in FY 2007 concerned nursing practice and quality assurance. To facilitate prompt communication between ADPH nurse practitioners and their collaborative physicians, a HIPAA-compliant electronic medical consultation network was implemented in April 2007. This network operates via the ADPH intranet system (Lotus Notes), but can also be accessed via the Internet. The network allows nurse practitioners (currently 43 in number) from 65 counties to consult with the Bureau's Director and its Medical Director for Women's Health, both of whom are physicians. (Two CHD systems, Mobile and Jefferson, do not participate in the network.) The nurse practitioner enters the patient information and submits it in a pending status. The physician on call for the day receives an e-mail notice of a pending consult,

accesses the system through an icon on the Lotus Notes workspace, and responds with recommendations. Upon completion of the consult, the nurse practitioner accesses a printable view of the consult and copies and prints it for the patient's medical record. This network will also be used for quality assurance purposes by the Alabama Board of Nursing to ensure compliance with Alabama statutes pertaining to nursing practice. As well, the network will facilitate auditing of medical charts by ADPH Central-Office auditors.//2008//

/2009/In May 2008 the Bureau added a sixth Division, the Breast and Cervical Cancer Division. As shown in the updated organizational chart for the Bureau, this division has 3 branches: Medical, Data Management, and Screening Coordinators. The new division includes 18 positions, 1 of which (Assistant Director) is vacant. Staff from the BCCP, located in the Women's Health Division, comprise the new division.

The Children's Health Division discontinued its Foster/Adoptive Parent Child Health Training Network Branch when the branch's director left the bureau.//2009//

ADRS'S ORGANIZATIONAL STRUCTURE

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

Cary F. Boswell, EdD, has been the ADRS Assistant Commissioner for CRS since January 1, 2002. Supervision of the 7 CRS district supervisors is directly under the CRS Assistant Commissioner. Dawn Ellis is the CRS Assistant Director, responsible for overseeing the day-to-day operations in field services, supervising the State Pediatric Traumatic Brain Injury (TBI) Coordinator, and supervising the program specialists for social work, nursing, policy, and MCH occupational therapy. David Savage is the State Supervisor for Professional Services, responsible for all other program specialists, training, and public awareness. Other administrative staff include the SPC, the State Youth Coordinator, the CRS State Youth Consultant, the Hemophilia Coordinator, a Patient Accounts Manager, and program specialists for each discipline. Positions for the Nutrition and Physical Therapy Program Specialists remain vacant.

/2007/CRS Assistant Commissioner Cary Boswell retired on May 1, 2006. Dawn Ellis, former CRS Assistant Director, was named as the new ADRS Assistant Commissioner. She is responsible for serving as the CSHCN Director and for supervising all 8 CRS district supervisors and several State Office staff members. An Assistant Director is yet to be named. Mrs. Ellis was also elected as the Association of Maternal and Child Health Program's (AMCHP's) Region 4 Director. Due to fiscal constraints, the State Youth Coordinator position was eliminated and all duties previously assigned to that position were assumed by the SPC and State Hemophilia Coordinator. Positions for the State TBI Coordinator and program specialists for nutrition, physical therapy, and social work remain vacant.//2007//

/2008/Several organizational changes have occurred. ADRS Assistant Commissioner Dawn Ellis left the agency in September 2006. Melinda Davis, former CRS District Supervisor, was named the new Assistant Commissioner for CRS in November 2006. She is the CSHCN Director and supervises all 8 CRS district supervisors and several State Office staff members. The Assistant Director position was eliminated, and duties were reassigned with Wanda Williams being named the Clinical/Policy Specialist and Julie Preskitt becoming the Special Programs Coordinator. Serving as TBI Coordinator is now part of Ms. Preskitt's duties. The Patient Accounts Manager is no longer a part of CRS. Her duties have been assumed by a member of the ADRS Third Party Unit. Following resignations, the Speech Language Pathologist Program Specialist was replaced

internally by a therapist from a CRS district office and the HIPAA Privacy Officer duties were reassigned. Positions for the State Youth Consultant and for program specialists for nutrition, physical therapy, and social work remain vacant.//2008//

/2009/CRS has refilled the Patient Account Manager position with a former Third Party Unit employee. A position for a Care Coordination Specialist has been added. This is a dedicated position to enhance care coordination activities within CRS, and the person filling it is also responsible for the social work program. The position was filled by a former district office worker. Physical therapy and nutrition program duties have been reassigned. The State Youth Consultant position remains vacant.//2009// An attachment is included in this section.

D. Other MCH Capacity

ADPH'S OTHER CAPACITY

/2008/Cost-center data provided by ADPH's Bureau of Financial Services were used to estimate the number of ADPH FTEs devoted to serving Title V populations. FTEs reported here are NOT limited to those paid for by Title V, because funds from other sources as well help pay for services to Title V populations.

Excluding WIC cost centers, 249.84 ADPH FTEs served Title V populations in FY 2006 (down from 270.9 in FY 2004, but up from 239.9 in FY 2005). Of these 249.84 FTEs, 80.5% were at the county level, 2.2% at the PHA level, and 17.6% at the State level. Positions that each accounted for more than 5.0% of the 249.8 FTEs were: social workers (53.9%, about the same as in FY 2005 and up from 49.4% in FY 2004); nurses, nurse practitioners, or midwives (25.9%, about the same as in FY 2005 and down from 31.4% in FY 2004); and ASAs (9.4%). The predominance of social worker FTEs is consistent with ADPH's emphasis on care coordination.

The number of non-WIC FTEs increased in FY 2006 relative to FY 2005, by 9.9 FTEs. Nearly all the increase was at the State level. Regarding type of position, the most notable increase in FY 2006 versus FY 2005 was for social workers, which increased by 5.2 FTEs.

Though not included in the preceding numbers, WIC FTEs serve Title V populations. In FY 2006, 247.5 FTEs were devoted to WIC (up from 240.3 FTEs in FY 2005 and about the same as in FY 2004).//2008//

/2009/Excluding WIC cost centers, 251.85 FTEs served Title V populations in FY 2007 (2 FTEs more than in FY 2006). These FTEs were geographically distributed as follows: 80.6% at the county level, 2.4% at the PHA level, and 16.9% at the State level. Again the positions accounting for 5.0% or more of the total non-WIC FTEs serving Title V populations were social workers (58.8%); nurses, nurse practitioners, or midwives (24.3%); and ASAs (7.8%). In FY 2007, 253.6 FTEs were devoted to WIC.

The preceding FTE counts do not include certain cost-center categories that serve Title V populations. For example, the breast and cervical cancer category totaled 15.8 FTEs in FY 2007. Services included in this category are provided to women of childbearing age, as well as to older women. A new cost-center category pertains to early detection of hearing loss. Only 1.9 FTEs were coded to this category in FY 2007, but this number is expected to increase in the future, when it will probably be added to the previously mentioned "non-WIC FTEs."//2009//

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

Thomas M. Miller, MD, MPH, FACOG, FHS's Director, has been with ADPH since 1987. His roles as clinician, consultant, and Assistant State Health Officer for PHA V particularly qualified him to serve as Director of FHS--a role he assumed in 1993. Other experience includes work as an

obstetrics/gynecology clinician in the private sector (before joining ADPH) and occasional labor and delivery coverage for the Montgomery County Maternity Waiver Program and for a private practitioner. He is a member of the Medical Association of the State of Alabama, a fellow of the American College of Obstetricians and Gynecologists (ACOG), and a member of the Alabama Section of ACOG, where he has been a Board member since 1992. Academic credentials include studies in medicine and public health.

/2007/Since circa October 2005, Dr. Miller has served as Assistant State Health Officer for Personal and Community Health. In this capacity he oversees HPCD, as well as FHS.//2007//

Chris R. Haag, MPH, the Deputy Director of FHS and the Title V Director, worked in the Madison CHD in Alabama for 2 years, where his duties included direction of health education activities and outreach services. He joined FHS in 1989 to direct an adolescent pregnancy prevention project. After the completion of that project, Mr. Haag held various positions with FHS, including Director of the Administration Division and, later, of the Professional Support Division. Academic credentials include studies in education and public health. Mr. Haag had been Deputy Director of FHS for several years before assuming the position of Title V Director in March 2005. This position had previously been held by Dr. Miller, who asked Mr. Haag to assume the position so that Dr. Miller could devote more time to being the Collaborative Physician for CHD nurse practitioners.

/2007/In May 2005 Grace Thomas, MD, FACOG, joined FHS as Medical Director for Women's Health. In this capacity she serves as collaborative physician for about 38 CHD nurse practitioners. Before joining FHS, Dr. Thomas worked as a private practitioner for over 10 years in New York City. There she served on the faculty of St. Luke's-Roosevelt Hospital Center, where she was preceptor for Residency Education and Co-Director of the Colposcopy Clinics. She is a member of the American Society for Colposcopy and Cervical Pathology, Fellow of ACOG, and a member of the Alabama Section of ACOG, for which she is a board member. Other board of directors affiliations include the Gift of Life Foundation (located in central Alabama) and the Alabama Campaign to Prevent Teen Pregnancy.//2007//

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

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

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

Stuart A. Lockwood, DMD, MPH, Director of OHU, joined the Bureau in 2001. Dr. Lockwood practiced dentistry in Alabama for 4 years before earning an MPH with a double major in dental public health and oral epidemiology. Prior to joining the Bureau, he worked for 12 years with CDC in the Division of Oral Health. A diplomate of the American Board of Dental Public Health, Dr. Lockwood was also the director of the Dental Public Health residency program at CDC.

Dan Milstead, BS, MBA, assumed acting directorship of the Administration Division in April 2005.

Mr. Milstead joined ADPH in January 1989 as Director of the WIC Division's Financial Management Branch. In this position he was responsible for all of WIC's accounting and reporting requirements with the U.S. Department of Agriculture's (USDA's) Food and Nutrition Services. In 1998 Mr. Milstead transferred to the Bureau of Financial Services to be the Director of Third Party Collections; in this capacity he managed the Department's billing operations and distribution of funds. In July 2000 he returned to FHS as Director of the WIC Financial Management Branch. In 2003 his position with the WIC Division was incorporated into the Administration Division, where he was responsible for the WIC and Family Planning Programs.

/2007/In February 2006 Mr. Milstead became Director of the Administration Division.//2007//

/2008/Bob Hinds, Director of the Newborn Screening Division, is a retired U.S. Air Force (USAF) Colonel, fighter pilot and Wing Commander, who held numerous command and management positions during his 30-year USAF career. A decorated combat veteran, Col. Hinds served in many locations and campaigns around the world to include Vietnam and "Desert Storm." Col. Hinds joined ACDRS as a volunteer in May 1999 and within a few weeks was hired as the Assistant Director of ACDRS. He became the ACDRS Director in September 2002. In January 2007 he assumed his new duties as Director of the Newborn Screening Division.//2008//

/2009/The position of Director of SPP, which became vacant in March 2007, was filled in July 2007 by Janice M. Smiley, MSN, RN, who has been with ADPH since 1996. Ms. Smiley's background includes 25 years of experience in maternal child nursing and worksite wellness. Academic credentials include an undergraduate degree in nursing and a graduate degree in nursing administration. Ms. Smiley plays a key role in developing strategies to improve public awareness regarding the causes and prevention of infant deaths and revitalize the State's regionalized system of perinatal care.

Carolyn J. Battle, MS, RD, was appointed State WIC Director in December 2007. Ms. Battle has been with ADPH for 18 years and joined FHS in 2000 as Director of Nutrition Services for the Alabama WIC Program. Her prior experience includes work at the local level as a county WIC nutritionist and at the area level as Area 5 Nutrition Director. She has previous experience as a clinical dietitian for a hospital and for a facility that provided long-term care to mentally retarded persons. Ms. Battle's credentials include an advanced degree in nutrition, registration as a dietitian by the Commission on Dietetic Registration of the American Dietetic Association, and licensing as a dietitian by the Alabama Board of Examiners for Dietetic/Nutrition Practice.//2009//

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

CRS'S OTHER CAPACITY

/2009/As of April 2007 there are 219.95 FTEs in the field: 8 district supervisors, 70.3 ASAs, 50 social workers, 31 nurses, 19 rehab assistants, 8.4 parent consultants, 8 nutritionists, 7 audiologists, 6 speech/language pathologists (SLPs), 5.75 physical therapists (PTs), 3 occupational therapists (OTs), 2 medical care benefits specialists, and 1.5 rehab counselors. There are 8.5 budgeted vacancies: 2 social workers, 2 PTs, 1.5 audiologists, 1 nurse, 1 ASA, 0.5 parent consultant, and 0.5 rehab counselor.

The State Office has 11 administrative and 5.3 clerical FTEs, respectively. Administrative staff include 2 nurses, 2 SLPs, 2 audiologists, 1 rehabilitation counselor, 1 parent consultant, 1 social worker, 1 patient account manager, and 1 OT. There is a vacancy for a .5 FTE youth consultant.//2009//

Key senior administrative staff of CRS include the Assistant Commissioner, the Assistant

Director, and the State Supervisor for Professional Services. The MCH/OT Program Specialist is responsible for planning, evaluation, and data analysis. Biographical information on staff in these positions follows.

Cary F. Boswell, EdD is the Assistant Commissioner of ADRS/Director of CRS. His background includes experience in special education, supported employment, and transition initiatives. Academic credentials include an undergraduate degree in business administration and a graduate degree in special education-mental retardation/program administration.

Dawn E. Ellis, RN, MPH is the CRS Assistant Director. Her background experience is in pediatric nursing and administration, including neonatal intensive care, early intervention, and grants management. She also served as a CRS district supervisor. She is a member of the American Public Health Association and the National Rehabilitation Association. Academic credentials include an undergraduate degree in nursing and a graduate degree in public health-MCH.

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

Julie Preskitt, MS, OT, MPH is the MCH/OT Program Specialist. Her experience includes high-risk follow up and provision of occupational therapy services to CYSHCN in pediatric hospital and early intervention settings. She is a member of the American Occupational Therapy Association. Academic credentials include undergraduate degrees in biology and occupational therapy and graduate degrees in occupational therapy and public health-MCH.

During FY 2004, there were 3 changes in the CRS State administrative staff. Following resignations, the Audiology Program Specialist was replaced internally by an audiologist from a CRS district office, the SLP Program Specialist was replaced externally by a former school system therapist, and the PT Program Specialist position remains vacant.

Through a partnership with United Cerebral Palsy (UCP) of Mobile, CRS employs 12 parents of CYSHCN as LPCs. UCP employs and supervises the LPCs, provides insurance and benefits, and supports State and Local Advisory Committee activities. The SPC, based in CRS's State Office, advises in collaborative inter-agency efforts, recruits additional parent participation, facilitates the State Parent Advisory Committee, coordinates the parent-to-parent network, and publishes the Parent Connection.

//2007//The following administrative changes have occurred for CRS: Following Dr. Cary Boswell's retirement, Dawn Ellis was named the new ADRS Assistant Commissioner and Director for CRS. The State Youth Coordinator was transferred to a local district office to resume care coordination duties. Her previous duties related to youth activities and transition were assumed by other State Office staff members.//2007//

//2008/ ADRS Assistant Commissioner Dawn Ellis left the agency in September 2006. Melinda Davis assumed this role in November. Key senior administration of CRS was reorganized in March 2007 to include the Assistant Commissioner, the State Supervisor for Professional Services, the Clinical/Policy Specialist, and the Special Programs Coordinator (formerly MCH/OT Program Specialist, who retains responsibility for planning, evaluation, and data analysis). Biographical information on the new staff follows.

Melinda Davis, MS, CCC-A is the Assistant Commissioner for ADRS and the Director of CRS. Her background includes pediatric audiology, speech-language pathology, administration, and service provision to CYSHCN in clinical and school system settings. She served as a District

Supervisor in a local CRS office for 9 years and briefly as the CRS Assistant Director before assuming her current position. She is a member of the American Speech-Language and Hearing Association and the Speech and Hearing Association of Alabama. Her academic credentials include an undergraduate degree in communication disorders and a graduate degree in audiology.

Wanda Williams, RN, M.Ed is the Clinical/Policy Specialist. Her extensive experience in pediatric nursing includes public health, early intervention, administration, and service provision to CYSHCN. She is a certified rehabilitation counselor and her academic credentials include undergraduate and graduate degrees in nursing and rehabilitation counseling.//2008//

//2009//CRS key administrative staff remained the same during FY 2007. A Care Coordination Specialist was added and the Patient Account Manager position was refilled.//2009//

E. State Agency Coordination

Coordination of the Title V Program with programs or entities specifically mentioned in the Guidance (reference #6 in Appendix D) for this section occurs in the context of FHS and CRS seeking to accomplish their respective missions and identify priority MCH needs, rather than under a particular plan to coordinate with specific programs. Since FHS administers the Title X Family Planning Grant and WIC, coordination with these 2 entities is built into FHS's organizational structure and internal collaborative mechanisms. Similarly, CRS and VRS are major divisions of ADRS, facilitating collaboration between the Title V Program and VRS. Concerning identification of Medicaid-eligible infants and pregnant women--via SCHIP, discussed in Section III.A and under NPM #13, ADPH and Medicaid collaborate to identify Medicaid-eligible infants and pregnant women and help with their applications for Medicaid coverage. Concerning SSA, as discussed in Section III.B, SSI beneficiaries less than 16 years old are eligible for CRS services; some ways that CRS coordinates with SSA are also discussed in Section III.B. CRS's collaboration with SSA via the DDUs and CRS's involvement with families are discussed later in this section.

FHS and CRS have collaborated via inter-agency meetings held 3 times a year and partnership on such tasks as preparing the MCH reports/applications and conducting 5-year MCH needs assessments. Description of some of each organization's collaborations follows.

ADPH COORDINATIONS AND COLLABORATIONS

Description of certain collaborations (some of which are discussed elsewhere in this document) involving external groups follows. Unless otherwise stated, the collaborations began prior to FY 2004 and are expected to continue in some form through FY 2007 or later.

FHS's Collaborations with External Entities

Women's Health Branch staff collaborate with many statewide and community groups and governmental and private organizations to address various issues, such as with: the Alabama Chapter of the March of Dimes (AMOD) on the March of Dimes' campaign to reduce the prevalence of prematurity; Medicaid on an 1115(a) Family Planning Waiver (see Section III.A), SPAC to promote a strong regionalized system of perinatal care (see NPM #17), and regional Fetal and Infant Mortality Review (FIMR) teams to review infant deaths (see SPM #7). (NPMs and SPMs are respectively discussed in Sections IV.C. and IV.D.)

The aforesaid collaboration with AMOD to reduce the prevalence of prematurity began in October 2002, when SPP partnered with AMOD to begin the March of Dimes campaign in Alabama. The planning phase of the partnership continued through December 2002. In January 2003 press conferences were held in the State's 5 perinatal regions to announce the campaign on prematurity. RPAC members and AMOD volunteers presented the 2 campaign goals: to 1)

increase public awareness of the problems of prematurity to at least 60%, and 2) decrease the rate of preterm birth in the U.S. by at least 15%. Target audiences for the campaign were the general public, pregnant women, and health care providers.

/2008/The partnership with AMOD to reduce the prevalence of prematurity continues and is discussed in Section IV.E, as part of the discussion on HSI #1A.//2008//

Children's Health Division (formerly Child Health Branch) staff collaborate with several entities, such as with: local child death review teams to implement ACDRS (see SPM #7), delivery hospitals to assure that newborns receive appropriate biochemical and hearing screening (see NPMs #1 and #12), SCHIP and Medicaid to promote enrollment of eligible infants and children in ALL Kids and Medicaid (see NPM #13), and, as a member of the State Suicide Prevention Task Force, with various organizations to prevent suicide. Several members of the division are members of the Alabama Partnership for Children's Parenting Kit Committee and the Covering Kids and Families State Coalition. The Parenting Kit Committee recently revised and updated the Parenting Video, which is part of a kit given to mothers of newborns. The kit offers immediate access to information and resources on infant growth and development and on care of infants. /2007/In FY 2005 ACDRS teamed with the Gift of Life Foundation, a public and private sector partnership in central Alabama, to fund a "Cribs for Kids" pilot program. The program provides safe, separate infant sleeping surfaces to families who would otherwise have none, in order to prevent sleep-related deaths.//2007//

/2008/Newborn screening is now the responsibility of the newly formed Newborn Screening Division.//2008//

/2009/ The Newborn Screening Division has formed the Alabama Newborn Screening Advisory Committee, which has a diverse collection of members who are interested in improving the health of Alabama's infants. The committee meets quarterly to give the Newborn Screening Program recommendations and advice on the conduct of the program.//2009//

/2007/In 1999 WIC joined the Alabama Farmer's Market Authority and the Alabama Cooperative Extension Systems in a pilot project to provide fresh, unprepared, locally grown fruits and vegetables to WIC participants in 3 clinics in Montgomery County. This pilot, the WIC Farmer's Market Nutrition Program, expanded to include 16 counties in FY 2005. The program allows participants to shop at local farmers' markets, learn how to prepare fresh fruits and vegetables, and consume nutrient-rich fruits and vegetables. The program not only reinforces the nutrition counseling provided by the WIC Program, but assists small farmers to market their produce to a population including many individuals who do not typically go to farmers' markets.//2007//

/2008/In FY 2006, 22 Alabama counties participated in the WIC Farmer's Market Nutrition Program. Despite decreased federal funding, the program will expand to 24 counties in FY 2007.//2008//

/2009/In FY 2007, 24 Alabama counties participated in the WIC Farmer's Market Nutrition Program. The program will expand to 25 counties in FY 2008.//2009//

In FY 2004 the Alabama Integrated Nutrition Education Partnership, which included WIC nutritionists, combined with the Alabama Obesity Task Force (AOTF) to work on a statewide plan to reduce the risks of obesity and related health problems. Various subcommittees will work to implement strategies to educate Alabamians on obesity issues.

/2007/Members of the State WIC staff serve on 2 of the AOTF subcommittees involved in implementing the task force's State plan and co-chair 1 of these subcommittees. Another task force subcommittee developed an FY 2006 State Nutrition Action Plan (SNAP). This subcommittee included 3 ADPH nutritionists (1 from WIC) and persons from SDE's Child Nutrition Program, the State Food Stamps Program, and the Alabama Cooperative Extension System. SNAP supports the AOTF State Plan and emphasizes healthful eating and physical activity for all Alabamians, with an emphasis on USDA Food and Nutrition Service populations.//2007//

/2008/Members of AOTF and the Alabama Cooperative Extension System updated SNAP for FY 2007 and implemented the updated program in October 2006. The FY 2006 SNAP was evaluated

in November 2006. Some revisions were made in the evaluation process and to the FY 2007 SNAP in February 2007. One member of the State WIC staff continues to serve on 1 of the AOTF subcommittees.//2008//

/2009/The WIC staff member who chaired the above subcommittee remains on the subcommittee, but no longer chairs it. Members of the SNAP subcommittee of AOTF continued implementing the FY 2007 Alabama SNAP plan in FY 2008.//2009//

FHS convened the MCH Needs Assessment Advisory Group (MCH Advisory Group) in January 2005 as part of the FY 2004-05 MCH needs assessment process. Via this advisory group, FHS collaborated with many persons from other agencies and organizations, with ADPH staff located outside of FHS, with out-stationed FHS staff, and with several health care consumers. (More information on the MCH Advisory Group is provided in Section 1 of the 2004-05 MCH Needs Assessment Report [reference #1]). Additionally, staff from FHS, CRS, Medicaid, UAB School of Public Health's MCH Department, UAB's Civitan Center, and the UAB Pediatric Pulmonary Center meet 3 times a year to keep abreast on activities of common concern and to plan for coordinated initiatives affecting children. Moreover, the respective Directors of the Children's Health Division and the MCH Epi Unit (formerly the Epi/Data Branch) serve on the UAB Pediatric Pulmonary Center's State Advisory Committee.

/2007/In early FY 2006 the Children's Health Division implemented the Foster/Adoptive Parent Child Health Training Network. This program is staffed by a nurse manager who will provide training and education to foster and adoptive parents and DHR staff who interface with these parents. Topics to be covered include children's health, child safety and development, and cardiopulmonary resuscitation and first aid.//2007//

/2009/Due to the network's director leaving the Bureau, the Foster/Adoptive Parent Child Health Training Network was discontinued as of August 2007.//2009//

/2008/In FY 2006 the Women's Health Division collaborated with USA and MHMR to pilot the Fetal Alcohol Prevention Project, in the context of ADPH's Family Planning Program (Family Planning), in 4 counties (Jefferson, Montgomery, Mobile, and Tuscaloosa). This project screens Family Planning clients for alcohol abuse, provides counseling, and refers clients who are alcohol abusers to MHMR for treatment services. A fetal alcohol prevention educational brochure was developed for clients. The division also collaborated with the UAB Department of Preventive Medicine on a project to educate--and refer when indicated--Latino individuals regarding family planning, STDs, and cancer prevention. The latter is a National Cancer Institute-funded project that will be piloted in Jefferson County in FY 2007 and 7 other Alabama counties in FY 2008.//2008//

/2009/FHS's School and Adolescent Health Program (SAH), also discussed in Section IV.A, engages in collaborations to promote the health of adolescents and school-age children. For example, the program distributes a statewide E-Newsletter every other month to about 350 school nurses and school health advocates. The SAH Director partners with the Alabama Association of School Boards, Alabama Chapter of the American Academy of Pediatrics (AAP), and the Alabama Campaign to Prevent Teen Pregnancy to increase awareness of issues concerning coordinated school health. She has made presentations across the State on coordinated school health, pandemic flu planning for schools, and autism spectrum disorder. In collaboration with others within and external to ADPH, the SAH Program is distributing a monthly handout on wellness to school nurses, for distribution to school employees.//2009//

FHS's Collaborations with Other ADPH Entities

Many collaborations occur within FHS and among FHS staff and other ADPH staff. For example, Family Planning staff collaborate with many ADPH units and programs at the State and local level to coordinate projects and provide input and technical assistance on family planning. For instance, they collaborate with the Bureau of Disease Control's STD Control Division and the BCL on the Title X Infertility Prevention Project, with the Department's Center for Health Statistics

(CHS) on the Title X Regional Network for Data Management and Utilization Project, and the Public Health Nursing Section on Title X training activities. FHS staff continue to provide administrative and programmatic support to CHDs and to participate in monthly meetings of ADPH Area Nursing Directors, Area Social Work Directors, and Area Administrators to share information and offer technical assistance. Additionally, WIC staff hold bimonthly meetings with the Nutrition Area Coordinators to provide updates on policies and procedures and provide information about technical assistance. Moreover, MCH Epi Unit staff collaborate with persons from FHS and other Department units when preparing the MCH reports/applications.

As well, FHS continues its commitment to ensuring that children and women of childbearing age receive adequate treatment for phenylketonuria (PKU). The WIC Program provides infant formulas and 19 medical foods, as prescribed by clients' physicians, for infants, children, and women diagnosed with PKU. Via its Newborn Screening Program, FHS provides these 19 foods for the treatment and management of PKU to children and to women of childbearing age who have PKU and cannot afford the food.

/2007/In FY 2004, due to ADPH's FY 2004 budget cuts discussed in Section III.B, FHS needed to prioritize activities and allocate resources accordingly. Thus, FHS requested and received DHR's permission to re-channel FY 2004 TANF dollars received by FHS, which otherwise would have supported the Alabama Unwed Pregnancy Prevention Program (AUPPP), toward the purchase of Depo-Provera. This reallocation of funds led to phasing out of AUPPP before the end of FY 2004. In FY 2006 FHS continues to receive DHR funds for the purchase of contraceptives. These funds are used mainly for long-term non-surgical contraceptives, such as Depo-Provera and the patch.//2007//

/2008/In FY 2006 the Women's Health Division, via negotiations with DHR, secured a contract for additional TANF funds in FY 2007 to purchase non-surgical contraceptives for Family Planning clients.//2008//

/2007/As of April 2006, WIC staff hold quarterly meetings with the Area Nutrition Directors (formerly called Nutrition Area Coordinators) to provide updates on policies and procedures and to provide technical assistance. The meetings were changed from bimonthly to quarterly in order to coincide with the PHA Directors' meetings, thus allowing the Area Nutrition Directors to attend these meetings.//2007//

As previously stated, the MCH Advisory Group convened in January 2005 included ADPH staff from outside FHS. These staff included several Central-Office staff members, several PHA staff members, and 1 person from a CHD. (Several invited CHD staff did not attend.) Additionally, in FY 2004 certain Area- and county-level staff, as well as out-stationed State-level staff, helped with the FY 2004-05 MCH needs assessment. For instance, Social Work Directors or their designees from each PHA provided a list of potential recipients for the MCH Organizations Survey conducted in early CY 2004. Further, 14 county-level, Area-level, or out-stationed State-level staff facilitated or helped facilitate 1 or more community discussion groups in early CY 2004.

In early FY 2005 the Director of FHS began devoting more time to his continuing role as Collaborative Physician for all CHD-employed nurse practitioners, all of whom work in the area of women's health. The role of Collaborative Physician includes ongoing review and revision of protocols used by the nurse practitioners, training of nurse practitioners, assurance that protocols are followed, provision of consultation for situations not covered by the protocols, and other activities assuring the provision of appropriate, high quality services by nurse practitioners. As part of this effort, the Professional Support Division's Consultant Branch planned and convened a training event for CHD nurse practitioners, held in January 2005. Attendance at this event was mandatory for all CHD-employed nurse practitioners. The Director of FHS was 1 of the presenters at this event. Per informal feedback, the training was viewed by attendees as being quite successful, pertinent, and useful.

/2007/As discussed in Section III.D, FHS now has a Medical Director for Women's Health who collaborates with CHD nurse practitioners. FHS's Director now oversees 2 bureaus, FHS and

HPCD.

FHS's Healthy Child Care Alabama Program, discussed under HSCI #7A in Section III.F, collaborated with HPCD's Injury Prevention Division to provide Fire Safety Training in October 2005, using "Frankie's Fire Safety Activity Book," created by the Injury Prevention Division. Further, Healthy Child Care Alabama and UAB School of Nursing sponsored "Safe Environments for Children," a statewide "train the trainer" workshop, in February 2006.//2007//
/2009/Healthy Child Care Alabama collaborated with ADPH's Center for Emergency Preparedness to provide infection-control training for child care providers and children in child care using the "Mimi Mouse" and "Pandemic Influenza" training materials./2009//

ADPH Collaborations Described Elsewhere

Other collaborations are discussed in appropriate places throughout this report. Further, many other internal and external partnerships and collaborations in which FHS is involved are discussed in Section 2 of the 2004-05 MCH Needs Assessment Report (reference #1). Only 3 of the collaborations discussed there are listed below:

1) In FY 2004, teaming of ACDRS staff with the Birmingham and Mobile Healthy Start Projects to fund hospital-based parent education programs on shaken baby syndrome.

2) Ongoing collaboration between FHS's Healthy Child Care Alabama Program and HPCD's Cancer Prevention Program, to teach the Sun Safety Program to children attending child care centers, the children's parents, and the providers of child care.

3) Ongoing partnership of FHS's WIC Division with the Health Department's Bureau of Communicable Disease's Immunization Division to provide "Golden Books" to mothers who bring their child's immunization record when coming for WIC certification or recertification. This is a way that the WIC Division participates in the national WIC Healthy Children Ready to Read Initiative, and may help the Immunization Division update their immunization registry.
/2007/ The WIC Division and the Immunization Division plan to complete the Golden Books Project in 2006. Remaining books will be distributed according to established criteria.//2007//
/2008/The final distribution of Golden Books occurred in early FY 2007. Clinics were allowed to distribute the books to WIC patients at their discretion for bringing in immunization records, keeping appointments, coming to classes, etc.

In FY 2006 and early FY 2007, the MCH Epi Unit convened periodic meetings to plan approaches to collecting, analyzing, and reporting on data pertaining to deaths from unintentional drug overdose. Several FHS staff and several other ADPH staff attended 1 or more of these meetings. In consultation with attendees at these meetings, the MCH Epi Unit prepared a report on deaths due to drug-related and alcohol-induced causes. This report is discussed in Section II.C., and its executive summary is attached to that section.

Discussion of disaster preparedness, which entails multiple collaborations, is attached to Section III.A.//2008//

CRS COORDINATIONS AND COLLABORATIONS

CRS has ongoing coordination with State and federal programs that strengthen the overall Title V program. The placement of CRS as a division within ADRS facilitates coordination of program planning and service delivery with other divisions, including EIS, SAIL, and VRS. EIS and VRS staff members are co-located with CRS staff in most locations around the State. Implementation of a transition plan for clients from CRS to VRS for vocational guidance is a priority focus for those clients for whom this is appropriate. CRS sponsors 16 Early Intervention programs statewide and continues active participation on the Governor's ICC and subcommittees and DCCs.

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

CRS serves as a member of the State Newborn Hearing Screening Advisory Committee. This group meets once a year to provide input to ADPH, the lead agency in Alabama for the Universal Newborn Hearing Screening Program. Member agencies meet throughout the year as the State Early Hearing Detection and Intervention Committee to address ongoing State needs.

CRS supports FVA and VOICES for Alabama's Children. CRS's SPC and the parent of a child enrolled in CRS together function as the FVA Co-coordinators and the Region IV Family Voices Co-coordinators. CRS also supports the Alabama Governor's Youth Leadership Forum, an annual leadership and career skills training opportunity for Alabama high school youth with disabilities.

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

CRS is committed to participation in many State-level collaborative planning efforts affecting CYSHCN. CRS serves on the State and local CPCs, as well as on the State Head Start Disability Advisory Committee, to provide guidance in accessing health, education, and welfare service systems. Other State-level systems development councils on which CRS participates include SPAC and the State Multi-Needs Child Task Force. Other key agencies involved with most of these councils include Medicaid, SDE, and MHMR. The CRS SPC, CRS LPCs, and CRS families participate on a variety of inter-agency committees and task forces, such as Healthy People 2010 work groups, the State Improvement Grant Taskforce on Recruitment, Preparation and Retention through SDE, the UAB Civitan International Research Center Consumer Advisory Committee, the Special Education Action Committee Advisory Group, the Olmstead Core Workgroup, the Newborn Screening Task Force, the Oral Health Coalition, the Arthritis Coalition, Individual and Family Support Councils, the Northeast Alabama Safe Kids Steering Committee, the Family to Family Health Information Council, the Alabama Respite Resource Network, a local UCP Board, and the Statewide Technology Access and Response (STAR) Advisory Committee.

As mentioned in the preceding discussion of State-level collaborations, CRS participates in the Oral Health Coalition. The purpose of CRS's involvement with this coalition is to highlight access-to-care issues for CYSHCN whose disability may be a barrier to receiving routine and specialized dental care. This organization consists of some 31 public and private agencies and groups, with its stated purpose "to ensure every child in Alabama enjoys optimal health by providing equal and timely access to quality, comprehensive oral health care, where prevention is emphasized, promoting the total well-being of the child." A CRS staff member participated in and served as a presenter for the FY 2004 Alabama Dental Summit. With the completion of the initial Robert Wood Johnson (RWJ) grant funding, the Oral Health Coalition continues project activities, develops materials about prevention and intervention for lawmakers, policy makers, and the general public, and disseminates dental awareness kits via alternative methods and funding

sources. Future planning includes convening a subcommittee, to include a pedodontist and an orthodontist, to promote improved dental outcomes for CYSHCN. CRS continues to integrate dental health initiatives for CYSHCN into the program.

CRS partners with Medicaid in various ways. Although EPSDT services are now the responsibility of the primary care provider for all children under Medicaid managed care arrangements, CRS coordinates services with the medical home to ensure access to specialty care and related services through Medicaid funding for all CYSHCN served by the program. CRS continues its inter-agency agreement with Medicaid to provide Children's Specialty Clinic Services throughout the State, which enhances access to services for Medicaid recipients. CRS serves as the reviewer of all requests for Medicaid funding for augmentative communication devices and power wheelchairs. CRS serves in an advisory role to Medicaid for program and policy decisions likely to affect CYSHCN and served as a voice for this population in the planning for the new waiver for PCCM, Patient 1st (discussed in Section III.A).

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

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

/2007/Due to budget constraints, CRS now sponsors only 13 EIS programs and no longer provides monetary support to camps. CRS staff provided input to Medicaid on the impact of the Deficit Reduction Act (DRA) on CYSHCN and the possibility of a buy-in program.//2007//

/2008/CRS continues to provide input to Medicaid on DRA implications for CYSHCN. Also, a data-sharing agreement has been re-established to match CRS enrollment data with Medicaid data to correctly identify those with coverage and also determine those with SSI coverage.

CRS staff members participate on ADPH's Special Populations Task Force, which addresses emergency preparedness for vulnerable populations and plans for medical needs shelters. CRS serves as the voice of CYSHCN and families on the State Newborn Screening Advisory Committee related to expanding newborn screening, developing surveillance methods, and establishing follow-up procedures.//2008//

/2009/CRS collaborations continue as above with the following changes: CRS staff participate in 2 Medicaid-led grants: Together for Quality and Alabama Assuring Better Child Health and Development (see Section IV.C, NPMs #3 and #5 for more information). ADRS received a grant through the National Organization on Disability and Bush Clinton Katrina Fund to provide emergency preparedness training for staff and partners who will provide this training to people with disabilities and their families. CRS no longer reviews power wheelchair requests, but continues to review augmentative communication device requests. CRS is partnering with schools, daycares, and Head Start centers in underserved areas to provide onsite screenings for hearing loss and scoliosis.//2009//

F. Health Systems Capacity Indicators

Introduction

Discussion of HSCIs follows. In most cases, discussion of trends is based on numbers available by mid-April 2007. By that time, numbers of individuals served are sometimes--but not always--available for the reporting year, FY 2006. Therefore, discussion of trends in numbers served may or may not extend through FY 2006. Further, preliminary numbers for vital events (births and deaths) occurring in 2006 will not become available before late June 2007. Thus, any discussion of trends in vital events will not cover 2006 events. For numbers served and for vital events, Form 17 may include numbers that were not available by April 2007, but were added to the form prior to submission of this MCH 2006 Report/2008 Application.

In some cases, previous MCH reports/applications or the Alabama 2004-05 MCH Needs Assessment Report (reference #1) are referenced. These documents can be requested by e-mailing acowden@adph.state.al.us.

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

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	90.6	93.2	83.7	79.4	93.3
Numerator	2736	2833	2562	2437	2865
Denominator	302071	304098	306124	307001	307001
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007

For reasons discussed in this indicator's year 2006 field note, the numerator is obtained by summing numbers provided by Blue Cross and Blue Shield of Alabama (BCBS) and by the Alabama Medicaid Agency (Medicaid). The numerator therefore represents the number of hospital discharges of 0-4 year-old children in calendar year 2007, where the child was enrolled in either BCBS or Medicaid.

For reasons discussed in the year 2005 field note, denominators for this indicator are projected populations for 0-4 year-old Alabama residents, as reported by the Center for Business and Economic Research (CBER), the University of Alabama. However, because CBER has not provided a year 2007 population projection for this age group, we are using the corresponding projection for year 2006 as the best estimate for the denominator. We considered using the year 2007 population projection for this age group that is available on the U.S. Census Bureau's Web site. However, the latter projection (299,605) is notably lower than the corresponding CBER projection for 2006 (307,001), and the methods for arriving at the CBER projection versus the Census Bureau's projection may not be comparable. (Using the denominator of 299,605 yields an estimated asthma hospitalization rate of 95.6 hospitalizations per 10,000 0-4 year-old children.)

Medicaid has continued consulting with providers of care for children with asthma about appropriate quality-of-care indicators for asthma, for incorporation into the electronic health information system referenced in the field note to year 2006.

Notes - 2006

Alabama still does not have a representative, centralized hospital discharge database. However, the Bureau of Family Health Services (FHS) believes that most Alabama children and youth obtain health insurance through BCBS or Medicaid. Further, according to Medicaid, BCBS insures about 80% of the State's insured non-Medicare population and has 68% of all Medicaid third-party liability policies; except for a small percentage, Medicaid insures the remaining Alabama population (reference: "Together for Quality," a proposal submitted by Medicaid to the U.S. Department of Health and Human Services in October 2006). Accordingly, numbers obtained from Medicaid and BCBS provide the numerators for our respective estimates of this indicator. Details regarding the numerators and denominators for these estimates are in the year 2005 field note for this indicator.

With funds granted to implement the previously referenced "Together for Quality" proposal, in fiscal year 2007 Medicaid initiated a project to create a statewide electronic health information system that links Medicaid, State health agencies, providers, and private payers. FHS is seeking to determine if the system could be designed to allow generation of a database for surveillance of key indicators of morbidity, including asthma, in Title V populations. Medicaid's initial response to this idea, as a long-term goal, has been positive. Further, Medicaid is consulting with experts in asthma for input on appropriate quality-of-care indicators for asthma, for incorporation into the electronic health information system.

Notes - 2005

Alabama still does not have a representative, centralized hospital discharge database. The lack of such a database is discussed in the narrative for Health Systems Capacity Indicator #9A.

Respective numerators for calendar years 2002-2006 estimates are the total numbers of discharges for inpatient hospitalizations due to asthma among 0-4 year-old enrollees in either BCBS or Medicaid. Denominators are the projected population of 0-4 year-old Alabama children for those respective years, reported by CBER.

The reason for using population-based denominators for 2002-06, rather than the total reported numbers of 0-4 year-old enrollees in BCBS and Medicaid, is that for 2002, 2003, and 2004 respectively, the total reported number of BCBS and Medicaid enrollees in this age group exceeded the projected population for this age group. The apparent over-estimate of total enrollees, along with failure to capture hospitalizations among children who are enrolled in other plans or have no insurance, would markedly underestimate the rate. Population projections provide a reasonably stable denominator, and most children in the State are presumably insured by BCBS or Medicaid. Taking the preceding issues into account, we consider the projected population to be the preferable denominator. Nevertheless, we recognize that the reported estimates are likely to be somewhat lower than the actual hospitalization rates, since hospitalizations of children who are uninsured or enrolled in other plans are not counted.

Narrative:

Trends and Data-Related Issues:

See this indicator's Form 11 field notes for data sources and issues.

This indicator is reported as the estimated number of hospitalizations of children from 0 through 4 years of age for asthma, per 10,000 children in this age group. As detailed in field notes, 2002 was the 1st year for which current methods were used to estimate this indicator. From an estimated baseline of 67.3 hospitalizations per 10,000 children in this age group in 2002, this indicator increased to 90.6 hospitalizations per 10,000 children in 2003, increased slightly in 2004, declined to 83.7 hospitalizations per 10,000 children in 2005, and again declined to 79.4 hospitalizations per 10,000 children in 2006. There has been no clear trend in this indicator, the asthma hospitalization rate for children aged 0-4 years. The 2-year combined rates for the beginning and end of the surveillance period (79.0 hospitalizations per 10,000 children in 2002-03 and 81.5 hospitalizations per 10,000 children in 2005-06) do not notably differ.

/2009/The estimated asthma hospitalization rate in 2007 among 0-4 year-old Alabama residents was 93.3 hospitalizations per 10,000 children in this age group. Though this is the highest rate on record during the surveillance period (2002-2007), the year 2007 rate is only slightly higher than the year 2004 rate of 93.2 hospitalizations per 10,000 children; and the year 2006 rate was notably lower than the rates for 2005 and 2007. Thus, the asthma hospitalization rate in 0-4 year-old Alabama residents shows no clear trend.

As discussed in the year 2007 Form 17 field note for this indicator, the U.S. Census Bureau's projected year 2007 population for this age group is notably lower than CBER's projected year 2006 population for this age group. In FY 2009, we may begin using U.S. Census Bureau projected populations as the denominator for rates from 2007 forward.//2009//

Activities, Strategies, and Developments:

Ceteris paribus, appropriate medical care should decrease the hospitalization rate for persons with asthma. A Health Plan Employer Data and Information Set (HEDIS[™])-based indicator for enrollees in ALL Kids, Alabama's SCHIP, is used to monitor appropriately prescribed medication for asthma. This indicator is not monitored for preschool children but is monitored for older ALL Kids enrollees, and findings for children aged 5-9 years might correlate with appropriate medical management of preschool children with asthma. The referenced HEDIS indicator is: "the percentage of enrolled members 5-56 years of age who were identified as having persistent asthma during the year prior to the measurement year and who were appropriately prescribed medication during the measurement year." (The numerator and denominator for this measure, including specific medications considered to be appropriate, are specified in Alabama SCHIP's most recent annual report. The oldest ALL Kids enrollees are 19 years of age.) Per this measure, of 5-9 year-old ALL Kids enrollees with persistent asthma, the percentage who were appropriately prescribed medication for asthma increased (improved) from 74% (239/322) in FY 2004 to 79% (255/322) in FY 2005, and then markedly improved to 95% (225/237) in FY 2006. This indicator improved for ALL Kids enrollees in other age groups studied as well (10-17 years, 18-19 years, and 5-19 years.) ALL Kids staff believe that this progress was supported by the 24-hour ALL Kids nurse line and care management for asthmatic children provided by BCBS, the medical vendor for ALL Kids (references #7-#8).

/2009/In FY 2007, of 5-9 year-old ALL Kids enrollees with persistent asthma, 96.2% (276/287) were appropriately prescribed medication for asthma. This percentage is slightly higher than the corresponding percentage of 94.9% in FY 2006--and both of these percentages are notably better than corresponding percentages in FYs 2004-2005.//2009//

In FY 2005 FHS's Social Work Consultant and SCHIP staff began holding discussions regarding case management of children who have asthma and diabetes and who also have high utilization of health care services (emergency room visits, hospitalizations, etc.). Subsequently, ALL Kids began piloting the asthma case management program in October 2006, in several sites in the State that have a high prevalence of pediatric asthma. This pilot is to last 18 months and has an evaluation component administered by UAB. In the pilot, a comprehensive set of services is provided by ADPH care coordinators, in coordination with BCBS Management staff. FHS partners with ALL Kids in the implementation of this pilot, and expects to see growth in the number of children with asthma who receive care coordination. The pilot is further discussed under SPM #1, in Section IV.D.

/2009/The clinical phase of the pilot ended on March 1, 2008, and the evaluation is in progress.//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	124.5	124.9	128.7	126.9	
Numerator	45152	45771	48965	50173	
Denominator	36265	36660	38033	39531	
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

As shown and discussed for previous years, the Alabama Medicaid Agency report used for this indicator consistently provides a numerator that is larger than the denominator, resulting in a percentage that exceeds 100%. The report available for 2007, entitled "Alabama Title XIX Annual EPSDT Participation Report," states that 41,007 individuals under 1 year of age were eligible for EPSDT in fiscal year (FY) 2007, and that the "total eligibles receiving at least one initial or periodic screen," in this age group in FY 2007, was 63,004. Using these numbers, respectively, as the denominator and numerator yields an estimate of 153.6%.

The Title V Information System does not permit us to directly enter a percentage exceeding 100%, so this field is left blank. In FY 2009 we will consult with Medicaid in an effort to better estimate the numerator for this measure.

Notes - 2006

The total number of eligibles receiving at least 1 periodic screen, 50,173, accounts for all the screens done in FY 2006--regardless of the child's possible change in eligibility. The average period of eligibility for infants (under 1 year) was only 76.3% of a year during this reporting period.

Notes - 2005

The total number of eligibles receiving at least 1 periodic screen, 48,965, accounts for all the screens done in FY 2005--regardless of the child's possible change in eligibility. The average period of eligibility for infants (under 1 year) was only 76.0% of a year during this reporting period.

Narrative:

Trends and Data-Related Issues:

All estimates for this indicator pertain to FYs. Estimates for this measure have far exceeded 100% throughout the surveillance period, but were fairly consistent (ranging from 122%-129%) throughout 2001-2005. We assume, for practical purposes, that 90% or more of Medicaid enrollees under 1 year of age receive at least 1 initial periodic screen.

/2009/As discussed in the year 2007 Form 17 field note for this indicator, the year 2007 estimate for this indicator was 153.6%, and FHS will consult with Medicaid in an effort to better estimate the numerator for this measure./2009//

See corresponding notes to Form 17 for data-related issues, including data sources.

Activities, Strategies, and Developments:

ADPH's activities to promote care coordination of children from birth through 9 years of age, especially EPSDT-enrolled children, may contribute to receipt of well child care for all Medicaid-enrolled infants. These activities are discussed under SPM #1, located in Section IV.D. Further, as discussed under NPM #7, ADPH's Immunization Division sends vaccine pamphlets to parents of all 4-month-old infants in the State, for whom addresses are available, to remind them of the importance of vaccines. Such reminders may promote well child care for all infants, including Medicaid-enrolled infants.

/2009/ADPH continues to provide care coordination as described under SPM #1./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	76.1	81.9	94.3	96.7	94.7
Numerator		222	82	208	213
Denominator		271	87	215	225
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

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

Notes - 2006

Methods for estimating this indicator, as well as the underlying rationale, are discussed in this indicator's field note for 2005.

The source document for the 2006 estimate is: Alabama's December 2006 submission of the "Framework for the Annual Report of the State Children's Health Insurance Plans under Title XXI of the Social Security Act. FY 2006."

Notes - 2005

All estimates for this indicator pertain to fiscal years (FYs). Estimates for 2003-2006 are based on different methods than the estimate for 2002. Thus, the estimate for 2002 does not provide an appropriate baseline for assessing trends in this indicator.

In FY 2006, after considering methodological issues involved, ALL Kids staff and Maternal and Child Health Epidemiology Unit staff agreed that a standardized measure used in annual reports produced by ALL Kids would provide the best available estimate for the proportion of ALL Kids-enrolled infants who receive 1 or more well child visits. (ALL Kids is Alabama's State Children's Health Insurance Program [SCHIP].) The indicator chosen via this consultation is based on specifications provided by the Health Plan Employer Data and Information Set (HEDIS [TM]), and reports well child visits in the first 15 months of life. In these field notes, this chosen indicator is subsequently termed the "HEDIS-based indicator." Estimates for all years shown are those reported for the HEDIS-based indicator.

Reasons for choosing the HEDIS-based indicator are detailed in the narrative discussion of this health systems capacity indicator. Basically, the HEDIS-based indicator pertains to children who turned 15 months old during the reporting year and who were continuously enrolled in ALL Kids from 31 days of age. Per the ALL Kids' federally submitted FY 2005 Annual Report, the "Definition of Population Included" in the HEDIS-based indicator is: the percentage of enrolled members who turned 15 months old during the measurement year, who were continuously enrolled from 31 days of age and who received either 0, 1, 2, 3, 4, 5, 6 or more well child visits

with a primary care provider during their first 15 months of life.

The source document for the 2005 estimate is: Alabama's submission of the "Framework for the Annual Report of the State Children's Health Insurance Plans under Title XXI of the Social Security Act. FY 2005."

Narrative:

Status and Data-Related Issues:

Through the MCH 2002 Report/2004 Application, due to database limitations detailed in the MCH 2004 report/2006 application, estimates for this measure usually exceeded 100%.

As stated elsewhere in this document, Alabama's SCHIP is named "ALL Kids." In FY 2004 ALL Kids, BCBS, and MCH Epi Unit staff consulted about potential ways to better estimate the proportion of ALL Kids enrollees whose age was less than 1 year during the reporting year who received at least 1 initial or periodic screen. Based on this consultation, ALL Kids and MCH Epi staff developed another method for estimating the numerator and denominator for this indicator. However, the method developed in FY 2004 (which produced the estimate for FY 2002) most likely underestimated the proportion of ALL Kids infants who received age-appropriate screens, perhaps markedly. One reason for such underestimation was that some of the infants counted in the denominator may not have been due for a screen until on or after their first birthday, and screens after the first birthday would not have been counted in the numerator. Findings that were based on the method developed in FY 2004, as well as problems with this method, are detailed in the MCH 2004 Report/2006 Application.

In FY 2006, after further considering the methodological issues involved, ALL Kids staff and MCH Epi staff agreed that a standardized measure used in annual reports produced by ALL Kids would provide the best available estimate for the proportion of ALL Kids-enrolled infants who receive 1 or more well child visits. The indicator chosen via this consultation is based on specifications provided by HEDIS[™], and reports well child visits in the first 15 months of life. Though aware that the Title V definition of HSCI #3 pertains to the 1st year of life, we have chosen the HEDIS-based method to estimate HSCI #3 for several reasons. First, as just stated, the HEDIS-based method has the advantage of standardization. Second, we believe that reporting well child visits through the first 15 months of life, rather than through 12 months of life, better captures well child visits that are due and occur around the first birthday. Third, the Title V definition of HSCI #3 and the HEDIS specifications for well child visits in the first 15 months of life are aimed at obtaining similar information, which would presumably have similar implications for program evaluation and planning. Finally, the HEDIS-based indicator is readily available. Further efforts to refine our previous methods are not deemed feasible, and would be unlikely to produce better information than that produced by the HEDIS-based method.

The HEDIS-based indicator that we are using is precisely defined in notes to Form 17 for HSCI #3. Basically, this indicator pertains to children who turned 15 months old during the reporting year and who were continuously enrolled in ALL Kids from 31 days of age. Of such children enrolled in ALL Kids, the percentage who received 1 or more well child visits with a primary care provider during the reporting year has been as follows: 76.1% in FY 2003, 81.9% in FY 2004, 94.3% in FY 2005, and 96.7% in FY 2006. Thus, of infants enrolled in ALL Kids, the percentage who received 1 or more screens during the first 15 months of life improved from 76.1% in FY 2003 to 96.7% in FY 2006: a notable achievement!

Activities, Strategies, and Developments:

ALL Kids and FHS staff believe that several factors contributed to this achievement. Key among these factors are SCHIP activities to promote good health, which include written publications and the ALL Kids 24-hour nurse-line. Another key factor is the very good network of primary care providers who serve ALL Kids enrollees. ALL Kids activities are further discussed under NPM #13, located in Section IV.C. Further, as mentioned under HSCI #2 and discussed under NPM

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

/2009/As shown on Form 17, the estimated percentage of SCHIP-enrolled infants (under 1 year of age) who received at least 1 periodic screen has been at 94.3% or above since 2005./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	79.8	79.8	78.6	73.4	73.9
Numerator	47351	47024	47182	46861	47318
Denominator	59356	58956	60065	63838	63994
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

Notes - 2007

The estimate for year 2007 was added on September 19, 2008, and is not discussed in the narrative.

Notes - 2006

This estimate was provided by the Alabama Department of Public Health's Center for Health Statistics, per an internal report received on April 18, 2008. Conjecturally, the lower percentage reported for 2006 than for earlier years shown may be a reporting artifact, and the possibility of such an artifact will be explored by FY 2009.

Narrative:

Trends and Data-Related Issues:

All estimates for this indicator pertain to CYs. Annually prepared statistical live birth files collectively comprise the data source for this indicator.

From 1999 through 2005, per the Kotelchuck Index, the proportion of all live-born infants (without respect to race, plurality, or maternal age) whose mothers received adequate (including adequate plus) prenatal care ranged from 77.6% in 2000 to 79.8% in 2003 and 2004. Thus, the measure varied little over this period.

/2009/In 2006, this indicator declined to 73.4%. As stated in the Form 17 year 2006 field note, the possibility of a reporting artifact will be explored./2009//

Related Findings from MCH Needs Assessment Report:

Indicators of prenatal care are extensively discussed in Section 3 of the Alabama 2004-05 MCH Needs Assessment Report (reference #1), under the main heading, "Findings: Pregnant Women, Mothers, and Infants." In the Needs Assessment Report, findings on prenatal care are stratified according to race, source of payment for delivery, and in some cases, maternal age. Key findings from the Needs Assessment Report that pertain to prenatal care are summarized under HSCI

#5C.

Activities, Strategies, and Developments:

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

/2009/The above activities to encourage early and adequate prenatal care continue./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	85.9	87.1	88.9	88.5	89.6
Numerator	386624	403378	417705	442295	413797
Denominator	449906	463226	469972	499796	462044
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007

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

Notes - 2006

The HCFA-2082 report from which previous years' data were compiled is no longer produced for the Alabama Medicaid Agency (Medicaid).

The FY 2006 estimate is from Medicaid's query system and may not be comparable to estimates for prior years.

Narrative:

Status and Data-Related Issues:

From 2000 through 2006, this indicator varied little: ranging from 84.5% in 2000 to 88.9% in FY 2005.

/2009/The indicator increased slightly, to 89.6%, in FY 2007. However, Medicaid enrollment has been slowed by the federal Deficit Reduction Act, implemented in Alabama in June

2006, which requires states to document U.S. citizenship for persons applying for or renewing Medicaid coverage. Some previously Medicaid eligible families have been unable to produce birth certificates as proof of citizenship, so lost their Medicaid coverage. Therefore, there were fewer children enrolled in Alabama Medicaid in FY 2007 relative to FY 2006./2009//

Activities, Strategies, and Developments:

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

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

Though providing direct care to fewer children, ADPH seeks to facilitate enrollment of Medicaid-eligible children in Medicaid (see NPM #13). Further, ADPH engages in activities that help promote access to care for all children. For example:

1) CHDs continue to provide direct care to some children, though far fewer than in the 1980s and early 1990s.

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

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

4) In the Healthy Child Care Alabama Program, which has been in place since 1998, 10 Child Care Nurse Consultants work with childcare providers, children 0-5 years of age who receive out-of-home childcare, and the families of these children. These services are provided in 61 counties. Services include health and safety programs and information for child care providers and families of children in child care; health and safety programs for children attending child care programs; linkage of families and child care providers to community resources and services, including ALL Kids, Medicaid, EIS, and WIC; and assistance to child care providers with integration of CSHCN into the child care environment. For FY 2006, the Child Care Nurse Consultants (who are public health nurses administratively located in FHS) documented 1,276 trainings for 4,208 child care providers. Also in FY 2006, the Child Care Nurse Consultants distributed 5,269 handouts on support services, including materials translated into Spanish, for parents and child care providers during trainings and site visits.

/2009/The Healthy Child Care Alabama Program documented 2,089 site visits and provided 1,030 on-site health and safety trainings. The program's Nurse Consultants distributed 14,239 support service informational materials for parents and child care providers, including 2,460 applications for ALL Kids/Alabama Medicaid and 2,522 EIS and CRS fact sheets, brochures. or pamphlets./2009//

FHS staff have become aware of an increase, in early FY 2007, in the number of CHDs that have

been approached by primary medical providers to perform EPSDT screenings for their patients. Given this increase, in March 2007 the Deputy Director of FHS wrote to key PHA medical and administrative staff, PHA nursing directors, and PHA social work directors, saying that Bureau staff are available to assist CHDs with the details of moving back into the role of providing EPSDT services. The Director of FHS's Children's Health Division, who can provide current information on Medicaid procedures pertaining to EPSDT, is serving as the Bureau's liaison with CHDs on this issue.

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	46.5	49.8	51.4	53.0	65.3
Numerator	42774	46860	49619	52976	64652
Denominator	91927	94101	96606	99995	99022
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

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

Notes - 2006

The source document is: Alabama Title XIX Annual EPSDT Participation Report, FY 2006.

Notes - 2005

The source document is: Alabama Title XIX Annual EPSDT Participation Report, FY 2005.

Narrative:

Status and Trends:

See field notes for the data sources and/or reports used for this indicator.

The percent of EPSDT-enrolled children aged 6 through 9 years who received a dental service increased by 57% over a 7-year period: from 33.8% in FY 1999, to 53.0% in FY 2006. The corresponding average annual increase was 6.6% per year, based on a multiplicative model. ***//2009/This indicator improved remarkably in FY 2007, when an estimated 65.3% of 6-9 year-old Alabama Medicaid enrollees received a dental service.//2009//***

Activities, Strategies, and Developments:

Issues pertaining to oral health of children are discussed under NPM #9 and SPM #2, respectively located in Sections IV.C and IV.D. To briefly summarize, measures to promote oral health of children, including but not limited to EPSDT-enrolled children, include:

- 1) In collaboration with others, provision of dental services to certain populations of children who tend to have unmet dental needs, including provision of oral health services in CHDs and in school-based clinics.
- 2) Training of care coordinators with Patient 1st, Medicaid's primary care case management program, to promote good oral health for children and their families.

- 3) Participation in national Children's Dental Health Month and in the national "Give Kids a Smile" campaign.
- 4) Promotion of the provision of dental sealants, especially by general practitioners in the private sector.
- 5) Provision of training and assistance to CHD staff--including care coordinators, WIC nutritionists, and Alabama Healthy Childcare Coordinators--on ways to promote access to dental care and utilization of dental services.

/2009/The previously listed activities will basically continue in FY 2009. Establishment of for-profit and not-for-profit dental clinics that see only Medicaid-enrolled children has increased the availability of dental care for these children, so utilization of dental services by this population has increased. It is anticipated that a not-for-profit dental clinic will assume management of 1 of ADPH's county dental clinics by FY 2009, further increasing Medicaid-enrolled children's access to dental care. Further, Medicaid reimbursement for operation of a mobile dental van is a possibility if pending legislation concerning such a van is passed. The operation of such a van should further enhance Medicaid-enrolled children's access to and utilization of 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	18.3	16.2	15.1	13.6	14.5
Numerator	4327	3824	3591	3298	3533
Denominator	23635	23677	23845	24186	24442
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

The denominator was provided to each state by the Social Security Administration (SSA) for fiscal year (FY) 2007. It represents the number of children in Alabama who were under age 16 years and were receiving federally administered Supplemental Security Income (SSI) payments as of December 2007. The file is in Characteristic Extract Record format and is 100% data. The numerator is programmatic data based on a database match between Children's Rehabilitation Service and the Alabama Medicaid Agency.

Notes - 2006

The denominator was provided to each state by the SSA for FY 2006. It represents the number of children in Alabama who were under age 16 years and were receiving federally administered SSI payments as of December 2006. The file is in Characteristic Extract Record format and is 100% data. The numerator is programmatic data based on a database match between Children's Rehabilitation Service and the Alabama Medicaid Agency.

Notes - 2005

The denominator was provided to each state by the SSA for FY 2005. It represents the number of children in Alabama who were under age 16 years and were receiving federally administered SSI payments as of December 2005. The numerator is an estimate of programmatic data based on a calculated mean of percent decreases in this value since FY 2002. (To obtain an estimate for the numerator, the percent decreases in the numerator were calculated between FY 2002 and FY 2003 and between FY 2003 and FY 2004. Between FY 2002 and FY 2003, there was a 0.57% decrease and between FY 2003 and FY 2004 there was an 11.6% decrease. A mean percent decrease was calculated, 6.1%, and then this figure was used to project a decrease for FY 2005--subtracting 6.1% from the numerator for FY 2004 to yield an estimated numerator for FY 2005.)

Narrative:

The number of Alabama's children under 16 years old who receive SSI benefits has increased again this year. This number was obtained from the SSA, Supplemental Security Record. For FY 2006, there were 24,186 children in this category, compared with 23,845 in FY 2005. This difference represents about a 1.4% increase statewide for this FY and a 13.2% increase over the 21,360 children in FY 2001. During FY 2006, CRS and Alabama Medicaid established an inter-agency agreement to allow matching between the respective databases to identify children served by the CRS program who obtained Medicaid coverage through SSI. This allows CRS to query programmatic data to determine the numerator for this indicator. As has been noted in previous years, the number of SSI beneficiaries under age 16 years who are served by CRS has declined. CRS relies on the provision of informational materials and annual in-service visits to local SSA offices to encourage referrals of SSI recipients into the program. Contacts are made with all children newly awarded SSI. New CRS public awareness posters are to be placed in SSA offices to promote self referrals in this population.

/2009/The number of Alabama's children under 16 years old who receive SSI benefits has again increased this FY. This number was obtained from the SSA, Supplemental Security Record. For FY 2007, there were 24,442 children in this category, compared with 24,186 in FY 2006. This difference represents about a 1.1% increase statewide for this FY and a 14.4% increase over the 21,360 children in FY 2001. During FY 2007 CRS and Alabama Medicaid continued an interagency agreement to allow matching between the respective databases to identify children enrolled in the CRS program who obtained Medicaid coverage through SSI. This allows CRS to query programmatic data to determine the numerator for this indicator. For FY 2007, the number of SSI beneficiaries under age 16 years who are enrolled in CRS increased by about 7%. This reverses a trend of decline in this indicator seen since FY 2002. CRS relies on the provision of informational materials and annual in-service visits to local SSA offices to encourage referrals of SSI recipients into the program. Contacts are made with all children newly awarded SSI benefits. New CRS public awareness posters have been placed in SSA offices to promote self referrals in this population.//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)	2007	payment source from birth certificate	11.7	9.3	10.4

Narrative:

Status and Data-Related Issues:

In 2005, 12.3% of Medicaid infants versus 9.2% of non-Medicaid infants weighed less than 2,500 grams at birth. (In discussion of HSCIs #5A-#5D, "Medicaid infants" pertains to those whose delivery was paid for by Medicaid, and "non-Medicaid infants" to remaining infants.

/2009/In 2006, 12.0% of Medicaid infants, versus 9.0% of non-Medicaid infants, weighed less than 2,500 grams at birth./2009//

Low birth weight is known to be a risk factor for infant mortality. Further, as discussed in the background paper for SOM #2 (attached to Section II.C), the fact that babies from low-income households are at higher risk of infant death than those from higher income households has long been known. As a corollary, the higher prevalence of low birth weight among Medicaid, versus non-Medicaid, infants is presumably linked to socioeconomic status or factors linked with socioeconomic status. Moreover, the "non-Medicaid" group included in HSCI #5A includes a typically high-risk group: infants of "self paying" mothers, many of whom presumably have neither health insurance nor the means to pay for delivery. Therefore, the low birth weight gap between babies whose deliveries were paid for by Medicaid and babies whose deliveries were privately insured is probably wider than the gap reported for HSCI #5A.

Related Findings from MCH Needs Assessment Report:

Very low birth weight (VLBW) is discussed in Section 3 of the 2004-05 MCH Needs Assessment Report (reference #1), under "Findings: Pregnant Women, Mothers, and Infants." In that report, subgroups defined respectively by race and source of payment for delivery are compared regarding VLBW. VLBW, rather than low birth weight, was chosen because VLBW is a stronger predictor of infant mortality. Concerning source of payment, 3.4% of infants born to self-paying mothers were VLBW, 2.3% of infants born to Medicaid-enrolled mothers were VLBW, and 1.6% of infants born to privately insured mothers were VLBW.

Activities, Strategies, and Developments:

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

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

ADPH engages in several other initiatives that address risk markers for VLBW, including the following:

1) FHS's Women's Health Division engages in activities to reduce the incidence of adolescent pregnancy. These activities are described under NPM #8, and include provision by CHDs of family planning services for teens, including counseling regarding how to respond to pressure to engage in sexual activity; provision of care coordination for EPSDT-eligible teens who come to CHD Family Planning clinics; and operation of a toll-free hotline that provides information for teens on reproductive health and family planning services.

2) SPP is involved in various activities designed to reduce the prevalence of smoking during pregnancy. These activities are described under NPM #15. The core of these activities is partnership with AMOD to provide smoking cessation-counseling training for private delivering physicians' office staff statewide.

3) ADPH's activities to promote early prenatal care are described under NPM #18. Such activities include education of CHD Family Planning clients on the importance of early and continuous prenatal care, operation of a toll-free hotline that helps pregnant women access providers and educational materials; and Medicaid's continuation of their statewide Maternity Care Program.

4) WIC provides food vouchers and nutritional counseling to eligible pregnant women.

5) ADPH Family Planning clients are counseled by CHD staff about the importance of prenatal care, folic acid supplementation, etc.

//2009/The above activities--some of which are further discussed under NPM #s 8, 15, 17, and 18--continue. In FY 2008 the intent of SPP's AMOD-funded project is to address the issue of mothers who cease smoking during pregnancy but resume after the birth of their infant. Also in FY 2008, SPP is partnering with HPCD's Tobacco Prevention and Control Branch to implement and evaluate tobacco prevention and cessation activities targeting pregnant teens.//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	2007	payment source from birth certificate	11	9.1	10

Narrative:

Status and Data-Related Issues:

In CY 2005 the infant mortality rate was 10.7 deaths per 1,000 live births to Medicaid-enrolled mothers and 7.9 deaths per 1,000 live births to remaining mothers. As stated under HSCI #5A, the fact that babies from low-income households, as a group, are at higher risk of infant death than those from higher income households has long been known. As also discussed under HSCI #5A, the "non-Medicaid" group specified in HSCI #5A includes a typically high-risk group: infants of "self paying" mothers. Therefore, the infant mortality gap between babies whose deliveries were paid for by Medicaid and babies whose deliveries were privately insured is probably wider than the gap reported for HSCI #5B. Infant mortality rates increased in Alabama in 2005, relative to 2004: for the total population, for infants of Medicaid-enrolled mothers, and for infants of non-Medicaid mothers. Specifically, infant mortality rates increased as follows between 2004 and 2005, with numbers representing the number of infant deaths per 1,000 live births in 2004, followed by the corresponding number in 2005: in the total population, from 8.7 to 9.2 deaths per 1,000; in the Medicaid group, from 10.1 to 10.7 deaths per 1,000; and in the non-Medicaid group, from 7.5 to 7.9 deaths per 1,000. Final estimates for the total infant mortality rate are shown under National Outcome Measure #1 on Form 12 for the years 2002-2005, and are discussed in a Form 12 note to that measure.

//2009/In CY 2006 the infant mortality rate was 10.6 deaths per 1,000 live births to Medicaid-enrolled mothers and 7.0 deaths per 1,000 live births to remaining mothers.//2009//

Related Findings from MCH Needs Assessment Report:

In Section 3 of the 2004-05 MCH Needs Assessment Report (reference #1), various mortality indicators are graphically depicted according to source-of-payment subgroups for 2000-02 combined: risk of infant, neonatal, very early neonatal, and postneonatal death; birth weight-

specific risk of infant death; and cause-specific risk of infant death. Highlights from findings stratified according to source of payment for delivery include the following, all of which are for the years 2000-02:

1) Risk of infant (under 1 year of age) death was especially high for babies of "self-paying" mothers. Reported as the number of infant deaths per 1,000 live births, risk of infant death was 16.1 deaths per 1,000 among babies of self-paying mothers, 11.2 deaths per 1,000 among babies of Medicaid-enrolled mothers, and 6.7 deaths per 1,000 among babies of privately insured mothers.

2) Proportionately, gaps according to source of payment for delivery were widest during the postneonatal period. Reported as the number of postneonatal (28-364 days of age) deaths per 1,000 live births, risk of postneonatal death was 5.5 deaths per 1,000 among babies of self-paying mothers, 4.9 deaths per 1,000 among babies of Medicaid-enrolled mothers, and 1.8 deaths per 1,000 among babies of privately insured mothers.

3) Normal birth weight (2,500-4,249 grams) infants of Medicaid-enrolled mothers were 2.5 times more likely to die than normal birth weight infants of privately insured mothers. Reported as the number of infant deaths per 1,000 live-born normal birth weight infants, risk of infant death was 4.6 deaths per 1,000 normal birth weight babies of Medicaid-enrolled mothers, versus 1.8 deaths per 1,000 normal birth weight babies of privately insured mothers.

4) Compared to infants of privately insured mothers, infants of Medicaid-enrolled mothers were 3.9 times more likely to die from SIDS and 3.8 times more likely to die from externally caused injuries or conditions. There were 1.1 cases of SIDS per 1,000 babies of Medicaid-enrolled mothers, versus 0.3 cases of SIDS per 1,000 babies of privately insured mothers. There were 0.6 externally caused deaths per 1,000 babies of Medicaid-enrolled mothers, versus 0.2 externally caused deaths per 1,000 babies of privately insured mothers.

Activities, Strategies, and Developments:

Infant death review, discussed under SPM #7 in Section IV.D, is one way that FHS gathers information for use in development of strategies to reduce the infant mortality rate. As well, ADPH's activities to promote care coordination among EPSDT-enrolled children are intended to promote wellness and reduce morbidity among all Medicaid-enrolled children, including infants. Care coordination is discussed under SPM #1, in Section IV.D.

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

//2009/SPP is exploring potential funding sources for hiring 6 nurses and a research analyst to implement planning for statewide fetal and infant death review. As part of this process, ADPH submitted a proposal to Medicaid for matching funds to begin statewide infant death review. Medicaid agreed to the proposal.//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	2007	payment source from birth certificate	70.2	87.4	79.2

prenatal care beginning in the first trimester					
--	--	--	--	--	--

Narrative:

Status:

In CY 2005, mothers of 74.5% of Medicaid infants and 89.7% of non-Medicaid infants had received prenatal care in the first trimester.

/2009/In CY 2006, mothers of 73.0% of Medicaid infants and 90.1% of non-Medicaid infants had received prenatal care in the first trimester./2009//

Related Findings from MCH Needs Assessment Report:

The 2004-05 MCH Needs Assessment Report (reference #1) describes percentages of infants whose mothers had received late prenatal care, defined as beginning after the first trimester; had received inadequate prenatal care as defined by the Kessner Index; and had received no prenatal care. (Mothers receiving no care were also counted among those receiving inadequate care.) The Needs Assessment Report describes these findings according to race and to maternal age, as well as according to source of payment for delivery.

The following focuses on Needs Assessment Report findings described according to source of payment for delivery, and pertains to the 3-year period 2001-03. Of the 3 subgroups defined by source of payment for delivery (self pay, Medicaid, and private insurance), self-paying mothers were most likely to receive insufficient prenatal care, regardless of how "insufficient" was defined. Specifically, 36.8% of self-paying mothers had received late (after the first trimester) prenatal care, 34.5% of them inadequate care per the Kessner Index, and 17.7% of them no care.

As stated above, self-paying mothers were more likely to receive insufficient care than Medicaid-enrolled mothers, as well as privately insured mothers. However, regardless of how insufficient care was defined, Medicaid-enrolled mothers were more likely to receive insufficient care than privately insured mothers. Specifically, 25.9% of Medicaid-enrolled mothers had received late prenatal care (versus 5.0% of privately insured mothers), 7.3% of them inadequate care (versus 1.2% of privately insured mothers), and 1.0% of them no care (versus 0.3% of privately insured mothers).

Nevertheless, to reiterate, Medicaid-enrolled mothers were notably LESS likely to receive insufficient prenatal care than self-paying mothers were, especially if defined in terms of the Kessner Index or the total absence of care. Specifically, by juxtaposing pertinent numbers reported in the 2 preceding paragraphs: 25.9 % of Medicaid-enrolled mothers, versus 36.8% of self-paying mothers, had received late prenatal care; 7.3% of Medicaid-enrolled mothers, versus 34.5% of self-paying mothers, had received inadequate prenatal care; and 1.0% of Medicaid-enrolled mothers, versus 17.7% of self-paying mothers, had received no prenatal care.

Activities and Developments:

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

/2009/The above activities continue./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])	2007	payment source from birth certificate	66.7	80.5	73.9

Notes - 2009

In previous years, Title V Information Reporting System staff stated that the percentage reported for "All" in HSCI #5D should match that for the corresponding year for HSCI #4. Therefore, because HSCI #4 pertains to women 15 through 44 years of age, the percentages shown for HSCI #5D also pertain to women 15 through 44 years of age.

Narrative:

Status and Data-Related Issues:

/2009/In CY 2006 mothers of 66.3% of Medicaid infants and 80.4% of non-Medicaid infants had received adequate prenatal care as defined for this measure. Here, "Medicaid" and "non-Medicaid" pertain to the source of payment for delivery./2009//

The Medicaid versus non-Medicaid disparity between receipt of prenatal care has long been present. However, as discussed under HSCI #5A, the non-Medicaid group includes reportedly self-paying women, whose infants tend to be at higher risk for suboptimum outcomes. Accordingly, comparison of the Medicaid-enrolled subgroup to the privately insured group, rather than the entire non-Medicaid group, is a better way to describe prenatal care according to socioeconomic status. This comparison, as well as comparison of the Medicaid group to the self-paying group, is discussed under HSCI #5C.

/2009/In CY 2006 mothers of 84.6% of infants whose delivery was covered by private insurance had received adequate prenatal care as defined for this measure./2009//

Related Findings from MCH Needs Assessment Report:

Pertinent findings from the 2004-05 MCH Needs Assessment Report (reference #1) are summarized under HSCI #5C.

Activities, Strategies, and Developments:

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

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

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2007	133
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP	YEAR	PERCENT OF POVERTY LEVEL

programs for infants (0 to 1), children, Medicaid and pregnant women.		SCHIP
Infants (0 to 1)	2007	200

Notes - 2009

Medicaid covers infants whose household income is at or below 133% of the federal poverty level (FPL). SCHIP covers infants whose household income is greater than 133% of FPL, but does not exceed 200% of FPL.

Narrative:

Status:

Medicaid and SCHIP household income criteria for coverage of infants, shown on Form 18 and discussed in the field note to HSCI #6A, have not changed for several years.

Activities, Strategies, and Developments:

Alabama Medicaid programs and the ALL Kids Program, which is Alabama's SCHIP, are discussed in Section III.A. The ALL Kids Program is also discussed under NPM #13. As discussed under NPM #13, combined applications for ALL Kids, SOBRA Medicaid, Medicaid for Low Income Families, and the Alabama Child Caring Foundation's program are available at CHDs, as well as hospitals, provider offices, many other community locations, and the ALL Kids Web page.

//2009/The criteria remain the same, and the combined application continues being available as described above.//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 pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2007	133 100
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2007	200 200

Notes - 2009

Medicaid and SCHIP each has 2 age-specific income criteria for children and youth: 0-5 years inclusive, and 6-18 years inclusive.

For 0-5 year-olds, the upper parameter for Medicaid is 133% of the federal poverty level (FPL), and SCHIP eligibility specifies a household income greater than 133% of FPL, but not to exceed 200% of FPL.

For 6-18 year-olds, the upper parameter for Medicaid is 100% of FPL, and SCHIP eligibility specifies a household income greater than 100% of FPL, but not to exceed 200% of FPL.

Narrative:

Status:

Medicaid and SCHIP household income criteria for coverage of persons aged 1-5 years and 6-18 years (inclusive) are shown on Form 18 and discussed in the field note to HSCI #6B. These criteria have not changed for several years.

Activities, Strategies, and Developments:

Alabama Medicaid programs and the ALL Kids Program, which is Alabama's SCHIP, are discussed in Section III.A. The ALL Kids Program is also discussed under NPM #13. As discussed under NPM #13, combined applications for ALL Kids, SOBRA Medicaid, Medicaid for Low Income Families, and the Alabama Child Caring Foundation's program are available at CHDs, as well as hospitals, provider offices, many other community locations, and the ALL Kids Web page.

/2009/The criteria remain the same, and the combined application continues being available as described above./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	133
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Pregnant Women	2007	200

Notes - 2009

For pregnant women, the upper parameter for Medicaid eligibility is 133% of the federal poverty level (FPL). Alabama's SCHIP covers pregnant females only if they are less than 19 years of age and already eligible for ALL Kids, with household incomes exceeding the Medicaid criterion but not exceeding 200% of the FPL.

Narrative:

Status:

Alabama's SCHIP covers pregnant females only if they are less than 19 years of age and eligible for ALL Kids, with household incomes exceeding the Medicaid criterion (upper parameter of 133%) but not exceeding 200% of the FPL.

Activities, Strategies, and Developments:

Alabama Medicaid programs and the ALL Kids Program, which is Alabama's SCHIP, are discussed in Section III.A. Further, as discussed in Section III.A, the feasibility of expanding SCHIP coverage to include the unborn child has been under consideration. That is, plans are being considered to cover pregnant women whose household income does not exceed 200% of FPL and who are not eligible for coverage by another entity. Consequently, such expansion would enable provision of insurance coverage for prenatal care, delivery, and postpartum services for women whose household income does not exceed 200% of FPL if they are not eligible for coverage by Medicaid or another insurance program. Currently, the predominant thought is that such expansion, if it occurs, will be developed and implemented as an expansion of the Medicaid Program. Planning is preliminary, and no final decisions about the possible expansion have been made.

//2009/Discussions continued regarding the feasibility of expanding SCHIP coverage to include the unborn child, and projections were developed. However, this discussion has been tabled due to budget uncertainties.//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	1	No
Annual linkage of birth certificates and WIC eligibility files	2	Yes
Annual linkage of birth certificates and newborn screening files	2	Yes
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	1	No
Annual birth defects surveillance system	1	No
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2009

Narrative:

Birth/Infant Death Files:
MCH Epi staff analyze these linked files.

Medicaid/Birth Files:
These files are not being linked.

//2009/In early FY 2008 an MOU to link birth records and Medicaid files was approved by ADPH's legal staff and sent to Medicaid for consideration. As of May 2008, Medicaid has not replied concerning the MOU.//2009//

Birth/WIC Files:

By June 2005 SSDI staff had electronically linked about 85% of FY 2001 WIC prenatal registration records to CY 2000-01 live birth files.

/2009/Brief reports on findings from such linked files have been produced for 3 successive years: with the latest linkage including CY 2003-04 birth files./2009//

Birth/Newborn Screening Files:

In FY 2003 SSDI staff linked CY 2000 live birth records to newborn screening billing records. FHS does not routinely perform such linkage because we have other, more timely ways to monitor whether infants are being screened. Per a reporting system initiated in June 2004, if a hospital does not seem to be screening all their newborns, Newborn Screening staff can follow up on individual infants in the hospital. Findings from the system's database (June 2004 through circa March 2005) indicate that more than 99% of Alabama live-born infants born in Alabama hospitals were screened before discharge.

/2009/The above reporting system is still in place. As a complement to the above system, Newborn Screening staff have begun mapping all unsatisfactory specimens from their Case Management database, Neometrics(TM). This new system will automatically notify Newborn Screening staff about unsatisfactory specimens and thereby facilitate more timely follow up, to ensure that 100% of infants born in Alabama hospitals receive a valid screen. By FY 2009, Newborn Screening staff and MCH Epi Unit staff will discuss the feasibility of tracking screens among infants born elsewhere./2009//

Hospital Discharge Survey:

The State does not have a statewide hospital discharge database and, per a March 2007 contact with the Alabama Hospital Association (AHA), has no plans to develop one.

In FY 2007 Medicaid began a federally funded project to create a statewide electronic health information system that links Medicaid, State health agencies, providers, and private payers. The Bureau Director and the MCH Epi Unit Director are asking Medicaid to design the system with the potential to generate a database for surveillance of morbidity in Title V populations. Medicaid's initial response to this idea, as a long-term goal, has been positive.

/2009/At Medicaid's request, the MCH Epi Unit Director attended a federally sponsored national quality assurance workshop in January 2008. The workshop highlighted that Alabama is one of the few states without a statewide reporting system for hospital inpatient data, and that having such a reporting system is a prerequisite for participation in the Healthcare Cost and Utilization Project. In April 2008 Medicaid held a conference call, in which the MCH Epi Unit Director and the Women's Health Division Director participated, to follow up on this issue. Following the call, Medicaid staff were to discuss the issue with the Medicaid Commissioner, at which time consideration would be given to contacting the Governor's Office and the AHA to discuss our lack of such a system./2009//

Birth Defects Surveillance:

In early FY 2007 the Alabama Birth Defects Surveillance and Prevention Program provided FHS with reports: 1 of which includes a table showing certain birth defects counts and rates for 1999-2003 combined and a summary of methods used. Per this summary, 22 counties in south-central or south Alabama were represented in the system's database for the years 2002 and 2003: up from 2 counties being represented in 2000.

The feasibility of creating a statewide birth defects registry is being explored. In July 2006 AMOD convened a work group including representatives from ADPH, CRS, MHMR, USA and UAB Departments of Genetics, and the UAB School of Public Health. The work group's objective is to explore creation of a statewide birth defects registry to be housed at ADPH, using ADPH's cancer registry as a model. AMOD has proposed a State statute to require the registry of birth defects and to secure legislative support for allocation of new funding to ADPH to implement the registry. FHS staff are asking Medicaid to prioritize inclusion of ICD-9 codes for birth defects in the

previously mentioned electronic health information system.

/2009/Legislation to establish a birth defects registry in ADPH has been drafted and approved by the AHA, but will probably not be submitted to the State Legislature until FY 2009. If the legislation is passed, implementation would depend on funding./2009//

Pregnancy Risk Assessment and Monitoring System (PRAMS):

The Alabama PRAMS database is administratively located in CHS. CHS staff produce an annual report on Alabama PRAMS and respond promptly to requests for particular analyses.

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

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

Notes - 2009

As of June 6, 2008, year 2007 Youth Risk Behavior Survey (YRBS) findings for Alabama were not available on the Center for Disease Control and Prevention's YRBS Web page. The most recent year for which Alabama numbers were shown was 2005. By September 2008 we will consult with the Alabama Department of Public Health's Bureau of Health Promotion and Chronic Disease, where Alabama's YRBS program is administratively located, regarding when Alabama YRBS findings for 2007 will become available.

Narrative:

Trends and Data-Related Issues:

CDC's Youth Risk Behavior Survey (YRBS) System's Web site, which can be queried, and the Alabama Youth Tobacco Survey (AYTS) are the sources for estimating the prevalence of recent tobacco use among high school students. YRBS is conducted in odd years, and AYTS in even years. The target population for the National YRBS is public and private high schools in the 50 states and the District of Columbia, but the sampling frame for state (including Alabama) and local YRBSs includes only public schools (references #15-#16). The target population for AYTS is public high schools and middle schools (reference #17).

The pertinent indicator reported on the YRBS Web site is the percentage of students who smoked cigarettes or cigars or used chewing tobacco, snuff, or dip on 1 or more of the 30 days preceding participation in the survey. AYTS reports the percentage of students who had used "any form of tobacco" in the preceding 30 days. In the following narrative, the term "had recently used tobacco" refers to use of some form of tobacco in the past month, whether based on AYTS or on YRBS.

Per the 2006 AYTS (Table 18), 35.0% of Alabama public high school students had recently used tobacco. Estimates from AYTS for recent use of tobacco (34.7% for 2002, 33.4% for 2004, and 35.0% for 2006) have consistently been higher than presumably corresponding estimates from YRBS (30.5% for 2001, 31.5% for 2003, and 30.8% for 2005). All the preceding estimates are notably lower than the corresponding estimate for 1999, when 43.3% of Alabama high school students had recently used tobacco. However, whether using AYTS or YRBS to track trends in recent use of tobacco by youth, this indicator has failed to improve in recent years, which is cause for concern.

Whether the direction of the difference between findings from AYTS and the Alabama YRBS is due to methodological differences cannot be determined from information available to the MCH Epi Unit at this writing. An HPCD staff member has contacted SDE, requesting a description of

methodology for Alabama YRBS. If such material is received, ADPH staff will compare the description with a description of Alabama AYTS methods.

/2009/Due to competing priorities and a staff vacancy, the MCH Epi Unit has not followed up on the above methodological issues, but plans to do so by FY 2009. Alabama findings for 2007 are not yet posted on CDC's YRBS Web site./2009//

Activities, Strategies, and Developments:

In 1998, the Alabama Tobacco Use Prevention and Control Task Force was convened to develop a State plan for tobacco control. The task force was co-chaired by the Director of HPCD's Chronic Disease Prevention Division and a pediatrician practicing in the State. In 2000 the task force was reconvened, for the purpose of revising and updating the State plan to conform with CDC's "Best Practices for Comprehensive Tobacco Control Programs" report.

The publication, "Alabama Comprehensive Tobacco Use Prevention and Control Plan: 2000 -- The New Millennium" details the State plan for tobacco control (reference #9). The plan specifies 3 overall goals for tobacco prevention and control in Alabama: to

- 1) Prevent youth (under age 19 years) from becoming users of tobacco products.
- 2) Promote treatment of tobacco dependency through promotion of and increased access to cessation programs.
- 3) Reduce exposure to secondhand tobacco smoke.

The State plan for tobacco control focuses on 3 key components:

- 1) Prevention through schools. The aforesaid publication states: "School-based tobacco education should include effective and evaluated tobacco use reduction curricula that are compatible with the Health Literacy Goals and Content Standard established by the Health Education Course of Study." The publication further states that youth must be actively involved in all prevention efforts, including planning, implementation, and evaluation--if school-based efforts to prevent tobacco use are to be effective. The Alabama Administrative Code requires that all school property be tobacco free.
- 2) Prevention through public awareness education and community mobilization. Here, the State plan for tobacco control emphasizes advocacy by community groups and individual volunteers, including youth and adults.
- 3) Prevention through merchant education and public awareness of the Youth Access to Tobacco Products Law. Here, the State plan emphasizes that enforcement of Alabama Act 97-423, the Youth Access to Tobacco Products Law, is critical to preventing sales of tobacco to youth under 19 years of age. Per the plan, such enforcement can be accomplished through education of the general public, the law enforcement community, the judicial system, retailers, and youth.

IV. Priorities, Performance and Program Activities

A. Background and Overview

Any references or appendices cited in this MCH 2006 Report/2008 Application may be obtained by e-mailing acowden@adph.state.al.us.

BACKGROUND

Determination of the State's priorities, performance measures, and program activities occurs in the context of the Government Performance and Results Act (GPRA, Public Law 103-62). Figure 3 of the guidance for the MCH Services Block Grant reports/applications (reference #6, Appendix D) depicts the Title V Block Grant Performance Measurement System. This system is to begin with needs assessment and identification of priorities and is to culminate in improved outcomes for the Title V population. As shown in Figure 2 of the aforesaid guidance, assessing needs is part of a circular process that includes: assessing needs, examining capacity, selecting priorities, setting targets, identifying activities, allocating resources, and monitoring progress. Each component of this process receives input from a preceding component and feeds into the next component. As also shown in Figure 2 of the guidance, monitoring progress addresses the question of whether an outcome has improved, and the answer to this question feeds into the "identifying activities" component.

When designing, allocating resources to, and implementing programs, key ADPH and CRS staff consider the priority MCH needs identified through the most recent MCH needs assessment. ADPH or CRS supports or directly administers programs to directly address all of the 10 priority MCH needs (discussed in Section IV.B) identified through the FY 2004-05 MCH needs assessment. Section IV.B describes the relationship of the priority needs, the National and State Performance Measures, and the capacity and resource capability of the State's Title V program.

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

The State Title V Program's role in actions to address each performance measure varies, but falls within 1 or more of the 3 core public health functions of assessment, policy development, and assurance. The State Title V Program's role concerning a given performance measure may, therefore, pertain to 1 or more of the 10 essential public health services, especially to: 1) monitoring health status; 2) informing and educating people about health issues; 3) mobilizing community partnerships to identify and solve health problems; 4) developing policies and plans that support individual and community health efforts; 5) linking people to needed personal health services and assuring the provision of health care when otherwise unavailable; 6) assuring a competent public health work force; and 7) evaluating accessibility of personal and population-based health services. Accordingly, in FY 2003 the Bureau's Executive Committee and the Director of the Epi/Data Branch reviewed the 10 essential public health services, using the Capacity Assessment for State Title V (Cast-5) model (reference #10). The Cast-5 process was interrupted in FY 2004 due to then-urgent fiscal concerns, but some of the concerns identified during that process (such as non-competitive salaries for epidemiologists) have since been addressed. In early FY 2005 FHS focused on implementing and reporting the FY 2004-05 MCH needs assessment.

Services provided by the State Title V Program are intended to promote health and well-being, as well as to collectively achieve the long-term goal of having a positive effect on the 6 National Outcome Measures in this report/application. Effects of MCH programs are often incremental, rather than dramatic, however.

OVERVIEW OF PERFORMANCE MEASURES

Sections IV.C and IV.D respectively discuss the 18 NPMs and the 7 SPMs. Performance measures are discussed in numerical order, with a focus on MCH populations served and activities by level of the MCH Pyramid. The following are described for each performance measure: key activities in FY 2007, key activities initiated in early FY 2008, and plans for the remainder of FY 2008 and for FY 2009. Where indicated and permitted by space constraints, key activities prior to FY 2007 are reported as a context for FYs 2007-2009. Specific activities are described and categorized by the 4 MCH Pyramid service levels.

When trends are discussed in the narrative or Form 11 field notes to the performance measure, they are typically based on findings that are readily available to the writer as of April or May 2007, which often do not include the reporting year. When currently unavailable findings become available, they will be added to Form 11 at the first opportunity, but not discussed in this narrative.

//2008/Five performance measures specifically pertain to adolescent health (NPMs #8, #10, and #16; and SPMs #3 and #4). Each of these measures focuses on 1 aspect of adolescent health. Having several measures that each focus on 1 aspect of adolescent health is appropriate, but these measures should be viewed in the context of a comprehensive approach to adolescent health. The Bureau's SAH Program seeks to inform, educate, and empower parents, communities, and schools in Alabama to promote adolescent health. Discussion of the program follows.

The SAH Director provides presentations to public school faculty and staff to educate them on such issues as CDC's Coordinated School Health Model; wellness plans for adolescents; approaches to combating obesity in school-age children, including how to begin a body mass index (BMI) screening program in the school setting; State YRBS results; emergency preparedness; and pandemic influenza. She has made "Hand washing for the Classroom" posters available across the State, as well as a "Health Helpers in my School" worksheet to reinforce the coordinated school health process. Additionally, she works closely with school nurses around the State to afford educational opportunities on provision of student health services.

SAH Program activities extend beyond the public school setting, in order to educate a wide range of stakeholders on positive youth development. This process relates to the basic needs of adolescents and the impact these needs have on health-related choices in this age group. Trainings provided by the SAH Director involve how positive youth development elements can be programmed into the home, community, school, and academic curriculum. The SAH Director also educates stakeholders about how adolescent brain structure and adolescent developmental stages impact health risk behaviors; further, she educates stakeholders about how positive youth development impacts behaviors and resiliency. The SAH Director meets quarterly with various ADPH staff to update them on initiatives and opportunities to serve adolescents.//2008//

//2009/The SAH Program continues as a vital part of FHS's outreach. The program's director makes presentations to public school faculty and staff to educate them on stages of healthy adolescent development, protective factors that help adolescents avoid risky behaviors, adolescent brain development, and specific risk behaviors that are prevalent among the State's adolescents. Web casts have been provided via the Alabama Public Health Training Network, including topics such as "Risks and Resources in Adolescent Health," "Understanding Youth Culture," and "Generation Rx: The Pharming Phenomenon." The SAH Program sponsored a statewide adolescent health conference. The program continues partnering with Students Against Destructive Decisions and the FOCUS program to impact student leaders across the state who serve as role models.//2009//

B. State Priorities

/2007/IDENTIFICATION OF PRIORITY NEEDS VIA FY 2004-05 MCH NEEDS ASSESSMENT PROCESS

SELECTION PROCESS

Through the FY 2004-05 MCH needs assessment initially reported in July 2005, ADPH and CRS respectively identified 7 and 3 priority MCH needs. A review of the needs assessment process follows. This review is itself followed by a discussion of each identified priority need, including pertinent needs assessment findings. The specific years to which cited findings pertain are not always mentioned. The most recent pertinent data sources available during the FY 2004-05 MCH needs assessment were used, and the years for which data were available varied by source. Findings, including the years to which they pertain, are detailed in the report of that needs assessment (reference #1). A bound copy of the report can be obtained by e-mailing acowden@adph.state.al.us. As well, the report can typically be accessed from the Title V Information System Web site, which has the following url address: <https://perfdata.hrsa.gov/mchb/mchreports/>.

FHS's needs assessment process consisted of several components:

- 1) Assemblage and analysis of qualitative data from 12 community discussion groups.
- 2) Implementation and analysis of data from 2 mail surveys (1 of primary providers of health care; 1 of non-medical organizations serving women of childbearing age, children and youth, or families).
- 3) Analysis of vital statistics and U.S. Census data.
- 4) Child death review.
- 5) Infant mortality review.
- 6) Review of information from certain user-friendly Web sites, such as findings from CDC's YRBS.
- 7) Assemblage of the MCH Advisory Group.

At the single meeting of the MCH Advisory Group, FHS presented key findings from the FY 2004-05 MCH needs assessment, as well as 14 potential priority needs implied by the findings. Attendees were then asked to rank the potential priority needs, with the option of suggesting other priorities, first individually and then in breakout groups. The 7 priorities selected by FHS basically reflect MCH Advisory Group rankings.

CRS convened a Needs Assessment Advisory Committee on 3 occasions and pursued 3 methodologies in gathering qualitative and quantitative data: open family/youth forums, county-level surveys of public providers coordinating care for CYSHCN, and a youth survey. Findings were presented at the final advisory committee meeting and input on suggested priority needs was obtained. Afterward, the CRS State Office staff, 2 district supervisors, and 2 LPCs participated in a 1-day planning meeting to review the needs assessment data and the summary report from the advisory committee. The group sought to distinguish the top priority needs for CYSHCN in the State that CRS has the mission and capacity to address. Through a group consensus process, 5 areas under 3 priorities were identified for improvement. In follow-up meetings, the group selected 2 performance measures for further development and planning, based on available resources and areas of greatest need. The proposed priority needs, NPMs and SPMs, and annual plan activities were presented to the CRS Administrative Team and the State Parent Advisory Committee for approval.

The following discussion organizes priority needs according to the level of the MCH Pyramid to which they mainly pertain, though in reality the priorities cut across service levels. Terminology used in subsequent discussion to briefly refer to each need is shown parenthetically, following the full statement of the need.

PRIORITY MCH NEEDS, ACCORDING TO LEVEL OF SERVICE

DIRECT SERVICES:

PRIORITY 1: Improve health status of CYSHCN through increased access to comprehensive, quality primary and specialty care, and allied health and other related services.

The preceding priority need is similar to that identified in the previous needs assessment cycle, with modifications to include allied health and other related services in addition to primary and specialty medical care. Current needs assessment findings from open forums, county-level provider surveys, and youth surveys indicate that inadequate access to care for CYSHCN continues to be an issue throughout the State. Support for selecting this need includes transportation barriers, inadequate financing, inadequate distribution of providers, and the lack of specialized knowledge by all provider types related to care coordination, transition issues, behavioral management, and other unique needs of CYSHCN. NPM #3 (medical homes for CSHCN), NPM #4 (adequate insurance for CSHCN), NPM #5 (community-based systems), and SPM #5 (CYSHCN's access to care) relate to this need.

ENABLING SERVICES:

PRIORITY 2: Assure appropriate primary care, including prenatal care, for all Title V populations--including low-income, immigrant, and minority groups (assure primary care).

The need to assure primary care is broadly stated in order to accommodate a variety of concerns arising from FY 2004-05 MCH Needs Assessment findings and MCH Advisory Group members' views. These concerns encompassed the importance of all types of primary and preventive care for Title V populations. Prenatal care is specifically mentioned because of concerns regarding pregnant women who have neither health insurance coverage nor the means to pay for prenatal and obstetrical care. Many of the performance measures relate to the priority need to assure primary care: NPM #1 (newborn metabolic/hematologic screening), NPM #3 (medical homes for CSHCN), NPM #5 (community-based systems), NPM #6 (transition of youth with special health care needs [SHCN] to adult life), NPM #7 (immunization of 19-35 month-old children), NPM #9 (dental sealants for third graders), NPM #12 (newborn hearing screening), NPM #13 (uninsured children and youth), NPM #18 (prenatal care), SPM #1 (care coordination of 0-9 year-old EPSDT enrollees), SPM #2 (dental services for EPSDT enrollees), and SPM #5 (CYSHCN's access to care).

POPULATION-BASED SERVICES:

PRIORITY 3: Promote evidence-based health education and outreach regarding high priority topics (evidence-based health education and outreach).

Many of the findings from FHS's components of the FY 2004-05 MCH Needs Assessment pertained to preventable deaths, and a few to preventable morbidity. These concerns should be addressed in an evidence-based manner. Further, the Health Care Consumer breakout group, part of the MCH Advisory Group, designated collection and analysis of data as being of the highest priority. Most of the performance measures, especially the following, pertain to evidence-based health education and outreach: NPM #1 (newborn metabolic/hematologic screening), NPM #7 (immunization of 19-35 month-old children), NPM #8 (teen live birth rate), NPM #10 (motor

vehicle-crash deaths in children and youth), NPM #11 (breastfeeding), NPM #12 (newborn hearing screening), NPM #13 (uninsured children and youth), NPM #14 (overweight or obese 2-5 year-old children), NPM #15 (smoking during pregnancy), NPM #16 (suicide in 15-19 year-old youth), NPM #18 (prenatal care), SPM #1 (care coordination of 0-9 year-old EPSDT enrollees), SPM #3 (teen pregnancy), SPM #4 (use of tobacco or snuff by White male high school students), and SPM #7 (use of MCH data).

PRIORITY 4: Further reduce the adolescent pregnancy rate (reduce adolescent pregnancy).

Although the live birth rate and repeat live birth rate among 15-17 year-old teens and the pregnancy rate among 10-19 year-old adolescents continued to decline, adolescent pregnancy remains of great concern. Various socioeconomic disadvantages and suboptimal health outcomes, including infant mortality, have been linked with adolescent pregnancy. Though these links are not necessarily causal, some factors that predispose an adolescent to become pregnant may also place her infant at higher risk of death. The following performance measures relate to the need to reduce adolescent pregnancy: NPM #8 (teen live birth rate) and SPM #3 (teen pregnancy).

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

The priority need to prevent violent behavior is supported by FY 2004-05 MCH Needs Assessment findings regarding cause of death. For example, in 2001-03, homicide and suicide respectively caused 12% and 7.5% of deaths among 15-19 year-old youth. NPM #16 (suicide in 15-19 year-old youth) and SOM #1 (homicide/legal intervention death rate in 15-19 year-old African American males) pertain to this priority need.

PRIORITY 6: Reduce the prevalence of high-risk behaviors, including those predisposing to obesity, in adolescents (prevent high-risk behaviors in youth).

Findings that support the selection of this priority need come from mortality data and YRBS data. For example, in 2001-03 unintentional injuries caused 57% of deaths among 15-19 year-old youth, and motor vehicle crashes caused 74% of unintentional-injury deaths among 15-24 year-old youth. Per YRBS, the proportion of youth who rarely or never wear a seat belt has dropped substantially, so high-risk behavior can be modified. Behaviors among youth that need to be modified include cigarette use, smokeless tobacco use among White males, episodic heavy drinking, and use of illicit drugs. The following performance measures pertain to the need to prevent high-risk behaviors in youth: NPM #10 (motor vehicle-crash deaths in children and youth), NPM #16 (suicide in 15-19 year-old youth), and SPM #4 (use of tobacco or snuff by White male high school students).

INFRASTRUCTURE-BUILDING SERVICES:

PRIORITY 7: Reduce infant mortality, especially among African Americans (reduce infant mortality).

The priority need to reduce infant mortality accommodates a concern for all preventable infant deaths, while recognizing the need to reduce infant mortality among the Black population in particular. Respective risks of infant death were especially high for babies of adolescent mothers who had previously been pregnant, babies of mothers 16 years of age or younger, babies of "self-paying" mothers, and babies of Black mothers. Of all the performance measures, we deem NPM #17 (birth of VLBW babies at a perinatal center) to be most directly related to the need to reduce infant mortality.

/2008/(Note: In this document the term "Black" is generally used to refer to African Americans. However, the original wording of SOM #1 and Priority Need #7, which use the term "African American," is retained.)

Effective July 2007, SOM #2 is being added to the MCH report/application: the ratio of the infant mortality rate for Alabama to the infant mortality rate for the U.S. The background paper on this measure is attached to Section II.C./2008//

PRIORITY 8: Improve the capacity of CYSHCN to be fully integrated into their communities to live, learn, work, and play (full integration of CYSHCN).

This priority need for full integration of CYSHCN is continued from the previous needs assessment cycle and will offer opportunities for a multitude of program activities targeting community integration. Through the open forums, families of CYSHCN as well as youth with SHCN identified many frustrations related to inadequate integration into communities. Many aspects were discussed including services received from public education systems, community recreational opportunities, and transition issues. NPM #2 (family partnerships), NPM #3 (medical homes for CSCHN), NPM #4 (adequate insurance for CSHCN), NPM #5 (community-based systems), NPM #6 (transition), and SPM #6 (transition of youth with SHCN to adult life) relate to this need.

PRIORITY 9: Strengthen systems of family and youth support to enable CYSHCN and their families to participate more fully in program and policy development, to identify resources, and to benefit from the services they receive (strengthen family and youth support systems).

This priority need to strengthen family and youth support systems is similar to that identified in the previous needs assessment cycle, with modifications to include youth as well as a broader frame of reference. This need encompasses direct family and youth supports as well as enabling supports for participation in program decisions and policy development. As it calls for planning and implementation of activities across all aspects of the service system for CYSHCN in the State, it is designated as an infrastructure-building service. Through the youth surveys and open forums, families of CYSHCN reported a variety of needs for support services. These include transportation assistance, respite care, family counseling, care coordination, childcare, and mental health counseling. In addition, participants identified needs for resources to assist families when a child is newly diagnosed, skills for successful transition to adult life, and systems to ameliorate financial burdens and cultural and language barriers. NPM #2 (family partnerships), NPM #3 (medical homes for CSHCN), NPM #5 (community-based systems), and SPM #6 (transition of youth with SHCN to adult life) relate to this need.

PRIORITY 10: Further develop the Title V Program's capacity to collect and analyze health-related data and translate findings into information for key stakeholders (appropriately use MCH data).

Collection and analysis of data and translation of findings into information for stakeholders constitute a crucial part of needs assessment. Without sufficient capacity to perform these tasks, "needs assessment" would perhaps be based more on the interests and experiences of a few contributors than on broadly based, objective assessment of needs. Further, data capacity is important to other components of infrastructure-building: evaluation, quality assurance, monitoring, applied research, and information systems. Nevertheless, the priority need to appropriately use MCH data would not have been selected had it not earned the highest ranking of the Health Care Consumer MCH Needs Advisory breakout group, who decided that this priority need was crucial to the capacity to address other priority needs. SPM #7, a checklist-based measure of MCH data capacity, directly pertains to the priority need to appropriately use MCH data.

RELATIONSHIP OF PRIORITY NEEDS, PERFORMANCE MEASURES, AND CAPACITY/RESOURCE CAPABILITY OF THE STATE TITLE V PROGRAM

The preceding discussion lists the most relevant performance measures (and, in 2 cases, SOM)

for each priority need. FHS's and CRS's plans are based on their overall missions, recent developments, findings from studies conducted as part of 5-year MCH needs assessments and ongoing needs assessment, and input from each agency's needs assessment advisory group. Further, FHS's plans are based on input from SPAC.

As discussed in Section III.A, FHS and some CHDs have shifted their focus from direct services provided in the CHD to enabling services and community-based services. Fiscal issues facing ADPH and CRS in the past have been described in previous MCH reports/applications, and issues affecting current capacity are detailed in Sections III.B and III.D.

To briefly recap with respect to ADPH's capacity, projected shortfalls in State revenue for FY 2004 caused ADPH to aggressively cut or redirect expenditures, which affected certain FHS programs or contracts. Some of the expenditures were redirected to sustain SPP and the State Dental Program, though not at previous levels. Through careful use and, when necessary, redirection of funds, ADPH maintained, and in some ways enhanced, its capacity to serve Title V populations. ADPH funding stabilized by FY 2005 and is expected to remain stable or increase slightly in FY 2007. ADPH has been able, therefore, to add several new positions, which are discussed in Section IV.D.//2007//

/2008/As indicated in Section III.B, we previously expected funding to be stable through FY 2007. However, Title V MCH funding for Alabama sustained a substantial reduction of \$475,132: from \$12,348,388 for FY 2006 to \$11,873,256 for FY 2007. ADPH was able to use Title V MCH carryover funds to offset the decrease in funds, but any further reductions would have a detrimental effect on ADPH's capacity to provide MCH services.//2008//

/2007/By FY 2004 CRS had implemented significant budget reductions that resulted in cuts to purchased services for CYSHCN, as well as policy changes affecting programs and contractual agreements. CRS staff have focused on informing families and assisting them in locating alternative resources to fill any unmet needs. In addition to providing education to lawmakers related to the unique needs of CYSHCN, CRS leaders and families concentrated on public awareness of the potential impact of budget cuts in the hopes of securing additional funding and avoiding further reductions to critical services for families. Significant budget cuts were once again experienced by CRS in FY 2005, however.

Activities discussed in Sections IV.C and IV.D address specific performance measures and occur in the context of FHS's and CRS's respective missions and strategies.

METHODOLOGICAL NOTE

In the following respective discussions of NPMs and SPMs, average annual percent changes are often noted in the narrative and/or field notes. Unless stated otherwise, average annual percent changes are based on a multiplicative model that assumes a constant increase or decrease in the measure.//2007//

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
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	78	59	64	86	88

Denominator	78	59	64	86	88
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100

Notes - 2007

The 88 infants include 2 infants with hyperphenylalaninemia, rather than classic PKU. Depending on how high their phenylalanine levels are, some infants with hyperphenylalaninemia require dietary management.

Notes - 2006

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

a. Last Year's Accomplishments

Trends:

This indicator has remained at 100% in the years shown, but the number of newborns who screened positive increased notably: from 64 infants in CY 2005 (the first year that tandem mass spectrometry [TMS] was used for the entire year), to 86 infants in CY 2006, to 88 infants in CY 2007. This is an increase of 24 infants relative to the CY 2005 baseline. The increase was mainly--but not totally--in the number of infants who were confirmed as having sickle cell disease, which was as follows: 36 infants in CY 2005, 56 infants in CY 2006, and 51 infants in CY 2007. Though the increase of infants who screened positive for sickle cell disease in CY 2006 was notable, the increase does not necessarily indicate a trend. FHS will continue to monitor the number of positive screens in future years.

FY 2007:

Unless stated otherwise, the following occurred in FY 2007.

Direct:

The Newborn Screening Program (NSP) provided timely follow up to definitive diagnosis for infants who screened positive for metabolic or hematological disorders. For FY 2007 the following numbers of infants were identified as having hemoglobinopathies or the specified genetic disorders: hemoglobinopathies, 51; galactosemia, 2; congenital hypothyroidism, 18; congenital adrenal hyperplasia, 1; and biotinidase deficiency, 1. Fifteen infants were identified using tandem mass spectrometry (TMS) as having 1 of the following disorders: PKU, 8 infants (including 2 diagnosed with hyperphenylalaninemia instead of classic PKU); medium-chain acyl-CoA dehydrogenase deficiency (MCADD), 3 infants; very long-chain acyl-coenzyme A dehydrogenase deficiency (VLCAD), 1 infant; homocystinuria, 1 infant; glutaric acidemia, 1 infant; and carnitine transporter defect, 1 infant.

The NSP tandem mass screening panel was expanded to include the Organic Acid Disorder profile to aid in the diagnosis of 3-Hydroxy-methylglutaric aciduria (HMG), 3-Methylcrotonyl-C-oA (3-MCC), Beta ketothiolase (BKT), and Multiple carboxylase (MCD).

NSP routinely performed screening, including expanded TMS, on all first and second specimens. Specialty referral centers continued to provide confirmatory testing and treatment to patients identified through NSP. Genetic counseling, follow up, and nutritional counseling regarding treatment and dietary management were included.

Enabling:

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

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

NSP referred families of all infants diagnosed with sickle cell disease or trait for education and counseling. The referrals were to 7 community-based sickle cell organizations that collectively served all Alabama counties.

Thirteen patients with PKU received medical food and/or special formula through the Title V Program.

Population-based:

Updated newborn screening brochures in English and Spanish were provided to all 59 Alabama birthing hospitals.

Infrastructure-building:

A full time nurse supervisor has been hired to direct activities related to Cystic Fibrosis.

The NSP awarded a grant to UAB/Sparks Clinic to address the needs of families with inherited inborn errors of metabolism.

NSP continued to monitor the Alabama Voice Response System. The system was enhanced so that providers can obtain a fax copy of the report via the access number. Enrolled submitters can access screening tests via telephone 24 hours a day, 7 days a week.

NSP continued receiving a monthly hospital screening report that showed, by hospital, the number and percentage of newborns who had received an initial screening prior to hospital discharge. Data extracted from the report indicated that more than 99% of infants born in Alabama hospitals received their initial screening prior to hospital discharge.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide biochemical screening of newborns for mandated conditions and, via Tandem Mass Spectrometry (TMS), screen for certain other disorders for which screening is not mandated.	X	X	X	X
2. Refer infants with positive results for care coordination if there is no physician of record listed or appointment(s) for repeat screenings have been missed.		X		X
3. Refer families of all infants diagnosed with sickle cell disease to 1 of 7 community-based sickle cell organizations, for education and counseling.		X		
4. Monitor the Alabama Voice Response System, which enables enrolled submitters to access screening tests via telephone at any time.				X
5. Monitor monthly hospital screening reports that show, by hospital, the number and percentage of newborns who receive				X

an initial screening before hospital discharge.				
6. Develop protocol on issues in second testing as a part of routine newborn screening.				X
7.				
8.				
9.				
10.				

b. Current Activities

Direct:

Statewide screening for cystic fibrosis began in April 2008. With the addition of this test, and a State law that mandates hearing screening for every newborn, the Alabama NSP now screens for 28 of the 29 disorders recommended by the American College of Medical Genetics and the American Academy of Pediatrics.

Infrastructure-building:

RNPCs are providing in-service education classes to hospitals and pediatricians to address issues regarding specimen collection and unsatisfactory specimens.

NSP is providing standardized training manuals for blood screening collection to all 59 birthing hospitals.

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

The NSP Advisory Committee and its cystic fibrosis, metabolic, endocrine, and hemoglobinopathy subcommittees are developing action plans to provide guidance and support on policies and procedures to enhance all aspects of NSP.

NSP has formalized partnership with our medical specialists through an MOU that outlines the shared responsibility between ADPH and medical specialists.

c. Plan for the Coming Year

Direct:

NSP will continue to expand the current newborn screening test panel. Studies are being done to implement screening for 1 remaining disorder, tyrosemia type I, which would bring Alabama into compliance with recommendations by the American College of Medical Genetics.

NSP will continue to ensure that all newborns requiring follow-up testing and referral will receive services in a timely manner.

Infrastructure-building:

NSP will work with the cystic fibrosis centers to educate physicians on the treatment and management of cystic fibrosis.

RNPCs will continue to work with hospitals in their perinatal regions to provide training to hospitals to reduce the occurrence of unsatisfactory specimens.

NSP will establish practices and protocols to ensure that every newborn in the State is screened, and continue to maintain and update the NSP Web page. This Web page contains a variety of information, including a newborn screening brochure (English and Spanish versions) and fact sheets on the following disorders: biotinidase deficiency (a version for parents and a version for professionals), congenital adrenal hyperplasia, congenital hypothyroidism, galactosemia, PKU, and sickle cell disease and related red-blood-cell disorders. NSP staff will continue to participate

in national, regional, and local conferences to stay current with expanding trends in newborn screening.

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	66	66	66.1	66.1	70
Annual Indicator	66.1	66.1	66.1	66.1	59.9
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	59.9	59.9	59.9	59.9	59.9

Notes - 2007

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

Notes - 2006

Through 2006, each year shown for this indicator is pre-populated with the estimate for Alabama from the National Survey of CSHCN that was conducted in 2001. Additional information about this survey is provided below. Continued use of the estimate from the 2001 survey for annual performance objectives reflects that the survey is conducted only periodically, and a more recent estimate is not yet available. New data are expected to be released in FY 2007.

The National Survey of CSHCN utilized State and Local Area Integrated Telephone Survey (SLAITS) procedures. The survey is the result of analyses conducted by the staff of the Special Populations Surveys Branch, Division of Health Interview Statistics, National Center for Health Statistics, CDC, and provided to HRSA's Maternal and Child Health Bureau.

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

Notes - 2005

See this indicator's field note to year 2006 about data-related issues.

a. Last Year's Accomplishments

Using updated data from the National Survey of CSHCN (2005-06), 59.9% of Alabama families with CSHCN reported success for this measure, versus 57.4% of U.S. families. Per survey notes, this outcome can be compared to 2001 results. In the 2005-06 survey versus the 2001 survey, 6.2% fewer Alabama families reported success for this measure while numbers for U.S. families were virtually the same. Per the 2005-06 survey, in Alabama 89.1% of families reported that

doctors and other health care providers always or usually made them feel like a partner in their child's care, versus 87.7% nationally. Also, 89.4% of Alabama families reported that doctors and other health care providers always or usually are sensitive to their family's values and customs (89% for U.S.).

Enabling:

CRS continued to employ an SPC and 12 LPCs. The State Parent Advisory Committee held 1 meeting. Local Parent Advisory Committees (LPACs) hosted presentations on topics such as Individualized Education Plans (IEPs), Medicaid waivers, special education (presented in English and Spanish), nutrition, fire suppression, stress management, Social Security and SSI, respite care, caring for the caregiver, VRS, Medicaid reimbursement for school-based therapy, disability rights, and "Wheelin' Sportsmen."

Population-based:

CRS continued to publish the Parent Connection Newsletter, which is available in hard copy and on the ADRS Web site. It is also sent to national editors for CSHCN newsletters. A list serve was maintained for participants in the Parent to Parent Program; 401 messages were posted in FY 2007.

LPCs presented trainings on CRS, family-centered care, disability-related issues, and the parent perspective at schools, community colleges, childcare centers, etc. They also hosted Thanksgiving and Christmas events for CYSHCN and their families, including food and toy drives. Disability awareness was promoted through community health fairs, family fun days, and SAFE Kids Car Seat Checks.

Infrastructure-building:

The SPC and a CRS parent served both as the Region IV and FVA State Co-coordinators. CRS continued to support and partner with FVA, which included providing reimbursement for support for youth and families to participate in Healthy People 2010 work groups.

As a part of the FVA national data collection project, LPCs tracked types of services reported as lacking by families and the type of information provided by LPCs to families and professionals. In 2007 information was provided to 7,097 families and 2,470 professionals. Compared to FY 2006, this is an increase for families (from 5,693), but a slight decrease for professionals (from 2,501). The most common topics were community resources, Title V services, the Parent to Parent network, and disability-specific information.

LPCs attended State and national trainings. The Birmingham LPC was selected as a Family Scholar for the 2007 annual AMCHP meeting.

LPCs and families participated on CRS and inter-agency committees and task forces (refer to Section III.E), as well as many community projects and advisory groups such as the Individual and Family Support Council, Homeless Care Council, CPCs, Civitan International Research Center, Oral Health Coalition, Arthritis Coalition, Alabama Disabilities Advocacy Program's Protection and Advocacy for Individuals with Mental Illness, and "Sharing the Care" Respite Building Network. "Sharing the Care" was established to encourage faith-based respite for caregivers of people of all ages with disabilities. Guidelines were developed and training was provided for area churches.

The SPC was involved in trainings, both as presenter and participant. An AMCHP member, she was named a voting delegate and was the vice-chair of the Family Leadership Caucus. She was on inter-agency planning groups and advisory committees including the Inclusive Childcare Project, Early Intervention Conference Planning Committee, and the UAB Pediatric Pulmonary Center's State Advisory Committee. She chaired the affordability subcommittee for the Alabama Covering Kids and Families Coalition and participated on the Medicaid Buy-in subcommittee for the Ticket to Work/Medicaid Infrastructure grant and the State Newborn Screening Advisory

Committee. She participated in the national technical assistance site visit related to this initiative.

The family-professional partnership 2010 Work Group continued to be active via meetings and ongoing progress with action steps on their action plans.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

FY 2007 activities as described above are being continued in FY 2008 with the following additions or exceptions.

Enabling:

Following resignations, a new LPC was hired in the Opelika office and there is a vacancy in the Birmingham area.

The SPC and LPCs provided input on the proposed 2009 CRS State Plan and current and future activities. They also rated the agency on Form 13 characteristics, using a checklist format modified from a tool developed by the State of Wisconsin in December 2001. The compiled findings are attached to this subsection.

Population-based:

The list serve for the Parent to Parent Program had 155 postings by April 2008.

An attachment is included in this section.

c. Plan for the Coming Year

Unless stated otherwise, all previously discussed activities related to this measure will continue in FY 2009. A recap and notation of activities being newly implemented follows.

Enabling:

Family and professional collaboration in program and policy activities will be facilitated through

support of families for the CRS State Parent Advisory Committee and LPACs, training activities, publication of a newsletter, and employment of at least 1 parent consultant in each office.

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

Population-based:

CRS will update and modify its family satisfaction survey.

Infrastructure-building:

CRS will continue working with its partners and stakeholders to implement a State plan to ensure that by 2010 families of CYSHCN will partner in decision making at all levels and will be satisfied with the services they receive. The work group's current action plan includes steps and strategies toward increasing education and empowerment of consumers, developing a qualitative survey of families and professionals to explore their relationships and how they relate to the quality of services provided, and incorporating family-professional partnerships into curricula for physicians and nurses.

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

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	53	53	53.9	53.9	60
Annual Indicator	53.9	53.9	53.9	53.9	50
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	50	50	50	50	50

Notes - 2007

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

Notes - 2006

Through 2006, each year shown for this indicator is pre-populated with the estimate for Alabama from the National Survey of CSHCN that was conducted in 2001. Additional information about this survey is provided below. Continued use of the estimate from the 2001 survey for annual performance objectives reflects that the survey is conducted only periodically, and a more recent

estimate is not yet available. New data are expected to be released in FY 2007.

The National Survey of CSHCN utilized State and Local Area Integrated Telephone Survey (SLAITS) procedures. The survey is the result of analyses conducted by the staff of the Special Populations Surveys Branch, Division of Health Interview Statistics, National Center for Health Statistics, CDC, and provided to HRSA's Maternal and Child Health Bureau.

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

Notes - 2005

See this indicator's field note to year 2006 about data-related issues.

a. Last Year's Accomplishments

Using updated data from the National Survey of CSHCN (2005-06), 50% of Alabama families with CSHCN reported success for this measure versus 47.1% of U.S. families. Per survey notes, this outcome cannot be compared to 2001 results due to changes in methodology. In Alabama, 93.6% of families reported having a usual source of sick care versus 94.3% nationally, and 97.5% of Alabama and U.S families reported having a usual source of routine preventive care. About 98% of CRS enrollees reported having a primary care provider (PCP), a figure greatly improved from the FY 1996 baseline of 62%. Usual source of care was reported by 95% of youth responding to a survey for the FY 2004-05 MCH Needs Assessment. These youth were not all CRS enrollees so may not have had staff assistance in linking to PCPs, but the lower figure may suggest difficulties in maintaining a usual source of care as youth age.

The 2005-06 National Survey of CSHCN included baseline results for early and continuous screening for special health care needs. Overall, 62.3% of Alabama families with CSHCN reported success for this measure versus 63.8% of U.S. families. In Alabama, CSHCN with a medical home were more likely to be screened early and continuously (65.3%) than were those without a medical home (58.8%).

Enabling:

CRS continued efforts to identify community PCPs willing to accept CYSHCN as patients. Families without medical homes were helped with linkage to appropriate community PCPs. A database of PCPs of CRS enrollees was used to identify local providers with experience with CYSHCN to facilitate linkage. The 59.4% of CRS enrollees with Medicaid were provided a medical home through the Patient 1st Program. Patient 1st focuses on and provides financial incentives for physicians to provide all aspects of a medical home. CRS works closely with Medicaid providers to receive appropriate referrals to facilitate comprehensive EPSDT services.

Population-based:

CRS continued collaboration with ALL Kids, Alabama's SCHIP, to establish a protocol to include information about medical homes and CRS in a packet of information for families who indicate they have a child with SHCNs at enrollment.

Infrastructure-building:

A Medicaid CD-ROM training to provide continuing medical education related to medical homes was available to PCPs and allied health professionals. Medicaid provides enhanced reimbursement to PCPs who successfully complete the training. CRS and FVA contributed to this project and continued to promote its usage. CRS was listed among the materials as a resource for CYSHCN.

The CRS data system, CHARMS (Children's Health and Resource Management System), created a service summary for each enrollee. CRS staff members print this for families and can share it with the medical home physician to facilitate better coordination and to help streamline

the system of care for CRS clients. Discussions continued on establishing an electronic mailbox for CRS physicians to link with CHARMS to enhance communication and facilitate information exchange including service summaries, follow up from clinic visits, and on-line referrals.

Medicaid received a grant to further screening initiatives in the State. Under this grant, Alabama's Assuring Better Child Health and Development (ABCD) project worked with pediatricians to link EPSDT, Patient 1st, and other public health initiatives through well child visits to enhance child health and development through the inclusion of standardized developmental screenings. Pilot sites were established in 3 cities to choose tools and determine the most appropriate methodology for adoption of the initiative in pediatric practices statewide. CRS staff participated with private medical providers and other State agencies on project work groups. These included 1) policy improvement, 2) screening tools, 3) measurement and evaluation, 4) information, resources, and referral, and 5) statewide spread and implementation.

Medical Home and Early and Continuous Screening 2010 Work Groups continued to be active via meetings and ongoing progress with action steps on their action plans.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement Alabama's 2010 Action Plan for CYSHCN.		X	X	X
2. Feature medical home concept in newsletters and the CRS Family Guide.		X	X	
3. Distribute information through the State Children's Health Insurance Program (SCHIP) about medical homes and the CRS Program to families.			X	
4. Provide ongoing educational and CRS-related materials to enhance partnerships with primary care physicians recognized as CRS courtesy staff.			X	X
5. Identify physicians willing to accept CYSHCN and assist families at the local level with linkage to medical homes.		X		X
6. Continue to promote communication with the medical home by sending reports of clinic visits, service summaries, and recommendations to physicians.		X		
7. Continue to facilitate referrals by maintaining enrollment forms on the public Web site and accepting referrals via phone, fax, or hard copy.		X	X	X
8. Continue to collaborate on advisory committees and work groups related to Medicaid's grant projects, Together for Quality (see National Performance Measure [NPM] #5) and Alabama's Assuring Better Child Health and Development.		X	X	X
9.				
10.				

b. Current Activities

FY 2007 activities as described above are being continued in FY 2008 with the following additions or exceptions.

Infrastructure-building:

CRS spoke with selected PCPs to determine interest in and capability to access an electronic mailbox for linkage with CHARMS. CRS has decided to postpone development of electronic linkages outside the system at this time. CRS is participating in Medicaid's Together for Quality initiative (see NPM #05) and will wait to determine appropriate technology that will work

functionally with this effort. Local offices continue to send hard copy reports of clinic visits, service summaries, and recommendations to medical home providers. CRS enrollment forms are available on the public Web site and referrals are accepted via phone, fax, or hard copy.

c. Plan for the Coming Year

Unless stated otherwise, all previously discussed activities related to this measure will continue in FY 2009. A recap and notation of activities being newly implemented follows.

Enabling:

CRS staff will continue to meet with community medical providers to identify PCPs willing to accept CYSHCN as patients. Partnerships will be enhanced between CRS and Alabama's PCPs who are recognized as CRS courtesy staff physicians through the provision of ongoing educational and CRS-related public-policy awareness materials. Families of CYSHCN without medical homes will continue to be assisted at the local level with linkage to appropriate, community-based PCPs.

Infrastructure-building:

CRS will continue working with its partners and stakeholders to implement a State plan to ensure that by 2010 all CSHCN will receive ongoing comprehensive care through a medical home. The work group's current action plan includes steps and strategies toward providing education to families regarding the medical home concept, educating providers and insurance payers concerning reimbursement issues for care for CYSHCN, and facilitating better communication methods between specialists and medical home physicians to improve care for CYSHCN.

CRS will also continue working with its partners and stakeholders to implement a State action plan to ensure that by 2010 all children will be screened early and continuously for SHCNs. The work group's current action plan includes steps and strategies toward increasing public and professional awareness of services and agencies available for early and continuous screening through education, promoting access to early and continuous screening through the medical home model, and supporting data capacity for integration of screening results obtained through Alabama's birth defect surveillance expansion.

CRS offices will continue to promote communication with the medical home by sending reports of clinic visits, service summaries, and recommendations to physicians. CRS will continue to facilitate referrals by maintaining enrollment forms on the public Web site and accepting referrals via phone, fax, or hard copy.

CRS will continue to collaborate on advisory committees and work groups related to Medicaid's grant projects Together for Quality (see NPM #05) and Alabama's Assuring Better Child Health and Development.

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	59	59	59.7	59.7	62
Annual Indicator	59.7	59.7	59.7	59.7	65
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	65	65	65	65	65

Notes - 2007

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

Notes - 2006

Through 2006, each year shown for this indicator is pre-populated with the estimate for Alabama from the National Survey of CSHCN that was conducted in 2001. Additional information about this survey is provided below. Continued use of the estimate from the 2001 survey for annual performance objectives reflects that the survey is conducted only periodically, and a more recent estimate is not yet available. New data are expected to be released in FY 2007.

The National Survey of CSHCN utilized State and Local Area Integrated Telephone Survey (SLAITS) procedures. The survey is the result of analyses conducted by the staff of the Special Populations Surveys Branch, Division of Health Interview Statistics, National Center for Health Statistics, CDC, and provided to HRSA's Maternal and Child Health Bureau.

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

Notes - 2005

See this indicator's field note to year 2006 about data-related issues.

a. Last Year's Accomplishments

Using updated data from the National Survey of CSHCN (2005-06), 65% of Alabama families with CSHCN reported success for this measure, versus 62% of U.S. families. Per survey notes, this outcome can be compared to 2001 results. Per the 2005-06 survey versus the 2001 survey, 5.4% more Alabama families and 2.4% more U.S. families reported adequate insurance. Per the 2005-06 survey, in Alabama CSHCN managed by prescription medicines more often reported adequate insurance (71.2%) than those with above-routine need or use of services (63%) or functional limitations (54.2%). A similar disparity was seen nationally.

FY 2007 data show a decreased percentage of CRS enrollees with insurance (83%); the number of uninsured clients rose to 2,107. This is not a true representation of insurance status in the program. In 2007 CRS began offering onsite screenings for scoliosis and hearing loss and insurance information was not gathered on participants. Currently the CRS data system (CHARMS) does not accommodate such exceptions, so all screening participants were identified as uninsured, artificially inflating the number of uninsured CRS enrollees and decreasing the overall percentage of those with insurance. The number of screening participants (1,328) could not simply be subtracted from the uninsured total as insurance status was unknown. This data issue will be addressed in the next year. Historically, the percentage of CRS enrollees with private insurance, SCHIP, or Medicaid coverage has steadily risen. It was 88% in 2006, 85.2% in 2005, 82.3% in 2004, 83.2% in 2003 and 81.5% in 2002. The number of uninsured in the program has fallen. There were 1,429 uninsured CRS enrollees in 2006, 1,705 in 2005, 2,450 in 2004, and

2,446 in 2003. The 1,429 uninsured CRS enrollees in 2006 is a 63% decline from the 3,885 uninsured CRS enrollees in 1997, the first reporting year.

Direct:

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

Enabling:

CRS identified children potentially eligible for Medicaid, ALL Kids, or SSI, and assisted with applications. CRS helped its 308 ALL Kids enrollees with annual renewal as needed. CRS paid insurance premiums for coverage accessible through employment, Consolidated Omnibus Budget Reconciliation Act (COBRA), the Alabama Health Insurance Plan, or ALL Kids for 17 clients whose families were unable to afford the cost.

Infrastructure-building:

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

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

CRS staff have had basic training on insurance verification and assessment of benefit packages. This assures that third-party resources are used appropriately and aids staff in discussing plan benefits with families to help them better understand and use them.

CRS continued to assist clients as needed with meeting the DRA of 2005 requirements for citizenship and identity for Medicaid application. Staff assisted in obtaining official birth certificates and also with identity verification, using a form developed by CRS and approved by Medicaid. Through a data-sharing agreement with Medicaid, CRS identified enrollees who lost Medicaid coverage at the time DRA requirements were phased in. Local staff contacted each family to determine if the loss was due to citizenship or identity issues and assisted with re-establishing coverage.

CRS continued to modify CHARMS. A second phase was released in May 2007. This module focused on scheduling and electronic billing, which enhances third-party reimbursements and communication with families.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement Alabama's 2010 Action Plan for CYSHCN.		X	X	X
2. Refer 100% of children with no health insurance enrolled with CRS to Supplemental Security Income (SSI), Medicaid, or SCHIP and assist with applications as needed.		X		
3. Identify 100% of CRS clients for whom it is appropriate to pay insurance premiums and provide this service.		X		

4. Continue implementation of the CRS work plan for the Health Insurance Portability and Accountability Act (HIPAA) and provide training to new and current staff.				X
5. Continue collaboration with Alabama's SCHIP, ALL Kids, to implement an expanded benefit package for CYSHCN enrolled in CRS (ALL Kids Plus) and to advocate for expanded services for all CYSHCN enrolled in basic ALL Kids.		X		X
6. Train selected district staff members as insurance specialists/consultants to assure that third-party resources are used to the maximum potential and to provide an expert resource for families about benefit packages and options.		X		X
7. Advocate for the unique needs of CYSHCN, especially those with more complex conditions and/or functional limitations and those with above-routine need/use of services, and for the incorporation of necessary services in basic insurance plans.				X
8.				
9.				
10.				

b. Current Activities

FY 2007 activities as described above are being continued in FY 2008 with the following additions or exceptions.

Infrastructure-building:

Through the HIPAA Privacy Officer (a CRS staff member) and HIPAA Security Officer, ADRS provides training and updates for all staff members on HIPAA regulations. New posters related to protecting patient privacy and electronic transmission of client information were provided to all ADRS offices, including all divisions. In May, 2008, the HIPAA Privacy Officer will provide a "HIPAA 101" training for all staff using the agency's new video on demand technology. This will be available permanently and can be used for new staff orientation or review purposes. Privacy notices are provided to all clients and families, are available in Spanish, and are posted in all field offices/clinics.

The Adequate Insurance 2010 Work Group continues to be active via meetings and ongoing progress with action steps on its action plan.

c. Plan for the Coming Year

Unless stated otherwise, all previously discussed activities related to this measure will continue in FY 2009. A recap and notation of activities being newly implemented follows.

Direct:

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

Enabling:

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

Infrastructure-building:

CRS will continue working with its partners and stakeholders to implement a State plan to ensure that by 2010 all families of CYSHCN will have adequate public and/or private insurance to pay for the services they need. The work group's current action plan includes steps and strategies

designed to increase awareness and sensitivity to the needs of CYSHCN and their families, identify pertinent policies and barriers in order to streamline the process for families to access services for CYSHCN; train workers, disciplines, companies, providers, and consumers; identify available care coordination, develop models of flexible benefit plans, identify options for accessing insurance for the uninsured, coordinate with ADPH to determine what is done with the pediatric health history requested in Medicaid applications, and collaborate with the transition work group regarding transition to young adulthood since the same services and types of providers are needed.

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

CRS will train selected district staff members as insurance specialists/consultants to assure that third-party resources are used to the maximum potential and to provide an expert resource for families to discuss benefits packages to help them better understand and utilize the options provided through their individual insurance plan.

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

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	73	73	73.7	73.7	78
Annual Indicator	73.7	73.7	73.7	73.7	91.7
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	91.7	91.7	91.7	91.7	91.7

Notes - 2007

Indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration (HRSA) and the U.S. Centers for Disease Control and Prevention (CDC) in 2005-06. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2 surveys are not comparable for this indicator.

Notes - 2006

Through 2006, each year shown for this indicator is pre-populated with the estimate for Alabama from the National Survey of CSHCN that was conducted in 2001. Additional information about this survey is provided below. Continued use of the estimate from the 2001 survey for annual

performance objectives reflects that the survey is conducted only periodically, and a more recent estimate is not yet available. New data are expected to be released in FY 2007.

The National Survey of CSHCN utilized State and Local Area Integrated Telephone Survey (SLAITS) procedures. The survey is the result of analyses conducted by the staff of the Special Populations Surveys Branch, Division of Health Interview Statistics, National Center for Health Statistics, CDC, and provided to HRSA's Maternal and Child Health Bureau.

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

Notes - 2005

See this indicator's field note to year 2006 about data-related issues.

a. Last Year's Accomplishments

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

Direct:

In FY 2007 CRS served 16,346 CYSHCN, provided 14,612 clinic visits, responded to 4,358 requests for information or referral, and furnished 95,279 encounters by physicians, dentists, and CRS staff.

Due to increased State funding CRS was able to resume purchased services for families up to 300% of FPL.

Hearing and Teen Transition Clinics were expanded to new locations. New Speech Pathology Clinics provide services to children with communication deficits where other resources are unavailable. In Birmingham, 3 new clinic initiatives were being developed in 2007. The Limb Deficiency Clinic will offer evaluations and recommendations for children with congenital or traumatic limb amputations. The Pediatric Orthopedic Specialty Clinic will provide evaluation of complex orthopedic conditions. The Cystic Fibrosis Newborn Clinic will provide follow up for infants who test positive for cystic fibrosis on Alabama's expanded newborn screening panel. To increase access in rural areas, specialty evaluation clinics such as Feeding, Augmentative Communication Technology, and Seating, Positioning, and Mobility were held in community locations outside CRS offices (homes, schools, and CHDs). CRS continued to evaluate needs and modify services to fill gaps.

CRS served 442 infants/children through ADPH's Universal Newborn Hearing Screening Program. CRS continued to be critical to the system of care for children who fail newborn hearing screening. CRS audiologists provided second-level screening and offered diagnostic and intervention services via evaluations, hearing aid dispensing, and hearing aid orientation.

Population-based:

CRS presented to all 21 State SSA offices, increasing awareness to enhance the system for families. Contacts were made with all children newly awarded SSI.

CRS began offering community-based onsite screenings for scoliosis and hearing loss. More than 1,500 screenings were provided in school systems, daycare centers, and Head Start locations in underserved areas.

Infrastructure-building:

CRS continued to maintain/modify its case management and data collection software (CHARMS) as needed (deployed 2005). Phase II (clinic scheduling/electronic billing) was released in May

2007.

Funding continued for multidisciplinary developmental evaluations at Civitan International Research Center/Sparks Clinics in Birmingham.

CRS partnered with EIS to increase access to early intervention services for eligible infants/toddlers by sponsoring 13 community-based projects, serving about 650 children per month in 2007.

CRS collaborated with ongoing statewide emergency preparedness efforts. See the attachment to Section III.A for detailed information. A CRS office and a local Independent Living Center provided emergency preparedness training and disaster kits to people with disabilities.

CRS participated with the UAB-MCH Collaborative on issues related to CYSHCN in communities. This group includes the UAB School of Public Health (MCH division), the UAB Pediatric Pulmonary Center, and programs for Leadership Education in Adolescent Health and Leadership Education in Neurodevelopmental and Related Disabilities. CRS staff provided trainings for students in these programs. Members of the collaborative participated in 2010 work groups and other CRS activities.

CRS staff participated with Alabama Medicaid's transformation grant, Together for Quality. These federal grants help states design and implement reforms to increase quality and efficiency in state Medicaid programs. Alabama seeks to build an integrated health care system that focuses on better health outcomes and improves quality of life for Medicaid recipients. Goals include: reduce duplication of service, prevent fragmented information, increase access to medical data, and improve care coordination. Medicaid plans to create a statewide electronic health information system that will link Medicaid, State health agencies, providers, and private payers and establish access to individual health information, claims, immunization records, prescription data, and lab results.

CRS continued its lead role in implementing Alabama's Healthy People 2010 Action Plan for CYSHCN via 6 work groups of key stakeholders targeting goals for CYSHCN.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement Alabama's 2010 Action Plan for CYSHCN and expand activities to involve local communities.		X	X	X
2. Serve at least 17,000 CYSHCN through the local CRS offices.	X	X	X	X
3. Support the Alabama Early Intervention System (EIS) by increasing access to EIS services for eligible individuals.		X		
4. Give a presentation on CRS to the staff in every Social Security Administration office in Alabama.			X	
5. Work cooperatively with other agencies to implement the Universal Newborn Hearing Screening Program (discussed under NPM #12) and to support Alabama's expanded newborn screening initiatives through appropriate follow-up care.	X	X	X	X
6. Collaborate with ongoing emergency preparedness efforts related to CYSHCN and their families.				X
7. Modify and update CRS electronic client information management system (CHARMS).				X
8. Continue participation with the UAB-Maternal and Child Health (MCH) Collaborative.				X

9. Continue to collaborate on advisory committees and work groups related to Medicaid's grant projects, Together for Quality and Alabama's Assuring Better Child Health and Development (see NPM #3).		X	X	X
10. Promote cultural competence in the system of care for CYSHCN and their families through collaborations and partnerships.	X	X	X	X

b. Current Activities

FY 2007 activities as described above are being continued in FY 2008 with the following additions or exceptions.

Direct:

The Limb Deficiency Clinic began in February 2008. The Pediatric Specialty Orthopedic Clinic will begin Summer 2008. The Cystic Fibrosis Newborn Clinic began in April 2008. The latter clinic is a collaboration among CRS, Children's Hospital of Alabama, and ADPH's Newborn Screening initiative.

Population-based:

Community-based onsite screening efforts for hearing loss and scoliosis are expanding. These are provided at health fairs and for school systems (public and private), daycare centers, and Head Start locations in rural or underserved locations.

Infrastructure-building:

CRS has established a data-sharing agreement with ADPH's Universal Newborn Hearing Screening Program to provide data on second-level hearing assessments for infants who fail initial screening. CRS has created a new electronic page in CHARMS to capture this data and will begin electronic transmission of this information directly to ADPH in May 2008.

In addition to the individual work groups addressing goals for CYSHCN, Alabama's Healthy People 2010 initiative is being expanded to include activities and training at the community level.

All ADRS offices in Montgomery, including the State Office, will move to a new space during the summer of 2008. These upgraded facilities will expand access to care and provide additional meeting space for staff training.

c. Plan for the Coming Year

Unless stated otherwise, all previously discussed activities related to this measure will continue in FY 2009. A recap and notation of activities being newly implemented follows.

Direct:

At least 17,000 CYSHCN, including SSI recipients, will receive information and referral services, health and rehabilitative services, care coordination services, and enabling services arranged through local CRS offices, including assistance with referrals and applications to other agencies.

CRS will work cooperatively with other public and private agencies in Alabama to ensure access to appropriate diagnostic procedures and intervention services for all children identified with hearing impairments through universal newborn hearing screening. CRS will continue to provide second-level hearing screening and diagnostic and intervention services through pediatric audiology evaluations, hearing aid dispensing, and hearing aid orientation. CRS will monitor and evaluate the statewide initiative to directly dispense hearing aids to children and youth with hearing loss and increase collaborations with VRS and VRS-Deaf/Blind Services Division.

CRS will work cooperatively with other public and private agencies to support Alabama's

expanded newborn screening initiatives through appropriate follow up, care coordination, information/referral, and rehabilitation services as needed.

Population-based:

A CRS representative will present every SSA office in Alabama with information about rehabilitation services, including care coordination, available to CYSHCN through CRS.

Infrastructure-building:

CRS will work with its partners and stakeholders to implement a State plan to ensure that by 2010 community-based service systems will be organized so that families can use them easily. The work group's current action plan includes steps and strategies toward using the structure of the "Family Resource Center" toolkit to construct a "system map" of community-based services that will meet the needs of CYSHCN and their families/caregivers.

CRS will continue its lead role in implementing Alabama's 2010 Action Plan for CYSHCN and expand activities to involve local communities.

CRS will continue to collaborate on advisory committees and work groups related to Medicaid's grant projects, Together for Quality and Alabama's Assuring Better Child Health and Development.

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

CRS will continue to modify and update CHARMS as needed.

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

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

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	6	6	6	6	10
Annual Indicator	5.8	5.8	5.8	5.8	38.3
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?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	38.3	38.3	38.3	38.3	38.3

Notes - 2007

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

Notes - 2006

Through 2006, each year shown for this indicator is pre-populated with the estimate for Alabama from the National Survey of CSHCN that was conducted in 2001. Additional information about this survey is provided below. Continued use of the estimate from the 2001 survey for annual performance objectives reflects that the survey is conducted only periodically, and a more recent estimate is not yet available. New data are expected to be released in FY 2007.

The National Survey of CSHCN utilized State and Local Area Integrated Telephone Survey (SLAITS) procedures. The survey is the result of analyses conducted by the staff of the Special Populations Surveys Branch, Division of Health Interview Statistics, National Center for Health Statistics, CDC, and provided to HRSA's Maternal and Child Health Bureau.

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

Notes - 2005

See this indicator's field note to year 2006 about data-related issues.

a. Last Year's Accomplishments

Using updated data from the National Survey of CSHCN (2005-06), 38.3% of Alabama families with CSHCN reported success for this measure versus 41.2% of U.S. families. Previous Alabama estimates for this measure were not reliable and, per survey notes, this outcome cannot be compared to 2001 results due to changes in methodology. Alabama sample sizes were too small to meet reliability standards when stratified by response categories; however, national patterns indicated differences by reason for inclusion as CSHCN. CSHCN managed by prescription medicines more often reported success (49.9%) than those with above-routine need or use of services (31.6%) or functional limitations (29.9%).

Direct:

CRS staff worked individually with youth to ensure linkage to adult health care providers and community systems. Teen Transition Clinics were ongoing in Mobile, Birmingham, and Huntsville. ADRS hired joint CRS/VRS audiologists to help transition youth and young adults with hearing loss to vocational or work-related rehabilitation services.

Enabling:

CRS continued to support its State YAC, comprised of CRS youth who participated in leadership training through the annual Alabama Governor's Youth Leadership Forum (YLF). YAC advises CRS on policy related to services for youth and promotes development of a system that facilitates transition. YAC involvement and activities have been more limited in 2007 due to the inability to find and hire a replacement for the CRS State Youth Consultant (former CRS State Youth Consultant completed college and was hired as a full-time teacher). CRS announced the position, but there were no applicants.

A YAC member submitted articles for the "Youth News" insert to the CRS Parent Connection Newsletter.

Population-based:

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

Several offices hosted events for youth with SHCN, focusing on issues important as they enter young adulthood, including personal care and sexuality. Mobile hosted the fifth annual "It's a Girl Thing," and Homewood held a "Just4Girls" tea and a "Just4Guys" workshop.

Infrastructure-building:

A joint effort between CRS and VRS was established to identify challenges in the referral and transition process. The ADRS Continuum of Transition focuses on strengthening the continuum of services provided by each division. As a part of the overall strategic plan, a liaison council was formed to develop a framework for divisions to provide comprehensive, quality services to youth with disabilities. Transition liaisons were identified from both divisions for each district office, and ongoing training was provided. An electronic referral system was launched between CRS and VRS. Division-specific talking points were created to assist staff in presenting agency services to youth and families. A template for a written transition plan for CRS youth was developed to guide families, youth, and staff in transition to all aspects of adult life, including work, health care, community, education, and training. (This has been modified as a part of an expanded initiative related to transition specialists. See "Current Activities.")

CRS collaborated with VRS, local schools, and community resources to hold Transition Information Expos in all CRS districts. The events were specific to each local community but targeted youth with SHCN, families, teachers, and local service providers. The events featured a full day of speakers (including youth) who covered transition topics. They also provided networking opportunities, equipment on display, resource fairs, and information on adaptive recreational opportunities.

CRS collaborated with the Children's Advisory Council for MHMR, ADRS Deaf Services Transition Committee, and ADRS Services for the Blind on initiatives related to transition.

Youth provided input on FY 2007 activities and the FY 2008 plan at a February 2007 YAC meeting. During a follow-up conference call YAC members discussed and rated CRS youth involvement in FY 2006, using a modification of CRS's format for rating family involvement for Form 13. CRS staff presented this tool to national colleagues during a Healthy and Ready to Work conference call (April 2007). Healthy and Ready to Work has developed Form 13A for use by State CSHCN programs to document youth involvement. A completed version for Alabama is attached to this section.

Youth were supported to participate in all Healthy People 2010 work groups, including the one related to transition.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement Alabama's 2010 Action Plan for CYSHCN.		X	X	X
2. Facilitate collaboration and partnerships through support of youth on the CRS Youth Advisory Committee.		X	X	X
3. Facilitate collaboration and partnerships through training activities, articles in the family newsletter, and employment of a State Youth Consultant.		X	X	X
4. Youth Advisory Committee activities will include meetings, conference calls, workshops, and information sessions for parents.		X		X

5. Collaborate with Vocational Rehabilitation Service to implement interdepartmental plan to promote transition, including written plans for all CYSHCN in the program.		X	X	X
6. Have youth with special health care needs as co-presenters at all transition-related trainings.			X	
7. Expand transition materials and resources including public relations tools, brochures, notebooks, transition guides, etc.			X	
8. Collaborate with Vocational Rehabilitation Service, schools, and local community resources to hold Transition Information Expos in each district.		X	X	X
9. Assure that transition planning is sensitive to the unique needs of all CYSHCN, especially those with more complex conditions, functional limitations, and/or above-routine need or use of services.		X	X	X
10. Provide ongoing training and development opportunities for Social Work Transition Specialists to assure that these staff members maintain expertise with transition issues and have updated resource materials.			X	X

b. Current Activities

FY 2007 activities as outlined above continue in FY 2008 with the following additions or exceptions.

Direct:

Teen Transition Clinic expanded to Montgomery in March 2007.

As transition for CYSHCN can be complex, especially for those with more extensive needs and functional limitations, CRS is developing staff social work positions focused on transition. At age 14 to 16, all CRS youth are transferred to the caseload of their district's Social Work Transition Specialist. These staff have expertise in all aspects of transition to help the youth and family plan for adulthood. A Care Coordination Worksheet has been created for all CRS clients, with transition issues included. A transition plan template is being created for use with clients ages 14-21.

Enabling:

CRS is revising the job description for the State Youth Consultant and will renew recruiting efforts.

VRS and SDE have created Young Adults in Transition (YAiT), to increase communication, disability awareness, and resources about transition. As part of the 2007 State Transition Conference, YAiT members provided training on self-determination and directing the IEP process to youth with disabilities at 2 area schools.

Infrastructure-building:

Transition Resource Expos continue. Each district has one yearly, rotating among the individual offices in the district.

c. Plan for the Coming Year

Unless stated otherwise, all previously discussed activities related to this measure will continue in FY 2009. A recap and notation of activities being newly implemented follows.

Enabling:

CRS will facilitate youth and professional collaboration in program and policy activities through employment of a CRS State Youth Consultant, support of youth on the CRS State YAC, training

activities, and articles in the Parent Connection Newsletter. YAC activities will include conference calls, face-to-face meetings, workshops, and information sessions for parents of YAC members.

Population-based:

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

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

Infrastructure-building:

CRS will continue working with its partners and stakeholders to implement a State plan to ensure that by 2010 all youth with SHCN will receive the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence. The work group's current action plan includes steps and strategies designed to increase availability of and access to all health care services needed as children become adults, increase employment outcomes for youth with SHCN, promote independence as it relates to the individual by empowering CYSHCN to achieve life goals, and ensure that transition issues are addressed in all other 2010 work groups.

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

CRS will continue collaboration with VRS to implement the interdepartmental continuum plan to promote transition services for youth with SHCN, including the development of a written transition plan for all participants in the program.

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

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

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	83.8	86.9	83.8	85.1	86.4
Annual Indicator	78.9	82.6	82.3	85.3	81.9
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	87.7	89	89	89	89

Notes - 2007

Values for all years are from the National Immunization Survey conducted by the U.S. Centers for Disease Control and Prevention (CDC). Tables published by CDC do not provide numerators and denominators, which is why these items are left blank, but show a 95% confidence interval of + or - 5.8 for Alabama in FY 2007.

As indicated by the confidence interval, this indicator can fluctuate notably from year to year, and the decline in 2007 relative to 2006 was not statistically significant. However, because this indicator can fluctuate and was notably below the objective for FY 2007, we set the objective for 2012 at 89.0%: the same as the objective for 2009-2011. The specific CDC table used was "tab03_antigen_state.xls," "Q3/2006-Q2/2007." Children in this survey were born between July 2003 and December 2005.

Notes - 2006

Values for all years are from the National Immunization Survey conducted by CDC. Tables published by CDC do not provide numerators and denominators, which is why these items are left blank, but show a 95% confidence interval of + or - 5.1 for Alabama in FY 2006. As indicated by the confidence interval, this indicator can fluctuate notably from year to year. For this reason, we set the objective for 2011 at 89.0%: the same as the objective for 2009 and 2010. The specific CDC table used was "tab03_antigen_state.xls," "Q3/2005-Q2/2006." Children in this survey were born between July 2002 and January 2005.

Notes - 2005

Tables published by CDC show a 95% confidence interval of + or - 6.2 for Alabama in FY 2005. Since this indicator did not improve in 2005, we set the objective for 2010 at 89.0%, the same as the objective for 2009.

a. Last Year's Accomplishments**Trends:**

This indicator has not shown a clear trend over the years shown. In FY 2007 an estimated 81.9% of the target population were fully immunized. The corresponding value for the U.S. was 80.4%.

Cross-cutting:

The Immunization Division, located in the Department's Bureau of Communicable Disease, is basically responsible for some enabling services and for population-based and infrastructure-building services designed to promote full immunization of infants and toddlers. For several years the division has maintained a Web page, which is further discussed under "Current Activities." Activities occurring in FY 2007 (unless stated otherwise) follow and, unless otherwise indicated, were carried out by the Immunization Division.

Direct:

CHD staff immunized infants and children seen in clinics.

Enabling:

The sending of postcards to parents of 11-month-old CHD patients to remind parents of vaccines that will become due after the first birthday continued.

Population-based:

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

The Alabama Perinatal Hepatitis B Program continued. This program is a case management system that serves public and private HBsAg-positive maternity patients in Alabama. (HBsAg is an antigen produced by the hepatitis B virus.) In the program, the State Perinatal Hepatitis B Coordinators work closely with private medical practices and CHDs to ensure that patients are informed about hepatitis B. As well, efforts are made to identify and screen all household and

sexual contacts for HBsAg and antibodies to the hepatitis B virus and to give hepatitis B vaccine if indicated. The case management system extends to the infants of HBsAg-positive patients to ensure that they receive proper biologicals at birth and at the recommended times in infancy, as well as to ensure that titers are drawn following completion of the 3-dose series of hepatitis B vaccine.

Infrastructure-building:

Maintenance of the Immunization Provider Registry with Internet Technology (ImmPRINT) continued. This registry makes childhood vaccine histories available to all the State's vaccine providers. Many federally qualified health centers (FQHCs) continued using ImmPRINT, and 291 private medical facilities in Alabama were enrolled in ImmPRINT.

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

Provision of satellite down-link sites for programs presented by CDC and administration of the Vaccines for Children (VFC) Program for the State also continued. As of early FY 2007 the Immunization Division was providing vaccine and support for 558 active public and private VFC providers, compared to 540 such providers in early FY 2004, 566 providers in early FY 2005, and 539 providers in early FY 2006.

Via the Public Health of Alabama County Operations Network (PHALCON), provision of educational materials required for the Immunization Program for on-site printing by CHDs continued. These materials were available in English and Spanish. Making such materials available in this way has decreased storage needs at the Central-Office and county levels. Procedures to identify CHD Child Health patients who were 4 months of age or older and had not been vaccinated continued. The groundwork for these procedures had been laid in FY 2003, when the Immunization Division retooled a computer program, run from ImmPRINT, to identify these infants and children. Subsequently, in June 2003 immunization records in ImmPRINT were linked directly to PHALCON, allowing CHD staff to access patient vaccination history, including vaccines provided through the private sector. CHDs were then to track Child Health patients aged 4 months or older who had not been vaccinated, since this group of infants and children are considered least likely to complete the vaccine series.

Table 4a, National Performance Measures Summary Sheet

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

6. Provide vaccine-level audits in federally qualified health centers and for some private providers.				X
7. Administer the Vaccines for Children (VFC) Program for the State.				X
8. Operate the Immunization Outreach Program, which enables Alabama physicians to determine if their practice is on track to meet the Healthy People 2010 objective of having 90% of 2-year-old children appropriately vaccinated.				X
9. Provide continuing education and materials on immunization to CHDs.		X		X
10. Using a file linking ImmPRINT records with ADPH's patient encounter database, identify and track CHD Child Health patients aged 4 months or older who have not been vaccinated.	X	X		X

b. Current Activities

Cross-cutting:

FY 2007 activities basically continue. The number of sites enrolled in the VFC Program is now 558, compared to 583 sites in early FY 2007. The Immunization Division provides vaccine and support for all the enrollees.

The division continues maintaining a Web page on immunization and certain diseases. For example, the page includes the childhood and adolescent immunization schedule, an "Immunization Page just for Kids," and information on ImmPRINT. As well, the page includes links to CDC materials on National Infant Immunization Week (April 19-26, 2008) and National Immunization Awareness Month (in August). Further, the page provides information on VFC, the Perinatal Hepatitis B Program, and the Immunization Outreach Program.

An April 2008 press release by ADPH urged the public to learn the risk factors for viral hepatitis during May, Hepatitis Awareness Month.

c. Plan for the Coming Year

FY 2007 and 2008 activities, recapped below, will basically continue in FY 2009.

Cross-cutting:

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

Direct:

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

Enabling:

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

Population-based:

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

Infrastructure-building:

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

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	35.2	33.8	26.8	25.1	24.8
Annual Indicator	27.3	27.4	25.3	27.2	28.3
Numerator	2660	2672	2486	2683	2789
Denominator	97295	97694	98093	98695	98695
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	24.6	24.3	24.1	23.9	23.9

Notes - 2007

This estimate was added on September 19, 2008, and is not discussed in the narrative. Because a year 2007 population projection for this age group is not readily available to the Bureau of Family Health Services, the year 2006 population projection is shown as our best estimate for this population in year 2007 as well. By fiscal year (FY) 2009, the bureau will seek to develop population estimates for this age group in recent years. Toward the end of a decade, population projections, which are based on the most recent U.S. Census, tend to become inaccurate.

The objective for 2012 has been set to match that for 2011. We are aware that objectives for 2006 and 2007 have not been met and that objectives for 2008 forward are unlikely to be met, given the increase in this indicator 2 years in a row. By late fiscal year 2009 we will revise objectives from 2010 onward, based on the most recent 3-year baseline available for this rate at that time.

Notes - 2006

All estimates are for calendar years (CYs). All denominators shown represent 60% of the population projection for females aged 15-19 years in the specified CY. These projections are made by Alabama's Center for Business and Economic Research.

Like other objectives from 2006 onward, the objective for 2011 requires a continuing annual decline of 1.0% from the 2005 baseline.

Notes - 2005

See field note to year 2006 for data sources and methods.

Comparing 2-year rates, this rate declined (improved) from 30.35 live births per 1,000 females aged 15-17 years in 2001-02 to 26.3 live births per 1,000 such females in 2004-05. This decline represents an average annual decline of 4.6% (per a multiplicative model), or an overall decline of 13.4%. Objectives from 2006 onward require a modest annual decline of 1.0% from the 2005 baseline. These objectives are somewhat challenging, nevertheless, since the 2005 baseline rate is notably lower than any other rate during the 5-year period shown, and continuation of the previous rapid decline should not be assumed.

a. Last Year's Accomplishments

Trends and Data-Related Issues:

The live birth rate for 15-17 year-old teenagers notably declined (improved) through 2005. For example, comparing 2001-03 to 1996-98, this rate declined by 31%. That is, in 2001-03, 29 out of every 1,000 females aged 15-17 years gave birth to a live-born infant, compared to 43 per 1,000 in 1996-98 (reference #1). In 2005 the rate was lower still, with 25 out of every 1,000 females aged 15-17 years giving birth to a live-born infant. However, in 2006 the rate increased slightly, to 27.2 live births per 1,000 females in this age group. Though the status in 2006 was better than in 2003 through 2005, future trends in this indicator, and especially in SPM #3, merit monitoring. Because NPM #8 counts only live-born infants, rather than all pregnancies among 15-17 year-old teens, SPM #3 tracks the pregnancy rate for this age group.

Historical Context Through FY 2005:

The Alabama Abstinence-Until-Marriage Education Program (AAEP) had used federal funding for FYs 1998-2002 to provide abstinence education to youth aged 17 years and younger. AAEP's goals have been to reduce the occurrence of out-of-wedlock sexual activity and STDs by providing abstinence education to youth aged 17 years and younger. The federal funding for this program ended in FY 2003 and was not reauthorized, but Congress extended a continuing resolution that provided federal funding quarterly for FYs 2003-2006.

The Alabama Community-Based Abstinence-Until Marriage Education Program (ACAEP) had used federal funding for FYs 2002-2004 to provide abstinence education to adult role models and to youth aged 12-18 years. Funding for ACAEP ended in June 2004, however, so the program was discontinued at that time. In January 2004 and June 2005, ADPH submitted a competitive application for federal funding to provide community-based abstinence-until-marriage education to adults in the community and to youth aged 12-18 years in schools and communities in FYs 2005 and 2006 respectively. Each application was approved but, due to lack of funds to support all approved applications, the federal agency was unable to fund the project in FY 2005 or FY 2006.

FY 2007:

Unless stated otherwise, the following activities occurred in FY 2007.

Direct:

CHD Family Planning clinics served 22,578 teens in CHDs in FY 2007.

Enabling:

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

EPSDT-eligible teens who presented in CHD Family Planning Clinics were referred to the care coordinator after their clinical exam. The care coordinator reinforced the information and education provided by the nurse regarding birth control, STDs, and HIV/AIDS. All teens presenting at Family Planning Clinics were considered to be at high risk for pregnancy and were offered care coordination. A teen assessment worksheet was used to gather psychosocial information for teens who accepted care coordination.

Population-based and Infrastructure-building:

The toll-free InfoConnection hotline to provide educational information for teens regarding reproductive health and family planning services continued. A Web-based electronic care coordination system (CCRS, discussed in Section III.A) for sending referrals from ADPH's Central Office to the PHAs and/or counties was implemented in FY 2007.

Abstinence education for AAEP was not reauthorized, but the U.S. Congress extended a continuing resolution that provided federal funding quarterly through FY 2007. AAEP funded 8 projects that provided interventions and mentoring programs in schools to about 38,000 youth in

39 counties. A statewide media campaign used billboards, press releases, and a Web site to promote abstinence until marriage.

A video on prevention of sexual coercion, developed by the State of Virginia for patient viewing, was modified for use in CHDs, and copies were distributed to all CHDs. In April 2007 ADPH provided a statewide satellite training on prevention of sexual coercion, created for ADPH Central-Office, PHA, and CHD staff involved in provision of family planning services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide family planning services for teens coming to CHDs for such services.	X			
2. Counsel teens coming to CHDs for family planning services, regarding how to respond to pressure to engage in sexual activity.		X		X
3. Provide care coordination for teens who come to CHD Family Planning clinics and are eligible for Alabama Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.		X		X
4. Operate InfoConnection, the toll-free telephone line that provides educational information for teens on reproductive health and family planning services.			X	
5. Administer the Alabama Abstinence-Until-Marriage Education Program (AAEP), which implemented a statewide media campaign to promote the abstinence-until-marriage message.			X	X
6. Through AAEP, channel federal funds to eligible community groups seeking to prevent adolescent pregnancy.			X	X
7.				
8.				
9.				
10.				

b. Current Activities

Direct and Enabling:

CHD Family Planning clinics continue to serve teens who present there. Services include clinical, educational, counseling, and care-coordination services.

Population-based and Infrastructure-building:

The toll-free hotline, InfoConnection, continues.

AAEP's activities have basically continued in FY 2008, since the U.S. Congress continued federal funding through June 30, 2008. Continuation of activities after June will depend on whether abstinence education funding is extended through the fourth quarter of FY 2008. AAEP's progress toward achieving the program's goals is being evaluated.

c. Plan for the Coming Year

Direct and Enabling:

CHD Family Planning clinics will continue to serve teens who present there. Services will include clinical, educational, counseling, and care-coordination services.

Population-based and Infrastructure-building:

The toll-free hotline, InfoConnection, will continue.

Contingent on continuation of federal funding of abstinence education by Congress in FY 2009, ADPH may submit an application for federal funding to continue to provide abstinence-until-marriage education in Alabama schools to youth aged 17 years and younger.

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	67	23.2	23.7	24.2	26.7
Annual Indicator	22.7	22.9	23.2	26.4	26.4
Numerator	384			629	629
Denominator	1692			2380	2380
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	27	27.2	27.5	27.7	27.7

Notes - 2007

Another observation-based survey on the prevalence of dental sealants is expected to be conducted in FY 2009. Until then, we are using the observation-based numbers for FY 2006 as our best estimates for years in which a survey of dental sealants is not conducted.

Since we do not have current observation-based data, we have set the year 2012 objective to match the year 2011 objective.

Notes - 2006

The provisional estimate for 2006 is from an observation-based, representative statewide survey of dental sealants among third-grade children in the State, conducted from January through May 2006. Objectives from 2007-2010 have been revised, and the one for 2011 set, to require an annual increase (improvement) of 1.0% from the (unrounded) provisional 2006 baseline.

Targets for FYs 2002 and 2003 were set prior to those years, using the only then-available estimates for 1999 and 2000 as baseline years. The then-available estimates were based on parental report and were spuriously high, leading to unrealistically high targets for FYs 2002 and 2003.

Notes - 2005

For estimates from FY 2001 through FY 2005, only that for FY 2003 was based on a direct-observation survey of a statewide representative sample of third graders. Such a survey has not been conducted since FY 2003. We therefore estimated the percentage for FY 2004 by multiplying 1.01 times the observation-based percentage for FY 2003, and that for FY 2005 by multiplying 1.01 times the aforesaid interpolated estimate for FY 2004. The factor of 1.01 was chosen because, based on 2 observation-based point estimates, the annual rate of improvement between FYs 1991 and 2003 had been 1.061%. Numerators and denominators are not provided for interpolated estimates, shown for 2004 and 2005.)

Interpolated estimates will be provided until findings from another representative, direct-observation survey of dental sealants in Alabama third graders become available. Family Health Services' Oral Health Unit staff and University of Alabama School of Dentistry in Birmingham pediatric residents began such a survey in January 2006 and plan to complete it in FY 2007. Data from these screenings are to be included in the U.S. Centers for Disease Control and Prevention's National Oral Health Surveillance System database.

From the 2003 baseline, targets require an annual improvement of 2.1% per year--a modest improvement, but twice that of the estimated historical rate of improvement of 1.061% per year.

a. Last Year's Accomplishments

Historical Context:

The OHU and the University of Alabama School of Dentistry in Birmingham (School of Dentistry) have partnered to periodically conduct observation-based, representative, statewide surveys of dental sealants among third-grade Alabama children. The last survey of this nature was conducted in FY 2006.

FY 2007:

The following activities occurred in FY 2007.

Direct:

CHD dental clinics provided 3,819 dental sealants, and school-based programs provided 131 sealants. The JCDH Dental Program continued to operate at less than full staffing, which reduced the number of sealants that would otherwise have been provided.

Enabling:

Per collaboration between OHU staff and FHS's social work staff, 72 Patient 1st care coordinators were trained to promote good oral health, including utilization of sealants, for children and their families.

Population-based:

During National Children's Dental Health Month and "Give Kids a Smile" initiatives, OHU staff and several districts of the Alabama Dental Association collaborated to provide press releases, literature distribution, and other outreach promoting dental sealants.

Infrastructure-building:

An article written by OHU staff was published in the Alabama Dental Association Newsletter to inform readers of the low percentage of Alabama children with sealants and to encourage increased provision of sealants, especially by general dental practitioners in the private sector.

No observation-based survey of dental sealants among Alabama third-grade children was conducted in FY 2007.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. In collaboration with others and as opportunities and funds arise, provide dental services (including application of dental sealants when indicated) to certain populations of children who tend to have unmet dental needs.	X			X
2. Train care coordinators with Patient 1st (Alabama Medicaid's primary care case management program) to promote good oral health for children and their families.		X		X
3. Participate in national Children's Dental Health Month.			X	

4. Participate in the national "Give Kids a Smile" campaign.			X	
5. Through the Alabama Dental Association Newsletter, encourage increased provision of dental sealants, especially by general dental practitioners in the private sector.				X
6. As feasible, in collaboration with the University of Alabama School of Dentistry in Birmingham, periodically conduct an observation-based, representative, statewide survey of dental sealants among third-grade children.				X
7.				
8.				
9.				
10.				

b. Current Activities

FY 2007 activities have basically continued in FY 2008.

Infrastructure-building:

In FY 2008 a bill was introduced into the State legislature for the Alabama Board of Dental Examiners to regulate the use of mobile dental vans and portable equipment (which would allow for Medicaid reimbursement for services). Use of mobile dental vans (both public and private) in the future may enhance access to dental services, including placement of sealants.

c. Plan for the Coming Year

Cross-cutting:

Unless previously stated otherwise, FYs 2007 and 2008 activities will basically continue in FY 2009. These activities include provision of dental sealants by some CHD staff and school-based clinics, collaboration between OHU staff and Patient 1st care coordinators, collaboration with various partners to perform outreach, and collaboration as feasible with School of Dentistry staff and students to promote access to dental care, including provision of dental sealants. As well, an observation-based survey on the prevalence of dental sealants is expected to be conducted in FY 2009.

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	7.7	7.5	6.4	5.8	6.2
Annual Indicator	5.4	6.6	6.5	6.3	
Numerator	50	62	61	59	
Denominator	934255	935145	936034	935525	
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	6.1	6	5.9	5.7	5.7

Notes - 2007

Due to the time required to receive, manage, and edit vital statistics data, final year 2007 death files are not yet available for Alabama. Our experience has shown that the incomplete, provisional files available at this time sometimes provide misleading results. If the final files are available by August 2008, staffing resources permit us to analyze the files, and the Title V Information System can be accessed in September 2008, we will provide the year 2007 estimate in September 2008. Otherwise, the estimate will be provided by July 2009.

Though the final year 2006 file is available, staffing limitations have delayed analysis of the file. We expect to have a final estimate for 2006 by September 2008.

Due to the lack of a final estimate for 2006 or 2007, the objective for 2012 has been set to match that for 2011.

Notes - 2006

The 2006 rate is provisional. Per Center for Health Statistics staff, the 2006 death file includes all the deaths, though they are waiting for the cause of death for about 100 records.

All denominators represent the population projection for children 14 years of age and younger in the specified calendar year. These projections were made by Alabama's Center for Business and Economic Research.

Objectives for 2003-2005 are retained from the Maternal and Child Health Services Block Grant 2003 Report/2005 Application. The objective for 2006, developed in FY 2005, required an annual decline of 2.0% from the 3-year baseline of 6.6 deaths per 100,000 in 1999-01 and was not achieved. Objectives from 2007 forward require a decline of 2.0% per year from the unrounded provisional 3-year rate for 2004-06 (6.5 per 100,000), considering that rate as the 2005 baseline.

Notes - 2005

This indicator increased from 6.2 deaths per 100,000 in 2001-02 to 6.6 deaths per 100,000 in 2004-05. However, the indicator has not shown a consistent trend in recent years (2001-2005).

a. Last Year's Accomplishments

Status and trends:

This indicator has shown no consistent trend in recent years. In 2006 the motor vehicle-crash mortality rate among persons 14 years of age and younger was 6.3 deaths per 100,000 persons in this age group.

Historical backdrop:

Key legislative events have included the Alabama Graduated Driver's License legislation and recent amendments to previous legislation concerning child safety restraints. Discussion of these laws follows.

The Alabama Graduated Driver's License legislation took effect in October 2002. Under this law, restrictions apply to 16-year-old drivers and to 17-year-old drivers who have been licensed for less than 6 months. Restricted drivers cannot have more than 4 passengers, not counting their parents, in the car. Additionally, except under certain circumstances, they cannot drive between midnight and 6 A.M. unless accompanied by a parent, guardian or, with the consent of the parent or guardian, a licensed adult driver. The circumstances in which they do not need to have a parent or guardian or licensed adult designee of the parent or guardian with them are when the teenager is driving to or from work or a school or church event, or driving due to an emergency.

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

legislative requirements regarding motor vehicle safety restraints for children and youth and included deleting a phrase limiting the previous legislation to children under the age of 6 years; deleting wording from the previous legislation implying that standard seat belts would constitute an adequate restraint system for 4-5 year-old children; expanding the definition of "motor vehicle" under this law to include all but taxis and motor vehicles with a seating capacity of 11 or more passengers (for these excluded vehicles, every person transporting a child is responsible for assuring that the child is properly restrained); adding statements to specify size-appropriate restraint systems; increasing the fine for violation of the law from \$10 to \$25 for each offense, with the stipulation that the charges may be dismissed by the trial judge and no court costs shall be assessed upon proof of acquisition of an appropriate child passenger restraint; adding a point system in order to identify habitually negligent drivers and habitual or frequent violators; and adding a requirement that \$15 of an imposed fine shall be used to distribute vouchers for size-appropriate child passenger restraint systems to Alabama families of limited income, with said money to be distributed to the Alabama Head Injury Foundation, which administers the voucher program free of charge.

FY 2007:

All of the following infrastructure-building activities occurred in FY 2007.

ACDRS continued reviewing all unexpected or unexplained infant and child deaths, including those due to motor vehicle crashes, per the mandating legislation described in Section III.B.

ACDRS enjoyed participation from all but 1 of the 41 Local Child Death Review Teams, and that one team was in the process of reconvening at year's end. Most of ACDRS's State Team vacancies were filled and the State Team became more active in the program.

The Alabama Graduated Driver's License legislation and the FY 2006 amendments concerning requirements for child safety restraints in motor vehicles continued to be operative.

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

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Administer the Alabama Child Death Review System (ACDRS), to review unexpected deaths of children and youth.			X	X
2. Through ACDRS, monitor deaths of infants, children, and youth due to motor vehicle crashes.				X
3. [Appropriate State authorities] enforce the graduated driver's license law.				X
4. [Appropriate State authorities] enforce the law concerning motor vehicle safety restraints for children and youth, which was recently amended to strengthen standards.				X
5. [The Alabama Department of Public Health's Bureau of Health Promotion and Chronic Disease, the Southeast Child Safety Institute, and other external entities] jointly conduct the Booster Seat Advocacy Program.			X	X
6.				

7.				
8.				
9.				
10.				

b. Current Activities

Cross-cutting:

Unless previously stated otherwise, FY 2007 activities basically continue in FY 2008. For example, ACDRS continues to monitor and review all unexpected or unexplained child deaths as mandated by law. Participants in the Booster Seat Advocacy Program are locating sites where booster seats will be distributed. Further, in conjunction with HPCD's Injury Prevention Division, ACDRS is developing a new educational brochure and outreach campaign on driving safety tips for teenagers.

c. Plan for the Coming Year

Cross-cutting:

Unless previously stated otherwise, FYs 2007 and 2008 activities will basically continue in FY 2009. To briefly recap, these include:

- 1) Review of all unexpected or unexplained deaths of infants, children, and youth.
- 2) Distribution of educational brochures and posters about all-terrain vehicle safety.
- 3) Continuation and support of the Booster Seat Advocacy Program.
- 4) Continued enforcement, by appropriate State authorities, of the Alabama Graduated Driver's legislation and the amended child safety restraint legislation.

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				26.1	27.1
Annual Indicator		25.6	23.2	28.3	
Numerator		13714	12835	16533	
Denominator		53569	55363	58353	
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	28.2	29.4	30.5	30.5	30.5

Notes - 2007

Estimates for this indicator are for calendar year (CY) and are from Pregnancy Risk Assessment Monitoring System (PRAMS) data, managed by the U.S. Centers for Disease Control and Prevention (CDC). Alabama PRAMS is a population-based mail/telephone survey of Alabama

residents who recently gave birth in the State. A stratified complex sampling design is used, and numbers reported here are weighted to represent all live births occurring in Alabama to Alabama residents. Because data are based on a sample, some statistical imprecision is expected. Observations for which breastfeeding status is unknown or unreported are excluded from the denominator.

Due to time required for data management, data for a given year do not generally become available to the states until at least 16 months after the end of the data collection year. For example, PRAMS data for 2004 were not available by June 2006. The Alabama Department of Public Health's Center for Health Statistics will provide numbers from the PRAMS 2007 dataset soon after CDC provides the dataset, but numbers for 2007 are not expected to be available before April 2009.

When available, confidence intervals for the following estimates are shown parenthetically. For the surveillance period 2000-2004, the weighted percentage of PRAMS mothers who were breastfeeding at the time increased slightly each year: from 20.3% (17.7-22.9) in 2000 to 25.5% (22.5-28.8) in 2004. Though the estimate then declined to 23.5% (20.6-26.6) in 2005, it increased to 28.3% in 2006. (Estimates shown on Form 11 for 2004 and 2005 are preliminary estimates that were provided before the State's PRAMS reports for those years were published. At this time, the Title V Information System does not allow us to directly correct estimates for those years.)

Objectives through 2010, set in FY 2006, require an average annual increase (improvement) of 4.0% per year, from the unrounded 2003 baseline of 23.2%. We are aware that the estimated prevalence for CY 2006 exceeds (is better than) objectives for 2007 and 2008. However, since the estimate for this measure may fluctuate from year to year, the objectives through 2010 are sufficiently challenging, and later objectives have been set to match the 2010 objective. If this indicator improves 3 years in a row, objectives may be revised upward.

Notes - 2006

Estimates for this indicator are for CYs and are from PRAMS data, managed by CDC. See note to year 2007 for more information about PRAMS.

Notes - 2005

Estimates are from PRAMS data. See the year 2006 field note for information about survey design and methods. The percentage of mothers who were breastfeeding at the time of the survey is used as a surrogate for the percentage breastfeeding at 6 months following delivery, since the survey questionnaire is sent to mothers about 2-4 months after delivery.

Per weighted PRAMS data for 2005, 23.2% of surveyed women were breastfeeding at the time of the survey. The numerator was therefore estimated by multiplying .232 times the weighted denominator.

a. Last Year's Accomplishments

Status and Trends:

As stated in the year 2007 field note to Form 11 for this indicator, the estimated percentage of mothers who were breastfeeding when the infant was about 6 months of age increased slightly each year--from 20.3% in 2000 to 25.5% in 2004--and then declined slightly in 2005, but increased to 28.3% in 2006. The time at which the mother was surveyed is used as a surrogate for 6 months following delivery.

The following activities occurred in FY 2007 unless stated otherwise.

Population-based:

WIC continued to increase public awareness of the importance of breastfeeding. For example, the WIC Breastfeeding Coordinator was interviewed by 2 local television stations. In addition, she

exhibited at the Annual State Nurses Association conference in Montgomery to promote breastfeeding to nurses and nursing students statewide. As well, she provided breastfeeding information for the Alabama's Health Newsletter each month and held a breastfeeding class for expectant teens at the Montgomery Early Head Start facility.

Infrastructure-building:

The WIC Breastfeeding Coordinator continued training WIC staff and offering breastfeeding education to staff from Alabama hospitals. Presentations on breastfeeding were made at CHDs and local hospitals. She served on the board of the Alabama Lactation Consultant Association (formerly the Alabama Breastfeeding Coalition), which continued to meet quarterly and helped to sponsor the "Multidisciplinary Perspectives in Perinatal Care" conference, held during August 2008 in Birmingham. Also, the coordinator served on the Alabama Wellness Coalition and on the Alabama Breastfeeding Committee (formerly the Alabama Breastfeeding Task Force), which was coordinated by the SPP and met quarterly. Nurses, doctors, lactation consultants, and various other health professionals are members of the committee. Quarterly meetings were held by video conference throughout the State, and subcommittees were formed. The group focused on how to encourage, support, and protect breastfeeding in Alabama.

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

USDA awarded funding to maintain and expand the Breastfeeding Peer Counselor Program. Blount (in north Alabama), Montgomery, and Mobile counties were the pilot sites for this program. Breastfeeding initiation rates increased in each of the pilot sites. "Loving Support through Peer Counseling Training" was held in May 2008 in Montgomery for WIC Staff. This training utilized "Loving Support Three Step Counseling" techniques.

A WIC Infant Breastfeeding Report was sent to PHA Nutrition Directors quarterly. The report provides breastfeeding initiation and duration rates for each clinic and PHA.

The Breastfeeding Resource Guide was updated and placed on ADPH's Web site. Materials were distributed to each CHD to promote Breastfeeding Awareness Month.

The Annual WIC Nutrition Education and Breastfeeding Promotion Workshop was held in January 2008.

AMOD awarded a grant to SPP to be used to provide preconceptional health and infant care counseling training for physicians who care for infants and for their staff. The infant care counseling training included a component on how to promote and support breastfeeding. SPP staff provided training to 22 physician offices, with 30 physicians and 228 office staff members being trained. As well, SPP collaborated with various agencies and organizations to promote breastfeeding.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Through television interviews, exhibits at professional meetings, and/or other appropriate media, promote public awareness of the importance of breastfeeding.			X	
2. Present breastfeeding education programs to CHD staff and, upon request, to hospitals.				X
3. Collaborate with the Alabama Breastfeeding Coalition, the Alabama Lactation Consultant Association and, when indicated, other groups to promote breastfeeding.			X	X
4. With support from a U.S. Department of Agriculture grant,			X	X

maintain and expand the Alabama Breastfeeding Peer Counselor Program.				
5. Send a quarterly infant breastfeeding report, based on WIC data, to Nutrition Directors for each of the State's 11 Public Health Areas.				X
6. Post the Breastfeeding Resource Guide on ADPH's Web site.			X	X
7. Distribute materials to each CHD to promote Breastfeeding Awareness Month.			X	X
8. With support from the Alabama Chapter of the March of Dimes, provide training on infant care counseling, which includes a component on breastfeeding, for physicians who care for infants and their staff.				X
9.				
10.				

b. Current Activities

FY 2007 activities are expected to basically continue through FY 2008. Some updates follow.

Population-based and Infrastructure-building:

The Breastfeeding Coordinator and 2 representatives from Alabama attended the Second National Conference of State/Territory Breastfeeding Coalitions, held in Virginia in January 2008.

The Alabama Lactation Consultant Association and the Alabama Breastfeeding Committee will continue to meet.

The Breastfeeding Peer Counseling Program expanded to 6 clinics by April 2008. The new sites are JCDH (3 clinics), Dallas County, Pike County, and Lee County. Trainings for new peer counselors will be conducted for local clinic staff.

The U.S. Department of Health and Human Services selected the Birmingham Healthy Start program as 1 of 10 community demonstration sites to implement the "Business Case for Breastfeeding" project, in collaboration with the Alabama Breastfeeding Committee. In June 2008 the Alabama Breastfeeding Committee, ADPH, Birmingham Healthy Start, and the UAB School of Public Health's MCH Department announced a statewide initiative to increase the numbers of businesses who provide lactation support to breastfeeding employees. The Business Case for Breastfeeding is part of a nationwide emphasis led by MCHB.

The Alabama Lactation Consultant Association will conduct a breastfeeding conference in August 2008.

Conference calls among the WIC Breastfeeding Coordinator, SPP staff, and Medicaid are planned for the purpose of promoting breastfeeding.

c. Plan for the Coming Year

Population-based and Infrastructure-building:

FYs 2007-2008 activities are expected to basically continue in FY 2009. These include provision of additional training for the Breastfeeding Peer Counselor Program, implementation of a strategic breastfeeding plan for Alabama communities via the Alabama Breastfeeding Committee's "Breastfeeding Friendly Communities" subcommittee, training of WIC staff, and provision of breastfeeding education statewide. The Business Case for Breastfeeding training project is expected to continue.

As well, the AMOD grant to SPP will continue. With support from the grant, SPP staff will continue providing training, including the component on breastfeeding, for physicians who care for infants

and for their staff, and will continue collaborating with other agencies to promote breastfeeding.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	85	87.5	90	95.2	95.3
Annual Indicator	95.6	88.2	95.1	94.3	95.9
Numerator	55846	51459	56371	58531	61342
Denominator	58397	58369	59300	62100	63986
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	95.4	95.5	95.6	95.7	95.7

Notes - 2007

All estimates pertain to calendar years (CYs). The denominator for each year is the number of occurrent live births during the year. Denominators for 2006 and 2007 are provisional.

The numerator for 2003 is based on hospitals performing screenings in CY 2003. This numerator was estimated by multiplying the estimated number of live births in 2003 (56,986) in hospitals participating in the Newborn Hearing Screening Program by .98. The factor of .98 was applied to allow for failure to screen a few infants in participating hospitals due to equipment failure or other issues. (Based on contacts with and reports submitted by participating hospitals, the Newborn Hearing Screening Coordinator estimated that at least 98% of live-born infants in these hospitals had undergone hearing screening prior to discharge).

Objectives for 2006 onward were set to gradually reach 95.6%, the highest value on record for this indicator, by 2010, increase slightly in 2011, and then remain stable. We are aware that the observed value of 95.9% in 2007 slightly surpasses (is slightly better than) objectives through 2012. However, given historical values for this indicator (60.2% in 1999, 84.0% in 2001, and 88.2% in 2004) and the potential for yearly fluctuations, remaining at or slightly above 95% would represent a notable achievement. Further, the estimate for 2005-07 combined is 95.1%, which is less than objectives from 2006 onward.

Notes - 2006

All estimates pertain to CYs. The denominator for each year is the number of occurrent live births during the year.

Notes - 2005

See year 2006 note.

a. Last Year's Accomplishments

Historical Context:

Alabama's Listening, Alabama's Universal Newborn Hearing Screening (UNHS) Program, which is administratively located in FHS, has been very successful in implementing the UNHS Program

throughout the State. All of Alabama's 59 birthing hospitals have voluntary universal newborn hearing screening programs in place. On October 23, 2002, hospitals began reporting hearing screening results on the blood spot form. Tracking of infants for hearing loss began at that time.

Status:

In FY 2007, 95.9% of infants born in Alabama's 59 birthing hospitals were screened for hearing impairment before hospital discharge.

FY 2007:

In FY 2007 many activities contributed to the UNHS Program's continued success. Key activities follow. Unless stated otherwise, the activities were conducted by UNHS Program staff.

Cross-cutting:

ADPH continued to have a UNHS Coordinator on staff. The UNHS Coordinator tracked infants who did not pass or did not have a hearing screening to ensure they received appropriate follow-up services. Tracking and follow up included letters to parents and primary care providers, followed by telephone calls to parents and primary care providers to obtain follow-up hearing screening or diagnostic evaluation results.

Enabling:

ADPH's Care Coordination Program continued providing case management services for the UNHS Program to Medicaid-enrolled infants. There were care coordinators in all of the State's 67 counties. The care coordinators contacted parents, primary care providers, and hospitals in their county to obtain information regarding hearing screening and follow-up status. They provided this service through telephone calls, letters, and home visits.

Infrastructure-building:

Hearing screening equipment continued to be available to be used as loaner equipment by hospitals when equipment was being repaired. The goal of the loaner equipment was to reduce the number of infants leaving the hospital without a hearing screening.

Monthly statistical reports continued to be provided to each hospital participating in the UNHS Program. These reports included number of infants born, number screened, number who passed screening, number who did not pass screening, and the number who missed or refused screening. Each hospital was provided with their individual results and statewide results.

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

The UNHS Program continued to contract with a part-time audiologist to serve as the hospital consultant for birthing hospitals participating in the program. The audiologist used the above mentioned hospital reports to identify hospitals in need of assistance or hands-on training.

The UNHS Program continued to have a nurse coordinator work .50 FTE for the program. This nurse coordinator assisted the Newborn Hearing Screening Coordinator in providing follow up for infants who failed or missed the initial hearing screening and infants identified with risk factors associated with late-onset hearing loss.

The UNHS Program initiated a contract with Children's Hospital HEAR Center. The purpose of this contract was to provide loaner hearing aids to children identified with hearing loss through the UNHS Program.

As well, the UNHS Program initiated a contract with USA, in which USA provided a doctoral-level audiology student assistant who worked 10 hours a week under the direction of the UNHS

Coordinator. The student assistant provided follow-up services and hospital training.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement the State's Universal Newborn Hearing Screening (UNHS) Program.	X	X	X	X
2. Track infants who did not pass or did not have a hearing screening to ensure they receive appropriate follow-up services.		X		X
3. Track infants identified with risk factors for late-onset hearing loss.		X		X
4. Provide care coordination for the UNHS Program to Medicaid-enrolled infants.		X		X
5. Through a part-time audiologist, provide consultation and, when necessary, hands-on training to hospitals participating in the UNHS Program.				X
6. When equipment belonging to a hospital participating in UNHS is being repaired, loan equipment for newborn hearing screening to the hospital.				X
7. For each participating hospital, provide monthly statistical reports tabulating the number of newborns who had hearing screening and the results of screenings.				X
8. Contract with Auburn University for a doctoral-level audiology student to provide follow-up services and hospital training, on a part-time basis and under the direction of the UNHS Coordinator.		X		X
9. Contract with the Children's Hospital HEAR Center to provide loaner hearing aids to children identified with hearing loss through the UNHS program.				X
10.				

b. Current Activities

FY 2007 activities are basically being continued in FY 2008.

The UNHS Program planned and hosted the second Annual Southeast Region Early Hearing Detection and Intervention Conference in November 2007 in Birmingham, Alabama. This conference brought together stakeholders in the Southeast Region. The goal was to provide nationally recognized speakers and allow for information sharing among states and stakeholders that would promote improvement of the universal newborn hearing screening programs.

The UNHS Program discontinued the contract with USA for the doctoral-level audiology student assistant.

c. Plan for the Coming Year

Unless previously stated otherwise, FYs 2007 and 2008 activities will basically continue in FY 2009. To recap, these activities include:

- 1) Cross-cutting--keeping a UNHS Coordinator on staff.
- 2) Enabling--providing case management services for the UNHS Program to infants receiving Medicaid.
- 3) Infrastructure-building--loaning hearing screening equipment to hospitals, providing monthly

statistical reports, contracting with Auburn University for a doctoral-level audiology student assistant, contracting with a part-time audiologist to serve as a hospital consultant, providing follow up for infants who failed or missed the initial hearing screening and infants identified with risk factors associated with late-onset hearing loss, and contracting with Children's Hospital HEAR Center to provide loaner hearing aids to children identified with hearing loss through the UNHS Program.

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	11.1	8.6	8.5	7.3	6.9
Annual Indicator	8.6	7.4	4.5	7.4	
Numerator	95000	81000	49000	82000	
Denominator	1101000	1095000	1083000	1114000	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	6.8	6.8	6.7	6.6	6.6

Notes - 2007

Reference for estimates is Historical Health Insurance Table 5 (HIA-5), obtained from a U.S. Census Web site. Table HIA-5 does not yet include estimates for 2007. When estimates for 2007 are provided on the U.S. Census Web site, this report/application will be updated accordingly at the first opportunity.

As stated in the note for 2006, the objectives for 2007 may be challenging--but will be retained unless trends over a 3-year period indicate that the objectives shown are clearly too low or too high.

Notes - 2006

Reference for estimates is the revised Historical Health Insurance Table 5 (HIA-5), which pertains to persons under 18 years of age, obtained from the U.S. Census Web site on April 17, 2008. As of April 2008, the Title V Information System does not allow us to directly enter revised numbers for 2003 or 2004. Therefore, estimates shown for these years are from the original Historical Health Insurance Table 5 (HI-5). According to HIA-5 (which is preferable to HI-5), the percentage of Alabama residents under 18 years of age who were uninsured was 7.9% (87,000/1,101,000) in 2003 and 6.3% (69,000/1,096,000) in 2004.

Because the references round numbers of individuals to thousands, percentages calculated by the Title V Information System's Web-based reporting package sometimes differ slightly from estimates shown in Census Bureau tables.

Objectives through 2006 were retained from previous years. Objectives for 2007 onward require an average annual decline (multiplicative model) of 1.0% per year, from the 3-year baseline for

2003-05, using Table HI-5. (Table HIA-5 was not available to the writer when objectives for 2006-2011 were set.) For the purpose of computing objectives for 2007 onward, to minimize random fluctuation from year to year, this 3-year percentage (7.10582%) was considered to be the 2004 baseline. Objectives from 2007 onward therefore require a 1.0% annual reduction from a baseline of 7.10582% for 2004. Because the objectives are carried to only 1 decimal, they sometimes remain the same 2 years in a row.

We recognize that the observed value for 2005 is notably below (better than) the objectives for subsequent years. However, estimates for this indicator can fluctuate from year to year, especially since they are based on a sample. Further, the estimate of 4.5% for 2005 is the lowest on record and surprisingly low: whether compared to Alabama's estimate of 7.4% in 2006 or the U.S. estimate of 10.9% in 2005. Additionally, the estimated percentage of uninsured Alabama residents under 18 years of age rose to 7.4% in 2006--which was very slightly above (worse) than the objective for that year. Therefore, the objectives for 2007 onward may be challenging. However, they will be retained unless trends over a 3-period indicate that the objectives shown are clearly too low or too high.

Notes - 2005

Reference for estimates is the revised version of the Historical Health Insurance Table 5 (HIA-5), obtained from a U.S. Census Web site. See note to 2006 for methodological information.

According to their policy, the U.S. Census Bureau does not provide standard errors when the numerator is fewer than 75,000. Therefore, Table HIA-5 does not provide the standard error for the estimate shown for 2005 (4.5%). For this reason, we cannot assess whether the unusually low estimated percentage for 2005 is significantly lower (in the statistical sense) than the corresponding estimated percentages for 2004 and 2006.

Objectives through 2005 were retained from previous years. The objective for 2006 requires an average annual decline of 0.5% (multiplicative model) from the 2004 baseline of 7.4% (81,000/1,095,000) that was reported in the original version of Historical Health Insurance Table 5 (HI-5).

a. Last Year's Accomplishments

Status and Trends:

In the discussion that follows, the source for the prevalence of non-insurance from 1999-2006 is the Census Bureau's revised Historical Health Insurance Table 5 (HIA-5). The source for the prevalence of non-insurance in earlier years is the Census Bureau's original Historical Health Insurance Table 5 (HI-5). Because numbers shown for NPM #13 on Form 11 for 2003 and 2004 are from HI-5, the following discussion does not precisely coincide with Form 11.

In 2006, 7.4% of Alabama children and youth had no health insurance. This prevalence is the third lowest on record for the State. Combining the years 2004-2006, 6.1% of Alabama children and youth were uninsured.

Trends show substantial progress. The prevalence of non-insurance among Alabama children and youth declined from 9.4% in 1999 to 7.4% in 2006: a decline of 22.1%. Further, from 1999-2006 (the only years shown in HIA-5), the prevalence of non-insurance among Alabama children and youth was lower than the corresponding prevalence for the U.S. For example, in 2006, 7.4% of Alabama children and youth, versus 11.7% of U.S. children and youth, were uninsured.

Extending the surveillance period indicates even more progress in Alabama. Per HI-5, 22.0% of Alabama children and youth lacked health insurance in 1987, compared to 12.9% of U.S. children and youth. Comparing 2006 to 1987, the prevalence of non-insurance among Alabama children and youth declined by 67%.

FY 2007:

Unless stated otherwise, the following activities occurred in FY 2007 and continued from previous years.

Continuing Crosscutting:

The 14 Regional Coordinators for ALL Kids developed partnerships with stakeholders around the State in order to assist with identification of uninsured children, and targeted efforts to enroll those children in one of the State's programs. One of the 14 coordinators targeted efforts to Hispanic communities, identifying and training community leaders as application assistors. Applications and brochures were available in English and Spanish. Spanish language media efforts (radio) were developed in some areas of the State with high Hispanic populations. The ALL Kids program contracted for multi-language telephone interpretation services.

ALL Kids staff attribute the continued decline in the rate of uninsured children in the State to several factors: 1) continuing collaboration among Medicaid, ALL Kids, and the Alabama Child Caring Foundation (the latter provides limited benefits for uninsured children with incomes under 235% FPL, who are not otherwise eligible for one of the State-sponsored programs); 2) extensive partnerships with providers, community agencies, schools, faith-based organizations, and others who assist with enrollment efforts; 3) simplified application processes; and 4) effective media campaigns.

Population-based:

Combined applications for ALL Kids, SOBRA Medicaid, Medicaid for Low Income Families, and the Alabama Child Caring Foundation's program were available at CHDs, as well as hospitals, provider offices, many other community locations, and the ALL Kids Web page. In addition the joint application was available on line. Use of the Web-based application continued to increase.

Infrastructure-building:

The ALL Kids Enrollment Unit included a SOBRA Medicaid eligibility unit placed there in FY 2002. The ALL Kids premium collection processes included ability to accept credit card payments on line or by phone, as well as payments made by postal mail. Payment plans were available for families.

The following were newly implemented in FY 2007. In response to Centers for Medicare and Medicaid Services-mandated verification of Citizenship and Identity by Medicaid, the joint application was revised to allow a parent to establish the identity of a child under 16 years of age via affidavit. Further, a change in benefit structure allowed children with cystic fibrosis to get certain vitamins over the counter. In addition, ALL Kids' benefits for substance abuse were changed to provide for 3 inpatient days, and up to 90 days for partial hospitalization, intensive outpatient, and/or day treatment (maximum of 20 of these days for partial hospitalization). Previously the benefit had been 30 days inpatient.

United Behavioral Health continued serving as the vendor for delivery of ALL Kids behavioral health services--having received that responsibility from BCBS in FY 2005.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Administer Alabama's SCHIP, which is called ALL Kids.		X	X	X
2. Through the 14 Regional Coordinators for ALL Kids, develop partnerships with stakeholders around the State to assist with identification of uninsured children.			X	X
3. Outreach to the Latino community to provide information, including materials written in Spanish, about ALL Kids.			X	X

4. As part of outreach to the Latino community, identify and train Latino community leaders to serve as ALL Kids application assistors.		X		X
5. Also as part of outreach to the Latino community, contract for multi-language telephone interpretation services for ALL Kids.		X		X
6. Make combined applications for ALL Kids, SOBRA Medicaid, Medicaid for Low Income Families, and the Alabama Child Caring Foundation available at CHDs, at various other places, and on the ALL Kids Web page.		X	X	X
7. Periodically review the ALL Kids application process, and revise as needed and feasible. In FY 2007 the process was revised to allow a parent to establish the identity of a child under 16 years of age via affidavit.				X
8. Periodically review ALL Kids benefits, and revise as needed and feasible. In FY 2007 changes pertaining to certain over-the-counter vitamins for children with cystic fibrosis and to coverage for treatment of substance abuse were made.				X
9.				
10.				

b. Current Activities

Crosscutting:

ALL Kids' FY 2007 activities basically continue in FY 2008.

In addition to posting the previously referenced combined application, the ALL Kids Web page continues posting various information or links including the following: contact information for regional coordinators, a link for ordering educational and outreach materials, and a link to the insurance vendor for help in finding a provider. Further, the page links to "Covering Alabama Kids and Families" information, including a video about health coverage for children and teens.

Infrastructure-building:

New eligibility guidelines for monthly and annual gross income, effective February 2008, have been released and are posted on the ALL Kids Web page. Guidelines show income eligibility according to the child's age (under 6 years and 6-18 years) and the family's size: for Alabama Medicaid, All Kids "Low Fee," All Kids "Free," and the Alabama Child Caring Foundation.

ADPH and Alabama Medicaid have been chosen to participate in the Southern Institute on Children and Families' technical assistance grant project. Alabama was 1 of only 8 states chosen for this grant, which the State will use to improve enrollee retention and renewal rates for ALL Kids and Medicaid.

Since May 1, 2008, behavioral health benefits for ALL Kids enrollees have again been managed by BCBS, the same vendor that manages medical benefits.

An electronic signature is expected to become an option for online applications.

c. Plan for the Coming Year

Activities occurring in FY 2007 and FY 2008 will basically continue in FY 2009. To recap, these include the following.

Crosscutting:

ALL Kids Regional Coordinators will continue engaging in local efforts to build partnerships in order to identify and enroll uninsured children. New efforts will be developed through collaborative school screening efforts in some communities. Staff from ALL Kids, Medicaid, and the Alabama Child Caring Foundation will continue collaboration to make the application process more

seamless. Joint applications will continue to be available around the State. Increased efforts will be made to promote the use of the Web-based application.

Population-Based:

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

Infrastructure-building:

Location of a SOBRA Medicaid eligibility determination unit in the ALL Kids Enrollment Unit will continue. The 2 policies newly implemented in 2007--that is, ability for parent to establish the child's identity via affidavit on the joint application, and coverage of over-the-counter vitamins for children with cystic fibrosis--will continue.

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				30.1	29.9
Annual Indicator		30.4	30.9	28.7	
Numerator		9187	9313	14300	
Denominator		30221	30140	49806	
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	29.8	29.6	29.5	29.4	29.4

Notes - 2007

The U.S. Centers for Disease Control and Prevention's (CDC's) Pediatric Nutrition Surveillance System (PedNSS) data for measuring the number and percentage of Alabama children, age 2 to 5 years, who are overweight (body mass index [BMI] at or above the 95th percentile) or at risk of becoming overweight (BMI at or above the 85th percentile to the 95th percentile) are used to calculate this indicator.

Because the FY 2005 PedNSS data in Table 6C became available in January 2007, we anticipate that FY 2007 data will be available by around January 2009. Once 2007 PedNSS findings become available to the Bureau of Family Health Services (FHS), we will update Form 11 at the first opportunity.

The objective for 2012 has been set to match that for 2011.

We are aware that the observed value of 28.7 % in FY 2006 is slightly below (better than) the objectives for 2007-2008. However, 3 data points, especially ones without a consistent direction (up slightly in 2005, then down in 2006), do not provide a compelling reason for changing objectives at this time. Objectives will be reconsidered by FY 2010.

Notes - 2006

The reference is "Table 6C, 2006 Pediatric Nutrition Surveillance, Alabama--Comparison of Growth and Anemia Indicators by Contributor, Children Aged <5 years." Per this reference, 15.0% of the children had a BMI that had reached the 85th percentile but was less than the 95th percentile; and 13.7% of the children had a BMI at or above the 95th percentile. Adding these 2 percentages together, 28.7% of the children had a BMI at or above the 85th percentile. The numerator was estimated by multiplying the denominator by .287.

FHS has insufficient data for describing historical trends in this indicator, which would be useful for setting objectives. Further, expecting dramatic reductions in the prevalence of overweight or being at risk for overweight may not be realistic. Accordingly, the objectives are based on a slow decline, from the 2004 baseline, of 0.5% per year.

Notes - 2005

See year 2006 field note to this indicator for data source.

The denominator and numerator are determined from data for Alabama in Table 6C, 2005, CDC Pediatric Nutrition Surveillance, "Comparison of Growth and Anemia Indicators by Contributor, Children Aged < 5 Years." The denominator is the total number of WIC-enrolled Alabama children provided in Table 6C (30,140). The numerator is determined by multiplying the number of WIC-enrolled Alabama children (30,140) by the proportion of these children with a BMI at or above the 85th percentile to the 95th percentile (.156), then multiplying the number of WIC-enrolled Alabama children (30,140) by the proportion of these children with a BMI at or above the 95th percentile (.153), and adding the 2 products together.

In April 2006 we learned that, due to data management problems that cannot be resolved at this time, the Alabama PedNSS data for 2004 and 2005 included information from only 45 of 67 counties in Alabama. The included counties, determined alphabetically, were Autauga County through Madison County. Two major population areas were missed: Mobile (in southern Alabama) and Montgomery (in south-central Alabama) Counties. The 45 counties included in the PedNSS data represent about 62% of WIC-enrolled children in the State, based on the number of WIC-enrolled children on the January 2007 WIC enrollment-participation report. The Alabama Department of Public Health's Computer Systems Center staff will seek to resolve the aforesaid data management problem by FY 2008.

a. Last Year's Accomplishments

Historical Context:

Crosscutting (Enabling, Population-based, Infrastructure-building):

The following initiatives occurred in FY 2006 and provide a historical context for the reporting year.

AOTF, which organized in FY 2004, published an AOTF State Plan in FY 2005. As stated in Section III.E, State WIC staff served on 2 of the AOTF subcommittees involved in implementing this plan and co-chaired 1 of the subcommittees. Another ATOF subcommittee developed the FY 2007 SNAP for Alabama, which supported the AOTF State Plan and emphasized healthful eating and physical activity for USDA Food and Nutrition Service populations in Alabama. This subcommittee included 3 ADPH nutritionists (1 from WIC, who chaired the subcommittee) and persons from SDE's Child Nutrition Program, the State Food Stamps Program, and the Alabama Cooperative Extension System.

The FY 2005-06 WIC Nutrition Education Plan, which focused on prevention of childhood obesity, continued to be implemented in all WIC clinics. As part of this plan, WIC clinic providers educated parents of all 1-5 year-old clients on the importance of daily physical activity throughout the year.

At the Annual WIC Training Conference in October 2005, a "Fit WIC Award" session recognized WIC staff from 12 clinics that formed "Fit WIC" teams during FY 2005 to support each other with

their personal fitness goals and to become better fitness role models for WIC enrollees. Five new staff Fit WIC teams were formed at WIC clinics during FY 2006.

PHA and State WIC staff developed an FY 2007-08 Nutrition Education Plan (FY 2007-08 Education Plan) for all ADPH WIC clinics. The plan focused on prevention of obesity and built on the FY 2005-06 Education Plan.

Also in FY 2006, the Overweight Risk Criteria Report (which was developed in FY 2004 to compute baseline FY 2003 data on the percentage of WIC-enrolled children who were overweight or at risk of becoming overweight) was revised to include data on the number and percentage of overweight postpartum and breastfeeding WIC-enrolled women. The revised report was run for FY 2005, and the FY 2005 data pertaining to WIC-enrolled children was compared with FY 2003 and FY 2004 data.

Status:

In FY 2006, 28.7% of 2-5 year-old Alabama WIC enrollees had a body mass index (BMI) at or above the 85th percentile.

FY 2007:

All of the following occurred in FY 2007.

Crosscutting (Enabling, Population-based, Infrastructure-building):

The FY 2007-08 Education Plan was implemented in all WIC clinics. It expanded the FY 2005-06 education plan by focusing on prevention of obesity for the entire family and targeting breastfeeding and postpartum WIC-enrolled women in addition to WIC-enrolled children. WIC clinic providers educated women and parents of 1-5 year-old enrollees targeted in the plan concerning the importance of daily physical activity and healthful eating. Four new educational materials that encouraged physical activity and healthful eating for families were developed for use with the education plan. Incentive items were distributed to encourage physical activity as follows: From October through March, pedometers were distributed to WIC-enrolled breastfeeding and postpartum women; and from April through September, beach balls were distributed to WIC-enrolled children.

Work continued on the implementation phase of the AOTF State Plan, with a member of the State WIC staff serving on 1 of the task force subcommittees.

The FY 2007 Alabama SNAP was implemented in all USDA food assistance programs in Alabama, including WIC. Due to competing priorities, the chair of the SNAP subcommittee (from WIC) resigned in June, and a new subcommittee chair was elected.

As part of the FY 2007-08 Nutrition Education Plan, a Fit WIC Awards presentation was given at the statewide WIC Training Conference in October, recognizing 5 clinic Fit WIC Teams in the State. A "Best Fit WIC Team" award was given. A training session was also held at the conference to explain the FY 2007-08 Education Plan to WIC clerks and garner their support.

The Overweight Risk Criteria Report was run for FY 2006 for comparison with previous years' data. In addition, CDC Pediatric Nutrition Surveillance System (PedNSS) data for FY 2005 for Alabama were used to ascertain the percentage of WIC-enrolled children aged 2-5 years who had a BMI at or above the 85th percentile.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement and periodically update the WIC Nutrition		X		X

Education Plan for all ADPH WIC clinics.				
2. In the WIC Nutrition Education Plan, focus on prevention of obesity in the entire family, especially targeting WIC-enrolled children and WIC-enrolled breastfeeding and postpartum women.		X		X
3. As part of the focus on preventing obesity in the family, educate WIC-enrolled women and parents of 1-5 year-old WIC enrollees about the importance of daily physical activity and healthful eating.		X		
4. Also as part of the WIC Nutrition Education Plan, develop and distribute brochures encouraging physical activity and healthful eating for families.		X		
5. Also as part of the WIC Nutrition Education Plan, distribute items that encourage physical activity: such as pedometers for WIC-enrolled women and beach balls for WIC-enrolled children.		X		
6. Maintain membership in the Alabama Obesity Task Force.				X
7. Along with members of the above task force and U.S. Department of Agriculture food assistance programs in Alabama, develop, implement, and periodically update the State Nutrition Action Plan.				X
8. Also as part of the WIC Nutrition Education Plan, form "Fit WIC Teams" among CHD WIC staff, for group support in achieving personal fitness goals and providing fitness role models for WIC enrollees.				X
9. Monitor the percentage of WIC-enrolled children who are overweight or at risk of becoming overweight.				X
10.				

b. Current Activities

FY 2007 activities have basically continued in FY 2008. Certain updates follow.

Crosscutting (Enabling, Population-based, Infrastructure-building):

AOTF continues implementing its State Plan. A member of the State WIC staff serves on 1 AOTF subcommittee.

WIC and the other USDA food assistance programs in Alabama continue to participate in the Alabama SNAP subcommittee of ATOF. The subcommittee continues implementing the FY 2007 Alabama SNAP for FY 2008.

The FY 2007-08 WIC Nutrition Education Plan continues to be implemented. From October through March, measuring cups were given to women enrolled in WIC; and "Berenstain Bears and Too Much Junk Food" books will be given to WIC-enrolled children from April through September. All WIC clinics will participate in the Breastfeeding Awareness Campaign in August and the "Fruit and Veggies: More Matters" Campaign in September.

PHA and State WIC staff are developing the FY 2009-10 Nutrition Education Plan for all WIC clinics. It will build on the 2007-08 Education Plan focusing on prevention of obesity among WIC-enrolled children and breastfeeding and postpartum women.

The Overweight Risk Criteria Report was run for FY 2007 for comparison with previous years' data. CDC PedNSS data for FY 2006 for Alabama will also be used to monitor the percentage of 2-5 year-old children on WIC who have a BMI at or above the 85th percentile.

c. Plan for the Coming Year

Crosscutting (Enabling, Population-based, Infrastructure building):
AOTF will continue implementing its State Plan.

WIC and the other USDA food assistance programs in Alabama will continue to participate in AOTF's SNAP subcommittee.

The 2009-10 Education Plan to address prevention of obesity in WIC-enrolled children and breastfeeding and postpartum women will be implemented in all ADPH WIC clinics in October 2009. It is anticipated that many of the 2007-08 Education Plan activities will continue as part of the 2009-10 Education Plan. These include emphasis on the importance of physical activity and healthful eating at WIC nutrition education visits with WIC enrollees targeted in the plan, distribution of incentive items pertaining to physical activity and healthful eating to WIC enrollees, and Breastfeeding Awareness Month and "Fruit and Veggies: More Matters Month" promotions in ADPH WIC clinics. A new promotion called "Mooove to 1% Lowfat or Fat Free Milk" is also being planned for WIC enrollees targeted in the plan who are 2 years of age and older.

The Overweight Risk Criteria Report will be run to monitor FY 2008 data on number and percentage of WIC-enrolled postpartum and breastfeeding women who are overweight and the number and percentage of WIC-enrolled children who are overweight or at risk of overweight. CDC's PedNSS data for Alabama will be used to monitor the percentage of 2-5 year-old WIC-enrolled children who have a BMI at or above the 85th percentile.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				12.5	16.6
Annual Indicator		17.5	18.6	15.4	
Numerator		9589	10377	9142	
Denominator		54797	55912	59372	
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	15.7	14.9	14.1	13.3	13.3

Notes - 2007

See year 2006 note for data source.

Due to time required for data management, data for a given year do not generally become available to the states until at least 16 months after the end of the data collection year. For example, Pregnancy Risk Assessment Monitoring System (PRAMS) data for 2004 were not available by June 2006. The Alabama Department of Public Health's Center for Health Statistics will provide numbers from the PRAMS 2007 dataset soon after the U.S. Centers for Disease Control and Prevention (CDC) provides the dataset, but numbers for 2007 are not expected to be available before April 2009.

We are aware that the objective for 2007 is higher (worse than) the observed status in 2006. However, this sample-based estimate can fluctuate markedly from year to year, and the objective for 2007 is lower (better than) the year 2005 estimate of 18.6%. Accordingly, we are retaining previously set objectives and are setting the objective for 2012 to match that for 2011. Objectives will be reconsidered by FY 2010.

Notes - 2006

Estimates for this indicator are for calendar year and are from PRAMS data, managed by CDC. Alabama PRAMS is a population-based mail/telephone survey of Alabama residents who recently gave birth in the State. A stratified complex sampling design is used, and numbers reported here are weighted to represent all live births occurring in Alabama to Alabama residents. Because data are based on a sample, some statistical imprecision is expected. Observations for which smoking status is unknown or unreported are excluded from the denominator.

For the surveillance period 1994-2003, per Alabama PRAMS, the weighted percentage of mothers who had smoked in the last 3 months of the referent pregnancy was 15.2% in 1994, increased to 16.2% in 1995, declined slightly each year through 2000, increased to 15.6% in 2001, then declined slightly 2 years in a row, bringing it to 13.3% in 2003. Very roughly speaking, this is an average annual decline (improvement) of 1.5%, per a multiplicative model. The objective for 2006 was set to require a steeper annual decline, of 2.0%, from the 2003 baseline, the only baseline available when the objective was set (circa May 2006). However, given the status of this indicator in recent years (17.5% in 2004 and 18.6% in 2005), expecting a 2.0% decline from the 2003 baseline of 13.3% does not seem reasonable. Accordingly, objectives from 2007 through 2011 require a steady decline (of 5.4% annually) from the unrounded 2005 baseline (18.6%), to return to 13.3% (the lowest estimate on record for this indicator) by 2011.

Notes - 2005

Estimates are from PRAMS data. See this indicator's year 2006 field note for information about survey design and methods.

Per weighted PRAMS data for 2005, 18.6% of Alabama residents giving birth in Alabama had smoked during the last trimester of the referent pregnancy. The numerator was therefore estimated by multiplying .186 times the denominator.

a. Last Year's Accomplishments

FY 2005-06 Backdrop (Infrastructure-building):

The following activities provide a backdrop for FY 2007 activities. In FY 2005 SPP wrote a strategic plan for FYs 2005-2007, 1 element of which was to decrease the percentage of women who smoke during pregnancy. SPP partnered with AMOD to provide smoking cessation-counseling training for private delivering physicians' office staff statewide. Specifically, AMOD funded a grant for RNPCs to recruit and train office staff of 100 delivering physicians (20 in each of the 5 perinatal regions) to provide a brief smoking cessation intervention for their pregnant patients who smoked. The evidence-based smoking cessation 5-A's model (ask, advise, assess, assist, arrange) was implemented in the training, which was provided by RNPCs in "lunch and learn" sessions.

AMOD's FY 2006 grant also provided for preconceptional counseling by SPP staff. RNPCs participated in a train-the-trainer workshop for the PT +3 counseling model, which was used to train physicians' office staff in provision of preconceptional counseling for female patients of childbearing age. The training included information on prevention and/or discontinuation of tobacco use. PT +3 is a standardized educational method (developed several years ago by ADPH, Alabama Medicaid, and Upjohn Pharmaceuticals) with educational aids designed for those at risk of unintended pregnancy. The intent of PT +3 is to provide individualized, patient-centered counseling and education in a succinct, straightforward manner--in order to enhance the recipient's ability to hear, understand, and master a basic set of critical behaviors. The acronym

stands for:

1) P = Personalize the problem.

2) T = Tackle it! That is, set a therapeutic Tone, Assess Current knowledge, provide the Knowledge, Listen for feedback, and Educate again as needed.

3) +3 = Summarize in 3 points.

Status:

Per PRAMS data, 15.4% of Alabama females giving birth to a live-born infant in 2006 had smoked in the last 3 months of the pregnancy.

FY 2007 (Infrastructure-building):

SPP's strategic plan for FY 2007 changed when the State Health Officer launched several initiatives to reduce the infant mortality rate. One of the initiatives was the expansion of the newborn screening panel.

The AMOD grant continued. With support from this grant, RNPCs continued providing lunch and learn training sessions for private delivering physicians' office staff statewide. The following numbers of providers were trained in FY 2007: 22 physicians, 1,825 nurses, and 617 ancillary staff. However, due to the change in SPP's strategic plan, the sessions did not focus on smoking cessation training. Instead, they focused on proper blood specimen collection and handling procedures for newborn screening.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Partner with the Alabama Chapter of the March of Dimes (AMOD) to provide smoking cessation-counseling training for selected private physicians' office groups statewide.				X
2. Provide the above training to the following types of physicians and their office staff: physicians who deliver babies, pediatricians who care for infants, and family physicians who care for infants.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure-building:

The AMOD grant has been extended to include FY 2008. The extended grant includes provision of preconceptional health and infant care training for family practice and pediatric office groups who serve infants, in addition to delivering physicians' office groups who were not trained in FY 2005 or FY 2006. The intent of the FY 2008 project is to address the issue of mothers who cease smoking during pregnancy but resume after the birth of their infant. Underlying rationale for addressing this issue is mainly 2-fold. First, environmental smoke is a contributing factor to SIDS and respiratory conditions during infancy. Further, should the mother continue smoking,

subsequent pregnancies may be affected.

SPP is partnering with HPCD's Tobacco Prevention and Control Branch to implement and evaluate effective tobacco prevention and cessation activities for pregnant teens.

c. Plan for the Coming Year

Infrastructure-building:

SPP will write a proposal to AMOD to extend the current grant for FY 2009.

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	8.1	8.1	8.5	7.1	8.3
Annual Indicator	5.4	9.0	7.2	9.8	
Numerator	18	30	24	33	
Denominator	330739	332792	334845	336848	
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	8.2	8	7.8	7.7	7.7

Notes - 2007

Due to the time required to receive, manage, and edit vital statistics data, final year 2007 death files are not yet available for Alabama. Our experience has shown that the incomplete, provisional files available at this time sometimes provide misleading results. If the final files are available by August 2008, staffing resources permit us to analyze the files, and the Title V Information System can be accessed in September 2008, we will provide the year 2007 estimate in September 2008. Otherwise, the estimate will be provided by July 2009.

Though the final year 2006 file is available, staffing limitations have delayed analysis of the file. We expect to have a final estimate for 2006 by September 2008.

The rationale for setting objectives for 2006 through 2011 is described in the note to year 2006. Due to the lack of a final estimate for 2006 or 2007, the objective for 2012 has been set to match that for 2011. We are aware that the objectives from 2007 onward are very aggressive, given the recent fluctuations in this indicator and the trend described in the note to year 2006. Objectives will be reconsidered in FY 2009, when final estimates for the years 2006 and 2007 should be available.

Notes - 2006

The 2006 rate is provisional. Per the Alabama Department of Public Health's Center for Health Statistics staff, the 2006 death file includes all the deaths--though they are waiting for the cause of death for about 100 records.

All denominators represent the population projection for children 15-19 years of age in the specified calendar year. These projections are made by Alabama's Center for Business and Economic Research.

Comparing 2004-05 to 2001-02, this indicator increased (worsened) by an average of 2.7% per year, for an overall increase of 8.2% (from 7.5 deaths per 100,000 in 2001-02 to 8.1 deaths per 100,000 in 2004-05). The indicator has fluctuated over the years shown, however. The objective for 2006 requires a decline of 0.5% from the 2005 baseline. Given the marked fluctuation in this indicator from year to year, however, a single-year baseline is not appropriate for setting objectives. Therefore, objectives for 2007-1010 were revised, and the objective for 2011 set, to require a 2.0% annual decline from the provisional 3-year rate for 2004-06. When setting objectives, this rate (8.66115 deaths per 100,000) was considered to represent the year 2005 baseline.

Notes - 2005

See year 2006 note about denominators, which applies to the denominator for 2005 as well.

a. Last Year's Accomplishments

Trends:

See Form 11 note.

Historical Context:

ADPH's efforts to prevent suicide have been mainly carried out through the Alabama State Suicide Prevention Task Force (Suicide Prevention Task Force) and ACDRS, both of which are discussed below.

The Suicide Prevention Task Force, which first met in March 2002, is concerned with suicide regardless of age. The Social Work Unit in the Department's Office of Professional and Support Services has assumed the lead for ADPH's involvement with this task force. In FY 2003 the task force developed a Web site, hosted by ADPH and MHMR, providing information about suicide and pertinent available resources. In FY 2004 the task force completed the Alabama State Suicide Prevention Plan, and the ACDRS Director joined the task force. In September 2004 the task force launched a statewide media campaign to publish the toll-free number for suicide-related crisis calls.

The State Suicide Prevention Plan is posted on ADPH's Web site. Goals of the plan are to: 1) recognize suicide as a problem affecting Alabama; 2) outline a strategy for the prevention of suicide in Alabama; and 3) identify federal, State, and local resources to support implementation of Alabama's Suicide Prevention Plan.

The 15 strategies for achieving the above goals are attached. Generally the strategies pertain to suicide regardless of age. The 2 strategies that particularly address suicide among youth are listed below:

Strategy 9--Develop and implement safe and effective programs in educational settings for youth that address adolescent distress, provide crisis intervention, and incorporate peer support for individuals seeking help.

Strategy 10--Enhance community care resources by increasing the use of schools and workplaces as access and referral points for mental and physical health services and substance abuse treatment programs; and provide support for persons who survive the suicide of someone close to them.

ACDRS, created by legislation enacted in 1997, is mandated to review all unexpected deaths of children from birth through 17 years of age and is located in the Bureau's Children's Health Division. In FY 2003 ACDRS created the Infant and Child Death Investigation Task Force, in accordance with the mandating legislation's charge to develop a standardized infant and child

death investigation curriculum. For several years ACDRS has maintained a Web page providing information about causes of death in children and youth. In collaboration with the Suicide Prevention Task Force, in FY 2005 ACDRS developed a "Prevent Youth Suicide" educational brochure, which was distributed throughout the State.

FY 2007:

The following occurred in FY 2007.

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

The Suicide Prevention Task Force, ACDRS, and the curriculum developed by the Infant and Child Death Investigation Task Force continued. ADPH continued maintaining Web pages on the Suicide Prevention Task Force and on ACDRS.

The Suicide Prevention Task Force hosted 2 statewide training events featuring the President/Chief Executive Officer of the QPR Institute, who is a clinical psychologist. Each 2-hour training, 1 for school counselors and 1 for mental health professionals, was available via Web-cast to professionals across the U.S. (The QPR Institute is a training organization located in the State of Washington, with a primary goal of providing suicide prevention educational services and materials to professionals and the general public. "QPR" stands for "Question, Persuade, and Refer.")

The position of ACDRS Director, which had been vacant for several months due to the promotion of the director to another position, was filled in August 2007. The ACDRS Assisant Director remained a member of the Suicide Prevention Task Force. The task force continued to meet quarterly, to promote the Alabama State Suicide Prevention Plan, and to maintain a toll-free number for suicide-related crisis calls. ACDRS continued to distribute the "Prevent Youth Suicide" brochure, including a Spanish-translated version that was first produced in FY 2006.

The training course that was previously developed by the Infant and Child Death Investigation Task Force continued to be taught at all Alabama police academies.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Administer ACDRS to review unexpected deaths, including suicide, of Alabama children and youth.			X	X
2. With the Alabama Department of Mental Health and Mental Retardation (MHMR), continue involvement in the Alabama Suicide Prevention Task Force.			X	X
3. Along with MHMR and in collaboration with the Suicide Prevention Task Force, host a Web page providing information pertaining to suicide prevention and related resources.			X	X
4. Along with other members of the Suicide Prevention Task Force, promote the Alabama Suicide Prevention Plan.				X
5. In collaboration with the Suicide Prevention Task Force, participate in public awareness efforts and/or training events concerning suicide prevention.			X	X
6. As part of the public awareness efforts, distribute an educational brochure on prevention of suicide among youth.			X	
7. Through the Infant and Child Death Investigation Task Force formed by ACDRS, provide curriculum for a training course for child death investigators, to be taught at Alabama police academies.				X

8. Maintain a Web page about causes of death in children and youth.			X	
9.				
10.				

b. Current Activities

Cross-cutting:

Unless previously indicated otherwise, FY 2007 activities basically continue in FY 2008. Updates for FY 2008 follow.

In September 2008, along with the rest of the nation, Alabama will recognize Suicide Prevention Week. This year the week's theme is "40 Years of Suicide Prevention: Moving Forward with Education and Training." One of the goals during the week is to provide better education and training for those who are in a position to respond to persons at risk for suicide.

The American Foundation for Suicide Prevention plans to hold "Out of the Darkness" Community Walks in more than 100 communities across the nation. One such walk is to be held in Birmingham, Alabama in September 2008.

The American Association of Suicidology will hold workshops across the country, entitled "Recognizing and Responding to Suicide Risk: Essential Skills for Clinicians." The workshops will train clinicians on how to identify risk factors for suicide and to develop effective treatment programs to prevent suicide. One of these workshops will be held in Birmingham, Alabama on September 27-28.

Due to the resignation of the ACDRS Assistant Director, the Bureau's membership on the Suicide Prevention Task Force has been interrupted. However, the ACDRS Director expects to attend future meetings of the task force.

c. Plan for the Coming Year

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

Unless previously stated timeframes indicate otherwise, activities carried out by the Suicide Prevention Task Force and by ACDRS in FYs 2007 and 2008 will basically continue in FY 2009.

To briefly recap, these activities include:

- 1) Implementation of the 15 strategies included in the Suicide Prevention Plan.
- 2) Membership of the ACDRS Director and/or Assistant Director on the Suicide Prevention Task Force.
- 3) Maintenance of Web pages on suicide and on ACDRS.
- 4) Distribution of the "Prevent Youth Suicide" brochure, in English and Spanish versions.
- 5) Maintenance of the toll-free number for suicide-related crisis calls.
- 6) Implementation of a suicide-prevention media event in September 2009.
- 7) Provision of the training course, developed by the Infant and Child Death Investigation Task Force, at all Alabama police academies.

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	86.4	88.2	79.8	81.4	82.3
Annual Indicator	79.4	80.9	80.6	79.8	84.1
Numerator	965	953	1041	1016	1133
Denominator	1216	1178	1291	1273	1348
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	83.1	83.9	84.7	85.6	85.6

Notes - 2007

The estimate for this indicator was added on September 19, 2008, and is not discussed in the narrative.

Before the year 2007 estimate was available, the objective for 2012 was set to match that for 2011. We are aware that the provisional year 2007 estimate for this indicator surpasses (is better than) the objectives shown for 2008 and 2009. However, previous trends do not support an assumption that the future status of this indicator will match or exceed the provisional year 2007 estimate. Objectives will be reconsidered by fiscal year 2010, based on the most recent 3-year baseline that is available when the objectives are reconsidered.

Notes - 2006

Comparing 2004-05 to 2001-02, this indicator worsened slightly, beginning at 82.0% in 2001-02 and ending at 80.8% in 2004-05. Overall, the indicator showed no consistent trend during 2001-2005. (Numbers for 2001 are not shown on Form 11.)

Objectives from 2006 forward require a slow increase (improvement), by 1.0% per year (per a multiplicative model), from the 2005 baseline. Objectives are challenging, however, since the highest value for this indicator from 1999 through 2006 was 83.4% (in 2002).

a. Last Year's Accomplishments

Historical Context (Infrastructure-building):

As discussed in Section III.B, the Alabama Perinatal Health Act, enacted in 1980, established the SPP and the mechanism for its operation under the direction of the State Board of Health and SPAC, with SPAC representing the RPACs. The State Committee of Public Health, which is part of the State Board of Health, typically meets on a monthly basis. SPAC met on a quarterly basis through FY 2005. In FY 2006 SPAC began conducting face-to-face meetings annually, rather than quarterly, and conducting official business only at this annual meeting. Limiting official business to SPAC's annual meeting and assuring the presence of a quorum at this meeting ensured compliance with the Open Meetings Act, a State statute enacted in October 2005.

The RPACs make recommendations to SPAC regarding perinatal concerns, and SPAC advises the State Health Officer on the SPP. SPP is based on the concept of regionalization of health care, a systems approach designed to ensure that pregnant women and their newborns have access to the appropriate level of care. SPP is administratively located in FHS.

By August 2002 SPP had created and filled 5 RNPC positions, 1 for each of the State's 5

perinatal regions. The RNPCs act as executive directors for the RPACs, to help the RPACs address regional perinatal issues, and serve as liaisons between SPAC and the RPACs. Activities of the RNPCs include recruiting RPAC members, completing annual needs assessments for their respective regions, working with the RPACs to revitalize the State's system of regionalized perinatal care and to develop a regional plan to address VLBW, and providing educational offerings to certain physician office groups serving Title V populations. Though some of the educational offerings do not directly pertain to whether VLBW babies are born at perinatal centers, they strengthen regional perinatal networks that influence all aspects of perinatal care.

A brief paper, written in June 2007, on potential barriers to birth of VLBW babies at perinatal centers is attached.

Status:

In 2006, 79.8% of VLBW Alabama residential live births occurred at perinatal centers. Here, "perinatal centers" are defined as teaching or non-teaching hospitals with 1 or more full-time neonatologists, an NICU, and 2 or more obstetricians.

FY 2007:

The following activities occurred in FY 2007 unless stated otherwise.

Infrastructure-building:

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

AMOD funded provider educational workshops and grand rounds in each perinatal region, focusing on delivering physicians and on pediatricians and family practitioners who care for infants, as well as the office staff of these physicians. Each RNPC coordinated these educational events in her region. Topics included newborn screening, the effects of perinatal drug abuse, preterm labor, and the importance of good preconceptional health in efforts to reduce the risk of preterm birth. The SPP Director and the AMOD Program Director attended the Alabama Chapter of the AAP meeting to encourage support of AMOD and SPP efforts.

AMOD continued to provide supplies and educational materials for quarterly meetings of maternal-infant nurse managers in each perinatal region. Each RNPC coordinated and conducted these meetings, which continued building a network among perinatal providers in order to strengthen regionalization of perinatal care. (As well, AMOD funded a program to provide lunch and learn training for office staff of 20 delivery physicians. These trainings are discussed under NPM #15.)

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Administer the State Perinatal Program (SPP), to promote a strong system of regionalized perinatal care.				X
2. Convene annual meetings of the State Perinatal Advisory Council (SPAC).				X
3. Through the Bureau of Family Health Services' 5 Regional Nurse Perinatal Coordinators, support SPAC and the 5 Regional Perinatal Advisory Councils.				X
4. In partnership with AMOD, in each perinatal region provide educational offerings for providers--such as workshops, grand rounds, and "lunch and learn" sessions that collectively cover a				X

variety of topics, including preterm birth.				
5. In the above educational offerings, focus on the following types of physicians and their office staff: physicians who deliver babies, pediatricians who care for infants, and family physicians who care for infants.				X
6. Also in the above educational offerings, cover such topics as the importance of good preconceptional health and the effects of perinatal drug abuse.				X
7. Liaise with professional physician organizations, to encourage support of the efforts of AMOD and the SPP.				X
8. Coordinate meetings of maternal-infant nurse managers in each perinatal region.				X
9.				
10.				

b. Current Activities

SPP continues operating under the State Board of Health and SPAC.

AMOD funded an FY 2008 grant, and the SPP program will continue to provide newborn screening training to physicians' office staff (discussed under NPM #15).

An FY 2009 grant from AMOD will support expansion of SPP activities to include training health professionals to provide preconceptional counseling and infant-care education to patients. The training is to be provided to office staff of delivering physicians and physicians who give care to infants. In preparation to provide the training, the RNPCs participated in a train-the-trainer workshop for the PT +3 counseling model (explained under NPM #15), which will be used to train the health care professionals in the provision of preconceptional counseling for females of childbearing age. The focus of the preconceptional-counseling education is risk assessment and health promotion through medical and psychosocial interventions, which may affect whether VLBW babies are born at perinatal centers. Care for the preterm infant is the focus of the infant-care education.

Huntsville Hospital (in Perinatal Region 1, in north Alabama), USA Hospital (in Perinatal Region 4, in south Alabama), and Baptist South Hospital (in Perinatal Region 5, in southeast Alabama) applied to AMOD for grant money to present an NICU workshop "Premie for a Day," at each of these facilities in FY 2008.

c. Plan for the Coming Year

Infrastructure-building:

FYs 2007-2008 activities will basically continue in FY 2009. These activities include: 1) nurse manager quarterly meetings sponsored by AMOD; 2) the AMOD grant to provide smoking cessation-counseling training, newborn screening training, preconceptional-counseling training, and infant-care education for physicians' office staff; and 3) interaction of SPP staff with regional stakeholders in perinatal health to maintain and strengthen the regionalized network of perinatal care. Whether additional NICU workshops will be provided will depend on available funding.

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	87.6	86.7	87.8	83	83.4

Annual Indicator	83.6	83.7	82.5	81.2	79.2
Numerator	49635	49499	49743	51115	50818
Denominator	59356	59170	60262	62915	64180
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	83.8	84.2	84.6	85.1	85.1

Notes - 2007

The year 2007 estimate for this indicator was added on September 19, 2008, and is not discussed in the narrative. As shown, this indicator was lower (worse) in 2007 than in any of the 4 preceding years. The Alabama Department of Public Health is concerned about this decline and will seek to further assess the decline and to increase access to quality prenatal care throughout the State.

Before the year 2007 estimate was available, the objective for 2012 was set to match that for 2011. Objectives will be reconsidered by fiscal year 2010, based on the most recent 3-year baseline that is available when objectives are reconsidered.

Notes - 2006

For all years shown, the numerator is the number reporting prenatal care as beginning during the 1st, 2nd, or 3rd month, based on the birth certificate item: "Month of Pregnancy Prenatal Care Began—First, Second, etc."

Comparing 2004-05 to 2001-02, the indicator barely changed (from 82.6% in 2001-02, to 83.1% in 2004-05. (Numbers for years prior to 2003 are not shown on Form 11.) Given the barely perceptible improvement in this indicator in recent years, the objectives for 2006-2010 are challenging: though they require that the status increase by only 0.5% per year (per a multiplicative model), from the 2005 baseline.

Notes - 2005

See this indicator's Form 11 field note for year 2006 for a description of the numerator.

a. Last Year's Accomplishments

Trends:

This indicator has now declined slightly 2 years in a row: in 2005 and again in 2006. Review of the MCH 2002 Report/2004 Application in conjunction with the numbers shown on Form 11 provides a surveillance period from 1998 through 2006. In this 9-year period, the percentage of Alabama infants born to women receiving prenatal care beginning in the first trimester ranged from 81.2% in 2006 to 83.7% in 2004. Thus, though the indicator has not declined dramatically and might have stabilized or improved in 2007, the status in 2006 was slightly worse than in any other year during the surveillance period.

Historical Context:

Cross-cutting:

As discussed in Section III.A, by March 2005 it was determined that the private sector had the capacity to provide all the prenatal care required under the SOBRA Medicaid program. For this reason and because of financial and liability-related issues, ADPH decided to withdraw from providing prenatal care. Most CHDs made a parallel decision to no longer provide care coordination for pregnant women.

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

Access to prenatal care may be determined by the availability of health insurance coverage for pregnancy. Most of the deliveries reported as being "self pay" on the State's live birth certificate presumably involve mothers who have no insurance coverage for prenatal care and do not qualify for Medicaid. Because no State programs were available for uninsured pregnant women, in FY 2005 FHS collaborated with ALL Kids to explore the feasibility of expanding SCHIP to include the unborn child. Federal regulation allows for SCHIP coverage of the unborn children of uninsured women who are not eligible for Medicaid--to provide insurance coverage for prenatal, delivery, and postpartum services for mothers whose children would be SCHIP eligible.

FY 2007:

Unless stated otherwise, the following occurred in FY 2007.

Direct and Enabling:

Per Form 7, 1,389 pregnant women received Title V-funded services in CHDs in FY 2006. Nearly all (98.5%) of these women received their care from Mobile CHD. Because ADPH withdrew from provision of direct prenatal care in March 2005, many if not most of the services provided to pregnant women in CHD settings were presumably enabling in nature.

CHD Family Planning clients were provided information about the importance of early, continuous prenatal care.

ADPH continued marginal involvement in the provision of care coordination to pregnant women. As in FY 2006, in FY 2007 the Department provided care coordination via subcontract with a Medicaid Primary Contractor in 7 counties--Cullman, Houston, Dale, Henry, Geneva, Coffee, and Mobile.

Population-based:

FHS continued operation of a toll-free hotline that helps pregnant women access providers and provides educational materials about pregnancy.

Infrastructure-building:

The Medicaid Maternity Care Program continued. This system--described under "Historical Context" and in Section III.A--addressed early entry into care, compliance with care, referral patterns, and delivery services.

Medicaid pays for emergency deliveries of some uninsured women who are not eligible for Medicaid coverage of their prenatal care. Per a CY 2005 paid-claims report received from Medicaid in June 2006, in CY 2005 Medicaid paid for 2,915 emergency deliveries, and 2,682 of these deliveries were of Latino women. Thus, FHS roughly estimated that each year about 2,700 Alabama residents could qualify for coverage of prenatal care under SCHIP, if that program were expanded as envisioned in FY 2005. Further, the number who would qualify for such coverage could increase if the number of births to Latino Alabama residents increased in the future. As stated under "Historical Context," in FY 2005 FHS collaborated with ALL Kids to explore the feasibility of expanding SCHIP to include the unborn child. Alabama SCHIP further considered such an expansion in FY 2007. The predominant thought was that expansion of SCHIP to cover the unborn child, if it occurred, would be implemented as an expansion of the Medicaid Program, but no decision was made.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Educate CHD Family Planning clients on the importance of early and continuous prenatal care.		X		
2. In some counties (7 counties as of April 2007), provide care coordination for pregnant women.		X		
3. Operate a toll-free hotline that helps pregnant women access providers and educational materials.			X	
4. [The Alabama Medicaid Agency will] continue the Medicaid Maternity Care Program statewide.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Enabling:

Provision of information to CHD Family Planning clients about the importance of early and continuous prenatal care continues.

Population-based:

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

Infrastructure-building:

Medicaid's contract with the 10 Primary Contractors has been extended through September 2008. In June 2008 the upcoming new contract was released for bid. Currently, with the exception of 1 non-profit agency, all of the 10 Primary Contractors are hospital-based. The new contract is to be for 2 years; however, due to a change in Alabama regulations, the contracts could conceivably be extended to cover 5 years.

In early FY 2008 discussions continued regarding the feasibility of expanding SCHIP coverage to include the unborn child, and projections were developed. However, this discussion has been tabled due to budgetary uncertainties.

c. Plan for the Coming Year

Direct:

As previously stated, ADPH does not plan to provide direct prenatal care.

Enabling:

Whether the 7 counties that currently provide maternity care coordination under subcontract with a Medicaid Primary Contractor, as discussed under "Last Year's Accomplishments," will continue doing so is not known.

Provision of information to CHD Family Planning clients about the importance of early and continuous prenatal care will continue.

Population-based:

Operation of the previously mentioned toll-free hotline will continue.

Infrastructure-building:

Alabama Medicaid is expected to continue operation of the Medicaid Maternity Care Program, under an anticipated new contract that is to begin on October 1, 2008.

The MCH Epi Unit will continue tracking NPM #18 and reporting findings to key Bureau staff. As part of the upcoming 5-year MCH needs assessment (to be reported in FY 2010), surveillance will be extended to include CY 2007; and findings will be stratified according to source of payment for delivery, race, and ethnicity. As well, qualitative information regarding issues affecting access to and utilization of early prenatal care will be solicited. Methods for obtaining qualitative information will include mailed surveys (1 to primary care providers and 1 to non-medical organizations serving Title V populations) and either community discussion groups or key informant interviews.

D. State Performance Measures

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				4.5	4.7
Annual Indicator	3.2	4.7	4.3	5.2	6.1
Numerator	9127	13824	12781	15853	18144
Denominator	287446	293882	296576	302638	297163
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	6.1	6.1	6.2	6.2	6.2

Notes - 2007

All years shown pertain to fiscal years (FYs).

The numerator is from an Alabama Department of Public Health EPSDT care coordination report, and the denominator was provided by the Alabama Medicaid Agency. The numerator and denominator are unduplicated counts.

As stated in the note to FY 2006, well documented historical trends over time are not available as a basis for projecting future trends. Nevertheless, because observed values surpassed (were better than) the targets for 2006 and 2007, we have revised the objectives for 2008-2009 upward to 6.1%, and those for 2010-2012 upward to 6.2%. On the surface, objectives for 2008-2012 appear modest, compared to the 2007 baseline of 6.1%. However, the observed value may fluctuate and--especially without well documented historical trends--we are not confident that it will remain as high as 6.1%. Therefore, remaining at 6.1% for 3 years and achieving a status of 6.2% by 2012--as shown in the objectives--would be a notable accomplishment. If the observed value for this indicator notably increases in FY 2008, objectives will again be revised upward.

Notes - 2006

For FY 2006, the numerator represents the number of 0-9 year-old children who received care coordination from ADPH care coordinators in that FY (unduplicated count), and was provided by the Bureau of Family Health Services' Social Work Branch. The denominator represents the number of Alabama Medicaid-enrolled 0-9 year-old children who were eligible for EPSDT services in FY 2006, and was provided by an Alabama Medicaid Agency staff member. The

denominator is also an unduplicated count, meaning that each child was counted 1 time regardless of length of duration of eligibility.

Due to methodological issues described in this indicator's field note to year 2005, well documented historical trends over time are not available as a basis for projecting future trends. Objectives from 2006 onward require an annual increase (improvement) of 4.0%, from the unrounded FY 2005 baseline. Though the targets would result in a status of just 5.2% in FY 2010 (versus a status of 4.3% in FY 2005), they are aggressive in terms of the number of children who would be served. That is, assuming that the number of 0-9 year-old EPSDT enrollees in FY 2010 is the same as the number in FY 2005, targets require that about 15,422 0-9 year-old EPSDT enrollees receive care coordination in FY 2010. Compared to 12,781 such individuals in FY 2005, this is an increase of about 2,641 individuals. Under the same assumptions, the objective for year 2011 would require that, compared to FY 2005, an additional 3,234 children would be served in 2011.

Notes - 2005

During FY 2005, per ADPH's Care Coordination Report (FHA60099/PHFHA692), 12,781 patients 0-9 years of age received EPSDT Care Coordination.

The denominator comes from Alabama Medicaid Agency's Form HCFA-2082 (Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services; Section D [1], Eligibles for Medical Care by Age, Race, Ethnicity, and Sex; Alabama, FY 2005, page 18).

Methodological issues may account for the slight reported decline in FY 2005, versus FY 2004. That is, due to the availability of an FY 2005 report for the 0-9 year age group, the 95% assumption used for estimating this indicator for FYs 2003 and 2004 (see year 2004 field note) was not necessary.

a. Last Year's Accomplishments

MCH Population Served: Children.

Trends:

The status of this indicator improved slightly 2 years in a row: from 4.3% in FY 2005, to 5.2% in FY 2006 and 6.1% in FY 2007. Comparing 2007 to 2005, an additional 5,363 EPSDT-enrolled children aged 0-9 years received care coordination: an increase of 42%.

Rationale for measure:

The measure pertains to the priority MCH need to assure primary care.

Backdrop:

Patient 1st Care Coordination under EPSDT guidelines was first implemented in March 2004. Per these guidelines, Medicaid no longer required a referral from the patient's primary medical provider or a dentist for care coordination to be provided by CHD staff. Care coordination helps clients access needed medical, social, and educational services.

In FY 2005 ADPH's Bureau of Home and Community Based Services began partnering with USA to pilot TeleHealth, a home-based monitoring system for adults and children with chronic medical needs, in PHA 6. The program included care coordination, which has been a key element in the program's success.

Since circa FY 2005 ADPH Central-Office staff have used the computerized Alabama Care Coordination Records Network (ACORN), which is accessed by an ADPH internal computer server, to document care coordination of patients receiving that service through ADPH. By FY 2006, FHS had begun developing infrastructure for the Web-based Care Coordination Referral System (CCRS), which was designed to receive referrals.

FY 2007:

The following occurred in FY 2007.

Cross-cutting (Enabling and Infrastructure-building):

Patient 1st care coordination continued to grow, especially that provided to children under EPSDT. In FY 2007, 68 FTEs provided care coordination to Patient 1st children (up from 61 FTEs in FY 2006). Compared to earlier years, more complex care coordination was required, and specific protocols for the following categories of care coordination were added: newborn hearing screening, lead screening, asthma, and diabetes. The number of referrals for follow up on newborn screening--to assure that infants identified as having or potentially having hematologic or metabolic disorders or hearing impairment receive appropriate care--continued to grow.

In December 2006 Medicaid began making direct referrals to ADPH for care coordination of patients who have been discharged by their primary medical provider and need help in finding a new provider, and patients who use the emergency room inappropriately. Also, ADPH partnered with Alabama Medicaid to provide the chronic disease case management under Medicaid's Together for Quality federal grant. The conditions involved are stated under "Current Activities."

The TeleHealth program became statewide. Patient 1st care coordination was a component of most TeleHealth referrals.

In October 2006 ALL Kids began piloting an asthma care coordination program in 5 counties (Blount, St. Clair, Shelby, Calhoun, and Talladega). A comprehensive set of services was provided by ADPH care coordinators, in coordination with BCBS management staff. FHS partnered with ALL Kids to implement this pilot. (Funding sources often use the term "case management" to refer to the array of services that are called "care coordination" in this document.)

A social worker was hired in February 2007 to monitor CCRS, the Web-based system for receiving care coordination referrals. In March 2007 Patient 1st care coordinators received training on this system, which was piloted in April. Referrals from the Central Office FHS staff and Alabama Medicaid began being processed through CCRS in May 2007.

Patient 1st care coordinators worked with STEPS, a CDC-funded program located in HPCD, to provide care coordination to Medicaid-enrolled children with asthma who were seen at a medical center in Troy (in Pike County). The first referrals were received in late July 2007.

FHS's social work staff continued providing quarterly trainings for ADPH care coordinators. These trainings included information on protocol and on working with children with chronic conditions and their families.

ADPH consulted with Medicaid on ADPH's difficulty, which had become evident in FY 2006, in providing the federally required matching dollars for care coordination under Patient 1st. Medicaid agreed to pay half the federal match in FY 2008 on any Medicaid-related growth in ADPH's care coordination services relative to FY 2007.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Administer the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Care Coordination Program.		X		X
2. Provide care coordination to EPSDT-eligible children and youth who are seen at county health departments (CHDs) and need the service.		X		
3. As well, provide care coordination to patients, including		X		

children, who are directly referred by the Alabama Medicaid Agency to the Alabama Department of Public Health (ADPH) for care coordination.				
4. Through care coordination, help eligible patients access needed medical, social, and educational services.		X		
5. Through care coordination, assure that newborns identified as having or potentially having hematologic or metabolic disorders or impaired hearing receive appropriate follow up.		X		X
6. In partnership with the University of South Alabama, implement the In-Home Monitoring Program, a home-based monitoring system for adults and children with chronic medical needs.		X		X
7. Pilot and evaluate an asthma care coordination program, in which ADPH care coordinators and Blue Cross and Blue Shield of Alabama management staff partner to provide services.		X		X
8. Via ADPH's computerized system for tracking care coordination services (ACORN), document care coordination of individuals receiving that service through ADPH.				X
9. Implement the Web-based Centralized Care Coordination Referral System, for the purpose of receiving on-line referrals to ADPH for care coordination.				X
10. Provide quarterly training events for ADPH care coordinators.				X

b. Current Activities

Cross-cutting (Enabling and Infrastructure-building):

Care coordination remains a component of TeleHealth, which is now called the In-Home Monitoring Program.

The clinical phase of the ALL Kids asthma care coordination pilot ended in March 2008 and is being evaluated by ALL Kids and UAB.

In February 2008, under Alabama Medicaid's Together for Quality program, ADPH partnered with Medicaid to implement pilot studies on care coordination. Specifically, in February 2008 asthma care coordination pilots began in Bullock and Pike Counties. In March 2008 diabetes care coordination pilots began in these same 2 counties. Later in FY 2008, pilots of care coordination for asthma and diabetes will begin in 6 other counties. Additional trainings have been added that focus on care coordination provided in these pilots.

CCRS continues, and each month several hundred referrals are transmitted through this system to PHAs or counties. Because of limited funding, referrals sent through this system are limited to those made by FHS staff (mostly for elevated lead levels or newborn screening issues) or by Medicaid. The number of referrals for newborn screening continues to grow rapidly, and cystic fibrosis was added to Alabama's newborn screening panel in March 2008.

The STEPS asthma care coordination continues in Pike County and has been well received by physicians and patients. By December 2007 the program's care coordinator was receiving the maximum number of referrals that she could serve.

c. Plan for the Coming Year

Cross-cutting (Enabling and Infrastructure-building):

Whether care coordination for asthma will continue under ALL Kids is contingent on results of the evaluation referenced under "Current Activities."

The previously discussed Together for Quality care coordination pilots in 8 counties (Bullock,

Pike, Montgomery, Tuscaloosa, Lamar, Pickens, Calhoun, and Talladega) will continue until March 2009, when UAB and Alabama Medicaid will begin evaluating the pilots. If the evaluation is positive, Medicaid will consider adding other chronic diseases to the panel for care coordination.

Referrals through CCRS are expected to continue growing in number.

The STEPS asthma care coordination program in Pike County is expected to continue.

The In-Home Monitoring Program, which includes a care coordination component, and quarterly trainings of ADPH care coordinators will continue. In addition, care coordination trainings focusing on asthma and diabetes will be held as required in the 8 counties where care coordination for these conditions is being piloted, as part of Medicaid's Together for Quality initiative.

State Performance Measure 2: *Of children and youth enrolled in Alabama Medicaid's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, the percentage who received any dental service in the reporting year.*

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				37	38.1
Annual Indicator	31.5	34.5	35.9	37.0	45.0
Numerator	151911	169766	180089	188475	226476
Denominator	481845	491853	501766	509155	503051
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	39.2	40.4	41.6	42.9	45

Notes - 2007

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

Notes - 2006

The numerator and denominator for this measure come from the Alabama Medicaid Agency's Title XIX FY Annual EPSDT Participation Report; Alabama, FY 2006, page 1. Per this report, the age range is from birth through 20 years.

From the 2003 baseline, this indicator has improved each year. Comparing 2006 to 2003, the indicator improved by an average of 5.5% per year (multiplicative model). The target for 2006 was reached. Expecting a continued annual improvement of 5.5% may not be reasonable. Therefore, the target for 2011 requires the same rate of improvement (3.0% per year) as previously set targets for 2006 through 2010.

Notes - 2005

The numerator and denominator for this measure come from the Alabama Medicaid Agency's Annual EPSDT Participation Report; Alabama, FY 2005, page 1.

Comparing 2005 to 2003, this indicator improved by an average of 6.7% per year. Comparing 2005 to 2004, this indicator improved by 4.0%. However, these 3 data points (1 for each year) are insufficient for assessing long-term trends, so targets assuming either of these rates of

improvement (6.7% or 4.0% per year) may be unrealistic. Therefore, objectives from 2006 through 2010 require an annual rate of improvement of 3.0%, from the unrounded 2005 baseline. If previous (or better than previous) trends continue through 2007, more aggressive objectives will be set.

a. Last Year's Accomplishments

MCH Population Served: Children and youth.

Status:

In FY 2007, 45.0% of children and youth (from birth through 20 years of age) enrolled in Alabama Medicaid's EPSDT Program received a dental service on 1 or more occasions.

FY 2007:

Unless stated otherwise, the following activities occurred in FY 2007.

Direct:

CHD staff provided oral health services in 26,467 encounters in CHDs and 1,702 encounters in school-based clinics. As part of oral health promotion and educational outreach, OHU staff distributed a total of about 50,000 toothbrush and toothpaste sets to children statewide, to CHD nurses and case managers, to Healthy Alabama childcare nurse coordinators, and to others.

Population-based:

OHU promoted fluoridation initiatives statewide and implemented fluoride mouth rinse programs in select schools. Dental screenings were provided in select schools to determine the oral health status of children and refer as needed.

In FY 2007 OHU developed an oral health Web page, as part of ADPH's Web site, to post information on State oral health data, fluoridated communities in the State, oral health education materials, and other links to oral health information statewide and nationally.

Infrastructure-building:

OHU coordinated the placement of a mobile dental van to provide services to children in underserved communities, screened and referred selected children qualified for receiving services from the van, coordinated staffing of the van, and provided supplies for the van. OHU staff trained and assisted CHD staff, including Patient 1st care coordinators and WIC nutritionists, in promoting access to dental care and utilization of needed dental services.

OHU contracted with a UAB pediatric dentist in FY 2007. In conjunction with this contract, the dental school students and staff promoted access to care by participating in statewide dental screenings. This collaborative initiative addressed workforce issues and shortages by placing some dental students and residents in CHD dental clinics and some community health centers.

OHU continued collaborating with multiple partners to implement the State Oral Health Plan, developed in FY 2000 by a policy team of Alabama public health professionals attending a National Governor's Association workshop. The plan is administered by Alabama Medicaid, who convenes the Oral Health Coalition of Alabama on a quarterly basis. In FY 2007 this coalition updated an Oral Health Fact Sheet for distribution to legislators and other policy makers. OHU staff continued serving on the Alabama Medicaid Dental Task Force, which addresses oral health issues in Medicaid.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide oral health services in CHDs and in school-based clinics.	X			

2. Coordinate the staffing and placement of a mobile dental van to provide services to children in under-served communities, and provide supplies for the van.	X			X
3. Train and assist CHD staff, including care coordinators and WIC nutritionists, in promoting access to dental care and utilization of needed dental services.		X		X
4. Promote fluoridation initiatives statewide, and implement fluoride mouth rinse programs in selected schools.			X	X
5. Via contract with a UAB pediatric dentist, place dental students and residents in CHD dental clinics and in selected community health centers statewide.				X
6. Collaborate with multiple partners to implement the State Oral Health Plan, which is administered by the Alabama Medicaid Agency.				X
7. Serve on the Alabama Medicaid Dental Task Force.				X
8. Serve on an oral health work group of the Health Committee of the Governor's Black Belt Commission.				X
9.				
10.				

b. Current Activities

Crosscutting:

FY 2007 activities basically continue in FY 2008. Updates follow.

Enabling:

An OHU staff nurse continues to provide oral health education and training sessions to other public- and private-sector health care providers and to community-based organizations. OHU staff are working with ALL Kids Area Coordinators to address access to dental services for Latino children and their families.

Population-based:

The OHU director serves on an oral health work group of the Health Committee of the Governor's Black Belt Commission. One focus of this work group is promoting and implementing community water fluoridation in non-fluoridated areas.

c. Plan for the Coming Year

Crosscutting:

Unless previously stated otherwise, FYs 2007 and 2008 activities will basically continue in FY 2009. Additional activities planned for FY 2009 follow.

Enabling:

OHU, the Alabama Chapter of the AAP, and the Alabama Academy of Pediatric Dentistry will collaborate to train pediatric physicians and residents, family practice physicians and residents, and other health professionals throughout the State on risk assessment, oral health education, and referral for dental services. Included in the training will be application of fluoride varnish.

While continuing to promote community water fluoridation among non-fluoridated communities, OHU staff will also work with fluoridated communities that indicated they are considering discontinuing fluoridation, an issue that arose during FY 2007.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				38.3	36.8
Annual Indicator	40.1	39.8	37.4	40.6	
Numerator	3906	3893	3671	3882	
Denominator	97295	97694	98093	95688	
Is the Data Provisional or Final?				Final	
	2008	2009	2010	2011	2012
Annual Performance Objective	36.1	35.4	34.7	34	34

Notes - 2007

The final vital statistics files needed for this estimate are not available for the year 2007. The year 2007 estimated pregnancy rate for this age group will be provided circa June 2009.

The objectives, which were set from earlier baselines, are very aggressive in light of the 2006 baseline. The year 2012 objective was set to match the year 2011 objective; and objectives will be revised by 2010 unless the rate declines markedly in 2007.

Notes - 2006

The numerator for this estimate is the number of reported pregnancies--including live births, fetal deaths, and abortions--among females aged 15 through 17 years in the calendar year (CY). The denominator is the estimated number of females aged 15 through 17 years in the CY.

Data sources for the numerator are Alabama vital statistics files for, respectively, live births, fetal deaths, and abortions.

The denominator is derived by applying the factor .6 to the estimated population of Alabama 15-19 year-old females. Estimated population numbers often differ notably from projected population numbers--which probably accounts for the notable drop in the denominator in 2006 relative to earlier years. (Denominators shown for 2003-2005 are based on projected population numbers.) Thus, the lower denominator in 2006 is probably a reporting artifact. Using the 2005 projected population of 98,093 as the denominator for the 2006 rate yields an estimated pregnancy rate of 39.6 per 1,000. Thus, the rate may have increased by 2.2 pregnancies per 1,000 15-17 year-old females in 2006, rather than by 3.2 pregnancies per 1,000.

The secondary source from which we derived the year 2006 denominator shown on Form 11 is "County Health Profile Alabama 2000," which cites the primary source as the U.S. Census Bureau, at the following url address: <http://www.census.gov/popest/counties/asrh/CC-EST2006-alldata.html>. Because estimated populations are probably more accurate than projected populations, especially in the latter half of a decade, we plan to use the estimated population for this denominator until the year 2010 census has been implemented and reported.

Notes - 2005

See field note to 2006 for a description of the numerator and denominator and the databases and sources from which these are derived.

Comparing 2005 to 2000, the value for this indicator declined (improved) by an average of 6.3% per year (multiplicative model), and the target for year 2006 was surpassed in 2005. Expecting a continued rate of decline of this magnitude may not be realistic. On the other hand, targets set circa May 2006 (when the year 2005 estimate was not available) may not have been sufficiently challenging. Therefore, targets for years 2007-2010 have been reset, and the target for 2011 added (in June 2007), to proceed from the combined 3-year baseline for 2003-05 (39.1358 pregnancies per 1,000 15-17 year-old females). Considering this 3-year baseline as the baseline for 2004, the newly set targets require a decline (improvement) of 2.0% per year (multiplicative

model). (The target for 2006, which is retained, requires a 2.0% annual decline from the unrounded, single-year 2004 rate.)

a. Last Year's Accomplishments

MCH Population Served: Children and youth.

The following discussion focuses on the rationale for SPM #3 and on trends in teen pregnancy, then recaps pertinent activities discussed elsewhere.

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

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

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

Trends from 2000-2005:

The following rates pertain to the number of pregnancies among 15-17 year-old Alabama females per 1,000 such females. Among all Alabama females in this age group, the rate declined from 51.7 pregnancies per 1,000 females in 2000 to 37.4 pregnancies per 1,000 females in 2005: for an overall decline of 27.7%, and an average annual decline of 6.3%. In absolute numbers, the number of pregnancies per year among 15-17 year-old Alabama teens declined from 4,973 pregnancies in 2000 to 3,671 in 2005--so that there were 1,302 fewer of these pregnancies in 2005 than in 2000. Further, considering that there were more 15-17 year-old Alabama females in 2005 than in 2000 (98,093 versus 96,099, 1,405 fewer pregnancies in this age group occurred in 2005 than would have occurred if the year 2000 rate had prevailed.

Comparing 3-year rates, the pregnancy rate for all Alabama 15-17 year-old females declined from 47.0 pregnancies per 1,000 in 2000-02 to 39.1 pregnancies per 1,000 in 2003-05, for an average annual decline of 5.9% per year. In 2003-05, the pregnancy rate for 15-17 year-old Alabama females was higher for Black and other (non-White) females versus White females: 53.0 pregnancies per 1,000 Black and other females, versus 31.1 pregnancies per 1,000 White females. Comparing 2003-05 to 2000-02, overall declines in the pregnancy rate were similar for these 2 groups: 17.5% for Black and other females (53.0 per 1,000 versus 64.2 per 1,000), and 16.1% for White females (31.1 per 1,000 versus 37.1 per 1,000).

Status in 2006:

In contrast to preceding trends, the pregnancy rate among 15-17 year-old Alabama females increased notably in 2006, to 40.6 pregnancies per 1,000 females in this age group.

FY 2007:

FY 2007 activities for reducing the adolescent pregnancy rate, as well as the historical backdrop to these activities, are fully discussed under NPM #8, in Section IV.C. Highlights are recapped below.

Direct:

Family Planning served 22,578 teens in CHDs.

Enabling:

Distribution of 4 pamphlets by CHDs to teen Family Planning clients continued: 2 pamphlets on consensual sex and Alabama law that had been developed by DHR, "20 Ways to Respond to Sexual Pressure," and "Before You Date an Older Guy."

EPSDT-eligible teens seen in CHD Family Planning clinics were provided with teen family planning counseling and with care coordination.

Population-based:

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

Population-based and Infrastructure-building:

AAEP continued. To promote the abstinence-until-marriage message, AAEP funded 8 projects that provided interventions and mentoring programs in schools, to about 38,000 youths in 39 counties. Additionally, AAEP implemented a statewide media campaign.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide family planning services for teens coming to CHDs for such services.	X			
2. Counsel teens coming to CHDs for family planning services, regarding how to respond to pressure to engage in sexual activity.		X		X
3. Provide care coordination for teens who come to CHD Family Planning clinics and are eligible for Alabama Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.		X		X
4. Operate InfoConnection, the toll-free telephone line that provides educational information for teens on reproductive health and family planning services.			X	
5. Administer the Alabama Abstinence-Until-Marriage Education Program (AAEP), which implemented a statewide media campaign to promote the abstinence-until-marriage message.			X	X
6. Through AAEP, channel federal funds to eligible community groups seeking to prevent adolescent pregnancy.			X	X
7.				
8.				
9.				
10.				

b. Current Activities

The following activities are repeated from the discussion of NPM #8.

Direct and Enabling:

CHD Family Planning clinics continue to serve teens who present there. Services include clinical, educational, counseling, and care-coordination services.

Population-based and Infrastructure-building:

The toll-free hotline, InfoConnection, continues.

AAEP's activities have basically continued in FY 2008, since the U.S. Congress continued federal funding through June 30, 2008. Continuation of activities after June will depend on whether abstinence education funding is extended through the fourth quarter of FY 2008. AAEP's progress toward achieving the program's goals is being evaluated.

c. Plan for the Coming Year

Direct and Enabling:

The following direct and enabling activities are repeated from the discussion of NPM #8.

CHD Family Planning clinics will continue to serve teens who present there. Services will include clinical, educational, counseling, and care-coordination services.

Population-based and Infrastructure-building:

The toll-free hotline, InfoConnection, will continue.

Contingent on continuation of federal funding of abstinence education by Congress in FY 2009, ADPH may submit an application for federal funding to continue to provide abstinence-until-marriage education in Alabama schools to youth aged 17 years and younger.

Infrastructure-building:

As part of the upcoming 5-year MCH needs assessment that is to be reported in July 2010, the MCH Epi Unit will analyze trends in adolescent pregnancy from 2000 through 2007, stratifying results according to race and ethnicity. As well, qualitative input concerning a variety of issues, including adolescent pregnancy, will be solicited. This input will be obtained mainly through 2 mail surveys (1 of medical providers and 1 of non-medical organizations serving Title V populations) and either community discussion groups or key informant interviews.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				29	28.7
Annual Indicator	27.3	29	32	32	
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	
	2008	2009	2010	2011	2012
Annual Performance Objective	28.4	28.1	27.9	27.9	27.9

Notes - 2007

As of June 6, 2008, year 2007 Youth Risk Behavior Survey System (YRBSS) estimates for Alabama are not available on the U.S. Centers for Disease Control and Prevention's (CDC's) Web site. By September 2008 we will consult with the Alabama Department of Public Health's Bureau of Health Promotion and Chronic Disease, in which Alabama's YRBSS is administratively located, to learn when an estimate will be available.

Because no recent estimates are available, the year 2012 objective has been set to match the objectives for 2010-2011.

Notes - 2006

YRBS, which can be queried to obtain an estimate of smokeless tobacco use among White males, is conducted in odd years only. The currently available report from the Alabama Youth Tobacco Survey, which is for 2006, does not concurrently report this indicator by sex and race.

The YRBS-based rate for year 2005 is shown as our best estimate of the rate for 2006.

Due to the absence of a current survey-based estimate for 2006, as well as to the lack of consistent improvement in this indicator in recent years, the 2011 objective was set to match the 2010 objective. As stated in the year 2005 field note for this indicator, the objectives are more challenging than they appear.

Notes - 2005

This estimate was obtained by querying CDC's YRBS Web site (<http://apps.nccd.cdc.gov/YRBSS/>) on June 20, 2006. The Web site does not provide the numerator and denominator, but provides the 95% confidence interval, which is plus or minus 6.3 for this estimate.

Objectives for this measure were not set until FY 2006, so are left blank for 2005 and earlier years. Objectives require that the value for this indicator return to the 2004 level (29.0%) in 2006, then decline by 1.0% per year through 2010. These objectives are more aggressive than they appear, given the lack of consistent improvement in this indicator over the surveillance years (1995, 1997, 1999, 2001, 2003, 2004, and 2005). During these years, the status of this indicator ranged from 25.0% in 2001 to 32.0% in 2005, with a median of 29.3% in 1997. The target of 27.9% for 2010 is lower than all but 2 of the observed values over the surveillance period.

a. Last Year's Accomplishments

MCH Population Served: Children and youth.

Historical context:

Per the 2005 YRBS survey, about 1 in 3 (32.0% of) White male Alabama public high school students had used chewing tobacco or snuff in the 30 days preceding the survey. This prevalence was 1.8 times that for their U.S. counterparts, and 2.5 times that for Black male Alabama high school students. A high rate of smokeless tobacco use among junior and senior high males and adult males has been a focus in Alabama in recent years. In FY 2004 smokeless tobacco and oral cancer were highlighted when a former Auburn University football star developed cancer at the base of his tongue. His admitted use of smokeless tobacco for the previous 25 years and his willingness to become a spokesperson against such use provided a unique opportunity to educate health care providers and the public on the dangers of smokeless tobacco. In FYs 2004 and 2005 collectively, statewide news releases and 3 articles written for the State's dental newsletter were distributed. Also in those years, using ADPH Alabama Cancer Registry data, an Oral Cancer Fact Sheet was developed and distributed jointly by ADPH, the Alabama Dental Association, and the School of Dentistry. In February 2005 ADPH organized an oral cancer symposium, held at the annual dental alumni association meeting. The aforesaid football star was 1 of 6 speakers, who included staff from HPCD's Tobacco Prevention Division, to address nearly 300 attendees. A month later an ADPH staff member spoke at the UAB School of Medicine Continuing Education course on oral cancer in Alabama. Through the Tobacco-Free Coalition of Alabama, the former football star spoke at a statewide youth leadership conference in Montgomery in the spring of 2005.

FY 2007:**Population-based:**

Throughout FY 2007 the former football player continued to address health care professions, youth groups, and faith-based groups on his experience with smokeless tobacco and oral cancer. Also, with funding from HPCD's Tobacco Prevention Division, a former major league baseball player and oral cancer survivor spoke to several high school student bodies in southeast

Alabama in the spring of 2007.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. In partnership with external entities, raise public awareness about smokeless tobacco use: through such means as educational events for health care professionals, high school students, and faith-based or civic groups.			X	X
2. [By the end of FY 2008] create an Oral and Pharyngeal Cancer Task Force.				X
3. [By the end of FY 2008] begin developing a State plan for addressing the use of smokeless tobacco.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Crosscutting (Population-based and Infrastructure-building):

It is hoped that, by the end of FY 2008: 1) An Oral and Pharyngeal Cancer Task Force will be created, and 2) work will begin on developing a State plan for addressing the use of smokeless tobacco.

Population-based:

In FY 2008 the former football and baseball stars continued their public awareness campaign about smokeless tobacco use.

c. Plan for the Coming Year

Crosscutting (Population-based and Infrastructure-building):

FY 2008 activities will basically continue in FY 2009. These include 1) convening an Oral and Pharyngeal Cancer Task Force, and 2) developing a State plan for addressing the use of smokeless tobacco. The tasks are to be performed collaboratively, however, in partnerships including external stakeholders, as well as representatives from FHS's OHU, HPCD's Tobacco Prevention and Control Division, and HPCD's Comprehensive Cancer Control Program.

State Performance Measure 5: *The degree to which the State CSHCN Program assures that all CSHCN have adequate access to primary and specialty care and allied health and other related services.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				2	3
Annual Indicator				1	13
Numerator				1	13
Denominator	15	15	15	15	15

Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	14	15	15	15	15

Notes - 2007

This state performance measure (SPM) was created in response to 2004-05 MCH needs assessment data from providers and families. It involves improving the knowledge base of health care providers in local communities related to the unique needs of CYSHCN and their families. The checklist measurement tool has been revised for use in assessing FY 2007 activities forward. The checklist originally created was very narrow in that each item was dependent on another and progress could only begin by developing a specific training module. This did not adequately capture Children's Rehabilitation Service's (CRS's) efforts related to this SPM and unnecessarily caused duplication of effort. The CRS State Office staff engaged in much discussion about activities that would promote the objective of this SPM and developed a revised checklist measurement tool. The new tool better represents groups of activities that support progress on this SPM. The performance measure itself has not changed. The checklist measurement tool has new items, but the scale is the same (0-15). Goals for future years have been revised. Scores for previous years are not comparable to the current measure. A scored checklist measuring progress on this performance measure is attached to Section IV.D SPM #5, "Last Year's Accomplishments." Please see the narrative sections for SPM #5 for more detailed information.

Notes - 2006

This performance measure involves improving the knowledge base of health care providers in local communities related to the unique needs of CYSHCN and their families.

During FY 2006 CRS experienced staff changes in critical leadership positions and a significant restructuring of duties in the State Office. This in addition to competing priorities limited CRS's ability to address this performance measure.

Notes - 2005

This is a new SPM. During FY 2005 CRS began internal discussions of topics for inclusion in training materials, possible methods of information dissemination, and potential task force members from family groups and other representatives from the statewide system of care for CYSHCN. No target objective was set for FY 2005.

CRS is currently in the process of developing a task force of partners and key stakeholders, including CYSHCN and their families, to address this new performance measure. Responsible personnel are identifying pre-existing materials and those to be developed. Training methods will be determined for information dissemination.

Refer to the note section of the detail sheet associated with this measure to view the checklist that will be used in scoring the measure in next year's Block Grant annual report/application.

a. Last Year's Accomplishments

This SPM was created in response to FY 2004-05 MCH needs assessment data from providers and families. It involves improving the knowledge base of health care providers in local communities related to the unique needs of CYSHCN and their families. The measurement tool originally created was very narrow in that each item was dependent on another and progress could only begin by developing a specific training module. This was too narrow to adequately capture CRS efforts on this objective and unnecessarily caused duplication of effort. After much discussion, the measurement tool has been revised to better represent groups of activities that support progress on this SPM. The performance measure itself has not changed. The checklist measurement tool has new items, but the scale is the same and goals for future years have been revised. Scores for previous years are not comparable to the current measure. A scored checklist measuring progress on this performance measure is attached to this section.

Population-based:

CRS staff have provided materials and training to health and professional service providers in several ways. Brochures and presentations about CYSHCN and the CRS program were given to more than 50 medical home/primary care providers and their office staffs throughout the State. A presentation was made to the Speech and Hearing Association of Alabama and during the Region 4 Early Hearing Detection and Intervention conference.

CRS staff have provided materials and training to students and interns in the following programs: Pediatric Pulmonary Center (family-centered care, CYSHCN, and MCH Block Grant performance measurement and accountability), UAB School of Public Health's MCH Division (needs assessment for CYSHCN, CYSHCN, and the CRS program, including care-coordination and family-centered care), UAB School of Nursing-pediatric nurse practitioner program (CYSHCN and the CRS program), and 3 of 5 State Speech-Language Pathology training programs (CYSCHN and the CRS program).

Materials on specific disabilities and special health care needs were provided in CRS offices, clinics, and parent resource rooms and at CRS public awareness displays for health fairs and conferences. Examples include materials on hearing loss, juvenile rheumatoid arthritis, epilepsy, and speech-language development. CRS staff helped ADPH develop 2 brochures about emergency preparedness for CYSHCN and 1 about medical needs shelters. These are disseminated in local CRS offices.

Infrastructure-building:

CRS staff, including the State Parent Consultant and LPCs, participated in the following task forces, committees, interagency meetings, and partner agency initiatives to promote awareness of the unique needs of CYSHCN: EIS Governor's Interagency Coordinating Council (ICC), EIS's District ICCs, the State and county CPCs, District Coordinating Councils for special education and social services, State Newborn Hearing Screening Advisory Committee, State Newborn Screening Advisory Committee, State Head Start Disability Advisory Committee, State Multi-Needs Child Taskforce, SDE Taskforce on Recruitment, Preparation, and Retention, Healthy People 2010 work groups, UAB Civitan International Research Center Consumer Advisory Committee, UAB Pediatric Pulmonary Center State Advisory Committee, Affordability Subcommittee for Alabama Covering Kids and Families Coalition, Medicaid Buy-in Subcommittee for Ticket to Work, Special Education Action Committee Advisory Group, Inclusive Childcare Project, Oral Health Coalition, Individual and Family Support Councils, Northeast Alabama Safe Kids Steering Committee, Family to Family Health Information Council, Alabama Respite Resource Network, Statewide Technology Access and Response (STAR) Advisory Committee, ADPH's Special Populations Taskforce, Oral Health Coalition, 2 Medicaid-led grants (Together for Quality and Alabama Assuring Better Child Health and Development), Alabama Disabilities Advocacy Program's Protection and Advocacy for Individuals with Mental Illness, and "Sharing the Care" Respite Building Network.

CRS continued being a critical part of the system of care for CYSHCN in local communities and an active partner with providers, families, and other agencies to represent the unique needs of CYSHCN. Staff members, including parent consultants, were active in State and community initiatives and provided technical assistance and other resources as needed.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to host or directly provide training for health and professional service providers to CYSHCN to increase			X	X

awareness of the unique needs of CYSHCN, including cultural competence, family-centered care, medical home, and care coordination.				
2. Continue to host or directly provide training for students and interns in health professional schools to increase awareness of the unique needs of CYSHCN, including cultural competence, family-centered care, medical home, and care coordination.			X	X
3. Expand presentations to include students at schools of social work and medical schools in the State.			X	X
4. Continue to develop new materials, modify existing materials, and/or disseminate resources related to the unique needs of CYSHCN, including the core components of cultural competence, family-centered care, and care coordination.			X	X
5. Expand informational materials to include the topics of medical home, cultural competence, care coordination, family-centered care, and the Children's Rehabilitation Service's (CRS's) expanded initiatives related to care coordination and transition.			X	X
6. Continue participation in State and local task forces, committees, etc. to promote the unique needs of CYSHCN, cultural competence, family-centered care, medical home, care coordination, and available technical assistance.				X
7. Continue to be an active presence in local communities and provide technical assistance and other resources as needed by providers of service to CYSHCN and their families.	X	X	X	X
8. Explore the development of a Web site to provide information related to this performance measure.			X	X
9.				
10.				

b. Current Activities

FY 2007 activities as outlined above continue in FY 2008 with the following additions or exceptions.

Population-based:

Most materials currently disseminated by CRS relate to specific disabilities or special care needs, CYSHCN in general, or the CRS program. CRS is exploring existing materials from national sources and other states related to medical home, cultural competence, care coordination, and family-centered care. These will be modified for use in Alabama. Also, CRS is expanding its care coordination program and services related to transition. Materials about these new initiatives will be developed.

CRS will present to the University of Alabama School of Social Work later in FY 2008. The presentation will include information on CYSHCN, CRS, and care coordination. The CRS SPC and members of the Healthy People 2010 work group related to family and professional partnerships would like to present on family-centered care to students at the UAB School of Medicine.

c. Plan for the Coming Year

Unless stated otherwise, all previously discussed activities related to this measure will continue in FY 2009. A recap and notation of activities being newly implemented follows.

Population-based:

CRS will continue to host or directly provide training for health and professional service providers to CYSHCN to increase awareness of the unique needs of CYSHCN, including the core

components of cultural competence, family-centered care, medical home, and care coordination.

CRS will continue to host or directly provide training for students and interns in health professional schools to increase awareness of the unique needs of CYSHCN, including the core components of cultural competence, family-centered care, medical home, and care coordination.

CRS will expand presentations to include students at schools of social work and medical schools in the State.

CRS will continue to develop new materials, modify existing materials, and/or disseminate resources related to the unique needs of CYSHCN, including the core components of cultural competence, family-centered care, and care coordination.

CRS will expand informational materials to include the topics of medical home, cultural competence, care coordination, family-centered care, and the expanded CRS initiatives related to care coordination and transition.

Infrastructure-building:

CRS will continue participation in State and local task forces and committees, interagency meetings, and partner agency initiatives to promote the unique needs of CYSHCN and the concepts of cultural competence, family-centered care, medical home, care coordination, and technical assistance resources available within the State.

CRS will continue to be an active presence in local communities and provide technical assistance and other resources as needed by providers of service to CYSHCN and their families.

CRS will explore the development of a Web site to provide information related to this performance measure. This was suggested during February 2007 meetings of the Youth Advisory and State Parent Advisory Committees. Families and youth suggested topics for inclusion such as transition to adult health care, disability-specific topics, and links to other resources.

State Performance Measure 6: *The degree to which the State CSHCN Program collaborates with schools, advocacy groups, and families to enhance inclusive participation by CYSHCN in their schools and communities.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				2	3
Annual Indicator				1	12
Numerator				1	12
Denominator	15	15	15	15	15
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	13	14	15	15	15

Notes - 2007

This state performance measure (SPM) was created in response to 2004-05 MCH needs assessment data from providers and families. It involves providing training and promoting advocacy both for families and for schools and communities. The checklist measurement tool has been revised for use in assessing FY 2007 activities forward. The checklist originally created was very narrow in that each item was dependent on another and progress could only begin by developing a specific training module. This did not adequately capture Children's Rehabilitation Service's (CRS's) efforts related to this SPM and unnecessarily caused duplication of effort. The

CRS State Office staff engaged in much discussion about activities that would promote the objective of this SPM and developed a revised checklist measurement tool. The new tool better represents groups of activities that support progress on this SPM. The performance measure itself has not changed. The checklist measurement tool has new items, but the scale is the same (0-15). Goals for future years have been revised. Scores for previous years are not comparable to the current measure. A scored checklist measuring progress on this performance measure is attached to Section IV.D SPM #6, "Last Year's Accomplishments." Please see the narrative sections for SPM #6 for more detailed information.

Notes - 2006

This performance measure involves providing training and promoting advocacy both for families and for schools and communities.

During FY 2006 CRS experienced staff changes in critical leadership positions and a significant restructuring of duties in the State Office. This in addition to competing priorities limited CRS's ability to address this performance measure.

Notes - 2005

This is a new SPM. During FY 2005 CRS began internal discussions of topics for inclusion in training materials, possible methods of information dissemination, and potential task force members from family groups and other representatives from the statewide system of care for CYSHCN. No target objective was set for FY 2005.

CRS is currently in the process of developing a task force of partners and key stakeholders, including CYSHCN and their families, to address this new performance measure. Responsible personnel are identifying pre-existing materials and those to be developed. Training methods will be determined for information dissemination.

Refer to the note section of the detail sheet associated with this measure to view the checklist that will be used in scoring the measure in next year's Block Grant annual report/application.

a. Last Year's Accomplishments

This performance measure was created in response to needs assessment data from providers and families. It involves providing training and promoting advocacy both for families and for schools and communities. The measurement tool originally created was very narrow in that each item was dependent on another and progress could only begin by developing a specific training module. This was too narrow to adequately capture CRS efforts on this objective and unnecessarily caused duplication of effort. After much discussion, the measurement tool has been revised to better represent groups of activities that support progress on this SPM. The performance measure itself has not changed. The checklist measurement tool has new items, but the scale is the same and goals for future years have been revised. Scores for previous years are not comparable to the current measure. A scored checklist measuring progress on this performance measure is attached to this section.

Enabling:

CRS staff, including parent consultants, regularly participated in the Individual Education Plan (IEP) process of CYSHCN enrolled in the State CSHCN Program.

Population-based:

The SPC provided trainings on many topics and in several venues, including a session on Family Voices and family-centered care to the UAB Pediatric Pulmonary Center trainees. LPCs presented trainings on CRS, family-centered care, disability-related issues, and the parent perspective at schools, community colleges, and childcare centers. CRS staff disseminated brochures and made presentations on CYSHCN and the CRS program to schools throughout the State. CRS nurses, social workers, physical therapists, occupational therapists, nutritionists, speech-language pathologists, and audiologists provided technical assistance to teachers and

other classroom personnel related to the needs of CYSHCN and to their inclusion in school and recreational settings.

Local Parent Advisory Committees hosted presentations for families on topics such as IEPs, Medicaid waivers, special education, nutrition, stress management, Social Security and SSI, respite care, caring for the caregiver, VRS, Medicaid reimbursement for school-based therapy, disability rights, and "Wheelin' Sportsmen."

Infrastructure-building:

CRS staff, including the State and LPCs, participated in the following task forces, committees, interagency meetings, and partner agency initiatives: EIS's Governor's ICC, EIS's District ICCs, State and county CPCs, District Coordinating Councils for special education and social services, Healthy People 2010 work groups, State Head Start Disability Advisory Committee, State Multi-Needs Child Task Force, SDE Taskforce on Recruitment, Preparation, and Retention, UAB Civitan International Research Center Consumer Advisory Committee, Special Education Action Committee Advisory Group, Olmstead Core Workgroup, Inclusive Childcare Project, Individual and Family Support Councils, Northeast Alabama Safe Kids Steering Committee, Family to Family Health Information Council, Alabama Respite Resource Network, STAR Advisory Committee, Alabama Disabilities Advocacy Program's Protection and Advocacy for Individuals with Mental Illness, "Sharing the Care" Respite Building Network, and the ADRS Continuum of Transition for Youth with Special Health Care Needs.

CRS continued to be a critical part of the system of care for CYSHCN in local communities and an active partner with schools, families, and other agencies to promote inclusion of CYSHCN in schools and communities. Staff members, including parent consultants, were active in State and community initiatives and provided technical assistance and other resources as needed.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CRS staff, including parent consultants, continue participation in the Individual Education Plan (IEP) process of CRS-enrolled CYSHCN.		X		
2. Continue to develop a transition plan that includes promotion of integration into local communities including school, work, and recreation for all youth enrolled in CRS.		X		X
3. Continue to host or directly provide training for families including special education rights, participation in the IEP process, and advocacy for integration into school and community activities.			X	X
4. Continue to host or directly provide training for local educational agency staff and provide technical assistance related to the health needs of CYSHCN and promotion of their full integration into the educational and recreational setting.			X	X
5. Continue participation in State and local task forces, committees, etc. to promote a comprehensive, collaborative effort to address the participation of families and CYSHCN in their schools and communities.				X
6. Continue training for CRS staff, including parent consultants, on school health issues for CYSHCN, participation in IEP development, and strategies to promote full integration of CYSHCN into their school environment.				X

7. Continue to be an active presence in local communities and to provide technical assistance and other resources as needed by providers of service to CYSHCN and their families.	X	X	X	X
8. Explore the development of a Web site to provide information related to this performance measure.			X	X
9.				
10.				

b. Current Activities

FY 2007 activities as outlined above continue in FY 2008 with the following additions or exceptions.

Enabling:

As discussed in NPM #6, CRS is developing staff social work positions focused on transition. Persons filling the positions will be called Social Work Transition Specialists. At age 14 to 16, all CRS youth are transferred to the caseload of these staff members with expertise in all aspects of transition. A transition plan template is being created for use with clients ages 14-21. This will be a "living" document to assist CRS youth and families in preparing for adulthood, including integration in local communities.

Infrastructure-building:

In June 2008 Alabama's Disabilities Advocacy Program will provide training for CRS staff on IEP development and effective participation in the IEP process.

c. Plan for the Coming Year

Unless stated otherwise, all previously discussed activities related to this measure will continue in FY 2009. A recap and notation of activities being newly implemented follows.

Enabling:

CRS staff, including parent consultants, will continue to participate in the IEP process of CRS-enrolled CYSHCN. All youth enrolled in CRS will continue to have a transition plan that includes promotion of integration into local communities including school, work, and recreation.

Population-based:

CRS will continue to host or directly provide training for families including special education rights, effective participation in the IEP process, and skills building in advocating for integration into school and community activities (education, recreation, etc.).

CRS will continue to host or directly provide training for local educational agency staff and provide technical assistance related to the health needs of CYSHCN and promotion of their full integration into the educational and recreational setting.

Infrastructure-building:

CRS will continue participation in State and local task forces and committees, interagency meetings, and partner agency initiatives to promote a comprehensive, collaborative effort to address the participation of families and CYSHCN in their schools and communities.

CRS staff, including parent consultants, will continue to be trained on school-related health issues for CYSHCN, effective participation in IEP development, and strategies to promote full integration of CYSHCN into their school environment. CRS will continue to be an active presence in local communities and provide technical assistance and other resources as needed by providers of service to CYSHCN and their families.

CRS will explore the development of a Web site to provide information related to this performance

measure. This was suggested during February 2007 meetings of the Youth Advisory and State Parent Advisory Committees. Families and youth suggested topics for inclusion such as general transition issues, special education law and rights, a listing of specific disabilities and possible challenges associated with them, tips for teachers and allied health providers in working with families (family-centered care, listening, communication, etc.), tips for families in connecting with providers (expression of concerns, effective and assertive communication, etc.), and links to other resources.

State Performance Measure 7: *The degree to which the Bureau of Family Health Services (Bureau) collects, analyzes, and disseminates findings from data pertinent to ongoing maternal and child health (MCH) needs assessment.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				6	9
Annual Indicator	5	5	5	8	14
Numerator	5	5	5	8	14
Denominator	18	18	18	18	18
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	14	14	14	18	18

Notes - 2007

The scored checklist for FY 2007 is attached to Section IV.D, State Performance Measure (SPM) #7, "Last Year's Accomplishments."

Objectives for 2008 and 2009 have been revised upward, to match the score achieved in 2007. Due to competing reporting responsibilities, further progress on the criteria for this measure is not expected until 2011, when the target is the maximum score for this indicator. Whether this maximum score will be achieved, however, depends on future staffing and budgetary resources and on emerging issues.

Notes - 2006

Items in the checklist have not changed since its development.

Notes - 2005

Each criterion and its score for FY 2005 are stated in the notes to the detail sheet for SPM #7.

a. Last Year's Accomplishments

MCH Populations Served: Pregnant women, mothers, and infants; children; CSHCN.

Rationale: This measure pertains to 2 MCH priority needs: to 1) promote evidence-based health education and outreach, and 2) develop capacity to collect and analyze health-related data. The measure also pertains to 4 of the 10 essential public health services (reference #18): to 1) monitor health status; 2) inform, educate, and empower people about health issues; 3) mobilize community partnerships, and 4) develop policies and plans that support individual and community efforts.

Criteria for this measure, scored for FY 2007, are attached. Stated "item" numbers pertain to items in the attached checklist.

Historical Context:

Concerning item 1, In FY 2006 SPP continued infant death reviews in each of the State's 5

perinatal regions. Each of the 5 RNPCs collected data from records of 20 infant deaths occurring in FY 2005 in her perinatal region. Because of an increase in deaths of Latino infants in 2005, each RNPC reviewed a larger representation of deaths of Latino infants in her region. (Recent trends in infant mortality for Latino infants, from 2002-2005, in Alabama are discussed in the attachment to this text.) RPAC subcommittees in each perinatal region formed the case review teams; and each RNPC reported the findings and recommendations from her region's case review team to a community action team in the resident county of the infant.

FY 2007:

Unless states otherwise, all the following activities occurred in FY 2007.

Crosscutting (Population-based and Infrastructure-building):

Concerning item 1, SPP explored potential funding sources for hiring 6 nurses and a research analyst to implement planning for statewide fetal and infant death review. As part of this process, ADPH submitted a proposal to Medicaid for matching funds to begin statewide infant death review. Medicaid agreed to the proposal.

Concerning item 2, ACDRS continued maintaining the program's Web page, which allowed on-line submission of data from the Local Child Death Review Teams and provided information on underlying legislation, the child death review process, causes of child death, summary recommendations of the State Child Death Review Team, links to nationwide resources related to child death review, and downloadable versions of all ACDRS publications. ACDRS also continued maintaining a comprehensive, searchable database that contained all data collected since the inception of the program. All 41 Judicial Circuits continued having a Local Child Death Review Team Chairperson, and ACDRS continued having nearly 60 Local Child Death Review Teams in the State. All but 1 of the ACDRS Local Child Death Review Teams was active in the review of cases. Collectively, these local teams reviewed 93% of the 2004 cases assigned to them, increased from 64% of cases being reviewed circa 1998, and 80% being reviewed in 2001-2003.

Due to competing reporting responsibilities, no progress has been made on item 3.

Item 4 concerns a data-based report involving a particular MCH issue. The groundwork for this task was begun in FY 2006, when the MCH Epi Unit organized an ADPH internal work group, the Drug Overdose Work Group, to follow up on certain findings in the 2004-05 MCH Needs Assessment Report. The work group held its final meeting in November 2006. In December 2006 the MCH Epi Unit produced a report (discussed in Section II.C), "Deaths Due to Drug-Related and Alcohol-Induced Causes, Alabama, 1999-2005: with a Focus on the 15-44 Year-Old Age Group."

Item 5 concerns a needs assessment report on pregnancy and infancy. Again the Bureau lay the groundwork for completing this task in FY 2006, by inviting SPAC to comment on draft materials to be posted on the State MCH Title V Web page. In response, 1 SPAC member expressed concern about the infant mortality gap between Alabama and the U.S. In FY 2007, in collaboration with this SPAC member, the MCH Epi Unit developed an SPM on this mortality gap and prepared a background paper on the new outcome measure. Key findings from this paper are summarized in Section II.C, and the entire paper is attached to Section II.C.

Item 6 concerns a reader-friendly needs assessment report on children and youth. The Bureau per se has not produced such a report. However, in December 2006 the UAB School of Education, with guidance from the Bureau's Coordinator of Adolescent Health, produced a report (in Appendix F) on identifying priority adolescent needs.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service
------------	--------------------------

	DHC	ES	PBS	IB
1. Via collaboration with the Alabama Medicaid Agency and other stakeholders, lay the groundwork for conducting statewide infant death review.				X
2. Administer the Alabama Child Death Review System, to review unexpected deaths of children and youth.				X
3. Maintain the ACDRS Web page, which allows on-line submission of data from the Local Child Death Review Teams and provides information on the child death review process, causes of child death, and recommendations of the State Child Death Review Team.			X	X
4. Periodically produce a strongly data-based, collaborative report addressing a particular MCH issue: either an emerging issue or a longstanding issue that requires focused study.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Crosscutting (Population-based and Infrastructure-building):

SPP continues to explore potential funding for statewide fetal and infant death review.

ACDRS continues its activities.

A masters-level epidemiology student intern from the UAB School of Public Health was assigned to the MCH Epi Unit, to work 20 hours per week for 3 months from mid-September to mid-December 2008. She updated the maternal and infant profiles periodically produced by the MCH Epi Unit for the State and its 5 perinatal regions and made a slide presentation on the profiles to SPP staff. The slides were emailed to the RNPCs, to be adapted for use as indicated in each region. The profile for the State comprises the last 2 pages of the the attachment to Section II.C. Corresponding profiles for each perinatal region can be obtained by e-mailing the Director of the MCH Epi Unit, at acowden@adph.state.al.us.

The MCH Epi Unit will lay the groundwork for conducting the 5-year MCH needs assessment to be reported in FY 2010. However, the unit is experiencing staffing limitations: due to the resignation of the unit's research analyst and delay in securing additional staff. As well, the MCH Epi Unit applied for placement of an Epidemiology Fellow from a program jointly operated by the Council of State and Territorial Epidemiologists and CDC. Though a match occurred, the Fellow chose another career option and did not accept the fellowship.

c. Plan for the Coming Year

Crosscutting (Population-based and Infrastructure-building):

In FY 2009 SPP will implement a statewide review of all infant and fetal deaths of 20 weeks gestation or more. The program will use the model developed by ACOG for fetal and infant mortality reviews. Case review teams, to be established in accordance with the ACOG model, will be composed of RPAC members; and the RNPCs will assist with coordination of the case reviews. Based on the findings from the healthcare record reviews, the case review teams will make recommendations regarding potential ways to reduce the occurrence of infant deaths. The RNPCs will also assist in establishment of community action teams. The case review teams' recommendations will be presented to the community action teams, in order to facilitate community participation in development of strategies to reduce infant mortality within the

communities where the deaths occurred.

ACDRS's activities will basically continue in FY 2009: including maintenance of the system's Web page, maintenance of the system's database, performance of child death review by local teams, and distribution of educational brochures on infant/child death prevention strategies.

The Director of the MCH Epi Unit will spearhead planning and implementation of the data-collection phase of the federally required, comprehensive 5-year MCH needs assessment that is to be reported in FY 2010. The depth and comprehensiveness of this assessment will be affected by whether the MCH Epi Unit's staffing needs are met and whether funds are made available for contracting out the implementation of and analysis of findings from community discussion groups and/or key informant interviews.

E. Health Status Indicators

/2007/INTRODUCTION

References and Data-Related Issues:

References are listed in Appendix D, which can be requested by e-mailing acowden@adph.state.al.us.

The 2004-05 MCH Needs Assessment Report (reference #1, sometimes termed "Needs Assessment Report") is often referenced in discussion of HSIs and can be requested at the above e-mail address.

For most vital statistics-based HSIs, percent changes compare the combined rate for the latter 2- or 3-year period to that for an earlier 2- or 3-year period in order to minimize random fluctuation. Percent changes are based on a multiplicative model. Average annual percent changes are also based on a multiplicative model and assume a constant increase or decrease over the surveillance period.

As part of the FY 2004-05 MCH needs assessment, more detailed analysis of many MCH indicators was performed than is feasible to perform annually. Where deemed pertinent to a particular HSI, some of these analyses are recapped in the following discussion.

The following discussion was mainly written in mid-June 2006 and mainly updated in May 2007.

Utilization of HSIs:

The Web-based guidance for this section suggests that HSIs be described regarding the degree to which the indicator:

- 1) Provides information on the State's residents.
- 2) Helps direct public health efforts.
- 3) Serves as a surveillance or monitoring tool.
- 4) Functions as an evaluative measure.

General discussion of the above issues follows.

Information on State's Residents:

All the indicators provide information on the State's residents, but no single indicator provides a complete picture of an issue. With this caveat, unless stated otherwise in the discussion of a particular HSI, FHS considers it to be an informative indicator.

Direction for Public Health Efforts:

Seldom should a single indicator direct public health efforts. However, in many cases an indicator

comprises part of a larger picture that suggests a direction for public health efforts. Accordingly, unless stated otherwise in the discussion of a particular HSI, FHS considers it to have potential use in directing public health efforts: when viewed along with other pertinent indicators and in the context of external forces.

Surveillance or Monitoring Tool:

Most of the HSIs are important surveillance tools. Accordingly, unless stated otherwise in the discussion of a particular HSI, FHS considers it to be an important surveillance tool. However, in an effort to allocate personnel resources wisely, at any given time ADPH must prioritize very few MCH indicators for intensive, multivariate analysis and careful consideration. In this context, some HSIs are not deemed by FHS to merit reporting on an annual basis. Other HSIs, though reported on an annual basis, are not prioritized for multivariate analysis or careful consideration at this time.

Evaluative Measure:

Many forces outside of the control of public health professionals influence most key MCH indicators. Further, rarely is a rigorous, systematic, multi-factorial study of cause and effect feasible in a public health setting. Therefore, rarely does a single MCH indicator suffice for rigorous evaluation of an MCH program. Consequently, most HSIs should be viewed as descriptive measures of health status, rather than as evaluative measures per se. When going in the wrong direction, however, any given HSI can serve as a warning: indicating that the HSI or a related indicator should be prioritized for multivariate study and collaborative consideration.

//2009/Due to the time required to receive certificates and carefully edit files, the final statistical live birth file for 2007 is not yet available, and may not be available until October 2008. Previous experience has shown that preliminary vital statistics estimates made at this time of year (the June after the reporting year) are often misleading. Therefore, vital statistics numbers for 2007 are not cited in this narrative.//2009//

HSI #1A: PERCENT OF LIVE BIRTHS WEIGHING LESS THAN 2,500 GRAMS.

Utilization:

Low birth weight includes VLBW (less than 1,500 grams) and moderately low (1,500-2,499 grams) birth weight. Because VLBW is a much stronger predictor of infant death than moderately low birth weight is, FHS's MCH Epi Unit does not consider HSI #1A to be an especially important surveillance tool. As a corollary, though we report HSIs #1A and #1B on Form 11, we do not use either of these indicators as a key monitoring tool or evaluative measure. Accordingly, we do not use either of these measures to direct public health efforts. Consequently, trends in HSIs #1A and #1B are not discussed in the following narrative. Instead, the following focuses on birth weight-specific risks of infant death and on approaches to addressing low birth weight.

Birth Weight-Specific Risks of Infant Death:

Low birth weight newborns are more likely than normal birth weight newborns to die during the 1st year of life. Further, within the low birth weight category, risk of infant death declines dramatically as birth weight increases. The following birth weight-specific risks of infant death pertain to babies born to Alabama residents in 2000-02. Eighty-nine percent of babies weighing less than 500 grams at birth, and 45% of babies weighing 500-749 grams at birth, died during infancy. Due to their relative rarity, infant deaths in the higher birth weight categories are reported per 1,000 live births, rather than as percents. Among 750-1,499 gram newborns, 74 of every 1,000 died in infancy. Among 1,500-2,499 gram newborns, 16 of every 1,000 died in infancy. Among normal birth weight (2,500-4,249 grams) infants, 3 (3.2) of every 1,000 died in infancy.
//2009/Due to limited resources and competing priorities, we do not analyze infant mortality for each of the above categories on an annual basis. However, birth weight-specific infant mortality for these categories will be analyzed in FY 2009, as part of the upcoming 5-year MCH needs assessment that is to be reported in July 2010.//2009//

Approach to Addressing Low Birth Weight:

FHS's overall strategy for addressing low birth weight has been to maintain and develop the infrastructure for regionalized health care; seek to ascertain what initiatives and services are most likely to reduce the frequency of VLBW, and develop strategies based on information so gathered. Ongoing interventions and services include:

- 1) CHDs' provision of family planning services with priority to low-income clients.
- 2) Education of CHD Family Planning clients about the importance of prenatal care. Other initiatives to promote early prenatal care are discussed under NPM #18.
- 3) WIC's provision of food vouchers and nutritional counseling to eligible pregnant women.
- 4) Initiatives, described under NPM #8, to reduce the occurrence of adolescent pregnancy.
- 5) Initiatives, described under NPM #15, to reduce the occurrence of smoking during pregnancy.

All of the preceding initiatives and services pertain to HSIs #1B, #2A, and #2B, as well as #1A. Further, the State seeks to address sub-optimum pregnancy outcomes, including low birth weight, through SPAC, discussed under HSI #2A and NPM #17.

//2008/Because low birth weight and age at gestation are related, efforts to reduce the prevalence of prematurity pertain to low birth weight. As stated in Section III.E, since October 2002 SPP has partnered with AMOD on the National March of Dimes' campaign to reduce the prevalence of prematurity. The national campaign has included sponsorship of research to identify factors that contribute to preterm birth, and some of that research has indicated that the health of women at the time of conception is a factor in pregnancy outcome. Based on that research, since FY 2006 RNPCs have conducted staff development programs on the importance of preconceptional care for delivering physicians' offices. These programs have been conducted with the support of AMOD and are discussed under NPM #15. For example, in FY 2006 RNPCs participated in a train-the-trainer workshop for the PT +3 counseling model, which was used to train physicians' office staff in provision of preconceptional counseling for female patients of childbearing age. The training included information on prevention and/or discontinuation of tobacco use. (The PT +3 model is described under NPM #15.) Other joint activities include a statewide perinatal conference on prematurity in FY 2006 and plans for one in FY 2007.//2008//

//2009/A statewide conference on prematurity was not held in FY 2007. Therefore, a perinatal conference with prematurity as the focus of discussion was held in each perinatal region. Two perinatal SPAC summits to address perinatal issues, including prematurity in Alabama, will be held in FY 2008.//2009//

HSI #1B: PERCENT OF LIVE SINGLETON BIRTHS WEIGHING LESS THAN 2,500 GRAMS.

Utilization:

See discussion of HSI #1A.

Approach to Addressing Low Birth Weight:

See discussion of HSIs #1A and #2A.

HSI #2A: PERCENT OF LIVE BIRTHS WEIGHING LESS THAN 1,500 GRAMS.

Utilization:

Because VLBW is a very strong predictor of infant death, FHS considers it to be a crucial surveillance tool, though the influence of several factors on the reported prevalence of VLBW limits this indicator's use as an evaluative measure. Nevertheless, the indicator identifies a high-

risk group, so may be helpful for directing public health efforts.

Several hypothetical explanations for the lack of improvement in VLBW merit consideration and data-based assessment. First, trends in multiple births, discussed in the 2004-05 MCH Needs Assessment Report, affect trends in VLBW. Second, the reporting issues described below (under "Trends") merit consideration. Third, the possibility that advances in prenatal and perinatal care have resulted in live births of some VLBW babies who would have died before birth in the absence of such care should be considered. Finally, the possibility of unfavorable trends, or at least failure to decline, in risk markers for women giving birth should be explored. Trends in certain risk markers are discussed in the 2004-05 MCH Needs Assessment Report.

Trends:

The reported prevalence of VLBW has generally increased slightly or remained stable for several years. For individual years from 2000-2005, this indicator ranged between 2.0% and 2.2%. The degree to which this indicator's increase or, at best, failure to decline reflects actual trends versus variation over time in reporting cannot be assessed from vital records alone. Researchers in Alabama have previously reported their perception that reporting of under 500 gram births, for which "the dividing lines between live birth, stillbirth, and spontaneous mid-trimester abortion are...often difficult to determine," had certainly increased (reference #12). Conceivably, this perceived increase in reporting of extremely low birth weight infants had actually occurred and may have continued.

/2009/In 2006, 2.0% of Alabama residential live births were VLBW, which is within the range stated above./2009//

Approach to Addressing VLBW:

Among infants born to Alabama residents in 2000-02, VLBW newborns were 78 times more likely to die before their first birthday than normal birth weight infants were. Strategy and certain initiatives designed to reduce the prevalence of VLBW are discussed under HSI #1A. SPAC is a key group through which strategy is implemented. The current objectives of SPAC, some of which address risk markers for VLBW, are to:

- 1) Reduce the number of pregnancies leading to birth intervals of less than 2 years.
- 2) Decrease the percentage of women who smoke during pregnancy.
- 3) Reduce the number of pregnancies among females 17 years old and younger.
- 4) Implement public awareness activities on the importance of preconceptional health.
- 5) Increase the breastfeeding rate, both for initiation and duration, to reflect AAP guidelines and Healthy People 2010 objectives.

/2008/In FY 2006 SPAC's objective about preconceptional health was broadened to include provider education, in addition to public awareness./2008//

/2009/In FY 2008 SPAC's objective to increase the prevalence of breastfeeding broadened to include activities to increase public awareness concerning the issue./2009//

FIMR of VLBW Infants:

The main purpose of Alabama's first statewide use of the FIMR model was to identify barriers that might prevent VLBW babies from being born at a perinatal center. Deaths of 61 VLBW infants who died in 2002 were reviewed. The deaths reviewed were divided into 2 groups, those born at a perinatal center and those born outside a perinatal center. Results of the reviews were identification of issues surrounding the pregnancies, plus recommendations from the case review teams to positively impact such pregnancies and births. A brief summary of these recommendations follows.

All 5 case review teams agreed that few of the deaths of VLBW infants were preventable in terms of medical and hospital care given at delivery or, subsequently, during hospitalization. However, each team identified issues surrounding the pregnancies that could be addressed through community actions or strengthening of the health care system. Salient recommendations about VLBW infants, made by the RPACs, pertained to: 1) improvement of risk assessment procedures, 2) provision of preconceptional counseling, 3) improvement of social services referrals, and 4) further strengthening of the system of regionalized perinatal care.

/2008/Statewide infant death reviews will continue as described under SPM #7, located in Section IV.D./2008//

HSI #2B: PERCENT OF LIVE SINGLETON BIRTHS WEIGHING LESS THAN 1,500 GRAMS.

Utilization:

FHS considers this indicator to be a crucial surveillance tool. With the exception that HSI #2B removes the effect of multiple births, however, this indicator has all the limitations described under HSI #2A. Nevertheless, like HSI #2A, HSI #2B helps identify high-risk groups, so may be helpful for directing public health efforts. Further, unlike HSI #2A, HSI #2B permits surveillance of VLBW unmixed with the effects of multiple births.

Trends:

From 2001 through 2005, from 1.5% to 1.7% of live singleton births to Alabama residents were VLBW.

/2009/In 2006, 1.6% of Alabama residential live singleton births were VLBW, which is within the range stated above./2009//

Approach to Addressing VLBW:

See discussion of HSIs #1A and #2A.

HSI #3A: DEATH RATE PER 100,000 DUE TO UNINTENTIONAL INJURIES AMONG CHILDREN AGED 14 YEARS AND YOUNGER.

/2008/Trends:

This indicator notably improved over the surveillance period, from 14.4 deaths per 100,000 in 2000-02 to 13.0 deaths per 100,000 in 2003-05: for an overall decline of 9.9%, or an average decline of 3.4% per year. In 2005 the death rate for unintentional injuries in this age group was 13.9 deaths per 100,000./2008//

/2009/In 2004-06, the mortality rate for unintentional injuries among Alabama residents aged 14 years and younger was 13.3 deaths per 100,000 persons in that age group, which was 2.4% higher than in 2003-05./2009//

Approach to Addressing Unintentional Injuries:

ADPH addresses unintentional injuries, regardless of age, through HPCD's Injury Prevention Division. FHS chiefly addresses unintentional injuries through ACDRS, discussed under NPM #10 and under SPM #7.

HSI #3B: DEATH RATE PER 100,000 FOR UNINTENTIONAL INJURIES AMONG CHILDREN AGED 14 YEARS AND YOUNGER DUE TO MOTOR VEHICLE CRASHES.

/2008/Trends:

The rate increased slightly, from 6.0 deaths per 100,000 in 2000-02 to 6.2 deaths per 100,000 in 2003-05: for an overall increase of 3.3%, or an average annual increase of 1.1%. In 2005 the death rate for motor vehicle crashes in this age group was 6.5 deaths per 100,000.//2008//

/2009/In 2004-06, the mortality rate for motor vehicle crashes among Alabama residents aged 14 years and younger was 6.5 deaths per 100,000 persons in that age group, which was 5.2% higher than in 2003-05.//2009//

Approach to Addressing Unintentional Injuries:
See discussion of HSI #3A.

HSI #3C: DEATH RATE PER 100,000 FROM UNINTENTIONAL INJURIES DUE TO MOTOR VEHICLE CRASHES AMONG YOUTH AGED 15-24 YEARS.

/2008/Trends:

The rate barely declined, from 42.1 deaths per 100,000 in 2000-02 to 41.8 deaths per 100,000 in 2003-05: for an overall decline of 0.6%. In 2005 the death rate for this cause in this age group was 41.0 deaths per 100,000.//2008//

/2009/In 2004-06, the mortality rate for motor vehicle crashes among 15-24 year-old Alabama residents was 44.4 deaths per 100,000 persons in that age group, which was 6.3% higher than in 2003-05.//2009//

Approach to Addressing Unintentional Injuries:
See discussion of HSI #3A.

HSI #4A: RATE PER 100,000 OF ALL NONFATAL INJURIES AMONG CHILDREN AGED 14 YEARS AND YOUNGER.

Utilization:

Alabama does not have a database for counting the numerator events for this indicator or for HSI #4B or #4C. Therefore, the numerator is estimated as described in the Form 20 note about HSIs #4A, #4B, and #4C, and in the FY 2006 Form 20 field notes for these indicators. Other than meeting federal reporting requirements, the only purpose served by the reported estimates for HSIs #4A, #4B, and #4C is to provide a rough, conjectural estimate of the number of individual Alabama residents in the specified age group who sustained the specified type of nonfatal injury, which is shown as the numerator on Form 20.

/2008/As stated under HSCI #9A, the MCH Epi unit is consulting Alabama Medicaid to determine if a statewide electronic health information system that Medicaid plans to develop could be designed to allow for generation of a public health database for surveillance of morbidity, including injuries.//2008//

HSI #4B: RATE PER 100,000 OF NONFATAL INJURIES DUE TO MOTOR VEHICLE CRASHES AMONG CHILDREN AGED 14 YEARS AND YOUNGER.

Utilization:
See discussion of HSI #4A.

HSI #4C: RATE PER 100,000 OF NONFATAL INJURIES DUE TO MOTOR VEHICLE CRASHES AMONG YOUTH AGED 15 THROUGH 24 YEARS.

Utilization:
See discussion of HSI #4A.

HSI #5A: RATE PER 1,000 WOMEN AGED 15 THROUGH 19 YEARS WITH A REPORTED CASE OF CHLAMYDIA.

/2008/After increasing 2 years in a row, this rate was 50.0 cases per 1,000 in 2006. Comparing 3-year periods, from a 2001-03 baseline of 33.3 cases per 1,000, this rate increased to 39.7 cases per 1,000 in 2004-06: for an overall increase of 19.2%, or an average increase of 6.0% per year. See discussion of screening practices under HSI #5B, which follows.//2008//

/2009/The year 2006 estimate shown on Form 20 uses the population estimate for the denominator, which yields a year 2004-06 rate of 40.1 per 1,000.

In 2007 there were 47.0 cases of chlamydia per 1,000 Alabama residents aged 15-19 years. This rate is lower than the corresponding rate for 2006, but notably higher than the corresponding rate for 2005.//2009//

HSI #5B: RATE PER 1,000 WOMEN AGED 20 THROUGH 44 YEARS WITH A REPORTED CASE OF CHLAMYDIA.

/2008/After increasing 3 years in a row, this rate was 16.5 cases per 1,000 in 2006. Comparing 3-year periods, from a 2001-03 baseline of 9.0 cases per 1,000, this rate increased to 13.0 cases per 1,000 in 2004-06: for an overall increase of 44.1%, or an average increase of 13.0% per year.

/2009/The year 2006 estimate shown on Form 20 uses the population estimate for the denominator, which yields a year 2004-06 rate of 13.1 per 1,000.//2009//

At least part of the increases in HSIs #5A and #5B in 2006 may be due to more frequent testing. In the fall of 2005 the State lab acquired the technology to utilize urine-based testing for chlamydia and gonorrhea, and the testing has been implemented in all CHDs. Using the amplified urine-based test has dramatically increased the number of individuals tested, especially among males. Persons attending CHD Family Planning and STD clinics are now routinely screened for gonorrhea and chlamydia, and testing is more readily available at off-site locations (such as college campuses, jails, health fairs, etc.). The higher sensitivity of the test, relative to the previously used test, has also resulted in the diagnosis of more infections. Per encounter-form data, 58,128 CHD female Family Planning clients were screened for chlamydia in FY 2006, 1,004 fewer than in FY 2005. Though these findings do not support the hypothesis that part of the increase in 2006 was due to more frequent testing, they do not refute the hypothesis because females other than Family Planning clients are tested. ADPH will continue to monitor HSIs #5A and #5B. MCH Epi staff, Women's Health Division staff, and staff from the STD Control Division, located in ADPH's Bureau of Communicable Disease, are consulting about the reported increases in HSIs #5A and #5B.

/2009/In 2007 there were 14.2 cases of chlamydia per 1,000 Alabama residents aged 20-44 years. This rate is lower than the corresponding rate for 2006, but higher than the corresponding rate for 2005.//2009//

INTRODUCTION TO DEMOGRAPHIC INDICATORS.

With 1 exception (an update on Medicaid enrollment), discussion of HSIs #6A through #9B is based on numbers available to the writer circa June 2005. Thus, except for the aforesaid update, the most recent year referenced in discussion of these indicators is 2004. However, except for 2 items in HSIs #9A and #9B, forms for the above indicators have been updated (circa June 2007) to report numbers for 2005. By December 2007, corresponding numbers for 2006 will be obtained for HSIs #6A through #8B. By early FY 2008 the MCH Epi Unit will provide a brief report that highlights salient findings concerning the preceding HSIs. For vital statistics-based and Census-based numbers, this report will be based on review of findings from 2002 through 2006. For indicators included in HSIs #9A and #9B, the report will be based on the most recent numbers

available over a 1- to 3-year period, depending on the data source.//2008//

/2009/Due to competing priorities and a vacant staff position, the MCH Epi Unit has not prepared the above-mentioned brief report. However, the forms for HSIs #6A through #9B have been updated with provisional numbers. By FY 2009 these provisional numbers will be finalized. Also, if feasible, corresponding findings for 2007 will be reported in the MCH 2008 Report/2010 Application. Salient findings concerning HSIs #6A through #9B will be discussed in the July 2010 report of the upcoming 5-year MCH needs assessment.//2009//

HSIs #6A AND #6B: DEMOGRAPHICS FOR INFANTS, CHILDREN AND YOUTH, ACCORDING TO AGE, RACE, AND ETHNICITY.

Discussion of these indicators is drawn from the 2004-05 MCH Needs Assessment Report.

Per HSI #6A, an estimated 1,550,411 persons from birth through 24 years of age lived in Alabama in 2004. Sixty-five percent of these persons were White, 32% Black, and 2.6% of other or of more than 1 race. Comparing numbers in 2004 to those from the Year 2000 Census is problematic because persons of unknown race were classified differently for 2004 than for 2000. Specifically, the Year 2000 Census reports numbers for a category that includes persons whose race is other than the categories shown in HSI #6A or is unknown. On the other hand, the numbers for 2004 are from the U.S. Census Bureau's population estimates, which allocate persons of "other or unknown" race into a race category.

Even so, the reported increase in the number of 0-24 year-old Asians living in Alabama is of interest. That is, the reported number of 0-24 year-old Asians living in Alabama increased by 6%: from 11,532 in 2000 to 12,180 in 2004. An increase of this magnitude is credible since, as discussed in the MCH Needs Assessment Report, a large Korean automotive manufacturer has recently established a presence in the State.

Again comparing 2004 to 2000, the number of Alabama children and youth from birth through 24 years of age declined by 0.8%, or by 12,623 individuals. Though small in terms of a percent change, the proportion of the State's population that is comprised of children and youth has been slowly declining for several years. As stated in the MCH 2003 Report/2005 Application, children and youth 19 years of age or younger comprised 28.5% of Alabama's population in 1999, versus 29.0% in 1994.

The following discussion compares numbers in 2004 (which are projections) to those in 2000 (which are not projections). Specific numbers under discussion are shown in the attached table, which is from the MCH Needs Assessment report. An estimated 45,423 Latino persons from birth through 24 years of age lived in Alabama in 2004, which is a 19% increase over 2000. The increase predominantly occurred in persons 14 years of age and younger. Again comparing 2004 to 2000, the number of Latino residents aged 20-24 years increased by just 1.9%, and the number aged 15-19 years declined by 1.3%.

A caveat on the population trends described in the preceding paragraph is necessary: The farther the years for which projections are made from the Census year on which the projections are based, the less accurate the projections are. Projections of the number of Latino residents in Alabama in the late 1990s probably substantially underestimated the actual number of Latino residents. The apparent undercount in the 1990s, however, does not negate the need for services for Latino individuals now living in the State.

Indeed, trends in numbers reported in HSI #6 indicate a continued need for culturally sensitive approaches to addressing health-related issues in Latino children and youth. Further, though the projected number of 15-19 year-old Latino Alabama residents in 2004 declined slightly relative to 2000, the number in 2004 (6,929) was 70% higher than the projected number in 1999 (4,080). More strikingly, the projected number of 20-24 year-old Alabama Latino residents in 2004

(10,026) was 2.5 times greater than the corresponding estimated number in 1999 (4,039). The higher projected number of 20-24 year-old Latino youth in 2004 relative to the 1990s reinforces the need to assure that the Latino population can access family planning services and obtain health insurance coverage for prenatal and perinatal care. Moreover, as 10-14 year-old Latino youth become young adults, access to health care for young adult Latino individuals will increase in importance.

HSIs #7A AND #7B: DEMOGRAPHICS FOR LIVE BIRTHS, ACCORDING TO MATERNAL AGE, RACE, AND ETHNICITY.

The following discussion compares numbers for 2004 to those for 1999. It updates a corresponding discussion in the 2004-05 MCH Needs Assessment Report that compares numbers for 2003 to those for 1999. Generally speaking, the direction of the change in 2004 versus 1999 was the same as the direction of the change in 2003 versus 1999.

Unless stated otherwise, counts of births pertain to live births to Alabama residents, and the race of an infant is presumed to be that of the mother. All discussion of these HSIs pertains to infants whose mother's age was reported.

In 2004, 59,105 infants were born alive to Alabama residents: 2,956 fewer (or 4.8% less) than in 1999. Sixty-eight percent of the 59,105 infants born in 2004 were White, 30% were Black, and 1.9% were of another or unknown race.

The racial composition of Alabama newborns changed slightly in 2004, compared to 1999: with White infants and Asian infants comprising slightly more of all live births, and Black infants comprising slightly less of all live births. Details of this change follow. Comparing 2004 to 1999, the number of live-born White infants declined by 3.8% (1,569 fewer infants) and the number of live-born Black infants by 9.1% (1,799 fewer infants). On the other hand, over the same period the number of live-born Asian infants increased by 62%: from 456 infants in 1999 to 738 infants in 2004 (282 additional infants). Therefore, comparing 2004 to 1999, White infants comprised a slightly higher percentage of all live births (67.8% versus 67.1%), Black infants a slightly lower percentage (30.3% versus 31.7%), and Asian infants a slightly higher percentage (1.2% versus 0.7%).

Comparing 2004 to 1999, most of the decline in numbers of live births occurred among babies born to adolescent mothers. That is, comparing 2004 to 1999, 1,811 fewer infants were born to mothers aged 19 years or younger. Comparing the same years, 1,261 fewer infants were born to mothers aged 20-34 years, and 116 additional infants were born to mothers aged 35 years or older.

The decline in the number of live births to adolescents occurred in both White infants and Black infants. Comparing 2004 to 1999, 773 fewer infants were born to White mothers aged 19 years or younger, a decline of 14%. Comparing the same years, 1,067 fewer infants were born to Black mothers aged 19 years or younger, a decline of 23%. Focusing on younger adolescents, comparing 2004 to 1999, the number of live births to females 17 years of age or younger declined by 23% for White infants and 24% for Black infants. In 2004, 3.5% of live births to White females and 7.8% of live births to Black females were to younger adolescents (respectively, down from 4.3% and 9.3% in 1999).

Again comparing 2004 to 1999, the number of live births declined for non-Latino individuals except for babies born to mothers 35 years of age or older. On the other hand, the number of live births to Latino females residing in Alabama more than doubled: from 1,594 Latino newborns in 1999 to 3,335 Latino newborns in 2004. The increase in live births to Latino females occurred for each maternal age group, as well as for all ages combined. In Alabama, the increase in Latino births began over a decade ago. Specifically, the number of live births to Latino Alabama residents had previously increased from 344 in 1990, to 1,595 in 1999: a 4.6-fold increase.

HSIs #8A and #8B: DEATHS OF CHILDREN AND YOUTH ACCORDING TO AGE, RACE, AND ETHNICITY.

HSIs #8A and #8B provide no information about cause of death or source of payment for delivery (a surrogate for socioeconomic status). Therefore, FHS does not typically use these HSIs when seeking direction in the formation of specific policies. Mortality among children and youth is extensively discussed in the MCH Needs Assessment Report. Mortality findings reported in that document are stratified according to such indicators as source of payment for delivery (for infant deaths only), race (White, Black), age at death, and cause of death.

However, FHS has not analyzed mortality among the Asian population, which is of interest in light of the previously described increase in the number of Asians residing in the State. Nor, except for infant deaths, have we recently analyzed mortality among the Latino versus non-Latino population, which is of interest given the continued increase in the number of Latino residents. Therefore, mortality estimates for these populations, derived by using HSI #8 for denominators and HSI #6 for numerators, are of interest.

Estimates discussed next are based on death (from HSI #8) and population (from HSI #6) numbers reported for 2004, in the MCH 2004 Report/2006 Application. (Note: See Form 21 for numbers for 2005.) The following populations are compared: Black versus White, Asian versus White, and Latino versus non-Latino. Two age groups are discussed: 0-9 years and 10-24 years. Mortality rates are reported as the number of deaths in the specified population, per 100,000 individuals in the specified population. Numbers may fluctuate from year to year, and we do not know whether the patterns described next have existed over a period of years. To reiterate, the following comparisons pertain to deaths among Alabama residents in 2004.

Black Versus White Children and Youth:

Among 0-9 year-old children, the mortality rate was higher for Black residents than for White residents (155.0 deaths per 100,000 versus 92.5 deaths per 100,000). Among 10-24 year-old children and youth, however, the mortality rate was slightly lower for Black children and youth than for their White counterparts (86.7 deaths per 100,000 versus 92.0 deaths per 100,000).

Taken together, several findings from the 2004-05 MCH Needs Assessment Report suggest that, if the death rate among 10-24 year-old White youth is indeed higher than that among their Black counterparts, unintentional injuries play a role. Though the age groups studied in the FY 2004-05 needs assessment do not match those for HSIs #6 and #8, the following findings are pertinent. Except where stated otherwise, the findings pertain to deaths in 2001-03 of Alabama residents:

- 1) 57% of deaths of 15-19 year-olds were due to unintentional injuries.

- 2) Among 15-19 year-olds, the death rate for unintentional injuries was higher among Whites than among persons of Black and other races (64.1 deaths per 100,000 versus 28.9 deaths per 100,000).

- 3) The rate of deaths attributed to unintentional poisoning more than doubled among 20-24 year-old White youth over the surveillance period (overlapping 3-year rates from 1998-2000 through 2001-03). In 2001-03, 52 deaths of White 20-24 year-old youth were attributed to unintentional poisoning. In contrast, in any 3 contiguous years of the surveillance period, only 2-3 deaths of Black and other-race 20-24 year-olds were attributed to unintentional poisoning. FHS's current approach to further studying deaths due to unintentional drug overdose is discussed under SPM #7, in Section IV.D.

/2008/A report on drug-related and alcohol-induced deaths in Alabama, with a focus on the 15-44 year-old population, is discussed in Section II.C. As well, the executive summary of that report is included in the attachment to Section II.C./2008//

Asian Versus White Children and Youth:

The mortality rate among 0-24 year-old Asian residents was lower than that among 0-24 year-old White residents (82.1 deaths per 100,000 versus 92.2 deaths per 100,000). The death rate among Asian children and youth residing in the State is likely to fluctuate markedly from year to year, however, since the number of deaths is small (10 deaths of 0-24 year-old Asian residents in 2004: 4 among 0-9 year-olds and 6 among 10-24 year-olds).

Latino Versus Non-Latino Children and Youth:

The mortality rate among 0-24 year-old Latino children and youth was higher than among their non-Latino counterparts (129.9 deaths per 100,000 versus 96.7 deaths per 100,000.) The direction of the difference was the same for 0-9 year-old children and for 10-24 year-old children and youth. Rates among Latino children and youth are also likely to fluctuate from year to year due to small numbers in the statistical sense (59 deaths of 0-24 year-old Latino residents in 2004: 28 among 0-9 year-olds and 31 among 10-24 year-olds).

HSI 9: MISCELLANEOUS DEMOGRAPHICS.

Only several findings from HSIs #9A and #9B were deemed to merit mention in the 2004-05 MCH Needs Assessment Report: those pertaining to dropping out of high school, households headed by a single adult, children and youth living in a foster home, the juvenile crime arrest rate, and enrollment in Medicaid and WIC. Some findings from that report follow, for the year 2004.

Four percent (3.8%) of high school students dropped out of school.

Of children and youth aged 0-19 years, 30% were in a household headed by a single adult (18% of White children and youth and 57% of Black children and youth); and 0.5% lived in a foster home. The juvenile crime arrest rate was 4,629 arrests per 100,000 persons aged 10-19 years.

Of 0-19 year-old persons, 487,989 were enrolled in Medicaid, and 208,647 in WIC. /2008/In 2005, 494,319 persons aged 0-19 years were enrolled in Medicaid: or 6,330 more than in 2004. Outreach efforts described under NPM #13 presumably contributed to this increase.//2008//

HSIs #10, #11, AND #12: GEOGRAPHIC LIVING AREA AND POVERTY LEVELS.

/2008/In 2005, 9.3% of the State's population of 0-19 year-old children and youth had household incomes at or below 50% of the FPL. Over one-third (36.5%) of the State's population (all ages) had household incomes at or below 200% of the FPL.//2008//

/2009/In 2006 over half (55.4%) of the State's population of 0-19 year-old children and youth lived in urban areas, and 44.6% of them lived in rural areas. Of 0-19 year-old children and youth, 11.5% had household incomes at or below 50% of the FPL. Again, over one-third of the State's population (all ages) had household incomes at or below 200% of the FPL.//2009//

An attachment is included in this section.

F. Other Program Activities

ADPH OTHER PROGRAM ACTIVITIES

Crosscutting:

Care Coordination

Provision of care coordination by ADPH is discussed in Section III.A and under SPM #1. Two channels via which ADPH provides care coordination are PLAN First, the Medicaid Family Planning Waiver discussed in Section III.A, and Patient 1st, Medicaid's PCCM. The EPSDT Care Coordination Program, discussed in many places in this document, is implemented under Patient

1st, the main channel through which ADPH provides care coordination.

As of early FY 2005, adults enrolled in Patient 1st are eligible for care coordination, which allows ADPH care coordinators to serve Patient 1st enrollees of all ages. For example, care coordinators are now reimbursed by Medicaid for providing information and counseling on birth control methods and STDs, including HIV, to adults. Reimbursement for providing care coordination services to adults is especially important for Medicaid-enrolled women receiving family planning services. Under PLAN First Medicaid does not reimburse for care coordination of Medicaid-enrolled persons; but now that Medicaid reimburses for care coordination for Patient 1st enrollees, eligible providers can be reimbursed for providing family planning-related care coordination to Medicaid enrollees.

/2009/In FY 2007 Medicaid began making direct referrals for care coordination in 2 new categories: adults identified by Medicaid as using the emergency room inappropriately and those who were discharged by their PCP and required assistance in locating a new PCP./2009//

/2008/In partnership with USA and the UAB School of Public Health, in April 2006 Bureau social work staff began piloting the federally funded Fetal Alcohol Spectrum Disorder (FASD) Care Coordination Project in 4 counties. Due to lack of funding, data collection for the pilot ended in March 2007./2008//

/2009/The statewide PLAN First care coordination training now includes information on screening patients for alcohol use and on FASD education. All PLAN First care coordinators now provide alcohol screening and, if needed, education and referral.

In October 2007 FHS was awarded a 3-year supplemental Title X grant to promote optimal birth spacing. The project includes enhancing services already provided by Family Planning care coordinators. Seven counties are involved in the pilot: Randolph, Coosa, Geneva, Coffee, Dallas, Lowndes, and Choctaw./2009//

Alabama Childhood Lead Poisoning Prevention Program (ACLPPP)

The goal of this CDC-funded program is to eliminate childhood lead poisoning by 2011. Case management is provided for all children with a confirmed blood lead level of 10 ug/dL or higher. Environmental inspections are included in the management of blood lead levels of 15 ug/dL or higher. Universal screening of children aged 6-72 months is conducted in 7 high-risk counties, while the remaining counties follow a targeted screening protocol, under which only children meeting certain social and medical criteria are screened. Primary prevention activities to increase awareness of lead-safe practices among parents, property owners, renovators, and child health providers are conducted statewide. In FY 2004, 16,509 blood lead screenings were reported for children aged 6-72 months; elevated blood lead levels were confirmed for 192 (1.1%) of these screenings.

/2007/In FY 2005, 15,504 blood lead screenings were done for 14,425 children, 201 (1.4%) of whom were referred for medical case management of elevated lead levels. As a result, 76 houses were investigated for environmental lead hazards. Follow-up inspections were conducted on homes where a child's blood lead level did not improve in 6 months. In mid-June 2006 FHS was notified that CDC funding for ACLPPP would end on June 30, 2006. Due to strong ADPH administrative support and a strong collaborative relationship with Medicaid, finalization of an amendment to the EPSDT MOU with Medicaid is imminent, in which Medicaid is expected to fund about 70% of ACLPPP and State dollars the remaining 30%./2007//

/2008/In FY 2006 ACLPPP continued as a partnership between Medicaid and ADPH. A total of 38,970 blood lead screenings were done for 35,726 patients ages 0-20 years, 212 (0.6 %) of whom were referred for medical case management of elevated lead levels. As a result, 82 houses were investigated for environmental lead hazards. Follow-up inspections were conducted on homes where a child's blood lead level did not improve in 6 months./2008//

/2009/In FY 2007 ACLPPP continued as a partnership between Medicaid and ADPH. A total of 36,846 blood lead screenings were done for 36,738 patients aged 0-21 years, 951 (3%) of whom were referred for medical case management of elevated lead levels. As a result, 100 houses were investigated for environmental lead hazards. Follow-up inspections were conducted on homes where a child's blood lead level did not improve in 6 months.//2009//

Population-based:

Form 9

This discussion pertains to numbers shown on Form 9 for the "MCH Toll-Free" line, which count calls to 2 lines: Healthy Beginnings, an MCH help line, and Info Connection, a line providing information on reproductive health to teens. Nearly all the calls counted were to the Healthy Beginnings line. There were a total of 1,628 calls to these lines in FY 2004. Most callers were seeking information about WIC; but the MCH line continued to receive calls on prenatal care, child health, immunizations, and Medicaid eligibility. Calls on prenatal care and child health issues have decreased over several years as the SOBRA Maternity and the Patient 1st Programs have increasingly utilized the private sector to provide care to enrollees.

/2007/The 2 lines received 2,454 calls in FY 2005: 2,245 of these were WIC-related, and a dedicated WIC helpline was begun in FY 2006.//2007//

/2009/The 2 lines received 2,040 calls in FY 2007.//2009//

CRS OTHER PROGRAM ACTIVITIES

Population-based:

CRS maintains toll-free lines, in operation during normal business hours, in the CRS State Office and 15 district offices. There were 41,469 calls to CRS's toll-free lines in FY 2004. This number is about 8% lower than the 44,863 calls received in FY 2003, but up from 40,556 in FY 2002 and from the FY 1997 baseline of 32,640 calls. Use of cell phones and area calling plans may contribute to the decreases noted in the number of calls to the toll-free lines.

/2007/There were 34,945 toll-free calls to CRS in FY 2005, about 16% fewer than in FY 2004.

This continued decrease is attributed to reasons stated above as well as the ability to e-mail questions to CRS's public Web site.

In September 2005 the toll-free line in the CRS State Office was converted to a 24-hour per day, 7-day per week hotline for those evacuees and residents of Alabama of all ages with disabilities who were impacted by Hurricane Katrina. The converted toll-free line received 590 calls in 1 month alone, with the vast majority of these being storm-related. ADRS employees, including all divisions, staffed the line and helped callers enroll in the appropriate division as applicable and provided information and referral to other agencies or community resources to meet additional needs. The CRS State Office line did not revert to a dedicated CRS line available during normal business hours until December 2005.//2007//

/2008/The CRS toll-free lines received 27,428 calls in FY 2006, a 21% decrease over FY 2005.

Cell phones, area calling plans, and e-mail options contribute to this decline. A new statewide public awareness campaign began in May 2007 and includes posters with the CRS State Office toll-free number as a single point of contact.//2008//

/2009/CRS received 25,983 calls on its toll-free lines during FY 2007. This represents about a 5% decrease from FY 2006. After the new public awareness campaign began in May 2007, 7 of 15 CRS offices saw an increase in toll-free calls compared with the same time frame in FY 2006. The single point of contact line saw a 30% increase over FY 2006.//2009//

G. Technical Assistance

FHS's TECHNICAL ASSISTANCE NEEDS

SSDI Project

The SSDI Project is FHS's primary means of support for data-related technical assistance. In FY 2003 the Epi/Data Branch assumed responsibility for coordinating the State's SSDI Project. The primary goal of the current (September 30, 2003 through August 31, 2006) SSDI Project is to enable FHS to further develop its capacity to manage, analyze, and report information from MCH databases listed in HSCI #9A, with continued focus on "annual linkage of birth records and WIC eligibility files" and "annual linkage of birth records and newborn screening files." Secondary focuses of the primary goal are 1) renewed exploration of the feasibility of linking birth records and Medicaid files, developing a statewide hospital discharge database, and/or developing a statewide birth defects registry; and 2) enhancement of the Bureau's capacity to analyze PRAMS data. The project has 3 secondary goals: to maintain and further develop the Bureau's capacity to 1) report valid estimates for the performance and outcome measures and HSCIs (in addition to HSCI #9A) in the MCH Services Block Grant; 2) conduct ongoing MCH needs assessment, including the comprehensive FY 2004-05 MCH needs assessment, to be submitted concurrently with this MCH 2004 Report/2006 Application; and 3) prepare and disseminate various reports of needs assessment findings, with the reports being tailored to particular readerships.

The most current report of Alabama's SSDI Project, submitted to HRSA on June 15, 2005, is in Appendix G, available as described in Section III.A. A brief description of SSDI activities follows. Largely using resources funded by the SSDI grant, the SSDI Coordinator has electronically linked CY 2000 Alabama live birth records to information from CY 2000 newborn screening billing records. Further, she has electronically linked about 85% of FY 2001 WIC prenatal registration records to CY 2000-2001 live birth records. Additionally, the SSDI Coordinator has produced 2 policy/protocol manuals that are available upon request: 1 on linking live birth records to newborn screening billing files, and 1 on linking live birth records to WIC prenatal registration records. In FY 2006 FHS will explore the feasibility of linking live birth records with Medicaid records. FHS considers it highly unlikely that a statewide hospital discharge database or a statewide birth defects registry will be developed in the near future. This view is based on previous experience and consultations, as well as the lack of a statewide, coordinated infrastructure for a centralized, statewide birth defects registry or hospital discharge database. The SSDI Project is further discussed under Section III.E.

/2007/Rather than including the aforesaid SSDI report that was submitted in June 2005, Appendix G now includes the Alabama SSDI new, competitive application submitted to HRSA on June 16, 2006. The project proposed in this application is to begin on November 1, 2006 and end on October 31, 2011. The "Maternal and Child Health Discretionary Project Abstract" from this application is attached. The "Goals and Objectives" portion of the abstract follows, somewhat paraphrased.//2007//

/2009/Instead of the above application, the in-progress noncompeting SSDI application, which is to be submitted to HRSA by July 15, 2008, will be added to Appendix G. Similarly, instead of the abstract mentioned above, an excerpt from the in-progress application is attached to this section. The excerpt concerns progress on data capacity objectives of Alabama's SSDI Project.//2009//

/2007/To further develop the capacity to manage, analyze, and report information from MCH databases listed in HSCI #9A, project staff will, by 04/30/07, link live birth records and WIC eligibility files for a single FY. By 10/31/07, project staff will develop the infrastructure for linking live birth records/infant death records and Medicaid files. To seek to improve data capacity for the performance and outcome measures found in the MCH Block Grant, project staff, by 07/15/07, will continue to complete required cells for Forms 11, 12, and 17-21. In order to enhance the capacity to conduct ongoing needs assessment, project staff, by 10/31/08, will update current needs assessment tools or develop new ones. Further, by 10/31/09, project staff will have collected new primary data for the next MCH needs assessment.//2007//

/2008/Birth Defects Surveillance:

Some of the following information is extracted from discussion of HSCI #9A. Since 2002 the Alabama Birth Defects Surveillance and Prevention Program's database has represented 22 counties in south-central or south Alabama: up from 2 counties being represented in 2000. Further, the feasibility of creating a statewide birth defects registry is being explored. In July 2006 AMOD convened a work group including representatives from ADPH, CRS, MHMR, USA and UAB Departments of Genetics, and the UAB School of Public Health. The work group's objective is to explore creation of a statewide birth defects registry to be housed at ADPH, using ADPH's cancer registry as a model. AMOD has proposed a State statute to require the registry of birth defects and to secure legislative support for allocation of new funding to ADPH to implement a birth defects registry. On May 15, 2007, the Alabama Legislature's Web site posted a Senate bill, but no House bill, on a birth defects registry.//2008//

/2009/Some of the information included in this update is included in discussion of HSC #9A or SPM #7.

The research analyst who had been located in the MCH Epi Unit and had served as the State's SSDI Project Coordinator resigned in March 2008. FHS has requested permission to replace the research analyst position with a Health Services Administrator II position and to fill the new position with an experienced grant writer; but as of May 8, 2008, this request remains with the State Personnel Department. Should this request be granted and the new position be filled with an experienced grant writer, the MCH Epi Unit Director would delegate many of her Title V grant-writing responsibilities and serve as the State's SSDI Project Coordinator.

Live birth files for 3 successive periods (respectively CYs 2001-02, 2002-03, and 2003-04) have now been linked to WIC prenatal registration files (respectively FYs 2001, 2002, and 2003), and brief reports on findings from these 3 sets of linked files have been prepared.

In early FY 2008 a draft of an MOU to link birth records and Medicaid files was approved by ADPH's legal staff and sent to Medicaid for consideration. As of May 8, 2008, Medicaid has not replied concerning this MOU.

As of May 2008, the Bureau is considering whether recent developments indicate a need to change the focus of the State's SSDI Project. One such development is Medicaid's interest in developing the framework for a statewide hospital inpatient data reporting system, which is a prerequisite for participation in the Healthcare Cost and Utilization Project. As part of a Medicaid-selected team, the MCH Epi Unit Director attended a federally sponsored national quality assurance workshop in January 2008; and this workshop seemed to increase Medicaid's awareness of the need for a statewide hospital inpatient reporting system. The MCH Epi Unit Director then participated in a conference call held by Medicaid in April 2008 to discuss this need. Should Medicaid take concrete steps toward development of a statewide hospital inpatient data reporting system, ask that ADPH partner with them, and indicate that development of such a system takes priority over linking birth records with Medicaid records, we may utilize some SSDI personnel time to support development of a hospital inpatient data reporting system. (In accordance with the secondary goals of SSDI, some SSDI resources would continue being used toward meeting Title V reporting requirements.) However, developing such a system would require much collaboration and support, including the support of the AHA, and would be very expensive and labor intensive. Thus, SSDI staff could make only a small contribution to the overall effort.

Legislation to establish a birth defects registry in ADPH has been drafted and approved by the AHA, but will probably not be submitted to the State Legislature until FY 2009. If the legislation is passed, implementation would depend on funding.//2009//

FHS's Suggestions for Regional Technical Assistance

FHS suggests regional workshops on 2 topics. We believe that these workshops would be helpful to other Title V Programs, as well as to FHS.

First, we suggest that the Maternal and Child Health Bureau (MCHB) consider providing regionally based, annual updates regarding the MCH Services Title V Block Grant Program report/application guidance and Web-based reporting package. We further suggest that these updates be provided in several locations around the country, without charge to the states. Compared to the updates currently provided at AMCHP's annual conference, regional trainings would allow more interaction among regional stakeholders and MCHB. Further, providing the updates without cost would remove potential financial barriers to the attendance of persons who prepare the MCH reports/applications but are not members of AMCHP.

/2007/FHS continues to believe that regionally based, annual updates regarding the MCH report/application guidance and Web-based reporting package, as described above, would be helpful.//2007//

/2008/FHS continues to believe that regionally based, annual updates regarding the MCH report/application guidance and Web-based reporting package, as described above, would provide useful technical assistance.//2008//

/2009/Due to outstanding support by MCHB staff and consultants during preparation of the MCH reports/applications, FHS withdraws its request for regionally based updates regarding the MCH report/application guidance.//2009//

Further, we suggest that MCHB consider providing regionally based, hands-on workshops regarding analysis of the 2003 National Survey of Children's Health database. Such workshops could promote efficient, informed utilization by State Title V Programs of that database, which should be a useful tool when evaluating or planning policy and programs concerning children and youth.

/2007/The Web site for the 2003 National Survey of Children's Health is very user-friendly and can be queried for stratified findings, including confidence intervals, on a variety of indicators. FHS therefore withdraws its suggestion for regionally based, hands-on workshops regarding analysis of data from this survey.//2007//

/2009/FHS suggests that MCHB consider providing a national, hands-on workshop on best-practices for analyzing and reporting qualitative data collected via open-ended questions: whether the data are collected through mail surveys, community discussion groups, focus groups, key informant interviews, or other approaches. Workshop participants should have the opportunity to analyze an actual qualitative database during the workshop. As well as providing hands-on training, the workshop should offer suggestions to minimize interjection of the analyst's biases or preferences into the analysis and report. However, to assure that the workshop training could be utilized during the upcoming 2009-2010 5-year MCH needs assessment, it would need to be provided by early FY 2009.//2009//

CRS's TECHNICAL ASSISTANCE REQUEST

Further technical assistance is requested by CRS in 1 area during FY 2005. The agency would like to use technical assistance monies for further consultation in data gathering and implementation of activities related to the Alabama Healthy People 2010 initiative.

/2007/CRS requests technical assistance as previously stated.//2007//

/2008/CRS requests technical assistance in 2 areas. First, the agency would like some basic MCH and CSHCN training provided for staff. The agency employs over 200 people in its State Office and in 15 local offices, many of whom have had little or no formal public health education. CRS suggests a workshop or series of workshops conducted by MCHB representatives directly or through the support of UAB School of Public Health to provide baseline training for CSHCN program staff. This will assist them in understanding the CRS role as Alabama's Title V CSHCN

program and how this fits with national objectives. Also, CRS would like to request technical assistance from the National Center for Cultural Competence in assessing the cultural competence of its service delivery program and for training to improve this at all levels.//2008//

***/2009/CRS requests technical assistance from the National Center for Cultural Competence in assessing the cultural competence of its service delivery program and for training to improve this at all levels.//2009//
An attachment is included in this section.***

V. Budget Narrative

A. Expenditures

V. BUDGET NARRATIVE

A. EXPENDITURES

ADPH

/2008/Form 3: State MCH Funding Profile

Line 8. (Other Federal Funds)--Expenditures increased by 22.7%. The majority of \$31.3 million increase in FY 2006 is attributed to WIC and Immunizations. The FY 06 budget for both programs was based on 2004 activity. During this time period the WIC Program grew from \$112.8 to \$121.0 million which is an increase of \$8.2 million. Immunization Program costs increased from \$20.5 to \$43.3 million, an increase of \$22.8 million or 111.5%. The Immunizations VFC Federal entitlement program attributed approximately \$10.0 million to this increase jumping from \$18.8 to \$28.9 million. CHD's made up the balance with increased vaccine costs for non-eligible going from \$4.4 to \$14.4 million, an increase of \$10 million.

/2008/Form 4: Budgeted Details by Types of Individuals Served (I) and Sources of Other Federal Funds (II)

Line I. a. (Pregnant Women)--Expenditures for FY 2006 was 71.9% below the budgeted amount. As mentioned in our last submission, this decline is a reflection of ADPH's decision to withdraw from providing prenatal services. However, programs still exist in Mobile and Houston Counties. Also, CHD's are providing postpartum exams through Home Health visits.

Line I. c. (Children 1 to 22 years)--Expenditures increased from budget by 43.9%. The primary reasons for the increased expenditures derives from Patient 1st and EPSDT Care Coordination programs for children, birth to age 21. This rapid growth has occurred since the FY 2006 budget was developed in 2004. In FY 2004 children visits made up 75% of all Child Health visits compared to 82% in FY 2006. Care Coordination accounts for approximately \$6.5 million of the increase. Resources previously directed to prenatal services have been redirected toward these growth programs and as a result costs have increased since 2004.

Line I. f. (Administration) -- Expenditures decreased from budget by 69.3%. In FY 2004, a coding error incorrectly charged a county allocation of \$1.645 million to MCH Administration. Also, in FY 2004 Maternity was still a major program and in FY 2006 there is an accumulative effect of a reduction in administrative expenditures which is the result of ADPH's decision to discontinue providing prenatal services. The FY 2006 budget was based on these inflated expenditures from 2004.

/2008/Form 5: State Title V Program Budget and Expenditures by Types of Services

Line II. (Enabling Services) -- Expenditures decreased from budget by 30.5%. The FY 06 budget was developed based on Programs that were at peak growth in FY 2004. As mentioned in previous submissions, ADPH's decision to withdraw from prenatal care affects programs connected to this service and continues to decline in FY 2006. As a result, the FY 2006 budget was inflated based on 2004 information. Programs that were affected: Maternity Case Management, Contract Maternity Care Coordination, and Teen Family Planning Care Coordination which account for the majority of the \$2.7 million reduction in expenditures.

Line III. (Population-Based Services) -- Expenditures increased from budget by 35.4%. The primary reason for the increase in expenditures can be attributed to a redirection of resources to the EPSDT Care Coordination Program. This Program has grown rapidly from 2004 and makes up the majority of the \$2.8 million difference in the budget.

Line IV. (Infrastructure Building Services) -- Expenditures decreased from budget by 29.8%. The budget for FY 2006 was based on FY 2004 activities of several programs that were at peak

growth but later phased out or experienced funding cuts by 2006. Programs no longer active included: Abstinence Community Based and AUPPP which accounts for \$1.6 million. Reductions in Abstinence Education and FHS Administration totaling \$600,000 make up the \$2.0 million difference in budget and expenditures.//2008//

/2009/Narratives referring to FY 2007 expenditures for Forms 3, 4 and 5 have been deleted to remain within the maximum character limits.

/2009/Form 3: State MCH Funding Profile

Line 3. (State Funds)--FY 2007 State Funds expenditures decreased from budgeted amount by (16.6%) or a net of \$5,501,588. This net decrease in State Funds is the product of changes in Total Program costs and the Other/Federal support from base year 2005 compared to FY 2007 Budget. Since 2005 Total Program Costs has shown a small increase of 1.5% or \$925,000 and Other/Federal support (most of this growth has been in ADPH earned income) has increased \$5.8 million, the difference between these two factors result in a net decrease in State Funds of \$4.9 million. CRS reported a decrease in State Funds of \$578,000 during this period making the total difference of \$5,501,588.

Line 5. (Other Funds)--FY 2007 Other Funds expenditures decreased from budgeted amount by (12.0%) or \$518,817. This decrease is the difference in CRS requested versus received dollars. The actual expenditures are a more accurate reflection of funds received than the estimate represented in the budgeted amount.

Line 6. (Program Income)--FY 2007 Program Income expenditures increased from budgeted amount by 11.0% or \$3,365,392. This net increase resulted from an FY 2007 Budget that was based on actuals for the year 2005 which did not reflect the growth in ADPH's care coordination efforts. Net earned income in FY 2007 increased by \$5.525 million with EPSDT, Family Planning and Patient First Care Coordination accounting for the majority of the change. CRS reported a \$2.160 million decrease in program income which was reflected in the net change. A better comparison would be to use FY 2006 expenditures figure of \$33.6 million to FY 2007 expenditures of \$33.85 million, the difference is minimal.

Line 8. (Other Federal Funds)--FY 2007 Other Federal Funds expenditures increased from budgeted amount by 32.1% or a net of \$44,562,872. The majority of this increase is attributed to WIC and Immunizations Programs. The FY 2007 Budget was developed using 2005 activity which did not reflect these recent increases over the two year period: WIC caseload has increased 6.3% from a monthly average of 118,751 to 126,239 which resulted in an \$18.9 million increase in food costs. Immunizations experienced tremendous growth with the VFC Federal entitlement program and vaccines provided by CHD's increasing from \$23.2 million in FY 2005 to \$48.2 million in FY 2007, a \$25 million increase. Ryan White Care Act Title II grant for Women, Infants Children and Youth increased from \$2.2 million in FY 2005 to \$3.1 million in FY 2007 a 1.9% increase or \$842,000.

/2009/Form 4: Budget Details by Types of Individuals Served (I) and Sources of Other Federal Funds (II)

Line I. a. (Pregnant Women)--FY 2007 Pregnant Women expenditures decreased from budgeted amount by more than (70.8%) or \$4,926,435. The budgeted amount for FY 2007 was based on the current FY 2005 activity of \$6.9 million. This did not properly reflect ADPH's declining commitment to withdraw from providing prenatal services which is evident in the FY 2007 expended amount of \$2.034 million. Programs still exist in Mobile and Houston Counties, including postpartum home visits; CHD's provide postpartum exam visits.

Line I. c. (Children 1 to 22 years)--FY 2007 Children 1 to 22 years old expenditures

increased from budgeted amount by more than 14.4% or \$4,786,969. This increase resulted from an FY 2007 Budget that was based on actuals for the year 2005 which did not reflect the continued growth in ADPH's care coordination efforts. As previously mentioned in our note for FY 2006, Patient 1st and EPSDT Care Coordination programs for children, birth to age 21 have continued to grow accounting for the majority of this increase. Patient 1st care coordination has added a new electronic referral system that has increased case management caseloads and staff to handle these cases. Referrals for case management have increased for Newborn Screening, Hearing, and Lead Program. From FY 2006 to FY 2007, Plan 1st and Patient 1st FTE's have increased 28% from a total of 124 to 159. In FY 2007 visits for Children 1 to 22 have increased 10% to 72,796 from 66,139 in FY 2006. Redirection of resources from prenatal services to growth programs has resulted in increased costs.

Line I. d. (Children with Special)--FY 2007 CSHCN expenditures decreased from the budgeted amount by more than (11.6%) or \$3,431,255. For 2007 CRS reported that the decrease in budget and expenditures reflects the difference in requested versus received funds and the decrease in program income.

**//2009/Form 5: State Title V Program Budget and Expenditures by Types of Services
Line I. (Direct Health Care Services)--FY 2007 Direct Health Care Services expenditures decreased from budgeted amount by more than (11.5%) or \$6,076,588. This decrease resulted from an FY 2007 Budget that was based on actuals for the year 2005 which did not properly reflect the impact of changes in the provision of direct health care that would be evident in subsequent years. As mentioned in previous applications, changes in the healthcare environment, especially in Medicaid's managed care, have caused a shift in the provision of direct medical services from CHD's to private providers. This redirection of resources can be seen in the increases in population-based and infrastructure building services.**

Line II. (Enabling Services)--FY 2007 Enabling Services expenditures decreased from budgeted amount by more than (22.3%) or \$2,041,778. The budgeted amount for FY 2007 was based on the current FY 2005 activity. This decrease was primarily in Maternity Services which was approximately a \$2.0 million program in FY 2005 declining in FY 2007 to \$825,000 or a \$1.1 million decrease. Also, CRS reported a \$1.054 million decrease for the same time period. For 2007 a redirection of resources by ADPH and CRS is evident in the decrease in enabling services and a corresponding increase in population/infrastructure services.

Line III. (Population Based Services)--FY 2007 Population Based Services expenditures increased from budgeted amount by more than 26.6% or \$2,708,765. This increase resulted from an FY 2007 Budget that was based on actuals for the year 2005 which did not reflect the continued growth in ADPH's care coordination efforts. In FY 2005 expenditures for EPSDT Care Coordination totaled approximately \$6.6 million and in 2007 increased 33% (\$2.2 million) to \$8.8 million.

Line IV. (Infrastructure Building Services)--FY 2007 Infrastructure Building Services expenditures increased from budgeted amount by more 28.0% or \$2,209,766. As mentioned previously FY 2007 Budget was based on actual activity in 2005 which did not reflect the current environment and the redirection of resources from direct/enabling services to population based/infrastructure building services. CRS was the majority of this increase from FY 2005 to FY 2007 and was attributed to a revise in methodology as mentioned in the CRS Budget Narrative for Expenditures Form 5. //2009//

CRS

2004 Form 3: State MCH Funding Profile

Line 6 (Program Income)--The only significant variation in expenditures for CRS was in program

income. CRS expenditures for FY 2004 were \$2.1 million less than the budgeted amount. The budgeted funds reported each year for program income are only an estimate. Therefore, actual expenditures more accurately reflect the funds received.

/2007/ Significant variations in expenditures for CRS were seen in program income (Form 3, Line 6) and in expenditures by level of the MCH Pyramid (Form 5, Lines 1-4). CRS program income for FY 2005 was \$5.2 million less than the budgeted amount. The actual expenditure is a more accurate reflection of funds received than is the estimate represented in the budgeted amount. In FY 2005 CRS revised its calculation methodology to more accurately depict percentages of the overall CSHCN budget expended per level of the MCH Pyramid. The resulting formula reflects significant reductions in expenditures for direct services, with significant increases in expenditures in enabling and infrastructure-building services.//2007//

/2008/ Form 3: State MCH Funding Profile

Line 5 (Other Funds) -- The Budget for FY 2006 was set in the FY 2004 application. This was based on expenditures for FY 2003 and the CRS budget request at that time. The difference in other funds represents the difference in requested versus received dollars. The actual expenditure is a more accurate reflection of funds received than the estimate represented in the budgeted amount. Setting the FY 2006 budget in FY 2004 does not allow the agency to adjust for trends noted in third party reimbursements.

/2008/Form 4: Budgeted Details by Types of Individuals Served (I) and Sources of Other Federal Funds (II)

Line I. d. (CSHCN) -- Expended differs from budgeted amount by (19.8%). The difference between FY 2006 budget and expenditures reflects the difference in requested versus received funds and the decrease in program income.

/2008/Form 5: State Title V Program Budget and Expenditures by Types of Services

(Lines I. -- IV.) -- In FY 2005 CRS revised its calculation methodology to more accurately depict percentages of the overall CSHCN budget expended per level of the MCH Pyramid. This allows CRS to set budgets that are more in line with actual expenditures. Again, the FY 2006 budget was set in FY 2004, before the revisions were made. FY 2006 expenditures are a more accurate reflection of how CRS allocates resources by service type. Significant reductions for direct services and increases in enabling, population-based, and infrastructure-building services are represented by actual FY 2006 expenditures.//2008//

/2009/ As per Block Grant requirements, the Budget for FY 2007 was set in the FY 2005 application. This was based on expenditures for FY 2004 and the CRS budget request at that time. This method does not allow the agency to adjust for trends noted in third party reimbursements. It also does not allow comparison to the FY 2007 Operations Plan, which is built after final funding levels are set. The agency's Operations Plan is a more accurate reflection of agency's budget since it is the actual budget as opposed to a budget request.

Form 3: State MCH Funding Profile

Line 5 (Other Funds) -- The difference in other funds represents the difference in requested versus received dollars. The actual expenditure is a more accurate reflection of funds received than the estimate represented in the budgeted amount.

Line 6 (Program Income) -- The difference in program income reflects a difference in expected versus received reimbursements from third-party insurers. CRS expenditures for FY 2007 were about \$2.1 million less than the budgeted amount. The budgeted funds reported each year for program income are only an estimate. Therefore, actual expenditures more accurately reflect the funds received.

Form 4: Budgeted Details by Types of Individuals Served (I) and Sources of Other Federal Funds (II)

Line I. d. (CSHCN) --Expended differs from budgeted amount by about \$3.4 million (11.6%).

The difference between FY 2007 budget and expenditures reflects the difference in requested versus received funds and the decrease in program income.

Form 5: State Title V Program Budget and Expenditures by Types of Services (Lines I. -- V.) --In FY 2005 CRS revised its calculation methodology to more accurately depict percentages of the overall CSHCN budget expended per level of the MCH Pyramid. This allows CRS to set budgets that are more in line with actual expenditures. FY 2007 expenditures are a more accurate reflection of how CRS allocates resources by service type. Significant decreases are noted in direct, enabling, and population-based services. Significant increases are shown for infrastructure-building services. Total FY 2007 actual expenditures are significantly reduced compared to budget for reasons described above. //2009//

B. Budget

V. BUDGET NARRATIVE
B. BUDGET

ADPH

In FY 2006 the Department anticipates overall spending to be down in ADPH's budgeted MCH cost centers, when compared to FY 2005. This expectation does not take into consideration any unforeseen federal reductions in Title V funding to the State. Additionally, ADPH expects to see a decrease in the Family Planning program income from approximately \$28.2 million in FY 2005 to approximately \$26.8 million in FY 2006. This reduction is due to the loss of \$1.4 million in DHR funding for contraceptives. For FY 2006, Title X increased the grant award by \$173,588, to \$4.941 million. Also, for FY 2006 there is potential for growth in the Patient First Adult Care Coordination Program, which started in March 2005. As the federal and State appropriations are reduced, additional budget reductions are anticipated in FY 2006.

//2007//In FY 2006 Title V funding was cut \$408,388, from \$12,348,338 to \$11,940,000. The Department anticipates level spending in ADPH's budgeted MCH cost centers for FY 2007. This does not take into consideration any further federal reductions in Title V funding to the State. Additionally, ADPH expects total Family Planning services to remain level, at approximately \$27.3 million in FY 2006 and approximately \$27.9 million in FY 2007. For FY 2007, Title X funding decreased from \$5.1 million to \$5.0 million. Also, program income for EPSDT Care Coordination, which started March 2004, has grown from \$2.3 million in FY 2004 to an estimated \$4.6 million in FY 2006. For FY 2007 there is still potential for some growth in the EPSDT Care Coordination Program. For 2007 we received notice of CDC's intention to eliminate \$741,000 in funding for the State's Childhood Lead Poisoning Prevention Program. (ADPH's plan for funding this program is very briefly discussed in Section IV.F.) If federal and State appropriations are reduced, additional budget reductions can be anticipated for FY 2007.//2007//

//2008//For FY 2007 Title V funding remained level at \$11,875,207. The Department does not expect Title V funding for FY 2008 to increase. Spending in MCH cost centers will remain at current 2007 levels. ADPH projects total Family Planning services to increase from \$26.9 million in 2007 to approximately \$32.1 million in 2008. For FY 2008, we anticipate Title X funding to remain at the same level as 2007 approximately \$5.0 million. Early 2007, ADPH received notice from Department of Health and Human Services, Administration for Children and Families that it will eliminate \$957,000 in funding for the State's Abstinence Until Marriage Education Program (AAEP) has not been reauthorized by Congress and is set to expire June 30, 2007. A new division Newborn Screening, was created in early 2007. This new division, supported entirely by Lab receipts, combines the MCH Newborn Screening Follow-up Program (previously supported by Title V dollars) and the Newborn Screening Lab. Due to this merger, the division increased in size from \$130,000 to \$1.05 million. Currently, ADPH is negotiating with Medicaid concerning the match for the Patient 1st/EPSTDT and is not expanding this program. Patient 1st/EPSTDT Care

Coordination generated program income of \$7.0 million in FY 2006.//2008//

/2009/For FY 2009 the General Fund budget as passed by the State Legislature was based on projected shortfall in revenue. The Department anticipates that this shortfall will have some impact on overall spending. For FY 2008 Title V funding level decreased \$191,474 to \$11,683,733. The Department anticipates level funding for Title V in FY 2009. Spending in MCH cost centers will remain at current 2008 levels. This does not take into consideration the possibility of future reductions in Title V funding to the State. ADPH projects total Family Planning services to increase from \$31.8 million in 2008 to approximately \$33.8 million in 2009. For FY 2009, we have submitted our Title X Family Planning funding application requesting \$5.2 million. Early 2007, ADPH received notice from Department of Health and Human Services, Administration for Children and Families that the State's Abstinence Until Marriage Education Program (AAEP) would expire June 30,2007 and eliminate \$957,000 in funding. However, AAEP was reauthorized and funded to June 30, 2008. Congress has not indicated that it will reauthorize or allow the AAEP to end. //2009//

CRS

See Forms 2-5. Funds spent on CYSHCN will support activities to address NPM #s 2-6 and the 2 SPMs developed by CRS. Under "Other Federal Funds," anticipated funding is included for the MCHB Comprehensive Core Hemophilia Grant and for the EIS services to Part C-eligible infants and toddlers. Anticipated use of the budgeted monies is justified by the level of the pyramid:

Direct Health Services

CRS--Includes direct community-based services of specialty medical care, care coordination, and ancillary care through the CRS specialty clinic programs and information and referral services for CYSHCN who are uninsured or under-insured for needed services and supports, including SSI-eligible children 0-16 years of age.

Enabling Services

CRS--Includes transportation reimbursements, translation services, coordination with local educational agencies and with VRS for youth transition services, a toll-free line in every district office, and parent consultant activities to assist families to advocate for their needs and to provide family support services offered through district offices.

Population-based Services

CRS--Includes State activities to screen/identify CYSHCN as early as possible and outreach to families to provide information and assistance in seeking and attaining services through multiple awareness mechanisms.

Infrastructure-building Services

CRS--This includes State-level administrative activities to support the CRS community-based service system and the continuous quality assurance process, including standards of care and outcome measures. Also included are interagency collaboration to improve/expand the service delivery system for CYSHCN (including those with TBI), in-service training, and health status surveillance and other measurement activities. At the community level, infrastructure-building services include staff, family, and youth support for local system development activities.

Other expenditures for infrastructure include a redesigned CRS management information system to collect and analyze data, the use of communication/information technology for public awareness and client/family education as appropriate, and the efforts towards the Alabama Healthy People 2010 Action Plan for CYSHCN.

See Forms 2-5. ADPH contracts with ADRS, Division of CRS, to provide services to CSHCN, and allocates Title V dollars to CRS for this effort. Due to budget constraints in the State in FY 2004, ADPH reduced Title V funding to CRS to the required 30% of the federal MCH block grant (about \$3.7 million) compared to previous funding levels at 35.46% (about \$4.5 million). For FY 2005,

however, ADPH increased its allocation to the State CSHCN Program to 32% (about \$3.9 million), and "Budgeted Federal Allocation" (Line 1, Form 3) represents this change. This level of funding is expected to continue for FY 2006. CRS continues to overmatch its federal dollars through its State allocation by over \$3 million. For FY 2004, budgeted monies for State funds (Line 3, Form 3) represent an additional \$332,528 allocated by the State legislature. For FY 2005, in addition to its State allocation (\$7.7 million), the CRS Budget Request includes funds from EIS for the provision of early intervention services to Part C-eligible infants and toddlers (\$2.1 million), a separate State allocation for the Alabama Hemophilia Program (\$1.1 million), and program income from third party reimbursements (\$11.7 million). These funds, in conjunction with the Federal Title V allocation, comprise 99.9% of the projected CRS budget for FY 2005. Budgeted monies under "Other Federal Funds" (Line 10, Form 2) are significantly different from FY 2004, as \$16,500 was represented in additional funds from a grant through the Champions for Progress Center to host a conference related to Healthy People 2010. CRS continues to receive \$28,700 from MCHB as a sub-grantee to Georgia to provide comprehensive care to persons with hemophilia. CRS anticipates no other federal funds for special projects or grants in FY 2006. CRS has requested an additional \$2.6 million from the State legislature for FY 2006, as represented in "State Funds" (Line 3, Form 3). An additional \$1 million is requested for the Alabama Hemophilia Program, as represented in "Other Funds" (Line 5, Form 2). Also for FY 2006, anticipated program income (Line 6, Form 3) has been modified to more accurately reflect the third party reimbursement trends from FY 2004 and FY 2005.

/2007/ See Forms 2-5.

Per federal reporting requirements, the FY 2006 budget was set in the application submitted in the previous year and may not be adjusted. However, particular line items for FY 2006 have been modified within ADRS-CRS to more accurately reflect the FY 2006 fiscal operations plan. These modifications are based on actual funds received by ADRS from the Alabama Legislature and on trend data for program income. Although the changes cannot be reflected in the budgeted amounts for FY 2006 in the federal reporting system, they are discussed in the following section. The FY 2007 budget is based on CRS's budget request.

ADPH contracts with ADRS, Division of CRS, for services to CSHCN and allocates Title V dollars to CRS for this effort. During FY 2005, ADPH allocated 32% (about \$3.9 million) of federal MCH block grant funding to CRS. This level of funding was continued during FY 2006 (about \$3.8 million due to reductions in the federal MCH Block Grant to the State). This level of funding is expected to continue for FY 2007.

CRS continues to overmatch its federal dollars through its State allocation. For FY 2006, in addition to its State allocation (\$8.2 million), the CRS budget includes funds from EIS for the provision of early intervention services to Part C-eligible infants and toddlers (\$2.2 million), a separate State allocation for the Alabama Hemophilia Program (\$1.5 million), and program income from third party reimbursements (\$10.2 million). These funds, in conjunction with the federal Title V allocation, comprise 99.9% of the projected CRS budget for FY 2006.

Budgeted monies under "Other Federal Funds" (Line 10, Form 2) are significantly different from FY 2005, as \$16,500 was represented in additional funds from a grant through the Champions for Progress Center to host a conference related to Healthy People 2010. This was a single year grant that will not be continued in future FYs. CRS continues to receive \$28,700 from MCHB as a sub-grantee to Georgia to provide comprehensive care to persons with hemophilia. CRS anticipates no other federal funds for special projects or grants in FY 2007.

CRS has requested an additional \$5.2 million from the State legislature for FY 2007, as represented in "State Funds" (Line 3, Form 3). An additional \$250,000 is requested for the Alabama Hemophilia Program, as represented in "Other Funds" (Line 5, Form 2). Also for FY 2007, anticipated program income (Line 6, Form 3) has been modified to more accurately reflect the third party reimbursement trends from FY 2005 and FY 2006.//2007//

/2008/ See Forms 2-5.

ADPH continues to contract with ADRS, Division of CRS, for services to CSHCN and allocates Title V dollars to CRS for this effort. During FY 2006, ADPH allocated 32% (about \$3.8 million) of federal MCH block grant funding to CRS. This level of funding was continued during FY 2007 and is expected to continue for FY 2008.

CRS continues to overmatch its federal dollars through its State allocation. In FY 2007, CRS received an additional \$4.6 million State allocation over its FY 2006 funding level. For FY 2007, in addition to its State allocation, the CRS budget includes funds from EIS for the provision of early intervention services to Part C-eligible infants and toddlers (\$2.2 million), a separate State allocation for the Alabama Hemophilia Program (\$1.8 million), and program income from third party reimbursements (\$7.7 million). These funds, in conjunction with the federal Title V allocation, comprise 99.9% of the projected CRS budget for FY 2007.

CRS continues to receive \$28,700 from MCHB as a sub-grantee to Georgia to provide comprehensive care to persons with hemophilia. CRS anticipates no other federal funds for special projects or grants in FY 2008.

The FY 2008 budget is based on CRS's current budget request. This includes a request for an additional \$1.8 million from the State legislature for FY 2008, as represented in "State Funds" (Line 3, Form 3). Also for FY 2008, anticipated program income (Line 6, Form 3) has been modified to more accurately reflect the third party reimbursement trends from FY 2006 and FY 2007.//2008//

/2009/ See Forms 2-5. ADPH continues to contract with ADRS, a Division of CRS, for services to CSHCN and allocates Title V dollars to CRS for this effort. During FY 2007, ADPH allocated 32% (about \$3.7 million) of federal MCH block grant funding to CRS. This level of funding was continued during FY 2008 and is expected to continue for FY 2009.

CRS continues to overmatch its federal dollars through its State allocation. In FY 2008, CRS received an additional \$1.8 million over its FY 2007 State allocation. For FY 2008, in addition to the State allocation, the CRS budget includes funds from EIS for the provision of early intervention services to Part C-eligible infants and toddlers (\$2 million), a separate State allocation for the Alabama Hemophilia Program (\$1.6 million), and program income from third party reimbursements (\$8.2 million). These funds, in conjunction with the federal Title V allocation, comprise 99.9% of the projected CRS budget for FY 2008. CRS continues to receive \$28,700 from MCHB as a sub-grantee to Georgia to provide comprehensive care to persons with hemophilia. CRS anticipates no other federal funds for special projects or grants in FY 2009.

The FY 2009 budget is based on CRS's current budget request. This includes a request for an additional \$1.7 million from the State legislature for FY 2009, as represented in "State Funds" (Line 3, Form 3). Also for FY 2009, anticipated program income (Line 6, Form 3) has been modified to reflect the third party reimbursement trends from FY 2007 and FY 2008.//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.