Maternal and Child Health Services Title V Block Grant

Alabama

FY 2024 Application/ FY 2022 Annual Report

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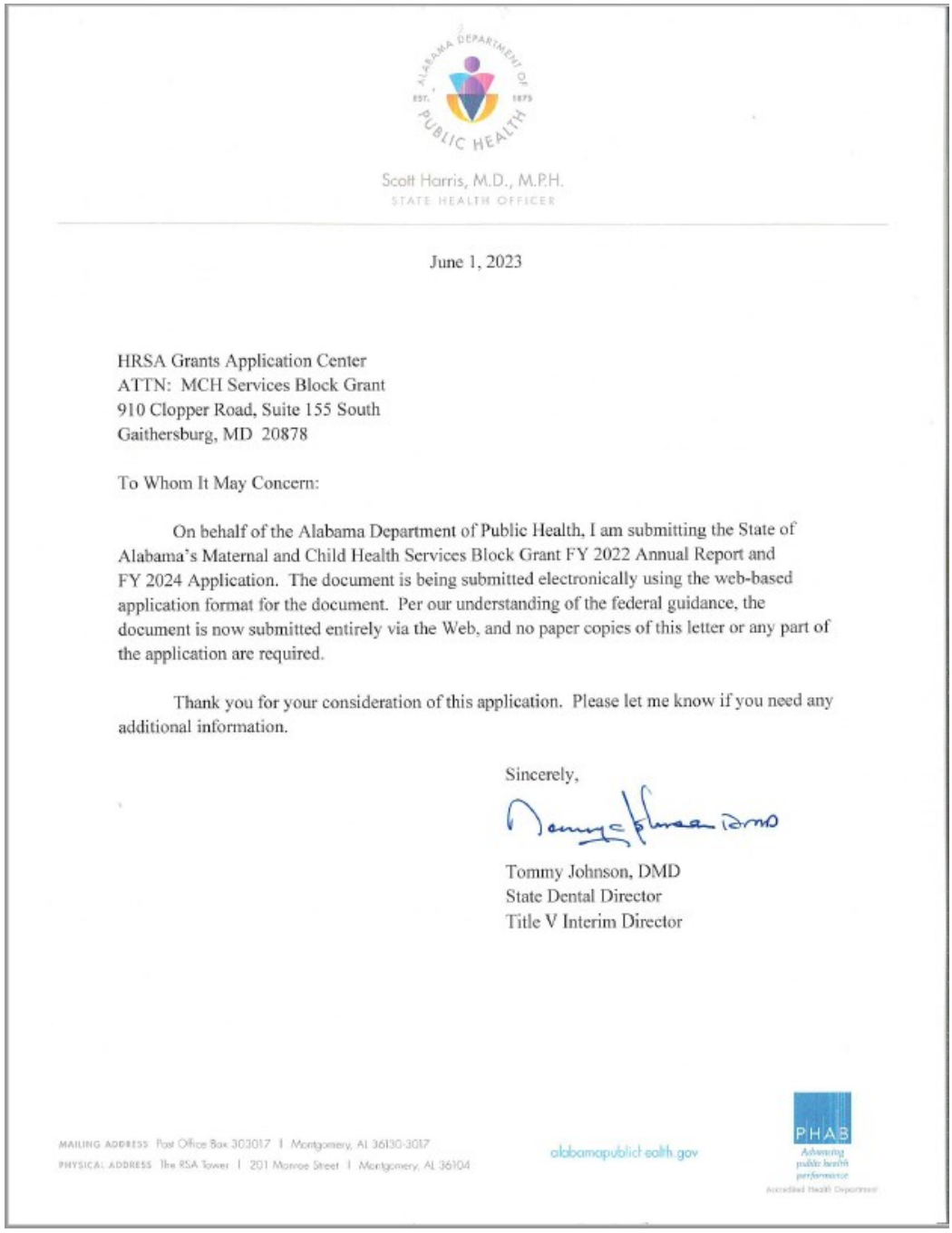
I. General Requirements

I.A. Letter of Transmittal



Scott Harris, M.D., M.P.H.
STATE HEALTH OFFICER

June 1, 2023

HRSA Grants Application Center
ATTN: MCH Services Block Grant
910 Clopper Road, Suite 155 South
Gaithersburg, MD 20878

To Whom It May Concern:

On behalf of the Alabama Department of Public Health, I am submitting the State of Alabama's Maternal and Child Health Services Block Grant FY 2022 Annual Report and FY 2024 Application. The document is being submitted electronically using the web-based application format for the document. Per our understanding of the federal guidance, the document is now submitted entirely via the Web, and no paper copies of this letter or any part of the application are required.

Thank you for your consideration of this application. Please let me know if you need any additional information.

Sincerely,

Tommy Johnson, DMD
State Dental Director
Title V Interim Director

MAILING ADDRESS: Post Office Box 303017 | Montgomery, AL 36130-3017
PHYSICAL ADDRESS: The RSA Tower | 201 Monroe Street | Montgomery, AL 36104

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I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January 31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

The Alabama Department of Public Health (ADPH) is the primary health agency for the state, operating with the mission to promote, protect, and improve Alabama's health. Public health functions are shared by state and local offices. Statewide programs are coordinated through the Central Office; the eight public health districts have the responsibility for delivering public health services and programs specific to the needs of their designated areas; and on the local level, the 67 county health departments (CHD) work to preserve, protect, and enhance community health and environments.

ADPH Bureau of Family Health Services (FHS), located in the Central Office, administers the Title V Maternal and Child Health (MCH) Services Block Grant Program. ADPH contracts with Children's Rehabilitation Service (CRS), a division of the Alabama Department of Rehabilitation Services (ADRS), to administer services to children and youth with special health care needs (CYSHCN). Other divisions and programs administered by FHS and ADRS include:

- Title X Family Planning (FP) Grant
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- State Perinatal Program (SPP)
- Healthy Childcare Alabama (HCCA) Program
- Cancer Prevention and Control Division
- Pregnancy Risk Assessment Monitoring System (PRAMS) Program
- Oral Health Office (OHO)
- Alabama Childhood Lead Poisoning Prevention Program (ACLPPP)
- Adolescent Pregnancy Prevention Branch (APPB)
- Alabama's Early Intervention (EI) System
- Vocational Rehabilitation Service (VRS)
- State of Alabama Independent Living Service

The MCH Epidemiology (Epi) Branch, also housed in FHS, pairs analytical staff members with bureau programs to provide data analysis and reporting support. Title V utilizes epi staff to support implementing, monitoring, and evaluating Title V Block Grant Program strategies. Furthermore, Alabama Title V Program staff collaborate with other ADPH and ADRS staff and with a variety of local, state, and federal stakeholders to assess the magnitude of factors impacting the state of health of Alabama's MCH population. Program staff rely on these partnerships to prioritize population health needs and create methods of addressing current and emerging needs.

MCH Needs

Needs assessments for the Alabama Title V Program are collaboratively conducted by FHS and CRS. An analysis of quantitative and qualitative data gathered through paper and web-based surveys, focus groups, key informant interviews, and from select databases and national surveys yielded a variety of issues for the population health domains. After convening advisory committee meetings in March 2020, national priority areas and state needs were identified. Title V staff implement, evaluate, and update strategies as necessary.

ADPH Highlights

The following information is a summary of 2021-2025 priority needs, strategies, and accomplishments. See section III.E.2.c. State Action Plan Narrative by Domain for additional information.

NPM|1 – Well-Woman Visit

ESM 1.1 - Proportion of women age 15-55 who report receiving a preventive medical visit in the past 12 months by increasing total enrollment percentage in the Well Woman Program by 2 points annually

NPM 3 – Risk-Appropriate Perinatal Care

ESM 3.1 - Percent of delivering hospitals convened at a meeting to share data and discuss the Alabama Perinatal Regionalization System Guidelines

ESM 3.2 - Number of steps of the CDC's Level of Care Assessment Tool (LOCATe) process completed in order to design and align the Alabama Perinatal Regionalization System Guidelines with the national criteria for the maternal levels of care

SPM 8 - Decrease number of infants dying from Sudden Infant Death Syndrome (SIDS)

NPM 5 – Safe Sleep

ESM 5.2 - Number of sleep-related infant deaths

ESM 5.3 - Number of trainings facilitated to assist healthcare professionals and first responders, who interact with expecting and new mothers, with being trained on safe sleep recommendations

NPM 6 – Developmental Screening

ESM 6.1 - Proportion of children birth to age 19 that received a well child appointment in the past year

ESM 6.2 - Proportion of children birth to age 19 that received a developmental screening in conjunction with a well child appointment in the past year

SPM 1 - Percent of children who receive a blood lead screening test at age 12 and 24 months of age

SPM 5 - Increase the proportion of Early Head Start (EHS) programs participating in the Early Head Start Child Care Partnership (EHSCCP) grant program that maintain 10% of their population with children with special needs.

SPM 6 - Percent of staff trained at day care provider/centers on CPR/First Aid

ESM 6.3 - Proportion of children aged 12 & 24 months that have a reported blood lead screening in the past year

NPM 10 – Adolescent Well-Visit

ESM 10.1 - Proportion of adolescents aged 12 to 19 that received an adolescent well visit in the past year

NPM 13 – Preventive Dental Visit

ESM 13.1.1 - Percentage of dental providers receiving information/education regarding importance of preventive dental visits for expectant mothers

ESM 13.1.2 - Percentage of dental providers that received information/education regarding their perinatal patients about the FDA approved HPV vaccine in order to reduce the risk of oropharyngeal, cervical, and other HPV-related cancers

ESM 13.2.1 - Percentage of providers receiving information/education regarding importance of preventive dental visits for children ages 1-17 years of age

ESM 13.2.2 - Percentage of dental providers that received information/education regarding informing their families of patients at 9 years of age about the FDA approved HPV vaccine in order to prevent future oropharyngeal, cervical and other HPV-related cancers

In Alabama, very low birth weight infants (‹1500 g) represented less than 1.8 percent of all births in 2021 but accounted for 181 deaths out of the total 443 infant deaths**.** ADPH has renewed its collaboration with the Alabama Hospital Association (AlaHA) to focus on high-risk pregnant women and infants delivering at the appropriate level of care. Sudden unexpected infant death (SUID) is defined as the death of an infant less than 1 year of age who suddenly or unexpectedly dies. In 2021, 101 infant deaths were attributed to SUID. ADPH continues to address SUID through safe sleep education, training of medical personnel and community workers, and distribution of cribs to families without a safe sleep environment. Over 300 cribs were distributed in FY 2022.

For expectant Alabamians, 1 in every 111 pregnancies will end in stillbirth. Disparities persist, and Black women are two times more likely to lose a baby to stillbirth than White women. Count the Kicks is an evidence-based public health campaign that teaches expectant parents the method for and importance of tracking their baby's movements in the third trimester of pregnancy. Alabama Title V leadership introduced the campaign in 2021 and since that time, 151 healthcare professionals have ordered educational materials; 75,745 educational pieces were mailed out; and 642 expectant parents downloaded the app. One Alabama couple who downloaded the free Count the Kicks app to track their baby's movements believes that the app helped save their baby's life. While using the app, the couple noticed that the baby's movements were abnormal. The family swiftly sought medical care and safely delivered a healthy baby girl.

The Well Woman Program provides preconception and/or interconception health care to women through education on healthy living and preventative screenings. The program addresses obesity, hypertension, high cholesterol, and

diabetes. In fiscal year (FY) 2022, the program enrolled 554 participants. Fifty percent of the participants experienced a decrease in body mass index (BMI).

In 2022, the number of children less than 18 years of age receiving at least one blood lead level (BLL) screening was 47,340; an increase of 34.8 percent from 2021.

In FY 2022, OHO hosted Assistant Surgeon General Timothy Ricks, D.M.D, F.I.C.D. Rear Admiral Ricks presented on health disparities, access to dental care, and the oral health workforce. OHO staff conducted oral screenings for 8,716 children in Pre-K, Head Start, kindergarten, and third grade. The Tuscaloosa County Health Department (TCHD) Dental Clinic completed 1,104 oral exams and 885 cleanings; and applied 186 sealants, 1,012 fluoride treatments, and 100 silver diamine fluoride treatments.

Public Health District Initiative

In November 2019, Alabama Title V leadership initiated a plan to transform our population health efforts. Title V staff collaborated with the ADPH district administrators to identify and train district MCH coordinators, whose roles would be to manage the replication of evidence-based Central Office programs in the CHDs and local communities. FHS also worked with program coordinators in the Jefferson County Department of Health (JCDH) and Mobile County Health Department (MCHD) to expand their community evidence-based programs. The projects were designed to focus on counties and communities with adverse health outcomes in an effort to reduce the health disparities in our state. Below are high-level highlights from FY2022.

- A total of 2,347 youth and adults participated in suicide prevention training.
- Over 1,500 pregnant women and children received oral exams.
- There were 165 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) visits in 2 CHD clinics.
- Seventy-eight maternity clients received injury prevention education and infant supplies and safety items during the JCDH baby safety showers.
- Over 700 college and university students received healthy lifestyle information.

CRS

CRS' mission embodies the principles of comprehensive, community-based, and family-centered care. The mission of CRS is to enable CYSHCN and adults with hemophilia to achieve their maximum potential within a community-based, culturally competent, family-centered, comprehensive, coordinated system of services.

CRS continues to operate seven programs to serve CYSHCN and their families. Services provided in each of these programs are funded in full or in part by Title V funds. The seven programs are Clinical Medical; Clinical Evaluation; Hemophilia; Care Coordination; Information and Referral; Parent Connection; and Youth Connection. Family engagement is supported in partnership with Family Voices of Alabama (FVA) and the Family to Family Health Information Center (F2F HIC). Coordinated health services are delivered via 14 community-based offices across 7 districts. Through statewide partnerships with various entities and agreements with the state's two tertiary-level pediatric hospitals, CRS continues to bridge gaps in the system of care for CYSHCN and their families. These partnerships increase the state's capacity to address the health, social, and educational needs of CYSHCN.

CRS is committed to creating a culture of continuous quality improvement (QI) to improve service delivery for CYSHCN and their families and has incorporated quality improvement throughout the activities and approaches in the State Action Plan. CRS Leadership, the Block Grant State Action Plan Team, and the CRS Management Team continually work to identify gaps in services, ways to improve access to care, and how best to help CYSHCN and their families

navigate the complex system of care.

CRS Highlights

The following information is a summary of 2021-2025 priority needs, strategies, and accomplishments. See section III.E.2.c. State Action Plan Narrative by Domain for additional information. The performance measures to address the children with special health care needs (CSHCN) priority needs are outlined below:

NPM 12 – Transition

ESM 12.1 – Percent of YSHCN enrolled in State CSHCN Program who report satisfaction with their transition experience to adulthood

SPM 2 – Strengthen and enhance family/youth partnerships, involvement and engagement in advisory groups, program development, policymaking, and system- building activities to support shared decision making between families and health-related professionals

SPM 3 – Increase the capacity of families to connect CYSHCN to the health and human services they require for optimal behavioral, developmental, health, and wellness outcomes through our Care Coordination Program

CRS State Leadership convened a Transition Task Force to review the current CRS transition process and determine ways to strengthen the use of the Got Transition® Six Core Elements of Health Care Transition™ tools. The task force has been meeting monthly to identify ways to improve overall service delivery for youth with special health care needs (YSHCN). This work has included utilizing survey data from the annual Transition Survey administered by the University of Alabama at Birmingham (UAB) School of Public Health (SOPH), Department of Health Care Organization and Policy, Applied Evaluation and Assessment Collaborative (AEAC). Initial task force work has focused on ensuring the Transition Readiness Assessment is tailored to assist all CRS YSHCN and their families frame a smooth transition from childhood into adulthood. Providing individuals and families with a foundation to develop a plan focused on the needs of their youth is key to a successful transition to adulthood.

FVA in partnership with CRS held the 2023 Partners in Care Summit in person after a 2-year break due to COVID-19. The summit focused on the Blueprint for Change: A National Framework for a System of Services for Children and Youth with Special Health Care Needs. There were over 150 people in attendance and participants learned about the history and development of the Blueprint for Change, how to bring the Blueprint to life, and a special session focused on Critical Area 2: Family and Child Well-Being and Quality of Life. The summit provided CRS Leadership and staff the opportunity to enhance their knowledge of the Blueprint and identify ways to utilize the principles outlined in the Blueprint to improve service delivery.

The CRS Care Coordination Program provides a multidisciplinary approach to care coordination to ensure CYSHCN and their families connect to wrap-around services they require for optimal behavioral, developmental, health, and wellness outcomes. CRS delivers services using a multi-disciplinary team approach and care coordinators are essential team members. CRS Leadership has used survey data from the annual Care Coordination Family Survey administered by the AEAC to strengthen the Care Coordination Program. Baseline composite measure data indicated families did not have a clear understanding of a plan of care (PoC). CRS was able to incorporate survey data in the release of the newly designed PoC. The new PoC is a living document that is updated throughout the year. Ongoing updates strengthen interactions between the care coordinators and families. In the newly designed PoC families are active participants and the primary identifier of what goals and actions will best meet the needs of their child and family. Care coordinators will now have the capability to share the PoC with families and providers through a goal sheet that includes the agreed-upon goals, action steps, and responsible party. Having a printed goal sheet will remind families of the steps needed for optimal care.

III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

The Alabama Title V MCH Program funds strategically support personnel and the implementation, monitoring, and evaluation of MCH-focused activities, data collection, and program evaluation. Staff establish local, state, and federal partnerships to develop, identify, and recommend quality and equitable, preventive, educational, and early treatment strategies to prevent illness, injury, disease, and death, and to eliminate disparities. Title V funds support breastfeeding; well visits; community water fluoridation; developmental screenings; transition; fetal, infant, and maternal mortality review committees; and advocacy to increase equity and improve access to quality medical and dental care services. Staff works to ensure that public health care laws, rules, and regulations are followed to ensure optimal health of Alabamians through early identification, early diagnosis, and follow-up.

Alabama Title V staff convene task forces, steering committees, and work groups that collaborate to ensure the MCH population has access to care and resources to take charge of and improve their health and their families' health. Alabama Title V leverages funding and partnerships to educate, develop legislative rules or bills, and ensure uniform and safe standards of service and care. Title V and other federal, state, and local funds cover activities and staffing related to cancer prevention (colorectal, cervical, breast, and oropharyngeal), teen pregnancy prevention, healthy childcare, lead exposure, newborn screening, as well as case management and care coordination services for pregnant women, infants, children, and adolescents, including CYSHCN.

Alabama Title V funds are used to fill gaps in health care, providing services not otherwise supported through non-federal MCH dollars, particularly in CHDs. The Alabama Title V MCH Program works to respond to emerging MCH needs, supporting families and adapting programming as needed. FHS administration ensures that a continual and comprehensive review of finances and programming is in place so that utilization of Title V funds fully supports state priority needs in alignment with federal guidelines.

III.A.3. MCH Success Story

Children's Rehabilitation Service

Guntersville's Gabe Marsh never shies away from a challenge.

Born with no legs and one arm, Gabe was adopted by the Marsh family when he was only 1 week old. From an early age, Gabe desperately wanted to learn to swim with his 12 brothers and sisters. By 5 years old, he was winning races and by 9, he was traveling the country and earning awards at the Paralympics and Pan-Am games.

Today, he is an accomplished swimmer and was presented in 2022 with the Ken and Betty Joy Blankenship Student Achievement Athlete of the Year Award, which honors Alabama students who have, "by ability and effort, achieved a level of excellence in the areas of academics and athletics that is commensurate with their potential."

"It was a great accomplishment," Gabe said. "My principal took a chance on me. Out of all the other students who were good at football or basketball, he decided to pick me. It was a very big thing for me."

Now his sights are set on the 2024 Paralympics and a trip to Paris.

In the meantime, Gabe has been working on his career goals at Snead State Community College. He plans to pursue a degree in theology and hopes to become a preacher and motivational speaker.

Gabe's care coordinator through the Huntsville CRS office, Mark Kearley, said he is very excited about the impact Gabe will have on others. The determination and commitment that he gives to his sport are just as strong in his educational and career pursuits.

Kearley helped Gabe secure a manual wheelchair when he was 12, which improved his mobility tremendously. After completing a pre-vocational evaluation, Kearly enrolled him in amputee, seating, and transition clinics where he and his family worked together with the CRS clinic team to explore and address his options in planning for his future. With this improved mobility, Gabe has been able to earn and save money while going to school by working at McDonald's.

The next step in Gabe's journey to independence is the adaptive driver program as he transitions into VRS, a part of his continuum of care with ADRS.

"It's just a great partnership to have all of us working together," he said.

Kearley, reflecting on a conversation that he and Gabe had years ago, said, "I remember Gabe saying, 'Mark, I never want to quit. If I fail, I'm going to try again. If I fail, I'm going to try again. If I fail, I'm going to try again,'" he said. "That's his motivation."

III.B. Overview of the State

Background

Alabama is the thirtieth largest state and is sometimes called the Yellowhammer State, after the state bird. It is bordered by Tennessee to the north, Georgia to the east, Mississippi to the west, and Florida and the Gulf of Mexico to the south. Montgomery is the state capital and the location of the Central Office of ADPH. The largest urban areas in Alabama are the cities of Birmingham, Mobile, Montgomery, and Huntsville. Birmingham is the largest city in the state and the location of UAB Hospital which has one of the state's level-one trauma hospitals. Mobile is the state's port city and the third-largest metropolitan area. It considers itself the cultural center of the Gulf Coast and the birthplace of America's original Mardi Gras. Huntsville, the fourth largest city, has experienced exponential growth in the last 10 years because of its national defense installations and high-technology industries. Huntsville considers itself the star of Alabama. As such, it has become a star in the fight for better community health through the creation of Healthy Huntsville. This effort focuses on the core concepts of nutrition and exercise to encourage its residents to embrace healthy lifestyles.

The state of Alabama is divided into eight Public Health Districts and each Public Health District Office is overseen by a district health officer or district administrator. District offices manage CHDs in all 67 counties. CHD staff work to preserve, protect, and enhance the general health and environment of the community by:

- Providing health assessment information to the community
- Providing leadership in public health policy
- Assuring access to quality health services and information, preventing disease, and enforcing health regulations

ADPH operates on a mission to promote, protect, and improve Alabama's health with a focus on healthy people and healthy communities. In 2019, ADPH leadership released a 5-year strategic plan. The plan focuses on five main areas and goals which are outlined below:

Health Outcome Improvement

Goal: Improve specific health outcomes or health disparities so that Alabama is a healthier place to live and work

Financial Sustainability

Goal: Increase available funds to continue to promote, protect, and improve the health of Alabamaians

Workforce Development
Goal: Strengthen the performance and capacity of the ADPH workforce so that the ability to serve our customers increases

Organizational Adaptability
Goal: Adapt to changes in the healthcare environment so that programs and processes are increasingly effective and efficient

Data-Driven Decision Making
Goal: Become data-driven in analysis and decision-making so that leaders and programs make informed decisions

In 2021, the ADPH Office of Health Equity and Minority Health (OHEMH) was re-imagined. After structural inequities were magnified during the COVID-19 pandemic, OHEMH developed a 3-year plan for elevating health equity throughout departmental programs and policies. Utilizing data to identify communities at the highest risk of poor social determinants of health, the office, and its partners seek to deliver intentional strategies that will support access to healthcare resources for underserved and rural populations, improve culturally and linguistically appropriate communication around healthcare issues, and develop health equity plans to address future public health emergencies at the community and state levels.

In 2023, the OHEMH will host a series of health literacy programs to further equip communities to deal with future public health emergencies. Additionally, OHEMH plans to include healthcare assessments of unincorporated and rural communities; development of emergency preparedness plans that recognize the distinct needs of specific disabled populations rather than grouping disabled populations into one broad category; COVID-19 testing in communities without access to free testing; development of community ambassadors/trusted community health workers to share public health information and prevention resources; and development of youth leadership groups and community advisory committees that focus on community wellness and prevention.

The State of Alabama CSHCN Program is administered by CRS, a division of ADRS. CRS' mission embodies the principles of comprehensive, community-based, and family-centered care. The mission of CRS is to enable children and youth with special health care needs and adults with hemophilia to achieve their maximum potential within a community-based, culturally competent, family-centered, comprehensive, coordinated system of services. Coordinated health services are delivered via 14 community-based offices across 7 districts.

SELECTED CHANGES IN ALABAMA'S POPULATION /ECONOMIC ENVIRONMENT AND POVERTY LEVELS/TRENDS IN NUMBERS OF ALABAMA TITLE V-SERVED PERSONS

Total Population

According to the 2021 1-year estimate from the American Community Survey (ACS), 5,039,877 people reside in Alabama.

Looking at the single race category, 65.1 percent (3,281,881/5,039,877) were White and 25.9 percent (1,305,106/5,039,877) were Black. Asians only make up 1.4 percent (68,813/5,039,877) of Alabama's population. Within the Asian population, Koreans and Asian-Indian are the largest groups residing in Alabama. Looking at ethnicity, 95.3 percent (4,802,443/5,039,877) were non-Hispanic and only 4.7 percent (237,434/5,039,877) were of

Hispanic origin. Within the Hispanic population, the three largest ethnic groups were Mexican, Puerto Rican, and Cuban.

0-24 Year-Old Residents

For 2021, ACS grouped Alabamians who were under 24 years old into five groups. In total, 1,588,669 were 24 years old or younger. A more detailed age breakdown is as follows: 18.3 percent (290,091/1.588,669) were 5 years or younger; 18.8 percent (298,540/1,588,669) were between 5 and 9 years old; 21.3 percent (337,730/1,588,669) were between 10 and 14 years old; 21.3 percent (338,347/1,588,669) were between 15 and 19 years old; and 20.4 percent (323,961/1,588,669) were between 20 and 24 years old.

Live Births

According to numbers retrieved on March 25, 2022, from the National Center for Health Statistics website, in 2020, there were a total of 57,647 live births to Alabama residents, a slight decrease (approximately 1.7 percent) from the 58,615 live births in 2019 for the state. There were 5,233 (approximately 9.1 percent) live births to mothers of Hispanic origin in the same year. Of the non-Hispanic mothers, approximately 56.7 percent were White; 30.8 percent were Black; 1.5 percent were Asian; 0.2 percent were American Indian or Alaska Native; and approximately 0.07 percent were Native Hawaiian or Other Pacific Islander.

The charts below reflect additional vital statistics data.

Vital Statistics, 2020-2021

	Number	Rate/Percent	
Births	57,643	11.7	(Per 1,000 Population)
Births to Teenagers	3,837	12.6	(Per 1,000 Females Aged 10-19 Years)
Low Weight Births	6,228	10.8	(Percent of All Live Births)
Births to Unmarried Women	27,877	48.4	(Percent of All Live Births)
Deaths	64,779	13.2	(Per 1,000 Population)
Marriages	35,826	7.3	(Per 1,000 Population)
Divorces	18,022	3.7	(Per 1,000 Population)
Induced Terminations of Pregnancy	7,467	7.8	(Per 1,000 Females Aged 15-44 Years)
Infant Deaths (Neonatal + Postneonatal)	404	7.0	(Per 1,000 Live Births)
Neonatal Deaths (0-27 days of life)	224	3.9	(Per 1,000 Live Births)
Postneonatal Deaths (28-364 days of life)	180	3.1	(Per 1,000 Live Births)

Total estimated state population is 4,921,532.

Source: ADPH 2021 Annual Report

	Number	Rate/Percent	
Births	58,040	11.5	(Per 1,000 Population)
Births to Teenagers	3,700	11.6	(Per 1,000 Females Aged 10-19 years)
Low Weight Births	6,070	10.5	(Percent of All Live Births)
Births to Unmarried Women	26,950	46.4	(Percent of All Live Births)
Deaths	68,760	13.6	(Per 1,000 Population)
Marriages	38,192	7.6	(Per 1,000 Population)
Divorces	18,158	3.6	(Per 1,000 Population)
Induced Terminations of Pregnancy	8,294	8.5	(Per 1,000 Females Aged 15-44 years)
Infant Deaths (Neonatal + Postneonatal)	443	7.6	(Per 1,000 Live Births)
Neonatal Deaths (0-27 days of life)	232	4.0	(Per 1,000 Live Births)
Postneonatal Deaths (28-364 days of life)	211	3.6	(Per 1,000 Live Births)

Total estimated state population is 5,039,877.

Source: ADPH 2022 Annual Report

Alabama's Leading Causes of Death, 2020-2021

Cause of Death	Rank	Number	Rate[1]	Population
Total		**64,779**		**4,921,532**
Heart Diseases	1	14,739	299.5	
Malignant Neoplasms	2	10,458	212.5	
Coronavirus Disease 2019	3	6,549	133.1	
Chronic Lower Respiratory Diseases	4	3,430	69.7	
Cerebrovascular Diseases	5	3,390	68.9	
Alzheimer's Disease	6	3,094	62.9	
Accidents	7	3,005	61.1	
Diabetes Mellitus	8	1,450	29.5	
Influenza and Pneumonia	9	1,114	22.6	
Nephritis, Nephrotic Syndrome, and Nephrosis	10	1,083	22.0	
Septicemia	11	1,035	21.0	
Chronic Liver Disease and Cirrhosis	12	966	19.6	
Suicide	13	793	16.1	
Parkinson's Disease	14	715	14.5	
Essential (Primary) Hypertension and Hypertensive Renal Disease	15	706	14.3	
All Other Causes, Residual		12,252		

[1]Rate is per 100,000 population.

Source: ADPH 2021 Annual Report

Cause of Death	Rank	Number	Rate[1]	Population
Total Causes of Death		**68,760**		**5,039,877**
Heart Diseases	1	15,144	300.5	
Malignant Neoplasms	2	10,412	206.6	
Coronavirus Disease 2019	3	9,468	187.9	
Accidents	4	3,443	68.3	
Cerebrovascular Diseases	5	3,359	66.6	
Chronic Lower Respiratory Diseases	6	3,278	65.0	
Alzheimer's Disease	7	2,724	54.0	
Diabetes Mellitus	8	1,654	32.8	
Septicemia	9	1,183	23.5	
Nephritis, Nephrotic Syndrome, and Nephrosis	10	1,161	23.0	
Chronic Liver Disease and Cirrhosis	11	1,040	20.6	
Influenza and Pneumonia	12	1,032	20.5	
Suicide	13	821	16.3	
Essential (Primary) Hypertension and Hypertensive Renal Disease	14	768	15.2	
Homicide	15	744	14.8	
All Other Causes, Residual		12,529		

[1]Rate is per 100,000 population.

Source ADPH 2022 Annual Report

ECONOMIC ENVIRONMENT AND POVERTY LEVELS

According to ACS, 16.1 percent (794,326/4,920,613) of those who resided in Alabama during 2021 were below the FPL. Compared to other racial groups, African-Americans have the highest percentage of 26.0 percent (327,284/1,260.356) within their group. Comparing the percentages for the ethnicity groups, those with Hispanic origin had the highest percentage of 24.5 percent (56,551/230,804).

TRENDS IN NUMBERS OF ALABAMA TITLE V-SERVED PERSONS

Per guidance on the completion of Forms 5a and 5b, the methods used for calculating the entries have changed; thus, data reported in this application/annual report will not be directly comparable to previous years. From our annual report year 2021, there were 1,725 pregnant women; 12,833 CSHCN; and 46,189 “Others” served under Title V.

CRS staff continually participate in community awareness and outreach activities to educate individuals about services for CYSHCN and their families. The following figures represent trends in CYSHCN who received services directly from CRS. In FY 2022, CRS served 13,777 CYSHCN, an increase of 7.36 percent over FY 2021. Of the 13,777 served, 82 percent were under the age 16. In FY 2021, CRS served 12,833 CYSHCN, an increase of 6.13 percent over FY 2020. The 2021 increase is attributed to clinics resuming operations after the brief shutdown in FY 2020 due to COVID-19 and is in line with normal growth.

CRS staff reached approximately 86,610 CYSHCN and their families via incoming toll-free calls, information and referrals, Parent and Youth Connection and ADRS Facebook pages, ADRS/CRS website, outreach activities, local hearing screenings, and FVA activities. The FY 2022 number reached is 40 percent over the 2019 pre-COVID-19 number reached of 62,000. The increase in the number reached is largely due to an increased use of social media.

Issues important to understanding the health needs of the state's population include the healthcare environment, selected changes in the state’s population, the number of state Title V-served individuals, funding issues, and special challenges in the delivery of services to CYSHCN. Also key to understanding the health needs of the state's Title V populations are salient findings from the current five-year comprehensive Needs Assessment and priority MCH needs based on these findings which are discussed further in this MCH report/application.

THE HEALTH CARE ENVIRONMENT

Changes that have occurred in Alabama's healthcare environment have caused a shift in the provision of direct medical services from CHDs to private providers. This shift has been especially evident with respect to the provision of services to pregnant women, children, and youth. Because the shift continues to affect ADPH's role in providing services, salient history and current conditions concerning the healthcare environment are both summarized here.

Care Coordination Program

EPSDT Care Coordination Program

ADPH in partnership with Alabama Medicaid provides EPSDT care coordination services to Medicaid-eligible infants and children with elevated lead levels, infants with failed hearing screenings, and infants with questionable or unsatisfactory newborn screenings in the hospital. Care coordination services are comprehensive services that assist eligible individuals in gaining access to needed medical, social, educational, and other services. Non-Medicaid recipients receive care coordination services from ADPH central office staff in FHS. In FY 2022, ADPH provided case management services to 3,354 infants who did not pass the Newborn Screening or Newborn Hearing Screening at birth and 1,177 children with an elevated BLL. FY 2022 ended with 7 full-time equivalents (FTEs) providing services to the identified infants and children.

Title X Care Coordination Program

Care coordination services are provided through a Title X Supplemental Grant for women seeking family planning services in underserved communities. Care coordinators provide family planning support and related health services that will improve the overall health of individuals in underserved counties. The counties served are Barbour, Bibb,

Blount, Bullock, Butler, Chambers, Chilton, Dallas, Fayette, Hale, Lowndes, Macon, Marengo, Pike, Randolph, Russell, Shelby, Walker, Wilcox, and Winston. Care coordinators provide FP risk assessments and assist women in reducing the rate of unplanned pregnancies, sexually transmitted infections, and cervical cancer. In FY 2022, ADPH provided Title X case management services to 2,109 patients.

Early Head Start Care Coordination Program

ADPH in partnership with the Department of Human Resources (DHR) provides long-term care coordination services to children attending an Early Head Start Program or Family Day Care Home participating in the Early Head Start (EHS) Child Care Partnership Grant (EHSCCP). The goal is to ensure that children's medical and early learning needs are met as they enter the public school system. Children ages 6 weeks old through 4 years of age attending an EHS program or daycare participating in the EHSCCP Program are eligible. If a child enrolled in a center or EHS program is identified as having special needs, the care coordinators assist the centers and the parent/guardian as needed to obtain an individualized family service plan (IFSP). Care coordinators can help with accessing community resources and support services; free children's books and educational material; services that support early learning, health, and family wellbeing; services for special needs; choosing a doctor or dentist; scheduling an appointment; and appointment reminders. In FY 2022, ADPH provided EHS case management services to 917 patients.

Collaboration between CRS and Medicaid

The Alabama Medicaid Commissioner has emphasized children's issues as an agency priority and specific Medicaid staff members are assigned to work with CRS. Meetings between Medicaid and CRS are held quarterly to discuss any issues or concerns regarding services provided to Medicaid recipients with special healthcare needs. If issues arise outside the quarterly meetings, the CRS Medicaid liaison will contact Medicaid to discuss them. In addition, CRS staff participate in advisory committees and work groups associated with various Medicaid initiatives.

To ensure consistent quality, statewide standards of care, and access to community-based clinical services, Medicaid and CRS have negotiated a list of approved multidisciplinary clinics. CRS operates these clinics within Medicaid's Children's Specialty Clinic Services Program requirements, which include that the required practitioners be credentialed in accordance with Medicaid Administrative Code. CRS clinics employ physicians, nurses, social workers, physical therapists, audiologists, nutritionists, occupational therapists, and speech/language pathologists (SLP). CRS works with Medicaid to add new specialty clinics or modify existing clinics as needed.

Throughout the COVID-19 pandemic, CRS worked closely with Medicaid to maintain a continuum of service delivery for Medicaid recipients in the state. CRS is continuing to work closely with Medicaid as the COVID-19 public health emergency (PHE) comes to an end. Medicaid is providing ongoing guidance regarding coverage changes due to the ending of the PHE and changes resulting from the Medicaid COVID-19 unwinding. CRS leadership is ensuring staff are provided with the most up-to-date information. The ADRS Commissioner and other state agency leaders advocated to continue coverage for telemedicine visits which were enacted as part of the PHE. As a result of these efforts, Medicaid announced the implementation of a Telemedicine Policy effective June 1, 2023.

CRS is 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 reviews all statewide requests to Medicaid for augmentative communication devices (ACDs) and houses all Medicaid prior authorization (PA) requests for ACDs. CRS is the only provider of medically necessary orthodontia for Medicaid recipients. CRS works closely with the Medicaid Dental Director regarding coverage for medically necessary orthodontia services.

CRS has an ongoing collaboration with Medicaid to meet Health Insurance Portability and Accountability Act (HIPAA)

standards for privacy and billing. CRS staff have access to Medicaid eligibility data for confirming coverage as outlined in the provider agreement between Medicaid and ADRS.

Medicaid Family Planning Waiver and Related Issues

The 1115(a) Family Planning Waiver Proposal, submitted by ADPH and Medicaid to the Health Care Financing Administration (HCFA) in FY 1999, was implemented in October 2000. [HCFA became the Centers for Medicaid and Medicare Services (CMS)]. This waiver, called Plan First, expanded Medicaid eligibility for FP services to 133 percent of the Federal Poverty Level (FPL) for women ages 19-55 years of age. The Plan First FP Program includes coverage for women ages 19 to 55 with incomes up to 141 percent of FPL. Coverage for men aged 21 and older with incomes up to 141 percent of FPL for vasectomies only. A standard income disregard of 5 percent of the FPL is applied if the individual is not eligible for coverage due to excess income. In November 2016, Medicaid submitted a waiver amendment to add care coordination for males enrolled in Plan First to receive vasectomies and vasectomy-related services.

UAB evaluates the implementation of Plan First. The evaluation determines progress on six goals: enrolling 80 percent of eligible women under age 40, maintaining a high level of awareness of the Plan First Program among enrollees, increasing utilization of Plan First services by enrollees to 70 percent, increasing the portion of Plan First enrollees who receive smoking cessation services to 85 percent, maintaining birth rates among Plan First participants, and making sterilization services available to income-eligible men over age 21. According to the Plan First Market Analysis report, the Alabama Family Planning Program provides services to approximately 33 percent of all Plan First enrollees statewide. The evaluation determined the program paid for itself by reducing costs associated with births and noted participants with the lowest birth rates are those who received risk assessments or care coordination and those who use Title X Family Planning services. The waiver has been extended through September 2022. Medicaid has consistently expanded services with each renewal, most recently adding care coordination services for males seeking sterilization services.

The State Children's Health Insurance Program (CHIP)

CHIP was added to the Social Security Act by the Balanced Budget Act of 1997. Alabama was the first state in the nation to have a federally approved CHIP. The Bureau of Children's Health Insurance administers ALL Kids, Alabama's separate CHIP. ALL Kids provides comprehensive health coverage to eligible children and uses the Blue Cross Blue Shield of Alabama provider network. In addition to the ALL Kids Program, as a result of provisions in the Affordable Care Act, CHIP also funds a group of Medicaid-eligible children (MCHIP), which is administered by Medicaid. In FY 2022, there were 195,948 children enrolled in CHIP with 71,151 enrolled in ALL Kids and 124,797 enrolled in MCHIP.

CHIP also developed the ALL Babies Program. ALL Babies is a collaborative project between CHIP and FHS, with a focus on pregnant women and unborn babies in Montgomery, Macon, and Russell Counties. Medical insurance coverage is provided to women who are not eligible for insurance allowing access to prenatal care. ADPH provides care coordination services to pregnant women and their infants up to 3 months of age that qualify for ALL Babies Health Insurance. The goal is to reduce infant mortality and poor pregnancy outcomes. Pregnant women and/or their infants in Montgomery, Macon, and Russell Counties qualify for care coordination services. Care coordinators help participants gain access to medical care, health education, and other services and resources. Care coordinators educate mothers on safe sleep practices, WIC, breastfeeding, the importance of dental care for mother and baby, developmental milestones, etc. They also aid with medical appointments for the mother and baby and refer to community agencies for needs such as food, utilities, rental assistance, diapers, and clothing. Care coordination

uses culturally and linguistically appropriate services to address the health beliefs, practices, and needs of diverse participants. During FY 2022, the program provided coverage to 711 enrollees.

CRS Services to Certain Medicare Enrollees

In FY 2022, CRS served 50 clients with Medicare benefits. All clients were adults with bleeding disorders. CRS assisted clients with Medicare coverage to select the health plan option that best addressed their needs and helped them locate Medicare pharmacies for factor treatment of bleeding disorders. In FY 2022, CRS paid insurance premiums for 13 clients with bleeding disorders.

Special Challenges in Delivery of Services to CYSHCN

Addressing the service delivery needs of Alabama's CYSHCN presents special challenges due to CYSHCN often needing services from multiple systems. Service delivery can be further compounded by barriers to accessing care such as a family's financial circumstances, geographic location, and low health literacy. These barriers became even more apparent during the pandemic.

The COVID-19 PHE ending and unwinding of the COVID-19 Medicaid continuous coverage requirement could bring additional challenges for CYSHCN and their families. Currently, over 75 percent of individuals receiving services through CRS are Medicaid recipients. CRS care coordinators are working to mitigate potential delays in care due to families not having current Medicaid EPSDT screenings or experiencing a loss of Medicaid coverage. Families in need of updated EPSDT screenings could face long delays due to children making up 66 percent of Alabama's Medicaid population. This could be especially challenging for CYSHCN as they are often seen by specialty providers with a limited number of appointments. Care coordinators are also educating families about the importance of notifying Medicaid of any changes to their contact information to avoid missing important notifications regarding eligibility. All CRS staff members are working to ensure CYSHCN and their families receive the most up-to-date information regarding Medicaid coverage and other impacts related to the PHE ending.

Despite the PHE ending, CRS has worked to permanently implement some of the safety practices implemented during COVID-19. These practices include utilizing screening procedures, managing waiting areas, and limiting the number of individuals that can accompany the child to the clinic. Parents and caregivers provided feedback that these measures increased their confidence in bringing their CYSHCN to CRS offices. Our mission has always been to provide quality clinical services to CYSHCN and their families, and we are continuing to meet their needs.

CRS faced continued challenges in rural areas. The state is largely rural, with greater population concentrations surrounding three larger urban areas (Mobile, Birmingham, and Huntsville). In rural areas, more risk factors exist that could potentially increase the percentage of CYSHCN in the general child population, such as higher poverty levels and lower education levels. According to the U.S. Department of Agriculture Economic Research Service, the poverty rate in rural Alabama is 17.5 percent, compared with 14.1 percent in urban areas of the state, and 17.2 percent of the rural population has not completed high school. In 2019, 21.9 percent of Alabama's children ages 0-17 lived in poverty.

Comprehensively meeting the needs of CYSHCN in rural areas is even more difficult due to transportation barriers and limited access to providers with specialized experience in treating complicated health issues. Specialists and allied health professionals with pediatric experience are mainly located in the larger urban areas, necessitating travel to access them. In general, the state has poor public transportation systems. Although private programs exist in some areas and reimbursement for transportation is provided through various sources (including Medicaid and CRS), the state lacks the infrastructure to meet transportation needs in all locations. Thus, CRS continues to have an integral direct

service role in the state's system of care for CYSHCN through its 14 community-based offices. Via the provision of multidisciplinary medical specialty and evaluation clinics, care coordination, and family support throughout the state, more CYSHCN have access to care in their home communities. Public/private partnerships, including agreements with the state's two tertiary-level pediatric hospitals, enable CRS to bridge gaps in the system of care, thereby increasing the state's capacity to address the health, social, and educational needs of Alabama's CYSHCN.

Health Care Coverage and Healthcare Provider Access

Oral Health

Alabama is on the verge of a dental provider crisis. From the early 1970s until the early 1980s, federal dollars provided a means to enlarge the UAB School of Dentistry and accept more students – about 169 during those 10 years. When funding stopped, and larger numbers of dentists were graduating, the accepted class size was reduced back to the original size of 57 per year. Those excess graduates from the 70s and 80s began to reach retirement age around 2015, leading to a decrease in the number of dentists in the state that Alabama is still experiencing today. Additionally, an increase in the number of out-of-state students has resulted in less retention of graduates in the state.

In 2017, the Alabama Dental Association leadership became aware of an aging dentist workforce in the state, and considering the potential consequences to dental care if this issue wasn't addressed, the American Dental Association Health Policy Institute began to collect and analyze data on practicing dentists in each Alabama county. The findings were concerning and there has been little positive change in the subsequent years.
Alabama’s only dental school is located in Birmingham, which sits in Jefferson County. Many dentists are either leaving the state or staying in Jefferson County. Data from the Board of Dental Examiners of Alabama indicated between the years 1990 to 2014, an average of 25 of 57 (43 percent) graduates per class did not practice in Alabama in 2017. These graduates either no longer had an Alabama dental license or had one but lived out of state. Further, in 2017 there were more dentists in Jefferson County alone (545) than in our 54 non-urban counties (455). The American Dental Association Health Policy Institute reports from 2017 and 2022 revealed the following:

- In 2017 Alabama was last in the country in terms of dentists per 100,000 population with 41 dentists per 100,000. Alabama remains 51st in the country.
- In January 2017, 706 of 2,127 (33 percent) practicing dentists were 60+ years of age and that number increases as the counties become smaller in population and more rural.
- In 2022, there were 150 fewer dentists aged 60+ than in 2017 and there were 75 fewer dentists in the 60-64 age category than in 2017.
- Overall, there was a net loss of 34 dentists from 2017 to 2022. While 29 counties had fewer dentists in 2022 than in 2017, 20 counties gained dentists and 18 counties remained the same.
    - In our smallest 25 counties, 10 of them lost dentists, and in our 13 most urban counties 7 lost dentists.
- Females comprised 23 percent of the state's dentists in 2017, with 80 percent (400 of 499) practicing in the 9 largest counties. Between 2017 and 2022, there was a net loss of 150 male dentists and a net gain of 116 female dentists.
    - There was a net gain of 21 female dentists in our profoundly rural 41 counties and a net loss of 9 male dentists.

Many Alabama counties continue to be at risk of significant loss of dental services in the near future. The following is a list of counties at greatest risk:

- Greene and Clay Counties have no dentist.
- Coosa County has one dentist; That dentist is over 60 years of age and practices 2 days a week.
- Lowndes County has a Federally Qualified Health Center (FQHC) that has rotating dental staff from

neighboring Montgomery County. The clinic is open 4 days per week.

- Perry and Fayette Counties have only 1 dentist, each 50-55 years of age.
- Four counties have 100 percent of their dentists aged 60+ years of age.
- Four counties have between 60-83 percent of their dentists 60+ years of age.
- Five counties have 50 percent of their dentists 60+ years of age.

ADPH Office of Telehealth

The Telehealth Program equips 66 CHDs with telehealth carts that use digital technology to supply medical care, health education, and additional public health services. Collaborating with 15 healthcare agencies, ADPH staff facilitate services such as nephrology, neurology, cardiology, behavioral health, and HIV follow-up. The telehealth equipment is also utilized by ADPH staff for meetings and training events.

The telehealth office manages several grants that provide for the deployment of carts, specialty equipment, and funding for CHD staff to operate the equipment during telehealth appointments. ADPH continues to improve and increase the opportunities to use the telehealth carts by expanding the network of partners and upgrading equipment.

Telehealth Program staff also manage several grants that fund the testing and mitigation of the COVID-19 virus among people who are experiencing homelessness, and the expansion of telehealth throughout Alabama hospitals. Telehealth staff work with special partners to reach patients in rural communities. The office continues to improve and increase the usage opportunities of the telehealth carts by growing its network of partners and equipment upgrades to expand the reach of healthcare access across Alabama.

Primary Care and Rural Health

The Office of Primary Care and Rural Health (OPCRH) administers programs to improve healthcare access and quality in rural and medically underserved communities. As reported in the ADPHs 2022 Annual Report, 63 of Alabama's 67 counties have areas designated as being medically underserved. These underserved areas have a high prevalence of healthcare issues, including chronic diseases such as diabetes, hypertension, heart disease, and other challenges such as a high rate of substance abuse. OPCRH works closely with partners like the Alabama Rural Health Association, AlaHA, Alabama Primary Health Care Association, and departmental bureaus to address these health issues. Some of the major initiatives in OPCRH are the recruitment and retention of healthcare professionals and technical assistance to support 42 small, rural hospitals and health providers in transitioning to a new value-based healthcare system.

OPCRH utilizes a national, web-based recruitment system called National Rural Recruitment and Retention Network to recruit into medically underserved areas. During FY 2022, approximately 2,119 primary care practitioners were referred to rural hospitals and clinics in Alabama. Another recruitment program is the National Health Service Corps (NHSC), which has both scholarship and loan repayment components.

NHSC covers a wide array of health professionals such as physicians, dentists, nurses, and behavioral health professionals. Currently, there are 105 Alabama participants in NHSC. These programs are supplemented by a J-1 Visa Waiver Program, which enables placement of foreign-trained physicians in return for 3 years of service in medically underserved areas. There are 78 healthcare providers delivering medical care to rural and medically underserved Alabamians under the J-1 Visa Waiver Program. OPCRH assists communities in establishing Centers for Medicare and Medicaid services-certified rural health clinics. OPCRH provided technical assistance to 134 rural

health clinics.

OPCRH collaborates with various entities to address workforce issues essential to improving the health of Alabama residents. One such initiative is the partnership with the UAB Heersink School of Medicine - Huntsville Regional Medical Campus to develop a rational service area plan designed to identify workforce shortage areas more accurately for federal designation. These areas determine eligibility for certain federal grants as well as eligibility for NHSC and the J-1 Visa Waiver Program. Alabama's 42 small, rural hospitals are also assisted under federal grants administered by OCPRH which target improvement of operational efficiency, quality, and hospital sustainability.

In 2022, OPCRH worked to update the Health Professional Shortage Area designations. These areas determine eligibility for certain federal grants as well as eligibility for the NHSC Program and the J-1 Visa Waiver Program. Alabama's 42 small, rural hospitals are also assisted under federal grants administered by OCPRH which target improvement of operational efficiency, quality, and hospital sustainability. COVID-19 continued to present many financial and operational challenges to Alabama's rural hospitals, including an unprecedented level of hospital staff turnover. OPCRH works closely with AlaHA to provide relief and support to Alabama's small rural hospitals

III.C. Needs Assessment
FY 2024 Application/FY 2022 Annual Report Update

Needs assessments for Alabama's Title V program are collaboratively conducted by ADPH and ADRS, through FHS and CRS, respectively. An analysis of quantitative and qualitative data gathered through paper and web-based surveys, focus groups, key informant interviews, and from select databases and national surveys yielded a variety of issues for the population health domains. After convening advisory committee meetings, national priority areas and state needs were identified. See the MCH Title V Block Grant to States FY 2021 Application/FY 2019 Annual Report for more details regarding the process, goals, framework, methodology, level, and extent of stakeholder involvement, quantitative and qualitative methods, data sources used, data collection, finalization of priority needs, and development of the State Action Plan for the 5-year comprehensive needs assessment, as originally submitted.

Ongoing Needs Assessment Activities

To address the ongoing needs of the state's maternal and child population, the Alabama Title V MCH Program continually engages stakeholders and assesses changes in population health and emerging issues. Staff and stakeholders continue to develop and implement ESMs and SPMs, along with the activities outlined in the five-year State Action Plan during the FY 2021- 2025 reporting cycle.

ADPH

In FY2022, FHS began engaging in ongoing needs assessment activities to assess changing MCH population demographics, emerging health trends, and shifting program capacities.

The UAB AEAC conducted interviews with district MCH coordinators between May and July 2022. These interviews were intended to learn about staff members' level of understanding of the Title V Program and to gather information about district focus areas and activities; strengths and challenges; perceived MCH needs; and involvement with local partners and the general community. The coordinators identified strengths related to community partnerships, support, and resources, and noted transportation issues, barriers to healthcare access, and health and socioeconomic disparities experienced by rural and low-income populations as challenges. Perceived needs continued to align with priority needs identified for the 2020-2025 cycle. An additional need was identified to develop additional staff training related to Title V and MCH systems approaches. Staff training was developed for FY 2023.

In 2023, the Title V MCH leadership and the UAB AEAC developed and launched an MCH provider survey to gather feedback on progress related to addressing current priority needs and to identify any emerging needs. Survey analysis is in process. A similar family survey is anticipated to be launched in July 2023 and will be distributed through CHDs, social media, and in partnership with a community-based organization that assisted UAB with the 2020 Needs Assessment.

Changes in Title V Measurements

The MCH Epi Branch met with program staff from the Perinatal Health Division, the Child and Adolescent Health Division, OHO, and the Office of Women's Health to discuss the comments received during the Title V Block Grant Review. After these discussions, Alabama inactivated and modified measures due to data-related issues. The changes in measures could be the result of the following:

- Unavailable Data Sources
- Stronger Data Sources Available

- Similar Measures Being Reported

The measures below were inactivated and/or modified:

1. SPM 1-Percent of children who receive a blood lead screening test at age 12 and 24 months of age.
   Reason: After an internal review, SPM 1 and ESM 6.3 were the same. Alabama will continue to report the Medicaid numbers for ESM 6.3. For SPM 1, Alabama has decided to change the Medicaid data source to the Healthy Homes and Lead Positioning Surveillance System (HHLPSS) to better measure provider practice and laboratory reporting in regard to blood testing in children less than 3 years old. With this data source, Alabama can look at the total number of 2-year-old children who received a lead screening at both their 12 and 24-month follow-up visits. With this new data source, children with private health insurance or self-pay would also be included in this analysis. A new measure SPM 9 was added to replace this measure.

2. SPM 6-Percent of staff trained at daycare providers/centers on CPR/First Aid.
   Reason: The denominator was the total number of staff trained at daycare facilities. Alabama had to inactivate this measure due to the denominator no longer being captured.

3. ESM 1.1: Proportion of women aged 15-55 who report receiving a preventive medical visit in the past 12 months by increasing total enrollment percentage in the Well Woman Program by 2 points annually.
   Reason: The data source for this measure was originally looking at the BRFSS statewide number of completed preventive medical visits. The problem with this data source is that the Well Woman Program is only active within 9 counties. After meeting with the program staff, it was decided to change this measure to look at ways to increase Well Woman enrollment among FP participants. Well Woman has partnered with 211KNOW so participants can receive text messages on the importance of heart health.

4. ESM 5.1: Number of sleep-related deaths
   SPM 8: Decrease the number of infants dying from sudden infant death syndrome (SIDS).
   Reason: The Perinatal Division staff has decided to inactivate both measures due to being similar to the National Outcome Measure 9.5. Moving forward, the Perinatal Division will focus its efforts on strengthening hospital partnerships so the LOCATe and Perinatal Regionalization will be effective in reducing infant mortality within Alabama.

5. ESM 6.1: Proportion of children birth to age 19 that received a well child appointment in the past year.
   Reason: In past reports, the numerator for this measure only looks at the total number of EPSDTs provided within seven counties. The denominator looks at the statewide number of EPSDT screenings completed. Due to this limitation, the denominator needed to be changed to look at only children within this age group who visited any of the seven CHDs. ESM 6.4 was created to replace this measure.

6. ESM 6.2: Proportion of children birth to age 19 that received a developmental screening in conjunction with a well-child appointment in the past year
   Reason: After internal discussion, Help Me Grow only provides developmental screenings for only children up to 5 years old. In the past, the denominator included all children from birth to age 19. This may not be an accurate method to showcase the reach of services provided to this population.

7. ESM 10.1: Proportion of adolescents, aged 12 to 19, that received an adolescent well visit in the past year.
   Reason: Alabama originally used the National Survey of Child Health to determine the total number of adolescents aged 12 to 19 who completed an adolescent well visit that occurred with the CHDs. One

limitation of this data source is that the survey data does not include those between the ages of 18 and 19. After an internal review, Medicaid data will be used as the new data source to determine who received a well visit among adolescents within the 12 to 19 years age group. Utilization of this data source will help better link the efforts made by Well Woman, FP, and the Adolescent Pregnancy Prevention Programs to encourage this population to complete a well visit.

CRS

CRS engages in ongoing needs assessment activities to assess emerging needs, changing conditions, and system capacity. As part of the 2021-2025 Five-Year State Action Plan, CRS is soliciting feedback and seeking input regarding our transition and care coordination services. The UAB AEAC administers the annual surveys and analyzes the survey data. CRS values public input from individuals with lived experience and seeks input from families and youth on an ongoing basis through the State Parent Advisory Committee (SPAC), Local Parent Advisory Committees (LPAC), and Youth Advisory Committee (YAC). CRS also holds an annual Hemophilia Advisory Committee meeting to seek input into programmatic and policy issues related to the Alabama Hemophilia Program administered by CRS. Information collected during the various advisory committee meetings allows CRS leadership to continually assess the health needs of CYSHCN and the system capacity to address these needs. Additional efforts to solicit ongoing feedback include a series of staff and community partner surveys around access to services. These surveys are being administered and analyzed by UAB. Customer satisfaction cards are also being administered in some CRS offices to obtain feedback related to clinic operations.

Health Status and Needs of the MCH Population

Children with Special Health Care Needs

Per the 2020-2021 National Survey of Children's Health (NSCH) data, Alabama is trending better in the transition indicator than nationwide. The 2020-2021 NSCH data indicated 22.5 percent of YSHCN in Alabama receive the services necessary for transition to adult health care compared to 20.5 percent nationwide. The state and nationwide indicators are down from the 2019-2020 NSCH data which indicated 27.9 percent of YSHCN in Alabama received the services necessary for transition to adult health care compared to 22.5 percent nationwide.

Per 2020-2021 NSCH data, Alabama is trending better in the medical home indicator than nationwide. The 2020-2021 NSCH data indicated 47.3 percent of CSHCN have a medical home compared to 42.0 percent nationwide. The same indicator for 2019-2020 NSCH data indicated 42.9 percent of Alabama CSHCN had a medical home compared to 42.2 percent nationwide. Despite NPM 11 not being selected for the 2021-2025 five-year State Action Plan, CRS continues educating CYSHCN and their families on the benefits of a medical home through activities outlined in our SPMs.

Per 2020-2021 NSCH data, Alabama is trending better than the nationwide percentage in CSHCN receiving care in a well-functioning system at 17.6 percent compared to 13.7 percent nationwide.

Title V Program Capacity Organizational Structure

ADPH

Please see the **MCH Title V Block Grant to States FY 2021 Application/FY 2019 Annual Report** for more details regarding "ADPH's Organizational Structure" and "ADRS' Organizational Structure" for the 5-year assessment of needs, as originally submitted. Current organizational charts for ADPH, FHS, ADRS, and CRS are attached to this document.

Agency Capacity

Please see the **MCH Title V Block Grant to States FY 2021 Application/FY 2019 Annual Report** for more details regarding "ADPH Program Capacity" and "CRS Program Capacity" for the 5-year assessment of needs, as originally submitted. Following are updates reflecting changes that have occurred since the original submission.

ADPH Program Capacity

As part of the MCH Title V transformation, ADPH has moved to a more collaborative model for delivering Title V services. Title V staff have developed structures and processes to facilitate collaboration between state and county offices. These processes necessitate that state and CHD staff work together to design strategies and plans to improve community health. Resources have always been allocated to the CHDs where we know services were delivered to those in great need; however, the newer processes ensure the appropriate partners are involved as we assess the communities' needs and develop programs to improve the health of the local populations. Within the Title V MCH leadership team, there are four divisions and offices that develop and deliver programs and services to the MCH population, 1) the State Perinatal Division 2) the Office of Women's Health 3) the Child & Adolescent Health Division, and 4) OHO. The division and office directors along with the MCH coordinator lead the implementation and evaluation of the Title V strategies across the state, including the management of county MCH projects led by the district MCH coordinators located in six ADPH public health districts.

CRS Program Capacity

The Alabama Title V CSHCN Program ensures the capacity to promote and protect the health of CSHCN in our state. CRS' mission embodies the principles of comprehensive, community-based, and family-centered care. The mission of CRS is to enable children and youth with special health care needs and adults with hemophilia to achieve their maximum potential within a community-based, culturally competent, family-centered, comprehensive, coordinated system of services. Coordinated health services are delivered via 14 community-based offices across 7 districts. CRS staff are not restricted by district boundaries in the delivery of services and 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. CRS offices are co-located with EI and VRS in most locations, which facilitates service coordination and smoother transitions for CYSHCN.

CRS continues to operate seven programs to serve CYSHCN and their families. Services provided in each of these programs are funded in full or in part by Title V funds. The seven programs are Clinical Medical, Clinical Evaluation, Hemophilia, Care Coordination, Information and Referral, Parent Connection, and Youth Connection.

MCH Workforce Capacity

Please see the MCH Title V Block Grant to States FY 2022 Application/FY 2020 Annual Report for more details regarding "ADPH's MCH Workforce Development and Capacity" and "CRS Workforce Development and Capacity" for the 5-year assessment of needs, as originally submitted. The following are updates reflecting changes that have occurred since the original submission.

FHS

There have been major changes in FHS' program capacity with several positions vacant or experiencing high turnover. There have been four Title V directors in 4 years and three MCH Epi Branch directors in 3 years, with one only in position for 6 months. Since May 2022, Tommy Johnson, DMD, State Dental Director has served as the

acting MCH Title V director. Dr. Johnson previously served as FHS' acting deputy director from June 2021 through December 2021 and Acting bureau director from Dec 2021 through March 2022.

OHO was without a fluoridation coordinator starting in FY 2021 and continuing into FY 2022. This vacancy impacted the fluoridation grant process as well as water plant site visits. Mallory Rigsby joined OHO as the fluoridation coordinator on April 1, 2022. She has been an ADPH employee since December 2010. Ms. Rigsby has prior state experience in childhood lead poisoning prevention, tobacco cessation, and Food and Drug Administration (FDA) tobacco inspections. Academic credentials include an undergraduate degree in healthcare management.

Carolyn Miller was appointed as the director of the State Perinatal Division on October 16, 2021, and the director of the Office of Women's Health on May 1, 2022. Before that, she was the FHS social work director. Katrina Cuffey joined ADPH as the infant mortality prevention coordinator on September 1, 2022. She has worked for ADPH since 2019, starting as a staff nurse in rural CHDs. Ms. Cuffey's background includes 7 years of nursing experience in various practice settings as well as 8 years of teaching experience. Academic credentials include two bachelor's degrees and a graduate degree in education.

ADPH cost center data provided by ADPH's Bureau of Financial Services was used to estimate the number of ADPH FTEs devoted to serving Title V populations. FTEs reported here are not limited to those paid for by Title V, because funds from other sources also assist in paying for services to Title V populations. Excluding WIC cost centers, 354.38 FTEs served Title V populations in FY 2022. The positions accounting for 5 percent or more of the total non-WIC FTEs serving Title V populations were aides (5.3 percent), social workers (6.2 percent), nurses (32.1 percent), and nurse practitioners/midwives (9.16 percent), and mobile employees (9.41 percent). In FY 2022, 183.61 FTEs were devoted to WIC, increasing by 15.1 percent (or 27.68 FTEs) since FY 2021. In FY 2022, 1.25 FTEs were devoted to SSDI.

CRS

CRS has experienced several staff changes at the State Office. The clinic operations specialist position has been vacant since the beginning of FY 2023. CRS has faced many challenges in filling this position due to the changing nature of the workforce. As a result of COVID-19, many federal and private sector employers began offering more remote work options and other flexibilities currently not available in Alabama state government. An additional barrier is the location of the position. Several current CRS employees inquired about the position but ultimately did not want to uproot their families to relocate. The duties of this position have been temporarily reassigned to other state office specialists to ensure the continuation of services.

The Care Coordination Program specialist that started in April 2022 returned to her previously held position in August 2022 leaving the position vacant. Effective November 1, 2022, Kristin Moore accepted the Care Coordination Program specialist position. Ms. Moore has 12 years of social work experience. She began working for CRS in 2016 and most recently served as a social work specialist in the Montgomery CRS office. Her academic credentials include an undergraduate degree in psychology and a graduate degree in social work.

In addition, Ms. Susan Colburn who served as the state parent consultant (SPC) for over 26 years retired effective July 1, 2022. Ms. Colburn tirelessly advocated for policy change to improve the system of care, promoted a culture of family-centered care, and instilled the value of family engagement in all staff. CRS is currently recruiting a new SPC.

Data provided by the ADRS Personnel and Human Resources Division was used to provide the number of CRS FTEs devoted to serving CYSHCN. FTEs reported here are not limited to those paid for by Title V, because funds from other sources also assist in paying for services to CYSHCN.

As of April 2023, 194 FTEs are in the field: 7 district supervisors, 1 custodian, 46 administrative support assistants (ASAs), 48 social workers, 33 nurses, 16 rehabilitation assistants, 5 nutritionists, 11 audiologists, 10 physical therapists (PT), 9 SLPs, 5 occupational therapists (OT), and 3 rehabilitation counselors.

As of April 2023, 13 FTEs are at the State Office: 9 administrative and 4 clerical staff. Administrative staff includes 1 assistant commissioner, 1 assistant director, 1 health services administrator, 1 SLP, 1 audiologist, 1 nurse, 1 social worker, and 2 patient account managers.

CRS currently has 28 budgeted vacancies: 10 ASAs, 8 social workers, 3 nutritionists, 2 nurses, 1 epidemiologist, 1 rehabilitation specialist, 1 OT, 1 SLP, and 1 rehabilitation assistant.

Through a contract with Easter Seals of Central Alabama, CRS has on staff 10 parents of CYSHCN. As of April 2023, there is one part-time regional parent consultant (RPC), and nine part-time local parent consultants (LPCs). The SPC is based in CRS' State Office. The RPC and LPCs are based in their local CRS office. Currently, there is 1 SPC and two vacant LPC positions. See section III.E.2.b.ii. Family Partnership for additional information on these positions.

CRS also employs 2 part-time youth consultants (YCs) at the State Office under the Easter Seals contract. One of the YC positions is currently vacant.

Click on the links below to view the previous years' needs assessment narrative content:

2023 Application/2021 Annual Report – Needs Assessment Update

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$11,411,388	$11,482,727	$11,401,820	$11,482,727
State Funds	$27,113,028	$32,350,502	$24,722,324	$29,057,206
Local Funds	$0	$0	$0	$0
Other Funds	$1,536,572	$1,116,526	$1,571,751	$889,343
Program Funds	$32,697,532	$26,818,653	$32,132,060	$29,643,264
SubTotal	$72,758,520	$71,768,408	$69,827,955	$71,072,540
Other Federal Funds	$136,326,832	$124,110,692	$131,634,427	$113,668,064
Total	$209,085,352	$195,879,100	$201,462,382	$184,740,604

	2022		2023	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$11,482,727	$11,684,723	$11,523,951	
State Funds	$31,724,878	$38,348,573	$28,435,542	
Local Funds	$0	$0	$0	
Other Funds	$1,566,690	$892,986	$1,566,177	
Program Funds	$26,066,122	$29,024,019	$34,032,841	
SubTotal	$70,840,417	$79,950,301	$75,558,511	
Other Federal Funds	$123,892,360	$116,939,135	$113,526,397	
Total	$194,732,777	$196,889,436	$189,084,908	

	2024	
	Budgeted	Expended
Federal Allocation	$11,684,723	
State Funds	$37,841,184	
Local Funds	$0	
Other Funds	$1,577,948	
Program Funds	$33,881,586	
SubTotal	$84,985,441	
Other Federal Funds	$116,251,504	
Total	$201,236,945	

III.D.1. Expenditures

ADPH

As per Block Grant requirements, the budget for each reporting year was set two years' prior in the application (i.e., FY 2022 budget was set in the FY 2020 Annual Report). Over time, actual expenditures appear to give a more accurate reflection of costs expected instead of making estimates for a future budget environment two years out.

/2024/ The Alabama Medicaid Agency has implemented a Medicaid delivery system, The Alabama Coordinated Health Network (ACHN) with the purpose of providing for a flexible and more cost-efficient case management program structure. The new delivery system ended the department's ability to provide case management with family planning patients (FP). Fortunately, there were no impacts to care coordinator with the EPSDT and newborn hearing/screening programs due to this new system. Although the COVID-19 pandemic drastically altered FP service delivery models across the country, the pandemic also presented ADPH an opportunity that not only allowed uninterrupted statewide patient access to essential FP services, but also demonstrated the program's capacity for expansion into a new service delivery model. The ADPH continues to provide care coordination services to children identified with an abnormal Newborn Screening, Newborn Hearing Screening, and an elevated lead level.

The state should document and explain how the reported expenditures comply with the 30%-30%-10% requirements, as specified in Section 504(d) and Section 505(a)(3).

Alabama Maternal and Child Health Services Title V Block Grant has met the 30%-30%-10% requirement as specified in Section 504(d) and Section 505(a)(3). As indicated in Form 2, all MCH cost centers spending on Preventive and Primary Care for Children was 45.84%; transfer to Children's Rehabilitation Services met the federally required minimum of 30% of the Block Grant; and the administrative cost capped at 10%.

In addition, states should reflect on the number/percent of the MCH population who are served by Title V, as reported on Form 5, and provide a description of the state's efforts to expand its reach. Challenges faced by the state should be noted and addressed.

The Alabama Department of Public Health (ADPH) is currently attempting to provide a more complete report of persons served by Title V entities to better capture the full "reach" of the MCH Population. As an example, ADPH has sought to include estimates of educational programs and training in this effort. To better link the provision of services with the funding, ADPH is working to institute a cost accounting system which will allow for the tracking of funds by both population domain and level of the MCH service pyramid. See Form 5 for additional details on how the Alabama Title V program has sought to provide a more complete reporting of individuals served.

The state should describe how service supported by the MCH Block Grant reflect services that were not covered or reimbursed through the Medicaid program or another provider.

ADPH has only one program that is jointly funded by MCH and Medicaid through a Memorandum of Agreement (MOU). Medicaid agrees to reimburse ADPH for their proportionate share of the Fetal Infant Mortality Review (FIMR) Program services. Medicaid is billed on a quarterly basis for FIMR services based upon an agreed cost-basis capitated rate.

For a description of the FIMR project, refer to the Perinatal/Infant Health Annual narrative.

Form 2: MCH Budget/Expenditures Details

Line 1. (Federal Allocation) – FY 2022 Annual Report Expended amount of $11,684,723 was more than the FY 2020-2022 Application Budgeted Grant Award of $11,482,727, an increase of $201k or 1.759%. The final federal allocation for FY 2022 of $11,684,723 (6 B04MC45196-01-07) was received on 07/12/2022.

Line 3. (State MCH Funds) - FY 2022 Annual Report Expended increased to $38.3m from the FY 2020-2022 Application Budgeted amount of $31.7m, a difference of $6.6m or 20.9%. The State Match increase resulted from a combination of factors: (1) support income rising to $40.7m compared to $34.5m budgeted for FY 2022, a $6.2m difference; and (2) increase in actual expenditures for FY 2022 to $66.0m compared to the budget for FY 22 of $54.0m, a difference of $12.0m. The net differences of these two factors indicate that expenditures increased at a

higher rate than income which requires a higher match contribution by ADPH of approximately $6m. CRS share of the change in State Match is $831k or 6.8%.

Line 5. (Other Funds) – CRS FY 2022 Annual Report Expended was $892k which is a decrease from the FY 2020-2022 Application Budget reported at $1.57m, a decrease of $673k or -43%. See CRS explanation for Form 2.

Line 6. (Program Income) – FY 2022 Annual Report Expended amount of $29.0m increased from the FY 2020-2022 Application Budget of $26.0m, an increase $3.0m or 11.35%. Three programs that showed substantial increases in FY 2022 was not reflected in the projected budget: Family Planning Medicaid ($1.8m), EPSDT Care Coordination ($821k) and Department of Human Resources ($639k). The FY 2022 budget was built during a period of changing operations and anticipated lost in revenue from Medicaid's ACHN networks providing services. ADPH program income increased more than the expected projection.

Form 2 (+/- 10% Variance)				
MCH	Budget	Expended		+/-10%
Bud/Expenditure Details	FY 2022	FY 2022	Difference	Variance
Preventive/Primary Care for Children	$5,793,036	5,355,859	-$437,176	-7.55%
State MCH Funds	31,724,878	38,348,573	6,623,694	20.88%
Other Funds (CRS)	1,566,690	892,986	-673,704	-43.00%
Program Income	26,066,122	29,024,019	2,957,897	11.35%
Totals	**$65,150,726**	**$73,621,437**	**$8,470,711**	**13.00%**

Line 9. (Other Federal Funds) – Programs with significant dollar differences comparing FY 2022 Budget versus FY 2022 actual expended.

Early Head Start Program - FY 2022 Annual Report Expended of $878k decreased from the FY 2020-2022 Application Budget amount of $995k, a difference of $117k or -11.76%. The majority of changes were made to personnel costs with higher paid long-term employees leaving the program being replaced by entry level hires ($54k), also, an error in calculating indirect cost charged to the program ($35k) which was reflected in FY 2022 lower costs.

Abstinence Education Program – FY 2022 Annual Report Expended of $784k decreased from the FY 2020-2022 Application Budget amount of $887k, a difference of $103k or -11.68%. At the time of the FY 2020-2022 there were six sub-grantees providing programming services and in FY 2022 only four sub-grantees were providing services net change in cost ($94k). COVID 19 pandemic limited sub-grantees in providing services.

Personal Responsibility Education Program (PREP) – FY 2022 Annual Report Expended of $527k increased from the FY 2020-2022 Application Budget amount of $380k, a difference of $146k or 38.55**%.** Most of the difference in FY 2022, is increased expenditures in community projects ($22k) and advertising expenditures ($82k).

Alabama Pregnancy Risk Assessment Monitoring System (PRAMS) – FY 2022 Annual Report Expended of $157k decreased from the FY 2020-2022 Application Budget amount of $179k, a difference of $21k or -11.84%. FY 2022 decreases were in advertising ($16k) and routine supplies ($8k).

State Systems Development Initiative (SSDI) – FY 2022 Annual Report Expended of $169k increased from the FY 2020-2022 Application Budget amount of $115k, a difference of $54k or 47.12%. During FY 2020, the budget was developed when the program was under-staffed due to retirements and filling the positions does not happen quickly. The program is now fully staffed filling the Director and EPI positions.

Well Women Program – FY 2022 Annual Report Expended amount of $1.77m increased from the FY 2020-2022 Application Budget amount of $1.30m, a difference of $472k or 36.32%. The Well Woman program was implemented in January 2017 in three counties: Butler, Dallas, and Wilcox. The program has been expanded and Well Woman is currently offered in twelve counties in Alabama (Barbour, Butler, Dallas, Greene, Hale, Henry, Macon, Marengo, Montgomery, Perry, Russell, and Wilcox). Between implementation and fiscal year 2022, program support and staffing increased to cover the state office and program support in the new counties.

Form 3a: Budget and Expenditure Details by Types of Individuals Served (IA. Federal and IB. Non-Federal MCH Block Grant)

Line 1. (Pregnant Women) – FY 2022 Annual Report Expended amount of $394k decreased from the FY 2020-2022

Application Budget amount of $656k, a difference of $262k or -40%. As reported in the previous applications, Medicaid's Alabama Coordinated Health Network (ACHN) eliminated ADPH care coordination including maternity services. As of 2022, Mobile County Health Department is no longer providing maternity services.

Line 2. (Infants<1 year) – FY 2022 Annual Report Expended of $4.36m decreased from the FY 2022 Application Budgeted amount of $5.77m, a difference of $1.41m or -24.51%. From FY 2020 to FY 2022, infant activity declined by 6,287, a decrease of 53%. As expected, these services have been affected by Medicaid's Alabama Coordinated Health Network (ACHN).

Line 3. (Children 1-22 Years) – FY 2022 Annual Report Expended of $39.7m increased from the FY 2020-2022 Application Budget amount of $30.9m, a difference of $8.8m or 28.6%. FY 2022, the visits for children 1-22 years of age made up 90.1% of net total cost of $43.7m (excluded from cost PW, Infants, CRS, Adm.) which puts the children estimate at $39.4m. In FY 2020, visits were 86.2% based on net total cost of $35.9m which puts children 1-22 at $30.9m. The result is an increase in cost of $8.5m.

Line 5. (All Others - Adm) -- FY 2022 Annual Report Expended amount of $3.74m increased from the FY 2020-2022 Application Budget amount of $1.59m, a difference of $2.15m or 134.8%. In the FY 2020-2022 application, the budget was set at $1.59m, however, an error occurred when CRS payment was subtracted from administration cost report, as a result, the budget for FY 2020 was understated by $1.7m. The number that should have been reported for the FY 2020-2022 budget is $3.41m which would make the correct increase $331k or 9.72%. This increase can be attributed to rising costs associated with three cost-of-living raises totaling 8%.

Form 3a (+/- 10% Variance)

Individuals Served	Budget FY 2022	Expended FY 2022	Difference	+/-10% Variance
Pregnant Women	$856,613	$393,942	-$262,671	-40.00%
Infants< 1 Year	5,771,886	4,357,323	-1,414,564	-24.51%
Children 1-22 Years	30,898,294	39,741,255	8,842,961	28.62%
CSHCN	31,920,718	31,717,888	-202,830	-0.64%
All Others	1,592,907	3,739,893	2,146,985	134.78%
Totals	**$70,840,418**	**$79,950,300**	**$9,109,882**	**12.86%**

Form 3b: Budget and Expenditure Details by Types of Services (II A. Federal and II B. Non-Federal MCH Block Grant)

Line 2. (Enabling Services) - FY 2022 Annual Report Expended amount of $13.2m increased from the FY 2020-2022 Application Budgeted amount of $3.85m, a difference of $9.31m or 241.6%. ADPH's share of the increase in cost is $5.84m and the remaining $3.47m is CRS. In October 2021 to get a more complete picture of cost Family Planning (FP) cost center 021 was replaced by four new cost centers. One of which was Enabling Services FP Referrals ($3.62m), others added were FP Community Health Advisor ($741k) and FP Recruit Waiver ($18k). Also, added was Newborn Hearing Screening (NBHS) Case Management ($1.18m) which not previously in this category. CRS Enabling Services increased from $2.39m to $5.86m, a difference of $3.47m. See CRS explanation for Form 3b. //2024//

Form 3b (+/- 10% Variance)

Individuals Served	Budget FY 2022	Expended FY 2022	Difference	+/-10% Variance
Direct Services	$36,055,773	$38,456,514	$2,400,740	6.66%
Enabling Services	3,854,064	13,166,195	9,312,131	241.62%
Public Health Services	30,930,579	28,327,591	-2,602,987	-8.42%
Totals	**$70,840,416**	**$79,950,300**	**$9,109,884**	**12.86%**

CRS

//2024// As per Block Grant requirements, the budget for each reporting year is set two years' prior in the application (i.e., FY 2022 budget was set in the FY 2020 Annual Report). CRS bases the budget on expenditures for the preceding FY and the CRS legislative budget request at that time. This methodology does not allow for modification later based upon third party reimbursement trends or for comparison to the actual operations plan for that FY. The agency's

operations plan is built after final funding levels are set. It is a more accurate reflection of the agency's budget since it is the actual budget as opposed to a budget request. Therefore, the expenditures presented in the forms are more accurate than the estimates represented by the budgeted amounts.

Form 2: MCH Budget/Expenditures Details

Line 5. (Other Funds) – CRS FY 2022 Annual Report Expended amount of $892k decreased from the FY 2022 Application Budgeted amount of 1.5m, a difference of $673k or 43 percent. This decrease is a result of CRS expending less from the Hemophilia State Allocation due to an increase in the number of hemophilia clients with insurance coverage.

Form 2 (+/- 10% Variance)				
MCH	Budget	Expended		+/-10%
Bud/Expenditure Details	FY 2022	FY 2022	Difference	Variance
State MCH Funds	$12,209,205	$13,040,157	$830,952	6.81%
Other Funds	1,566,690	892,986	-673,704	-43.00%
Program Income	14,673,805	14,248,277	-425,528	-2.90%
Totals	$28,449,700	$28,181,419	-$268,281	-0.94%

Form 3b: Budget and Expenditure Details by Types of Services (II A. Federal and II B. Non-Federal MCH Block Grant)

To ensure accurate reporting of expenditures CRS staff met with ADRS accounting staff in FY 2022 to review the Title V Maternal and Child Health Services Block Grant to States Program Guidance and Forms and the Appendix of Supporting Documents. Upon review and discussion, it was determined that the previously used methodology was outdated.

Using new methodology and a greater understanding of the three levels of service it was determined that non-federal funds previously reported in Public Health Services and Systems on Form 3b Non-Federal MCH Block Grant should be allotted to direct services. CRS, as the Alabama CSHCN program, provides clinical medical and evaluation services to children and youth with special health care needs in the state and as such allots funds to provide these services. It was also determined that CRS care coordination activities should be reported in Enabling Services. These activities had previously been reported between Direct and Public Health Services and Systems. Given that the budget is set two years prior the FY 2022 expenditures are being compared to the budget created under the old methodology accounting for the differences. //2024//

III.D.2. Budget

ADPH

/2024/ Alabama remains one of the nation's only states that separates general government and education funding into two separate budgets: the General Fund and the Education Trust Fund (ETF). The $3.0 billion State General Fund passed is $50.1 million more than FY 2023. The General Fund budget will allocate $3 billion for non-education state programs, such as Medicaid, prisons, courts, law enforcement, mental health, public health, and others. The budget is 6 percent higher than FY 2023. Alabama's record-setting General Fund is generational money which makes possible greater investments in vital public services.

Most agencies would receive about the same amount as the current year. These agencies would receive budget increases: Medicaid by 9 percent increase, the Alabama Department of Corrections by 10 percent, and the Alabama Department of Mental Health by 8 percent. ADPH will receive $53 million which is $5.9 million more than the previous year.

In FY 2023, Alabama's Title V MCH Program received $11,684,723 and will be budgeted at this level for the FY 2024 application. The Title X FP Program was level funded for FY 2024 receiving $5,549,220.

Medicaid has implemented a delivery system that provides for a flexible and more cost-efficient case management program structure. The ACHN previously known as "Pivot Entities," is an innovative plan to transform health care provided to Medicaid recipients in Alabama. The program is designed to create a single care coordination delivery system that effectively links patients, providers, and community resources in each of the seven newly defined regions. Delivery of medical services is not part of this program. The ACHNs were implemented on October 1, 2019, but did not begin providing services until November 1, 2019.

The Patient 1st and Plan First case management programs ended on September 30, 2019. ADPH continues to provide care coordination services to children identified with an abnormal NBS, NBHS, or an elevated BLL.

As a safety net provider for the citizens of Alabama, ADPH facilitated a centralized statewide referral system for all providers including CoA. The electronic referral system saved taxpayer money by identifying children that were non-compliant with prescribed treatment plans. ADPH's seamless referral process was discontinued with the ACHN implementation.

FP provides access to quality family planning and related health services, giving priority to Alabama's low-income population in 81 service sites statewide. Services are provided to both females and males in a confidential manner. Examples of services provided through FP are physical exams including a medical history, Pap smear, clinical breast exam, and height, weight, and blood pressure check; counseling and education on all contraceptive methods; testing for pregnancy, HIV, and STD; issuing birth control supplies; counseling on pre-conception (planning your pregnancy); substance abuse and domestic violence screenings; and providing care coordination and referral services. During CY 2022, a total of 99,711 FP visits were completed. This is a slight increase from the previous CY.

Although the COVID-19 pandemic drastically altered FP service delivery models across the country, the pandemic also presented ADPH an opportunity that not only allowed uninterrupted statewide patient access to essential FP services but also demonstrated the program's capacity for expansion into a new service delivery model. Medicaid's approval of telehealth FP visits for Medicaid recipients, on a month-to-month basis since March 2020, facilitated ADPH's implementation of FP visits by telephone. Through telephone visits and subsequent curbside pick-up of

contraceptive supplies, ADPH nurse practitioners provided continuity of care and met essential FP needs of low-income patients across the state. During CY 2022, a total of 2,400 telehealth visits were completed.

The PHE formally ended on May 11, 2023. The parameters for the telehealth visits have been updated to reflect a video requirement, which is not currently in department protocol. ADPH providers were informed of this update and subsequently, telehealth services were suspended on May 31, 2023. The department is reviewing the ability to provide telehealth visits within the electronic health record at a future date. Costs and sustainability will be factors in the determination process.

In 2019, FP physicians began providing colposcopy services, traveling to selected CHDs on a rotating schedule, to facilitate easier access for patients within surrounding multi-county geographic areas. The addition and expansion of this critical procedure greatly facilitate continuity of care for patients who require follow-up of abnormal cervical cancer screening results. In early CY 2022, the limited protocol was updated to allow the program's six nurse practitioner seniors to also provide colposcopies. As a result, 592 colposcopies were completed during CY 2022 with 142 pre-invasive or invasive cervical cancers detected.

Despite event cancellations caused by COVID-19, social workers reported many successful outreach encounters, which included public speaking opportunities and disseminating FP messaging in the context of the Community Health Advisory (CHA) Initiative launched in 2019. By developing comprehensive educational campaigns, collaborating with community-based organizations for events in which they served as both event organizers and/or speakers, and tabling participation at numerous community events within their respective multi-county areas, staff were able to extend their reach into local communities. During the 2022 CY, FP social workers provided case management for 4,706 ADPH patients.

ADPH is continuing to feel the impacts of level funding with the FP grant. In late CY 2021, the department approved across-the-board pay scale increases for all nurses. Nursing staff play a major role in providing FP services at the state and clinic levels. Additionally, the legislature has continued to approve much-appreciated cost of living adjustments (COLA) for all merit employees. To offset some of these costs, the department is providing state funds to cover salaries for all FP administrative staff. Also due to level funding, the decision was made to discontinue the CHA Initiative.

A state should present a plan that describes how federal and non-federal Title V funds will be used to address the state's priority needs, improve performance related to the targeted MCH outcomes and expand its systems of care for both the MCH and CSHCN populations.

For more information on the domains, refer to Section III, where you will find the State Action Plan Narrative by Domain.

The budget narrative should highlight the State's MCH/CSHCN program and align with the identified MCH/CSHCN priorities. This discussion should clearly articulate how federal and non-federal MCH Block Grant funds will support the activities that are described in the State Action Plan for the upcoming budget period.

For more information on the domains, refer to Section III, where you will find the State Action Plan Narrative by Domain.

This discussion should include how MCH Block Grant funds support essential services, as defined by the

Title V MCH Services Block Grant Pyramid (Figure 1), for the three legislatively defined populations. The narrative discussion should provide an explanation of how the planned funding will support the budget estimates for individuals served and types of services provided, as reported on Form 3a and Form 3b.

The MCH Block Grant is a critical financial piece of support, along with other federal programs, and state support for ADPH programs that appear in the three defined populations: direct, enabling, and population-based services. Without these funding sources, services would be severely limited for individuals served and the types of service provided in Form 3a and Form 3b. In planning, sources of funding are adjusted for known or anticipated changes in the healthcare environment (i.e., Medicaid changes to ACHN provider services).

The cost accounting system of ADPH is a very critical operation. It is the process by which we track the amount of money spent on the services we provide to the public. From that information, reports are generated and made available to our funding sources, such as the federal government. These reports, in turn, are used to help us maintain funding to provide services to the public and to help us obtain additional dollars to improve or begin new services. The MCH cost centers are part of this system which captures the personnel costs and services provided through the MCH Block Grant Program. The current cost system was designed to capture costs but does not provide the type of persons served by Title V.

ADPH is currently attempting to provide a more complete report of persons served by Title V entities to better capture the full “reach” of the MCH Population. As an example, ADPH has sought to include estimates which now include consideration of educational programs and training in this effort. To better link the provision of services with the funding, the ADPH is working to institute a cost accounting system that will allow for the tracking of funds by both population domain and level of the MCH service pyramid. See Form 5 for additional details on how the Alabama Title V Program has sought to provide a more complete reporting of individuals served.

Refer to Section III for more information on the purpose and design of Title V and how funds support state MCH efforts.

The state should describe how it plans to meet and monitor the required match requirements, which includes a $3 match in non-federal funds for every $4 of federal MCH Block Grant funds expended [Section 503(a)] and the maintenance of effort from 1989 [Section 505(a)(4)].

The budget period for MCH funding is 2 years. The match is captured and calculated on the first fiscal year of the budget period. When the final September fiscal year cost report is received, all applicable costs are gathered for the various cost centers associated with the MCH 2-year grant budget period that have been provided to ADPH’s Bureau of Financial Services and the ADPH MCH program administrator. Applicable costs for the grant are calculated. Total expenditures for the MCH grant funds are calculated for the time frame of October 1 thru September 30 of the fiscal year. Total expenditures are subtracted from the total applicable costs to derive the available costs for match. The match requirement is 75 percent of the total MCH expenditures**;** the required match is compared to the amount of the applicable costs available for match to determine if there are excess costs above the required, calculated match amount. If there are excess costs, it is determined that we have met the required match needed for that MCH grant. The match is usually met in the first year's spending of the MCH grant. ADPH historically has excess match available making the calculation of match for the second year unnecessary. //2024//

CRS

/2024/ The State of Alabama CSHCN Program is administered by CRS, a division of ADRS. ADPH contracts with

CRS, to provide services for CSHCN and allocates Title V dollars to CRS for this effort. The ADPH allocated the required 30 percent, approximately $3.4 million to the CSHCN Program in FY 2022. In FY 2022, CRS received a state allocation of $12.2 million, a state allocation for the Alabama Hemophilia Program of $1.2 million, and program income from third-party reimbursements of $14.2 million. CRS received approximately $26,200 from MCHB as a sub-grantee to Hemophilia of Georgia to provide comprehensive care to persons with hemophilia. CRS received $135,000 from Boston University (BU) as a sub-awardee for the CMC Collaborative Improvement and Innovation Network to Advance Care (ColIN). All these funds are utilized to serve CYSHCN.

During FY 2022, CRS expended $558,394 of the $1.2 million state allocation for the Alabama Hemophilia Program. The difference in the budgeted versus expended amount is due to changes in healthcare policy that have resulted in an increase in the number of hemophilia clients with insurance coverage.

For more information on how federal and non-federal Title V funds will be used to address priority needs and support activities for CSHCN described in the State Action Plan for the upcoming budget period refer to Section III.E.2.c., where the State Action Plan Narrative by Domain can be found.

The state should describe how it plans to meet and monitor the required match requirements, which includes a $3 match in non-federal funds for every $4 of federal MCH Block Grant funds expended [Section 503(a)] and the maintenance of effort from 1989 [Section 505(a)(4)].

CRS overmatches its federal dollars through its state allocation. In FY 2022 and FY 2023,
CRS received level funding from the State ETF and General Fund budgets. CRS anticipates receiving level funding from the state for FY 2024 which ensures CRS can continue to meet the match. In FY 2022, in addition to the state allocation to fund services for CYSHCN, the CRS budget included a separate state allocation for the Alabama Hemophilia Program (approximately $1.2 million). //2024//

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Alabama

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

The Alabama Title V MCH Block Grant Program is administered by ADPH through FHS. Funds provided by the Title V Block Grant allow Alabama the opportunity to assure continued improvement in the health, safety, and well-being of pregnant women, infants, children, adolescents, and their families, including fathers and CYSHCN. ADPH provides a subgrant to ADRS to direct programs, services, and activities for the CSHCN population. ADPH Title V funds support staff resources and programming across the Perinatal Health Division, OHO, the Office of Women's Health, the Child and Adolescent Health Division, the Consultants-Pediatric Division, 67 CHDs in 8 Public Health Districts, and other sub-grantees and partner projects.

Like many Title V-funded states, Alabama supports the life course approach to MCH and further operates by providing the 10 essential services under the 3 tiers of the MCH Pyramid of Services.

FHS maintains partnerships with local and state agencies including, but not limited to, Medicaid, DHR, the Department of Mental Health, and local agencies participating in the Healthy Start Initiative. Staff participate in and lead state committees and initiatives, such as the Alabama Opioid Misuse in Women/Neonatal Abstinence Syndrome (OMW/NAS) Taskforce, State Perinatal Advisory Councils, the Oral Health Coalition of Alabama (OHCA), and the State of Alabama Infant Mortality Reduction Plan**,** to ensure consistent collaboration with stakeholders that can help strategically align MCH goals and activities. ADPH convenes partners and funds projects to enact public health policies, plans, and laws, and implement QI projects. These efforts are exemplified through the establishment of the Maternal Mortality Review Program (MMRP) and the continued involvement with the Alabama Perinatal Quality Collaborative (ALPQC). In addition to state and community relationships, ADPH maintains partnerships with federal agencies and receives technical assistance in the MCH transformation from agencies such as the Association of Maternal & Child Health Programs (AMCHP), the Centers for Disease Control and Prevention (CDC), the National MCH Workforce Development Center, and the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD). These national partnerships provide ADPH with evidence-based resources, an opportunity for creative thinking and constructive critique, as well as training that supports staff's work to improve the health status of the MCH population. FHS continues to identify new stakeholders and works toward a collective impact that supports the goals of Title V.

Staff supported by the Title V grant include public health professionals, data analysts, nurses, social workers, medical and dental providers, and financial and administrative personnel. The FHS bureau director and supporting program directors continually assess and monitor the MCH population health status and the implementation of evidence-based strategies to ensure FHS staffing is at an adequate level to meet those needs. Staff are also encouraged to pursue workforce development opportunities. While not funded by Title V funds, the WIC Division, the Cancer Prevention and Control Division, the Family Planning Division, and the Alabama Pregnancy Prevention Branch are located within the same bureau as the Alabama Title V MCH Program. The Alabama Newborn Screening Program was located in FHS until April 16, 2022, when it was reassigned to the Bureau of Clinical Laboratories (BCL). Outside of FHS, Title V staff collaborate with other ADPH bureaus and programs such as the BCL, Office of HIV Prevention and Care, Bureau of Children's Health Insurance, Bureau of Prevention, Promotion, and Support (BPPS), Center for Health Statistics (CHS), and others.

FHS collaborates with stakeholders to leverage program capacity to identify the priority needs of mothers, children, and families across the state and to develop strategies to meet those needs. The UAB AEAC and FHS Title V Program staff meet monthly to coordinate ongoing needs assessments support and assistance with data collection and reporting. Title V MCH programs develop and implement activities and initiatives that address the core functions

of assessment, assurance, and policy development. Program strategies are designed to increase awareness of health status, provide services, and promote behavior change to improve health outcomes among the MCH population. Coordinating strategies are developed for providers working with women, children, including CYSHCN, and families.

ADPH ensures local access to care and investigates emerging health problems by providing direct services through the CHDs. The six public health districts under the umbrella of ADPH receive Title V funding for core staff and infrastructure, which allows them to serve the immediate needs of the MCH population within Alabama's 67 counties. MCHD and JCDH are independent; however, both departments receive sub-awards to support MCH activities.

Through the MCH Transformation and the emphasis on performance and accountability, work continues within the public health districts to address local health needs, national performance measures (NPMs), national outcome measures (NOMs), and the seven evidence-based or -informed strategy measures (ESMs). The district MCH services and programs are coordinated by district MCH coordinators and monitored and assessed by the ADPH MCH coordinator. FHS district staff mobilize community leaders and facilitate partnerships between those leaders, policymakers, health care providers, and community members.

CRS

The State of Alabama CSHCN Program is administered by CRS, a division of ADRS. CRS provides services to CYSHCN and their families through the following programs: Clinical Medical, Clinical Evaluation, Hemophilia, Care Coordination, Information and Referral, Parent Connection, and Youth Connection. The mission of CRS is to enable CYSHCN and adults with hemophilia to achieve their maximum potential within a community-based, culturally competent, family-centered, comprehensive, and coordinated system of services. Coordinated health services are delivered via 14 community-based offices across 7 districts. Family engagement is supported in partnership with FVA and the F2F HIC.

The Title V CSHCN director serves as the Assistant Commissioner of ADRS and the director of CRS. This position reports directly to the ADRS Commissioner. CRS is organized into three levels – state, district, and local. At the state level, administrative staff provide program direction through policy and staff development, program planning and evaluation, data analysis, quality assurance, technical assistance, and fiscal management. The State Office staff are supported by the Title V grant. In addition, CRS contracts with a pediatrician that serves as the CRS medical director. The Medical director provides guidance on medical concerns, participates in policy development and QI initiatives, assists with recruiting specialty physicians, and serves as the pediatrician for the Teen Transition Clinic (TTC) as needed.

Alabama, like many other states, has too few pediatric specialty providers and the problem is much worse in rural areas. To address this issue CRS works with multiple partners through a variety of routes to ensure CYSHCN have access to quality care. For example, in FY 2022, CRS collaborated with the Department of Orthopedics at the University of South Alabama (USA) to address the pending retirement of a physician providing orthopedic services for CRS orthopedic clinics. The continued partnership with USA allowed for an expansion of clinics in rural areas. CRS also finalized an agreement with the Division of Pediatric Rehabilitation Medicine at Children's of Alabama Hospital (COA) that allowed CRS to expand neurology services across the state. The partnership with COA allowed one CRS office to resume neuromotor clinic after a 13-month break in services. These partnerships have allowed CRS to increase clinic frequency and provide expanded coverage ensuring a more comprehensive system of care for CYSHCN and their families. The goal is to improve systems of care and build bridges to connect specialty providers with the families who need these services.

CRS maintains partnerships with local and state agencies to promote family-centered, community-based, well-coordinated care for CYSHCN. Some key partnerships include Medicaid, FVA, UAB SOPH, the Department of Early Childhood Education (DECE), Alabama's EI Program, and VRS. In addition, CRS staff lead and participate in state committees and initiatives, such as the Alabama Child Health Improvement Alliance (ACHIA), Alabama Project LAUNCH Young Child Wellness Council, Alabama Conference of Social Work, State Interagency Transition Team, Oral Health Coalition of Alabama, Alabama Interagency Autism Coordinating Council, and local Children's Policy Councils (CPC). These committees and initiatives promote collaboration among key stakeholders to ensure all Alabama CYSHCN and their families receive quality care.

To further improve care for mothers, infants, and children, Alabama has an MCH Partnership meeting that occurs three times a year and consists of representatives of all of Alabama's Title V-funded programs as well as other MCH-related programs. CRS coordinates the Partnership Spring Meeting which includes scheduling the meeting, securing a speaker, and hosting. CRS State Office specialists represent CRS at all partnership meetings and share updates on services for CYSHCN and their families. Other MCH stakeholders include ADPH, FVA, UAB Pediatric Pulmonary Center, Medicaid, the Gift of Life Foundation, Inc., DECE, and Alabama EI.

As previously mentioned, a key partnership for CRS is CPC. Alabama's CPC is under the coordination of DECE. Each local CPC is chaired by the county's juvenile judge and has members from a diverse cross-section of public and private individuals interested in the general needs of all children and families in the state. The ADRS Commissioner serves as a member of the State CPC, and ADRS staff members participate in local meetings in all 67 counties within the state. Participation in the CPC allows CRS staff to share insight into the unique needs of CYSHCN and raise awareness of the implications that these needs have for resources in a local community.

In addition, ADRS CRS entered into an agreement with UAB SOPH, Department of Health Care Organization and Policy, AEAC to consult and assist with administering the activities outlined in the MCH Block Grant State Action Plan. These activities include survey design, administration, and analysis. CRS and AEAC hold monthly evaluation meetings to work collaboratively on the evaluation components and outcomes. AEAC supports evaluation efforts for multiple state agencies which allows them to assist CRS from a holistic and systems-level perspective.

CRS maintains a national partnership with AMCHP. The ADRS Assistant Commissioner is a member of the CYSHCN Summit/Blueprint for Change Steering Committee. CRS also receives technical assistance from the MCH Evidence Center, AMCHP, National Family Voices, and the National MCH Workforce Development Center. These national partnerships provide CRS with evidence-based resources and technical assistance opportunities to strengthen the administration of the State Action Plan for the CSHCN domain. They also provide an array of training opportunities to ensure staff are equipped to provide quality services to CYSHCN and their families. CRS actively works to identify new stakeholders and partnerships to further improve services for CYSHCN and their families.

Recognizing the importance of delivering quality healthcare services for CYSHCN, the Assistant Commissioner has supported ongoing projects with the National MCH Workforce Development Center. Working with the Center has provided access to subject matter experts and allowed staff to make valuable connections with other states' CSHCN programs. Most recently, CRS was selected to participate in the Population Health Learning Journey. Through participating in the Learning Journey we began working on our long-term aim to improve the system of care in Alabama so that CYSHCN and their families can access the pediatric specialty care they need when they need it. The goal is to reduce unnecessary burdens and inequities for CYSHCN and their families and improve their health outcomes and quality of life. CRS staff and outside partners have been analyzing the current service delivery model to identify opportunities to improve access to services and improve the quality of services provided. It is imperative to include health equity as part of the analysis and incorporate a goal of building an internal capacity to act on the social determinants that impact the health of

Alabama's CYSHCN. This includes identifying barriers CYSHCN and their families face that impact their ability to receive services and recognizing barriers that vary from community to community by culture, geography, financial status, and educational factors.

CRS has incorporated the AMCHP Standards for Systems of Care for Children and Youth with Special Health Care Needs in the development of the activities in the State Action Plan for the CSHCN domain. Specifically, the standards are being used to strengthen the existing Care Coordination Program and address the transition process. The standards are the foundation for the CRS Care Coordination Family Survey and ensure care coordination is patient-and-family centered, assessment-driven, and a team-based activity designed to meet the needs of children and youth while enhancing the caregiving capabilities of families. CRS is working to ensure PoCs are jointly developed, shared, and implemented among CYSHCN and their family, primary care provider, and/or the specialist serving as the principal coordinating physician, and members of the health care team. CRS has built its transition program around Got Transition's Six Core Elements of Health Care Transition™ framework. In accordance with the standards, CRS is implementing a system to elicit feedback on the transition process.

CRS is an active participant in policy development related to CYSHCN. This activity involves many of the partners previously discussed. In addition, the ADRS Assistant Commissioner serves as a member of the National Academy for State Health Policy (NASHP) Executive Advisory Committee. In this role, she co-chairs the Child and Family Health Committee. This committee's focus is on positively impacting health policy on a national and state level. Serving as a member allows input into topics for the NASHP Annual Conference. Topics currently being considered include children's mental health, perinatal health, systems of care of children with medical complexity (CMC), and prevention services in child welfare.

All the previously described partnerships and efforts assist CRS in administering the strategies outlined in the 2021-2025 MCH Block Grant State Action Plan. Coordination, collaboration, and partnerships are key to ensuring CYSHCN and their families have access to care that improves their overall quality of life. CRS staff at all levels continue to collaborate with current partners and seek to identify new partners.

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

III.E.2.b.i. MCH Workforce Development

ADPH

ADPH's Workforce Development (WFD) Program is coordinated by the Office of Management Support (OMS) in BPPS. OMS also provides oversight for Public Health Accreditation, Strategic Planning, Performance Management, and QI. The WFD program offers training and initiatives designed to help departmental employees develop personally and professionally. These opportunities result in employees that are capable of delivering high-quality public health services. The WFD Program goal is to use strategic planning to assure a competent public health workforce and to anticipate and prepare the workforce for changes in public health practice through the development of appropriate training programs and opportunities. Through WFD, staff training is offered on a continuous basis by the department and partners such as the State Personnel Department. In 2022, three new soft skills training courses were developed based on training gaps identified through an internal needs assessment survey. The courses, "Dealing with Difficult People," "Customer Service and Communication Skills," and "How to Work with a Multigenerational Workforce," were made available to staff across the state. A total of 49 soft skills training sessions and 52 supervisory training classes were held in 2022 with 1,764 participants. To recruit and retain a highly skilled workforce, the department supports hosting student interns enrolled in educational institutions around the state. Through the internship program, individuals are offered an opportunity to make a positive contribution and to develop professional skills and experience. The internship experience offers an opportunity for students to learn about the role and responsibility of public health, earn educational credits, gain valuable work experience, and explore new careers in public health. The department works with various educational institutions to provide non-clinical internship placements throughout the state public health system. Through a partnership agreement with UAB SOPH, the department hosts several graduate student interns each year.

Outside of state-sponsored development, employees seek opportunities available through national partnerships, such as AMCHP's MCH Epi Peer-to-Peer Cohort and the Council of State and Territorial Epidemiologists Mentorship Program. Regarding recruitment and retention, ADPH partners with various colleges and universities within the state to host current students in nursing, public health epidemiology, and other disciplines. These partnerships provide ADPH with the opportunity to recruit and retain a highly skilled workforce. Through the internship program, individuals are offered an opportunity to make a positive contribution and to develop professional skills and experience.

Alabama Tile V leadership continues to seek guidance and assistance from the National MCH Workforce Development Center and apply for training opportunities presented by the Center, AMCHP, HRSA, and other state and federal partners to ensure our workforce has the knowledge and tools necessary for effective program planning and implementation. Addressing equity was identified as a need during the 2020 needs assessment cycle. Tile V leadership continues to pursue and coordinate equity-focused training for all staff supported by the Title V MCH Block Grant. Other staff training is accessed as needed.

CRS

CRS is committed to ensuring a highly qualified diverse workforce that is equipped with the knowledge and skills to provide quality services to CYSHCN and their families. CRS collaborates with the ADRS Staff Development and Training Division which coordinates education, training, and professional development activities for all ADRS programs. Division staff have worked with CRS to identify training needs, develop training resources, and provide training opportunities that strengthen our MCH workforce. CRS utilizes the expertise available through the Staff Development and Training Division to ensure that staff are equipped with the resources and knowledge base to

implement the 2021-2025 State Action Plan.

As a result of working with the National MCH Workforce Development Center, CRS identified workforce development as a key area of focus and developed a Workforce Development subcommittee. The subcommittee continues to analyze current practices and identify areas for improvement. CRS leadership staff continue to use data from the Spring 2021 staff survey that assessed training needs. Survey data is also being used to improve the orientation process and strengthen employee skills. Identifying the most beneficial ways to support staff and provide them with the tools and resources needed to succeed in their positions is key to staff retention.

CRS management at all levels encourages staff participation in a variety of learning opportunities. Collaborations with ADPH, FVA, DHR, UAB, University of Alabama, COA, Alabama Department of Mental Health, and other partners allow for the identification of professional development and learning opportunities that ensure highly skilled and qualified staff. CRS State Office program specialists also assist multi-disciplinary staff in identifying relevant learning opportunities to specifically address the needs of CYSHCN and their families. These include the following annual events: Speech and Hearing Association of Alabama Convention; Alabama Conference of Social Work; Jacksonville State University Social Work Conference; Alabama Transition Conference; Partners in Care Summit; Autism Matters Conference; Alabama Traumatic Brain Injury Conference; Alabama Autism Conference; Assistive Technology Industry Association Conference; and the Early Intervention Preschool Conference. In addition to state-sponsored training opportunities, CRS State Office staff participate in opportunities provided by national partners such as AMCHP, the MCH Federal/State Title V Partnership, Skills Institutes offered by the National MCH Workforce Development Center, the North American Cystic Fibrosis Conference, and the Academy of Nutrition and Dietetics Food and Nutrition Conference.

CRS is committed to recruiting qualified staff to ensure the continued provision of quality services to CYSHCN and their families. CRS has developed strong partnerships with colleges and universities within the state to recruit prospective employees. Staff either exhibit or present at the following annual events: the University of Alabama Health Sciences Job Fair; the University of Alabama Career Fair; Tuskegee University Career Fair; Auburn University Audiology Doctoral Students; Troy University Rehabilitation Counselor Program; University of South Alabama OT students; Samford Speech Language Pathology School; and Jacksonville State Social Work Day. CRS SLPs present to university speech programs statewide and teach some SLP courses. To broaden the reach for potential recruitment opportunities the ADRS Human Resources Development Division implemented the Learning Experience and Placement Program (LEaP). This program can be accessed by individuals searching for internships across the United States and provides an electronic and streamlined approach to those individuals interested in interning at CRS. The wider reach of LEaP in turn increases recruitment opportunities for CRS.

To further ensure CRS has a workforce that is adequate in size, effectively trained, and properly supported, CRS Leadership and district supervisors gather approximately every 6 weeks for a management team meeting where they discuss issues relevant to service delivery, staffing concerns, and program challenges. This forum is also used to discuss ways to address the lack of specialists that serve CYSHCN in rural communities. These same staff also participate in the quarterly field leadership team meeting where the ADRS Commissioner and program directors provide updates that impact the individual divisions as well as the agency as a whole. The ADRS Commissioner is committed to ensuring a quality workforce and meets quarterly with the assistant ADRS Commissioner and CRS Leadership to hear updates and discuss issues surrounding service delivery including workforce development.

III.E.2.b.ii. Family Partnership

ADPH

ADPH continues exploring opportunities to involve families, youth, and fathers in more MCH activities. In light of the success of a key connection established during the comprehensive Needs Assessment that assisted with hosting focus groups, we have begun discussions with UAB SOPH for plans to continue our partnership with the Alabama Network of Family Resource Centers. The aim is for the centers to connect ADPH directly with patients and families, especially those who are vulnerable and medically underserved, as well as their representatives, so that they may be involved in program design and policy-making to improve health and health care. ADPH has sought guidance from state and national partners on strategies to collaborate with community leaders and groups as well as families of every background in every step of program implementation, including needs and assets assessments, program planning, service delivery, program monitoring, and QI activities.

CRS

ADRS and CRS continue to have a commitment to family engagement and the principles of family-centered care. For over 30 years, this commitment has impacted every part of CRS from direct services to infrastructure building and population health work. CRS includes families in all training for staff to strengthen the partnership between families and professionals and reinforce the concepts of family-centered care. CRS' commitment to family engagement and family-centered care is evident through the Parent Connection Program. CRS makes a significant investment in family partnerships by employing individuals with lived experience that serve as Parent Consultants (PCs). The PCs carry out the activities of the Parent Connection Program.

The current PC structure includes a full-time SPC, two 2part-time RPCs, and 10 LPCs located in CRS community-based offices. These positions are filled by parents who are full-time caregivers of CYSHCN. The SPC coordinates the CRS Parent Connection Program, serves on the CRS Management Team, advises in collaborative interagency efforts, recruits additional parent participation, facilitates the State Parent Advisory Committee (SPAC), and publishes the Parent Connection newsletter. As a CRS staff member, the SPC is involved in all aspects of program planning and policy development. The SPC ensures the family perspective is included at the beginning stages of all activities. The RPCs supervise the LPCs and also serve as a PC in their local office. The RPCs and LPCs provide the family perspective in policy development, serve on various community groups, collaborate with other parent organizations, and provide training opportunities. The RPCs and LPCs are included in discussions about clinic operations at their respective offices. It is important that their input is included as they meet with families and learn of issues, concerns, or ideas that might not be shared with other staff. New staff in local CRS offices spend time in orientation with the LPCs to learn more about their role and the principles of family-centered care. Most importantly the LPCs provide ongoing support to families receiving services through CRS.

To ensure that YSHCN have a voice, CRS has a Youth Connection Program to facilitate youth involvement in policy development and decision-making. As part of the Youth Connection Program, CRS employs two part-time YCs. The individuals in these positions have lived experience and coordinate outreach efforts to share their lived experiences with YSHCN across the state. YCs utilize social media to increase connections with YSHCN in Alabama through the Youth Connection Facebook page. The YCs also interact and share their experience transitioning from pediatric to adult healthcare. YCs present at the annual Alabama Governor's Youth Leadership Forum (YLF). The YLF is an innovative, intensive, 5-day career leadership training program, sponsored by ADRS and hosted by Troy University. The forum helps shape high school students with disabilities through sessions on self-esteem, self-advocacy, career choice, independent living options, and leadership.

The SPC, RPC, LPCs, and YCs are an integral part of ongoing Needs Assessment activities and were involved in the five-year Needs Assessment process, including serving as members of the CRS Needs Assessment Leadership Team. The SPC and an LPC are part of the Block Grant State Action Plan team that meets monthly to discuss progress on the activities. As part of the 2021-2025 Block Grant State Action Plan, CRS implemented the use of the FESAT. Each CRS District developed a Family Engagement QI Initiative based on the FESAT results. The SPC and LPCs played an integral part in the FESAT scoring process and the development of the initiatives. See section III.E.2.c. State Action Plan Narrative by Domain CSHCN Annual Report for additional information.

Establishing advisory committees is an important component of the Parent and Youth Connection Programs. The SPC coordinates the SPAC, which brings together LPACs to meet with CRS State Office staff, as well as leadership from ADRS, and offers an opportunity for information to be shared by all attendees. The SPAC allows ADRS and CRS leadership to hear directly from those with lived experience as they share their stories and those of families with CYSHCN statewide.

The LPCs each coordinate an LPAC. These groups offer families the opportunity to provide input regarding CRS policy and program changes and to interact with local staff members. LPACs are opportunities for community partners to share information and for families to find mutual support by coming together with other families in their area. Some topics addressed in LPAC meetings include Medicaid Waiver, Alabama Lifespan Respite, and local recreation opportunities for families.

The YCs reach out to YSHCN to coordinate the Youth Advisory Council (YAC) and have a growing network across the state. The YCs hold YAC meetings to provide YSHCN a platform to inform CRS and its partners of concerns faced by YSHCN and to assist in developing programs to meet these needs. The YAC also provides a platform for youth to share and mutually support each other. In FY 2022, the frequency of YAC meetings continued to be impacted due to COVID-19 and a vacant YC position.

In addition to coordinating advisory committees, the parent consultants at all levels work to address the needs of Alabama's families of CYSHCN. Since December 2020, LPCs began coordinating and hosting a Facebook Live Family Connection Series. The LPCs continue to host and coordinate this series on a bimonthly basis. Families learn of resources such as SMART Home Solutions, Alabama's Assistive Technology Act (STAR), Individual and Family Support Council, Partners in Policymaking Alabama (PIPA), Alabama Council on Developmental Disabilities Network (DD Network), alternatives to guardianship, and Community Waiver Program (CWP).

In the first few weeks of the pandemic, it was clear that families were facing significant challenges. Working with the Family Resource Specialists from the F2F HIC, a private Facebook group was created entitled "AL Special Needs Parent Support Group". Post-pandemic, it was clear that families were still facing significant challenges, so the group continued. The group has over 1,500 members to date. The Facebook group continues to be a wonderful community where people share information freely, share supplies or equipment with each other, and provide support all facilitated by the connections in the group.

The SPC is a member of various statewide committees including the Mental Illness Advisory Committee, Mental Health Steering Committee, DD Network, University Centers for Excellence in Developmental Disabilities (UCEDD), Alabama Lifespan Respite Coalition, PIPA Advisory Committee, and serves as Mentor for PIPA cohorts. The RPC and LPCs serve on many state and local committees and task forces, such as Alabama Family Advisory Network (FAN) state team, STEP Program Steering Committee, Early Intervention District Coordinating Council, and Governor's Office on Developmental Disabilities (GOOD). The LPCs also represent CRS at many community events across the state, such as health fairs and expos. The LPCs coordinate the submission of nominees from each office for the "Hero of the Month" Award presented by the Kids Wish Network. Serving on these various committees and

participating in outreach activities allows them to strengthen partnerships and identify opportunities for new partnerships with others that serve CYSHCN. The SPC and LPCs also provide training to groups including UAB SOPH students and the UAB Pediatric Pulmonary Center (PPC) trainees.

Family Voices Partnership

CRS has maintained a strong partnership with FVA, home of Alabama's F2F HIC. The CRS LPCs collaborate with FVA to collect data about the needs expressed by families in the state and about the types of information shared with them. FVA uses a data collection system in the F2F HIC project which strengthens the Parent-to-Parent Program. CRS is partnering with FVA to maintain licenses and training needs for the data system. In FY 2022, information and assistance were provided in the areas of the six core outcomes, with the highest number of requests coming in the area of accessing community services, followed by accessing a medical home and partnering/decision-making with providers.

A significant collaboration between CRS and FVA has been the Partners in Care Summit, a project of the F2F HIC. CRS' continued support has helped the conference to grow and allowed for national speakers to present on topics related to medical homes, transition to adulthood, and family/professional partnerships. This conference has been attended by families, CRS staff from across the state, and other community partners. After a 2-year break due to COVID-19, the Summit returned virtually in 2022 with over 120 people registered from all over Alabama, as well as several other states. The 2023 Summit was held in person and focused on the Blueprint for Change: A National Framework for a System of Services for CYSHCN. There were over 150 people in attendance and participants learned about the history and development of the Blueprint for Change, how to bring the Blueprint to life, and a special session focused on Critical Area 2: Family and Child Well-Being and Quality of Life.

III.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

MCH Epidemiology Workforce

The MCH Epi Branch is organizationally located with the FHS Perinatal Health Division. MCH Epi staff perform ongoing data collection and analysis for the following FHS programs: Title V MCH Block Grant, FIMR, Alabama Newborn Screening, Early Hearing Detection and Intervention, FP, Well Woman, ACLPP, PRAMS, and Infant and Maternal Mortality Review. There have been major changes in the epidemiology program capacity within the last 2 years resulting in several vacancies needing to be filled. To continue to adequately serve programs until vacancies were filled, FHS initiated a partnership with UAB to support epidemiology and data analysis needs. Epidemiology staff continued to seek training and technical assistance from HRSA and other partners as needed. In March 2020, nine FTEs were working in the MCH Epi Branch. That number decreased to four in April 2021 and remained at four in 2022. Brief biographies of personnel in 2022 follow.

William V. Duncan, BS, has 21 years of experience with ADPH. He works as a public health research analyst in the MCH Epi Branch supporting the FP, Well Woman, and Childhood Lead Poisoning Prevention Programs. Academic credentials include an undergraduate degree in commerce and business administration. Mr. Duncan departed from FHS in May 2022.

Alice Irby, MPH, MS, joined FHS in 2016 and serves as the SSDI coordinator. She is an MCH epidemiologist, and currently, her major work involves federal grant management efforts related to MCH issues. Subjects of her work at ADPH have included vital statistics records, the Zika Pregnancy Registry, FP, maternal mortality, and COVID-19 pandemic efforts. Academic credentials include graduate degrees in biology and public health.

Julie Nightengale, MPH, is a research analyst and has worked with public health for 12 years. She worked in the FHS MCH Epi Branch at various times. During her tenure in FY22, Ms. Nightengale provided technical support to the PRAMS Program and participated in the calls for the MMRC. Academic credentials include an MPH in epidemiology. Ms. Nightengale departed from FHS in December 2022

Aijun Zhang, PhD, joined ADPH in September 2022 as a research analyst II for the MCH Epi Branch. He provides technical support for the Perinatal Health Division, specifically working with SAIMRP, FIMR, and PRAMS. Dr. Zhang earned his doctorate degree in biomathematics at Auburn University.

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

The purpose of the State Systems Development Initiative (SSDI) Grant is to develop, enhance, and expand the Alabama Title V MCH Program's data capacity. ESMs were selected by program staff and are submitted in the block grant application. Implementation plans are underway and program staff are either implementing or piloting selected ESMs per domain.

ADPH's capacity to provide MCH-related data enables programs such as FP, SPP, and the Child and Adolescent Health Division to make informed decisions on policy changes. The collaborative relationships that SSDI staff have with other ADPH entities strengthen the data capacity of FHS in general and of the SSDI Program in particular. With access to multiple data sources, MCH staff will be able to track each program's impact on the populations being served. This arrangement allows the resultant program data to be used to address important questions in a comprehensive manner.

FHS partners with many and varied organizations, such as Medicaid, to assure the achievement of the overall purpose of the federal SSDI Program and the MCH Block Grant. FHS staff (including the SSDI staff and MCH coordinator) and CRS staff collaborate to coordinate the Title V MCH Block Grant Application/Annual Report. SSDI program staff work closely with the MCH coordinator to ensure that all ADPH-related items for the application/annual report are uploaded in a timely manner.

ADPH's CHS provides access to the state's vital statistics data (birth, death, and fetal death) which is utilized by staff members to contribute to the MCH Block Grant Program. With assistance from SSDI staff and coaching from our partnership with the UAB evaluation team, FHS will work to identify and address ongoing barriers to accessing and analyzing data needs for the MCH Block Grant Program. Depending on the data source, MCH may not have access to the most current numbers. This does create barriers when MCH tries to update the performance measures.

ADPH has also taken steps to gain hospital discharge data. The Office of Informatics and Data Analytics (OIDA) plans to have hospital discharge data available after April 2023. Effective November 1, 2022, Tim Feuser was hired as the new MCH Epi Branch director and was appointed the SSDI project director. The SSDI coordinator remains heavily involved in collaborating with the MCH coordinator to complete tasks related to the MCH Block Grant. The SSDI coordinator is also involved in the ongoing needs assessment meetings and collaborative efforts with the UAB Evaluation Team. A strength of the program remains the good working relationship that the Alabama SSDI coordinator has with the SSDI project officer and HRSA representative.

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

ADPH

FHS MCH Epi Branch staff support several programs funded by Title V. Those programs include ACLPPP, Well Woman, SPP, MMR, and FIMR. Staff create data reports, complete data requests submitted by individuals within and outside ADPH, and participate in evaluation projects. The MCH Epi Branch has access to the following data sources: the Electronic Health Record system, the Healthy Housing and Lead Poisoning Surveillance System, PRAMS, FIMR, MMRC, and CHS. The MCH Epi Branch provides technical assistance to program managers in developing local, state, and federal reports. The branch's support is necessary to implement effective and evidence-based MCH strategies in an effort to prevent or reduce disease, injury, disability, and mortality. Staff also supported activities of the 2020 Title V Needs Assessment.

CRS

The ADRS Computer Services Division, in partnership with CRS, maintains and enhances the CRS Electronic Medical Record (EMR), CHARMS, and its Business Information System platform to ensure accurate data collection and reports. Within these systems, data is collected regarding clinic visits, community wrap-around services, care coordination case numbers, and expenditures on client services. Informational reports can be generated in these areas based on both demographic and diagnostic criteria. The system also has the capability of generating reports containing required Title V MCH Block Grant data.

The EMR task force holds regularly scheduled meetings regarding the EMR components that are unique to the CSHCN Program. Members of the task force include CRS State Office staff and computer services developers and programmers. The task force identifies and prioritizes needed improvements to ensure an efficient system and accurate data collection. Priority in FY 2022 was given to the completion of the development of a new plan of care for the CRS Care Coordination Program. In addition, CRS and computer services staff continued working to implement electronic prescribing services through NewCrop, developing an electronic growth chart, and enhanced reporting.

Working with the National MCH WFD Center, CRS leadership identified trackable efficiency measures. These measures include data elements from CHARMS that allow CRS to conduct quarterly reviews of overall clinic attendance, clinic attendance rates, and clinic revenue utilizing enhanced EMR reporting. Information is compiled in a dashboard and trends are discussed and shared at management team meetings. The information is also utilized in determining staffing ratios.

III.E.2.b.iv. MCH Emergency Planning and Preparedness

There is a State of Alabama Emergency Operations Plan (EOP) and an ADPH-developed EOP. The ADPH EOP is reviewed every 2 years, or as needed, by the Center for Emergency Preparedness (CEP), the State Health Officer, and all ADPH bureau staff with emergency assignments within the EOP. ADPH's EOP does not specifically include language to address the needs of the MCH population. However, it does provide the opportunity for special assistance requests from the CEP Social Work Coordinator to access resources for people who are considered vulnerable, underserved, disabled, or have special needs. CEP does recognize pregnant women and children as fitting into one of the above groups.

The State of Alabama EOP is written and managed by the Alabama Emergency Management Agency (AEMA). This publicly available document includes a letter of agreement in which it is described as an all-discipline, all-hazards plan that establishes a single, comprehensive framework for incident management. The letter also states that the Alabama EOP provides the structure and mechanisms for the coordination of state support to state, local, and tribal incident managers and for exercising direct state authorities and responsibilities. Furthermore, the EOP assists in reducing the vulnerability to all natural and man-made hazards; minimizing the damage and suffering caused by any disaster; and assisting in the response to and recovery from all-hazard incidents. The EOP was last updated in 2017 and changes must be submitted in writing, using an official EOP change request form.

The state's EOP does not specifically include language that addresses the needs of the MCH population. However, in the past when an emergency occurred that impacted women of childbearing age (i.e. Zika), the EOP leaders consulted with Title V MCH staff to create an appropriate response. Title V MCH staff provided a state action plan for ZIKA, led activities, participated in calls with the CDC, and directed actions to assist and monitor the health of pregnant women and infants, including the development of the Zika registry.

State agencies develop supporting EOPs in their Emergency Support Functions (ESFs). The ESFs are described by AEMA as providing the structure for coordinating state/federal interagency support for catastrophic and non-catastrophic events, disasters, or emergencies. The ESF structure includes mechanisms used to provide state support to counties and county-to-county support, both for declared disasters and emergencies under the Stafford Act and for non-Stafford Act incidents. An outline of the state agencies designated as ESFs in the Alabama EOP is as follows:

- ESF # 1 Transportation, AEMA
- ESF # 2 Communications, AEMA
- ESF # 3 Public Works and Engineering, Alabama Department of Transportation
- ESF # 4 Fire Fighting, Forestry Commission
- ESF # 5 Emergency Management, AEMA
- ESF # 6 Mass Care, Emergency Assistance, Housing and Human Services, DHR
- ESF # 7 Logistics Management and Resource Support, Alabama Department of Finance
- ESF # 8 Public Health and Medical Services, ADPH
- ESF # 9 Search and Rescue, AEMA
- ESF # 10 Oil and Hazardous Materials Response, Alabama Department of Emergency Management
- ESF # 11 Agriculture and Natural Resources, Alabama Department of Agriculture and Industries and Alabama Department of Conservation and Natural Resources
- ESF # 12 Energy, Alabama Department of Economic and Community Affairs
- ESF # 13 Public Safety and Security, Alabama Department of Public Safety
- ESF # 14 Long-Term Community Recovery, Office of the Governor
- ESF # 15 External Affairs, Office of the Governor

No Title V Program staff were involved or consulted in the planning and development of the Alabama EOP. Title V leadership is not included in the state's emergency preparedness planning before a disaster; however, Title V staff

are consulted in the response when pregnant women and children are impacted. Title V leadership is not currently a part of the Incident Management Structure (IMS); however, the Title V director was included in the past.

There were no gaps in emergency preparedness and/or surveillance data identified during the 2020 Title V MCH Needs Assessment. An exploration of those needs is a consideration for future annual MCH assessments. Following the last assessment, staff was immediately thrown into disaster response due to COVID-19. There has been no formal assessment of gaps in emergency preparedness and/or surveillance data to determine the state's ability to adequately assess and respond to MCH population and program needs, but the lessons learned during the COVID-19 response have changed certain protocols in the event of a future disaster or PHE.

FHS division directors submit Continuity of Operations Plans (COOP) annually to allow services to continue to be provided in the event of emergencies and disasters in accordance with the ADPH EOP. In addition to providing personal contact information and technology needs for staff, ADPH COOPs serve to do the following:

- Identify the core functions of each division, including populations served
- Keep lines of communication open with the FHS director and other ADPH administrators
- Provide operational guidance and supervision to FHS directors and managers
- Fulfill Incident Command System position functions and assists with pandemic response
- Coordinate communications with FHS directors and managers and other outside entities
- Identify emergency preparedness team assignments
- Establish protocols for the processing of critical procurements and payments (e.g. emergency PKU formula orders)

CRS

CRS plays a role in the state's emergency structure through serving as a member of Alabama's Functional and Access Needs in Disasters (FAND) Taskforce whose mission is to ensure equal access throughout all phases of emergency management. Through this partnership, CRS provides a voice for CYSHCN and their families in the development of emergency preparedness and response training. Graham Sisson, ADRS Deputy Attorney General and Director of the Governor's Office on Disability, serves as the chair of FAND and was appointed to be the liaison with the Governor's Mass Care Task Force (MCTF), which oversees the coordination of state-level planning and preparedness activities and FAND.

Members of FAND include agencies that serve individuals with functional and/or access needs during the preparedness, response, and recovery phases of a disaster. Examples of member constituencies are those who interact directly with people with disabilities including, but not limited to, health needs, mental health, sheltering, casework, and communications. Members include the Alabama Council for Developmental Disabilities and individuals with developmental disabilities. Task force members facilitate inclusive planning, preparedness, response, and recovery activities related to providing services to people with disabilities following a disaster. Activities include identifying resources, advocating to ensure effective communication for those with communicative barriers, ensuring persons with functional and accessible needs are involved in the planning process, and disaster-affected areas understand appropriate actions to accommodate persons with functional accessible needs.

III.E.2.b.v. Health Care Delivery System

III.E.2.b.v.a. Public and Private Partnerships

The Alabama Title V MCH Program fosters relationships with programs both internal to FHS and CRS, and across ADPH and ADRS which are not funded by the state Title V Program, but which serve the legislative-defined MCH populations. These partnerships help expand the state Title V Program's capacity and reach in meeting the needs of Alabama's MCH population. Similarly, the Title V Program partners with public and private organizations in the state and across the nation, leveraging federal and state program resources to improve and expand the service delivery capacity of the program. Alabama's ongoing commitment and efforts to build, sustain, and expand partnerships; to work collaboratively; and to coordinate with other MCH-serving organizations occur in the context of FHS and CRS seeking to accomplish their respective missions and identify priority MCH needs. The following are highlights of selected Alabama Title V collaborations.

FHS

Title V staff strengthen current partnerships and explore new collaborations with state public health and social service agencies, health services entities and practitioners, private organizations, and community organizations in order to support effective population-based health services delivery. The public and private partnerships allow FHS to leverage federal and state program resources, advancing the expansion and implementation of evidence-based strategies which contribute to the service delivery capacity of the Title V Program. Furthermore, these partnerships impact the manner in which the program is able to address health inequities in an effort to improve the health outcomes of the MCH population, supporting families and communities.

FHS aims to partner with Medicaid, AlaHA, state advocacy agencies, and others at every available opportunity. FHS routinely attends meetings with its partners and stakeholders, sits on committees with common goals, and invites them to participate in all statewide MCH programs. The Alabama Title V MCH Program continues to fund CHDs, which helps to support and improve the health of local communities. FHS also continues to look for opportunities to use Title V funds to coordinate with other community health service providers and with community-based systems in order to ensure continuity of care for all mothers and children.

OHO program partners with local governments, state agencies, and advocacy groups to support community water fluoridation regulation and infrastructure.

SPP, AlaHA, Alabama State Health Planning and Development Agency, and other partners continue to work to implement a fully coordinated system of perinatal regionalized care in Alabama.

Title V staff lead the State of Alabama Infant Mortality Reduction Plan (SAIMRP), a collaboration between staff from DECE, DHR, DMH, ADPH, Medicaid, and OMA. The staff have developed and implemented evidence-based strategies to improve maternal and infant health outcomes. The partnership is a special project funded by the Office of the Governor.

FHS partners with colleges, universities, and the National MCH Workforce Development Center to recruit and host interns, providing them with invaluable direct training and hands-on skills, and preparing them for future work as MCH professionals. Accordingly, the interns provide vital support to Title V funded programs.

ADPH leads, facilitates, and supports various taskforces, steering committees, coalitions, and work groups to provide education, outreach, training, and resources during legislative meetings, annual summits, health fairs, and other exhibiting opportunities. In addition to being educational, these occasions provide the opportunity for Title V staff and

partners to make recommendations for MCH strategies to improve health, prevent injuries, and reduce mortality for women, infants, children, and their families.

CRS

CRS is involved in several collaborative efforts with federal, state, and non-governmental partners to ensure access to quality health care and services for CYSHCN. Below are ways that CRS utilized partners to develop innovative ways to ensure a system of community-based services are provided to CYSHCN.

Woolley Institute for Spoken-Language Education (WISE)
CRS serves as the second-tier screener for NBHS and at times CRS serves as the initial screener. As a result, CRS audiology clinics have seen a significant increase in referrals. CRS employs pediatric audiologists who conduct diagnostic evaluations and provide direct services in hearing clinics throughout the state. Coupled with the growing number of referrals and CRS audiologists reaching their maximum capacity to provide services, CRS is partnering with WISE to improve access to services. WISE is a statewide, family-focused program working in collaboration with Alabama's EI System, local school systems, and private and public entities which advance the education of deaf children. Utilizing WISE as a vendor will provide access to the WISE mobile audiology unit. CRS will identify the areas of greatest need and coordinate scheduling with WISE. Providing these screenings via a mobile unit will improve access to services, reduce wait times and provide a timely diagnosis.

NICU Expansion
CRS in partnership with Huntsville Hospital launched a pediatric evaluation/NICU follow-up clinic to provide ongoing evaluation and guidance related to the development of high-risk children during the first 3 years of life. Since the clinic's inception, referrals from the hospital, as well as local pediatricians, have grown. Given the vast geography of the area served some families drive up to 200 miles round trip to access services. Recognizing the need to expand the clinic, a local Muscle Shoals pediatrician expressed an interest in partnering to provide the clinic at the Muscle Shoals CRS office. Through this partnership, CRS has improved access to care for over 58 families in 7 months. Expanding the clinic to an additional site did not come without challenges as many CRS staff are now working at both clinic sites. To ensure this did not impact the quality of services provided, additional staff were brought on through the use of vendors. The clinic is an evidence-based multidisciplinary, family-centered, evaluation/assessment clinic that identifies needed services for clients with multiple medical complaints, developmental delays, and/or complex needs. The clinic serves as a "hub" directing families to the most appropriate resources. Parents and caregivers are active participants and have the opportunity to ask questions of the clinic team. The pediatrician and family receive a clinic report. One local pediatrician expressed appreciation for the report and indicated that it made it easier to follow up on the parents' concerns.

Autism Diagnostic Clinic
CRS, in partnership with EI, the University of Alabama (UA), and the UAB Civitan-Sparks Clinic, developed a pilot Pediatric Evaluation – Autism Diagnostic Clinic for children currently enrolled in EI. Children are identified by EI to participate, screened for enrollment into CRS, and subsequently scheduled for the diagnostic clinic. Pilot data is being collected regarding clinic outcomes and will be used to impact and address the growing need for early Autism diagnosis. The pilot is currently being conducted at the Tuscaloosa and Homewood CRS offices.

Staff from the Department of Communicative Disorders at UA and the UAB Civitan-Sparks Clinic have been vital partners in providing staff training, consultation, and mentorship through case reviews. EI was able to provide funding for all CRS SLPs to receive intensive training in the administration of the Autism Diagnostic Observation Assessment (ADOS).

Alabama CHIP (known as ALL Kids)
CRS continued to participate as an ALL Kids provider utilizing the ALL Kids Plus component to provide an enhanced array of services for the unique needs of CYSHCN.–CRS continued meeting, as needed, with ALL Kids staff to discuss program and policy issues likely to affect CYSHCN.

ACHIA
CRS is an active member of ACHIA which is the state improvement partnership program working with the Alabama Chapter of AAP and pediatric practices across the state. The CRS Assistant Commissioner is a member of the ACHIA steering committee. Other members of ACHIA include Medicaid, CHIP, Title V, and COA.

CRS Genetics Clinic - Smith Family Clinic
CRS Huntsville continues to partner with The Smith Family Clinic for Genomic Medicine, LLC, a wholly-owned subsidiary of Hudson Alpha Institute for Biotechnology, to host a genetics clinic for CYSHCN. The clinic's mission is to diagnose patients who have been undiagnosed or misdiagnosed. The clinic geneticist has the unique opportunity to offer whole genome sequencing, provided by Hudson Alpha, which reads a patient's entire DNA. The data is analyzed to find genetic changes that may indicate the cause of a patient's disease. In some cases, these results yield information critical to directing the efficacy of a patient's treatment.

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

FHS

Within the state of Alabama, the Title V program and Title XIX Medicaid program share a common goal in working to improve the overall health of the MCH population. The agreement that FHS has in place with Medicaid outlines an agreement between the two agencies that allows FHS to provide clinical services, care coordination, and seek reimbursement from Medicaid for services rendered related to lead, EPSDT, and immunizations. There is no agreement between FHS and Medicaid that defines coordination to impact program outreach and enrollment, health care financing, waivers, or to dictate policy level decision making on issues related to MCH services, delivery, and coverage.

CRS

CRS partners with Medicaid in various ways. Although EPSDT services are the responsibility of the primary care provider for all children under Medicaid managed care arrangements, CRS coordinates services with the medical home to ensure access to specialty care and related services through Medicaid funding for all CYSHCN served by the program. CRS continues its inter-agency agreement with Medicaid to provide Children's Specialty Clinic Services throughout the state, which enhances access to services for Medicaid recipients. In order to ensure consistent quality, statewide standards of care, and access to community-based clinical services, Medicaid and CRS have negotiated a list of approved multidisciplinary clinics. CRS and Medicaid have negotiated a clinic encounter rate that Medicaid pays per specialty medical clinic visit of a Medicaid enrolled child. In addition to covering the cost of the clinic visit it helps fund wrap around services to the client.

Medicaid implemented a consolidated Care Coordination system through a Section 1915 (b) Waiver effective October 1, 2019. This consolidated system resulted in the formation of ACHN. CRS care coordinators have developed a close partnership and collaboration with the care coordination staff at the ACHN regional offices.

Medicaid has a wide variety of Home and Community-Based Waiver programs for which CYSHCN may be eligible. CRS care coordinators and LPCs educate families about the various waiver programs and assist families with the referral and application processes.

CRS serves as the reviewer of all requests for Medicaid funding for augmentative communication devices (ACD) and houses all Medicaid PA requests for ACDs. CRS is the only provider of medically necessary orthodontia for Medicaid recipients. CRS works closely with Medicaid's Dental Director regarding coverage for orthodontia services.

CRS serves in an advisory role to Medicaid for program and policy decisions likely to affect CYSHCN and its sub-group, children with medical complexity, and serves as a voice for this population. Medicaid staff members are assigned to work with CRS. Meetings between Medicaid and CRS are held quarterly to discuss any issues or concerns regarding providing services to Medicaid recipients with CSHCN. If issues arise outside the quarterly meetings, the CRS Medicaid liaison will contact Medicaid to discuss. In addition, CRS staff, including the SPC, participate on advisory committees and work groups associated with various Medicaid initiatives.

CRS staff are trained on Medicaid and CHIP program eligibility and diligently work to ensure that all coverage options have been explored for any uninsured child. If a client is found to be uninsured the CRS care coordinator will assist the parent/guardian in submitting a joint application for Medicaid, CHIP, and the Federally Facilitated Marketplace. The joint eligibility system determines which of the programs the child is eligible to receive coverage.

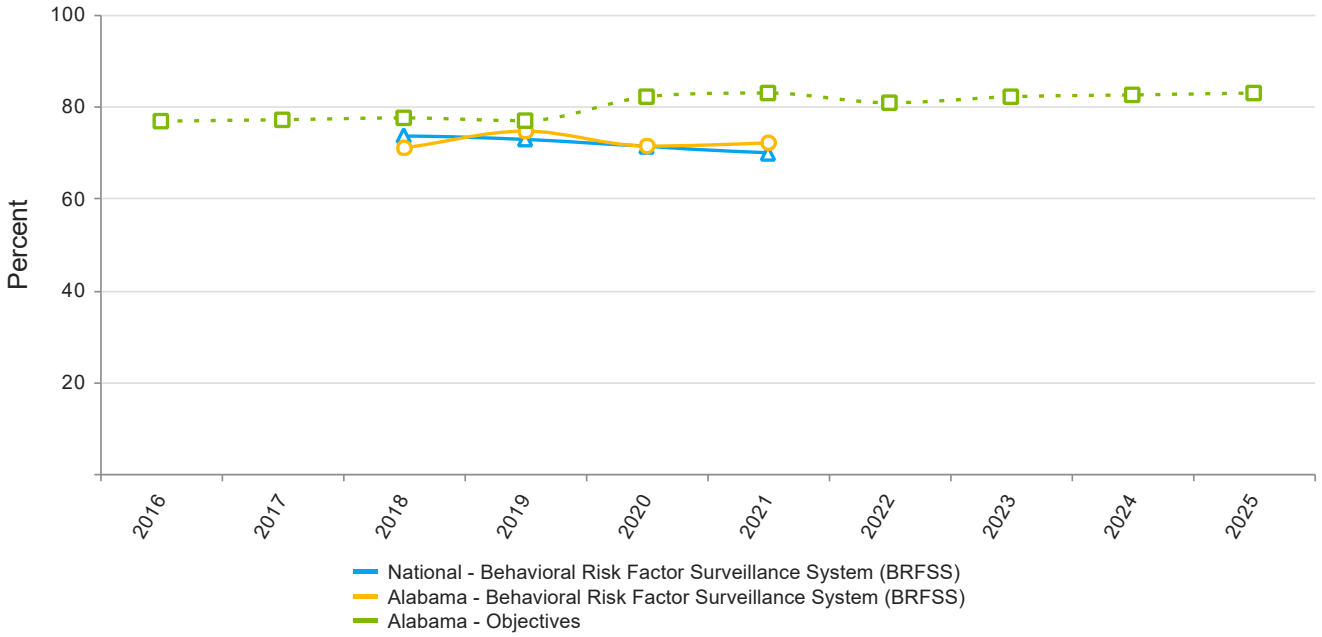
Alabama has a low incidence of uninsured children, which is due to a focus on education and outreach regarding insurance coverage for children. CRS also works with private insurers to ensure coverage for services for CYSHCN.

III.E.2.c State Action Plan Narrative by Domain

Women/Maternal Health

National Performance Measures

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Indicators and Annual Objectives



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective			82	82.8	80.7
Annual Indicator		70.8	74.4	71.4	72.0
Numerator		599,429	629,176	607,073	622,981
Denominator		846,286	846,056	850,307	865,327
Data Source		BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year		2018	2019	2020	2021

Previous NPM-1 BRFSS data for survey year 2017 that was pre-populated under the 2018 Annual Report Year is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives			
	2023	2024	2025
Annual Objective	82.0	82.4	82.8

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Proportion of women age 15-55 who report receiving a preventive medical visit in the past 12 months by increasing total enrollment percentage in the Well Woman Program by 2 points annually.

Measure Status:	Inactive - Replaced				
State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	44.5	44.9	45.4	45.8	46.2
Annual Indicator	43.2	43.2	43.2	43.2	43.2
Numerator	1,081,373	1,081,373	1,081,373	1,081,373	1,081,373
Denominator	2,505,795	2,505,795	2,505,795	2,505,795	2,505,795
Data Source	BRFSS and U.S. Census	BRFSS and U.S. Census	BRFSS and U.S. Census	BRFSS and U.S. Census	BRFSS and U.S. Census
Data Source Year	2015	2015	2015	2015	2015
Provisional or Final ?	Final	Final	Final	Final	Final

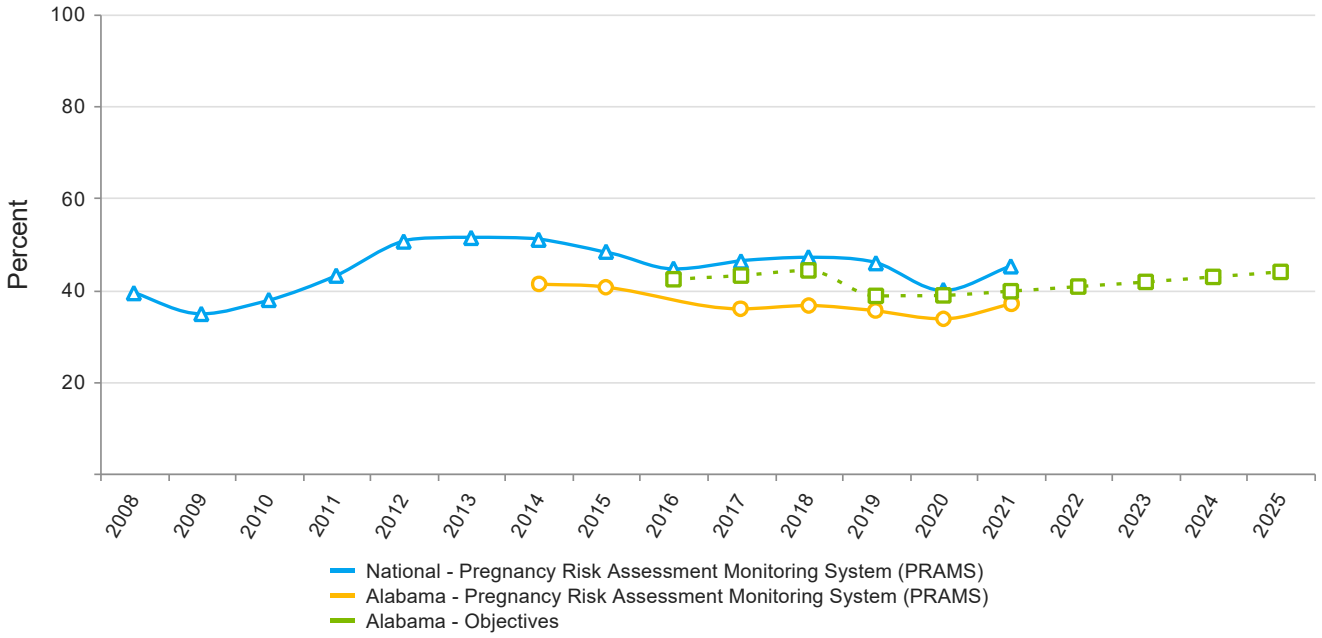
ESM 1.2 - Increase the percentage of women receiving both FP services and WW services by 2 percent within active WW counties.

Measure Status:	Active

State Provided Data	
	2022
Annual Objective	
Annual Indicator	5.1
Numerator	200
Denominator	3,885
Data Source	Cure MD
Data Source Year	FY 2022
Provisional or Final ?	Final

Annual Objectives		
	2024	2025
Annual Objective	7.1	9.1

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy
Indicators and Annual Objectives



Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	44.2	38.7	38.8	39.7	40.7
Annual Indicator	40.6	36.0	35.4	33.6	37.1
Numerator	22,286	19,726	19,451	15,240	19,911
Denominator	54,955	54,751	54,884	45,331	53,737
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2017	2019	2020	2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	41.7	42.8	43.9

Evidence-Based or –Informed Strategy Measures

ESM 13.1.1 - Percentage of dental providers receiving information/education regarding importance of preventive dental visits for expectant mothers

Measure Status:	Active		
State Provided Data			
	2020	**2021**	**2022**
Annual Objective			3
Annual Indicator	0		14.9
Numerator	0		1,021
Denominator	500		6,840
Data Source	Oral Health Program		Oral Health Program
Data Source Year	2020		FY 2022
Provisional or Final ?	Final		Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	6.0	9.0	10.0

ESM 13.1.2 - Percentage of dental providers that received information/education regarding their perinatal patients about the FDA-approved HPV vaccine in order to reduce the risk of oropharyngeal, cervical, and other HPV-related cancers

Measure Status:	Active		
State Provided Data			
	2020	**2021**	**2022**
Annual Objective			3
Annual Indicator	0		14.9
Numerator	0		1,021
Denominator	500		6,840
Data Source	Oral Health Program		Oral Health Program
Data Source Year	2020		FY 2022
Provisional or Final ?	Final		Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	6.0	9.0	10.0

State Action Plan Table

State Action Plan Table (Alabama) - Women/Maternal Health - Entry 1	
Priority Need	
Lack of preventive dental visits across all Title V populations, especially for those uninsured.	
NPM	
NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy	
Objectives	
By 2025, increase the percentage of dental providers who receive education on the importance of preventive dental visits for expectant mothers by 10 percent.	
By 2025, increase the percentage of dental providers who are provided education and support on the provision/referral for HPV vaccine by 10 percent. (create a provider Services survey and gather baseline data.)	
Strategies	
Educate and reach out to oral health providers to improve understanding of preventive dental visits during pregnancy and through ads utilizing television, streaming, and social media platforms.	
Promote HPV education, and HPV vaccine education, promotion and referral using the #WATCHYOURMOUTH campaign developed through a partnership with Mitchell Cancer Institute.	
ESMs	**Status**
ESM 13.1.1 - Percentage of dental providers receiving information/education regarding importance of preventive dental visits for expectant mothers	Active
ESM 13.1.2 - Percentage of dental providers that received information/education regarding their perinatal patients about the FDA-approved HPV vaccine in order to reduce the risk of oropharyngeal, cervical, and other HPV-related cancers	Active
NOMs	
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	

State Action Plan Table (Alabama) - Women/Maternal Health - Entry 2

Priority Need

High levels of maternal mortality.

NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Objectives

Provide routine classes, to women participants, that promote health, breastfeeding, safe sleep, and make referrals to other programs that impact maternal mortality.

Strategies

Offering more classes for women participants in WIC in counties with higher rates of maternal mortality than the state rate or in at least 5 counties.

ESMs	Status
ESM 1.1 - Proportion of women age 15-55 who report receiving a preventive medical visit in the past 12 months by increasing total enrollment percentage in the Well Woman Program by 2 points annually.	Inactive
ESM 1.2 - Increase the percentage of women receiving both FP services and WW services by 2 percent within active WW counties.	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Well Woman Program

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

ESM 1.1 - Proportion of women age 15-55, who report receiving a preventive medical visit in the past 12 months by increasing total enrollment in the Well Woman Program by 2 points annually.

The goal of the ADPH Well Woman Program is to provide preconception and/or interconception health care to women as a foundation for wellness and to reduce cardiovascular disease (CVD) risk factors through education on healthy living and prevention and/or early detection of disease. This work also serves to assist in increasing the longevity and quality of life for women age 15 to 55 in Alabama. The program enhances access to preventative screenings for CVD, wellness checks, and vision and oral screenings. Free services to address issues such as obesity, hypertension, high cholesterol, and diabetes are also offered. After being enrolled in Well Woman, women are given the opportunity to participate in behavioral change programs addressing chronic diseases, food choices and portion control, physical activity, and smoking cessation. All program components are related to the delivery of screening, diagnosis, treatment of hypertension, and delivery of support to participants receiving Well Woman services.

The program began as a pilot program in FY 2017 with three counties and has been fortunate to expand to several counties in Alabama due to federal Title V grant funding and funds from the Office of the Governor. In FY 2022, the Well Woman Program expanded from six to twelve counties in Alabama. The increased number of program counties offering services allows for growth and the provision of more information for the continuation of care regarding preconception and interconception care, as well as promoting healthy lifestyle behaviors to women in the public health districts.

In October 2021, at the beginning of FY 2022, the program began a trial clinical travel team approach as a pilot in ADPH's West Central District (Hale, Greene, and Perry Counties) to broaden services to a population of women in a medically underserved region of Alabama known as the "Black Belt". Generally, the program's clinical staff model consists of a nurse practitioner, social worker, registered nurse, clinic aide, and administrative support assistant II. However, the pilot program in Greene, Hale, and Perry Counties consisted of a clinical team that traveled to each county to conduct Well Woman Program visits on their respective clinic days. The goal for the composition of the clinical travel team was a nurse practitioner, social worker, and clinic aide. Staffing continued to be an obstacle throughout the year and these counties were unable to continue to provide Well Woman services after September 30, 2022. However, Marengo and Wilcox Counties resumed Well Woman services at the end of FY 2022. Future expansion is a goal of the program to continue to give women in each public health district the opportunity to receive preventative screenings and education in lifestyle modifications for health and wellness. There have been discussions with various ADPH districts, but there have not been any confirmed start dates for any of the potential counties. The map below illustrates the Well Woman counties available in FY 2022.

The Well Woman Program utilizes the New Leaf curriculum, which is a nationally recognized scientific-based intervention tool that emphasizes practical strategies for making changes in dietary intake and physical behaviors. There is also a licensed nutritionist that works with Well Woman participants as a part of the program to educate and provide resources, so participants can make informed choices about their eating habits. As physical activity is an important component of ensuring the health, partnerships with local community businesses and programs allow participants to engage in physical activity either virtually or in person. The program accepts referrals from a variety of sources including, but not limited to self-referrals, referrals from community partners, local physicians, and other programs within ADPH such as FP. Referrals are also received from ALL Babies care coordinators and health and wellness messaging through 211KNOW.

As a beta test campaign, 211KNOW was piloted in the Well Woman Program near the final quarter of FY 2021 and was a great success. As a result, the text messaging continued into FY 2022. The Office of Women's Health and Well Woman Program partnered with the Alabama Women's Commission and Explore Media to compile researched nutritional and physical activity information provided through weekly text messages to program participants to promote health and well-being. Participants received these educational messages at the same time twice weekly which allowed them to have access to recipes, self-improvement, physical activity tips, and other tools to empower women in their journey to adopt a healthier lifestyle. The geographical areas targeted within Alabama in 2022 were Sumter, Hale, Choctaw, Marengo, Greene, Perry, Dallas, Wilcox, Bibb, Chilton, Coosa, Tallapoosa, Clay, Randolph, Autauga, Lowndes, Elmore, Montgomery, Macon, Lee, Chambers, Russell, Bullock, Pike, Barbour, Butler, and Crenshaw Counties. The campaign sent a total of 38 messages to the targeted audience and there was a total of 1,896 links accessed from 2,137 subscribers in the same targeted geographical area throughout the year.

Evaluation of the growth and sustainability of the program have been met with innovative strategies. Telehealth is incorporated into the program protocol as an option for nurse practitioners' follow-up in completing the Risk Reduction Counseling session. The Risk Reduction Counseling session includes a review of medical history, healthy lifestyle assessment (to include preconception/interconception and healthy life planning), lab and clinical results from the enrollment screening; review and/or conduct (if not done) CVD 10-year risk calculation and discuss; review of baseline/risk reduction data information in the EHR; determination of target blood pressure reading for participants

with hypertension; review of participant's priority areas and determine readiness for change; discuss diet, physical activity and determine ability to participate in physical activity. With the addition of Well Woman staff, plans were made to offer nutrition classes, support groups, and physical activity resources available virtually as well. Program implementation of virtual means created flexibility and the opportunity to reach program participants in a capacity that has the potential to impact their lifestyle and behaviors regarding the goals made to improve health.

While there were various staffing challenges throughout FY 2022, there were also successes. The Well Woman Program added staff and made changes to include a division director, social work supervisor, epidemiologist supervisor, and statistician in the ADPH Central Office; social worker coverage for counties in the Southwestern and Southeastern Public Health Districts; and a second nutritionist. The addition of staff was important in continuing to provide the best care and education to program participants, creating a continuity in services throughout each of the program counties, and continuing evaluation and organization of program components to ensure that the program was able to continue to address the needs of participants and the community.

The Well Woman Program has been included as one of several strategies of the SAIMRP and has identified key strategies and barriers in programmatic efforts. Strategies of the program to meet the needs of participants and achieve established performance measure targets are to decrease the percentage of women enrolled with a blood pressure reading greater than the target range annually and increase the percentage of women enrolled in the program from a referral by a community partner. The barriers are poor follow-up from participants, poor treatment regimen adherence, and unfavorable beliefs about hypertension risk due to being asymptomatic. There are various components of the program that are key in providing the opportunity for healthy lifestyle education and change in order to address these strategies and barriers such as preconception/interconception health planning; CVD risk factor screenings; risk reduction counseling to help women understand their risks and discuss the participant's readiness to change; and health coaching and support to help women discover healthy lifestyle behaviors to prevent, minimize, or delay the onset of chronic disease.

In FY 2022, the Well Woman Program enrolled a total of 554 participants. Of these 554 participants, 14 percent enrolled with a BMI >25 (overweight); 76 percent enrolled with a BMI >30 (obese); and a total of 50 percent showed a decrease in BMI from enrollment to their second appointment. The program recognizes hypertension as a systolic reading greater than or equal to 130 and a diastolic reading greater than or equal to 80. On the initial Well Woman visit, 59 percent of participants had a blood pressure reading greater than 130/80. On the second visit, 55 percent of participants had a reading of 130/80 or greater which shows a slight decrease. The average age of participants enrolled in 2022 was 37.5 years of age with 90 percent of participants enrolled identifying as Black, 2 percent of participants enrolled identifying as Hispanic, and 8 percent identifying as White.

Program Success Story:
A 54-year-old woman was referred to the Well Woman Program by a friend and enrolled in March 2022. When she enrolled, she weighed 277 pounds with a BMI of 45. She stated that she barely had an appetite and was mostly eating processed snacks, i.e. crackers and chips when hungry. She admitted that her self-esteem was very low because of her weight gain, which she stated started after getting hurt at work. She could not work out or go to the gym as she had previously done prior to her injury. This led to her unhealthy eating habits and becoming more sedentary in her lifestyle.

Since enrolling in the Well Woman Program, she now goes to the gym a minimum of 3 days a week. She enjoys the sauna and strength training machines. She states that being back in the gym has motivated her to leave the house and work on a plan to become healthy again. Although she still snacks on processed foods, she now understands the importance of eating "real" food. She was eating no fruits or vegetables, and very little meat when she enrolled in the program. She is now consuming vegetables and fish after being educated on the importance of a well-balanced diet.

This participant has lost 10 pounds since enrolling in the program, has gained more self-esteem, and is now making better choices concerning her diet to become an overall healthier person.

Oral Health Office

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

ESM 13.1.1 - Percentage of dental providers receiving information/education regarding the importance of preventive dental visits for expectant mothers

ESM 13.1.2 - Percentage of dental providers that received information/education regarding their perinatal patients about the FDA-approved HPV vaccine in order to reduce the risk of oropharyngeal, cervical, and other HPV-related cancers

Early in FY 2022, ADPH OHO had the privilege of hosting Timothy Ricks, D.M.D, F.I.C.D., during the November 2021 quarterly meeting of the Oral Health Coalition of Alabama (OHCA). Rear Admiral (RADM) Ricks was the Assistant Surgeon General at the time and his presentation to the very diverse OHCA membership spanned a broad range of topics which were then narrowed to pertinent Alabama-specific topics and concerns. This meeting was the first in-person OHCA meeting to be held since the beginning of the COVID-19 pandemic. Oral health disparities/inequalities, access to dental care, and the oral health workforce—all of which greatly impact our state—were addressed. Also of particular interest, and in perfect alignment with Alabama's state oral health plan, multi-directional integration of oral health and overall health strategies were discussed.

After the meeting, campaigns and initiatives underway and proposed in Alabama were shared with RADM Ricks. One such topic was the nationally recognized #WATCHYOURMOUTH Oral Cancer Awareness Campaign, created through the collaborative efforts of OHO and USA Health Mitchell Cancer Institute. A subsequent and resulting article was featured in the US Public Health Service Chief Dental Officer Newsletter Issue #63. Dentists and hygienists in attendance at the meeting were granted between four and seven continuing education credits from the Alabama Board of Dental Examiners upon request from OHO. RADM Ricks visit to Alabama was also featured in the ADPH's agency newsletter, *Alabama's Health*.

In addition to the in-person presentation of RADM Ricks, the OHCA virtually welcomed Jane Grover, D.D.S., M.P.H, Director, Council on Advocacy and Prevention of the American Dental Association for her presentation titled *Action*

for Dental Health: Practice-Based Community Strategies.

Pay It Forward

The partnership between OHO and HandsOn River Region and its Pay It Forward Program is in its fifth year. Through this partnership, OHO provides a grant in the amount of $25,000.00 annually to help low-income citizens who lack dental insurance receive needed dental treatment and give back to the community at the same time. HandsOn River Region provides staffing for Pay It Forward to orchestrate a value-based program allowing clients to log volunteer hours (choosing from over 200 nonprofit agencies in the River Region) in exchange for dental treatment. Initially, the target population was expectant mothers vetted through the Gift of Life Foundation. Since its inception, the program has expanded to include expectant fathers enrolled in the Gift of Life Foundation programs, as well as chronically unemployed individuals. The partnership was recognized as a best practice by the Association of State and Territorial Dental Directors (ASTDD) in 2020. The program has experienced its share of challenges due to the closing of dental offices during COVID-19, as well as a decrease in the number of participating dentists, citing the need to see their own patients that could not be seen during the pandemic.

Tuscaloosa County Health Department (TCHD) Dental Clinic

While great thought goes into the projects and campaigns of OHO, there are times that plans encounter obstacles that prevent the expenditure of funds on their intended target. Decreased travel expenses and decreased requests for Fluoridation Grant money resulted in funds that needed to be redirected. The Central Office of ADPH has only one dental clinic over which it has purview, TCHD Dental Clinic. Over the years, the clinic chairs fell into disrepair and, due to their age, parts were often not available. By redirecting the unused funds of the OHO fluoridation program, three new operatory chairs and exam lights were installed allowing for the continued safe and efficient treatment of patients. WIC participants at the TCHD clinic receive oral health education from the dental students that rotate through the dental clinic. Ten pregnant women were screened in 2022 at the dental clinic.

Calhoun Community College and Wallace State Community College

Realizing the desperate need for access to oral health care, the Northern District of ADPH embarked upon a partnership with two community colleges within their District. Calhoun Community College and Wallace State Community College both have dental hygiene programs. Wallace State's program is well established with graduates

spanning over 20 years, with Calhoun's program experiencing its inaugural year in 2022. Both programs have agreed to accept ADPH MCH population patient referrals for preventive dental services, in-kind, for preventive dental visit supplies. Additionally, educational materials and discussions regarding the importance of preventive dental visits for children ages 1-17 years and expectant mothers are provided. Interprofessional collaboration is evidenced as well by education regarding the Human Papilloma Virus (HPV) and promotion of the HPV vaccine which targets not only cancers of the head and neck but five additional cancers throughout the rest of the body. Questionnaires are completed by patients at the end of their visits to gauge patients' increased knowledge of the importance of good oral health as a result of the interaction with the student hygienists. The partnership benefits both patients' well-being as well as providing the programs and students with a much-needed patient population. We anticipate and welcome the continued growth of the mutually beneficial partnership. The partnership was featured in ADPH's agency newsletter, *Alabama's Health*.

Ongoing activities in Alabama to improve oral health:

Water Fluoridation

OHO provides funding opportunities for community water systems to apply for grants up to $25,000.00 each ($100,000 total) for the purpose of updating old fluoridation equipment, purchasing/upgrading fluoridation equipment, or initiating community water fluoridation. The OHO fluoridation coordinator sends RFPs statewide to all systems, both adjusting and non-adjusting. Preference is given to any system that wishes to initiate fluoridation. There were two grantees in FY 2022. The Waterworks Board of the City of Birmingham was awarded $25,000.00 and the Perdido Bay Water, Sewer and Fire Protection District Inc was awarded $11,943.00. While increasing numbers of systems are opting to reconsider their fluoridation efforts, 123 CDC Water Fluoridation Quality Awards were awarded in Alabama in 2022 (for 2021/one year in arrears), an 11 percent increase over last year (109). More information is available on Alabama's community water fluoridation efforts at alabamapublichealth.gov.

Oral Health Education

To further the promotion of preventive dental visits for expectant mothers, OHO began adding oral health messages to the Well Woman Program's 211KNOW campaign. The following is an example of a featured message: "Some bacteria that cause gum disease are common to pre-term and low-birth weight babies. Both of these conditions are associated with infant mortality. Preventive dental visits are important before, during, and after pregnancy to improve healthy birth outcomes."

After being postponed for over 2 years due to COVID-19, Alabama's first Remote Area Medical (RAM) event

occurred on April 23 & 24, 2022 in Gadsden, Alabama. RAM was initially founded in 1985 by pilots and physicians with the goal of bringing medical care to isolated areas of the globe but immediately began getting requests from rural parts of the United States. In Alabama, about 10 percent of residents have no medical coverage at all. Many of those with health insurance don't have supplemental policies for vision and dental. The event offered patients opportunities to receive treatment from two of the three disciplines: medical, optometry, and dental. Sixty dental chairs were in use, clinically staffed primarily by close OHO partners from the UAB School of Dentistry. Numerous ADPH volunteers from various areas of the state assisted in a variety of roles. The RAM event was featured in ADPH's agency newsletter, *Alabama's Health*, and on *al.com,* which is self-declared as Alabama's largest news site.

The OHO director was invited by ASTDD to be on a committee for the development of a publication for raising awareness about the importance of older adult oral health and increasing collaborative efforts to improve health and well-being. The publication, *Older Adult Oral Health Resources for Collaboration,* was completed and released in September 2022. It is a free resource available electronically on the ASTDD website. Hard copies are also available by request through OHO.

ADPH Public Health District Initiative

ADPH, JCDH, and MCHD coordinators submitted MCH FY 2022 project proposals to address needs within the Women/Maternal Health Domain. The following is a summary of those county projects.

East Central Public Health District

Obesity is a problem in Alabama. In 2021, Alabama's rate of adult obesity was 39.9 percent, which places the state in the third-highest position in the nation. The obesity rates are higher in the East Central Public Health District. In Montgomery County, 56.1 percent of the residents are overweight or obese. In Macon County, 40 percent are obese and in Russell County, 38.5 percent are obese. Expansion of the Well Woman Program was selected as the district's strategy to help continue the fight against obesity and for improved women's health.

The Well Woman Program continued to be implemented in Montgomery, Macon, and Russell Counties to enhance access to healthcare for women ages 15 to 55, provide preconception and interconnection care counseling, provide risk assessment and behavior modification, to prevent and/or manage a chronic disease, and reduce maternal and infant morbidity and mortality. The district coordinator and clinic staff partnered with community programs, including The Gift of Life Foundation, Inc. (a Healthy Start Program grantee), the Wellness Coalition, and the Alabama Cooperative Extension System, in order to continue implementing the district's Well Woman Program. The program has had some great success. The enrollees have seen a 2 percent decrease in BMI and one participant has lost over 100 pounds. The program and its partners were able to host their first annual Well Woman and Safe Sleep Conference in Montgomery. Over 200 Alabamians were educated on healthy lifestyles and the MCH Program. The district MCH coordinator also partnered with Alabama State University and Auburn University to distribute healthy lifestyle information to over 700 students.

Southeastern Public Health District

According to the 2020 Maternal Mortality Review, Alabama had the third highest national rate of maternal mortality at 36.4 per 100,000 live births. According to the 2022 Robert Wood Johnson County Health Rankings, Barbour County's overall health outcome rank declined from the previous rank of 45 in 2020, to 51 in 2021, to 56 in 2022. Henry County's rank has declined from 13 in 2020, to 17 in 2021, to 20 in 2022. Barbour County saw an increase by 1 percent in low-birth-weight deliveries, now at 12 percent. Henry County experienced the same increase in the percentage of low-birth weight deliveries to 11 percent. In Barbour County, 17 percent of adults are uninsured. In

Henry 16 percent of adults are uninsured. Barbour County has a ratio of 2,740:1 population to primary care physicians. Henry has a ratio of 3,440:1 population to primary care physicians. Diseases of the heart were the leading cause of death in Barbour County, causing 152 deaths under the age of 75. Diseases of the heart were the second leading cause of death in Henry County, resulting in 72 deaths under the age of 75. The district focused its efforts to address its morbidity and mortality issues by continuing to implement the Well Woman Program in an effort to increase preventive medical visits in two of its counties with elevated risks for maternal mortality.

During FY 2022, Barbour County enrolled 72 participants in the Well Woman Program. Henry County enrolled 61 participants, with a total of 133 enrollees. Due to FY 2022 being the first year of implementing the program, decreases in risk factors such as blood pressure were unmeasurable. There was a total of five participants regularly attending the Eufaula Recreation Center gym membership. There were five main community partners to support the Well Woman program, including Wallace Community College, The Eufaula Pregnancy Resource Center, the Chamber of Commerce, the UAB Cancer Center, and the Cooperative Extension Office.

The Southeastern Public Health District also made strides to address infant mortality rates during FY 2022. In 2020, the District had a rate of 7.6 for all 10 counties. It is noted that every county within the district experienced at least 1 infant death during 2020, with a total loss of 37 precious infants. According to the ADPH Center for Health Statics, Henry County had an alarming rate of 12.4 per 1,000 live births, the highest in the district. Houston County was second at a staggering 11.2 per 1,000 live births. Barbour County followed at 10.8 per 1,000 live births. All counties in the district, not including Butler and Coffee, were listed as higher than the national average.

During FY 2022 the district collaborated with the regional perinatal coordinator to evaluate the creation of the Safe Bama Baby Safe Sleep Survey. The premise is to implement this survey in the three district counties with the highest infant mortality rates. Safe Sleep Ambassadors will identify pregnant WIC recipients, meet with the identified expecting parents, and provide a tote bag with safe sleep-related items, such as: pacifier, brochures, and onsies that remind the parent to place the baby on their back for sleep. A consent form was developed and approved through the Internal Review Board (IRB). The form is presented to the expecting parent for permission to conduct the Safe Bama Baby Safe Sleep Survey. If the expecting parent provides consent, the survey is completed during the third trimester of pregnancy. The survey will help to provide individualized education and identify the lack of a safe sleep space for the expected infant. If a safe sleep space is needed, the Safe Sleep Ambassador will assist with a referral for a Cribs for Kids® pack ‘n play from FHS. The incentive item for completing the survey will include a Snoozzzette zip-able blanket from Cribs for Kids®. The zip-able blanket reinforces safe sleep practices.

Mobile County Health Department (MCHD)

MCHD has a primary care division, Family Health (FH), with clinics located throughout Mobile County. These FH clinics are designated as FQHCs and Primary Medical Homes. FH serves uninsured, underinsured, Medicaid recipients, and those with other forms of health insurance. MCHD has patient care coordinators to help navigate community members to various services provided at the agency.

As stated previously, Alabama has the third highest maternal mortality rate in the United States at 36.4 per 100,000 live births. The state’s maternal mortality rates among Black mothers remain disparaging with poverty, a lack of education, and the lack of access to quality maternal care being among the key factors.

The MCHD MCH program helps to encourage and promote healthy women during pregnancy, childbirth, and postpartum. The program provides education, resources, access, and referrals to recommended prenatal and well-childcare appointments; infant and maternal mortality prevention education services; behavioral health services to

address postpartum depression and other concerns; newborn screenings; child immunizations; and maternal, infant, and child nutrition through WIC services.

The goal of the MCHD MCH Program is to increase awareness of factors that adversely affect the health of mothers and babies, increase and promote education and resources available to mothers living in Mobile County, and provide services to decrease the rates of infant and maternal mortality in the county and state.

The MCH Family Support/Home Visitation Programs support social group activities with young pregnant and parenting youth & teens aged 10-19. The programs promote oral health and dental screenings, educate on the importance of breastfeeding, provide education on safe sleep practices, promote car seat safety, provide education and referrals to doula services, and encourage positive parenting in collaboration with the Fatherhood Initiative Program. The Family Support/Home Visitation Program serviced over 100 families and children in FY 2022.

The month of March was specifically devoted to strategic planning and emphasizing women's wellness. The MCH program staff participated in March's group connect activity with Family Support/Home Visitation to promote the importance of taking care of yourself. There was a presentation advocating for yearly reproductive health screenings, frequent sexually transmitted disease testing, violence prevention, and tobacco usage prevention.

Throughout the year, the MCHD MCH coordinator attended women's health luncheons, summits, and workgroups, focused on varied topics, such as the impact of stigma on those with substance use disorder, environmental justice workgroup, health care quality, and parent engagement. The MCHD MCH coordinator also participated in weekly outreach initiatives at the MCHD/FH WIC clinic sites to share information, resources, and incentives with mothers who presented for their WIC appointments. In addition, the MCHD MCH coordinator developed community partnerships and participated in many other outreach events throughout the county.

Northern Public Health District

Oral Health was the chosen area of focus for the Northern Public Health District in order to address deficiencies in the lack of access and availability of dental care within the district. The goal was to recruit and establish resource options for access to dental care for the target population, children ages 0-17, and expectant mothers. The district MCH coordinator and the OHO established a partnership with Calhoun Community College and Wallace State Community College. Per the MOU between the colleges and the district, the colleges agreed to provide preventive health hygiene dental services and education to ADPH MCH clients, to provide data regarding number of clients served, and to provide ADPH outreach documents for distribution to potential clients requesting and needing preventive dental health services. The district was responsible for identifying patients in need of preventive dental health services, promoting the availability of free preventive dental services, and purchasing oral care supplies and materials to provide preventive dental services for the ADPH clients served. Additionally, the OHO coordinated with the colleges allowing dental hygiene students to provide teaching opportunities as feasible, within the scope of ADPH and the Alabama Dental Practice Act practice opportunities.

The following are the FY22 highlights of the district MCH partnership with Calhoun Community College and Wallace State Community College.

1. A dental care screening tool was developed to allow the CHD WIC staff to identify patients needing assistance with dental treatment and other related resources.
2. Oral health information cards were produced in English and Spanish and disseminated to promote the oral health partnership.

3. Dental incentive items were ordered for dissemination at health fairs and different community organizations as needed.
4. Forty-four WIC clients were referred and two individuals received a dental exam.
5. A total of 94 patients were served by dental hygiene students, 6 of them being pregnant women.
    a. Thirty-two patients received dental cleanings and exams at Wallace State and 62 patients at Calhoun, exceeding the initial goal of 50 expectant mothers and children receiving dental cleanings and exams.
6. Each patient completed a patient satisfaction survey.

More than 700 oral health information cards about the oral health partnership and 500 incentive items were provided to the 12 CHDs, community organizations, public schools, provider offices, and community health and resource fair events within the district. This distribution exceeded the initial goal of providing 500 pieces of educational information.

Additionally, the district MCH coordinator attended health and community resource fairs and events, participated in various community organization meetings throughout the twelve-county district, and visited obstetrics and gynecology offices across the district sharing information about oral health and resources available through ADPH.

Southwestern Public Health District

ADPH's 2019 Marengo County profile indicates 12.7 percent of females are aged 15-44. According to the 2019 State Health Assessment, nutrition and physical activity ranked as one the top health concerns in the district. In 2019, Marengo County reported that 27 female deaths were due to heart disease and 2 deaths because of diabetes.

Due to the poor health outcomes for women in Marengo County, the Southwestern Public Health District decided to implement the evidence-based Well Woman Program. The district's goal was to improve the overall health of women in Alabama and to reduce morbidity and mortality rates by providing a comprehensive foundation for wellness, health promotion, disease identification, and management while promoting healthy lifestyles through health counseling/coaching, education, and coordination with community support services.

Due to staffing shortages, the Well Woman Program was not implemented in Marengo County until September 2022. Due to the late start, during FY 2022, only one Well Woman participant was enrolled. The district hopes to see these numbers improve by continuing to promote the Well Woman Program in Marengo County.

Other ADPH Women/Maternal Health Programs

Office of Women's Health (OWH)

OWH was created in 2002 through the Alabama Legislature Act 2002-141 to be an advocate for women's health issues through the formation of the OWH's Health Steering Committee. The steering committee consists of physicians, nurses, pharmacists, dieticians, and business leaders appointed by their professional organizations. The OWH is located in FHS and is directed by the perinatal division director. The OWH steering committee meets quarterly to receive updates on activities at ADPH and address current issues related to women's health, which may include topics such as maternal mortality, mental health, barriers to care, and health equity.

Family Planning (FP)

ADPH FP Program provides confidential family planning and related comprehensive health care services throughout

the state to women, men, and adolescents in need of reproductive health care. In CY 2022, FP and its sub-recipients, JCDH and MCHD, served 46,827 clients. Over 29,000 clients reported incomes of 100 percent or less than the FPL, and more than 21,000 of the clients served during CY 2022 were uninsured. However, ADPH also provides FP services to patients insured by Medicaid (Plan First and/or full Medicaid) or Blue Cross Blue Shield of Alabama. ADPH FP services include reproductive life planning; contraceptive counseling; breast and cervical cancer screenings, and follow-up; and screening and treatment for sexually transmitted infections. Clients also receive referrals for health care services outside the scope of FP through partnerships with other ADPH programs. Those partner programs include the Alabama Breast and Cervical Early Detection Program, and external entities, such as DHR, contracted professional services providers, and ACHN. Clients have access to a broad range of contraceptive methods, including long-acting reversible contraceptives (LARC). During CY 2022, just over 31 percent of clients selected a LARC method. During CY 2022, FP clients and service provision were dramatically impacted by the onset of the COVID-19 pandemic. With Medicaid's approval, ADPH implemented a virtual visit model, which allowed the continued provision of essential FP services. Beginning in March 2021, Medicaid extended approval for telehealth FP visits on a month-to-month basis. Telehealth visits are especially beneficial to ADPH clients whose access to services may be limited by barriers, such as lack of transportation, inability to fit in-person visits into hourly work schedules, and lack of childcare. FP Program NPs completed over 2,400 telehealth visits during CY 2022.

In 2019, FP physicians began providing colposcopy services, traveling to selected CHDs on a rotating schedule, in order to facilitate easier access for patients within surrounding multi-county geographic areas. The addition and expansion of this critical procedure greatly facilitate continuity of care for patients who require follow-up of abnormal cervical cancer screening results. As a result, 592 colposcopies were completed during the reporting period and as a result, 142 pre-invasive or invasive cervical cancers were detected.

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

WIC provides federal grants managed by the United States Department of Agriculture (USDA), Food and Nutrition Service (FNS) to states for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding and non-breastfeeding postpartum women, and to infants and children up to age 5 who are found to be at nutritional risk. Each state receives an annual food and Nutrition Services Administration (NSA) allocation. In addition to the food and NSA allocation, each state is entitled to an annual Breastfeeding Peer Counseling (BFPC) grant award to further support breastfeeding among WIC participants. Alabama's WIC program is managed by FHS. There is no state match requirement to receive WIC funding and no state or other federal program funds are provided to support Alabama's WIC Program. The fiscal year for WIC begins October 1, and runs through the following September 30.

During FY 2022, Alabama's WIC program responded to the Abbott formula recall and the resulting nationwide formula shortage. In February 2022, Abbott (one of the largest formula manufacturers in the nation) recalled several powdered formula products and temporarily closed the affected formula manufacturing facility. This resulted in a widespread and long-lasting infant formula shortage that the nation has still not fully recovered from over a year later. Although Alabama's WIC contract formula manufacturer is Mead Johnson, the effects of the nationwide formula shortage required Alabama to implement alternative noncontract formula options to effectively feed the more than 25,000 infants served by Alabama's WIC program. Alabama WIC implemented numerous formula waivers made available at the federal level to respond to this nationwide emergency. As flexibilities and timelines continue to change, Alabama's WIC program shifts to make necessary changes to care for the infants served by WIC, which represent approximately half of the infants born in Alabama. Communication has been key to ensuring accurate messaging and understanding of evolving needs and available resources. Alabama WIC has utilized multiple communication platforms including news releases, social media, text messaging, website updates, the WIC app,

and verbal messaging from WIC staff to participants. Currently, FNS is unwinding infant formula flexibilities with a tiered return to normal formula offerings. Noncontract formula alternatives ended on February 28, 2023. Additional sizes and products of contract brand formulas are set to expire on April 30, 2023, and waivers related to specialty formulas for medically fragile infants are set to expire on June 30, 2023. FNS remains in close communication with WIC state agencies, infant formula manufacturers, and large retail corporations to assess the need for additional flexibilities beyond the current unwinding schedule.

One opportunity realized with the nationwide infant formula shortage is the potential for more new mothers to be open to breastfeeding. Breastfeeding promotion and support are available for moms and babies enrolled in WIC. Breastfeeding support includes information on techniques to improve supply, infant latch, and other components of successful lactation. Moms desiring to breastfeed can receive breast pumps and be paired with a breastfeeding peer counselor to provide additional support. Breastfeeding peer counselors are funded through the BFPC grant while breast pumps are purchased with WIC food funds. During FY 2023, Alabama WIC launched Pacify, a mobile app providing 24/7 video calls with International Board Certified Lactation Consultants (IBCLCs). Alabama’s WIC program is excited to provide real-time access to IBCLCs whenever WIC breastfeeding moms need it and hopes this innovation will enhance and improve the breastfeeding experience resulting in an increase in initial breastfeeding rates as well as the duration of time WIC infants are breastfed. Alabama’s WIC program is open to data-driven innovations, methodologies, and new technologies to further support breastfeeding promotion and support efforts.

Nationally, WIC is focusing on outreach, innovation, modernization, and new technologies to remove barriers and increase participation. Alabama's WIC program utilizes a portion of NSA funds on outreach activities, such as recruitment and retention efforts aimed at increasing WIC participation. Alabama’s WIC program utilizes electronic benefit transfer (EBT), known as eWIC in Alabama. Issuing food benefits through eWIC significantly improves the shopping experience and allows WIC participants to redeem benefits at different stores based on their current needs. WIC families can purchase some or all of their WIC benefits during a single shopping trip. For authorized vendors offering self-checkout, WIC shoppers can also utilize self-checkout with eWIC. Another innovative outreach method utilized in Alabama is the WIC mobile app. The Alabama WIC app is a one-stop shop for several resources including eligibility requirements, a map to find the nearest WIC clinic, the WIC-approved foods brochure, a bar code scanner that can be used while shopping to determine if a food is included in the WIC approved product list, a custom-built appointment reminder, healthy recipes, breastfeeding resources, a convenient link to online nutrition education classes, and social media posts to stay up-to-date with any current WIC news. Alabama’s WIC program also partners with WICHealth to provide online nutrition education to WIC participants that easily accessible with age-appropriate feeding topics to support healthy nutrition at all stages from pregnancy through birth, infancy, toddler years, and early childhood. In addition to new technologies, WIC continues to utilize partnerships with other organizations to reach potentially eligible families. For example, WIC partners with Head Start programs to provide outreach and additional sites for WIC enrollment. As many families served by Head Start may be eligible to receive WIC, this is an ideal partnership for both programs. Another alternate site for WIC enrollment includes select birthing hospitals in Alabama. Future outreach plans include partnerships under the new WIC Community Innovation and Outreach (CIAO) grants, which are open to community-based and other non-WIC partners serving WIC’s eligible population. The first round of CIAO grants will be awarded in the summer of 2023.

During FY 2022, Alabama’s WIC program continued to enroll new participants and certify existing clients remotely through federally approved WIC waivers implemented during COVID-19. WIC appointments were conducted over the telephone or other remote means, with in-person appointments remaining available on a case-by-case basis for those with special needs. Moving into FY 2023, Alabama's WIC program began to safely reopen WIC clinics to the public while continuing remote appointments for those unable to attend in person. During FY 2022, the monthly

average of participants receiving WIC benefits was 108,661. With the return to in-person services, the WIC caseload is beginning to grow and exceeded 110,000 by the spring of 2023. To support WIC participation, Alabama's WIC Program implemented text message notifications to let families know that benefits were added to their eWIC cards. Beginning in June 2021, WIC participants began receiving a temporary increase in cash value benefits (CVB) for fresh fruits and vegetables. Monthly CVBs initially increased from $9 per child and $11 per woman, to a flat rate of $35 per participant. Tiered CVBs were implemented during FY 2022 with children receiving $24, pregnant and postpartum women receiving $43, and breastfeeding women receiving $47. These amounts increase to $25 per child, $44 for pregnant and postpartum women, and $49 for breastfeeding women in FY 2023. Due to the significant increase in CVBs, Alabama's WIC program expanded produce options to include both fresh and frozen fruits and vegetables, adding thousands of frozen fruits and vegetables to the WIC-approved product list in FY 2023. During FY 2024, Alabama's WIC program hopes to implement opt-in text messaging to notify participants of newly added and expiring WIC benefits. This endeavor will help with benefit redemption as WIC benefits must be redeemed within 30 days of issuance prior to expiration. More information is available on the ADPH website at www.alabamapublichealth.gov/wic.

Maternal Mortality Review Program

The Maternal Mortality Review Committee (MMRC) is comprised of a diverse group of individuals from all over the state. There are a total of 58 members with a variety of disciplines/specialties that include: obstetricians/gynecologists, maternal-fetal medicine, pathologists, psychiatrists, substance use disorder specialists, cardiologists, emergency physicians, registered nurses (RN)/nurse practitioners, social workers, family physicians, certified nurse midwife, PharmD, anesthesiology, public health, a diversity officer, private insurance and Medicaid, hematology/oncology, community health worker, March of Dimes, ALPQC, the DHR, Gift of Life Foundation. Inc., coroner, Women's Foundation of Alabama, and My Care Alabama. The MMRC has reviewed COVID-19-related deaths as they occurred in order to increase knowledge of the impact of the virus on pregnant and postpartum women and develop recommendations for medical providers.

Women/Maternal Health - Application Year

During the 2019-2020 Title V Needs Assessment, Alabama selected NPM 1 and NPM 13 as its areas of focus for women/maternal health for FY 2021-2025. The ESM supporting activities for each NPM will be implemented as described below.

Well Woman Program

NPM 1 - Percent of women, ages 18-44, with a preventative medical visit in the past year

ESM 1.1 - Increase the percentage of women receiving both Family Planning services and Well Woman services by 2 percent within active Well Woman Program counties.

The Well Woman Program staff changed the ESM to better capture and measure the work that is being done in each of the active Well Woman Program counties. Referrals are received from a variety of sources such as community partners, self-referrals, and community health fairs, but a large source of referral is within the county health department through FP. The program plans to implement a newly developed social work protocol that gives guidance in recruitment and follow-up, make changes to the clinical documentation to better document referrals received and audit program progress, and reorganize the Well Woman Program's clinic protocol manual to provide more continuity in care throughout all CHDs. There is also an option within FP documentation to refer and enroll participants into the Well Woman program. Informational flyers are displayed throughout the CHDs and staff are educated about the Well Woman Program and the positive impact it can have on women between the ages of 15-55 through education on the prevention of chronic disease and sustainability of a healthier lifestyle.

Looking to FY 2024, the Well Woman Program plans to create several tools and processes to continue to better organize the program to provide continuity of services to all counties. The Well Woman Program Central Office staff are working to develop and implement social work protocol and training for program staff, monitor risk reduction sessions to ensure the sessions have been completed with all participants, develop a standard method for evaluating the physical activity component of the program, work with FHS epidemiologists and the ADPH Office of Field Operations to update social work documentation in the electronic health record (EHR), work with the program medical director to develop an audit tool, and reorganize the clinic protocol to increase efficiency in clinic visits.

Oral Health Office

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

ESM 13.1.1 - Percentage of dental providers receiving information/education regarding the importance of preventive dental visits for expectant mothers

ESM 13.1.2 - Percentage of dental providers that received information/education regarding their perinatal patients about the FDA-approved HPV vaccine in order to reduce the risk of oropharyngeal, cervical, and other HPV-related cancers

For FY 2024, opportunities for in-person presentations have been confirmed at the Second District Dental Society, the Gulf Coast Dental Conference—including a panel of speakers from the ADA, and two virtual Alabama Dental Association hosted sessions with our partners at USA Mitchell Cancer Institute and VAX2STOPCANCER occurring in Big Sky Montana.

Maternal Mortality Review Program

In FY 2024, the MMRC will continue to meet quarterly to review cases. State funds through the general fund budget will continue for the MMRP. These funds were secured through the efforts of the March of Dimes and the Medical Association of the State of Alabama. The program is currently reviewing deaths 3 years after they occur. In order to review deaths in a more timely manner, the MMRP is in the process of creating a subcommittee to review motor vehicle accidents and homicides. The program will also incorporate the community vital signs dashboard into our reviews. The dashboard was developed by a team at Emory University with support from the Division of Reproductive Health Maternal Mortality Prevention Team at CDC. It aims to support MMRC conversations around social determinants of health specific to each individual death.

Perinatal/Infant Health

National Performance Measures

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
Indicators and Annual Objectives

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	84.5	84.2	83.6	83.8	84.8
Annual Indicator	72.6	75.4	74.1	77.6	77.6
Numerator	788	857	854	847	847
Denominator	1,086	1,137	1,153	1,092	1,092
Data Source	Alabama Center for Health Statistics	Alabama Center for Health Statistics	Alabama Center for Health Statistics	Alabama Center for Health Statistics	Alabama Center for Health Statistics
Data Source Year	2018	2019	2020	2021	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	77.9	78.0	87.2

Evidence-Based or –Informed Strategy Measures

ESM 3.1 - Percent of delivering hospitals convened at a meeting to share data and discuss the Alabama Perinatal Regionalization System Guidelines

Measure Status:	Active			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			0	10.9
Annual Indicator	8.7		0	53.2
Numerator	4		0	25
Denominator	46		46	47
Data Source	Alabama State Perinatal Program Data		Alabama State Perinatal Program Data	Alabama State Perinatal Program Data
Data Source Year	2020		2021	2022
Provisional or Final ?	Final		Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	21.8	32.7	43.6

ESM 3.2 - Number of steps of the CDC's LOCATe process completed in order to design and align the Alabama Perinatal Regionalization System Guidelines with the national criteria for the maternal levels of care

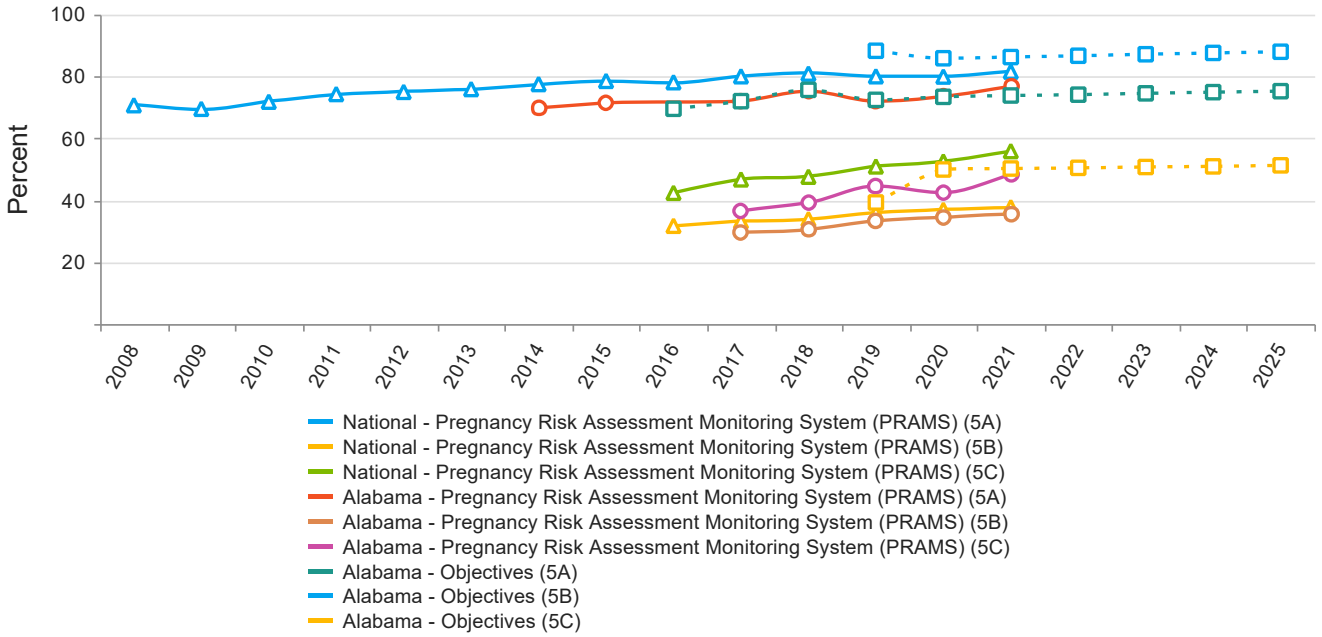
Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			1	1
Annual Indicator	0		0	3
Numerator				
Denominator				
Data Source	Alabama State Perinatal Program Data		Alabama State Perinatal Program Data	Alabama State Perinatal Program Data
Data Source Year	2019		2019	2022
Provisional or Final ?	Final		Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	2.0	2.0	3.0

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Indicators and Annual Objectives



NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	75.5	72.3	73.3	73.7	74
Annual Indicator	71.3	72.1	72.0	73.3	76.8
Numerator	38,245	37,735	37,266	31,945	39,817
Denominator	53,663	52,309	51,781	43,605	51,868
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2017	2019	2020	2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	74.4	74.8	75.1

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2019	**2020**	**2021**	**2022**
Annual Objective	88.1	85.7	86.1	86.5
Annual Indicator	29.8	33.3	34.6	35.7
Numerator	15,619	16,967	15,074	18,338
Denominator	52,446	50,878	43,622	51,403
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2019	2020	2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	87.0	87.4	87.8

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2019	**2020**	**2021**	**2022**
Annual Objective	39.3	49.9	50.2	50.4
Annual Indicator	36.7	44.4	42.3	48.3
Numerator	19,218	22,734	18,238	24,583
Denominator	52,355	51,234	43,152	50,900
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2019	2020	2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	50.7	50.9	51.2

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - Number of sleep-related infant deaths

Measure Status:	Inactive - There is overlap between NOM 9.5 and ESM 5.1. Alabama has decided that there is no added value in tracking SIDS deaths in addition to SUID deaths.

State Provided Data				
	2019	2020	2021	2022
Annual Objective			63.9	62
Annual Indicator	70	99	102	101
Numerator				
Denominator				
Data Source	ADPH Center for Health Statistics	ADPH Center for Health Statistics	ADPH Center for Health Statistics	ADPH Center for Health Statistics
Data Source Year	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final

ESM 5.2 - Number of trainings facilitated to assist healthcare professionals and first responders, who interact with expecting and new mothers, with being trained on safe sleep recommendations

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			2.5	2.5
Annual Indicator	2		0	3
Numerator				
Denominator				
Data Source	Alabama State Perinatal Program Documentation		Alabama State Perinatal Program Documentation	Alabama State Perinatal Program Documentation
Data Source Year	2020		2021	2022
Provisional or Final ?	Final		Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	3.1	3.9	4.9

State Performance Measures

SPM 8 - Decrease number of infants dying from Sudden Infant Death Syndrome (SIDS)

Measure Status:	Inactive - There is overlap between NOM 9.5 and SPM 8. Alabama has decided that there is no added value in tracking SIDS deaths in addition to SUID deaths.

State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	10.6	
Numerator	43	
Denominator	404	
Data Source	Alabama Center for Health Statistics	
Data Source Year	2020	
Provisional or Final ?	Provisional	

State Action Plan Table

State Action Plan Table (Alabama) - Perinatal/Infant Health - Entry 1	
Priority Need	
High levels of infant mortality (and associated factors of preterm birth and low birth weight).	
NPM	
NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)	
Objectives	
Increase the percent of delivering hospitals convened at a meeting to share data and discuss the Alabama Perinatal Regionalization System Guidelines.	
Strategies	
Convene the delivering hospitals to share data and discuss the Alabama Perinatal Regionalization System Guidelines.	
ESMs	**Status**
ESM 3.1 - Percent of delivering hospitals convened at a meeting to share data and discuss the Alabama Perinatal Regionalization System Guidelines	Active
ESM 3.2 - Number of steps of the CDC's LOCATe process completed in order to design and align the Alabama Perinatal Regionalization System Guidelines with the national criteria for the maternal levels of care	Active
NOMs	
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	
NOM 9.1 - Infant mortality rate per 1,000 live births	
NOM 9.2 - Neonatal mortality rate per 1,000 live births	
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	

State Action Plan Table (Alabama) - Perinatal/Infant Health - Entry 2

Priority Need

High levels of infant mortality (and associated factors of preterm birth and low birth weight).

NPM

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Objectives

Complete the steps of the CDC's Level of Care Assessment Tool (LOCATe) process in order to design and align the Alabama Perinatal Regionalization System Guidelines with the national criteria for the maternal levels of care.

Strategies

Implement the CDC's Level of Care Assessment Tool (LOCATe) process in order to align and implement the national criteria for the maternal levels of care.

ESMs	Status
ESM 3.1 - Percent of delivering hospitals convened at a meeting to share data and discuss the Alabama Perinatal Regionalization System Guidelines	Active
ESM 3.2 - Number of steps of the CDC's LOCATe process completed in order to design and align the Alabama Perinatal Regionalization System Guidelines with the national criteria for the maternal levels of care	Active

NOMs

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

State Action Plan Table (Alabama) - Perinatal/Infant Health - Entry 3

Priority Need

High levels and worsening trends of sleep-related/SUID deaths.

NPM

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Objectives

Increase by 5 percent annually, the percentage of WIC prenatal participants placing their infants to sleep on their backs by providing safe infant sleep education.

Strategies

Provide safe sleep education to WIC prenatal participants in order to increase the percent placing their infants to sleep on their backs.

ESMs	Status
ESM 5.1 - Number of sleep-related infant deaths	Inactive
ESM 5.2 - Number of trainings facilitated to assist healthcare professionals and first responders, who interact with expecting and new mothers, with being trained on safe sleep recommendations	Active

NOMs

NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

State Action Plan Table (Alabama) - Perinatal/Infant Health - Entry 4

Priority Need

High levels and worsening trends of sleep-related/SUID deaths.

NPM

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Objectives

Decrease by 3 percent annually, the number of sleep-related infant deaths by implementing targeted consistent safe sleep education to caregivers, child health providers, health care providers, and hospital systems.

Strategies

Implement targeted consistent safe sleep education to caregivers, child health providers, health care providers, and hospital systems.

ESMs	Status
ESM 5.1 - Number of sleep-related infant deaths	Inactive
ESM 5.2 - Number of trainings facilitated to assist healthcare professionals and first responders, who interact with expecting and new mothers, with being trained on safe sleep recommendations	Active

NOMs

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

State Action Plan Table (Alabama) - Perinatal/Infant Health - Entry 5

Priority Need

High levels and worsening trends of sleep-related/SUID deaths.

NPM

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Objectives

Increase by 25 percent annually, the number of trainings facilitated to assist healthcare professionals and first responders, who interact with expecting and new mothers, with being trained on safe sleep recommendations.

Strategies

Facilitate trainings to assist healthcare professionals and first responders, who interact with expecting and new mothers, with being trained on safe sleep recommendations.

ESMs	Status
ESM 5.1 - Number of sleep-related infant deaths	Inactive
ESM 5.2 - Number of trainings facilitated to assist healthcare professionals and first responders, who interact with expecting and new mothers, with being trained on safe sleep recommendations	Active

NOMs

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

State Perinatal Program

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

ESM 3.1 - Percent of delivering hospitals convened at a meeting to share data and discuss the Alabama Perinatal Regionalization System Guidelines

ESM 3.2 - Number of steps of the CDC's Level of Care Assessment Tool (LOCATe) process completed in order to design and align the Alabama Perinatal Regionalization System Guidelines with the national criteria for the maternal levels of care

Very low birth weight infants (‹1,500 grams or 3.25 pounds) are the most fragile newborns with a risk of death over 40 times higher than that of normal birth weight infants (>=2,500 grams or 5.5 pounds). In Alabama, although they represented less than 1.8 percent of all births in 2021, VLBW infants accounted for 181 deaths out of total of 443 infant deaths, or 40.8 percent of all infant deaths. VLBW infants are significantly more likely to survive and thrive when born in a facility with a Level-III neonatal intensive care unit, a subspecialty facility equipped to handle high-risk neonates. In 2021, there were 847 VLBW infants born in a hospital with a Level III or above NICU out of total of 1092 VLBW births in Alabama. That was 77.6 percent of the VLBW births delivered in Level III or above NICUs in Alabama, and a 3.5 percent increase in the rate from 74.1 percent in 2020.

ADPH has renewed its collaboration with AlaHA to focus on high-risk pregnant women and infants delivering at the appropriate level of care. A workgroup was formed with staff from representative delivering hospitals and AlaHA to explore how the Alabama Perinatal Regionalization System Guidelines are used by hospitals and what challenges they had encountered. As a result of recommendations from this workgroup, LOCATe, from the CDC, was introduced to delivering hospitals in a virtual statewide meeting in April 2021. AlaHA encouraged hospitals to complete the survey on a voluntary basis. Over half of delivering hospitals participated and most completed an assessment of both their neonatal care and maternal care levels. Each hospital received its own results. Aggregated results were shared with ADPH and all delivering hospitals.

The results from LOCATe are used to guide the perinatal regionalization workgroup’s discussions about QI opportunities. Representatives from the Alabama Chapter of the American Academy of Pediatrics, the Alabama Section of the American College of Obstetricians and Gynecologists, and staff from the Alabama Perinatal Quality Collaborative (ALPQC) have been added to the workgroup.

NPM 5 - Percent of infants placed to sleep on their backs

ESM 5.1 - Number of trainings facilitated to assist healthcare professionals and first responders, who interact with expecting and new mothers, with being trained on safe sleep recommendations

ESM 5.2 - Number of sleep-related infant deaths

ESM 5.3 - Number of trainings facilitated to assist healthcare professionals and first responders, who interact with expecting and new mothers, with being trained on safe sleep recommendations

The three commonly reported types of SUID include sudden infant death syndrome (SIDS), unknown cause, and

accidental suffocation and strangulation in bed. These deaths often occur during sleep or in the infant's sleep area. In 2021, there were 101 SUIDs out of 443 total infant deaths. That was 22.8 percent of the total infant deaths in Alabama, which was a 2.4 percent decrease in SUID from 25.2 percent in 2020. ADPH continues to address SUID through safe sleep education, training of medical personnel and community workers, and distribution of cribs to families without a safe sleep environment.

In September 2022, our partners with the Child Death Review (CDR) organized two trainings on SUID investigations geared towards law enforcement, but open to all relevant professionals, including FIMR staff. FIMR staff participated and assisted in promoting the trainings.

The ADPH Perinatal Health Division also worked to bring attention to the tragedy of sleep-related deaths through a satellite training in August titled, "Talking with Parents and Caregivers about Safe Sleep." Continuing education credits were awarded to both social workers and nurses. The recording can be accessed on-demand from the Alabama Public Health Training Network webpage on the ADPH website and has been viewed online by approximately 500 individuals.

The division has helped promote the availability of free portable cribs to a variety of family services providers, including maternity care coordinators at the ACHNs, Blue Cross Blue Shield of Alabama's Baby Yourself® program nurses, labor and delivery nurse managers, and hospital case managers. New initiatives to reach expectant families at car seat clinics and select community events in Montgomery and Macon Counties have also started. In FY 2022, over 300 cribs were distributed to families statewide who lacked a safe place for their infant to sleep.

An ADPH press release highlighting updates to the American Academy of Pediatrics' "Recommendations for Reducing Infant Deaths in the Sleep Environment" was shared by local news networks in Montgomery, Mobile, and Huntsville. The new guidelines added details with more focus on the baby's sleep surface, which should be firm, flat, and should not be shared with others. Based on the updated recommendations, the Baby Box Initiative has been changed to use Baby Boxes only as a temporary, emergency sleep place as a stop-gap until the family can be provided with a pack n' play or other more permanent solution.

Ongoing activities in Alabama to improve birth outcomes and reduce morbidity and mortality:

Fetal/Infant Mortality Review (FIMR)

Regional perinatal nurses continue to present de-identified case summaries to our Regional Perinatal Advisory Committee (RPAC) case review teams for discussion. These teams are made up of regional professionals from law enforcement, medical providers, social workers, coroners, DHR, and Medicaid. The teams discuss the cases, the contributing factors, and make recommendations to prevent similar tragedies in the future. The region-specific recommendations are brought to the cross-sector Community Action Teams (CATs) for implementation.

State Perinatal Advisory Committee (SPAC)

SPAC brings together professionals from across sectors in the perinatal domain statewide at quarterly meetings where guest speakers provide information related to perinatal topics, relevant state agencies give updates regarding services to pregnant women and infants, and one perinatal region is spotlighted to give updates on trends they are seeing in fetal/infant deaths and the implementation of CAT initiatives.

Breastfeeding

WIC breastfeeding staff and Perinatal Health Division staff work closely with community partners to identify resources that support breastfeeding families and to find new ways for connecting families with those resources. In close collaboration with the Alabama Breastfeeding Committee and The Wellness Coalition, resource lists have been published and shared in statewide and local formats. This aligns with the priority need, “Lack of or inadequate access to breastfeeding supports.”

There is also much work surrounding the public support for and visibility of breastfeeding. The Wellness Coalition, based in central Alabama, continues its “Breastfeeding is Normal” campaign with life-size cutouts of women of color breastfeeding their children, often along with a support person. Stickers proclaiming, “I Support Breastfeeding” and window decals declaring “Breastfeeding Welcome Here” have been widely distributed by The Wellness Coalition.

Collaborating Partners and Initiatives for the MCH Populations

Count the Kicks

Healthy Birth Day, Inc. is the non-profit organization that created Count the Kicks. Their mission is to improve birth outcomes through programming, advocacy, and support while reducing racial disparities that persist. Count the Kicks helps save babies from preventable stillbirth, prevents preterm births, and improves outcomes for moms. CDC lists a change in a baby’s movements as one of its 15 urgent maternal warning signs. Count the Kicks educates expectant parents on the importance of tracking their babies’ movements in the third trimester of pregnancy and notifying a medical provider if they notice a change. In Iowa, where the program began, there has been a 32 percent decrease in the stillbirth rate and a 39 percent decrease in the stillbirth rate among African American women. This is the type of decrease we want to see happen in Alabama and is why ADPH has partnered with Count the Kicks, to bring their evidence-based materials and resources to our state.

The hallmark tool of Count the Kicks is a free kick-counting app. This free app is in 16 languages and is for expectant mothers in their third trimester of pregnancy. Count the Kicks provides evidence-based tools and resources for free to anyone in the state that works directly with expectant parents. Visit www.CountTheKicks.org to learn more and order free materials today.

From October 1st, 2021, through September 30th, 2022, 151 healthcare professionals placed orders for Count the Kicks educational resources. There were 75,745 Count the Kicks educational resources such as brochures, app reminder cards, and posters mailed out to 642 expectant parents who downloaded the app. These numbers continue to grow as healthcare professionals share this resource with more Alabamians.

Alabama Perinatal Quality Collaborative (ALPQC)

ALPQC has been working closely with providers and hospitals to implement AIM Patient Safety Bundles on Hypertension in Pregnancy and Neonatal Opioid Withdrawal Syndrome. The Perinatal Health Division staff serve on the steering committee of ALPQC and staff from ALPQC serve on various workgroups and committees led by ADPH.

March of Dimes

The Perinatal Health Division director is a participant in the March of Dimes workgroups on policy, services, and

support related to substance abuse disorders for pregnant women and new mothers. The workgroups meet regularly to strategize methods to reduce barriers to treatment and increase advocacy for pregnant women and new mothers with substance use disorders.

State of Alabama Infant Mortality Reduction Plan

Many activities of the SAIMRP have been integrated into the above report. Below is a summary of activities not reported elsewhere.

Safe Sleep

DHR began a new digital ad campaign in January 2022 with the launch of a new safe sleep website: www.safesleepalabama.com and targeted digital ads on Google and Facebook that direct to the website. The ads have reached a wide audience in Macon, Montgomery, and Russell Counties, totaling 1,806,744 views resulting in 22,988 clicks on the ad for more information.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

SBIRT is a comprehensive, integrated public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. This strategy involves training healthcare providers and care coordinators in implementing SBIRT and the associated tools to aid in identifying and providing referrals for women who may be experiencing substance abuse, domestic violence, and/or depression. Screening maternity patients and identifying risky use patterns and/or potential mental health issues allows risky behaviors to be addressed before the behaviors worsen, which increases positive health outcomes for moms and babies in Alabama.

This strategy came out of repeated recommendations from MMRC and aligns with the education portion of the need priority “lack of or inadequate substance abuse treatment and prevention education, including detox, addiction, and rehabilitation/recovery services.”

First Teachers

The Department of Early Childhood Education (DECE) offers evidence-based home visiting programs via the Nurse-Family Partnership (NFP) and Parents as Teachers (PAT) models in over half of the counties in the state. This collection of projects funded by the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program and other sources, aligns with several priority needs including access to health resources, access to breastfeeding support, and support for pregnant and parenting teens and young/new parents. Through the SAIMRP, NFP programs were funded in Macon, Montgomery, and Russell Counties, and a PAT program was funded in Russell County.

Prematurity Prevention

With the discontinuation of the strategy to promote the hormone treatment 17P, a new strategy to prevent preterm birth had to be found. After consulting research from academic sources as well as policy sources, and exploring several possible strategies to address prematurity, group prenatal care was selected as the new prematurity strategy. A strong team of cross-sector stakeholders was gathered to form a strategy workgroup. Due to its lack of maternity care providers in the county, Macon County was chosen as the pilot location for the strategy. This strategy aligns with the priority need, “inequitable access to health resources based on race/ethnicity, socioeconomic status, geographic location, and education.”

ALL Babies

This ADPH program, which aligns with the priority need, “Lack of or inadequate comprehensive, affordable health and dental insurance,” was designed to improve the health of mothers and babies by providing low-cost, comprehensive healthcare coverage for unborn children through the Children’s Health Insurance Program (CHIP).

This program currently operates in Montgomery, Macon, and Russell Counties. There are no premiums for coverage, and eligibility criteria are broad, allowing more eligible mothers to enroll. Mothers who meet the eligibility criteria are offered a wide range of benefits, including but not limited to, mental health and substance use disorder services. Benefits are all-inclusive healthcare services which include, maternity, preventive, hospital, pharmacy, dental, etc. Benefits can begin on the date an application is received by CHIP or Medicaid and continue through 60 days postpartum. Care coordination services provided by social workers provide easy navigation of all aforementioned services to promote the health of both mother and baby.

Noteworthy accomplishments:

- From January 2020 through September 2022, 1,179 women were enrolled in the program
- From October 1, 2021, through September 30, 2022, 349 babies were delivered
- Beginning October 2021, enrollees received continuous health messaging such as information about WIC, Baby Yourself®, Count the Kicks, and more including ALL Babies educational awareness materials and phone contact from ALL Babies staff

ADPH Public Health District Initiative

ADPH, JCDH, and MCHD coordinators submitted MCH FY 2022 project proposals to address needs within the Perinatal/Infant Health Domain. These projects focused on infant mortality and injury prevention and below is a summary of those efforts.

East Central Public Health District

Infant mortality in Alabama has been historically higher than in other states and within the state, some counties follow a similar trend. Coosa County has a rate of 23.5 infant deaths per 1,000 live birth, Bullock County has a rate of 16.5, and Lowndes County of 16.4. These counties have the highest infant mortality rate in the East Central District, and as such, were selected as the target counties for the district's Infant Safe Sleep Outreach and Education project. The Infant Safe Sleep Outreach and Education project included community education on safe sleep environments and marketing for the ABCs of safe sleep. Throughout the year ABCs billboards were placed in each targeted county, and the district MCH coordinator attended community meetings, events, and health fairs to share SIDS/SUID, Count the Kicks, and other perinatal health information. The coordinator also visited community agencies, churches, and businesses to reach parents and grandparents with the purpose of promoting and raising awareness of safe sleep.

In addition to the community outreach, the district MCH coordinator formed partnerships with several community agencies, including the Gift of Life Foundation, Inc. and the Wellness Coalition. The partnership with the Wellness Coalition has allowed the creation/placement of lactation rooms on the campus of Tuskegee University, at the Montgomery CHD, and at local churches throughout the East Central District. The coordinator also partners with the Coalition to host monthly baby depots in Macon and Montgomery Counties. The depots are a one-stop place where parents and caregivers receive information on healthy babies and healthy moms.

Jefferson County Department of Health

JCDH operates the From Day One (FDO) Program, with the goal of improving pregnancy and birth outcomes for the women and infants in Jefferson County. FDO is a comprehensive patient-centered program designed to educate and support expectant mothers from the first trimester of pregnancy through their child's first year of life. FDO promotes early access to prenatal care and connects families to beneficial community resources. The patients

served by FDO consist of high-risk pregnant women, their infants, and maternal partners. Emphasis is placed on low-resource, low income, under-insured, uninsured, and minority patient populations. FDO works with Connection Health to provide community health workers (CHWs) to achieve the program goals. Connection Health CHWs provide the day-to-day monitoring of each participant in the program. In previous studies, it was shown that the western area of Jefferson County accounted for 66 percent of burn injuries, 55 percent of bicycle injuries, and 57 percent of poisonings admitted to the COA. With the use of zip code mapping, it was determined that the majority of FDO participants live in western Jefferson County.

FDO program participants receive a baby safety shower in their third trimester of pregnancy. The goal of the Baby Safety Shower is to increase client knowledge on infant safety, thereby reducing the number of childhood injuries and improving infant mortality. Each shower is planned as a special event for the program participant, one supportive person, and all children under age 5 in the household. Baby Safety Showers are held quarterly at JCDH and last approximately two and a half hours. During the Baby Safety Shower, JCDH staff, community partners, and first responders deliver presentations covering a variety of infant health, injury prevention, and safety topics. Participants receive education on safe sleep, breastfeeding, fire safety, gun safety, personal safety, car seat safety, stress reduction, and oral health. Also, at the conclusion of the shower, participants take home safety-related items.

At enrollment, FDO participants complete a demographic questionnaire that includes questions about infant and childhood injury risk factors currently in their homes. Also, before entering the Baby Safety Shower, participants complete a pre-test to determine baseline knowledge of injury prevention and childhood safety. When showers are held in person, simultaneous interpretation is utilized for participants with limited English proficiency. Printed information is also provided in Spanish.

Due to COVID-19, the format for the Baby Safety Showers was temporarily changed to a virtual presentation and touchless distribution model. Break-out rooms were utilized when the FDO showers were held via Zoom. Break-out rooms allowed the participants with limited English proficiency to participate with interpreters in those rooms. Preparation for the virtual showers included a participant survey to assess Wi-Fi access.

In the year 2022, there were a total of 4 showers and 78 maternity clients participated. Since July 2018, when the first Baby Safety Shower was held, there have been a total of 19 baby safety showers with a total of 239 maternity clients and 161 family members participating.

The touchless distribution drive-up was held at the local health department in order for the participants to receive the “in-kind” gifts. The safety items distributed in 2022 were Dreambaby® Household Safety Kits, diapers, safety tubs, and Graco® Pack ‘n Play playards. The Graco® playards were donated by the IMPACT Family Counseling Cribs for Kids Program. IMPACT also provided safe sleep information and demonstration during the shower. Diapers were provided by the local diaper bank and feminine products were provided by the Junior League of Birmingham.

One month after the Baby Safety Shower each participant completes a post-test to evaluate knowledge and retention of safety education provided at the shower. In 2022, the pre-test score range for each question was 69 to 94 percent, and after the shower, the post-test score range was between 94 and 100 percent.

Finally, CHWs make a third trimester home visit to verify or help with the installation of the safety-related items. In 2022, due to COVID-19, the third trimester home visits were completed virtually. In May 2022, the visits returned to in-person, and in December 2022 the showers returned to in-person events. When a participant has completed the full 18-month FDO program, a face-to-face evaluation is done in the home that includes questions about the of use of safety-related items and safety knowledge received at the baby safety shower. A 6-month post-graduation phone interview and evaluation are completed to ensure sustained safety adherence. This evaluation assesses safety

knowledge and collects data on any preventable injuries sustained at home since safety shower participation.

Mobile County Health Department

The infant mortality rate is significant in Alabama. According to ADPH reports, in 2021, the rate increased to 12.1 from the 2020 rate of 10.9. The infant mortality rate for White mothers was 5.8, an increase from 5.2 in 2020. The infant mortality rate declined among Hispanic mothers from 7.2 (37 infant deaths) in 2020 to 5.2 (29 infant deaths) in 2021. The infant and maternal mortality rates among Black infants and mothers remain disparaging with poverty, a lack of education, and the lack of resources to receive quality maternal care among the key factors.

In December 2021, Royce V. Smith was hired by MCHD as its new Maternal and Child Health Program coordinator. She swiftly jumped into her new role within the division, completing the Safe Sleep Certification training with the Safe Sleep Academy and working to prepare information to teach academy participants and community members about reducing infant mortality rates through safe sleep education. Throughout the year, the MCH coordinator attended various community meetings and met certified consultants in order to gain knowledge about Count the Kicks, health disparities, FIMR, perinatal safety, and lactation. This knowledge allows her to educate program participants and promote resources that positively impact perinatal and infant health. The MCH coordinator participated in several webinars to learn more about maternal and child health and become better educated on topics such as breastfeeding, health disparities, immunizations, and maternal mental health.

With the lingering effects of the Covid-19 pandemic, MCH education and community outreach participation resumed for FY 2022 in the month of October under limited restrictions. Safe sleep classes continued with the participants of the Family Support/Home Visitation program. MCH program staff participated in numerous community outreach events disseminating educational materials on breastfeeding, car seat safety, and safe sleep. There were 23 safe sleep classes held during FY 2022 and all were held virtually due to ongoing safety concerns related to the COVID-19 pandemic. There was one class taught with the assistance of a Spanish translator. Each class participant received a portable Pack ‘n Play playards for their baby and printed certificates for completing the class.

In addition to the community events and group connect activities, MCH program staff promoted many health observances such as International Prenatal Prevention Month, Maternal Mental Health, and the Maternal and Child Stillbirth Prevention Act which promoted awareness of infections transmitted from mother to baby during pregnancy or the delivery process. The coordinator also collaborated with the Lead Poisoning Prevention coordinator and traveled to several local daycare centers and pediatric doctor’s offices throughout the county distributing over 500 flyers on MCH services, including breastfeeding. The coordinators also partnered to record a Wellness Wednesday segment highlighting the effects of lead in breastmilk that was aired on the agency’s YouTube channel with the information presented on other agency social media platforms such as Facebook and Twitter.

Southeastern Public Health District

Infant health continues to be an issue in the Southeastern Public Health District. According to the 2022 Robert Wood Johnson County Health Rankings report, Barbour County saw an increase of 1 percent in low-birth-weight deliveries, now at 12 percent. Henry County experienced the same increase and the percentage of low-birth-weight deliveries was reported as 11 percent.

As reported in the 2020 ADPH infant mortality report, the district had an infant mortality rate of 7.6 for all 10 Counties. Every county within the district experienced at least 1 infant death in 2020, with a total loss of 37 infants. According to the ADPH Center for Health Statics, Henry County had an alarming rate of 12.4 per 1,000 live births, the highest in

the district. Houston County was second at a staggering 11. 2 per 1,000 live births. Barbour County followed at 10.8 per 1,000 live births. Eight of the 10 Southeastern District counties were listed as having an infant mortality rate higher than the national average.

During FY 2022 the district collaborated with the regional perinatal coordinator to create the Safe Bama Baby Safe Sleep Survey. The survey and consent form were approved by the Internal Review Board (IRB). The consent form will be presented to the expecting parent to gain permission to conduct the Safe Bama Baby Safe Sleep Survey. The plan was to implement this survey in the three district counties with the highest infant mortality rates. District staff certified as Safe Sleep Ambassadors through Cribs for Kids® will identify and meet with pregnant WIC recipients and gift them a tote bag with safe sleep educational materials and related items. If the expecting parent provides consent, the survey is completed during the third trimester of pregnancy. The survey will help to craft individualized education and identify the lack of a safe sleep space for the expected infant. If a safe sleep space is needed, the Safe Sleep Ambassador will assist with a referral for a Cribs for Kids® pack ‘n play from FHS. The incentive item for completing the survey will include a “Snoozzzette” zip-able blanket from Cribs for Kids®. The zip-able blanket reinforces safe sleep practices.

Other ADPH Perinatal/Infant Health Programs

Pregnancy Risk Assessment Monitoring System (PRAMS)

ADPH has been collecting data on mothers and their newborns through the PRAMS Program since 1993. Surveys are mailed to the mother’s home address to be completed. If a survey is not completed and returned to ADPH, contracted staff phone the mothers to complete the survey. Incentive items are given to the mothers when the surveys are completed. The data collected from mothers in Alabama regarding their health, maternal attitudes, and experiences before, during, and shortly after pregnancy can help identify ongoing and emerging issues and assist in developing policies and initiatives moving forward.

Of the 1,399 women who received PRAMS surveys in 2022, 785 completed the surveys, which is a return rate of 56.1 percent. This reporting year, data from PRAMS surveys were presented to the regional perinatal nurses through the FIMR Program and shared with their CATs. The data was a tool to assist CATs with developing initiatives in their communities to address maternal and infant health. Additionally, the PRAMS data was presented to members of the OWH Steering Committee at a quarterly meeting in 2022. The steering committee membership consists of volunteers throughout the state with an interest in women’s health, including health providers, educators, and community workers. The PRAMS data will be useful in their work promoting health for women.

In 2023, the MCH Epi Branch will collaborate with staff from the Well Woman Program and the Maternal Mortality Review Program to strengthen health services provided to women and develop recommendations for maternal health based on the data analysis.

Alabama Newborn Screening Program

The Alabama Newborn Screening Follow-up Division is part of the BCL. It is a coordinated system encompassing newborn screening, care coordination, evaluation, diagnosis, intervention, and management of conditions. The newborn screen includes the bloodspot screen, newborn hearing screen, and pulse oximetry screen to detect critical congenital heart defects. The goal of newborn screening is to identify certain genetic and congenital disorders early to reduce infant morbidity, death, intellectual disability, and other developmental disabilities.

Newborn screening allows treatment to be initiated within the first few weeks of life, preventing some of the complications associated with disorders. Early diagnosis may reduce morbidity, mortality, intellectual disability, and other developmental disabilities. The program works in partnership with pediatric subspecialists throughout the state to ensure all babies identified with presumptive positive results receive appropriate diagnostic evaluation and treatment. The program's subspecialists participate in provider education webinars and on the Alabama Newborn Screening Advisory Committee. Additionally, six community-based sickle cell organizations provide counseling services and follow-up for children identified with sickle cell disease or trait.

Newborn screening is mandated by public health law and is a collaborative effort between the BCL and FHS. The BCL performs blood analysis of approximately 150,000 specimens each year for 33 core conditions, and over 50 conditions including secondary disorders that may be found inadvertently when screening for a core condition. In addition, the BCL manages a web-based system, Secure Remote Viewer, which allows medical providers to access newborn screening results online. During 2022, the BCL received approximately 789 presumptive positive lab referrals, 2,855 did not pass hearing screenings, and identified 206 infants with a newborn screening condition (see table below).

2022 Core Conditions Confirmed

NBS Screening Disorders based on DOB for calendar year 2022	Number of Presumptive Positives	Number of Infants Identified	Number Referred for Intervention/Specialty Care
3-Hydroxy-3-methyglutaric aciduria	0	0	0
3MCC	2	1	1
Argininosuccinic aciduria	2	2	2
Beta Ketothiolase deficiency	0	0	0
Biotinidase deficiency	2	2	2
Carnitine uptake defect (CUD)	20	0	0
Citrullinemia type 1	28	0	0
Classic Galactosemia	24	1	1
Classical Phenylketonuria (PKU)	24	7	7
Congenital Adrenal Hyperplasia	21	4	4
Congenital Hypothyroidism	84	57	57
Critical Congenital Heart Disease	1	0	0
Cystic Fibrosis	235	6	6
Glutaric acidemia type 1	8	0	0
Hearing Loss	2,855	58	58
Holocarboxylase Synthase Deficiency	0	0	0
Homocystinuria	46	0	0
Isovaleric acidemia	5	1	1
LCHAD (Long-chain)	0	0	0
Maple Syrup Urine Disease	17	0	0
MCADD (Medium-chain)	21	5	5
*Methylmalonic acidemia (Cbl A, B)	22	0	0
*Methylmalonic acidemia mutase		0	0
*Propionic acidemia		1	1
Multiple Carboxylase Deficiency	0	0	0
SCID	81	0	0
S Beta thalassemia	3	3	3
SC disease	23	23	23
SS Disease	33	33	33
Trifunctional protein deficiency	0	0	0
Tyrosinemia Type I	62	0	0
VLCAD (very long chain)	5	0	0
SMA (February 14, 2022)	20	2	2
TOTALS	3644	206	206

*Same analyte is used

The Alabama Early Hearing Detection and Intervention (EHDI) Program, Alabama's Listening, ensures that all infants receive a hearing screening prior to hospital discharge and that they are referred for further testing and intervention if they do not pass the inpatient newborn hearing screen. The Alabama EHDI Program is federally funded through a grant from the Health Resource and Services Administration (HRSA) and the CDC. The goal of the program is to follow the Joint Committee on Infant Hearing Guidelines, which is screening by 1 month of age, diagnostic hearing

evaluation by 3 months of age, and referral to early intervention by 6 months of age to ensure optimal language acquisition, academic achievement, and social and emotional development. The Alabama EHDI Program continues to undergo many challenges with following these guidelines as diagnostic facilities return post-COVID-19 pandemic to normal business hours and scheduling families for follow-up. Additionally, the Alabama EHDI Program will have federal grant funding terminating in 2024.

There have been some important changes to the Alabama Newborn Screening Program (NSP)

- Testing began for Spinal Muscular Atrophy (SMA) – February 14, 2022.
- The NSP was administratively reassigned from the FHS to the BCL effective April 16, 2022, with case management continuing to be administered and monitored by FHS.
- In 2023, there are plans to include the addition of three conditions to the Alabama Newborn Screening Panel including X-linked adrenoleukodystrophy (X-ALD), Pompe disease, and Mucopolysaccharidosis type I (MPS I).

Perinatal/Infant Health - Application Year

During the 2019-2020 Title V Needs Assessment, Alabama selected NPM 3 and NPM 5 as its areas of focus for perinatal/infant health. The ESM supporting activities for each NPM will be implemented as described below.

State Perinatal Program

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

ESM 3.1 - Percent of delivering hospitals convened at a meeting to share data and discuss the Alabama Perinatal Regionalization System Guidelines

ESM 3.2 - Number of steps of the CDC's Level of Care Assessment Tool (LOCATe) process completed in order to design and align the Alabama Perinatal Regionalization System Guidelines with the national criteria for the maternal levels of care

All steps of the LOCATe process have been completed, but since not all delivering hospitals participated, the FHS will change ESM 3.2 to measure the percentage of delivering facilities that have completed the LOCATe survey.

NPM 5 - Percent of infants placed to sleep on their backs

ESM 5.2 - Number of trainings facilitated to assist healthcare professionals and first responders, who interact with expecting and new mothers, with being trained on safe sleep recommendations

Other Perinatal/Infant Health Activities

Perinatal Regionalization

Feedback from hospital staff in the Infant Mortality Reduction Perinatal Regionalization workgroup have requested assistance smoothing the communication within and between facilities when a mom and/or baby may require a higher level of care. Bringing members of each facility's team to have frank discussions about capabilities and level declared will be an on-going process. We are working to develop an online perinatal directory that lists all delivering hospitals in the state with their self-declared levels of neonatal care and contact numbers for maternal and neonatal transfers/consults. We are also looking at offering sample tools such as transfer and consult agreements that hospitals can adapt for their own use, if they need to establish new relationships with specialists or facilities.

Because only half of Alabama's delivering hospitals participated in the initial implementation of the LOCATe tool, there has been discussion of reopening it for a second round.

Educating providers and facilities on maternal levels of care will continue, though there are currently no plans to ask facilities to declare their level of maternal care.

Safe sleep

SPP will continue to distribute Cribs for Kids®, streamlining the referral process, reaching out to new referral sources, and improving data collection on the cribs sent. The growth in crib distribution has been encouraging.

The program hopes to increase its use of social media to spread the word about safe sleep and explore more interactive and engaging ways to inform the public about what a safe sleep environment looks like.

The program is working to collaborate with Law Enforcement Academies in Alabama to get SUID investigation on the curriculum for cadets.

Fetal/Infant Mortality Review

FIMR data will be moving from an internal system to the National FIMR database for entering case information. Moving to the national system will allow for better comparisons across states and easier data mining. The SPP is also adding a nurse abstractor in Region IV who will be working closely with the nurse abstractor in Mobile. These steps will allow the regional perinatal coordinator to invest more time in the Region IV CATs. The SPP is expecting additional funding for CATs in all the perinatal regions, which will assist with education, outreach, and other implementation of recommendations from the RPAC case review teams.

Breastfeeding

With the passage of the PUMP Act, ensuring that families know their legal rights around breastfeeding has become a priority. In collaboration with The Wellness Coalition, wallet cards with Alabama and federal laws regarding the right to breastfeed in public and the right to break time for expressing milk will be printed and widely distributed. The cards will also connect families to other breastfeeding resources.

Medicaid

Medicaid has announced that NFP services will be reimbursed. As NFP providers are trained and certified as Medicaid providers, access to these services will expand across the state.

ALPQC

A multi-year Maternal Health Innovation HRSA grant has been awarded to UAB and the ALPQC. Additional funding is being sought to support and expand AIM Patient Safety Bundle implementation at facilities statewide as well as generally improving perinatal health across the state.

Group Prenatal Care

Group Prenatal Care has been described as routine prenatal appointments combined with childbirth education classes and a pregnancy support group. Research has found a decreased incidence of preterm birth in group prenatal care participants. In addition, the American College of Obstetricians and Gynecologists states the following in their 2018 Committee Opinion on Group Prenatal Care: “Bringing patients with similar needs together for health care encounters increases the time available for the educational component of the encounter, improves efficiency, and reduces repetition. Evidence suggests patients have better prenatal knowledge, feel more ready for labor and delivery, are more satisfied with care in prenatal care groups, and initiate breastfeeding more often.”

To implement this strategy, ADPH will partner with a maternity care provider who will travel to the Macon CHD in Tuskegee to provide prenatal care in the group format. An information letter was sent to providers and provider practices in the region with an outline of the project. In the letter, providers were encouraged to apply for the project when the request for applications (RFA) was released in December of 2022.

Incorporation of beneficiary voice has been a guiding principle in the project's development. A survey to gather community input on bringing Group Prenatal Care to Tuskegee was approved by ADPH's Overview and Approval of Research Committee. The survey has been distributed in both electronic and paper forms.

In addition to the CenteringPregnancy® site due to start in August of 2023, there are hopes of expanding group prenatal care to other maternity care deserts in the state. Some funding is available through the Maternal Health Innovation grant that ALPQC has received.

Babypalooza

SPP looks forward to continuing a new partnership with Babypalooza, reaching thousands of moms and families in Alabama's larger cities.

Infant Mortality Awareness Summit

SPP is looking forward to returning to an in-person format for the annual summit, organized in collaboration with Alabama's Healthy Start grantees, the Gift of Life Foundation, Inc. and Birmingham Healthy Start Plus, Inc.

Count the Kicks

In Fall 2022, Alabama became the first state (aside from Iowa) to promote Count the Kicks in dental offices. Campaign materials were mailed to 1,500 offices throughout the state. The mailouts included a cover letter describing the program, posters, refrigerator magnets, and educational brochures. A training video was recorded between the representative and a member of the Board of Dental Examiners of Alabama was placed on the OHO website which awards Alabama licensed dentists and hygienists two continuing education hours for viewing. In 2023. a proclamation was signed by Governor Kay Ivey declaring December as Count the Kicks Month in Alabama. Healthy Birth Day, Inc. Program Director Megan Aucutt traveled to Alabama from Iowa to take part in the ceremony. Also present for the proclamation signing were Mrs. Shamari Cooke and her infant daughter, Aspen Cooke. Baby Aspen was safely birthed due to Mrs. Cooke's knowledge of kick counting and her diligent use of the Count the Kicks app. The SPP and the OHO plan to continue to promote Count the Kicks in Alabama.

Alabama Governor Kay Ivey

Standing left to right: Carolyn Miller, Director, State Perinatal Division and Office of Women's Health, ADPH; Amanda Martin, Bureau Director, Bureau of Family Health Services, ADPH; Dr. Gary Pugh, Medical Officer, Bureau of Family Health Services, ADPH; Samille Jackson, Title V Maternal Child Health Coordinator, ADPH; Dr. Tommy Johnson, State Dental Director, Office of Oral Health, ADPH; Dr. Melodie A. Jones, Board of Dental Examiners of Alabama; Shamari and Aspen Cooke, Mother and *Count the Kicks* Baby Save; Megan Aucutt, Director of Programs, Healthy Birth Day, Inc. and *Count the Kicks*; Dr. Tiffany Taft, Full Spectrum Doula and Maternal/Fetal Wellness Advocate, Chief Wellness Officer and Founder of Sacred Soul Wellness, *Count the Kicks* Ambassador; Dr. Scott Harris, State Health Officer, ADPH

ADPH Public Health District Initiative

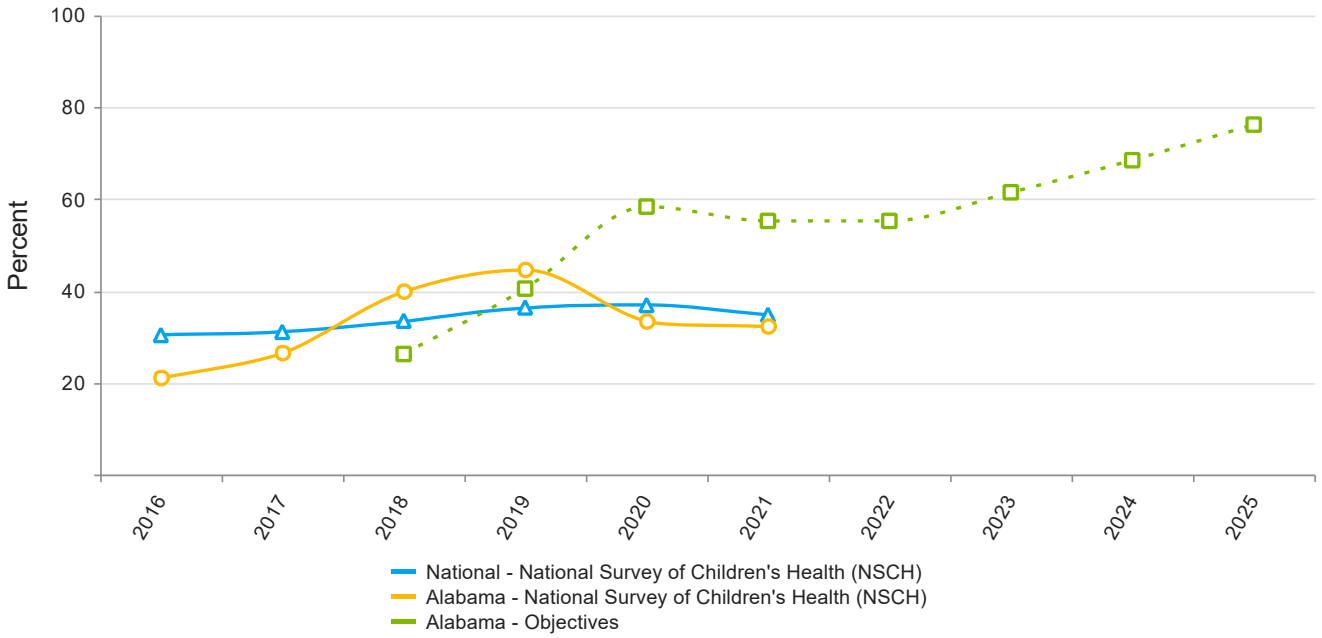
All public health district projects will continue with the same population and domains of focus in FY 2024. The district

MCH coordinators will continue to collaborate with Title V leadership working towards expanding projects throughout Alabama communities.

Child Health

National Performance Measures

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	26.3	40.5	58.3	55.2	55.2
Annual Indicator	26.6	39.8	44.6	33.3	32.2
Numerator	38,521	53,496	54,906	40,489	40,979
Denominator	145,031	134,315	122,972	121,453	127,325
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	61.4	68.4	76.1

Evidence-Based or –Informed Strategy Measures

ESM 6.1 - Proportion of children birth to age 19 that received a well child appointment in the past year

Measure Status:	Inactive - Replaced			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			1	1.6
Annual Indicator			1.6	25.3
Numerator			331	489
Denominator			20,412	1,935
Data Source			Child and Adolescent Health Division	Child And Adolescent Health Division
Data Source Year			2021	FY 2022
Provisional or Final ?			Final	Final

ESM 6.2 - Proportion of children birth to age 19 that received a developmental screening in conjunction with a well-child appointment in the past year

Measure Status:	Inactive - Help Me Grow only provides developmental screenings for children up to 5 years old.			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			1.9	1.9
Annual Indicator	1.8		1.8	1.8
Numerator	22,363		22,363	22,363
Denominator	1,219,436		1,219,436	1,219,436
Data Source	APC and U.S. Census Bureau Population Estimates		APC and U.S. Census Bureau Population Estimates	APC and U.S. Census Bureau Population Estimates
Data Source Year	2018		2018	2018
Provisional or Final ?	Final		Final	Final

ESM 6.3 - Proportion of children aged 12 & 24 months that have a reported blood lead screening in the past year

Measure Status:	Active			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			56.8	59.9
Annual Indicator	54.6	56.2	59.3	56.4
Numerator	33,751	32,982	36,814	34,885
Denominator	61,836	58,688	62,081	61,904
Data Source	Alabama Medicaid	Alabama Medicaid	Alabama Medicaid	Alabama Medicaid
Data Source Year	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final

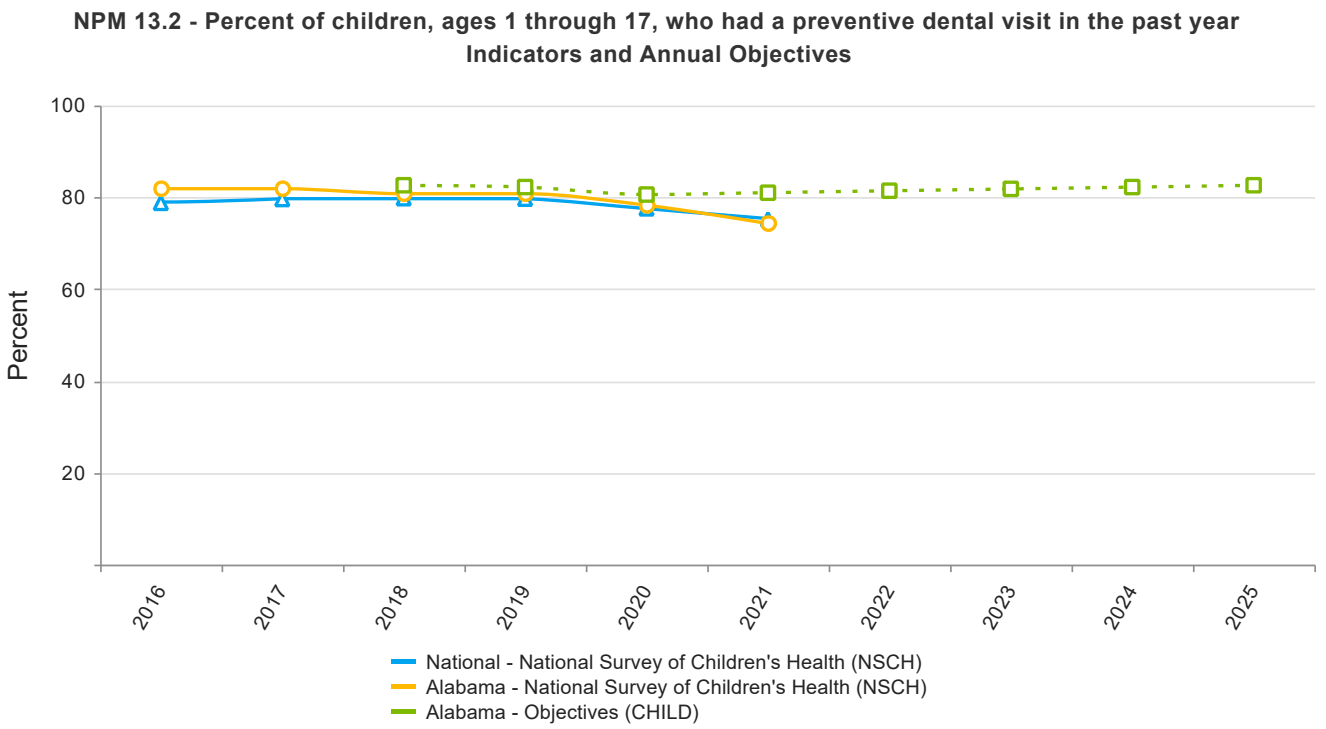
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	60.5	61.1	61.7

ESM 6.4 - Proportion of children birth to age 19 that received a well child appointment in the past year

Measure Status:	Active

State Provided Data	
	2022
Annual Objective	
Annual Indicator	25.3
Numerator	489
Denominator	1,935
Data Source	Child And Adolescent Health Division
Data Source Year	FY 2022
Provisional or Final ?	Final

Annual Objectives		
	2024	2025
Annual Objective	25.0	25.0



NPM 13.2 - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	82.5	82.1	80.5	80.9	81.3
Annual Indicator	81.7	80.7	80.8	78.2	74.3
Numerator	836,024	830,091	838,606	800,897	741,934
Denominator	1,023,434	1,028,454	1,037,949	1,024,513	998,660
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	81.7	82.1	82.5

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - Percentage of providers receiving information/education regarding importance of preventive dental visits for children ages 1-17 years of age

Measure Status:	Active		
State Provided Data			
	2020	**2021**	**2022**
Annual Objective			3
Annual Indicator	0		14.9
Numerator	0		1,021
Denominator	500		6,840
Data Source	Oral Health Program		Oral Health Program
Data Source Year	2020		FY 2022
Provisional or Final ?	Final		Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	6.0	9.0	10.0

ESM 13.2.2 - Percentage of dental providers that received information/education regarding informing their families of patients at 9 years of age about the FDA-approved HPV vaccine in order to prevent future oropharyngeal, cervical, and other HPV-related cancer

Measure Status:	Active		
State Provided Data			
	2020	**2021**	**2022**
Annual Objective			3
Annual Indicator	0		14.9
Numerator	0		1,021
Denominator	500		6,840
Data Source	Oral Health Program		Oral Health Program
Data Source Year	2020		FY 2022
Provisional or Final ?	Final		Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	6.0	9.0	10.0

State Performance Measures

SPM 1 - Percent of children who receive a blood lead screening test at age 12 and 24 months of age

Measure Status:	Inactive - Replaced				
State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	53.3	73	55.1	56.8	59.9
Annual Indicator	72.2	54.6	56.2	59.3	21.4
Numerator	32,124	33,751	32,982	36,814	3,429
Denominator	44,467	61,836	58,688	62,081	16,024
Data Source	Alabama Medicaid	Alabama Medicaid Agency EPSDT data	Alabama Medicaid Agency EPSDT data	Alabama Medicaid Agency EPSDT data	HHLPSS
Data Source Year	2018	2019	2020	2021	2021-2022
Provisional or Final ?	Final	Final	Final	Final	Final

SPM 9 - Percent of 2 year old children who have received two blood lead tests at 12 and 24 months as recommended by the ACLPP Program

Measure Status:	Active

State Provided Data	
	2022
Annual Objective	
Annual Indicator	21.4
Numerator	3,429
Denominator	16,024
Data Source	HHLPSS
Data Source Year	2021-2022
Provisional or Final ?	Final

Annual Objectives		
	2024	2025
Annual Objective	20.0	20.0

State Action Plan Table

State Action Plan Table (Alabama) - Child Health - Entry 1	
Priority Need	
Lack of preventive dental visits across all Title V populations, especially for those uninsured.	
NPM	
NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	
Objectives	
By 2025 increase the number of dental providers who receive education on the importance of preventive dental visits for children ages 1-17 years by 10 percent.	
By 2025, increase the percentage of dental providers who are provided education and support on the provision/referral for HPV vaccine by 10 percent. (create a provider Services survey and gather baseline data.)	
Strategies	
Provide educational preventive dental materials and oral health kits to patients and providers, and promotion of importance of preventive dental visits via the annual “Share Your Smile with Alabama” smile contest.	
Promote HPV education, and HPV vaccine education, promotion, and referral using the #WATCHYOURMOUTH campaign developed through a partnership with Mitchell Cancer Institute.	
ESMs	**Status**
ESM 13.2.1 - Percentage of providers receiving information/education regarding importance of preventive dental visits for children ages 1-17 years of age	Active
ESM 13.2.2 - Percentage of dental providers that received information/education regarding informing their families of patients at 9 years of age about the FDA-approved HPV vaccine in order to prevent future oropharyngeal, cervical, and other HPV-related cancer	Active
NOMs	
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	

State Action Plan Table (Alabama) - Child Health - Entry 2

Priority Need

Lack of timely, appropriate, and consistent health and developmental screenings.

NPM

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Objectives

Increase by 1 percent the total number of EPSDT screenings performed in county health departments annually.

Strategies

Increase EPSDT sreenings in the county health departments.

ESMs	Status
ESM 6.1 - Proportion of children birth to age 19 that received a well child appointment in the past year	Inactive
ESM 6.2 - Proportion of children birth to age 19 that received a developmental screening in conjunction with a well-child appointment in the past year	Inactive
ESM 6.3 - Proportion of children aged 12 & 24 months that have a reported blood lead screening in the past year	Active
ESM 6.4 - Proportion of children birth to age 19 that received a well child appointment in the past year	Active

NOMs

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Alabama) - Child Health - Entry 3

Priority Need

Lack of timely, appropriate, and consistent health and developmental screenings.

NPM

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Objectives

Increase by 1% the total number of children birth to age 5 that receive the ASQ-3.

Strategies

Partner with Alabama Partnership for Children (APC) and Help Me Grow to monitor the number of developmental screenings.

ESMs	Status
ESM 6.1 - Proportion of children birth to age 19 that received a well child appointment in the past year	Inactive
ESM 6.2 - Proportion of children birth to age 19 that received a developmental screening in conjunction with a well-child appointment in the past year	Inactive
ESM 6.3 - Proportion of children aged 12 & 24 months that have a reported blood lead screening in the past year	Active
ESM 6.4 - Proportion of children birth to age 19 that received a well child appointment in the past year	Active

NOMs

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Alabama) - Child Health - Entry 4

Priority Need

Lack of timely, appropriate, and consistent health and developmental screenings.

SPM

SPM 9 - Percent of 2 year old children who have received two blood lead tests at 12 and 24 months as recommended by the ACLPP Program

Objectives

Until more data is available, to maintain the percentage of two year old children who have received two blood lead tests at 12 and 24 months as recommended by the Alabama Childhood Lead Poisoning Prevention Program to at least 20 percent.

Strategies

Increase the percentage of two year old children who were screened for lead poisoning at their 12 and 24 month follow-up visit.

State Action Plan Table (Alabama) - Child Health - Entry 5

Priority Need

Lack of timely, appropriate, and consistent health and developmental screenings.

Objectives

Ensure that all WIC participants benefit from EPSDT.

Strategies

Consistently referring children in health departments where EPSDT is provided or to their health care provider in countries that do not offer EPSDT.

State Action Plan Table (Alabama) - Child Health - Entry 6

Priority Need

Lack of timely, appropriate, and consistent health and developmental screenings.

Objectives

Intervene/refer patients identified as having mental health concerns/suicidal tendencies to appropriate healthcare professionals.

Strategies

Due to the increasing numbers of suicide in children/adolescents and failure to identify mental health concerns in children and adolescents proactively, partner with Suicide Prevention to incorporate questions related to mental health in initial and updated medical history questionnaires in an effort to identify potential mental health concerns.

Children's Health Branch

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

ESM 6.1 - Proportion of children birth to age 19 that received a well child appointment in the past year

ESM 6.2 - Proportion of children birth to age 19 that received a developmental screening in conjunction with a well child appointment in the past year

ESM 6.3 - Proportion of children aged 12 and 24 months that have a reported blood lead screening in the past year

Medicaid reported that for ages 0-18 years, out of 702,858 eligible children, 356,831 received a well visit during CY2022

Alabama Childhood Lead Poisoning Prevention Program

ACLPPP receives funding through a MOA with Medicaid, a cooperative agreement with CDC, and, more recently, through the Title V MCH Block Grant. The combined goals of these funding sources are to maintain a childhood lead poisoning prevention program that ensures blood lead testing and reporting enhances blood lead surveillance, improves linkages of lead-exposed children to recommended services, and develops targeted population-based policy interventions which prevent lead poisoning, with a focus on Medicaid-enrolled children.

Beginning in calendar year 2018, the ACLPPP blood lead reference value (BLRV) was adjusted to align with the CDC blood lead reference value of 5 micrograms per deciliter (µg/dL) based on the National Health and Nutrition Examination Survey's (NHANES) data. In October 2021, the CDC adopted a new BLRV of 3.5 µg/dL based on more current NHANES data. The ACLPPP aligned with the new BLRV in January 2022 with the intention of serving even more children going forward. This BLRV change has doubled case management referrals and prompted program expansion. A second nurse has been hired, increasing the capacity for close medical management as well as education and outreach. With a renewed focus on education and outreach, the ACLPPP anticipates surpassing all previous annual blood lead testing rates with a goal of decreasing the overall rate of children with BLL results at or above the current BLRV of 3.5 µg/dL.

In 2022, the preliminary number of children less than 18 years of age in Alabama receiving at least one BLL screen was 47,340, which is an increase of 34.8 percent from that reported in 2021. Of those children, 1,622 were reported to have at least one BLL result greater than or equal to the BLRV of 3.5 µg/dL. Based on program protocols, 1,288 were referred for case management services.

Education and outreach remained a program priority. An integral part of reaching program goals is the contract and partnership with subgrantee Mobile County. The MCHD provides targeted education and outreach for lead poisoning prevention in the high-risk city of Mobile. In FY 2022, the ACLPPP and MCHD participated in approximately 135 events, including professional conferences, community events, face-to-face meetings, news releases, and webinars. This allowed the program to share lead poisoning prevention information, including recommendations for testing and reporting, with medical providers, daycares, and the community. In addition, ACLPPP completed a mass mailout between April and September of 2022, providing medical practitioners with current program recommendations, available brochures for parents and lead workers, and program contact information.

Oral Health Office

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

ESM 13.2.1 - Percentage of providers receiving information/education regarding the importance of preventive dental visits for children ages 1-17 years of age

ESM 13.2.2 - Percentage of dental providers that received information/education regarding informing their families of patients at 9 years of age about the FDA-approved HPV vaccine in order to prevent future oropharyngeal, cervical, and other HPV-related cancers

Oral Health Screening

The Basic Screening Survey (BSS) of kindergarten and third grade students is typically conducted on a 5-year schedule. Alabama completed the BSS in 2012 but was unable to maintain the 5-year schedule in 2017 due to the position of state dental director being vacant until mid-October 2017. Shortly after the new director was identified, planning the BSS commenced. The complexities of the approval process by the Alabama State Department of Education, as well as identifying the funding mechanism through which to finance the project postponed the start date for the project into late 2019. Shortly after the survey initiation in 2019, the COVID-19 pandemic caused schools to sporadically close due to outbreaks and resulted in remote/virtual classes becoming commonplace. Having the random but systematic sample size of 60 schools selected by ASTDD already identified, the OHO staff of two embarked upon their journey of completing BSS. The staff's work ultimately culminated in a total of 2,957 kindergarteners and 2,607 third grade children in 52 schools being screened over a 2-year span. Of significance, the survey demonstrated 15 percent and 20 percent of kindergarten and third grade children, respectively, with untreated tooth decay higher than the national average. Of equal concern, only 10 percent (compared to the 2013 survey of 29 percent) had dental sealants compared to the national average of 42 percent. One possible factor in this finding is the correlation between the typical age of sealant placement (9–10-year-olds/third grade) corresponding with the closure of dental offices due to COVID-19. The BSS identified some areas of the state with a much higher incidence of dental decay, often corresponding with demographics where community water fluoridation was absent. As a result of these findings, numerous contacts were initiated with school officials, school nurses, and surrounding dental providers to highlight the areas of concern. In addition to treated/non-treated decay and sealant incidence, the OHO was able to obtain height and weight for the determination of body mass index (BMI) of the same population. The summary of the findings is as follows:

- Compared to kindergarten children, third grade children have a significantly higher prevalence of obesity (23 percent vs. 32 percent). Regardless of grade, the prevalence of obesity is similar for boys and girls.
- Compared to non-Hispanic White children, the prevalence of obesity is significantly higher among Black and Hispanic children (24 percent vs. 31 percent and 34 percent respectively).
- Compared to children attending schools with less than 25 percent of children eligible for the National School Lunch Program (NSLP), children attending schools with greater than 25 percent of students eligible for NSLP have a significantly higher prevalence of obesity (13 percent vs. 26 percent, 28 percent and 34 percent respectively).

BSS summary reports are available at alabamapublichealth.gov .

In addition to BSS, the OHO conducted screenings for 60 Head Start and Pre-K programs for a total of 3,152 children.

Tuscaloosa County Health Department Dental Clinic

WIC participants at the TCHD clinic receive oral health education from the dental students that rotate through the dental clinic. This education often ends in a dental home referral. Following is a total summary of the number of services provided at the dental clinic.

- Exams 1,104
- Prophylaxis (cleaning) 885
- Sealants 186
- Fluoride Treatments 1,012
- Silver Diamine Fluoride Treatments 100

Ongoing Activities in Alabama to Improve Oral Health:

Share Your Smile with Alabama

The fifth annual Share Your Smile with Alabama photo contest successfully concluded in February 2022, coinciding with National Children's Dental Health Month (NCDHM). The contest features a boy and girl third grade winner selected from non-professional photos submitted by parents/guardians throughout the state. The selected students were invited to the ADPH broadcast studio to participate in a live news conference where they were announced as the winners of the 2022 Share Your Smile with Alabama contest. The children were featured on billboards near their school and on posters and flyers which highlight NCDHM, the importance of preventive dental visits, the promotion of the HPV vaccine for boys and girls, and the importance of community water fluoridation. There were 258,000 total media impressions promoting NCDHM. The staff at the American Dental Association (ADA) have made a point to support the contest on a regular basis. Efforts are made to include the winners on other campaigns throughout the year, but their home location sometimes makes that problematic. Fortuitously, both parents of one of the winners were dentists, and both of them have begun to accept patients through the OHO partnership with the Pay It Forward Program. *Share Your Smile with Alabama* was also featured in ADPH's agency newsletter, *Alabama's Health*.

Strolling Thunder

Strolling Thunder is a national advocacy event by ZERO TO THREE. The events are held in cities across the nation and focus on policy solutions that ensure all babies and families have what they need to thrive including good health, strong families, and positive early learning experiences. This fun, family-friendly event allowed babies, toddlers, their families, and advocates for young children to gather at the Alabama State Capitol and bring attention to what families need to thrive. The event provided the opportunity to meet with state and local elected officials and gather information on how to raise strong babies focusing on topics such as literacy, infant and early childhood mental health (IECMH), breastfeeding, development, nutrition, and much more. Numerous ADPH divisions and programs attended as vendors providing information on their initiatives and educational materials. The OHO participated for the first time in 2022 providing answers (printed and verbal) to questions related to oral health importance during pregnancy, the care of children's teeth, and the importance of community water fluoridation. Oral health kits consisting of age-appropriate toothbrushes, toothpaste, floss, and toothbrush timers were provided to attendees ranging in age from toddlers to adults.

ADPH Public Health District Initiative

District MCH coordinators submitted project proposals in 2021 to address needs within the Child Health Domain. These county-specific projects targeted access to oral health care, increasing EPSDT visits, injury prevention, and suicide prevention in FY 2022.

Northeastern Public Health District

Good oral health is important to a child's physical, social, and mental development. Even though tooth decay can be prevented, most children in Alabama still develop cavities. Tooth decay is known as the most common chronic disease among children. It unequally affects minority and low–socioeconomic status children and is associated with many poor outcomes. Loss of teeth, impaired growth, decreased weight gain, poor school performance, and poor quality of life are among the few. The most recent data on children in Alabama showed 30-50 percent have early childhood caries. Potential risks for children often identified in WIC visits include infrequent daily dental hygiene and yearly dental exams. For the above reasons, the Northeastern Public Health District chose to focus on oral health. The goal of the project is to improve oral health in children ages 6 months to 5 years that are currently receiving WIC, to increase routine dental exams, and to identify dental caries. Partnerships were developed with the WIC nutritionists to complete a dental questionnaire to determine if a yearly exam has been completed and to screen for dental problems. At the conclusion of the screening, parents were given a list of dentists to choose from for their child's oral exam. Six months following the original WIC clinic screening, two office assistants and the district MCH coordinator follow up on each patient to determine if they have completed the oral exam with a dentist. Dental exams were verified through Medicaid data for those with Medicaid, and if the child did not have Medicaid, then the parents received a phone call to determine if the child completed their dental appointment. If these methods are unsuccessful an email is sent through the WIC EHR system, to attempt one last effort to contact parents. Each child referred for dental care received a toothbrush, toothpaste, and floss. Each child screened received educational materials to promote good oral health.

In FY 2022, 7,397 children in the WIC program were screened; 3,857 children were referred to a local dentist for an oral exam; 3,727 follow-up contacts were completed; and 871 children received oral exams.

The district MCH coordinator participated in several health fairs and events in the district and distributed dental education and incentive items to promote good oral health.

Northern Public Health District

Oral health was the chosen area of focus for the Northern Public Health District in order to address deficiencies in the lack of access and availability of dental care. The goal was to recruit and establish resource options for access to dental care for the target population, children ages 0-17, and expectant mothers. Through the partnership established with Calhoun Community College and Wallace State Community College, a total of 88 children received dental cleanings and exams through the colleges' dental hygiene programs.

Southwestern Public Health District

The 2022 Robert Wood Johnson County Health Report indicates a continued decline in the overall health outcome rank for both Marengo and Wilcox Counties. Marengo declined from 54th in 2020 to 57th in 2021. For 2022, Marengo County ranked 57th. In 2021 and 2022, Wilcox County remained the lowest rank for the state at 67. In 2022, Wilcox shows the rate for uninsured children at 3 percent with a high rate of children in poverty at 29 percent. The state average is 21 percent and the US average is 16 percent for uninsured children. Marengo County shows a rate of 4 percent of children as uninsured, along with a high rate of children in poverty at 30 percent for 2022.

EPSDT is designed to screen, diagnose. and treat the problems in children under the age of 21. Early identification supports the treatment of conditions before they become more complex and costly to treat. EPSDT visits will insure children and adolescents receive appropriate preventive physical, dental, mental, developmental care, and specialty services. For the above reasons, the Southwestern Public Health District chose to focus on increasing the number of children in the district undergoing/receiving an EPSDT screening. The overall goal is for Alabama children to be healthier as a result of receiving preventative services and support in the management of developmental issues and diseases.

A list of Medicaid-eligible patients past due for EPSDT screening visits was provided to CHD clerical staff who then contacted potential patients in Marengo and Wilcox Counties to schedule EPSDT screenings. Parents could schedule EPSDT visits at the CHDs or the children could be referred by their primary medical providers. If oral health, mental health, or developmental problems were Identified, the children received referrals for those specialty cares as needed. To promote the availability of EPSDT screenings at the CHDs, the district MCH coordinator provided outreach and education to local medical clinics and community groups regarding the importance of the EPSDT screenings. In addition, there were radio and newspaper advertisements in each county announcing the availability of EPSDT screenings at the CHDs and contact information for scheduling appointments.

Marengo and Wilcox Counties saw a 15 percent increase in the number of children seen in each clinic for EPSDT visits achieving the goal set for 2022. Marengo County completed 89 screenings for FY 2022, compared to 78 completed in FY 2021. The 2022 screenings completed in Marengo County resulted in 40 children receiving referrals or resources for dental care; 2 referrals to CRS; 2 for mental and behavioral health; 2 for vision; 3 for hearing; 2 additional lead screenings and 19 referrals for follow-up appointments with a primary medical provider. Wilcox County completed 76 screenings for FY 2022, compared to 37 screenings completed in 2021. The 2022 screenings completed in Wilcox County resulted in 24 children receiving referrals or resources for dental care; 2 referrals to CRS; 8 for vision; 2 for additional lead screening; and 7 referrals for follow-up appointments with the primary medical provider. With the continued promotion of the EPSDT program in Marengo and Wilcox Counties, the district projects a 15 percent increase in EPSDT visits in 2023.

West Central Public Health District

The West Central Public Health District is located in a more rural area of the state and dental services are severely

lacking in certain counties. There is no private dental provider in Greene County, and this is a barrier to care for the residents in the county. The OHCA State Oral Health Plan indicates that children in Greene County have a high risk for dental caries and lack a dental home. Data also show that poor dental hygiene and oral health can affect physical health. For the previously mentioned reasons, the district decided to focus on improving oral health care for pregnant women and children ages 21 and younger.

CHD WIC staff provided dental screenings to help identify children and pregnant women who needed dental care. A total of 2,986 WIC participants were screened for oral health needs and of those screened, 498 were referred for dental services. The district MCH coordinator partnered with the TCHD Dental Clinic to provide dental services for those who were identified as needing dental care if they did not already have a dental home. Dental services were provided by the TCHD dental staff twice a month at the Greene County Health Department (GCHD) which began seeing patients in July 2021. Following is a total summary of services provided at the GCHD dental clinic.

- Exams 70
- Prophylaxis (cleaning) 54
- Sealants 20
- Fluoride Treatments 67
- Silver Diamine Fluoride Treatments 8

In addition to providing services in Greene County, the TCHD dental staff and the Community Dental Health Program coordinator at UAB partnered together and completed 116 screenings at Eutaw Primary School. The district MCH coordinator also accompanied the dental staff as they screened 214 Pre-K students at several elementary schools in the Tuscaloosa County School System. Each child screened received a dental kit along with educational material to bring about awareness of the importance of good oral health. The dental kits included a toothbrush, toothpaste, dental floss, and a brushing timer.

The district MCH coordinator participated in several community events in Greene, Hale, and Tuscaloosa Counties. Dental information and promotional items were distributed at each of these community events to promote good oral health. Each child who kept their dental appointment at the TCHD and GCHD received a dental kit, along with a t-shirt or lunch bag/drawstring backpack that included additional promotional incentive items.

Other ADPH Child Health Programs

Healthy Child Care Alabama Program

HCCA is designed to address the integration of health concepts and child care health and safety issues in out-of-home child care by using the nurse health consultant and child care models. It is a collaborative effort between ADPH and DHR. HCCA nurse consultants provide services statewide in all 67 counties. Two HCCA nurse supervisors, based in Montgomery, provide oversight and management of the program and if required, interim services in the absence of a HCCA nurse consultant. Factors evaluated in selecting the base counties for the nurse child care health consultants are the availability of space in the CHDs; number of child care providers; willingness of local community members to support the initiative; areas of greatest need, such as rural and underserved areas; as well as recommendations from DHR with information relevant to the decision.

Following the ADPH COVID-19 response, HCCA revised production and performance measures for all consultants. These revisions included ongoing quality assurance visits, calls, and mail surveys. HCCA nurse consultants continued to provide services through ongoing barriers which included frequent cancellations directly related to

provider staffing. In FY 2022, providers continued to work to recruit and hire qualified staff.

Recorded HCCA productivity broke all former year totals by providing 7,508 health and safety classes to 38,648 provider staff in FY 2022. Credit hours for these classes totaled 17,191. FY 2023 will be the first-time productivity can be measured with the completed expansion model that was approved in FY 2019. As of this report, the HCCA expansion model is fully staffed. Documentation of all programming continues to be upgraded to measure more data sets, including office to flex time and productivity percentages. The A - Z Index on the ADPH website allows the provider to choose H for Healthy Child Care Alabama or C for Child Care, Child Care CPR First Aid Training, or Child Care Health and Safety training. The website has a page for parents with resources such as information on the flu; oral health; hand, foot, and mouth disease; Respiratory Syncytial Virus (RSV); immunizations; and head lice. The website also has a "just for kids" section that has flu, fire, sun, play safety, and germ activities. The website includes a page with related links that provide referral sources, such as DECE, ALL Kids, Help Me Grow Alabama, and DHR. The website can be accessed at HCCA | Alabama Department of Public Health (ADPH) (alabamapublichealth.gov).

HCCA nurses provide a medical perspective for health education and solutions related to or affecting children's health and safety. The following planned activities will be carried out by the project participants in both child care (on-site) and community (off-site) settings:

1. Assessing health and safety risks in the childcare environment and helping childcare providers to develop plans to remedy existing hazards.
2. Providing a link between child care providers and families of children in child care with community support services.
3. Coordinating training, information, and educational outreach for families and childcare providers in collaboration with other agencies.
4. Promoting knowledge of normal growth and development and providing information regarding referrals or intervention as needed.
5. Increasing awareness of poison control information through a partnership with the regional poison control center administered by COA.
6. Evaluating community child care needs.
7. Offering foundational programming in the areas of active play, child development, and nutrition to support providers who wish to apply for the stars quality rating and improvement system rating of one or two.
8. Providing cardiopulmonary resuscitation (CPR) and first aid certification training.

HCCA nurse consultants are available to providers by phone at all times throughout the day. In addition, HCCA nurse consultants provide flu information to providers for parents prior to September 1 each year. HCCA has plans to make information about child mental health available as well.

Child Passenger Safety

ADPH has long been a leader and partner in injury prevention and child passenger safety in the state. New funding has allowed for the expansion of those efforts. In 2019, BPPS received a grant from the Alabama Department of Economic and Community Affairs, which allowed the bureau to develop the Alabama Child Passenger Safety Program. The program provides education to caregivers on how to use child safety restraints correctly, recruits individuals to become child passenger safety technicians, and establishes and maintains car seat fitting stations statewide. Due to COVID-19 and the temporary reassignment of program staff as a result, this program was on

hiatus for the majority of 2020. The program did restart in late 2021, and ADPH child passenger safety technicians installed 37 car seats. In 2022, through partnerships with Georgia and Tennessee, three departmental staff members were trained as certified child passenger safety technician course instructors, enabling the department to launch its statewide Child Passenger Safety Training Program and add two new car seat fitting stations. The program hosts a monthly car seat clinic, available by appointment only, to educate caregivers, check car seats, and provide car seats to individuals who otherwise would not be able to obtain one. Throughout the year, information was distributed to 116 families who attended the car seat clinic.

Child Death Review

The Alabama Child Death Review System (ACDRS) reviews and identifies unexplained or unexpected child deaths in Alabama with the purpose of developing strategies to prevent such deaths from occurring. Forty-two local child death review teams throughout the state review child death cases each year. Many of the local review teams faced challenges over the past 2 years due to the pandemic. Those challenges included limited in-person meetings and delays in receiving reports from team members. For the 2020 reporting year, there were 286 reviewable cases; that number increased to 335 reviewable cases for the 2021 reporting year. Motor vehicle incidents; sleep-related deaths; and firearm, weapons, and assault-related deaths remain the three leading causes of death for children in Alabama. In September 2022, ACDRS sponsored a week of training for law enforcement, coroners, child advocates, and social workers. The SUID Investigation training included death scene re-enactment and scene reconstruction. Thirty attendees, made up of members of law enforcement and coroners, received training on how to better document and investigate infant and child deaths and child abuse cases. Attendees received investigation kits to take back to their jurisdictions to use when investigating cases.

The program continues to partner with UAB and the USA on prevention efforts in the state. Through awareness, education, and prevention efforts, ACDRS continues to work to make strides that reduce child deaths in Alabama.

Child Health - Application Year

During the 2019-2020 Title V Needs Assessment, Alabama selected NPM 6 and NPM 13 as its areas of focus for child health. The ESMs supporting activities for each NPM will be implemented as described below.

Children's Health Branch

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

ESM 6.4 - Proportion of children birth to age 19 that received a well-child appointment in the past year

ESM 6.2 - Proportion of children birth to age 19 that received a developmental screening in conjunction with a well-child appointment in the past year

ADPH staff have participated in multiple technical assistance sessions with UAB. Through these sessions, it was clarified that the data required for the measure and the data available were not contradictory. Due to the inability to obtain the correct data, the measure is being inactivated.

ESM 6.3 - Proportion of children aged 12 and 24 months that have a reported blood lead screening in the past year

After an internal review, Alabama has decided to change the data source to the Healthy Homes and Lead Positioning Surveillance System (HHLPSS) to better measure provider practice and laboratory reporting in regard to blood testing in children less than 3 years old. One limitation in using Medicaid data is that children with private health insurance or self-pay would be excluded. Moving forward, Alabama will look further into the data to see if it would be necessary to expand the time windows for the first and second lab tests.

SPM 6 is being retired due to the branch being unable to determine an accurate number of total staff in childcare businesses. Branch staff have reached out to the Alabama DHR Child Care Licensing Division and they are unable to provide a reliable estimate. The number of childcare staff in Alabama is a very fluid number and staffing is an ongoing concern for childcare businesses across the state. Without a reliable and accurate number, the branch is unable to calculate the percentage of staff trained and track this measure.

SPM 9 - Percent of 2-year-old children who have received two blood lead tests at 12 and 24 months as recommended by the Alabama Childhood Lead Poisoning Prevention Program

Oral Health Office

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year
ESM 13.2.1 - Percentage of providers receiving information/education regarding the importance of preventive dental visits for children ages 1-17 years of age

ESM 13.2.2 - Percentage of dental providers that received information/education regarding informing their families of patients at 9 years of age about the FDA-approved HPV vaccine in order to prevent future oropharyngeal, cervical, *and other HPV-related cancers*

The OHO plans to present at the 2023 Gulf Coast Dental Conference. The focus of the proposed presentations will be HPV-related oropharyngeal cancers and HPV vaccines. This opportunity aligns perfectly with the new ESM

focusing on HPV education directed to dental providers. The OHO will also be pursuing additional opportunities to educate dental providers at various conferences and meetings throughout the year.

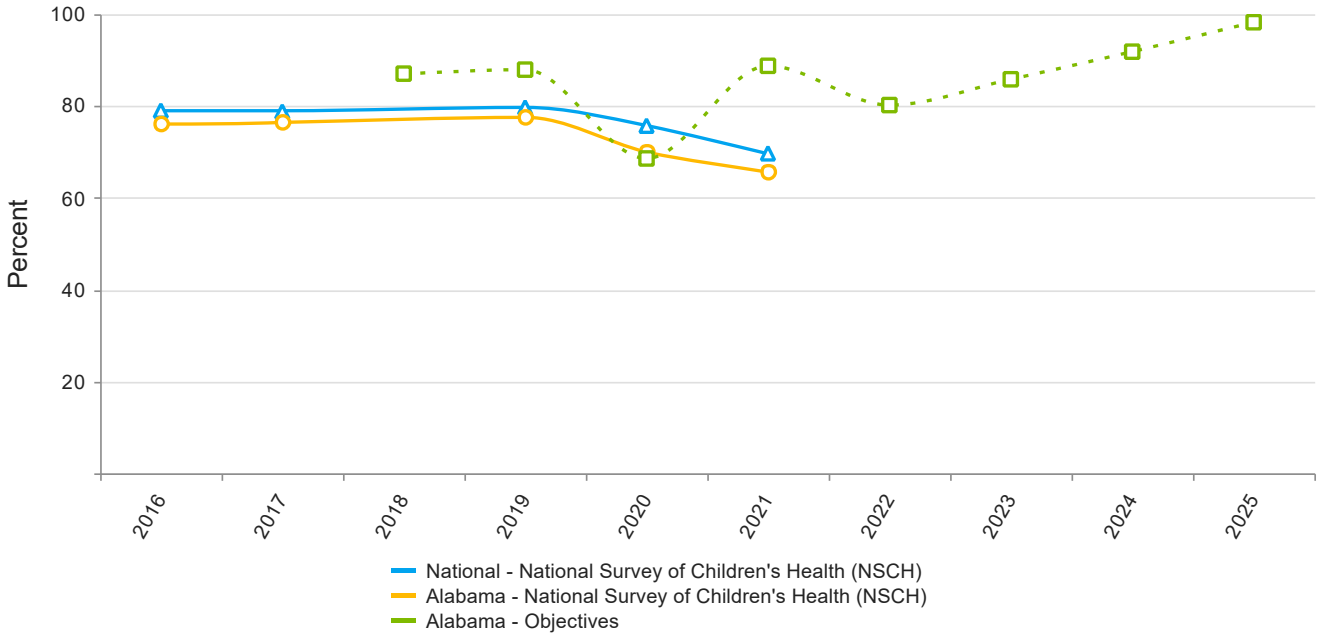
ADPH Public Health District Initiative

All public health district projects will continue with the same population and domains of focus in FY2024. The district MCH coordinators will continue to collaborate with the domain leads and MCH coordinators working towards expanding projects throughout Alabama communities.

Adolescent Health

National Performance Measures

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	86.9	87.8	68.5	88.6	80.1
Annual Indicator	76.3	76.3	77.4	70.0	65.6
Numerator	279,668	279,668	253,566	244,204	242,660
Denominator	366,499	366,499	327,459	348,830	369,817
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2016_2017	2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	85.7	91.7	98.1

Evidence-Based or –Informed Strategy Measures

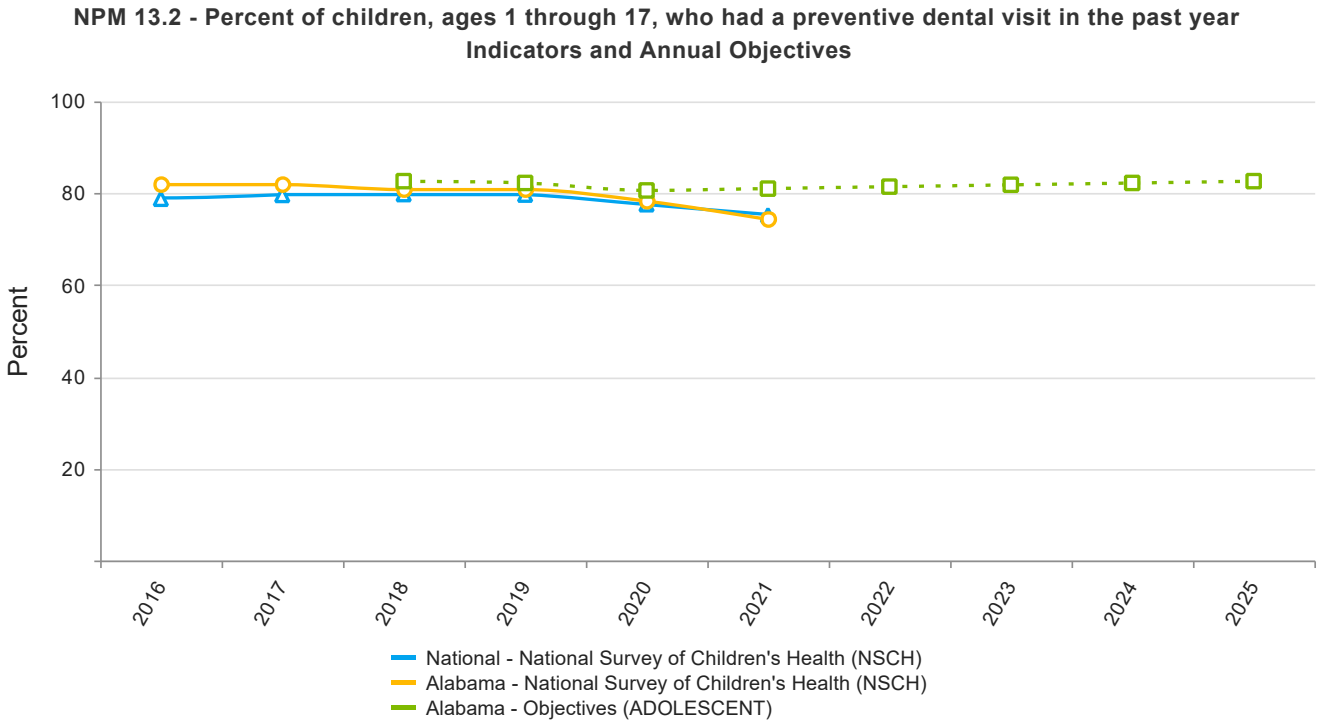
ESM 10.1 - Proportion of adolescents, aged 12 to 19, that received an adolescent well visit in the past year

Measure Status:	Inactive - Replaced			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			77.1	72.1
Annual Indicator	76.3		70	70
Numerator	279,668		244,204	244,204
Denominator	366,499		348,830	348,830
Data Source	NSCH		NSCH	NSCH
Data Source Year	2016-2017		2019-2020	2019-2020
Provisional or Final ?	Final		Final	Final

ESM 10.2 - Proportion of adolescents, aged 12 to 19, that received an adolescent well visit in the past year

Measure Status:	Active
State Provided Data	
	2022
Annual Objective	
Annual Indicator	34.5
Numerator	93,115
Denominator	270,078
Data Source	Medicaid
Data Source Year	FY 2022
Provisional or Final ?	Final

Annual Objectives		
	2024	**2025**
Annual Objective	35.0	35.0



NPM 13.2 - Adolescent Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	82.5	82.1	80.5	80.9	81.3
Annual Indicator	81.7	80.7	80.8	78.2	74.3
Numerator	836,024	830,091	838,606	800,897	741,934
Denominator	1,023,434	1,028,454	1,037,949	1,024,513	998,660
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	81.7	82.1	82.5

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - Percentage of providers receiving information/education regarding importance of preventive dental visits for children ages 1-17 years of age

Measure Status:	Active		
State Provided Data			
	2020	**2021**	**2022**
Annual Objective			3
Annual Indicator	0		14.9
Numerator	0		1,021
Denominator	500		6,840
Data Source	Oral Health Program		Oral Health Program
Data Source Year	2020		FY 2022
Provisional or Final ?	Final		Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	6.0	9.0	10.0

ESM 13.2.2 - Percentage of dental providers that received information/education regarding informing their families of patients at 9 years of age about the FDA-approved HPV vaccine in order to prevent future oropharyngeal, cervical, and other HPV-related cancer

Measure Status:	Active		
State Provided Data			
	2020	**2021**	**2022**
Annual Objective			3
Annual Indicator	0		14.9
Numerator	0		1,021
Denominator	500		6,840
Data Source	Oral Health Program		Oral Health Program
Data Source Year	2020		FY 2022
Provisional or Final ?	Final		Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	6.0	9.0	10.0

State Action Plan Table

State Action Plan Table (Alabama) - Adolescent Health - Entry 1	
Priority Need	
Lack of preventive dental visits across all Title V populations, especially for those uninsured.	
NPM	
NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	
Objectives	
By 2025 increase the number of dental providers who receive education on the importance of preventive dental visits for children ages 1-17 years by 10 percent.	
By 2025, increase the percentage of dental providers who are provided education and support on the provision/referral for HPV vaccine by 10 percent. (create a provider Services survey and gather baseline data.)	
Strategies	
Promote HPV education and HPV vaccine education, promotion, and referral using the #WATCHYOURMOUTH campaign developed through a partnership with Mitchell Cancer Institute.	
ESMs	**Status**
ESM 13.2.1 - Percentage of providers receiving information/education regarding importance of preventive dental visits for children ages 1-17 years of age	Active
ESM 13.2.2 - Percentage of dental providers that received information/education regarding informing their families of patients at 9 years of age about the FDA-approved HPV vaccine in order to prevent future oropharyngeal, cervical, and other HPV-related cancer	Active
NOMs	
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	

State Action Plan Table (Alabama) - Adolescent Health - Entry 2

Priority Need

Lack of timely, appropriate, and consistent health and developmental screenings.

NPM

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Objectives

Increase by 1 percent the total number of EPSDT screenings performed in county health departments annually.

Strategies

Increase EPSDT screenings in the county health departments.

ESMs	Status
ESM 10.1 - Proportion of adolescents, aged 12 to 19, that received an adolescent well visit in the past year	Inactive
ESM 10.2 - Proportion of adolescents, aged 12 to 19, that received an adolescent well visit in the past year	Active

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Children's Health Branch

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

ESM 10.1 - Proportion of adolescents aged 12 to 19 that received an adolescent well visit in the past year

For ESM 10.1, staff could not make any updates for FY22 since the National Survey of Children's Health did not capture 18- and 19-year adolescent data. After replacing ESM 10.1 with ESM 10.2, staff were able to report FY22 using Medicaid data on the total number of well visits.

Ongoing FHS Activities to Improve Adolescent Health

Oral Health Office

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

ESM 13.2.1 - Percentage of providers receiving information/education regarding the importance of preventive dental visits for children ages 1-17 years of age

ESM 13.2.2 - Percentage of dental providers that received information/education regarding informing their families of patients at 9 years of age about the FDA-approved HPV vaccine in order to prevent future oropharyngeal, cervical, and other HPV-related cancers

HPV Education and Vaccine Awareness

OHO chose to specifically incorporate education to providers about HPV-related oropharyngeal cancer/other head and neck cancers as well as promotion of the HPV vaccine within the definition of preventive dental visits in the NPMs. During preventive dental visits for expectant mothers and children ages 1-17 years old, additional pertinent information is provided regarding the effects of periodontal disease bacteria and pre-term, low birth-weight babies; the importance of cleanings to prevent decay; and the importance of community water fluoridation. The Gulf Coast Dental Conference (GCDC), Alabama's annual state meeting, was held in July 2022. Attendance of providers is typically well in excess of 1,000 individuals. The OHO prepared educational materials for the conference. Distribution of 1,021 packets during on-site registration enabled educational materials to be directly delivered to the providers.

The #WatchYourMouth campaign was featured in ADPH's agency newsletter, *Alabama's Health*. Campaign information and other oral cancer resources may be accessed at alabamapublichealth.gov. The OHO director was invited by ADA to be a panelist on a three-part training series, Preventing HPV Cancers in Action. The director's presentation occurred on April 20, 2022, and featured the #WatchYourMouth campaign as the basis for the presentation, *'Building Blocs'—Medical-Dental Collaboration Models and More.* All three courses may be accessed at ebusiness.ada.org/education. Additionally, Merck, the manufacturer of Gardasil-9, and ADA continue to promote the #WATCHYOURMOUTH campaign nationwide to multiple organizations and states.

As a part of the digital HPV awareness campaign with exploreMedia, in September 2022 the OHO identified dental and hygienist conferences and events and the UAB School of Dentistry as geofencing locations targeting women with children 9+ years of age. The digital ad campaign resulted in 487 people visiting the OHO's Oral Cancer webpage.

ADPH Public Health District Initiative

The ADPH district MCH coordinators submitted project proposals in 2021 to address needs within the Child Health Domain. These county-specific projects targeted access to oral health care and suicide prevention in FY 2022.

West Central Public Health District

In 2021, the ADPH BPPS reported suicide as the 12th leading cause of death in Alabama with 804 citizens dying by suicide in 2019. Evidence shows that suicide is the 2nd leading cause of death for ages 10-34. The 2019 suicide rate in Alabama was 16.4 per 100,000 population. The district set two goals related to suicide: 1) increase suicide awareness in pregnant women and adolescents by increasing the number of those trained in Question. Persuade. Refer. (QPR) and 2) increase suicide awareness in adolescents by increasing the number of adolescents trained in Response.

The QPR Gatekeeper Training is designed for those who are of high school age and older. In-person gatekeeper trainings were facilitated at six high schools within the Tuscaloosa County School System, two trainings were facilitated at the Bibb County Career Academy, and one virtual training was held for social workers at TCHD. A total of 1,211 youth and adults participated in the QPR Gatekeeper trainings. Participants are now able to recognize and respond to suicide warning signs, have an increased knowledge of depression and suicide, and know where to refer someone for help. The facilitator received letters of appreciation from the HOSA-Future Health Professionals (formerly Health Occupations Students of America, HOSA) organization at the Bibb County Career Academy. Some statements that were included in the letters were as follows:

- “I really enjoyed you coming and speaking to my class; Suicide is not an easy topic to discuss, but I am so glad that you informed us about the precautions you need to take to help someone.”
- “I really enjoyed listening to you speak. I also learned a lot of things I did not know.”
- “Your presentation on suicide was very important and helpful.”
- “I feel like I know how to approach the situation more safely.”

The HOSA instructor said, “Thanks so much for presenting the suicide awareness program to our students. It’s a relief to know they have a basic understanding about this serious issue.”

The evidence-based Response curriculum is designed for middle school age children and teens. Response increases a student’s awareness about what they can do to provide support and hope if a student or friend is thinking about suicide. This awareness is vital to any suicide prevention effort, as it is often peers who first notice or are told about a person’s thoughts or intent to end their life. The participants are then able to provide support and hope to students or friends who may be thinking about suicide and direct them on where to seek help. In-person trainings were facilitated at nine middle schools within the Tuscaloosa County School System and at the Boys and Girls Club in Tuscaloosa. A total of 1,136 youth participated in the Response trainings. The facilitator received a binder compiled of letters of appreciation from one middle school class at Sipsey Valley Middle School. Some statements that were included in the letters were as follows:

- “Thank you for telling us about suicide prevention and how to tell if someone has suicidal thoughts.”
- “Thank you for teaching us the importance of suicide and why not to joke about it.”
- “Some people just think it is a game, like it’s just a myth; But you taught us kids to not take suicide as a joke.”
- “Thank you for coming here and teaching us about suicide and how to help a friend out or how to know if a

friend is thinking about it and how to have a conversation with them; I will try and help someone one day if that ever happens with my family or friends."

- "Thank you for teaching us what to look for when somebody is struggling with harmful thoughts."
- "Now I'll know how to see signs that somebody is struggling."
- "What we learned from you was great information; Now I know suicide is a permanent solution to a temporary problem; I also know where to get help for anyone thinking about suicide; I never knew how much suicide can hurt family or friends, but now I do thanks to you."

A 6th-grade teacher said, "Thank you for speaking to our 6th graders about suicide prevention. You provided valuable information that will help our students at Sipsey Valley."

The district MCH coordinator participated in numerous community events in Greene, Hale, and Tuscaloosa Counties where suicide information and promotional items were provided at each of the community events. The MCH Coordinator managed a display table in the lobby of the TCHD to promote suicide awareness by making available informational pamphlets, resource cards, and incentive items to the public. All who participated in either the QPR Gatekeeper and Response trainings received incentive items such as a drawstring backpack, ink pens, lanyards, wrist bands, lip balm with the "Just Talk About It" suicide prevention logo and hotline number, and educational material.

Other ADPH Adolescent Health Programs

Adolescent Pregnancy Prevention Branch (APPB)

APPB works to reduce the incidence of unplanned pregnancies and sexually transmitted infections (STIs) among Alabama youth ages 10-19. The APPB's work is made possible through federal grants awarded to ADPH from the Department of Health and Human Services, Administration for Children and Families. The APPB works at the community level to provide opportunities and resources that promote the overall health and well-being of youth, which includes abstinence education, personal responsibility education, and overall positive youth development. During FY 2022, the APPB provided programming to approximately 1,650 youth in 15 Alabama counties. COVID-19 pandemic restrictions were lifted during this period and programming did resume at full capacity for some sub-grantees. Dallas County still had some limitations resulting from the pandemic which affected programming for them. Dallas County also experienced major staff turnover losing both of their facilitators by the end of the school term.

The Alabama Sexual Risk Avoidance Education Program (ASRAE) provides evidence-based or evidence-informed abstinence education to middle school-aged youth in schools and community settings. The purpose of ASRAE is to support decisions to abstain from sexual activity. Two community-based organizations that were supported with ASRAE funds delivered programming to youth in six Alabama counties. The selected curricula used were *Making a Difference!* and *HealthSmarts: Abstinence, Puberty, & Personal Health*. This programming equips youth with the tools needed to resist sexual risk behaviors and to make healthy relationship choices.

The Alabama Personal Responsibility Education Program (APREP) provides abstinence and contraceptive education to high-risk youth in community settings. The goal of the APREP is to reduce pregnancy and STIs, including HIV, among teens by using effective evidence-based programming. Two community-based organizations and one Central Office staff member continued to identify and partner with community organizations through which the personal responsibility programming could be delivered. The project reaches youth in foster care, group homes, detention facilities, and community organizations in nine counties. The project utilizes the evidence-based curricula, *Making Proud Choices: An Adaptation for Youth in Out-of-Home Care*, S*eventeen Days*, *Wise Guys,* and *Making Proud*

Choices! plus, adulthood preparation lessons taken from *Love Notes 2.1* and *Money Habitudes 2 for At-Risk Youth*. Adulthood preparation programming includes financial literacy and healthy relationships. Adulthood preparation programming is designed to promote a successful transition to young adulthood.

Public awareness efforts are key to successful teen pregnancy prevention. APPB partnered with exploreMedia to launch ads, digital media campaigns, and billboards promoting healthy decision-making regarding pregnancy prevention and STI reduction, including HIV, in target areas statewide. In addition, brochures were shared at community and school events.

Rape Prevention and Education Program

The Rape Prevention and Education Program, funded by CDC, provides prevention of sexual violence perpetration and victimization by decreasing sexual violence risk factors and increasing protective factors for the general population through community-level interventions in communities across Alabama via the Alabama Coalition Against Rape (ACAR) grant. The Preventive Health and Health Services Block Grant aims to reduce the incidence of rape and sexual violence in the state among adolescents between the ages of 10 and 18 through the implementation of prevention strategies that promote social norms, teach skills that enhance empathy and communication, and create protective environments in 32 counties through grants to ACAR and seven rape crisis centers.

Adolescent Health - Application Year

During the 2019-2020 Title V Needs Assessment, Alabama selected NPM 10 and NPM 13 as its areas of focus for adolescent health. The ESM supporting activities for each NPM will continue as described below.

Children's Health Branch

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

ESM 10.2 - Proportion of adolescents, aged 12 to 19, that received an adolescent well visit in the past year

Alabama originally used the National Survey of Child Health to determine the total number of adolescents aged 12 to 19 who completed an adolescent well visit that occurred with the CHDs. One limitation of this data source is that the survey data does not include those between the ages of 18 and 19. After an internal review, Medicaid data will be used as the new data source to determine who received a well visit among adolescents within the 12 to 19 years age group. Utilization of this data source will help better link the efforts made by Well Woman, FP, and the Adolescent Pregnancy Prevention Programs to encourage this population to complete a well visit.

Oral Health Office

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

ESM 13.2.1 - Percentage of providers receiving information/education regarding the importance of preventive dental visits for children ages 1-17 years of age

ESM 13.2.2 - Percentage of dental providers that received information/education regarding informing their families of patients at 9 years of age about the FDA-approved HPV vaccine in order to prevent future oropharyngeal, cervical, and other HPV-related cancers

OHO plans to educate dental providers by delivering presentations through various conferences, partnerships, and meetings.

OHO will distribute educational resources to dental providers through direct mailings and the promotion of awareness campaigns related to preventive dental visits and HPV.

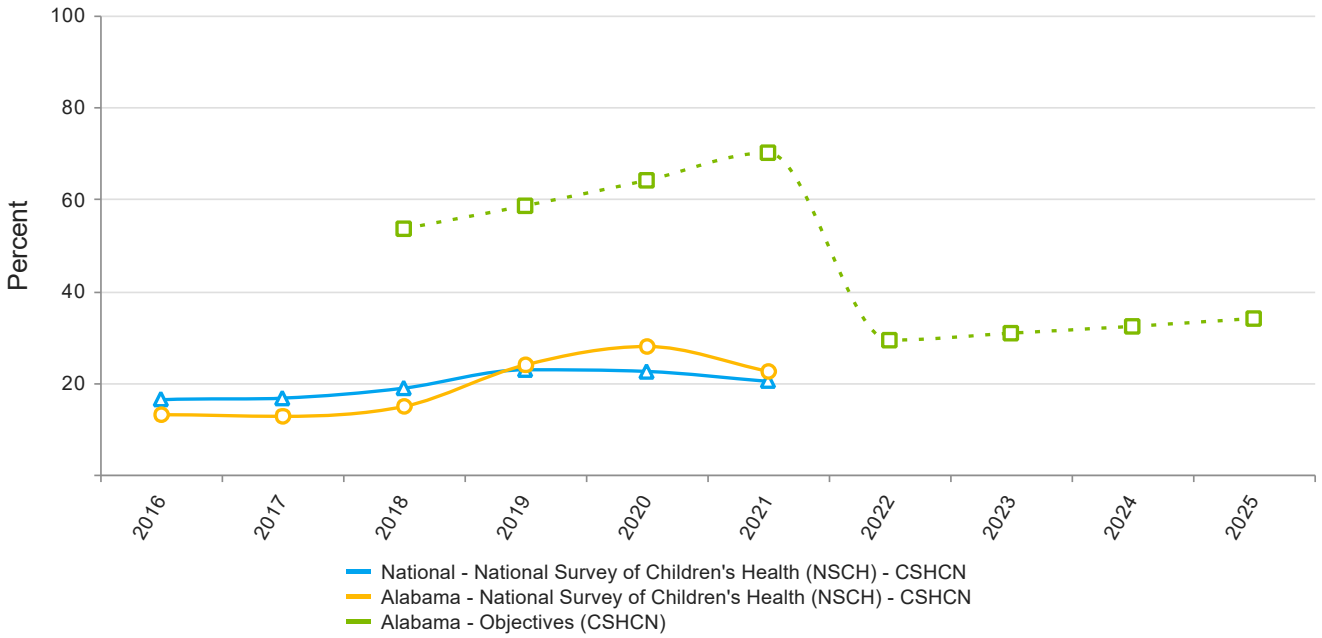
OHO will continue promoting oral cancer awareness and HPV vaccines for adolescents. There will be a revised oral cancer awareness campaign in 2024.

OHO plans to again request that Governor Kay Ivey sign a proclamation declaring February as Children's Dental Health Month and April as Oral Cancer Awareness Month in Alabama, to bring continued attention to the importance of oral health and the overall health of one of the state's most vulnerable populations.

Children with Special Health Care Needs

National Performance Measures

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care
Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	53.5	58.5	64	70	29.3
Annual Indicator	12.9	15.0	23.8	27.9	22.5
Numerator	13,867	14,975	21,076	25,741	22,337
Denominator	107,738	99,967	88,591	92,115	99,074
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	30.8	32.3	34.0

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Percent of YSHCN enrolled in State CSHCN program who report satisfaction with their transition experience to adulthood.

Measure Status:	Active			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			50	58
Annual Indicator			74.5	78
Numerator			38	39
Denominator			51	50
Data Source			CSHCN Program	CSHCN Program
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	67.0	77.0	89.0

State Performance Measures

SPM 2 - Strengthen and enhance family/youth partnerships, involvement and engagement in advisory groups, program development, policymaking, and system-building activities to support shared decision making between families and health-related professionals.

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			33	50
Annual Indicator			45.8	58.3
Numerator			11	14
Denominator			24	24
Data Source			CSHCN Program	CSHCN Program
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	67.0	88.0	100.0

SPM 3 - Increase the capacity of families to connect CYSHCN to the health and human services they require for optimal behavioral, developmental, health, and wellness outcomes through our Care Coordination Program.

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			50	58
Annual Indicator			33.1	38.6
Numerator			138	276
Denominator			417	715
Data Source			CSHCN Program	CSHCN Program
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	67.0	77.0	89.0

State Action Plan Table

State Action Plan Table (Alabama) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Lack of or inadequate access to services necessary for CSHCN to transition to all aspects of adult life.	
NPM	
NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care	
Objectives	
By 2025, increase the total score on the Six Core Elements of Health Care Transition™ 3.0 Current Assessment of Health Care Transition Activities for Transitioning Youth to an Adult Health Care Clinician from baseline to 90% (Baseline = FY 2020 total score of 68.75%). By 2025, increase the number of attendees at CRS Teen Transition clinic by 25% (Baseline = FY 2020 total attendees of 54).	
Strategies	
The state CSHCN program staff, including the Parent Consultant, will conduct a transition readiness assessment at age 14 using a standardized tool, administered periodically, and discuss needed self-care skills and changes in adult-centered care. The state CSHCN program staff, including the Parent Consultant, will incorporate transition planning into their existing plan of care, starting at age 14 partnering with youth and families in developing transition goals and preparing and updating a medical summary and emergency care plan. Provide education to families about Teen Transition clinic and the benefits of attending. Provide education to staff to guide implementation of transition strategies. The state CSHCN program staff will identify adult providers to accept program clients, complete a transfer package for youth leaving the program and follow-up with the provider regarding the YSHCN's transfer status. Obtain feedback on transition experience of young adults.	
ESMs	Status
ESM 12.1 - Percent of YSHCN enrolled in State CSHCN program who report satisfaction with their transition experience to adulthood.	Active
NOMs	
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	

State Action Plan Table (Alabama) - Children with Special Health Care Needs - Entry 2

Priority Need

Lack of or inadequate access to health and related services, especially in rural areas and for services identified as difficult to obtain.

SPM

SPM 3 - Increase the capacity of families to connect CYSHCN to the health and human services they require for optimal behavioral, developmental, health, and wellness outcomes through our Care Coordination Program.

Objectives

By 2025, increase by 10 percent the number of families of CYSHCN in the program who report receiving comprehensive care coordination.

Strategies

Develop and implement a survey for families to assess the comprehensiveness of and satisfaction with CRS Care Coordination services and connection to community resources. Utilize information from the surveys to improve the quality of care coordination for CYSHCN. Educate families on the importance of care coordination and its value in improving health care outcomes for CYSHCN through developing a Care Coordination Program fact sheet. Train CRS care coordinators to use a family and person-centered approach to care plan development. Ensure that families of CYSHCN have access to and are educated about the importance of connection to a medical home. Expand outreach activities to promote public awareness of CRS Care Coordination Services within the medical community and among families of CYSHCN. Develop an internal tracking mechanism for referrals to community resources for CYSHCN not enrolled with CRS.

State Action Plan Table (Alabama) - Children with Special Health Care Needs - Entry 3

Priority Need

Increase family and youth involvement and participation in advisory groups, program development, policy-making, and system building activities.

SPM

SPM 2 - Strengthen and enhance family/youth partnerships, involvement and engagement in advisory groups, program development, policymaking, and system-building activities to support shared decision making between families and health-related professionals.

Objectives

By 2025, increase the Engagement Score on the Family Engagement in Systems Assessment Tool (FESAT) by 10% above the baseline (baseline to be established in FY 2021). By 2025 the first cohort of participants will have completed the Family Leadership Training Institute.

Strategies

Administer the FESAT to assess progress on strengthening family/youth engagement within CRS. Incorporate the four domains of Family Engagement into staff development activities through the development of a Family Engagement Quality Improvement Initiative action plan within each CRS District. Conduct ongoing monitoring of District action plans to ensure incorporation of the four domains of Family Engagement. Utilize alternative methods to increase parent and youth involvement in advisory groups and program development i.e. Zoom meetings, Facebook Live meetings, and conference calls. Develop and conduct a Family Leadership Training Institute. Develop or modify a Family/Youth Partnership outreach campaign aimed at healthcare providers and related professionals to teach about the importance of engaging families/youth in the decision-making process. Utilize the Family/Youth Partnership outreach campaign materials at professional conferences and other community events.

The State of Alabama CSHCN Program is administered by CRS, a division of ADRS. CRS' mission embodies the principles of comprehensive, community-based, and family-centered care. The mission of CRS is to enable children and youth with special health care needs and adults with hemophilia to achieve their maximum potential within a community-based, culturally competent, family-centered, comprehensive, coordinated system of services. Coordinated health services are delivered via 14 community-based offices across seven districts. In Alabama, 21.7percent of children and youth ages 0-17 have a special health care need, higher than the national percentage (19.5percent). Based on these estimates, 235,129 children and youth in Alabama have a special healthcare needs (www.childhealthdata.org/browse/survey).

To fully implement the 2021 – 2025 Block Grant State Action Plan, CRS created a Block Grant State Action Plan team. The team includes the members of the CRS Needs Assessment Leadership team, an LPC, and a social work transition specialist. The team met monthly during FY 2022 to discuss activities surrounding the outlined strategies and work through any challenges encountered while attempting to carry out the activities.

In addition, ADRS CRS renewed the agreement with the UAB SOPH, Department of Health Care Organization and Policy, AEAC to consult and assist with administering the activities outlined in the Block Grant State Action Plan. These activities include survey design, administration, and analysis. AEAC and CRS held monthly meetings throughout FY 2022 to work collaboratively on evaluation components.

Priority Need – Lack of or inadequate access to services necessary for CSHCN to transition to all aspects of adult life.

National Performance Measure 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care.

ESM 12.1 – Percent of YSHCN enrolled in State CSHCN Program who report satisfaction with their transition experience to adulthood.

Ensuring YSHCN are equipped with the skills and tools necessary to transition to adult health care has always been a priority for CRS. At age 14, youth are transferred to their district's transition social worker. During FY 2022, these specialists continued to provide targeted, comprehensive transition services to help CRS-enrolled youth and their families plan for adulthood. Services include providing care coordination, transportation assistance, referral to community resources, and translation services when needed. Transition social workers use the Six Core Elements of Health Care Transition™ Transition Readiness Assessment for Youth and the Transition Readiness Assessment for Parents/Caregivers to assess transition readiness. CRS staff also participate in transition team meetings with local school districts to assist in transition planning.

In FY 2022, there were 19 CRS transition social workers serving 3,763 YSHCN ages 14-21. These social workers ensure that YSHCN have a Plan of Care (PoC) in place. The plan covers health/medical issues, educational needs, developmental and independent living skills, and transitioning to adult health care. The plan is updated annually with the youth and their family.

CRS offers YSHCN ages 12 to 21 the opportunity to participate in Teen Transition Clinic (TTC). In FY 2022, CRS had 73 YSHCN participate in TTC. The TTC is offered at five locations throughout the state and is a specialized clinic designed to assist YSHCN as they make the transition to adult life. YSHCN attending TTC participated in a vocational evaluation. The results of the evaluation are used to assist in identifying additional services, supports, and accommodations for high

school, college, and/or career in an effort to maximize the potential of each individual. During the clinic, the attendee and their family work together with a team to explore options in planning for the future. Topics include education, independent living, employment, assistive technology, and recreation. Based on the specific needs of the youth that is attending TTC the team may consist of the following: adolescent medicine physician; rehabilitation medicine physician; pediatrician; rehabilitation technology specialist; vocational assessment specialist; vocational rehabilitation counselor; community support specialists; physical therapist; nutritionist; audiologist; SLP; care coordinator; parents, other relatives; friends; and school staff among others. After completing the clinic, the attendee and their family are provided a copy of the vocational evaluation and a written summary from the clinic visit, along with team members' suggestions and resources for further planning. Vocational Evaluation reports can be shared with the school system for IEP planning and recommendations from the report are also used to support college accommodation. CRS collaborates with ADRS Vocational Rehabilitation Deaf/Hard of Hearing (HOH) unit to hold Deaf/HOH TTC. The Deaf/HOH TTC follows the TTC model but includes specialized team members such as pediatric and adult audiologists, sign language interpreters, and rehabilitation engineers with expertise in Deaf/HOH technology.

Some testimonies regarding CRS TTC:
"The team did a great job! Teen Transition Clinic was very informative. Thank you all very much!"
"The Teen Transition Clinic was helpful. It provided insight to information I did not know regarding transition and services. I appreciated that the Transition Specialist and Community Support Specialist with SAIL were able to be of assistance."
"I personally had a great experience. I felt listened to as a parent. All staff members/providers were kind and respectful. Madison said she had an interesting experience. She said she learned about all the things that can help her in college and get through life with a disability."

The Vocational Rehabilitation Service (VRS) program is also located within ADRS. A continuum of services between CRS and VRS is encouraged through regular meetings and consistent communication between CRS transition social workers and VRS counselors to ensure appropriate accommodations are in place for educational and employment success. CRS and VRS staff have continued to collaborate to address issues and challenges in the transition process. Throughout FY 2022, CRS and VRS staff continued to meet to assure that YSHCN received timely and appropriate services to assist them with health, education, and employment-related challenges.

CRS Transition social workers continue to build a network of adult health care providers for YSHCN. Having a strong network ensures that CRS can link YSHCN to the appropriate adult healthcare provider and community services. Building these networks occurs at the local level and is completed through in-person presentations to physicians providing adult healthcare and participation in outreach activities focused on transition. During the final quarter of FY 2022, CRS resumed conducting in-person outreach and marketing events including provider visits.

Throughout FY 2022, CRS continued to partner with the UAB Medicine Staging Transition for Every Patient (STEP) Medical Clinic. The STEP program started in September 2020 to assist with the transition to adult health care and was the first formal program of its kind in Alabama and the surrounding region. STEP is designed to facilitate the transition of care for patients with chronic/complex diseases of childhood as they are preparing to exit the COA system for the adult model of care at UAB. In FY 2022, the CRS transition and traumatic brain injury (TBI) social work specialists from the Homewood office continued to provide social work support in the STEP Clinic. In partnership with the UAB staff social worker, CRS social workers facilitate patient referrals between programs, assist with access to needed resources, and provide community-based follow-up. CRS staff also provide a link between UAB physicians and ADRS programs across the state, supporting a continuation of care for transitioning young adults with complex medical needs previously unavailable for this population. CRS also participated as a member of the planning committee for a Birmingham area transition conference targeting the needs of young adults with medical complexity in conjunction with UAB STEP, COA, and United Ability.

Another strong collaboration to enhance transition services for YSHCN needs in Alabama is with the local school systems. Representatives from CRS work with schools to plan and participate in Transition Resource Fairs in their local communities. These events promote awareness to students, caregivers, educational, medical, and other community stakeholders. Some of the topics presented included navigating complex medical transitions, becoming a better self-advocate, transitioning from high school to college, Medicaid waivers, and employment.

Enhancing the knowledge and skills of CRS transition social workers and other CRS care coordinators is critical to providing quality services. In FY 2022, CRS state leadership determined the need to review the use of the Six Core Elements of Health Care Transition™ tools within CRS. As a result of this review, some inconsistencies of use across the state were identified. Recognizing the need for guidance regarding the tools CRS leadership requested technical assistance from Got Transition® staff. Based on the guidance from Got Transition® staff and internal discussions a task force was formed to review the current CRS transition process and determine ways to strengthen the use of the Got Transition® tools in service delivery. Forming the Transition Task Force took some time because we wanted to ensure representation from each of the CRS districts. It was also important to identify individuals with extensive experience using the current process as well as those new to using the Six Core Elements of Health Care Transition™. Due to CRS experiencing several staff changes at the state office the first meeting of the task force was not held until the end of FY 2022.

CRS transition social workers attend the annual Alabama Transition Conference Training Series. This conference is a partnership between ADRS and Auburn University and provides attendees with updates regarding state and national transition policies and best practices when working with youth and young adults with special healthcare needs. In FY 2022 the conference was held virtually due to COVID-19.

In order to assess the effectiveness and individual satisfaction of CRS transition services CRS collaborated with the AEAC to develop a transition survey aimed at capturing the perception and experiences of transition-age youth enrolled in CRS services. The overall goal of the survey is to collect vital information from enrolled youth that could improve CRS transition services. CRS in collaboration with AEAC finalized the survey questions in early FY 2022. The AEAC then built the survey in Qualtrics and both entities conducted in-depth testing to ensure survey design and logic were correctly implemented. The transition survey required extensive testing as there were two survey tracks. Although the audience for the survey was youth with special health care needs ages 19-21 years, the team recognized that some youth would either need assistance from a parent, caregiver, or other relative to complete the survey or to answer on his/her/their behalf due to the nature of the special health care need or disability. Once testing was completed CRS began notifying staff and families of the Winter survey release.

After the survey release, AEAC staff kept CRS updated on survey response rates. After several weeks of minimal response rates, CRS convened a meeting of the transition care coordinators to discuss ways to increase the response rate, recognizing the options were limited due to the specificity of the survey sample. As a result of the discussion, it was discovered that there was an error in the initial query from Computer Services which resulted in an incorrect email list for survey distribution. The query was modified, and the survey was relaunched to the updated sample.

In FY 2022, CRS was only able to analyze the satisfaction measure due to a delay in receiving the overall survey data analysis from the AEAC. Although limited data was provided in FY 2022, the Block Grant State Action Plan team was able to discuss lessons learned regarding the survey distribution plan. A need was identified to establish reliable ways to ensure staff are collecting valid email addresses and updating existing emails. In addition, the team discussed ways to market the survey in FY 2023.

Priority Need – Increase family and youth involvement and participation in advisory groups, program development, policy-making, and system-building activities.

SPM 2 – Strengthen and enhance family/youth partnerships, involvement, and engagement in advisory groups, program development, policymaking, and system-building activities to support shared decision-making between families and health-related professionals.

ADRS and CRS have a long-standing commitment to family and youth engagement and the principles of family-centered care. For over 30 years, this commitment has impacted every part of CRS from direct services to infrastructure building and population health work. CRS makes a significant investment in family partnerships by employing those with lived experience through the CRS Parent Connection Program and Youth Connection Program. See section III.E.2.b.ii. Family Partnership for additional information on the Parent and Youth Connection Programs.

Recognizing the value of the National Family Voices Family Engagement in Systems Assessment Tool (FESAT) in assessing how well an organization supports family engagement in systems-level initiatives, CRS identified using the FESAT and its four domains of family engagement as part of the 2021-2025 Block Grant State Action Plan.

In the summer of FY 2022, CRS readministered the FESAT and held consensus scoring meetings. Administering the FESAT included distributing the tool along with the CRS FESAT Purpose and Instruction document to individuals who would be participating in the consensus scoring meetings. These individuals included CRS State Office staff, district supervisors, and LPCs that had previously participated in FESAT training. The only variation in those scoring the FESAT from the baseline in FY 2021 was the new care coordination program specialist at the State Office. This individual was able to view the previously recorded National Family Voices training to ensure knowledge of the FESAT and the scoring process. Each participant was instructed to score the FESAT based on their experience within CRS as an agency. These scores would then be discussed during the consensus scoring process.

UAB AEAC faculty and staff facilitated two consensus scoring sessions live via Zoom. Participants shared their initial scores for each question using the Zoom poll feature. The facilitator noted the variation in scores and encouraged discussion. Following the discussion, polls were re-launched, and participants again submitted a score that reflected his or her opinion after hearing the discussion. Consensus was reached on the score for each question based on the majority score of the final (second) poll. The consensus discussion served as an opportunity for participants to understand each other's points of view. It also raised awareness about the discrepancies in the knowledge of policies and specific activities surrounding family engagement that exist between those participating and created an awareness about the need to share information more broadly.

A comparison of the baseline FESAT scores to FY 2022 was conducted to identify areas of improvement. The overall Family Engagement Score was 83 percent in FY 2022 compared to the baseline score of 76 percent resulting in an 8-percentage point increase. The Family Engagement Quality Improvement Initiatives implemented in FY 2022 were the key to the increase. Each district team was able to tailor their plan to something meaningful which kept the four domains of family engagement at the forefront and fostered discussions among all staff. All domains increased in scoring except Representation. In reviewing the consensus scoring discussion notes for each FY, there appeared to be more in-depth discussion during FY 2022 as to the challenges within this domain. Challenges included difficulty finding bilingual and diverse families to serve on PACs as well as trust issues within Latino communities due to immigration laws. Awareness of these issues will assist CRS staff in identifying strategies to improve representation within family engagement.

In FY 2022, the Block Grant State Action Plan team identified the need for more in-depth reviews of the Family Engagement Quality Improvement Initiatives to ensure the plans were fully implemented and represented true family

engagement. To provide the support needed to ensure each district initiative was moving forward and reflective of true quality improvement took an extended amount of time and proved overwhelming for one staff person to manage in addition to their other duties. Given the Block Grant State Action Plan team members' involvement in the initiatives, it was decided that the districts would be divided among the team members who will then review the quarterly reports to provide feedback and technical assistance to the teams. They will also ensure teams are incorporating and sharing the National Family Voices Domains of Family Engagement fact sheets in staff development activities as they implement their initiatives. Due to staffing changes among key team members, liaison assignments were not made until the final quarter of FY 2022.

Ongoing efforts were made during FY 2022 to incorporate the Family Engagement QI Initiatives in CRS Management Team discussions. District supervisors presented their team's initiative, and the group was allowed to ask questions. The presentations provided the opportunity to further instill a culture of QI and continued education regarding the Plan, Do, Study, Act (PDSA) method. In addition, the Family Engagement QI Initiative site on SharePoint was continually updated. The SharePoint site provided each district supervisor the opportunity to review other initiatives and quarterly reports.

Priority Need – Lack of or inadequate access to health and related services, especially in rural areas and for the services identified as difficult to obtain.

SPM 3 – Increase the capacity of families to connect CYSHCN to the health and human services they require for optimal behavioral, developmental, health, and wellness outcomes through our Care Coordination Program.

The CRS Care Coordination Program provides a multidisciplinary approach to care coordination to ensure CYSHCN and their families connect to wrap-around services they require for optimal behavioral, developmental, health, and wellness outcomes. CRS delivers services using a multi-disciplinary team approach and care coordinators are essential team members. Working together, the team provides coordinated services to improve the quality of life for CYSHCN and their families. Care Coordination is provided by licensed social workers and registered nurses located in the 14 community-based offices across the state. In addition, there are social work specialists trained in transition and TBI. These social workers manage caseloads related to their assigned specialty.

All CRS care coordinators provide support to help families navigate the complex system of care for CYSHCN. This support includes providing options and ongoing need assessments for CRS medical and evaluation clinics, providing education regarding the health care needs, participating in school meetings and advocating for school-based services, exploring transportation options, locating community resources, making referrals for services, and helping families prepare YSHCN for transition to adulthood. Although there are limited transportation resources in the state, care coordinators are able to electronically complete Medicaid NET request forms which helps expedite reimbursement for transportation costs related to medical appointments. CRS care coordinators also advocate for CYSHCN and their families within and outside CRS to improve the system of care. Through these advocacy efforts, they develop a long-term relationship with the families built on trust and established individual goals.

Support also includes ensuring CYSHCN and their families have a medical home and that the CRS care coordinator is communicating regularly with the medical home. Although NPM 11 was not selected as part of the 2021-2025 action plan, CRS embraces the philosophy of providing family-centered, coordinated, ongoing comprehensive care within a medical home. Using a holistic approach, families are supported in working collaboratively with their doctors and other service providers to best meet the client’s needs. This support includes keeping the family informed of appointments, following up on recommendations by the medical home, and assisting with insurance needs. CRS care coordinators and LPCs assist families without medical homes to locate appropriate community primary care physicians (PCPs).

Alabama, like many other states, have too few PCPs who serve CYSHCN and too few pediatric specialty providers, especially in rural areas. CRS care coordinators continue efforts to identify community PCPs willing to accept CYSHCN as patients. Local care coordinators work to build relationships with PCPs that serve CYSHCN to establish referral services through outreach activities and participating in community events. These outreach efforts also include sharing information regarding CRS services and the CRS referral process through regular office visits and phone calls. Building relationships at the local level ensures that care coordinators have the connections to facilitate referrals to those providers with experience in providing services to CYSHCN.

Expanding outreach activities and promoting awareness of the CRS Care Coordination Program within the medical community and among families of CYSHCN is a top priority. In order for staff to have the needed resources to carry out these activities, the Block Grant State Action Plan team began efforts to create a Care Coordination Program booklet. In FY 2022, the team held several meetings to review and modify the draft verbiage accounting for the language level and phrasing used in the brochure as well as adjusting the flow of the information presented. The overall goal of the reviews was to ensure the language used was accessible to families and providers while adequately describing the services provided. The team had AEAC staff conduct a thorough review of the verbiage to assess the reading level and make recommendations. The Block Grant State Action Plan team in turn reviewed the suggested literacy changes to ensure they would not alter the information in a way that did not adequately capture CRS Care Coordination services. Once the team finalized the verbiage, the information was submitted to the ADRS Office of Communications and Information for design. While the brochure layout was being designed the team began developing a plan to conduct a PDSA related to the booklet. This plan included developing questions related to the brochure for the PDSA.

An additional key component of comprehensive care coordination includes a jointly developed PoC. CRS care coordinators develop, maintain, and update a PoC. The PoC is an annual assessment conducted with the family to identify needs/concerns, actions to address the needs/concerns, and a summary of services received. The plan is shared with families as well as providers. In FY 2020, the CRS State Care Coordination Program Specialist convened a group of CRS staff members that included care coordinators, social work specialists, physical therapists, computer services, nurses, and state office staff including the SPC to focus on improving the PoC. Major changes that resulted from the workgroup included allowing a multidisciplinary team to document in the PoC and the ability to automatically send the plan of care to the child's medical home. The group also focused on ensuring the PoC is jointly developed with the family, has value for the family, and is shared with the caregiver.

The following stories from CRS care coordinators illustrate the impact of CRS care coordination:
We have a 9-year-old that has been in our program for seven years. She has a genetic diagnosis that includes developmental delays, early onset scoliosis, and other issues. She is being raised by her grandmother. The grandmother recently told our new orthopedist and reiterated to me that our agency had been a Godsend to her. She stated that she did not know how she would have handled her granddaughter's health issues without the help and support from the CRS office. She went on to brag about all the workers in the clinics she attends orthopedics, hearing, and physicians that have worked with her while a client at CRS.

We have a NICU follow-up clinic attendee that was enrolled shortly after birth. His initial care coordinator went out on maternity leave and the CRS intern, under the supervision of the Social Work Administrator, took on leading care coordination for the family. Through a team effort between the two care coordinators and the intern working together seamlessly, we were able to provide support to the family as they navigated their new normal. The child was able to get established for social security benefits, coordinated with many medical providers, completed home visits, set up for respite care, and most importantly, trust was built with the caregivers. They constantly express appreciation for the care coordinators and therapists whom they interact with regularly. The caregivers

know that they can call us for support.

In order to assess the effectiveness of the CRS Care Coordination Program and determine those that report receiving comprehensive care coordination, CRS collaborated with the AEAC to develop a survey aimed at capturing the perceptions and experiences of those receiving care coordination services. The overall goal of the survey is to collect vital information from families that could improve CRS care coordination services. CRS in collaboration with AEAC developed the survey questions during FY 2021. In FY 2022, the AEAC built the survey in Qualtrics, and both entities conducted in-depth testing to ensure survey design and logic were correctly implemented. Once testing was completed CRS began notifying staff and families of the Spring survey release.

CRS and AEAC then worked to define the composite measure that would indicate whether or not a survey respondent believed they had received comprehensive care coordination. For purposes of this survey, "comprehensive care coordination" was defined based on the National Standards for Systems of Care for Children and Youth with Special Health Care Needs (http://cyshcnstandards.amchp.org/app-national-standards) and the National Care Coordination Standards for Children and Youth with Special Health Care Needs (https://www.nashp.org/national-care-coordination-standards-for-children-and-youth-with-special-health-care-needs/). In FY 2022, CRS was only able to analyze the composite measure data due to a delay in receiving the overall survey data analysis from the AEAC. Although limited data was provided in FY 2022, the Block Grant State Action Plan team was able to discuss the composite measure data which indicated families did not have a clear understanding of the PoC. The team discussed several options for improving understanding during FY 2023 as well as the potential for addressing survey language.

Children with Special Health Care Needs - Application Year

In the upcoming reporting year, CRS will continue to address the three priority needs identified for CSHCN for the 2021 - 2025 State Action Plan. These are lack of/or inadequate support for transition to all aspects of adulthood; increase family and youth involvement and participation in advisory groups, program development, policy-making, and system-building activities; and lack of/or inadequate access to health and related services, especially in rural areas and for services identified as difficult to obtain. See section III.E. 5-Year State Action Plan for additional information.

To fully implement the 2021 - 2025 Block Grant State Action Plan, CRS created a Block Grant State Action Plan team. The team includes the members of the CRS needs assessment leadership team, LPC, and a social work transition specialist. The team originally intended to meet quarterly but quickly recognized the need to meet monthly. Throughout the upcoming year, the Block Grant State Action Plan team will continue monthly meetings to review progress on the action plan for the CSHCN domain. During the monthly meetings team members provide status updates on the progress, or lack thereof, of efforts to address the identified measures. Updates also address activities surrounding the outlined strategies, accomplishments resulting from those activities, challenges encountered while attempting to carry out the activities, and needed revisions to the current activities. During FY 2024, CRS staff will continue to collaborate with current partners and seek to identify new partners to address the identified priority needs.

AEAC will continue to consult with and assist CRS in administering the activities outlined in the Block Grant State Action Plan. These activities include survey design, administration, and analysis. AEAC and CRS will continue to hold monthly meetings to work collaboratively on evaluation components of the action plan.

Outlined below are the activities the Block Grant State Action Plan team identified for FY 2024.

National Performance Measure 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care.

ESM 12.1 – Percent of YSHCN enrolled in State CSHCN Program who report satisfaction with their transition experience to adulthood.

In FY 2023, UAB AEAC administered the transition survey on behalf of CRS and conducted an analysis of the survey results. In FY 2024, CRS will receive a detailed survey report that includes comparison data from the baseline year. The Block Grant State Action Plan team will utilize the survey data to identify needed areas of improvement. The Block Grant State Action Plan team will include survey data as part of ongoing discussions to identify and implement strategies to strengthen the transition program. The team will also work to identify ways to share information related to the survey results with staff and families.

In FY 2024, CRS will implement identified strategies for increasing the transition survey response rate. These strategies include working with CRS clerical staff to ensure they are collecting and validating emails, providing transition social work specialists with an advance list of the survey sample so that they can ensure emails are valid, and promoting the survey release among staff to increase awareness. The AEAC will readminister the transition survey in FY 2024.

In FY 2023, CRS state leadership convened a Transition Task Force to review the current CRS transition process and determine ways to strengthen the use of the Got Transition® Six Core Elements of Health Care Transition™ tools. For FY 2024, the Transition Task Force will implement revised policies and procedures to improve overall service delivery. Implementation will include extensive training of CRS staff at all levels to ensure the transition is a part of the multi-disciplinary clinic approach.

To further ensure a continuation of care for transitioning young adults with complex medical needs, CRS will continue its partnership with the UAB STEP Medical Clinic. The STEP clinic serves as a referral source for CRS clients transitioning to adult care. In FY 2024, the CRS Assistant Commissioner and the director of the STEP clinic will continue meeting to identify ways to further the STEP clinic's reach. See section III.E.2.c. CSHCN Annual Report for additional information on the STEP clinic partnership.

In addition, CRS will continue to:

Identify transitioning youth, starting at age 14, through the EMR. Identified youth will be transferred to the social work transition specialist for coordination of transition activities. This includes incorporating transition planning into their existing PoC and partnering with youth and families to develop transition goals.

Provide care coordination and information and referral services to transitioning YSHCN.

Collaborate with VRS staff on the referral and transition process.

As part of the 2021 - 2025 needs assessment cycle CRS developed two new SPMs. Although each SPM is tied to one specific priority need the objectives and strategies will have a positive impact on other needs identified during the needs assessment process.

SPM 2 – Strengthen and enhance family/youth partnerships, involvement, and engagement in advisory groups, program development, policymaking, and system-building activities to support shared decision-making between families and health-related professionals. See section V. Supporting Documents to review the CSHCN Checklist Criteria Scoring Tool for SPM 2 2021-2025 5-year needs assessment for a complete list of activities.

For 2024, CRS will readminister the FESAT to assess progress on strengthening family/youth engagement within CRS. The AEAC will provide a detailed report of the consensus scoring discussions to include a comparison of the FESAT baseline scores. Information from the report will be utilized to foster conversations among the CRS management team and the LPCs. The Block Grant State Action Plan team members serving as Family Engagement Quality Improvement Initiative Liaisons will continue working with the district teams to ensure their plans are implemented and representative of true family engagement. The liaisons will continue conducting in-depth reviews of the quarterly reports and provide feedback and technical assistance to the teams. They will also ensure teams are incorporating and sharing the National Family Voices Domains of Family Engagement fact sheets in staff development activities as they implement their initiatives. For more information about the FESAT visit https://familyvoices.org/fesat/.

During FY 2024, CRS in collaboration with FVA will continue working with staff at the University of Iowa Division of Child and Community Health and Child Health Specialty Clinics (CHSC) to learn about their Family Leadership Training Institute. CRS would like to model a Family Leadership Training Institute based on the Iowa model. The CRS MCH coordinator, SPC, and RPC plan to conduct a site visit to experience some of the training institutes. The desired outcome for FY 2024 is to create a detailed action plan outlining the steps it will take to establish a CRS Family Leadership Training Institute.

CRS will coordinate with the ADRS Office of Communications and Information to begin developing or modifying a Family/Youth Partnership outreach campaign aimed at healthcare providers and related professionals to teach about the importance of engaging families/youth in the decision-making process.

SPM 3 – Increase the capacity of families to connect CYSHCN to the health and human services they require for optimal behavioral, developmental, health, and wellness outcomes through our Care Coordination Program.

In FY 2023, UAB AEAC administered the Care Coordination Family Survey on behalf of CRS and conducted an analysis of the survey results. In FY 2024, CRS will receive a detailed survey report that includes comparison data from the baseline year. The Block Grant State Action Plan team will utilize the survey data to identify needed areas of improvement. The Block Grant State Action Plan team will include survey data as part of ongoing discussions to identify and implement strategies to strengthen the Care Coordination Program. The team will also work to identify ways to share information related to the survey results with staff and families. The AEAC will readminister the care coordination survey in FY 2024.

Through the CRS Care Coordination Program, licensed social workers and registered nurses will work to ensure that families of CYSHCN have access to and are educated about the importance of a connection to a medical home. In FY 2024, CRS will include the medical home concept in staff training for care coordinators. Care coordination supervisory staff will have time during the quarterly supervisory Zoom to share information regarding providers that serve CYSHCN in their district.

In FY 2024, CRS will utilize the newly designed Care Coordination Program booklet to expand outreach activities and promote public awareness of CRS care coordination services within the medical community and among families of CYSHCN. The booklet will be shared with providers and at outreach events to serve as a reminder of the CRS Care Coordination Program and its value in improving healthcare outcomes.

In FY 2023, CRS released a newly designed PoC in the CRS EMR, CHARMS. The release included training on the new elements, goal setting, and utilizing a family and person-centered approach to care plan development. In FY 2024, the Care Coordination Program specialist will continue working with CRS staff to make needed modifications and enhancements.

Cross-Cutting/Systems Building

State Performance Measures

SPM 5 - Increase the proportion of EHS programs participating in the EHSCCP grant program that maintain 10 percent of their population with children with special needs.

Measure Status:	Active			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			0.6	0.6
Annual Indicator	0	40	40	80
Numerator	0	2	2	4
Denominator	6	5	5	5
Data Source	Program Data	Program Data	Program Data	Program Data
Data Source Year	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	0.8	1.0	1.0

SPM 6 - Percent of staff trained at day care provider/centers on CPR/First Aid

Measure Status:	Inactive - The Child and Adolescent Health Division is no longer able to report a denominator for this measure.

State Provided Data				
	2019	2020	2021	2022
Annual Objective			28.9	29.5
Annual Indicator	28.6	22.7	22.7	22.7
Numerator	6,157	4,886	4,886	4,886
Denominator	21,514	21,514	21,514	21,514
Data Source	Healthy Childcare Alabama Training Data	Healthy Childcare Alabama Training Data	Healthy Childcare Alabama Training Data	Healthy Childcare Alabama Training Data
Data Source Year	2019	2020	2020	2020
Provisional or Final ?	Final	Final	Final	Final

State Action Plan Table

State Action Plan Table (Alabama) - Cross-Cutting/Systems Building - Entry 1

Priority Need

Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they live, learn, work, and play.

SPM

SPM 5 - Increase the proportion of EHS programs participating in the EHSCCP grant program that maintain 10 percent of their population with children with special needs.

Objectives

Increase the number of early head start programs that accept children with disabilities by one provider per year.

Strategies

Increase the number of early head start programs that accept children with disabilities.

State Action Plan Table (Alabama) - Cross-Cutting/Systems Building - Entry 2

Priority Need

Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they live, learn, work, and play.

Objectives

Increase the number of WW visits performed at the local county health departments; Increase public awareness of program via social media & marketing materials.

Strategies

Increase the proportion of WW preventative visits in all program specific counties for women ages 15-55 and educating the public in all program specific counties of available WW services.

State Action Plan Table (Alabama) - Cross-Cutting/Systems Building - Entry 3

Priority Need

Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they live, learn, work, and play.

Objectives

Each county participating in WW program will establish a particular day of the week to offer WW services at the county health departments; WW staff will continue to assist identified at-risk women in having healthy pregnancies to avoid poor birth outcomes.

Strategies

Recruit women ages 15-55 to the WW program for cardiovascular disease risk factor screenings, healthy life/reproductive health planning (interconception and preconception care), health coaching and nutritional counseling.

State Action Plan Table (Alabama) - Cross-Cutting/Systems Building - Entry 4

Priority Need

Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they live, learn, work, and play.

Objectives

Program will continue to offer monthly support group meetings coordinated by social workers; nutritional classes per registered dietitian; and physical activity incentives, such as YMCA memberships, and through partnership with ADPH Nutrition and Physical Activity Division.

Strategies

WW program will provide risk reduction counseling to help clients understand their risks, health coaching to set goals for behavioral change, and offer nutritional counseling and support to WW participants to help discover healthy lifestyle behaviors.

State Action Plan Table (Alabama) - Cross-Cutting/Systems Building - Entry 5

Priority Need

Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they live, learn, work, and play.

Objectives

Continue to partner with community partners in selected counties for referrals into the program; increase the number of community partners in all counties participating in WW program to increase enrollment and broaden ethnicity of participants.

Strategies

Program will recruit all women aged 15-55 residing in counties participating in the WW program via marketing materials and social media.

State Action Plan Table (Alabama) - Cross-Cutting/Systems Building - Entry 6

Priority Need

Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they live, learn, work, and play.

Objectives

Increase & continue distribution of Spanish marketing materials to recruit Spanish speaking women aged 15-55.

Strategies

WW Program will continue to use Spanish speaking marketing materials to recruit population and offer Spanish literature for education and healthy lifestyle behaviors.

State Action Plan Table (Alabama) - Cross-Cutting/Systems Building - Entry 7

Priority Need

Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they live, learn, work, and play.

Objectives

Encourage/provide wellness visit to women, ages 15-55, who report not having a preventative visit in the last year regardless of insurance status.

Strategies

Target underinsured and/or uninsured women, ages 15-55, to enroll in WW program.

Cross-Cutting/Systems Builiding - Annual Report

The Alabama Title V MCH Program recognizes that health disparities and inequities are driven by many factors, including social determinants of health. To ensure that broad stakeholder voices could be heard and issues such as education, poverty, racism, housing safety, and other health-related inequities in our state are recognized, ADPH and CRS worked with UAB AEAC to create strategies that would assure equitable opportunities for participation in the 2020 Alabama Title V MCH Block Grant Needs Assessment. Throughout the systematic process of data collection and analysis for the Needs Assessment, several areas of disparity were identified across all domains. In March 2020, FHS convened stakeholders to hear a presentation of the data collected by AEAC, followed by sessions to rate and rank the identified needs. The need, “Inequitable access to health resources based on race/ethnicity, socioeconomic status, geographic location, and education” was ranked in the top three in all domains. Needs statements related to mental health were ranked in the top three in the Women’s/Maternal Health Domain and the Adolescent Health Domain. Needs related to mental health ranked fourth in the Child Health Domain. The Alabama Title V Leadership team identified an inclusive priority need statement for the 2021-2025 state action plan, “Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they live, learn, work, and play.” As this priority need crosses all domains, the related objectives and strategies for FY 2022 are highlighted below and incorporated throughout the population domain annual reports.

Workforce Development

In 2022, Title V leadership submitted a technical assistance request to HRSA for support in building staff capacity to address health equity and in effectively reporting activities in the annual application/report. The application resulted in the development of the Resilience, Equity, Diversity, and Inclusion Learning Sessions for Region IV. The goals of the sessions were: 1) identify and address root causes of burnout to build a resilient workforce; 2) recognize current strengths and areas of needed growth in addressing health equity; and 3) explore the tools necessary for diversity, equity, and inclusion work. The sessions also included baseline and follow-up reflection tools. Experts from the National Center for Education in Maternal and Child Health, the University of Washington, the National MCH Workforce Development Center , UAB, AMCHP, and CityMatCH collaborated to create and present six learning sessions over 4 months, April - July 2022. The session components were as follows:

- Session 1: Burnout, Resilience, and Meaningful Work. Understanding burnout and focusing on resilience to advance health equity
- Session 2: Guided Peer-to-Peer Learning. How Title V agencies across the country are addressing health equity and the social determinants of health
- Session 3: Equity. Asset framing as an innovative tool to advance health equity
- Session 4: Inclusion. Inclusion in our workplace and our communities
- Session 5: Diversity. Fostering a skilled, flexible, and diverse workforce
- Session 6: Putting It All Together. Debriefing, resource sharing, next steps, and Results-Based Accountability

Child Health

SPM 5 - Increase the proportion of Early Head Start (EHS) programs participating in the Early Head Start Child Care Partnership (EHSCCP) grant program that maintain 10 percent of their population with children with special needs.

- Increase the number of EHS programs that accept children with disabilities.

In 2022, four of the five program partners met their goal of maintaining at least 10percent of their population as children with special needs. ADPH continues to provide care coordination services that include working with centers

to identify children with special needs, assisting in obtaining the IFSP, verifying the number of special needs children monthly at each center, and reporting to DHR children not listed on their monthly report. ADPH also provides outreach to increase awareness and access for children with disabilities and special needs to a comprehensive child development program that provides early education and support services to children and families. Staff continue to work to increase the enrollment of children who are identified as having special needs and help to retain this population in the EHSCCP Program until the child ages out or is no longer eligible for enrollment.

SPM 6 - Percent of staff trained at daycare providers/centers on CPR/First Aid

Staff were unable to determine an accurate number of total staff in child-care centers. Staff have reached out to the DHR Child Care Licensing Division and they were unable to give us a reliable estimate. This is a very fluid number and staffing is an ongoing concern for child care across the state. Without a reliable, accurate number we are unable to calculate a percent. This SPM is now inactive.

Women's Health

- Increase the proportion of Well Woman preventative visits in all program-specific counties for women ages 15-55 and educate the public in all program-specific counties of available Well Woman services.
- Recruit women ages 15-55 to the Well Woman Program for cardiovascular disease risk factor screenings, healthy life/reproductive health planning (interconception and preconception care), health coaching, and nutritional counseling.
- Provide risk-reduction counseling to help clients understand their risks, health coaching to set goals for behavioral change, and nutritional counseling and support to WW participants to help discover healthy lifestyle behaviors.
- Recruit all women aged 15-55 residing in counties participating in the Well Woman Program via marketing materials and social media.
- Continue to use Spanish-speaking marketing materials to recruit the population and offer Spanish literature for education and healthy lifestyle behaviors.
- Target underinsured and/or uninsured women, ages 15-55, to enroll in the Well Woman Program.

The Well Woman program piloted a clinical travel team in Greene, Hale, and Perry Counties. The goal of this pilot project was to expand services to a population of women in a medically underserved region of Alabama known as the "Black Belt". Staffing was an obstacle throughout the year and these counties were unable to continue to provide Well Woman services.

OWH and the Well Woman Program partnered with the Alabama Women's Commission and exploreMedia for the 211KNOW educational campaign to send weekly text messages to promote health and well-being. Participants received weekly educational messages via text. The text messages provided access to healthy recipes, physical activity tips, and other tools to empower women on their journey to adopt a healthier lifestyle.

Telehealth was incorporated into the program protocol as an option for NPs follow-up in completing the Risk Reduction Counseling session. Well Woman Program staff offered nutrition classes, support groups, and physical activity resources virtually as well.

There was an increase in the proportion of preventative visits. Total program enrollment for FY 2021 was 268 and the total for FY 2022 was 554. Each county has a specific day(s) for the Well Woman Program clinic. Continual recruitment is done in each participating county and all of the resources are offered to participants of the program. There is also continuous involvement in community health fairs/events by ADPH public health educators, district MCH

coordinators, and Well Woman social workers to recruit women in each of the program counties. 211KNOW text messaging is also a source of referral for the program through the test messages and events that are attended by exploreMedia staff. Well Woman Program materials are also available in Spanish for distribution in counties.

Cross-Cutting/Systems Building - Application Year

The Alabama Title V MCH Program will continue to work with the OHEMH as well as the UAB AEAC to create strategies that will assure equitable access to ADPH and ADRS programs and services.

III.F. Public Input

The Alabama Title V MCH Block Grant Program is administered by the ADPH, through FHS. FHS does not directly administer aspects focusing on CYSHCN but contracts with CRS. CRS is a major division of ADRS, which administers services to this population.

Discussion of how FHS and CRS invite public input follows.

ADPH

FHS maintains a Title V MCH webpage (a part of ADPH's main website) and it may be accessed at www.alabamapublichealth.gov/mch. The MCH webpage informs the public about the Federal-State Title V partnership. The SSDI coordinator will continue to update the state Title V MCH website to link to the latest MCH Block Grant Annual Report/Application and to post any associated attachments. Also, the “contact us” page on this site provides a mechanism for the public to email comments directly to the MCH Title V program. The public can email comments directly to other FHS programs using their individual web pages on the ADPH site as well. Additionally, ADPH utilizes several sources of social media which are open to public comment. Well Woman takes advantage of the benefits of social media by hosting a Facebook page and permitting its social workers to post county program information. The Well Woman Facebook page facilitates open and public communication directly between the district Well Woman staff, partners, and program participants.

FHS seeks input on MCH issues through three key avenues: collaboration with SPAC, the five RPACs, and MMRC.

Furthermore, as part of the 2020 MCH Needs Assessment, FHS sought public input via the following initiatives: three web-based surveys (survey of families; survey of adolescents; and survey of healthcare providers serving women of childbearing age, children, youth, and their families), 17 focus groups, 22 key informant interviews, and a state advisory group meeting convened to select priority needs for the MCH needs assessment. Requests for copies of the 2020 Title V MCH Block Grant Comprehensive Needs Assessment can be sent through the Title V MCH webpage.

FHS seeks input by convening several state advisory groups that have consumer representation for persons affected by particular health issues. These groups respectively advise FHS on the following programs: NBS and FP. The NBS advisory group advises the bureau on both screening for hematological and biochemical disorders and on screening for hearing impairment.

The Family Planning Advisory Committee (FPAC) meets quarterly in conjunction with the OWH quarterly meetings. FPAC members broadly represent their various communities across the state and are knowledgeable of the family planning service needs in their area. A consumer of the program is also a member. The purpose of the committee is to provide feedback regarding the development, implementation, and evaluation of the FP program, as well as to review and approve any educational or informational material used in the program. This committee ensures that the family planning needs of the various communities are being met and that all educational and informational materials are suitable for the population and community for which they are intended.

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

recommendations were implemented.

The FHS Cancer Prevention and Control Division obtains public input through the Alabama Comprehensive Cancer Control Coalition. The Coalition meets quarterly to share resources and ideas and develop interventions that will reduce the burden of cancer in Alabama. The Coalition's goal is to implement the goals and objectives in the 5-Year Alabama Cancer Control Plan. The newest 5-year plan (2022-2026) was released in June 2022. The Coalition includes representatives from stakeholders including community organizations, advocates, cancer survivors, universities, hospitals, cancer centers, public health professionals, and private companies.

The Alabama WIC Program is federally funded by the USDA. Per federal regulations, all WIC agencies must post for public comment its annual State Plan and Procedure Manual. Receipt of federal funds is contingent upon completing this process.

CRS

As part of the FY 2019 – 2020 MCH needs assessment, CRS sought public input via the following initiatives: two web-based surveys (families and youth), five focus groups, 17 key informant interviews, and convening the CRS Needs Assessment Advisory Committee. Input from the CRS Needs Assessment Advisory Committee which consists of key partners and stakeholders was sought during an initial planning meeting and via the April 2020 online prioritization process. The online process allowed Advisory Committee members to enter detailed comments which CRS Needs Assessment Leadership Team took into consideration when selecting the priority needs. The CRS 2020 Title V MCH Block Grant Comprehensive Needs Assessment Summary can be accessed from the ADRS website at https://rehab.alabama.gov/news/blog.

CRS values public input from individuals with lived experience and seeks input from families and youth on an ongoing basis through the SPAC, LPACs, and YAC. These advisory groups allow stakeholders to provide input regarding policy development and program activities. Families and youth are compensated for participation in state advisory committees and childcare is provided to reduce barriers to participation. CRS assures cultural and linguistic competence and compliance with the Americans with Disabilities Act at all meetings. In addition, the SPC, LPCs, and YCs provide input into CRS special projects such as serving on the National MCH Workforce Development Center Population Health Learning Journey team.

CRS also holds an annual Hemophilia Advisory Committee meeting to seek input into programmatic and policy issues related to the Alabama Hemophilia Program administered by CRS. The committee consists of representatives interested in hemophilia from hospitals, voluntary agencies, medical specialists, adult hemophiliacs, and parents of hemophiliacs as well as the general public.

The ADRS Office of Communications & Information maintains the Department's website which includes CRS' webpage (www.rehab.alabama.gov/services/crs). The ADRS-Today feature of the ADRS website allows CRS to seek public comment through News Releases, a Media Gallery, and the ADRS blog. The CRS webpage provides a "contact us" feature for the public to email comments directly to CRS or call a 1-800 number for direct contact. CRS utilizes several sources of social media, which are always open to public comment. Both the SPC and YC utilize social media to foster communication among the general public, CRS staff, partners, and program participants through the Parent Connection and Youth Connection Facebook pages.

III.G. Technical Assistance

ADPH

In 2022 Title V Leadership submitted a technical assistance request to HRSA for support in building staff capacity to address health equity and in effectively reporting activities within the annual application/report. The application resulted in the development of the Resilience, Equity, Diversity, and Inclusion Learning Sessions for Region IV. The goals of the sessions were: 1) identify and address root causes of burnout to build a resilient workforce; 2) recognize current strengths and areas of needed growth in addressing health equity; and 3) explore the tools necessary for diversity, equity, and inclusion work. The project also included reflection tools and guided peer-to-peer learning.

In FY2022, FHS continued receiving technical assistance from UAB AEAC. Staff met with AEAC monthly to draft a plan to address ongoing needs assessment planning, evaluation training, and methods for improving the Title V State Action Plan.

In FY 2022, the UAB AEAC continued to provide Alabama Title V Program staff with and receive technical assistance in the areas of program development, evaluation, and partnership expansion. FHS staff have participated in two trainings. The first training focused on Title V, MCH systems, and the Title V MCH Block Grant. UAB is in the process of recording a version of the training that will be available as an orientation for new staff. The second training was focused on available domain-specific data and aligning priority needs, SPMs, and ESMs. There was also a systems-mapping discussion to identify current internal and external partners also working with the population and opportunities to expand.

CRS

CRS continues to utilize the technical expertise of National Family Voices and FVA in the performance of activities associated with strengthening and enhancing family/youth partnerships, involvement, and engagement. The CRS SPC and MCH coordinator are receiving technical assistance related to the FESAT through participation in the Family Voices Title V Community of Practice (CoP). As part of the CoP, Alabama has an assigned FESAT Coach that is providing guidance related to use of the FESAT and the Family Engagement Quality Improvement Initiatives.

CRS continues to access resources and participate in technical assistance opportunities provided through AMCHP. Currently the SPC and MCH Coordinator are receiving technical assistance through participation in AMCHP's Family Engagement CoP. Participation in the CoP is allowing us to network with other states, and gain insight into ways to strengthen the CRS Parent Connection program which in turn impacts the Block Grant State Action Plan SPM around family engagement.

CRS completed the Building Capacity to Advance Population Health Approaches for CYSHCN Learning Journey with the National MCH Workforce Development Center in August 2022. Although the Learning Journey ended, we are continuing our work to expand Population Health efforts. Therefore, we will continue to seek assistance from the Center.

CRS has previously received technical assistance from the MCH Evidence Center around resilience, equity, inclusion, and diversity and ways to strengthen the CSHCN section of the State Action Plan. CRS will continue to utilize technical assistance from the MCH Evidence Center as needed.

CRS will utilize technical assistance from the Catalyst Center to develop information and strategies about specific

financing and health insurance options available in the state, especially for youth and young adults in transition and CYSHCN that have difficulty obtaining coverage.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - AL TitleV Medicaid MOUs_June2023.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - CSHCN SPM 2 Checklist Criteria Scoring Tool FY22.pdf

Supporting Document #02 - CRS Comprehensive Care Coordination Measure_23.pdf

Supporting Document #03 - AL FY 2024 APPLICATION_FY 2022 ANNUAL REPORT_Acronyms.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - ADPH - ADRS Organizational Charts_072823.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Alabama

	FY 24 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 11,684,723	
A. Preventive and Primary Care for Children	$ 5,355,859	(45.8%)
B. Children with Special Health Care Needs	$ 3,505,417	(30%)
C. Title V Administrative Costs	$ 1,168,471	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 10,029,747	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 37,841,184	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 1,577,948	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 33,881,586	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 73,300,718	
A. Your State's FY 1989 Maintenance of Effort Amount $ 15,408,615		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 84,985,441	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 116,251,504	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 201,236,945	

OTHER FEDERAL FUNDS	FY 24 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Early Head Start - Child Care Partnerships (EHS-CC) Grant	$ 878,516
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 784,136
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 527,550
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 157,824
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program	$ 668,733
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 169,547
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 111,935,298
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > National Hemophilia Program	$ 29,900
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Well Woman	$ 1,100,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > CMC-COIIN Boston University	$ 0

	FY 22 Annual Report Budgeted		FY 22 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 11,482,727 (FY 22 Federal Award: $ 11,684,723)		$ 11,684,723	
A. Preventive and Primary Care for Children	$ 5,793,036	(50.5%)	$ 5,355,859	(45.8%)
B. Children with Special Health Care Needs	$ 3,444,819	(30%)	$ 3,505,417	(30%)
C. Title V Administrative Costs	$ 1,148,272	(10%)	$ 1,168,471	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 10,386,127		$ 10,029,747	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 31,724,878		$ 38,348,573	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 1,566,690		$ 892,986	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 26,066,122		$ 29,024,019	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 59,357,690		$ 68,265,578	
A. Your State's FY 1989 Maintenance of Effort Amount $ 15,408,615				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 70,840,417		$ 79,950,301	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 123,892,360		$ 116,939,135	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 194,732,777		$ 196,889,436	

OTHER FEDERAL FUNDS	FY 22 Annual Report Budgeted	FY 22 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Early Head Start - Child Care Partnerships (EHS-CC) Grant	$ 995,594	$ 878,516
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 887,883	$ 784,136
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 380,774	$ 527,550
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 179,020	$ 157,824
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program	$ 698,009	$ 668,733
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 115,245	$ 169,547
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH	$ 1,024	$ 0
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 119,307,681	$ 111,935,298
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > National Hemophilia Program	$ 26,200	$ 27,528
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Well Woman	$ 1,300,930	$ 1,773,467
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > CMC-COIIN Boston University		$ 16,536

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1. FEDERAL ALLOCATION**
	Fiscal Year:	**2024**
	Column Name:	**Application Budgeted**
	Field Note: Line 1. (Federal Allocation) – FY 2022 Annual Report Expended amount of $11,684,723 was more than the FY 2020-2022 Application Budgeted Grant Award of $11,482,727, an increase of $201k or 1.759%. The final federal allocation for FY 2022 of $11,684,723 (6 B04MC45196-01-07) was received on 07/12/2022.	
2.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: Line 1. (Federal Allocation) – FY 2022 Annual Report Expended amount of $11,684,723 was more than the FY 2020-2022 Application Budgeted Grant Award of $11,482,727, an increase of $201k or 1.759%. The final federal allocation for FY 2022 of $11,684,723 (6 B04MC45196-01-07) was received on 07/12/2022.	
3.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: Line 3. (State MCH Funds) - FY 2022 Annual Report Expended increased to $38.3m from the FY 2020-2022 Application Budgeted amount of $31.7m, a difference of $6.6m or 20.9%. The State Match increase resulted from a combination of factors: (1) support income rising to $40.7m compared to $34.5m budgeted for FY 2022, a $6.2m difference; and (2) increase in actual expenditures for FY 2022 to $66.0m compared to the budget for FY 22 of $54.0m, a difference of $12.0m. The net differences of these two factors indicate that expenditures increased at a higher rate than income which requires a higher match contribution by ADPH of approximately $6m. CRS share of the change in State Match is $831k or 6.8%.	
4.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: Line 5. (Other Funds) – CRS FY 2022 Annual Report Expended was $892k which is a decrease from the FY 2020-2022 Application Budget reported at $1.57m, a decrease of $673k or -43%. This decrease is a result of CRS expending less from the Hemophilia State Allocation due to an increase in the number of hemophilia clients with insurance coverage.	

5.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**

Field Note:
Line 6. (Program Income) – FY 2022 Annual Report Expended amount of $29.0m increased from the FY 2020-2022 Application Budget of $26.0m, an increase $3.0m or 11.35%. Three programs that showed substantial increases in FY 2022 was not reflected in the projected budget: Family Planning Medicaid ($1.8m), EPSDT Care Coordination ($821k) and Department of Human Resources ($639k). The FY 2022 budget was built during a period of changing operations and anticipated lost in revenue from Medicaid's ACHN networks providing services. ADPH program income increased more than the expected projection.

6.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Early Head Start - Child Care Partnerships (EHS-CC) Grant**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**

Field Note:
Line 9. (Other Federal Funds) – Programs with significant dollar differences comparing FY 2022 Budget versus FY 2022 actual expended.

Early Head Start Program - FY 2022 Annual Report Expended of $878k decreased from the FY 2020-2022 Application Budget amount of $995k, a difference of $117k or -11.76%. The majority of changes were made to personnel costs with higher paid long-term employees leaving the program being replaced by entry level hires ($54k), also, an error in calculating indirect cost charged to the program ($35k) which was reflected in FY 2022 lower costs.

7.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**

Field Note:
Line 9. (Other Federal Funds) – Programs with significant dollar differences comparing FY 2022 Budget versus FY 2022 actual expended.

Abstinence Education Program – FY 2022 Annual Report Expended of $784k decreased from the FY 2020-2022 Application Budget amount of $887k, a difference of $103k or -11.68%. In FY 2020-2022 there were six sub-grantees providing programming services and in FY 2022 only four sub-grantees were providing services net change in cost ($94k). COVID 19 pandemic limited sub-grantees in providing services.

8.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)**

	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: Line 9. (Other Federal Funds) – Programs with significant dollar differences comparing FY 2022 Budget versus FY 2022 actual expended. Personal Responsibility Education Program (PREP) – FY 2022 Annual Report Expended of $527k increased from the FY 2020-2022 Application Budget amount of $380k, a difference of $146k or 38.55%. Most of the difference in FY 2022, is increased expenditures in community projects ($22k) and advertising expenditures ($82k). COVID 19 pandemic limited sub-grantees providing services.	
9.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: Line 9. (Other Federal Funds) – Programs with significant dollar differences comparing FY 2022 Budget versus FY 2022 actual expended. Alabama Pregnancy Risk Assessment Monitoring System (PRAMS) – FY 2022 Annual Report Expended of $157k decreased from the FY 2020-2022 Application Budget amount of $179k, a difference of $21k or -11.84%. FY 2022 decreased were in advertising ($16k) and routine supplies ($8k).	
10.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: Line 9. (Other Federal Funds) – Programs with significant dollar differences comparing FY 2022 Budget versus FY 2022 actual expended. State Systems Development Initiative (SSDI) – FY 2022 Annual Report Expended of $169k increased from the FY 2020-2022 Application Budget amount of $115k, a difference of $54k or 47.12%. During FY 2020, when the FY 2022 budget was developed the program was under-staffed due to retirements and filling the positions does not happen quickly. The program is now fully staffed with a Director and EPI FTE’s.	
11.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Well Woman**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**

Field Note:
Line 9. (Other Federal Funds) – Programs with significant dollar differences comparing FY 2022 Budget versus FY 2022 actual expended.

Well Women Program – FY 2022 Annual Report Expended amount of $1.77m increased from the FY 2020-2022 Application Budget amount of $1.30m, a difference of $472k or 36.32%. The Well Woman program was implemented in January 2017 in three counties: Butler, Dallas, and Wilcox. The program has been expanded and Well Woman is currently offered in twelve counties in Alabama (Barbour, Butler, Dallas, Greene, Hale, Henry, Macon, Marengo, Montgomery, Perry, Russell, and Wilcox). Between implementation and fiscal year 2022, program support and staffing increased to cover the state office and program support in the new counties.

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Alabama

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 137,220	$ 137,220
2. Infants < 1 year	$ 1,517,756	$ 1,517,756
3. Children 1 through 21 Years	$ 5,355,859	$ 5,355,859
4. CSHCN	$ 3,505,417	$ 3,505,417
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 10,516,252	$ 10,516,252

IB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 256,722	$ 256,721
2. Infants < 1 year	$ 2,943,874	$ 2,839,568
3. Children 1 through 21 Years	$ 35,336,724	$ 34,385,395
4. CSHCN	$ 31,956,445	$ 28,212,471
5. All Others	$ 3,975,425	$ 3,739,893
Non-Federal Total of Individuals Served	$ 74,469,190	$ 69,434,048
Federal State MCH Block Grant Partnership Total	$ 84,985,442	$ 79,950,300

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**

Field Note:
Line 1. (Pregnant Women) – FY 2022 Annual Report Expended amount of $394k decreased from the FY 2020-2022 Application Budget amount of $656k, a difference of $262k or -40%. As reported in the previous applications, Medicaid's Alabama Coordinated Health Network (ACHN) eliminated ADPH care coordination. Mobile County services to pregnant women was included in the FY 2020-2022 budget projection which was then eliminated by ACHN cutting approximately 60% of the activity. The Perinatal Program continues to provide community outreach services to pregnant women.

2.	**Field Name:**	**IA. Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**

Field Note:
Line 2. (Infants<1 year) – FY 2022 Annual Report Expended of $4.36m decreased from the FY 2022 Application Budgeted amount of $5.77m, a difference of $1.41m or -24.51%. From FY 2020 to FY 2022, infant activity declined by 6,287, a decrease of 53%. As expected, these services have been affected by Medicaid's Alabama Coordinated Health Network (ACHN).

3.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**

Field Note:
Line 3. (Children 1-22 Years) – FY 2022 Annual Report Expended of $39.7m increased from the FY 2020-2022 Application Budget amount of $30.9m, a difference of $8.8m or 28.6%. FY 2022, the visits for children 1-22 years of age made up 90.1% of net total cost of $43.7m (excluded from cost PW, Infants, CRS, Adm.) which puts the children estimate at $39.4m. In FY 2020 visits were 86.2% based on net total cost of $35.9m which puts children 1-22 at $30.9m. The result is an increase in cost of $8.5m

4.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**

Field Note:
Line 5. (All Others - Adm) -- FY 2022 Annual Report Expended amount of $3.74m increased from the FY 2020-2022 Application Budget amount of $1.59m, a difference of $2.15m or 134.8%. In the FY 2020-2022 application, the budget was set at $1.59m, however, an error occurred when CRS payment was subtracted from administration cost report, as a result, the budget for FY 2020 was understated by $1.7m. The number that should have been reported for the FY 2020-2022 budget is $3.41m which would make the correct increase $331k or 9.72%. This increase can be attributed to rising costs associated with three cost-of-living raises totaling 8%.

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Alabama

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	$ 4,038,288	$ 3,928,525
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 1,979,098	$ 1,920,759
B. Preventive and Primary Care Services for Children	$ 1,682,358	$ 1,632,766
C. Services for CSHCN	$ 376,832	$ 375,000
2. Enabling Services	$ 1,813,209	$ 1,843,425
3. Public Health Services and Systems	$ 5,833,226	$ 5,912,773
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 124,345
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Other		
CRS: Purchased services, health insurance		$ 3,804,180
Direct Services Line 4 Expended Total		$ 3,928,525
Federal Total	$ 11,684,723	$ 11,684,723

IIB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	$ 37,884,805	$ 38,532,045
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 10,027,311	$ 11,552,026
B. Preventive and Primary Care Services for Children	$ 8,523,845	$ 9,819,950
C. Services for CSHCN	$ 19,333,649	$ 17,160,069
2. Enabling Services	$ 12,168,881	$ 8,795,986
3. Public Health Services and Systems	$ 23,247,032	$ 20,937,546
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 833,460
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 2,283,295
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Other		
ADPH: Non-Federal program cost for MCH activities		$ 35,415,290
Direct Services Line 4 Expended Total		$ 38,532,045
Non-Federal Total	$ 73,300,718	$ 68,265,577

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIA. Federal MCH Block Grant, 2. Enabling Services**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**

Field Note:
Line 2. (Enabling Services) - FY 2022 Annual Report Expended amount of $13.2m increased from the FY 2020-2022 Application Budgeted amount of $3.85m, a difference of $9.31m or 241.6%. ADPH's share of the increase in cost is $5.84m and the remaining $3.47m is CRS. In October 2021 to get a more complete picture of cost Family Planning (FP) cost center 021 was replaced by four new cost centers. One of which was Enabling Services FP Referrals ($3.62m), others added were FP Community Health Advisor ($741k) and FP Recruit Waiver ($18k). Also, added was Newborn Hearing Screening (NBHS) Case Management ($1.18m) which not previously in this category. CRS Enabling Services increased from $2.39m to $5.86m, a difference of $3.47m. See CRS explanation for Form 3b.

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Alabama

Total Births by Occurrence: 56,610 **Data Source Year: 2021**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	56,610 (100.0%)	3,644	206	206 (100.0%)

Program Name(s)				
3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect	Citrullinemia, Type I
Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease	Cystic Fibrosis
Glutaric Acidemia Type I	Hearing Loss	Holocarboxylase Synthase Deficiency	Homocystinuria	Isovaleric Acidemia
Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)
Primary Congenital Hypothyroidism	Propionic Acidemia	S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)
Severe Combined Immunodeficiences	ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency
X-Linked Adrenoleukodystrophy				

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Newborn Hearing	56,610 (100.0%)	2,855	58	58 (100.0%)

3. Screening Programs for Older Children & Women

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Alabama Childhood Lead Poisoning Prevention Program	47,334	1,158	749	749
Alabama Breast and Cervical Cancer Early Detection Program-Breast Cancer Screening	8,615	385	77	77
Alabama Breast and Cervical Cancer Early Detection Program - Cervical Cancer Screening	4,456	716	83	83

4. Long-Term Follow-Up

The Alabama Newborn Screening Program does not provide long-term follow-up and does not receive MCH funds to support their program. In 2022, the Newborn Screening Program were relocated from the Bureau of Family Health Services to the Bureau of Clinical Laboratories.

Form Notes for Form 4:

Core Recommended Uniform Screening Panel (RUSP), Newborn Hearing (“Total Number Receiving at Least One Screen”, presumptive positive, confirmed, and referred) data, childhood lead poisoning, are based upon calendar year information (January 1, 2022-December 31, 2022). Total births by occurrence, is based upon the most currently available calendar year information (January 1, 2021- December 31, 2021). The following programs named in the Screening Programs for Older Children and Women section are based upon fiscal year information (October 1, 2021-September 30, 2022): Alabama Breast and Cervical Cancer Early Detection Program (ABCCEDP) - Mammogram Screening & Alabama Birth and Cervical Cancer Early Detection Program-Cervical Cancer Screening data. At the time of receiving data, July 1, 2022-September 30, 2022 cases had not been accounted for by ABCCEDP. The number of cases that received treatment may change as the program continues to obtain data.

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2022**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: According to the ADPH CHS Vital Records, the number of live births that occurred in Alabama in CY 2021 was 56,610. Alabama utilized the 2021 Vital Stats birth file to determine if the recorded registration state was marked Alabama. Data in this section may not be comparable to previous years due to CY variance. Effective in CY 2018, the table previously utilized for our hospital of occurrence data was discontinued resulting in the use of a comparable table. Consequently, data in this section may not be directly comparable to previous years.	
2.	**Field Name:**	**Data Source Year**
	Fiscal Year:	**2022**
	Column Name:	**Data Source Year Notes**
	Field Note: The most currently available data analyzed for reporting purposes is 2021. Unless otherwise noted all remaining data in this section is Year 2022.	
3.	**Field Name:**	**Core RUSP Conditions - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2022**
	Column Name:	**Core RUSP Conditions**
	Field Note: This section includes the number of first time newborn screening samples that were received for testing at the Alabama Department of Public Health Bureau of Clinical Laboratories for Calendar Year 2022.	
4.	**Field Name:**	**Core RUSP Conditions - Total Number of Out-of-Range Results**
	Fiscal Year:	**2022**
	Column Name:	**Core RUSP Conditions**

	Field Note: Newborn screening disorder evaluated and included in this section (in addition to the Core RUSP Conditions listed) is the following: Multiple Carboxylase Deficiency. For the following conditions, the same analyte was screened: Methylmalonic academia (Cbl A, B), Methylmalonic academia mutase, and propionic academia. On October 1, 2018, screening was implemented for Severe Combined Immunodeficiency (SCID). In February 2022, spinal muscular atrophy was added to the Alabama Newborn screening panel. Beginning in March 2023, X-linked Adrenoleukodystrophy (X-ALD) and Adenosine Deaminase Deficiency for Severe Combined Immunodeficiency (ADA-SCID) were added to the Alabama newborn screening panel.	
5.	**Field Name:**	**Core RUSP Conditions - Total Number Confirmed Cases**
	Fiscal Year:	**2022**
	Column Name:	**Core RUSP Conditions**
	Field Note: The number in this section excludes babies who were born in Alabama but lived out of state.	
6.	**Field Name:**	**Core RUSP Conditions - Total Number Referred For Treatment**
	Fiscal Year:	**2022**
	Column Name:	**Core RUSP Conditions**
	Field Note: The number in this section excludes babies who were born in Alabama but lived out of state. Also, babies born in Alabama but moved out of state are excluded from this section. Consequently, resulting in Alabama being unable to follow up to ensure out of state early intervention.	
7.	**Field Name:**	**Newborn Hearing - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2022**
	Column Name:	**Other Newborn**
	Field Note: This section includes the number of first time newborn screening samples received for testing at the Alabama Department of Public Health Bureau of Clinical Laboratories for Calendar Year (CY) 2022.	
8.	**Field Name:**	**Newborn Hearing - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2022**
	Column Name:	**Other Newborn**
	Field Note: Year 2022 data is the most currently analyzed data available.	
9.	**Field Name:**	**Newborn Hearing - Total Number Confirmed Cases**
	Fiscal Year:	**2022**
	Column Name:	**Other Newborn**

	Field Note: Data results based on date of birth per CY. Year 2021 data is the most currently analyzed complete data available. The number in this section excludes babies who were born in Alabama but lived out of state. Also, babies born in Alabama but moved out of state are excluded from this section. Consequently, resulting in Alabama being unable to follow up to ensure out of state early intervention.	
10.	**Field Name:**	**Newborn Hearing - Total Number Referred For Treatment**
	Fiscal Year:	**2022**
	Column Name:	**Other Newborn**
	Field Note: Data results based on date of birth per CY. The number in this section excludes babies who were born in Alabama but lived out of state. Or babies born in Alabama but moved out of state. Consequently, resulting in Alabama being unable to follow up to ensure out of state early intervention.	
11.	**Field Name:**	**Alabama Childhood Lead Poisoning Prevention Program - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2022**
	Column Name:	**Older Children & Women**
	Field Note: Beginning with year 2022 data, the Centers for Disease Control (CDC) changed the presumptive positive screening range from ≥5 mcg/dL to ≥3.5 mcg/dL. Consequently, the numbers in this section may not be comparable to historical data.	
12.	**Field Name:**	**Alabama Childhood Lead Poisoning Prevention Program - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2022**
	Column Name:	**Other Newborn**
	Field Note: Presumptive positive screenings include children who had at least one capillary blood lead level at or above the blood lead reference value (BLRV) of 3.5 mcg/dL. If a child is positive during a presumptive lead screening, then additional testing will be completed to confirm if the child is positive. With this protocol, there will be overlap between the presumptive positive screens and total number of confirmed cases.	
13.	**Field Name:**	**Alabama Childhood Lead Poisoning Prevention Program - Total Number Confirmed Cases**
	Fiscal Year:	**2022**
	Column Name:	**Other Newborn**
	Field Note: Beginning with year 2022 data, the Centers for Disease Control (CDC) changed the blood lead reference value (BLRV) from ≥5 mcg/dL to ≥3.5 mcg/dL. The numbers in this section may not be comparable to historical data. All individuals with a reported blood lead test at or above the BLRV are referred for treatment.	

14.	**Field Name:**	**Alabama Childhood Lead Poisoning Prevention Program - Total Number Referred For Treatment**
	Fiscal Year:	**2022**
	Column Name:	**Other Newborn**
	Field Note: Beginning with year 2022 data, the Centers for Disease Control (CDC) changed the presumptive positive screening range from ≥5 mcg/dL to ≥3.5 mcg/dL. The numbers in this section may not be comparable to historical data. All confirmed cases will be referred for treatment. Presumptive cases does not include children who only had a Venous test at or above the BLRV. As mentioned in field note for B, the total number of referrals made was 1288. Referrals are made for both presumptive and confirmed cases.	
15.	**Field Name:**	**Alabama Breast and Cervical Cancer Early Detection Program-Breast Cancer Screening - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2022**
	Column Name:	**Older Children & Women**
	Field Note: The number of cases that received treatment may change as the program continues to obtain data. The Alabama Breast and Cervical Cancer Early Detection Program has been equally impacted by the pandemic and a decline in enrollment, screening and cancer cases has been observed. This program name has been listed in previous publications as "Alabama Breast and Cervical Cancer Early Detection Program - Mammogram Screening"	
16.	**Field Name:**	**Alabama Breast and Cervical Cancer Early Detection Program - Cervical Cancer Screening - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2022**
	Column Name:	**Older Children & Women**
	Field Note: The number of cases that received treatment may change as the program continues to obtain data. The Alabama Breast and Cervical Cancer Early Detection Program has been equally impacted by the pandemic and a decline in enrollment, screening and cancer cases has been observed.	

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Alabama

Annual Report Year 2022

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	3,931	51.2	0.0	10.0	0.1	38.7
2. Infants < 1 Year of Age	2,923	65.6	0.0	0.0	0.0	34.4
3. Children 1 through 21 Years of Age	24,519	78.7	0.0	10.3	9.3	1.7
3a. Children with Special Health Care Needs 0 through 21 years of age^	13,777	76.5	3.3	18.1	2.1	0.0
4. Others	2,998	62.2	0.0	23.9	1.8	12.1
Total	34,371					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	58,054	No	58,196	68.3	39,748	3,931
2. Infants < 1 Year of Age	56,610	No	56,755	99.4	56,414	2,923
3. Children 1 through 21 Years of Age	1,326,666	Yes	1,326,666	77.7	1,030,819	24,519
3a. Children with Special Health Care Needs 0 through 21 years of age^	299,998	Yes	299,998	28.9	86,699	13,777
4. Others	3,657,399	Yes	3,657,399	77.7	2,841,799	2,998

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2022**

Field Note:
For the last reporting period, the pregnancy numbers from MCHD was the only data source used. Due to closure of the services provided by Mobile, Alabama looked at other available data sources to highlight the services provided to pregnant women. During Fiscal Year 2022 (October 2021-September 2022), Alabama has identified two data sources that would not cause duplication for pregnant women. The first data source looked at the total number of FP participants who had a positive pregnancy test. To identify positive pregnancy tests, women must first have a visit called FP Problem Visit in their medical records. For the second data source, Cribs for Kids will enable mothers to help promote a safer sleep environment for their babies. Insurance information is only available for the FP data source. A Cribs for Kids Access Database was created to check for data quality and possible duplicates within that data source. Due to the large number of FP visits, the Statistical Analysis System (SAS) was used. To determine duplicates, a fake ID was created based on the catenation of the account number and “FiscalYear22”. With this step, SAS can generate a number sequencer based on how many times a participant has been seen in the data. Once the sequencer has been filtered to the first number, most duplicates within FP will be taken out. The final step in the deduplication process would be the review process to determine if there is any overlap between those enrolled in Family Planning and Cribs for Kids. Before deduplication, 3,634 had a positive pregnancy test and 299 received a crib for their infant. After deduplication, there were 3,931 pregnant mothers. Moving forward, deduplication of these data sources will be completed through a software called Link Plus. This software calculates probabilistic scores based on date of birth, race, and address information.

2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2022**

Field Note:
Alabama has identified multiple data sources that would provide direct and enabling services for infants less than 1 years old. For this population. Alabama has provided the following services: care coordination for newborn hearing and newborn screening; oral health checkups within the Northern districts; and EPSDT screenings. Alabama is not able to account for the potential overlap of these data sources. After review, the largest area of reach would be the 2,923 infants who received care coordination for newborn hearing. If an infant fails the hearing tests, then the infant will be referred to care coordination. In last year’s report, Alabama used the Vital Stats occurrent birth data among mothers between ages of 25 and 34. After internal review, this may not be accurate to showcase how Alabama is using Title V funds for direct and enabling services.

3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2022**

Field Note:
With Title V funding, the largest area of reach would be the completion of child and adolescent visits. In total, 24,519 child and adolescent visits were completed during FY 2022. Comparing last year's Annual Report, there was not a significant shift. Due to possible overlap of the data sources available, deduplication of the other data sources presented is not possible.

Even though deduplication is not possible, the section below will cover the additional direct and enabling services provided by OHO and the Child and Adolescent Health Division. With Title V funding, care coordination was provided for 59 non-Medicaid children who did not complete their Newborn Hearing test before one years old. The Childhood Lead Poisoning Prevention Program tested 186 children who did not have Medicaid insurance for lead poisoning. ADPH has provided the following direct and enabling services: oral health screenings, oral health kits, and oral health cleanings. ADPH has partnered with Calhoun Community College and Wallace Community College to provide preventive dental services for 122 individuals. The TCHD has completed 939 dental cleanings. In addition to the direct services listed, OHO has provided oral health kits to 16,692 individuals at community events and health fairs statewide. Oral health kits included age-appropriate toothbrushes, toothpastes, floss, and toothbrush timers.

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2022**

Field Note:
The "Primary Source of Coverage" percentages for CSHCN are obtained from the CRS report titled, "MCH Grant Clients by Insurance Status and County." The percentages for each source of coverage remain similar to the previous FY.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2022**

Field Note:
In FY 2022 (October 2021-September 2022), the WW program was active within nine counties. These counties included Barbour, Henry, Macon, Montgomery, Russell, Dallas, Greene, Hale, and Perry. The age group to be eligible for the WW program is between 15 and 55. With the Others population only looking at 22 and older, FP participants between the ages of 22 and 55 seen within the nine counties were counted. Following protocol, FP staff will refer their participants to the WW program if interested. In total, there were 2,998 FP participants who were between the ages of 22 and 55.

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2022**

	Field Note: During FY 2022 (October 2021-September 2022), there were 47 delivering hospitals within Alabama. Of these,15,493 baby books were distributed among 37 delivering hospitals. Baby books should reinforce the education curriculum provided by hospitals on how to prevent sleep-related deaths. Several of the delivering hospitals have the 'Baby Friendly' status. Due to their status, the hospitals do not want any material that will promote pacifiers. Moving forward, Alabama will look for literature that the baby friendly hospitals will approve. Ideally, all pregnant mothers within these hospitals should receive a baby book. With the use of Vital Stats birth data, Alabama can look at how many resident live births occurred at these hospitals for FY 2022. Among these hospitals, 39,772 resident births occurred during the selected timeframe. With this reference data, Alabama can determine how many baby books should be sent to each hospital.	
2.	**Field Name:**	**Pregnant Women Denominator**
	Fiscal Year:	**2022**
	Field Note: Using the Vital Stats birth files, the denominator represented the total number of resident live births for FY 2022 (October 2021-September 2022) was 58,196. For both Form 5A and 5B, FY 2022 was used, which is why Alabama will not be using the reference number provided.	
3.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2022**
	Field Note: In FY 2022 (October 2021-September 2022), the Alabama NSP completed 57,068 initial screenings. Due to possible duplication, infants who were transferred within 24 hours to another hospital would receive additional newborn screenings. Using the Vital Stats data, the MCH Epi Branch identified 644 infants who were transferred. The total number of infants who had at least one newborn screening completed should be 56,442. In last year's report, Alabama did a combination of occurrent data for live births among mothers aged 25 to 34 years old in 2020, unique page views to the Perinatal Website, and unique page views for the NSP website. The problem with this method is the possible overlapping of views for the two websites. With access to the total number of newborn screening data, Alabama can better correlate the numbers to any system or policy changes adopted by the Alabama NSP. No policy changes for the NSP have been reported.	
4.	**Field Name:**	**Infants Less Than One Year Denominator**
	Fiscal Year:	**2022**
	Field Note: During Fiscal Year (October 2021-September 2022), Vital Stats reported 56,755 occurrent births. For both Form 5A and 5B, Fiscal Year 2022 was used, which is why Alabama will not be using the reference number provided.	
5.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**

	Field Note: According to the 2020 Biennial Water Fluoridation Report published by the CDC, 4,467,001 Alabamians have access to community water system (CWS). Of these, 77.7 percent (3,469,133/4,467,001) received fluoridated water. In addition to the fluoridation system in place, three community water systems received a site visit. This site visit educated water operators in Talladega County and Lee County on the importance of using the CDC recommended level of fluoridation (.7 ppm) in their water system. Roughly 1,030,819 of children between the ages of 1 and 21 should have access to fluoridated water. Moving forward, the OHO will conduct 30 CWS site visits to encourage the continuation of maintaining the optimal fluoridation levels recommended by CDC. Since fluoridation is not mandated in Alabama, strengthening partnerships among CWS remains a top priority for the OHO.	
6.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**
	Field Note: The numerator is the number of CYSHCN reached by CRS for FY 2022 (86,610). The numerator includes the following: toll free calls, SS contacts, information and referrals, Facebook (ADRS, Parent Connection, and Youth Connection) reaches, ADRS website/CRS page hits, community hearing screenings, outreach reports, FVA contacts, and total served. Reference data was used for the denominator as it is the best estimate for children with special health care needs, 0 through 21 years of age in the state.	
7.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2022**
	Field Note: According to the 2020 Biennial Water Fluoridation Report published by the CDC, 4,467,001 Alabamians have access to community water system (CWS). Of these, 77.7 percent (3,469,133/4,467,001) of those who have access to a CWS received fluoridated water. Using the reference data for this population, roughly 2,841,799 of the males and females older than 21 should have access to fluoridated water.	

Data Alerts:

1.	Reported percentage for Others on Form 5b is greater than or equal to 50%. The Others denominator includes both women and men ages 22 and over. Please double check and justify with a field note.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Alabama

Annual Report Year 2022

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	58,196	33,655	16,215	6,083	141	789	53	1,196	64
Title V Served	58,196	33,655	16,215	6,083	141	789	53	1,196	64
Eligible for Title XIX	26,510	10,513	10,573	4,499	75	151	31	647	21
2. Total Infants in State	56,755	32,926	15,715	5,969	135	781	46	1,155	28
Title V Served	56,755	32,926	15,715	5,969	135	781	46	1,155	28
Eligible for Title XIX	25,890	10,285	10,262	4,453	73	150	29	627	11

Form Notes for Form 6:

Following the protocol set by Vital Stats, SAS was used to determine whether a mother should be categorized in the multiple race Non-Hispanic category or the single Non-Hispanic race categories listed in Form 6. For this report, Alabama is reporting the total number of births that occurred during FY 2022 (October 2021-September 2022). The 2021 births would be using the bridged race values to determine if the mother would be in the multiple Non-Hispanic race group. For the 2022 births, Vital Stats removed the bridged races. For future reports, Alabama will look at the 15 racial categories listed in the birth files to see if the mother selected multiple options for race.
For the single race category, there were minority groups that fell under the umbrella of the Non-Hispanic Asian group and the Non-Hispanic Native Hawaiian or Other Pacific Islander group. The next step to this analysis was to look at Hispanic status. To determine Hispanic status, there were 11 groups that would be classified as Hispanic Origin. The Others and unknown category would include unknown race, unknown Hispanic origin, or other.

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: Total deliveries represents the total number of Alabama resident live births that happened during FY 2022 (October 2021-September 2022).	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: During FY 2022 (October 2021-September 2022), perinatal regionalization identified and referred high risk mothers to hospitals with the appropriate level of care. Due to perinatal regionalization, Title V Served will be the same as the number for the total deliveries in State.	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: Alabama used Vital Stats data to identify Alabama residents whose payment source at delivery was Title XIX (Medicaid).	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: Total Infants in State represent the total number of occurrent births that happened with FY 2022 (September 2021-October 2022). Occurrent births included mothers who delivered in Alabama regardless of residency status.	

5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: During FY 2022 (October 2021-September 2022), Due to perinatal regionalization, Title V Served will be the same as the number for the total infants in State.	
6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: Using Vital Stats data, Alabama calculated the total number of births that occurred within Alabama whose payment source at birth was identified as Title XIX (Medicaid).	

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Alabama

A. State MCH Toll-Free Telephone Lines	2024 Application Year	2022 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 654-1385	(800) 654-1385
2. State MCH Toll-Free "Hotline" Name	Bureau of Family Health Services & MCH Info. Line	Bureau of Family Health Services & MCH Info. Line
3. Name of Contact Person for State MCH "Hotline"	Antionette Russell	Antionette Russell
4. Contact Person's Telephone Number	(334) 206-2948	(334) 206-2948
5. Number of Calls Received on the State MCH "Hotline"		612

B. Other Appropriate Methods	2024 Application Year	2022 Annual Report Year
1. Other Toll-Free "Hotline" Names	Alabama Department of Rehabilitation Services/Children's Rehabilitation Service	Alabama Department of Rehabilitation Services/Children's Rehabilitation Service
2. Number of Calls on Other Toll-Free "Hotlines"		1,119
3. State Title V Program Website Address	https://www.rehab.alabama.gov/services/crs http://www.alabamapublichealth.gov/mch	https://www.rehab.alabama.gov/services/crs http://www.alabamapublichealth.gov/mch
4. Number of Hits to the State Title V Program Website		18,263
5. State Title V Social Media Websites	https://www.facebook.com/CRS.ParentConnection https://www.facebook.com/CRS.YouthConnection https://www.facebook.com/rehab.alabama.gov/	https://www.facebook.com/CRS.ParentConnection https://www.facebook.com/CRS.YouthConnection https://www.facebook.com/rehab.alabama.gov/
6. Number of Hits to the State Title V Program Social Media Websites		43,362

Form Notes for Form 7:

MCH Toll-Free "Hotline"
The individual who previously collected this information retired during the data collection time for this annual report/application. There was a gap in filling the position, thus data was not collected and there was no known way to retrospectively collect this information. Thus, the number of calls to the hotline is an annual estimate based upon a 30-day count from December 28, 2022 through January 26, 2023. Efforts have been made to ensure that the data is being collected for the upcoming reporting year.

Effective January 1, 2019, The Healthy Beginnings number is also the FHS and MCH information line. This number can be used on all printed material and media for the following programs: Adolescent Pregnancy Prevention, the Dental Program, FP, OWH, Perinatal Program, and the WIC Program.

The State Title V Program website address includes the Alabama Department of Rehabilitation Service/CRS and the ADPH MCH Services Program websites.

The number of hits to the state Title V Program website consists of a combination of the number of hits that both websites received (CRS-17,144 and ADPH MCH – 1,119). During this reporting period, a new website design and Google Analytics was implemented for ADPH. Due to a glitch involving the new website, hits and unique visitors for ADPH website was not collected from January through May 2022. This issue has been resolved and complete information is available from June 2022 forward. Specifically for this report complete data for ADPH is from October 1, 2021 through December 31, 2021 and June 1, 2022-Sepbember 30, 2022.

Number of hits to the State Title V Program social media websites – FY 2022 numbers are reflective of actual numbers of people reached by posts on the Parent Connection, Youth Connection, and ADRS (CRS Specific Posts) Facebook pages. Increase in numbers due to the return of in person outreach efforts as COVID restrictions eased and expanded use of Facebook Reels to highlight events.

Form 8
State MCH and CSHCN Directors Contact Information

State: Alabama

1. Title V Maternal and Child Health (MCH) Director	
Name	Tommy Johnson
Title	State Dental Director and Interim Title V Director
Address 1	P O Box 303017
Address 2	
City/State/Zip	Montgomery / AL / 36130
Telephone	(334) 206-5398
Extension	
Email	tommy.johnson@adph.state.al.us

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Cathy Caldwell
Title	Assistant Commissioner
Address 1	602 South Lawrence Street
Address 2	
City/State/Zip	Montgomery / AL / 36104
Telephone	(334) 293-7049
Extension	
Email	cathy.caldwell@rehab.alabama.gov

3. State Family Leader (Optional)	
Name	Tammy Moore
Title	CRS Regional Parent Consultant
Address 1	234 Goodwin Drive
Address 2	
City/State/Zip	Birmingham / AL / 35209
Telephone	(205) 290-4597
Extension	
Email	tammy.moore@rehab.alabama.gov

4. State Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

Form Notes for Form 8:

Effective May 1, 2022, Dr. Tommy Johnson, State Dental Director, began serving as the Interim MCH Title V Director.

Effective July 1, 2022, Susan Colburn retired as the CRS State Parent Consultant. Tammy Moore, CRS Regional Parent Consultant, will serve as the Interim Family Leader.

Form 9
List of MCH Priority Needs

State: Alabama

Application Year 2024

No.	Priority Need
1.	Lack of or inadequate access to services necessary for CSHCN to transition to all aspects of adult life.
2.	Lack of or inadequate access to health and related services, especially in rural areas and for services identified as difficult to obtain.
3.	Increase family and youth involvement and participation in advisory groups, program development, policy-making, and system building activities.
4.	High levels of maternal mortality.
5.	High levels of infant mortality (and associated factors of preterm birth and low birth weight).
6.	High levels and worsening trends of sleep-related/SUID deaths.
7.	Lack of timely, appropriate, and consistent health and developmental screenings.
8.	Lack of preventive dental visits across all Title V populations, especially for those uninsured.
9.	Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they live, learn, work, and play.

Form Notes for Form 9:

None

Field Level Notes for Form 9:

Field Name:

Priority Need 9

Field Note:

The priority need edited due to character limitations. The original: lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life regardless of their age, disability status, education, gender identity, geographic location, income, insurance status/type, marital status, primary language, race/ethnicity, sexual orientation, or socioeconomic status.

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Lack of or inadequate access to services necessary for CSHCN to transition to all aspects of adult life.	Continued
2.	Lack of or inadequate access to health and related services, especially in rural areas and for services identified as difficult to obtain.	New
3.	Increase family and youth involvement and participation in advisory groups, program development, policy-making, and system building activities.	New
4.	High levels of maternal mortality.	New
5.	High levels of infant mortality (and associated factors of preterm birth and low birth weight).	New
6.	High levels and worsening trends of sleep-related/SUID deaths.	New
7.	Lack of timely, appropriate, and consistent health and developmental screenings.	New
8.	Lack of preventive dental visits across all Title V populations, especially for those uninsured.	New
9.	Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they live, learn, work, and play.	New
10.	Lack of support for pregnant and parenting teens.	New

Form 10
National Outcome Measures (NOMs)

State: Alabama

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	73.4 %	0.2 %	42,467	57,893
2020	71.3 %	0.2 %	40,959	57,481
2019	70.6 %	0.2 %	41,128	58,238
2018	70.8 %	0.2 %	40,629	57,415
2017	71.5 %	0.2 %	41,925	58,645
2016	71.8 %	0.2 %	42,282	58,911
2015	72.8 %	0.2 %	43,258	59,393
2014	72.7 %	0.2 %	42,851	58,929

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2022
Annual Indicator	10,000.0
Numerator	1
Denominator	1
Data Source	Bureau of Family Health Services Perinatal Health
Data Source Year	2022

NOM 2 - Notes:

At this time, Alabama does not have hospital discharge data that is reportable. Staff was required to enter data in this section to avoid a data alert. A number greater than "1" was required to be entered into the denominator section to proceed. To enable us to "complete" this section "1" was entered in the numerator and denominator sections. When hospital discharge data becomes available, we will update this section in future submissions.

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2021	41.9	3.8	122	291,018
2016_2020	38.7	3.6	113	292,115
2015_2019	34.3	3.4	101	294,125
2014_2018	28.5	3.1	84	294,932

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	10.4 %	0.1 %	6,053	58,030
2020	10.8 %	0.1 %	6,219	57,630
2019	10.5 %	0.1 %	6,136	58,590
2018	10.7 %	0.1 %	6,184	57,735
2017	10.3 %	0.1 %	6,038	58,902
2016	10.3 %	0.1 %	6,096	59,127
2015	10.4 %	0.1 %	6,218	59,641
2014	10.1 %	0.1 %	5,989	59,388
2013	10.0 %	0.1 %	5,805	58,134
2012	10.0 %	0.1 %	5,853	58,419
2011	9.9 %	0.1 %	5,896	59,331
2010	10.3 %	0.1 %	6,165	60,023
2009	10.3 %	0.1 %	6,454	62,443

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	13.1 %	0.1 %	7,609	58,033
2020	12.9 %	0.1 %	7,442	57,621
2019	12.5 %	0.1 %	7,311	58,586
2018	12.5 %	0.1 %	7,204	57,727
2017	12.0 %	0.1 %	7,090	58,909
2016	12.0 %	0.1 %	7,083	59,120
2015	11.7 %	0.1 %	6,999	59,640
2014	11.7 %	0.1 %	6,926	59,397
2013	11.8 %	0.1 %	6,842	58,140
2012	11.9 %	0.1 %	6,976	58,413
2011	11.9 %	0.1 %	7,032	59,327
2010	12.5 %	0.1 %	7,484	59,990
2009	12.5 %	0.1 %	7,801	62,420

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	30.9 %	0.2 %	17,904	58,033
2020	29.5 %	0.2 %	16,989	57,621
2019	29.4 %	0.2 %	17,240	58,586
2018	28.0 %	0.2 %	16,178	57,727
2017	27.0 %	0.2 %	15,927	58,909
2016	26.6 %	0.2 %	15,753	59,120
2015	25.4 %	0.2 %	15,146	59,640
2014	25.0 %	0.2 %	14,841	59,397
2013	25.6 %	0.2 %	14,912	58,140
2012	28.1 %	0.2 %	16,392	58,413
2011	29.3 %	0.2 %	17,410	59,327
2010	31.7 %	0.2 %	19,035	59,990
2009	33.0 %	0.2 %	20,593	62,420

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021/Q1-2021/Q4	2.0 %			
2020/Q4-2021/Q3	2.0 %			
2020/Q3-2021/Q1	2.0 %			
2019/Q4-2020/Q3	2.0 %			
2019/Q1-2019/Q4	2.0 %			
2018/Q4-2019/Q3	2.0 %			
2018/Q3-2019/Q2	2.0 %			
2018/Q2-2019/Q1	1.0 %			
2018/Q1-2018/Q4	1.0 %			
2017/Q4-2018/Q3	1.0 %			
2017/Q3-2018/Q2	1.0 %			
2017/Q2-2018/Q1	1.0 %			
2017/Q1-2017/Q4	2.0 %			
2016/Q4-2017/Q3	2.0 %			
2016/Q3-2017/Q2	2.0 %			
2016/Q2-2017/Q1	2.0 %			
2016/Q1-2016/Q4	2.0 %			
2015/Q4-2016/Q3	1.0 %			
2015/Q3-2016/Q2	1.0 %			
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	3.0 %			

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014/Q2-2015/Q1	4.0 %			
2014/Q1-2014/Q4	5.0 %			
2013/Q4-2014/Q3	6.0 %			
2013/Q3-2014/Q2	7.0 %			
2013/Q2-2014/Q1	11.0 %			

Legends:

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	7.2	0.4	418	57,892
2019	7.2	0.4	426	58,861
2018	6.9	0.4	401	57,970
2017	7.2	0.4	427	59,178
2016	8.3	0.4	494	59,405
2015	8.0	0.4	478	59,921
2014	7.3	0.4	438	59,650
2013	8.5	0.4	499	58,433
2012	8.8	0.4	517	58,721
2011	8.0	0.4	475	59,619
2010	8.6	0.4	516	60,330
2009	7.7	0.4	484	62,733

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	7.0	0.4	403	57,647
2019	7.7	0.4	452	58,615
2018	6.9	0.4	401	57,761
2017	7.4	0.4	435	58,941
2016	9.0	0.4	534	59,151
2015	8.3	0.4	496	59,657
2014	8.7	0.4	515	59,422
2013	8.6	0.4	500	58,167
2012	8.9	0.4	519	58,448
2011	8.2	0.4	488	59,354
2010	8.7	0.4	524	60,050
2009	8.3	0.4	517	62,475

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	3.9	0.3	226	57,647
2019	4.1	0.3	243	58,615
2018	4.4	0.3	252	57,761
2017	4.3	0.3	254	58,941
2016	5.4	0.3	321	59,151
2015	5.0	0.3	301	59,657
2014	5.1	0.3	305	59,422
2013	5.6	0.3	323	58,167
2012	5.8	0.3	340	58,448
2011	5.2	0.3	309	59,354
2010	5.4	0.3	323	60,050
2009	5.1	0.3	316	62,475

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	3.1	0.2	177	57,647
2019	3.6	0.3	209	58,615
2018	2.6	0.2	149	57,761
2017	3.1	0.2	181	58,941
2016	3.6	0.3	213	59,151
2015	3.3	0.2	195	59,657
2014	3.5	0.2	210	59,422
2013	3.0	0.2	177	58,167
2012	3.1	0.2	179	58,448
2011	3.0	0.2	179	59,354
2010	3.3	0.2	201	60,050
2009	3.2	0.2	201	62,475

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2020	225.5	19.8	130	57,647
2019	209.8	18.9	123	58,615
2018	249.3	20.8	144	57,761
2017	232.4	19.9	137	58,941
2016	309.4	22.9	183	59,151
2015	283.3	21.8	169	59,657
2014	301.2	22.6	179	59,422
2013	326.6	23.7	190	58,167
2012	296.0	22.5	173	58,448
2011	283.0	21.9	168	59,354
2010	299.8	22.4	180	60,050
2009	312.1	22.4	195	62,475

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	176.9	17.5	102	57,647
2019	170.6	17.1	100	58,615
2018	117.7	14.3	68	57,761
2017	191.7	18.1	113	58,941
2016	216.4	19.2	128	59,151
2015	184.4	17.6	110	59,657
2014	181.8	17.5	108	59,422
2013	171.9	17.2	100	58,167
2012	152.3	16.2	89	58,448
2011	143.2	15.5	85	59,354
2010	136.6	15.1	82	60,050
2009	155.3	15.8	97	62,475

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	5.0 %	0.7 %	2,756	55,187
2014	5.8 %	0.8 %	3,176	55,143

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2022
Annual Indicator	1,000.0
Numerator	1
Denominator	1
Data Source	Bureau of Family Health Services Perinatal Health
Data Source Year	2022

NOM 11 - Notes:

At this time, Alabama does not have Neonatal Abstinence Syndrome data. We were unable to complete this section without entering data for this NOM. A number greater than “1” was required to be entered into the denominator section to proceed. To enable us to “complete” this section “1” was entered in the numerator and denominator sections. If Neonatal Abstinence Syndrome data becomes available, we will update this section in future submissions.

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	12.7 %	1.2 %	126,839	999,444
2019_2020	13.8 %	1.5 %	141,357	1,024,407
2018_2019	13.4 %	1.6 %	138,913	1,035,959
2017_2018	12.2 %	1.6 %	125,032	1,022,648
2016_2017	11.9 %	1.5 %	120,775	1,016,617
2016	10.6 %	1.6 %	107,793	1,020,682

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	26.9	2.2	146	543,455
2020	26.7	2.2	143	535,078
2019	32.3	2.5	173	535,424
2018	26.9	2.3	144	534,364
2017	24.6	2.1	132	536,937
2016	22.9	2.1	123	537,913
2015	23.6	2.1	128	541,244
2014	25.0	2.1	136	543,901
2013	25.3	2.2	138	546,207
2012	26.3	2.2	145	551,124
2011	28.4	2.3	156	549,586
2010	26.0	2.2	144	553,130
2009	26.7	2.2	147	551,483

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	58.4	3.0	380	650,347
2020	47.9	2.8	297	620,337
2019	48.2	2.8	301	624,113
2018	46.2	2.7	289	626,175
2017	46.9	2.7	294	627,266
2016	50.4	2.8	316	626,927
2015	44.3	2.7	279	629,274
2014	43.3	2.6	274	632,306
2013	39.4	2.5	251	637,220
2012	45.1	2.7	291	644,819
2011	45.8	2.6	300	655,606
2010	45.4	2.6	301	663,126
2009	45.1	2.6	300	665,683

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019_2021	22.6	1.5	214	947,326
2018_2020	22.0	1.5	207	939,422
2017_2019	22.9	1.6	217	948,102
2016_2018	25.0	1.6	239	955,033
2015_2017	25.0	1.6	240	958,914
2014_2016	24.6	1.6	236	957,959
2013_2015	20.8	1.5	199	958,263
2012_2014	21.5	1.5	207	962,433
2011_2013	22.4	1.5	219	978,412
2010_2012	24.2	1.6	242	1,001,033
2009_2011	24.2	1.5	248	1,023,913
2008_2010	26.2	1.6	271	1,035,662
2007_2009	29.6	1.7	306	1,033,470

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2021	10.6	1.1	100	947,326
2018_2020	11.5	1.1	108	939,422
2017_2019	10.7	1.1	101	948,102
2016_2018	10.3	1.0	98	955,033
2015_2017	9.1	1.0	87	958,914
2014_2016	9.1	1.0	87	957,959
2013_2015	8.2	0.9	79	958,263
2012_2014	7.9	0.9	76	962,433
2011_2013	8.5	0.9	83	978,412
2010_2012	8.7	0.9	87	1,001,033
2009_2011	8.0	0.9	82	1,023,913
2008_2010	7.4	0.9	77	1,035,662
2007_2009	6.3	0.8	65	1,033,470

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	21.7 %	1.3 %	235,129	1,081,198
2019_2020	21.6 %	1.6 %	233,724	1,084,384
2018_2019	21.8 %	1.7 %	237,911	1,089,138
2017_2018	22.4 %	1.7 %	245,036	1,095,255
2016_2017	22.5 %	1.6 %	247,758	1,102,057
2016	21.3 %	1.8 %	235,517	1,106,270

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	17.6 %	2.7 %	41,106	233,348
2019_2020	15.8 %	2.6 %	36,716	231,943
2018_2019	12.9 %	2.2 %	30,632	237,911
2017_2018	13.2 %	2.5 %	32,403	245,036
2016_2017	16.3 %	2.7 %	40,287	247,758
2016	17.9 %	3.4 %	42,120	235,517

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	2.9 %	0.6 %	25,475	881,261
2019_2020	3.1 %	0.8 %	28,410	912,209
2018_2019	2.9 %	0.8 %	26,467	925,851
2017_2018	3.2 %	0.7 %	29,568	927,968
2016_2017	3.1 %	0.7 %	28,645	909,975
2016	2.2 %	0.8 %	19,716	882,862

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	13.8 %	1.3 %	121,838	883,723
2019_2020	11.4 %	1.3 %	103,989	910,886
2018_2019	10.0 %	1.4 %	91,976	917,778
2017_2018	11.8 %	1.5 %	108,519	919,536
2016_2017	14.3 %	1.6 %	129,491	904,244
2016	15.0 %	1.9 %	131,199	876,057

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	49.7 %	4.6 %	66,692	134,264
2019_2020	55.9 %	5.9 %	58,730	105,147
2018_2019	52.4 %	6.8 %	53,247	101,640
2017_2018	50.5 %	6.6 %	68,245	135,109
2016_2017	50.4 %	6.1 %	70,843	140,701
2016	45.4 %	6.8 %	52,413	115,425

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	91.1 %	1.0 %	984,302	1,080,719
2019_2020	88.8 %	1.3 %	962,447	1,083,631
2018_2019	87.6 %	1.5 %	952,023	1,086,836
2017_2018	88.1 %	1.6 %	957,626	1,087,156
2016_2017	88.1 %	1.5 %	963,574	1,093,625
2016	87.2 %	1.8 %	961,065	1,101,823

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	15.6 %	0.2 %	4,564	29,284
2018	16.2 %	0.2 %	6,225	38,400
2016	16.3 %	0.2 %	6,937	42,671
2014	16.3 %	0.2 %	7,077	43,509
2012	15.6 %	0.2 %	7,160	45,769
2010	15.8 %	0.2 %	7,246	45,743
2008	14.9 %	0.2 %	6,439	43,267

Legends:

Indicator has a denominator <20 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	13.9 %	1.4 %	28,174	203,329
2019	17.2 %	1.3 %	35,281	204,779
2015	16.1 %	1.4 %	33,723	209,650
2013	17.1 %	1.3 %	35,621	208,378
2011	17.0 %	1.8 %	35,387	207,991
2009	13.3 %	1.1 %	23,465	176,530
2005	14.6 %	0.9 %	31,002	211,879

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	22.1 %	2.3 %	101,215	458,988
2019_2020	21.8 %	2.5 %	102,455	469,704
2018_2019	17.3 %	2.4 %	81,449	469,615
2017_2018	16.1 %	2.3 %	74,048	458,822
2016_2017	18.2 %	2.3 %	79,213	434,616
2016	18.2 %	2.6 %	75,916	417,095

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	4.0 %	0.4 %	44,437	1,118,680
2019	3.1 %	0.3 %	34,038	1,086,191
2018	3.5 %	0.4 %	37,799	1,087,053
2017	2.9 %	0.2 %	31,668	1,091,184
2016	2.3 %	0.3 %	25,705	1,098,459
2015	2.8 %	0.2 %	30,460	1,107,192
2014	3.7 %	0.4 %	40,624	1,106,022
2013	4.5 %	0.4 %	50,076	1,110,389
2012	4.0 %	0.3 %	45,014	1,125,653
2011	5.2 %	0.4 %	58,831	1,123,644
2010	6.0 %	0.5 %	67,911	1,135,416
2009	6.1 %	0.4 %	68,872	1,125,665

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	65.7 %	4.6 %	38,000	58,000
2017	74.7 %	4.0 %	44,000	59,000
2016	72.3 %	3.4 %	43,000	59,000
2015	69.5 %	3.8 %	42,000	60,000
2014	73.5 %	3.7 %	44,000	60,000
2013	65.9 %	4.1 %	39,000	60,000
2012	70.4 %	4.6 %	42,000	60,000
2011	74.0 %	4.2 %	44,000	60,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	49.7 %	1.6 %	509,270	1,025,658
2020_2021	52.6 %	2.1 %	537,303	1,021,488
2019_2020	57.8 %	1.8 %	592,796	1,025,598
2018_2019	60.7 %	1.6 %	624,937	1,029,550
2017_2018	53.8 %	1.5 %	550,063	1,022,626
2016_2017	54.3 %	1.7 %	556,320	1,024,530
2015_2016	61.9 %	2.0 %	640,838	1,035,279
2014_2015	57.0 %	1.8 %	598,882	1,050,301
2013_2014	61.0 %	2.1 %	648,135	1,063,003
2012_2013	52.1 %	2.6 %	557,694	1,070,309
2011_2012	49.4 %	2.7 %	517,288	1,047,833
2010_2011	45.9 %	2.7 %	478,640	1,042,788
2009_2010	41.8 %	2.4 %	444,551	1,063,518

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	78.5 %	2.9 %	246,406	313,707
2020	67.3 %	3.2 %	210,518	312,784
2019	65.6 %	3.4 %	203,935	311,072
2018	64.7 %	3.2 %	201,534	311,649
2017	58.0 %	3.0 %	181,483	312,726
2016	51.7 %	3.3 %	162,799	314,880
2015	48.4 %	3.3 %	154,158	318,674

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	91.2 %	2.2 %	286,037	313,707
2020	92.1 %	1.9 %	288,061	312,784
2019	91.8 %	2.0 %	285,577	311,072
2018	89.4 %	2.3 %	278,746	311,649
2017	88.7 %	2.0 %	277,479	312,726
2016	91.7 %	1.7 %	288,789	314,880
2015	93.3 %	1.7 %	297,233	318,674
2014	88.6 %	2.1 %	283,448	319,757
2013	87.3 %	2.3 %	279,968	320,759
2012	81.7 %	3.1 %	262,973	321,732
2011	74.4 %	2.7 %	241,457	324,613
2010	68.4 %	3.1 %	217,469	317,811
2009	57.6 %	3.1 %	184,090	319,470

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	88.3 %	2.3 %	276,904	313,707
2020	82.7 %	2.6 %	258,533	312,784
2019	86.8 %	2.4 %	270,134	311,072
2018	80.0 %	2.7 %	249,374	311,649
2017	78.3 %	2.5 %	244,987	312,726
2016	72.4 %	2.9 %	227,907	314,880
2015	72.1 %	2.9 %	229,605	318,674
2014	71.6 %	2.9 %	228,967	319,757
2013	69.5 %	3.1 %	222,975	320,759
2012	60.5 %	3.6 %	194,524	321,732
2011	64.3 %	3.0 %	208,632	324,613
2010	47.7 %	3.3 %	151,723	317,811
2009	43.5 %	3.2 %	139,022	319,470

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	22.9	0.4	3,641	159,313
2020	24.8	0.4	3,788	152,853
2019	25.6	0.4	3,955	154,529
2018	25.2	0.4	3,924	155,697
2017	27.0	0.4	4,241	157,072
2016	28.4	0.4	4,480	158,008
2015	30.1	0.4	4,739	157,380
2014	32.0	0.5	5,009	156,495
2013	34.3	0.5	5,392	157,394
2012	39.2	0.5	6,195	158,036
2011	41.0	0.5	6,609	161,135
2010	44.0	0.5	7,343	166,863
2009	48.3	0.5	8,205	169,867

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	18.7 %	1.6 %	9,785	52,283
2020	20.8 %	1.7 %	9,048	43,590
2019	23.5 %	1.6 %	12,454	53,091
2018	17.3 %	1.4 %	9,112	52,710
2017	19.9 %	1.5 %	10,710	53,919
2015	16.3 %	1.3 %	8,898	54,491
2014	17.6 %	1.3 %	9,621	54,657

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	2.8 %	0.5 %	29,908	1,077,887
2019_2020	2.1 %	0.5 %	22,345	1,079,957
2018_2019	2.3 %	0.7 %	24,990	1,086,730
2017_2018	2.4 %	0.7 %	26,027	1,094,670
2016_2017	2.8 %	0.7 %	30,968	1,101,322
2016	3.5 %	1.0 %	39,076	1,104,799

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Alabama

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective			82	82.8	80.7
Annual Indicator		70.8	74.4	71.4	72.0
Numerator		599,429	629,176	607,073	622,981
Denominator		846,286	846,056	850,307	865,327
Data Source		BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year		2018	2019	2020	2021

Previous NPM-1 BRFSS data for survey year 2017 that was pre-populated under the 2018 Annual Report Year is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	82.0	82.4	82.8

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
All content in the "Federally Available Data" tables are pre-populated by HRSA and cannot be changed/altered.

Behavioral Risk Factor Surveillance System (BRFSS) is listed as the National Performance Measure 1 federally available data source in Title V Information System. We utilized the question in BRFSS for Alabama data year 2021, as our baseline, which referred to a routine checkup in the last year by gender. Specifically, we queried the BRFSS website “Prevalence Data & Data Analysis Tools” data (“Prevalence and Trends Data”). Location was set to “Alabama;” class was set to “Health Care Access/Coverage;” topic was set to “Last Checkup;” and year was set to “2019”. This query on January 4, 2023 provided Alabama with a baseline for 2021 of 81.2 percent of females indicating a routine checkup within the past year. This number differs slightly from the pre-populated overall FAD annual objective of 80.7 percent. Annual objectives for this measure from 2022 forward have been set to require an annual increase of 0.5 percent from the 2021 baseline of 81.2 percent of females.

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	84.5	84.2	83.6	83.8	84.8
Annual Indicator	72.6	75.4	74.1	77.6	77.6
Numerator	788	857	854	847	847
Denominator	1,086	1,137	1,153	1,092	1,092
Data Source	Alabama Center for Health Statistics	Alabama Center for Health Statistics	Alabama Center for Health Statistics	Alabama Center for Health Statistics	Alabama Center for Health Statistics
Data Source Year	2018	2019	2020	2021	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	77.9	78.0	87.2

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
At this time 2021 data is the most currently available data. When more currently available data is available and analyzed this section will be updated.
Annual Indicator data is automatically generated.
Annual Objective data is pre-populated by HRSA and can not be changed.

After review of the 2021 Block Grant Annual Report, the numerator and denominator reported for 2020 and 2021 reported low birth weight cases (Less than 2500 grams). Based on the measure, the number should only include cases where the birth weight was less than 1500 grams.

The numerator is defined as the number of all very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU). The denominator is defined as the number of all very low birth weight (VLBW) infants born in Alabama.

2.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
The numerator is defined as the number of all very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU). The denominator is defined as the number of all very low birth weight (VLBW) infants born in Alabama. Note that the data is based on calendar year and is one year behind, i.e, for 2022, data source year is for 2021. The objective settings for subsequent years was set to require a slight increase, specifically, 0.2 percent per year, from the 2021 baseline.

NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	75.5	72.3	73.3	73.7	74
Annual Indicator	71.3	72.1	72.0	73.3	76.8
Numerator	38,245	37,735	37,266	31,945	39,817
Denominator	53,663	52,309	51,781	43,605	51,868
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2017	2019	2020	2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	74.4	74.8	75.1

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
All content in the “Federally Available Data” table is pre-populated by HRSA and cannot be changed/altered.

Alabama’s PRAMS is the data source for the “Annual Objectives” table for this (A) NPM concerning the percentage of infants placed to sleep on their backs. The question analyzed was in reference to the position most chosen by mother for baby’s sleeping. The latest data provided by Alabama PRAMS coordinator (2017 results) indicated there were 72.2 percent of Alabama infants who were placed on their backs to sleep. The annual objectives was set to require an annual improvement of 0.5 percent from the 2017 baseline. Data in this section reflects the most recently available information provided directly from the Alabama’s Interim PRAMS coordinator. When data that is more current is available and analyzed, this section will be updated.

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2019	**2020**	**2021**	**2022**
Annual Objective	88.1	85.7	86.1	86.5
Annual Indicator	29.8	33.3	34.6	35.7
Numerator	15,619	16,967	15,074	18,338
Denominator	52,446	50,878	43,622	51,403
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2019	2020	2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	87.0	87.4	87.8

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
All content in the “Federally Available Data” table is pre-populated by HRSA and cannot be changed/altered.

Alabama PRAMS is the data source for the “Annual Objectives” table for this (B) NPM concerning the percentage of infants placed to sleep on a separate approved sleep surface. The PRAMS question to be analyzed in the most recent survey update (2016) is in reference to whether or not the new baby usually sleeps in a crib, bassinet, or pack and play. The latest data provided is the year 2017 results from Alabama PRAMS coordinator, who indicated that 84.4 percent of Alabama infants were placed to sleep in a crib, bassinet or pack and play. Objectives for 2017 forward have been set to require an annual improvement of 0.5 percent from the baseline. Data in this section reflects the most recently available information provided directly from the Alabama’s Interim PRAMS coordinator. When data that is more current is available and analyzed this section will be updated.

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2019	**2020**	**2021**	**2022**
Annual Objective	39.3	49.9	50.2	50.4
Annual Indicator	36.7	44.4	42.3	48.3
Numerator	19,218	22,734	18,238	24,583
Denominator	52,355	51,234	43,152	50,900
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2019	2020	2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	50.7	50.9	51.2

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
All content in the “Federally Available Data” table is pre-populated by HRSA and cannot be changed/altered.

Alabama PRAMS is the data source for the “Annual Objectives” table for this (C) NPM concerning the percentage of infants who sleep without soft objects or loose bedding. The PRAMS question to be analyzed in the most recent survey update (2016) is in reference to whether or not the new baby usually sleeps with a blanket, toys, cushions, or pillows (Questions 67f and 67g). The data in this section was provided directly by Alabama PRAMS coordinator. Objectives for 2017 forward have been set to require an annual improvement of 0.5 percent from the baseline. When data that is more current is available and analyzed, this section will be updated.

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	26.3	40.5	58.3	55.2	55.2
Annual Indicator	26.6	39.8	44.6	33.3	32.2
Numerator	38,521	53,496	54,906	40,489	40,979
Denominator	145,031	134,315	122,972	121,453	127,325
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	61.4	68.4	76.1

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
All content in the “Federally Available Data” table is pre-populated by HRSA and cannot be changed/altered.

The NSCH 2020-2021 report was utilized for the NPM 6 data source for determining annual objectives. Specifically, we queried the NSCH website by survey and topic for the 2 year combined data (as this data is listed as the most reliable estimate) for the State of Alabama. The starting point/topic selected was Title V Block Grant Measures and the specific National Performance Measure selected was number “6: Percent of children, age 9-35 months.” This query on January 6, 2023 of 2020-2021 data provided Alabama with 32.2 percent of parents completing a developmental screening tool during the past 12 months of children ages 9 through 35 months. Utilizing the NSCH 2020-2021 FAD annual objective as our 2022 baseline for this performance measure, we set an annual improvement of 11.3 percent for objectives in subsequent years.

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	86.9	87.8	68.5	88.6	80.1
Annual Indicator	76.3	76.3	77.4	70.0	65.6
Numerator	279,668	279,668	253,566	244,204	242,660
Denominator	366,499	366,499	327,459	348,830	369,817
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2016_2017	2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	85.7	91.7	98.1

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
All content in the “Federally Available Data” table is pre-populated by HRSA and cannot be changed/altered.

The NSCH 2019 report was utilized for the NPM 10 data source for determining annual objectives. Specifically, we queried the NSCH website by survey and topic for the year 2020-2021 for the state of Alabama. The starting point/topic selected was Title V Block Grant Measures and the specific NPM selected was number “10: Percent of adolescents, age 12 through 17 years, with a preventive medical visit in the past year.” This query on January 6, 2023 provided Alabama with a baseline for 65.6 percent of adolescents with one or more preventive medical visits in the past year. Utilizing the NSCH 2020-2021 FAD annual objective as our baseline for this performance measure, we set an annual improvement of 0.07 percent for objectives in subsequent years.

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	53.5	58.5	64	70	29.3
Annual Indicator	12.9	15.0	23.8	27.9	22.5
Numerator	13,867	14,975	21,076	25,741	22,337
Denominator	107,738	99,967	88,591	92,115	99,074
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	30.8	32.3	34.0

Field Level Notes for Form 10 NPMs:

None

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	44.2	38.7	38.8	39.7	40.7
Annual Indicator	40.6	36.0	35.4	33.6	37.1
Numerator	22,286	19,726	19,451	15,240	19,911
Denominator	54,955	54,751	54,884	45,331	53,737
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2017	2019	2020	2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	41.7	42.8	43.9

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
All content in the “Federally Available Data” table is pre-populated by HRSA and cannot be changed/altered.

Alabama PRAMS is the data source for the “Annual Objectives” table for this (13.1) NPM concerning the percentage of women who had a preventive dental visit during pregnancy. The question analyzed was in reference to the dental care percentages during pregnancy (i.e., teeth cleaned by a dentist or dental hygienist). The data (year 2017) was provided by the Alabama’s PRAMS coordinator, who indicated there were 36.0 percent of Alabama women who had preventive dental visits during pregnancy. Objectives for 2017 forward have been set for an annual improvement of 0.025 from the baseline. Note: Previous year reports may not be comparable due to the utilization of a historical data set.

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	82.5	82.1	80.5	80.9	81.3
Annual Indicator	81.7	80.7	80.8	78.2	74.3
Numerator	836,024	830,091	838,606	800,897	741,934
Denominator	1,023,434	1,028,454	1,037,949	1,024,513	998,660
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	81.7	82.1	82.5

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
All content in the “Federally Available Data” table is pre-populated by HRSA and cannot be changed/altered.

The NSCH 2020-2021 FAD report was utilized for NPM 13.2 data source for determining annual objectives. Specifically, we queried the NSCH website by survey and topic for the 2 year combined data (as this data is listed as the most reliable estimate) for the state of Alabama. The starting point/topic selected was Title V Block Grant Measures and the specific NPM selected was “13.2: percent of children, ages 1 through 17, who had a preventive dental visit in the past year.” This query on January 6, 2023 provided Alabama with 80.8 percent of children, age 1-17 years, who had a preventive dental visit in the past year for the 2020-2021 timeframe. Utilizing the NSCH 2020-2021 FAD annual objective as our baseline for this performance measure, we set an annual improvement of 0.005 for objectives in subsequent years. Note: previous year reports may not be comparable due to the utilization of historical data sets (Year 2018 or prior).

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Adolescent Health

Annual Objectives			
	2023	2024	2025
Annual Objective	81.7	82.1	82.5

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Alabama

SPM 1 - Percent of children who receive a blood lead screening test at age 12 and 24 months of age

Measure Status:	Inactive - Replaced				
State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	53.3	73	55.1	56.8	59.9
Annual Indicator	72.2	54.6	56.2	59.3	21.4
Numerator	32,124	33,751	32,982	36,814	3,429
Denominator	44,467	61,836	58,688	62,081	16,024
Data Source	Alabama Medicaid	Alabama Medicaid Agency EPSDT data	Alabama Medicaid Agency EPSDT data	Alabama Medicaid Agency EPSDT data	HHLPSS
Data Source Year	2018	2019	2020	2021	2021-2022
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Data guiding annual objectives for this state performance measure comes from the FY 2017 Alabama Medicaid Agency Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) report. In FY 2017, of the 64,372 total eligible receiving at least one initial or periodic screening for ages 1-2 years, 33,970 blood leads were screened/tested for persons in this age group. This data for FY 2017, represented 52.8 percent of children ages 1-2 years receiving a blood lead screening. Objectives for subsequent years have been set to require an annual increase of 1.0 percent from this baseline.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

	Field Note: Data guiding annual objectives for this SPM comes from the FY 2018 Alabama Medicaid Agency EPSDT report. In FY 2018, of the 44,467 total eligible receiving at least one initial or periodic screening for ages 1-2 years, 32,124 blood leads were screened/tested for persons in this age group. This data for FY 2018 represented 72.2 percent of children ages 1-2 years receiving a blood lead screening. Objectives for subsequent years have been set to require an annual increase of one percent from this baseline.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Data guiding annual objectives for this SPM comes from the FY 2019 Alabama Medicaid Agency EPSDT report. In FY 2019, of the 61,836 total eligible receiving at least one initial or periodic screening for ages 1-2 years, 33,751 blood leads were screened/tested for persons in this age group. This data for FY 2019 represented 54.6 percent of children ages 1-2 years receiving a blood lead screening. Objectives for subsequent years have been set to require an annual increase of one percent from this baseline.	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data guiding annual objectives for this SPM comes from the FY 2020 Alabama Medicaid Agency EPSDT report. In FY 2020, of the 58,688 total eligible receiving at least one initial or periodic screening for ages 1-2 years, 32,928 blood leads were screened/tested for persons in this age group. This data for FY 2020 represented 56.2 percent of children ages 1-2 years receiving a blood lead screening. Objectives for subsequent years have been set to require an annual increase of one percent from this baseline.	
5.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Data guiding annual objectives for this SPM comes from the FY 2021 Alabama Medicaid Agency EPSDT report. In FY 2021, of the 62,081 total eligible receiving at least one initial or periodic screening for ages 1-2 years, 36,814 blood leads were screened/tested for persons in this age group. This data for FY 2021 represented 59.3 percent of children ages 1-2 years receiving a blood lead screening. Objectives for subsequent years have been set to require an annual increase of one percent from this baseline.	
6.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
After internal review, Alabama has decided to change the data source to the Healthy Homes and Lead Positioning Surveillance System (HHLPSS) to better measure provider practice and laboratory reporting in regards to blood testing in children less than 3 years old. One limitation in using Medicaid data is that children with private health insurance or self-pay would be excluded. Moving forward, Alabama will look further into the data to see if it would be necessary to expand the time windows for the first and second lab tests.

In 2022, there were 16,024 children who were 2 years old that received at least one reported lead test. Alabama linked the 2021 reported lead tests to these children to see if the provider practice completed the first 12 month follow-up. After analysis, Alabama was able to identify 3,429 children who received both screenings at 12 and 24 months.

SPM 2 - Strengthen and enhance family/youth partnerships, involvement and engagement in advisory groups, program development, policymaking, and system-building activities to support shared decision making between families and health-related professionals.

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			33	50
Annual Indicator			45.8	58.3
Numerator			11	14
Denominator			24	24
Data Source			CSHCN Program	CSHCN Program
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	67.0	88.0	100.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
New SPM for the 2021-2025 5 Year Needs Assessment Cycle

Annual progress for SPM 2 is tracked utilizing a Checklist Criteria Scoring Tool. The tool allows the CSHCN program to monitor progress on meeting the objectives outlined in the action plan.

Scoring is based on a total score (maximum =24) and will be measured to monitor progress. Scoring: 0=not started/no progress; 1=initial activity/minimal progress; 2=some activity/moderate progress; 3=completed or sustaining level progress.

See the FY 2021 scored checklist titled CSHCN Checklist Criteria Scoring Tool for SPM 2 in section V. Supporting Documents.

2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Annual progress for SPM 2 is tracked utilizing a Checklist Criteria Scoring Tool. The tool allows the CSHCN program to monitor progress on meeting the objectives outlined in the action plan.

Scoring is based on a total score (maximum =24) and will be measured to monitor progress. Scoring: 0=not started/no progress; 1=initial activity/minimal progress; 2=some activity/moderate progress; 3=completed or sustaining level progress.

See the FY22 scored checklist titled CSHCN Checklist Criteria Scoring Tool for SPM 2 in section V. Supporting Documents.

SPM 3 - Increase the capacity of families to connect CYSHCN to the health and human services they require for optimal behavioral, developmental, health, and wellness outcomes through our Care Coordination Program.

Measure Status:	Active			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			50	58
Annual Indicator			33.1	38.6
Numerator			138	276
Denominator			417	715
Data Source			CSHCN Program	CSHCN Program
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	67.0	77.0	89.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
New SPM for the 2021-2025 5 Year Needs Assessment Cycle

Data Source = CRS Care Coordination Family Survey
The CRS Care Coordination Family Survey was under development during FY21. See section III.E.2.c. CSHCN Annual Report for additional information on survey development and design.

Data = FY21 data is reflective of the Care Coordination Family Survey conducted in FY22 on individuals receiving care coordination services in FY20 and FY21.
The survey was open March 10, 2022 through April 10, 2022.

Numerator = 138, Denominator = 417
Composite Measure: In order to be counted as receiving comprehensive care coordination, the respondent had to meet pre-determined criteria assessed by six specific questions focused on whether their care coordination was 1) assessment-driven, 2) patient and family centered, and 3) team-based. See section V. supporting documents for a detailed overview of the composite measure.

2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Data Source = CRS Care Coordination Family Survey
See section III.E.2.c. CSHCN Annual Report for additional information on survey administration.

Data = FY22 data is reflective of the Care Coordination Family Survey conducted in FY23 on individuals receiving care coordination services in FY22.
The survey was open March 20, 2023 through May 3, 2023.

Numerator = 276, Denominator = 715
Composite Measure: In order to be counted as receiving comprehensive care coordination, the respondent had to meet pre-determined criteria assessed by six specific questions focused on whether their care coordination was 1) assessment-driven, 2) patient and family centered, and 3) Team-Based. See section V. supporting documents for a detailed overview of the composite measure.

SPM 5 - Increase the proportion of EHS programs participating in the EHSCCP grant program that maintain 10 percent of their population with children with special needs.

Measure Status:	Active			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			0.6	0.6
Annual Indicator	0	40	40	80
Numerator	0	2	2	4
Denominator	6	5	5	5
Data Source	Program Data	Program Data	Program Data	Program Data
Data Source Year	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	0.8	1.0	1.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
This measure is new with the goal of tracking the number of EHS that maintain a specified level of CSHCN.

Objectives were set to increase by one program out of the six (e.g. 1/6=0.17) annually.

This measure was based upon the total number of program partners participating in the EHSCCP Grant. Program partners are allotted a total number of slots(children) per year. The number of actual center sites vary by geographic region, based upon size and need.

The total number of partners does not include the Auburn University Hub.

2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Before the end of 2020, there were only five program partners instead of six originally mentioned in this measure. Jefferson County Committee for Economic Opportunity (JCCEO) ended its agreement with the Department of Human Resources (DHR) and the slots were transferred to other centers.

In 2020, two of the five centers met their goal of 10 percent or higher. In 2021, it was discovered that special needs children were under reported to DHR. Therefore, the ADPH added policies to the Care Coordination Protocol to include working with centers to identify children with special needs, assisting in obtaining the IFSP, verifying the number of special needs children monthly at each center, and reporting to DHR children not listed on their monthly report. The desire is that these efforts will help to improve the percentage of children identified with special needs at each center.

Objectives beyond the year 2020 were set to increase by one additional program out of the five (e.g. 3/5=0.60) annually.

3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
In 2021, two of the five program partners met their goal of 10 percent or higher. Before the end of 2020, there were only five program partners instead of six originally mentioned in this measure. JCCEO ended its agreement with the DHR and the slots were transferred to other centers. Due to this, not all slots were assigned during the first months of the program term that ran from August 2020-July 2021. While enrolled in the EHSCCP program, children receive screenings, ongoing assessment, and referrals for evaluation of disabilities or special needs.

During year 2021, it was discovered that Special Needs Children were under reported to DHR. Therefore, the ADPH added policies to the Care Coordination Protocol to include working with centers to identify children with special needs, assisting in obtaining the IFSP, verifying the number of special needs children monthly at each center, and reporting to DHR children not listed on their monthly report.

4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
In 2022, four of the five program partners met their goal of maintaining at least 10 percent of their population as children with special needs. ADPH continues to provide Care Coordination services that include working with centers to identify children with special needs, assisting in obtaining the IFSP, verifying the number of special needs children monthly at each center, and reporting to DHR children not listed on their monthly report.

ADPH also provides outreach to increase awareness and access for children with disabilities and special needs to a comprehensive child development program that provides early education and support services to children and families. Staff continue to work to increase the enrollment of children who are identified as having special needs and help to retain this population in the EHS-CCP Program until the child ages out or is no longer eligible for enrollment.

Additionally, a child is counted if they are enrolled in the EHS-CCP program during the reported calendar year and were eligible for services under the Individuals with Disabilities Education Act (IDEA) during the same calendar year. Data is obtained from the DHR through EHS-CCP documentation provided by the Program Partners.

SPM 6 - Percent of staff trained at day care provider/centers on CPR/First Aid

Measure Status:	Inactive - The Child and Adolescent Health Division is no longer able to report a denominator for this measure.			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			28.9	29.5
Annual Indicator	28.6	22.7	22.7	22.7
Numerator	6,157	4,886	4,886	4,886
Denominator	21,514	21,514	21,514	21,514
Data Source	Healthy Childcare Alabama Training Data	Healthy Childcare Alabama Training Data	Healthy Childcare Alabama Training Data	Healthy Childcare Alabama Training Data
Data Source Year	2019	2020	2020	2020
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Objectives are set to increase one percent annually from the year 2019 benchmark value of 28.6 percent.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Objective not met due to COVID-19 resulting in many day care closures.	

SPM 8 - Decrease number of infants dying from Sudden Infant Death Syndrome (SIDS)

Measure Status:	Inactive - There is overlap between NOM 9.5 and SPM 8. Alabama has decided that there is no added value in tracking SIDS deaths in addition to SUID deaths.

State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	10.6	
Numerator	43	
Denominator	404	
Data Source	Alabama Center for Health Statistics	
Data Source Year	2020	
Provisional or Final ?	Provisional	

Field Level Notes for Form 10 SPMs:

None

SPM 9 - Percent of 2 year old children who have received two blood lead tests at 12 and 24 months as recommended by the ACLPP Program

Measure Status:	Active

State Provided Data	
	2022
Annual Objective	
Annual Indicator	21.4
Numerator	3,429
Denominator	16,024
Data Source	HHLPSS
Data Source Year	2021-2022
Provisional or Final ?	Final

Annual Objectives		
	2024	2025
Annual Objective	20.0	20.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
After internal review, Alabama has decided to change the data source to the Healthy Homes and Lead Positioning Surveillance System (HHLPSS) to better measure provider practice and laboratory reporting in regards to blood testing in children less than 3 years old. One limitation in using Medicaid data is that children with private health insurance or self-pay would be excluded. Moving forward, Alabama will look further into the data to see if it would be necessary to expand the time windows for the first and second lab tests.

In 2022, there were 16,024 children who were 2 years old that received at least one reported lead test. Alabama linked the 2021 reported lead tests to these children to see if the provider practice completed the first 12 month follow-up. After analysis, Alabama was able to identify 3,429 children who received both screenings at 12 and 24 months.

2.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**

Field Note:
Since the data source for this measure has changed, Alabama will set its initial annual objective to 20 percent for the the 2024 and 2025 objectives. When more data is available, the goals will be reviewed and adjusted.

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Alabama

ESM 1.1 - Proportion of women age 15-55 who report receiving a preventive medical visit in the past 12 months by increasing total enrollment percentage in the Well Woman Program by 2 points annually.

Measure Status:	Inactive - Replaced

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	44.5	44.9	45.4	45.8	46.2
Annual Indicator	43.2	43.2	43.2	43.2	43.2
Numerator	1,081,373	1,081,373	1,081,373	1,081,373	1,081,373
Denominator	2,505,795	2,505,795	2,505,795	2,505,795	2,505,795
Data Source	BRFSS and U.S. Census	BRFSS and U.S. Census	BRFSS and U.S. Census	BRFSS and U.S. Census	BRFSS and U.S. Census
Data Source Year	2015	2015	2015	2015	2015
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
The BRFSS question regarding “Last Checkup” for data year 2015, as the baseline, which referred to a routine checkup in the last year by gender. This query provided a baseline of roughly 76.2 percent of females. Objectives from 2017 forward have been set to require an annual increase of 0.5 percent from the 2015 baseline.

Beginning with year 2015 data, American FactFinder Annual Estimates was used to determine population estimates. Per the 2015 Census population estimates, a total of 2,505,795 women lived in Alabama. Of the total women in Alabama, 1,419,125 were females in the age group of 12-55 years: 56.6 percent of the total female population. Also, using the 76.2 percent from BRFSS, women ages 12-55 years receiving a preventive visit in the last year equates to 1,801,373 women, which is also 43.2 percent of the target population. The year 2015 baseline was set at 43.2 percent with an annual improvement objective of one percent. Note, Well Woman data was based upon 15-55 years of age. At this time discussions are being held by the Well Woman Program for future Technical Assistance to acquire a better understanding of the most appropriate manner to report measures for the MCH Block Grant.

2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
The Well Woman Program staff has decided to inactivate the measure. For FY 2022 (September 2021-October 2022), 36 percent (200/554) of WW participants were also enrolled in FP. To increase enrollment of WW among FP participants, a new measure was created.

ESM 1.2 - Increase the percentage of women receiving both FP services and WW services by 2 percent within active WW counties.

Measure Status:	Active

State Provided Data	
	2022
Annual Objective	
Annual Indicator	5.1
Numerator	200
Denominator	3,885
Data Source	Cure MD
Data Source Year	FY 2022
Provisional or Final ?	Final

Annual Objectives		
	2024	2025
Annual Objective	7.1	9.1

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: During FY 2022 (October 2021-September 2022), 5.1 percent (200/3,885) of the total FP participants seen within the active WW nine active counties were enrolled into WW. To increase awareness of the WW program and other important health topics, FP participants have the opportunity to receive text messaging services provided by 211KNOW. Text messages were sent with messages about self-improvement, recipes, exercise, and various resources that empower women to create a healthier lifestyle. 211KNOW flyers are disseminated by exploreMedia staff at various community events and by Well Women social workers in the CHDs and throughout the community through outreach events.	
2.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**
	Field Note: To meet this goal, WW will conduct targeted outreach to participants with chronic health conditions between the ages of 15 and 55. Protocol trainings are being held for the nurse practitioners, nurses, and the social workers to ensure that WW consultations are being completed.	

ESM 3.1 - Percent of delivering hospitals convened at a meeting to share data and discuss the Alabama Perinatal Regionalization System Guidelines

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			0	10.9
Annual Indicator	8.7		0	53.2
Numerator	4		0	25
Denominator	46		46	47
Data Source	Alabama State Perinatal Program Data		Alabama State Perinatal Program Data	Alabama State Perinatal Program Data
Data Source Year	2020		2021	2022
Provisional or Final ?	Final		Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	21.8	32.7	43.6

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
After internal review of 2019, an introductory seminar on Perinatal Regionalization had not been reported in 2021 submission of the Block Grant. Four delivering hospitals attended.

2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Change in denominator: a hospital in West Central Alabama opened their labor and delivery unit in April 2022. This brought the total number of delivering hospitals to 47.

There have been several meetings with delivering hospitals. Twenty-five hospitals have participated and completed the LOCATe survey.

3.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
Based on 2022 data, the Perinatal Program has achieved the annual objective. Looking at 2023, we are still meeting with hospitals to communicate the importance of adherence to appropriate levels of perinatal care. We are compiling a directory of delivering hospitals to facilitate calls for transfers and consults in cases of high-risk patients. Based on these activities, no changes in the annual objectives are needed.

ESM 3.2 - Number of steps of the CDC's LOCATe process completed in order to design and align the Alabama Perinatal Regionalization System Guidelines with the national criteria for the maternal levels of care

Measure Status:	Active			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			1	1
Annual Indicator	0		0	3
Numerator				
Denominator				
Data Source	Alabama State Perinatal Program Data		Alabama State Perinatal Program Data	Alabama State Perinatal Program Data
Data Source Year	2019		2019	2022
Provisional or Final ?	Final		Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	2.0	2.0	3.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
This measure serves to track implementation of the CDC LOCATe tool which is being utilized to align the Alabama Perinatal Regionalization System Guidelines with the national criteria for the Maternal Levels of Care. Objectives are set to increase hospital participation by five facilities per year. Unfortunately, due to COVID-19, the State Perinatal Program has been unable to move forward with this objective. The goal is to begin movement on this measure in the year 2022.

2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
The LOCATe process includes the following three steps: build support for participation, begin using the tool to collect data, analyze data and share results.

Preliminary work was started in 2019 and again in 2021 to build support for participation (step one). In 2022, all three of these steps were completed. The 25 hospitals that participated completed both the neonatal and maternal care modules of the LOCATe tool.

3.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
Upon review for 2022, the Perinatal Program is considering retiring this measure and replacing it with a measure of the percentage of delivering hospitals that have completed the LOCATe tool.

ESM 5.1 - Number of sleep-related infant deaths

Measure Status:	Inactive - There is overlap between NOM 9.5 and ESM 5.1. Alabama has decided that there is no added value in tracking SIDS deaths in addition to SUID deaths.

State Provided Data				
	2019	2020	2021	2022
Annual Objective			63.9	62
Annual Indicator	70	99	102	101
Numerator				
Denominator				
Data Source	ADPH Center for Health Statistics	ADPH Center for Health Statistics	ADPH Center for Health Statistics	ADPH Center for Health Statistics
Data Source Year	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: The objectives, set for an annual decrease of three percent, are based upon the benchmark year 2018, during which SUID was responsible for 70 of the 405 infant deaths.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The death number for 2020 has been updated based on the 2019 data source year.	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: After review of the 2021 block grant submission, the total number of sleep-related deaths for 2021 and 2019 used the same data source year (2018). The death number for 2021 has been updated based on the 2020 data source year.	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: After review, the Perinatal Division has inactivated this measure due to the measure being similar to what was reported for NOM 9.5.	

ESM 5.2 - Number of trainings facilitated to assist healthcare professionals and first responders, who interact with expecting and new mothers, with being trained on safe sleep recommendations

Measure Status:	Active			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			2.5	2.5
Annual Indicator	2		0	3
Numerator				
Denominator				
Data Source	Alabama State Perinatal Program Documentation		Alabama State Perinatal Program Documentation	Alabama State Perinatal Program Documentation
Data Source Year	2020		2021	2022
Provisional or Final ?	Final		Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	3.1	3.9	4.9

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
This measure is a new one, which serves to track the number of trainings facilitated to assist healthcare professionals and first responders, who interact with expecting and new mothers, during training on safe sleep recommendations

Objectives are based upon the number of trainings facilitated in the specified year and set to increase 25 percent annually.

2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
In the year 2020, due to COVID-19 only two trainings were conducted. These two trainings were virtual. In the year 2021, there were no trainings. The goal is to continue to increase trainings by 25 percent annually.

3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
During 2022, two trainings on safe sleep and sleep-related death scene investigation were held. There was one online seminar to teach healthcare professionals and first responders on how to talk to caregivers about safe sleep. This seminar continues to be available for online viewing.

Looking into 2023. the Perinatal staff is considering replacing this measure to better capture the reach and impact of safe sleep education provided statewide.

ESM 6.1 - Proportion of children birth to age 19 that received a well child appointment in the past year

Measure Status:	Inactive - Replaced			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			1	1.6
Annual Indicator			1.6	25.3
Numerator			331	489
Denominator			20,412	1,935
Data Source			Child and Adolescent Health Division	Child And Adolescent Health Division
Data Source Year			2021	FY 2022
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Objectives based upon EPSDT visits statewide in CHDs in FY 2021 to children birth to 19 and set to increase one percent annually.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: In FY 2022 (October 2021- September 2022), seven CHDs offered well child appointments. The numerator represents the total number of EPSDT screenings completed and billed by the CHDs. After internal discussion, the denominator was changed to only look at those between birth to age 19 seen within the seven counties. Of those seen within the CHDs, 25.3 percent (489/1,935) received a well child appointment.	

ESM 6.2 - Proportion of children birth to age 19 that received a developmental screening in conjunction with a well-child appointment in the past year

Measure Status:	Inactive - Help Me Grow only provides developmental screenings for children up to 5 years old.			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			1.9	1.9
Annual Indicator	1.8		1.8	1.8
Numerator	22,363		22,363	22,363
Denominator	1,219,436		1,219,436	1,219,436
Data Source	APC and U.S. Census Bureau Population Estimates		APC and U.S. Census Bureau Population Estimates	APC and U.S. Census Bureau Population Estimates
Data Source Year	2018		2018	2018
Provisional or Final ?	Final		Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Based upon the number of ASQ-3s completed in the past year as reported by the APC.

Benchmark data represents the # ASQ-3s completed in 2018 with objectives set for a 1 percent annual increase.

2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
After internal discussion, Help Me Grow only provides developmental screenings for children up to 5 years old. In the past, the denominator included all children from birth to age 19. This may not be an accurate method to showcase the reach of services provided to this population.

ESM 6.3 - Proportion of children aged 12 & 24 months that have a reported blood lead screening in the past year

Measure Status:	Active			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			56.8	59.9
Annual Indicator	54.6	56.2	59.3	56.4
Numerator	33,751	32,982	36,814	34,885
Denominator	61,836	58,688	62,081	61,904
Data Source	Alabama Medicaid	Alabama Medicaid	Alabama Medicaid	Alabama Medicaid
Data Source Year	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	60.5	61.1	61.7

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Data guiding annual objectives for this measure comes from the FY 2019 Alabama Medicaid Agency EPSDT report. In FY 2019, of the 61,836 total eligible receiving at least one initial or periodic screening for ages 1 to 2 years, 33,751 persons in this age group blood lead levels were screened/tested. For FY 2018, this figure represented 54.6 percent of children ages 1 to 2 years receiving a blood lead screening. Objectives for subsequent years have been set to require an annual increase of one percent from this baseline.

2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Data guiding annual objectives for this SPM comes from the FY 2020 Alabama Medicaid Agency EPSDT report. In FY 2020, of the 58,688 total eligible receiving at least one initial or periodic screening for ages 1 to 2 years, 32,928 persons in this age group blood lead levels were screened/tested. For FY 2020 this figure represented 56.2 percent of children ages 1 to 2 years receiving a blood lead screening. Objectives for subsequent years have been set to require an annual increase of one percent from this baseline.

3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Data guiding annual objectives for this SPM comes from the FY 2021 Alabama Medicaid Agency EPSDT report. In FY 2021, of the 62,081 total eligible receiving at least one initial or periodic screening for ages 1 to 2 years, 36,841 persons in this age group blood lead levels were screened/tested. For FY 2021 this figure represented 59.3 percent of children ages 1 to 2 years receiving a blood lead screening. Objectives for subsequent years have been set to require an annual increase of one percent from this baseline.

4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Data guiding annual objectives for this state performance measure comes from the FY 2022 Alabama Medicaid Agency EPSDT report. In FY 2022, of the 61,904 total eligible receiving at least one initial or periodic screening for ages 1-2 years, 34,885 blood leads were screened/tested for persons in this age group. This data for FY 2022 represented 56.4 percent of children ages 1-2 years receiving a blood lead screening. Objectives for subsequent years have been set to require an annual increase of one percent from this baseline.

ESM 6.4 - Proportion of children birth to age 19 that received a well child appointment in the past year

Measure Status:	Active

State Provided Data	
	2022
Annual Objective	
Annual Indicator	25.3
Numerator	489
Denominator	1,935
Data Source	Child And Adolescent Health Division
Data Source Year	FY 2022
Provisional or Final ?	Final

Annual Objectives		
	2024	2025
Annual Objective	25.0	25.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: In FY 2022 (October 2021- September 2022), seven CHDs offered well child appointments. The numerator represents the total number of Early and Periodic, Diagnostic, and Treatment (EPSDT) screenings completed and billed by the CHDs. After internal discussion, the denominator was changed to only look at those between birth to age 19 within the seven counties. Of those seen within the CHDs, 25.3 percent (489/1,935) received a well child appointment.	
2.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**
	Field Note: In FY 2022 (October 2021- September 2022), 25.3 percent (489/1,935) of children seen at the seven CHD's have completed a well child appointment. Since the method of calculation has changed, the annual objective will be set to a minimum 25.0.	

ESM 10.1 - Proportion of adolescents, aged 12 to 19, that received an adolescent well visit in the past year

Measure Status:	Inactive - Replaced			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			77.1	72.1
Annual Indicator	76.3		70	70
Numerator	279,668		244,204	244,204
Denominator	366,499		348,830	348,830
Data Source	NSCH		NSCH	NSCH
Data Source Year	2016-2017		2019-2020	2019-2020
Provisional or Final ?	Final		Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: The original baseline was based upon the NSCH 2016-2017 survey in which 76.3 percent of persons 12 to 17 years of age received a preventive medical visit.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Based upon the NSCH 2019-2020 survey, 70.0 percent of persons 12 to 17 years of age received a preventive medical visit. Objectives set for a one percent annual increase from the 2019-2020 benchmark indicator of 70.0 percent.	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: After review of ESM 10.1, Alabama has decided to move from the previous method of calculation for adolescents receiving a well visit. Medicaid data will be used to determine how many adolescents between the ages of 12 and 19 received a well visit. Utilization of this new data source will help better link the efforts made by WW, FP, and the Adolescent Pregnancy Prevention programs to encourage this population to complete a well visit.	

ESM 10.2 - Proportion of adolescents, aged 12 to 19, that received an adolescent well visit in the past year

Measure Status:	Active

State Provided Data	
	2022
Annual Objective	
Annual Indicator	34.5
Numerator	93,115
Denominator	270,078
Data Source	Medicaid
Data Source Year	FY 2022
Provisional or Final ?	Final

Annual Objectives		
	2024	2025
Annual Objective	35.0	35.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Alabama originally used the NSCH to determine the total number of adolescents aged 12 to 19 who completed an adolescent well visit that occurred with the CHDs. One limitation to this data source is that the survey data does not include those between the ages of 18 and 19. After internal review, Medicaid data will be used as the new data source to determine how many adolescents between the ages of 12 and 19 received a well visit. Utilization of this data source will help better link the efforts made by WW, FP, and the Adolescent Pregnancy Prevention programs to encourage this population to complete a well visit.	
2.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**
	Field Note: Until more data is available, the 2024 and 2025 annual objectives will be set to 35 percent.	

ESM 12.1 - Percent of YSHCN enrolled in State CSHCN program who report satisfaction with their transition experience to adulthood.

Measure Status:	Active			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			50	58
Annual Indicator			74.5	78
Numerator			38	39
Denominator			51	50
Data Source			CSHCN Program	CSHCN Program
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	67.0	77.0	89.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
New ESM for the 2021-2025 5 Year Needs Assessment Cycle

Data Source = CRS Transition Survey
The CRS Transition survey was under development during FY 2021.
See section III.E.2.c. CSHCN Annual Report for additional information on survey development and design.

Data = FY 2021 data is reflective of the Transition survey conducted in FY 2022 on individuals ages 19 – 21 receiving transition services in FY 2020 and FY 2021.
The survey was open December 13, 2021 through February 28, 2022.

Numerator = 38, Denominator = 51
The numerator includes all respondents who answered, “Very Satisfied” or “Somewhat Satisfied” on the questions “Thinking about all of the questions you just answered, how satisfied are you OVERALL with your CRS transition services?” OR “Thinking about all of the questions you just answered, how satisfied is your youth OVERALL with their CRS transition services?”

2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Data Source = CRS Transition Survey
See section III.E.2.c. CSHCN Annual Report for additional information on survey administration.

Data = FY 2022 data is reflective of the Transition survey conducted in FY 2023 on individuals between the ages of 19 – 21 receiving transition services in FY 2022.
The survey was open February 13, 2023 through April 4, 2023.

Numerator = 39, Denominator = 50
The numerator includes all respondents who answered, “Very Satisfied” or “Somewhat Satisfied” on the questions “Thinking about all of the questions you just answered, how satisfied are you OVERALL with your CRS transition services?” OR “Thinking about all of the questions you just answered, how satisfied is your youth OVERALL with their CRS transition services?”

ESM 13.1.1 - Percentage of dental providers receiving information/education regarding importance of preventive dental visits for expectant mothers

Measure Status:	Active		
State Provided Data			
	2020	**2021**	**2022**
Annual Objective			3
Annual Indicator	0		14.9
Numerator	0		1,021
Denominator	500		6,840
Data Source	Oral Health Program		Oral Health Program
Data Source Year	2020		FY 2022
Provisional or Final ?	Final		Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	6.0	9.0	10.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
This measure is new and has the goal of tracking increases in dental provider knowledge. The denominator is based upon program estimates of approximately 25 percent of total Alabama dentists (500 individuals). The FY 2022 baseline is set at three percent with a three percent annual improvement objective until reaching the overall ten percent dental provider reach goal. The OHO aims to implement this measure in the upcoming FY 2022.

2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
During the 2022 Alabama Statewide Gulf Coast Dental Conference, the OHO provided dental education materials to dentists and hygienists. The numerator represented those who attended the 2022 Annual Gulf Coast Conference. According to the Alabama Board of Dental Examiners, there are approximately 6,840 licensed hygienists and dentists for the state of Alabama. During this conference, a total of 1,021 attendees received training materials related to expectant mothers.

3.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
For 2023. the OHO will have in person opportunities to present at conferences and dental meetings. The annual objectives will remain the same.

ESM 13.1.2 - Percentage of dental providers that received information/education regarding their perinatal patients about the FDA-approved HPV vaccine in order to reduce the risk of oropharyngeal, cervical, and other HPV-related cancers

Measure Status:	Active		
State Provided Data			
	2020	**2021**	**2022**
Annual Objective			3
Annual Indicator	0		14.9
Numerator	0		1,021
Denominator	500		6,840
Data Source	Oral Health Program		Oral Health Program
Data Source Year	2020		FY 2022
Provisional or Final ?	Final		Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	6.0	9.0	10.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: This measure is new and has the goal of tracking increases in dental provider knowledge. The denominator is based upon program estimates of approximately 25 percent of total Alabama dentists (500 individuals). The FY 2022 baseline is set at three percent with a three percent annual improvement objective until reaching our overall 10 percent dental provider reach goal. The OHO aims to implement this measure in the upcoming FY 2022.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: During the 2022 Alabama Statewide Gulf Coast Dental Conference, the OHO provided dental education materials to dentists and hygienists. According to the Alabama Board of Dental Examiners, there are approximately 6,840 licensed hygienists and dentists for the state of Alabama. During this conference, a total of 1,021 attendees received training materials related to expectant mothers.	
3.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: For 2023, the OHO will have in person opportunities to present at conferences and dental meetings. The annual objectives will remain the same.	

ESM 13.2.1 - Percentage of providers receiving information/education regarding importance of preventive dental visits for children ages 1-17 years of age

Measure Status:	Active		
State Provided Data			
	2020	**2021**	**2022**
Annual Objective			3
Annual Indicator	0		14.9
Numerator	0		1,021
Denominator	500		6,840
Data Source	Oral Health Program		Oral Health Program
Data Source Year	2020		FY 2022
Provisional or Final ?	Final		Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	6.0	9.0	10.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
This measure is new and has the goal of tracking increases in dental provider knowledge. The denominator is based upon program estimates of approximately 25 percent of total Alabama dentists (500 individuals). The FY 2022 baseline is set at three percent with a three percent annual improvement objective until reaching the overall ten percent dental provider reach goal. The OHO aims to implement this measure in the upcoming FY 2022.

2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
During the 2022 Alabama Statewide Gulf Coast Dental Conference, the OHO provided dental education materials to dentists and hygienists. According to the Alabama Board of Dental Examiners, there are approximately 6,840 licensed hygienists and dentists for the State of Alabama. During this conference, a total of 1,021 attendees received training materials related to expectant mothers.

3.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
For 2023, the OHO will have in person opportunities to present at conferences and dental meetings. The annual objectives will remain the same.

ESM 13.2.2 - Percentage of dental providers that received information/education regarding informing their families of patients at 9 years of age about the FDA-approved HPV vaccine in order to prevent future oropharyngeal, cervical, and other HPV-related cancer

Measure Status:	Active		
State Provided Data			
	2020	**2021**	**2022**
Annual Objective			3
Annual Indicator	0		14.9
Numerator	0		1,021
Denominator	500		6,840
Data Source	Oral Health Program		Oral Health Program
Data Source Year	2020		FY 2022
Provisional or Final ?	Final		Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	6.0	9.0	10.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: This measure is new and has the goal of tracking increases in dental provider knowledge. The denominator is based upon program estimates of approximately 25 percent of total Alabama dentists (500 individuals). The FY 2022 baseline is set at three percent with a three percent annual improvement objective until reaching the overall 10 percent dental provider reach goal. The OHO aims to implement this measure in the upcoming FY 2022.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: During the 2022 Alabama Statewide Gulf Coast Dental Conference, the OHO provided dental education materials to dentists and hygienists. According to the Alabama Board of Dental Examiners, there are approximately 6,840 licensed hygienists and dentists for the state of Alabama. During this conference, a total of 1,021 attendees received training materials related to expectant mothers.	
3.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: For 2023, the OHO will have in-person opportunities to present at conferences and dental meetings. The annual objectives will remain the same.	

Form 10
State Performance Measure (SPM) Detail Sheets

State: Alabama

SPM 1 - Percent of children who receive a blood lead screening test at age 12 and 24 months of age
Population Domain(s) – Child Health

<table>
<tr><td>Measure Status:</td><td>Inactive - Replaced</td></tr>
<tr><td>Goal:</td><td>Increase the proportion of children aged 12 and 24 months that have a reported blood lead screening.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of Alabama 2 year old children that have a reported blood lead screening during 12 and 24 months</td></tr>
<tr><td>Denominator:</td><td>Number of Alabama 2 year old children</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Old Data Source: Medicaid
New Data Source: Healthy Homes and Lead Poisoning Surveillance System</td></tr>
<tr><td>Significance:</td><td>Lead is a potent and pervasive neurotoxicant. Elevated blood lead levels (EBBLs) can result in decreased IQ, academic failure, and behavioral problems in children. There are approximately half a million U.S. children, ages 1-5, with BLL above 3.5 micrograms per deciliter, the reference level at which CDC recommends public health actions be initiated. No safe BLL in children has been identified. Because lead exposure often occurs with no obvious symptoms, it frequently goes unrecognized. By school age, children with a history of lead exposure can exhibit poor attention and impulse control, with lower intelligence, and academic performance. A blood lead test is the only reliable way to identify a lead-poisoned child. Medicaid has required testing of enrolled children since 1989. Many states do not enforce the Medicaid requirement for children to be tested for lead poisoning. Medicaid-enrolled children are three times more likely to have EBLL than medicaid non-enrolled children, according to national studies.</td></tr>
</table>

SPM 2 - Strengthen and enhance family/youth partnerships, involvement and engagement in advisory groups, program development, policymaking, and system-building activities to support shared decision making between families and health-related professionals.
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	Strengthen and enhance partnerships between families, youth, healthcare providers, and related health professionals.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Annual Score on the Checklist Criteria Scoring Tool **Denominator:** Total Possible Points on the Checklist Criteria Scoring Tool
Data Sources and Data Issues:	Annual progress will be tracked utilizing a Checklist Criteria Scoring Tool which was created to monitor progress towards meeting the objectives outlined in the action plan. Scoring will be based on a total score (maximum=24) and will be measured yearly for increase or decrease from prior year. Scoring: 0=not started/no progress; 1=initial activity/minimal progress; 2=some activity/moderate progress; 3=completed or sustaining level progress. Data Issues: Failure to accurately document action on the criteria could lead to inaccurate annual scoring and inaccurate monitoring of progress on meeting the goals and objectives of the measure.
Significance:	Partnerships with individuals/families/family-led organizations are one of the guiding principles in developing the MCH Block Grant. The Title V MCH Block Grant Guidance to states defines family partnership as “the intentional practice of working with families for the ultimate goal of positive outcomes in all areas through the life course.” Our vision in creating this SPM is to recognize the value and importance of family/youth partnerships in our CSHCN program. Strengthening these partnerships and recognizing them as leaders who are continually engaged in the decision-making process will ensure that the programs and services we provide are family centered.

SPM 3 - Increase the capacity of families to connect CYSHCN to the health and human services they require for optimal behavioral, developmental, health, and wellness outcomes through our Care Coordination Program. Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	To provide comprehensive care coordination services needed by CYSHCN.
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of respondents who report receiving comprehensive care coordination services.</td></tr><tr><td>**Denominator:**</td><td>Number of survey respondents.</td></tr></table>
Healthy People 2030 Objective:	MICH-20: Increase the proportion of children and adolescents with special health care needs who receive care in a family-centered, comprehensive, and coordinated system.
Data Sources and Data Issues:	Data Source: CRS Care Coordination Family Survey will be developed to measure that comprehensive care coordination services are being provided to families. Comprehensive Care Coordination is a patient-and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the caregiving capabilities of families. Care coordination addresses interrelated medical, social, developmental, behavioral, educational, and financial needs in order to achieve optimal health and wellness outcomes. Baseline to be determined by 2021. Data Issues: A potential issue when collecting data using a survey format is a limited number of respondents which could impact the outcome.
Significance:	The Standards for Systems of Care for CYSHCN Version 2.0 defines pediatric care coordination as a patient-and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the care giving capabilities of families. Care coordination addresses interrelated medical, social, developmental, behavioral, educational, and financial needs to achieve optimal health and wellness outcomes. The Standards Cite care coordination under the Medical Home domain.

SPM 5 - Increase the proportion of EHS programs participating in the EHSCCP grant program that maintain 10 percent of their population with children with special needs.
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Increase the proportion of EHS programs participating in the EHSCCP grant program that maintain 10 percent of their population with children with special needs.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of EHS programs participating in the EHSCCP grant program that maintain 10% of their population with children with special needs **Denominator:** Number of EHS programs participating in the EHSCCP grant program
Data Sources and Data Issues:	DHR EHS Program Information
Significance:	Head Start is a federally funded, locally administered comprehensive child development program that provides early education and support services to children and families with household incomes up to 130 percent of poverty by federal standards (about $33,000 for a family of four). Head Start serves children ages 3 to 5, while EHS serves infants and toddlers. Many Head Start programs collaborate with child care and public preschool programs to serve eligible children, including children of migrant and tribal families. Head Start has expanded and innovated over its 50-year history, pioneering home visiting services, infant-toddler care, and raising the standard for teacher training. For example, the percent of Head Start teachers with a bachelor's degree or higher increased nationwide from 44 percent in 2007 to 73 percent in 2015, a direct result of requirements included in the 2007 Head Start reauthorization. The State(s) of Head Start report was supported with funding provided by the Bill and Melinda Gates Foundation. The findings, interpretations, and conclusions in this report are solely those of the authors. The State(s) of Head Start digest provides a printed narrative and summary information with charts. For more information on the State(s) of Head Start and detailed state-by-state profiles on quality access, and funding, please visit www.nieer.org.

SPM 6 - Percent of staff trained at day care provider/centers on CPR/First Aid
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Inactive - The Child and Adolescent Health Division is no longer able to report a denominator for this measure.
Goal:	Increase the percent of staff trained at day care provider/centers on CPR/First Aid in the past year
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of staff trained at day care provider/centers on CPR/First Aid in the past year **Denominator:** Number of staff trained at day care provider/centers in the past year
Data Sources and Data Issues:	Healthy Childcare Alabama Training Data
Significance:	Head Start is a federally funded, locally administered comprehensive child development program that provides early education and support services to children and families with household incomes up to 130 percent of poverty by federal standards (about $33,000 for a family of four). Head Start serves children ages 3 to 5, while EHS serves infants and toddlers. Many Head Start programs collaborate with child care and public preschool programs to serve eligible children, including children of migrant and tribal families. Head Start has expanded and innovated over its 50-year history, pioneering home visiting services, infant-toddler care, and raising the standard for teacher training. For example, the percent of Head Start teachers with a bachelor's degree or higher increased nationwide from 44 percent in 2007 to 73 percent in 2015, a direct result of requirements included in the 2007 Head Start reauthorization. The State(s) of Head Start report was supported with funding provided by the Bill and Melinda Gates Foundation. The findings, interpretations, and conclusions in this report are solely those of the authors. The State(s) of Head Start digest provides a printed narrative and summary information with charts. For more information on the State(s) of Head Start and detailed state-by-state profiles on quality access, and funding, please visit www.nieer.org.

SPM 8 - Decrease number of infants dying from Sudden Infant Death Syndrome (SIDS)
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Inactive - There is overlap between NOM 9.5 and SPM 8. Alabama has decided that there is no added value in tracking SIDS deaths in addition to SUID deaths.
Goal:	Increase the number of infants with a safe sleep environment
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** 43 **Denominator:** 404
Data Sources and Data Issues:	ADPH Center for Health Statistics
Significance:	Sleep related infant deaths are consistently one of the top three leading contributors of death for infants in Alabama. In 2020, 43 infants died of SIDS before their first birthday. The CDC recommends babies sleep in their own separate sleep space using a firm, flat surface covered only by a fitted sheet. Unfortunately, not all families in Alabama can afford a safe place for their babies to sleep. CDC "Helping Babies Sleep Safely" https://www.cdc.gov/reproductivehealth/features/baby-safe-sleep/

SPM 9 - Percent of 2 year old children who have received two blood lead tests at 12 and 24 months as recommended by the ACLPP Program
Population Domain(s) – Child Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Based on CDC recommendations, 2 year old children should complete a lead test screening at both their 12 and 24 month follow-up visits.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of 2 year old children who were tested for lead poisoning at their 12 month and 24 follow-up visit</td></tr>
<tr><td>Denominator:</td><td>Number of 2 year old children who were enrolled into the Healthy Homes and Lead Poisoning Surveillance System (HHLPSS)</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Healthy Homes and Lead Poisoning Surveillance System (HHLPSS)</td></tr>
<tr><td>Significance:</td><td>Lead is a potent and pervasive neurotoxicant. EBBL can result in decreased IQ, academic failure, and behavioral problems in children. There are approximately half a million U.S. children, ages 1-5, with BLL above 3.5 micrograms per deciliter, the reference level at which CDC recommends public health actions be initiated. No safe BLL in children has been identified. Because lead exposure often occurs with no obvious symptoms, it frequently goes unrecognized. By school age, children with a history of lead exposure can exhibit poor attention and impulse control, with lower intelligence and academic performance. A blood lead test is the only reliable way to identify a lead-poisoned child. This percentage represents the efforts taken by the Lead program to increase testing and improve reporting. For outreach, the nurse educator has completed site visits primarily at pediatric and family practice clinics. Brochures, posters, and testing recommendations are given to these clinics so that provider and their clients can receive lead poisoning prevention information.</td></tr>
</table>

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Alabama

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Alabama

ESM 1.1 - Proportion of women age 15-55 who report receiving a preventive medical visit in the past 12 months by increasing total enrollment percentage in the Well Woman Program by 2 points annually.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Inactive - Replaced
Goal:	Increase the proportion of women age 15-55 who report receiving a preventive medical visit in the past 12 months
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women age 15-55 who report having received a preventive visit in the past year **Denominator:** Number of women age 15-55 in Alabama
Data Sources and Data Issues:	BRFSS Question 3.4 National Survey of Children's Health K4Q20 Issues: State-level samples; NSCH not completed on an annual basis
Significance:	By implementing the WW protocol, the number of women who receive preventive medical visits, and help improve the health outcomes for women and children, also.

ESM 1.2 - Increase the percentage of women receiving both FP services and WW services by 2 percent within active WW counties.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	The goal is to increase WW enrollment among FP participants by 2 percent.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of FP participants enrolled in the WW Program **Denominator:** The total number of FP Participants within the active WW Counties.
Data Sources and Data Issues:	ADPH uses the electronic health records (EHR) system known as Cure MD to store data for the WW Program and FP.
Evidence-based/informed strategy:	The WW program addresses chronic health conditions through evidence-based strategies including the New Leaf curriculum and the CVD risk assessment.
Significance:	Increasing the enrollment in WW will help to reduce the CVD risk of women within reproductive age, resulting in healthier maternal and infant outcomes.

ESM 3.1 - Percent of delivering hospitals convened at a meeting to share data and discuss the Alabama Perinatal Regionalization System Guidelines
NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active
Goal:	Convene the delivering hospitals to share data and discuss the Alabama Perinatal Regionalization System Guidelines.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of delivering hospitals represented at the meeting **Denominator:** Number of delivering hospitals in Alabama
Data Sources and Data Issues:	Alabama State Perinatal Program Meeting Sign-In Sheets
Significance:	Related to Maternal, Infant, and Child Health (MICH)-33: Increase the proportion of very low birth weight (VLBW) infants born at Level III hospitals or subspecialty perinatal centers. Low birth weight or premature infants born in risk-appropriate facilities are more likely to survive. Multiple studies indicate VLBW infant mortality is lower for infants born in a Level III center (higher level of care) and higher for infants born in non-Level III centers. Implementation of this measure ensures that a system of regionalized care is implemented and VLBW infants are referred to the appropriate level of care facility before delivery.

ESM 3.2 - Number of steps of the CDC's LOCATe process completed in order to design and align the Alabama Perinatal Regionalization System Guidelines with the national criteria for the maternal levels of care
NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Implement the CDC's Level of Care Assessment Tool (LOCATe) Process in order to align and implement the national criteria for the Maternal Levels of Care</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>3</td></tr>
<tr><td>Numerator:</td><td>Number of steps of the CDC's Level of Care Assessment Tool (LOCATe) Process completed</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Alabama Perinatal Regionalization System Data</td></tr>
<tr><td>Significance:</td><td>Creation of a system that aligns the maternal levels of care with Alabama Perinatal Regionalization System Guidelines utilizing CDC LOCATe ensures that there is a regionalized system for neonates and moms in Alabama.

The CDC LOCATe tool is designed to help states and other jurisdictions monitor neonatal and maternal risk appropriate care. CDC LOCATe uses the minimum information necessary to identify a facility’s neonatal level of care, based on criteria by American Academy of Pediatrics, and maternal level of care based recently published criteria by the American College of Obstetricians and Gynecologists/Society for Maternal-Fetal Medicine.

According to the CDC, the steps of the CDC LOCATe Process are as follows:

Step 1: BUILD SUPPORT FOR PARTICIPATION - An agency or organization serving as a state champion for CDC LOCATe identifies stakeholders to help encourage birth facilities to use the CDC LOCATe tool. The champion builds relationships with facilities to work toward statewide participation.

Step 2: BEGIN USING TOOL TO COLLECT DATA - The champion sends the CDC LOCATe web link to facilities in the state and follows up with those that don't respond.

Step 3: ANALYZE DATA AND SHARE RESULTS - The champion sends data to CDC to analyze. CDC assesses levels of maternal and neonatal care and sends back results that can be used and shared as desired.</td></tr>
</table>

ESM 5.1 - Number of sleep-related infant deaths
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Inactive - There is overlap between NOM 9.5 and ESM 5.1. Alabama has decided that there is no added value in tracking SIDS deaths in addition to SUID deaths.
Goal:	Decrease by 3 percent annually, the number of sleep-related infant deaths by implementing targeted consistent safe sleep education to caregivers, child health providers, health care providers, and hospital systems.
Definition:	**Unit Type:** Count **Unit Number:** 200 **Numerator:** Number of sleep-related infant deaths **Denominator:**
Data Sources and Data Issues:	ADPH Center for Health Statistics
Significance:	Providing safe sleep education to targeted audiences that provide care to infants helps to ensure that consistent messaging is shared with families with hopes that more families will implement safe sleep recommendations with the ultimate goal of decreasing sleep-related infant deaths.

ESM 5.2 - Number of trainings facilitated to assist healthcare professionals and first responders, who interact with expecting and new mothers, with being trained on safe sleep recommendations
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Increase by 25 percent annually, the number of trainings facilitated to assist healthcare professionals and first responders, who interact with expecting and new mothers, with being trained on safe sleep recommendations
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of trainings facilitated to assist healthcare professionals and first responders, who interact with expecting and new mothers, with being trained on safe sleep recommendations **Denominator:**
Data Sources and Data Issues:	Alabama State Perinatal Program Documentation
Significance:	Facilitate the training of healthcare professionals and first responders, who interact with expecting and new mothers, on safe sleep recommendations

ESM 6.1 - Proportion of children birth to age 19 that received a well child appointment in the past year
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Inactive - Replaced
Goal:	Increase the proportion of children birth to age 19 that received a well-child appointment in the past year.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of EPSDT screenings performed in the CHDs in the past year **Denominator:** Number of children birth to age 19 who received services in the CHDs in the past year
Data Sources and Data Issues:	CHD EHRs
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families.

ESM 6.2 - Proportion of children birth to age 19 that received a developmental screening in conjunction with a well-child appointment in the past year
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Inactive - Help Me Grow only provides developmental screenings for children up to 5 years old.
Goal:	Increase the proportion of children birth to age 19 that received a developmental screening in conjunction with a well child appointment in the past year.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children birth to age 19 that received a developmental screening in conjunction with a well child appointment in the past year **Denominator:** Number of children birth to age 19
Data Sources and Data Issues:	APC and Help Me Grow Program Data
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families.

ESM 6.3 - Proportion of children aged 12 & 24 months that have a reported blood lead screening in the past year
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Increase the proportion of children aged 12 & 24 months that have a reported blood lead screening in the past year
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children aged 12 & 24 months that have a reported blood lead screening in the past year **Denominator:** Number of children aged 12 & 24 months
Data Sources and Data Issues:	Medicaid Data
Evidence-based/informed strategy:	Lead testing is a Medicaid mandate to be performed as part of the EPSDT checkup at the 12 month and 24 month visit. In addition, the testing is important to identify children who are exposed to lead and to provide corrective interventions.
Significance:	Early identification of developmental disorders or conditions that are contributors to development disorders.

ESM 6.4 - Proportion of children birth to age 19 that received a well child appointment in the past year
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Increase the proportion of children birth to age 19 that received a well-child appointment in the past year within the seven CHDs. The active CHDs include Butler, Clay, Geneva, Marengo, Randolph, Talladega, and Wilcox.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of EPSDT screenings performed in the CHDs in the past year **Denominator:** Number of children birth to age 19 who received services in the CHDs in the past year
Data Sources and Data Issues:	Ensemble was the data source to get the total number of EPSDT screenings. Ensemble is a budget tool to show how many visits were completed, billed, and paid for within the CHDs. The EHR system known as CureMD utilized by the CHDs was used to get the total number of children who received services provided by the seven MCH EPSDT active counties.
Evidence-based/informed strategy:	With this informed strategy, MCH is able to provide EPSDT screenings within seven CHDs. The creation of this measure would be used to see how Alabama can promote the importance of the EPSDT screenings among children within this age group. Alabama has an MCH coordinator stationed in two of the active counties to highlight the importance of EPSDT screenings.
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families.

ESM 10.1 - Proportion of adolescents, aged 12 to 19, that received an adolescent well visit in the past year
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Inactive - Replaced
Goal:	Increase the proportion of adolescents, aged 12 to 19, that received an adolescent well-visit in the county health departments in the past year
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of adolescents, aged 12 to 19, that received an adolescent well visit in the county health departments in the past year **Denominator:** Number of adolescents aged 12 to 19
Data Sources and Data Issues:	EHRs from CHDs
Significance:	Early identification of developmental disorders is critical to the well-being of adolescents and their families.

ESM 10.2 - Proportion of adolescents, aged 12 to 19, that received an adolescent well visit in the past year
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the proportion of adolescents with Medicaid Insurance, aged 12 to 19, that received an adolescent well-visit within Alabama</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>The number of adolescents with Medicaid insurance aged 12 to 19, that received an adolescent well-visit within Alabama</td></tr>
<tr><td>Denominator:</td><td>The total number of adolescents with Medicaid insurance aged 12 to 19.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Instead of using the NSCH, Medicaid will be able to provide a more accurate number on the total number of adolescents aged 12 to 19 who completed an adolescent visit. One limitation with this data source is that the number would not include adolescents who have either private/other insurance or no insurance.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>Alabama created this informed strategy to see how many adolescents between the ages of 12 and up to 19 completed a medical visit. According to Medicaid, adolescent Well Visits include the following: a physical exam, immunizations follow-up, developmental assessment, oral health risk assessment, and any needed referrals. With access to Medicaid data. Alabama will be able to determine how many individuals within this age group received a medical visit.</td></tr>
<tr><td>Significance:</td><td>Early identification of developmental disorders is critical to the well-being of adolescents and their families</td></tr>
</table>

ESM 12.1 - Percent of YSHCN enrolled in State CSHCN program who report satisfaction with their transition experience to adulthood.
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Measure Status:	Active
Goal:	To improve transition services and the overall transition experience.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of youth that indicate satisfaction regarding their transition experience. **Denominator:** Total number of youth surveyed.
Data Sources and Data Issues:	Survey based on the Six Core Elements of Health Care Transition 2.0 Health Care Transition Feedback Survey for Youth and the State and Local Area Integrated Telephone Survey (SLAITS) 2007 Survey of Adult Transition and Health (SATH). A potential issue when collecting data using a survey format is a limited number of respondents which could impact the outcome.
Significance:	The Standards for Systems of Care for CYSHCN Version 2.0 System Domain Transition to Adulthood indicates the system should contact the young adult/caregiver confirming transfer of care and eliciting feedback on experience with the transition process. Ensuring the successful transition of youth and young adults with special health care needs is essential to individual self-determination and self-management. Young adult/caregiver perception of satisfaction with their transition to adult health care will help determine QI measures to drive program development that supports the achievement of successful outcomes.

ESM 13.1.1 - Percentage of dental providers receiving information/education regarding importance of preventive dental visits for expectant mothers
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To help lower undesirable outcomes for pregnant women by educating dental providers on the importance of preventative visits for expectant women.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>The number of Alabama licensed dentists and hygienists who received educational materials on the importance of preventative dental visits for expectant mothers at the Annual Gulf Coast Dental Conference and other ALDA sanctioned meetings.</td></tr>
<tr><td>Denominator:</td><td>The number of Alabama licensed dentists and hygienists</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>OHO</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>To our knowledge, there is currently no evidence-based/informed strategy for dental provider training.</td></tr>
<tr><td>Significance:</td><td>Oral health is inextricably linked to overall general health and well-being. People with limited access to preventive oral health services are at greater risk for oral diseases that lead to sometimes devastating outcomes. There are profound and consequential oral health disparities within Alabama and the American population, as well as barriers hampering segments of the population from attaining optimal oral health. There are safe and effective measures to prevent the most common dental diseases such as dental caries, as well as more complex oral cavity disease processes. An increase in professionals educated on the need for oral health care and equity for certain populations and the need for collaboration between state and local agencies as well as regulatory bodies will contribute to diverse policies and advocacy for those in need.

It is important for providers to receive education on oral health for pregnant women as that is a great unmet need for this population. Potentially profound adverse pregnancy outcomes may result from lack of proper preventive dental care. It is incumbent upon the dental community to stay abreast of the most up-to-date information in order to promote and provide these services to better attain positive pregnancy outcomes.

Dental providers are also charged with the diagnosis and prevention of certain oral and oropharyngeal cancers through physical exams and referrals for the FDA-approved HPV vaccine, necessitating the need for continual education. This is extremely important in Alabama, as the state consistently ranks high in both incidence and mortality resulting from these oral cancers.</td></tr>
</table>

ESM 13.1.2 - Percentage of dental providers that received information/education regarding their perinatal patients about the FDA-approved HPV vaccine in order to reduce the risk of oropharyngeal, cervical, and other HPV-related cancers
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To provide dental providers education on the importance of HPV vaccinations</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>The number of Alabama licensed dentists and hygienists who received educational materials on the importance of HPV vaccinations at the Annual Gulf Coast Dental Conference and other ALDA sanctioned meetings.</td></tr>
<tr><td>Denominator:</td><td>The number of Alabama licensed dentists and hygienists</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>OHO</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>This is an emerging topic of discussion and consequently there is no known evidence-based strategy.</td></tr>
<tr><td>Significance:</td><td>Oral health is inextricably linked to overall general health and well-being. People with limited access to preventive oral health services are at greater risk for oral diseases that lead to sometimes devastating outcomes. There are profound and consequential oral health disparities within Alabama and the American population, as well as barriers hampering segments of the population from attaining optimal oral health. There are safe and effective measures to prevent the most common dental diseases such as dental caries, as well as more complex oral cavity disease processes. An increase in professionals educated on the need for oral health care and equity for certain populations and the need for collaboration between state and local agencies as well as regulatory bodies will contribute to diverse policies and advocacy for those in need.

It is important for providers to receive education on oral health for pregnant women as that is a great unmet need for this population. Potentially profound adverse pregnancy outcomes may result from lack of proper preventive dental care. It is incumbent upon the dental community to stay abreast of the most up-to-date information in order to promote and provide these services to better attain positive pregnancy outcomes.

Dental providers are also charged with the diagnosis and prevention of certain oral and oropharyngeal cancers through physical exams and referrals for the FDA-approved HPV vaccine, necessitating the need for continual education. This is extremely important in Alabama, as the state consistently ranks high in both incidence and mortality (presently 12th and 3rd, respectively) resulting from these oral cancers. In response, OHO has distributed HPV educational materials to licensed hygienists and dentists. OHO encourages dental providers to discus risk factors associated with HPV with their patients and to see their general doctor if they want additional information on HPV vaccination.</td></tr>
</table>

ESM 13.2.1 - Percentage of providers receiving information/education regarding importance of preventive dental visits for children ages 1-17 years of age
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	To provide dental providers education on the importance of preventive dental visits for children ages 1-17 years of age
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of Alabama licensed dentists and hygienists who received educational materials on the importance of preventative dental visits for children up to age 17 at the Annual Gulf Coast Dental Conference and other ALDA sanctioned meetings. **Denominator:** The number of Alabama licensed dentists and hygienists
Data Sources and Data Issues:	OHO
Evidence-based/informed strategy:	There is currently no known evidence-based information available on this subject at this time.
Significance:	Oral health is inextricably linked to overall general health and well-being. People with limited access to preventive oral health services are at greater risk for oral diseases that lead to sometimes devastating outcomes. There are profound and consequential oral health disparities within Alabama and the American population, as well as barriers hampering segments of the population from attaining optimal oral health. There are safe and effective measures to prevent the most common dental diseases such as dental caries, as well as more complex oral cavity disease processes. An increase in professionals educated on the need for oral health care and equity for certain populations and the need for collaboration between state and local agencies as well as regulatory bodies will contribute to diverse policies and advocacy for those in need. Dental providers are also charged with the diagnosis and prevention of certain oral and oropharyngeal cancers through physical exams and referrals for the FDA-approved HPV vaccine, necessitating the need for continual education. This is extremely important in Alabama, as the state consistently ranks high in both incidence and mortality resulting from these oral cancers.

ESM 13.2.2 - Percentage of dental providers that received information/education regarding informing their families of patients at 9 years of age about the FDA-approved HPV vaccine in order to prevent future oropharyngeal, cervical, and other HPV-related cancer
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To provide dental providers education on the importance of HPV vaccinations for children beginning at nine years old</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>The number of Alabama licensed dentists and hygienists who received educational materials on the importance of HPV vaccinations for children beginning at nine years old at the Annual Gulf Coast Dental Conference and other ALDA sanctioned meetings.</td></tr>
<tr><td>Denominator:</td><td>The number of Alabama licensed dentists and hygienists</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>OHO</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>There is currently no known evidence-based information available on this subject at this time.</td></tr>
<tr><td>Significance:</td><td>Oral health is inextricably linked to overall general health and well-being. People with limited access to preventive oral health services are at greater risk for oral diseases that lead to sometimes devastating outcomes. There are profound and consequential oral health disparities within Alabama and the American population, as well as barriers hampering segments of the population from attaining optimal oral health. There are safe and effective measures to prevent the most common dental diseases such as dental caries, as well as more complex oral cavity disease processes. An increase in professionals educated on the need for oral health care and equity for certain populations and the need for collaboration between state and local agencies as well as regulatory bodies will contribute to diverse policies and advocacy for those in need.

Dental providers are also charged with the diagnosis and prevention of certain oral and oropharyngeal cancers through physical exams and referrals for the FDA-approved HPV vaccine, necessitating the need for continual education. This is extremely important in Alabama, as the state consistently ranks high in both incidence and mortality (presently 12th and 3rd, respectively) resulting from these oral cancers. In response, OHO has distributed HPV educational materials to licensed hygienists and dentists. OHO encourages dental providers to discus risk factors associated with HPV with their patients and to see their general doctor if they want additional information on HPV vaccination.</td></tr>
</table>

Form 11
Other State Data

State: Alabama

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: Alabama

Annual Report Year 2022

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Daily	0		
2) Vital Records Death	Yes	Yes	Daily	0	Yes	
3) Medicaid	Yes	No	Annually	12	No	
4) WIC	Yes	No	Daily	0	No	
5) Newborn Bloodspot Screening	Yes	No	Annually	12	No	
6) Newborn Hearing Screening	Yes	No	Quarterly	3	No	
7) Hospital Discharge	No	No	Never	NA	No	
8) PRAMS or PRAMS-like	Yes	Yes	More often than monthly	12	No	

Other Data Source(s) (Optional)

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
9) EHR (CureMD)	Yes	Yes	Daily	0	No	
10) FIMR (Swaddle)	Yes	No	Annually	12	No	
11) Lead (HHLPSS)	Yes	Yes	Daily	0	No	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

Data Source Name:	**5) Newborn Bloodspot Screening**
	Field Note: Effective April 2022, the NSP was moved to a different state agency; however, the ADPH continues to receive essential information through a data request process.
Data Source Name:	**6) Newborn Hearing Screening**
	Field Note: Effective April 2022, the NSP was moved to a different state agency; however, the Alabama Department of Public Health continues to receive essential information through a data request process.
Data Source Name:	**7) Hospital Discharge**
	Field Note: The Alabama Department of Public Health Office of Informatics & Data Analytics is working to begin the data request process for hospital discharge data in the year 2023.

Other Data Source(s) (Optional) Field Notes:

Data Source Name:	**9) EHR (CureMD)**
	Field Note: The SSDI Project Director/MCH Epidemiology Branch Director, Tim Feuser, has direct access to this data source.
Data Source Name:	**10) FIMR (Swaddle)**

State of Alabama
Maternal and Child Health Services Block Grant
2022 Annual Report/2024 Application

List of Attachments

Where Cited in Report/Application	***Description or Title***
Section I.A.	Letter of Transmittal
Section I.B.	Fact Sheet: Form SF424
Section I.C.	Submit Certify Page
Supporting Document #01	Organizational Charts
Supporting Document #02	Acronyms and Abbreviated Names
Supporting Document #03	State Action Plan Table

ALABAMA DEPARTMENT OF PUBLIC HEALTH
EST. 1875

Scott Harris, M.D., M.P.H.
STATE HEALTH OFFICER

June 1, 2023

HRSA Grants Application Center
ATTN: MCH Services Block Grant
910 Clopper Road, Suite 155 South
Gaithersburg, MD 20878

To Whom It May Concern:

On behalf of the Alabama Department of Public Health, I am submitting the State of Alabama's Maternal and Child Health Services Block Grant FY 2022 Annual Report and FY 2024 Application. The document is being submitted electronically using the web-based application format for the document. Per our understanding of the federal guidance, the document is now submitted entirely via the Web, and no paper copies of this letter or any part of the application are required.

Thank you for your consideration of this application. Please let me know if you need any additional information.

Sincerely,

Tommy Johnson, DMD
State Dental Director
Title V Interim Director

SF-424 - Part 1

216331: PUBLIC HEALTH, ALABAMA DEPARTMENT OF

Due Date: 7/31/2023 11:59:00 PM (Due in: 0 days) | Section Status: Complete

Resources

View

Application | Action History | Funding Opportunity Announcement | FOA Guidance | Application User Guide

✔ **SF-424 - Part 1** ✔ SF-424 - Part 2

Fields with are required

Applicant Information

Applicant Identifier	216331
Legal Name	PUBLIC HEALTH, ALABAMA DEPARTMENT OF
CRS Entity Identification Number (e.g. 1-53-2079819-A-2)	1-63-6000619-B-6
Employer Identification Number (e.g. 53-2079819)	63-6000619
Organizational UEI	**WDVJK7FUB8A6**

Mailing Address (Required)

Address Type: (●) Domestic Address ( ) International Address [Refresh]

Specify Domestic Address (Street Address or PO Box Only or Rural Route)

(●) **Address**	Street Number 201 Street Name Monroe St. Select One STE Number 1350
( ) **PO Box Only**	Number
( ) **Rural Route**	Type Select Route Number Box
City	MONTGOMERY (Required if Zip is not specified)
Urbanization	(Used only for Puerto Rico(PR))
State	AL (Required if City is specified)
Zip Code (Lookup)	36104 - 3773 (Required if City is not specified)

Organizational Unit

Department Name	Alabama Department of Public H
Division Name	Bureau of Family Health Service

Type of Applicant

Applicant Type 1	A: State Government
Applicant Type 2	Select Applicant Type
Applicant Type 3	Select Applicant Type
If "Other" then specify:	

Person to be contacted on matters involving this application

Title of Position	Name	Phone	Email	Options
	Tommy Johnson	(334) 206-5398	tommy.johnson@adph.state.al.us	Change

Go to Previous Page

Save | Save and Continue

SF-424 - Part 2

216331: PUBLIC HEALTH, ALABAMA DEPARTMENT OF

Due Date: 7/31/2023 11:59:00 PM (Due in: 0 days) | Section Status: Complete

Resources

View

Application | Action History | Funding Opportunity Announcement | FOA Guidance | Application User Guide

SF-424 - Part 1 **SF-424 - Part 2**

Fields with are required

Areas Affected by Project (Cities, Counties, States, etc.) (Maximum 1) Attach File

No documents attached

Descriptive Title of Applicant's Project	Maternal and Child Health Services

Project Description (Maximum 1) Attach File

No documents attached

Project Abstract

Project Abstract	Approximately 2 pages (Max 4000 Characters with spaces).

Congressional Districts

Applicant	AL-02
Program/Project	AL-All Districts

Additional Congressional District (Maximum 1) Attach File

No documents attached

Proposed Project Period

Start Date	10/1/2023
End Date	9/30/2025

Estimated Funding

Federal (This amount is populated from Budget Section A - Total Federal New or Revised Budget.)	$11,684,723.00
Applicant (This amount is populated from Budget Section C - Non Federal Resources.)	$0.00
State (This amount is populated from Budget Section C - Non Federal Resources.)	$37,841,184.00

Local (This amount is populated from Budget Section C - Non Federal Resources.)	$0.00
Other (This amount is populated from Budget Section C - Non Federal Resources.)	$1,577,948.00
Program Income (This amount is populated from Budget Section C - Non Federal Resources.)	$33,881,586.00
Total	$84,985,441.00

State Executive Order 12372 Process

Is Application Subject to Review by State Executive Order 12372 Process? (List of participating states)	○ This application was made available to the State under the Executive Order 12372 Process for review on ○ Program is subject to E.O. 12372 but has not been selected by the State for review. ◉ Program is not covered by E.O. 12372.
Is Applicant Delinquent of any Federal Debt?	○ Yes ◉ No If "Yes", attach an explanation **Federal debt delinquency explanation (Maximum 1)** Attach File No documents attached

Authorized Representative

Title of Position	Name	Phone	Email	Options
	Tommy Johnson	(334) 206-5398	tommy.johnson@adph.state.al.us	Change

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ge that your Word document has been successfully uploaded.

I to a

st up
e con

I certify assurances and certifications, as specified in Appendix F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

Certified by samille.jackson@adph.state.al.us on 7/31/2023 3:01:29 PM

Cancel

Action

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e file to this section. The following image file formats are allowed: TIFF, JPG, PNG, GIF

Certified

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III.A.1. Executive Summary_Program Overvi~1.docx

nds Complement State-Supported MCH Efforts

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III.A.2. Title V Funds & MCH Efforts _072~1.docx

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III.A.3. MCH Success Story_072723.docx

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Supporting Document

Topic	Page
Organizational Charts	Attachment

ALABAMA PUBLIC HEALTH

State Government

State Board of Health

State Committee of Public Health

State Health Officer
Scott Harris, MD, MPH

Public Health Administrative Officer
Catherine M. Donald, MBA

Children's Health Insurance
Teela Sanders, JD
Administrative Services, ADPH Health Policy, ALL Kids Customer Service, Customer Services/Community Education, Program Operations and Professional Services, Program Services

Facilities Management and Technical Services
Kristi Rollins (Acting)
Technical Services

Financial Services
Shaundra B. Morris, MAcc, CPM

Health Statistics
Nicole Rushing, MPH
Administrative Services, Quality Assurance and Registration, Record Services, Special Services, Statistical Analysis

Information Technology
Regina Patterson
Administration, Business and Information Architecture, Database Administration, Logistics, Project Management Support, Technical Support

Centralized Billing Unit
Arnita Shepherd

Chief Medical Officer
Karen Landers, MD, FAAP

District Medical Officers
East Central/West Central, Northern/Northeastern, Southeastern/Southwestern

Clinical Laboratories
Sharon P. Massingale, PhD, HCLD
Administrative Support Services, Clerical, Clinical Chemistry, Microbiology, Newborn Screening, Quality Management, Sanitary Bacteriology/ Media, STD/Serology, Mobile

Medical Officer, Disease Control and Prevention
Burnestine Taylor, MD

- **Communicable Disease**
  Harrison Wallace, MPH
  Immunization, Infectious Diseases and Outbreaks, STD Control, Tuberculosis Control

Medical Officer, Family Health Services
Gary Pugh, DO, FACOG

- **Family Health Services**
  Amanda Martin, MSPH
  Administration, Child and Adolescent Health, Cancer Prevention and Control, Child and Adolescent Health, Family Planning, Office of Women's Health, Oral Health, Perinatal Health, WIC

Medical Director, Health Provider Standards
Karen Landers, MD, FAAP (Acting)

- **Health Provider Standards**
  Denise Milledge
  Assisted Living, Medicare Other, Nursing Home, CLIA, Licensure, Certification

Home and Community Services
Choona Lang, BSN, MHA, DHEd
Accounts Payable, Accounts Receivable, Budget and Personnel, Home Care Services

HIV Prevention and Care
Sharon Jordan, BS, MPH

Informatics and Data Analytics
Sherri Davidson, PhD, MPH

General Counsel
Brian Hale, JD

Compliance

Chief of Staff
Michele Jones, MS

Emergency Medical Services
Jamie Gray, BS, AAS, NRP

Environmental Services
Sherry Bradley, MPA
Community Environmental Protection, Food/Milk Lodging

Prevention, Promotion, and Support
Jamey Durham, MBA
Behavioral Health, Emergency Preparedness, Health Media and Communications, Management Support, Nutrition and Physical Activity, Pharmacy, Primary Care and Rural Health, Wellness

Program Integrity
Debra Thrash, CPA, CIA

Radiation Control
David Turberville
Licensing and Registration, Environmental Radiation, Emergency Planning and Response, X-Ray Inspection, Radioactive Materials Inspection

Human Resources
Brent M. Hatcher, SPHR

Employee Relations
Civil Rights, ADA

Field Operations
Ricky Elliott, MPH

Local Health Services
Public Health Districts
County Health Departments

Clinical Management and Practice
Kaye Melnick, MSN, RN
Nursing, Social Work, Clerical, Electronic Health Record

Telehealth
April Golson

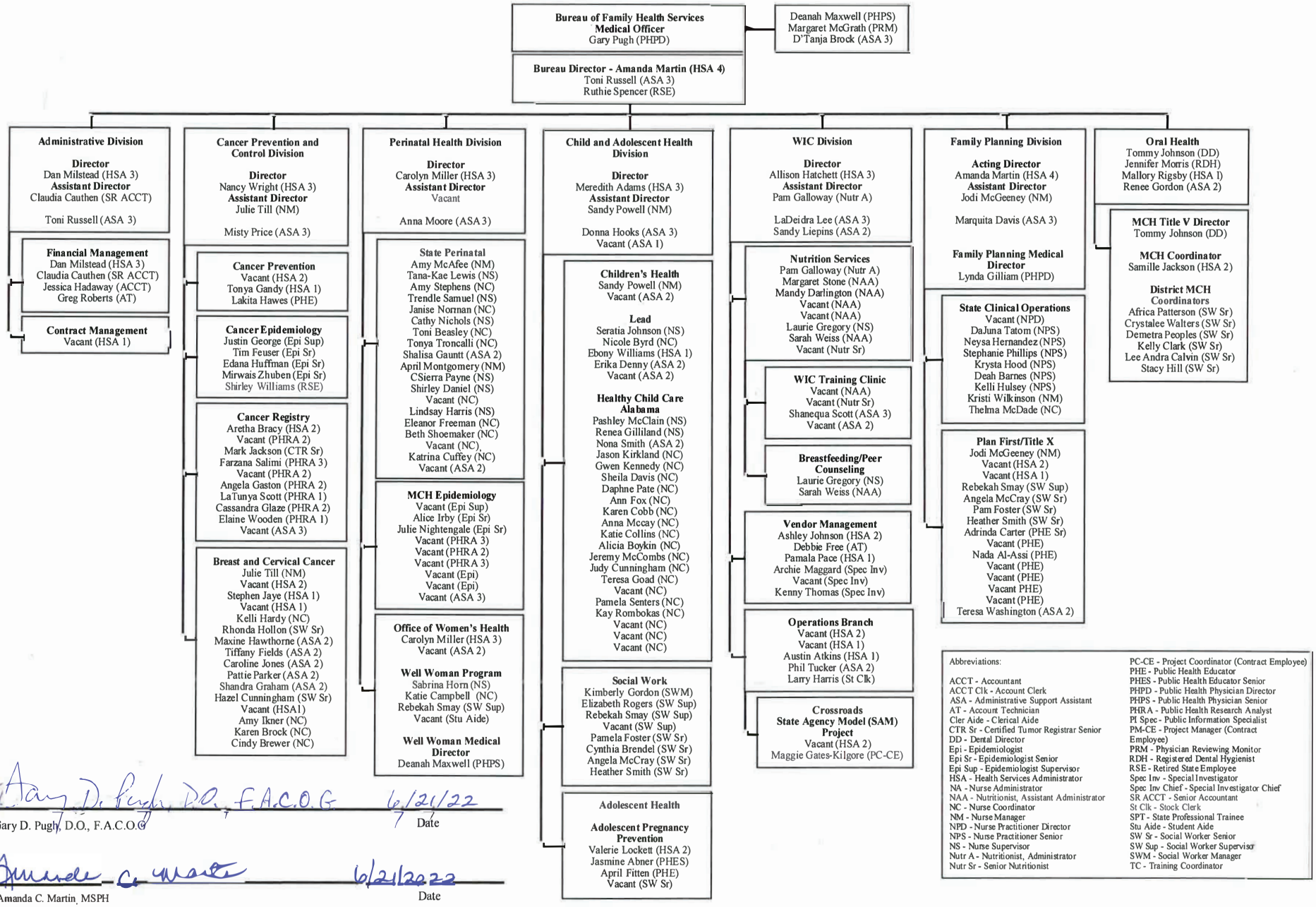
Governmental Affairs and Community Relations
Carolyn Bern, MPA

Health Equity and Minority Health

May 6, 2022

Scott Harris

State Health Officer



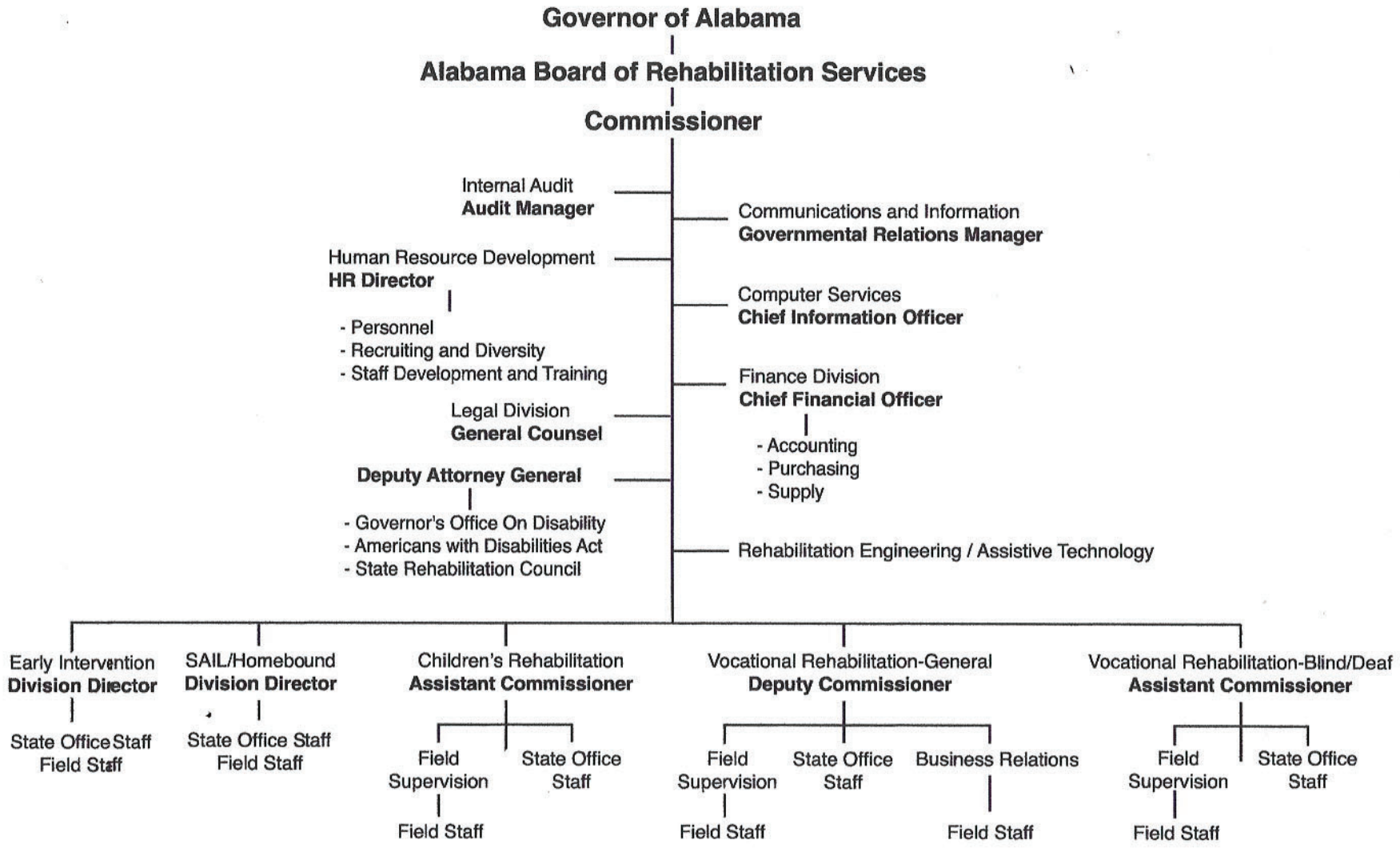
Gary D. Pugh, D.O., F.A.C.O.G. 6/21/22

Gary D. Pugh, D.O., F.A.C.O.G. Date

Amanda C. Martin 6/21/2022

Amanda C. Martin, MSPH Date

Alabama Department of Rehabilitation Services Organizational Chart



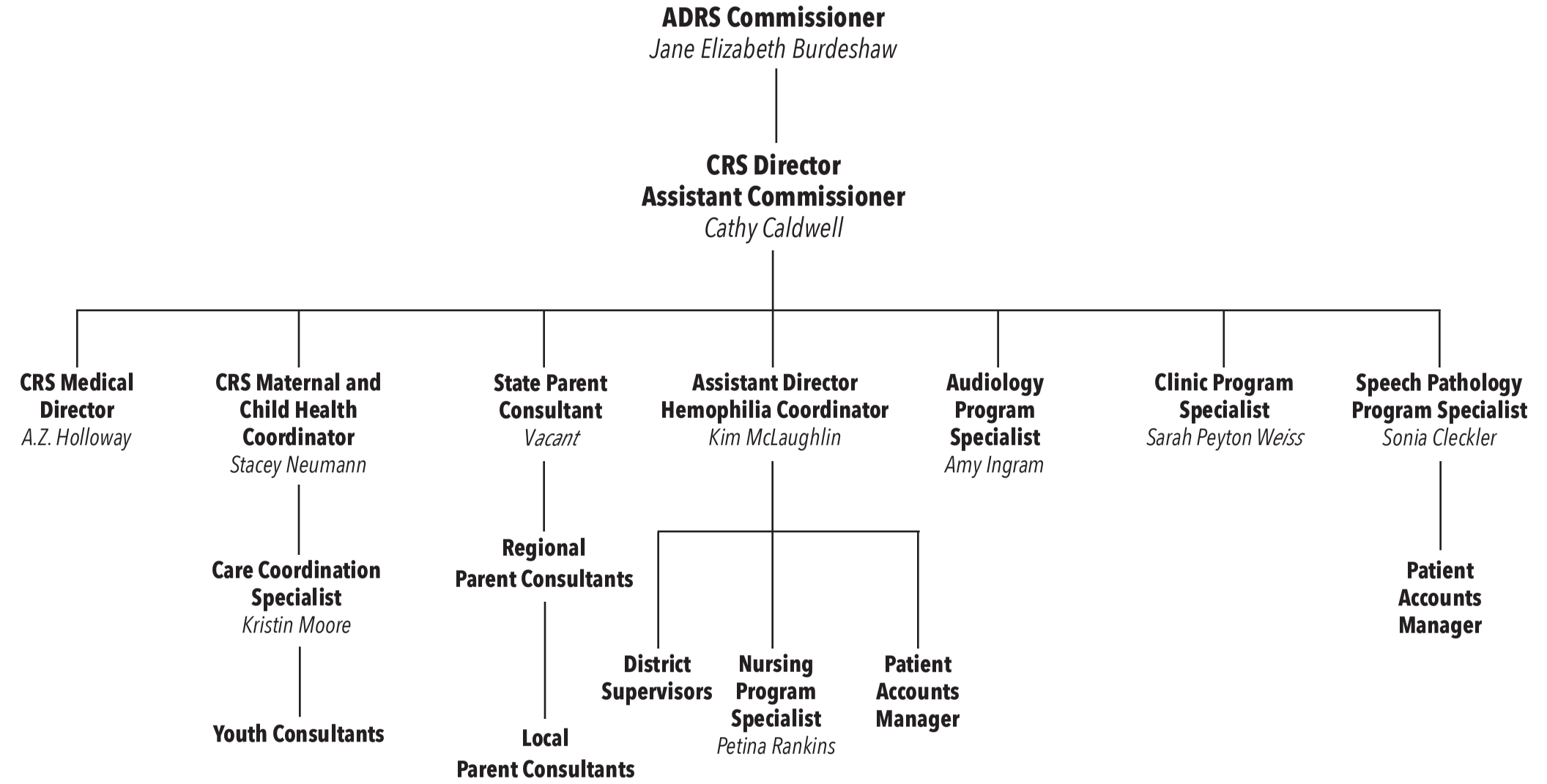
June 13, 2022
Commissioner, Alabama Department of Rehabilitation Services

ADRS

Alabama's children and adults with disabilities

Children's Rehabilitation Service

Organizational Chart



7/23

Supporting Document

Topic	Page
Acronyms and Abbreviated Names	Attachment

Acronyms and Abbreviated Names

Acronym/Name	***Explanation***
AAEP	Alabama Abstinence-Until-Marriage Education Program, Alabama Abstinence Education Program
AAP	American Academy of Pediatrics
AAPD	Alabama Chapter of the Academy of Pediatric Dentistry
ABC	Alabama Breastfeeding Committee
ABR	Auditory Brainstem Response, Auditory Brain Response
ACA	Affordable Care Act
ACAR	Alabama Coalition Against Rape
ACCF	Alabama Child Caring Foundation
ACCP	Alabama Child Caring Program
ACD	Augmentative Communication Devices
ACDD	Alabama Council on Developmental Disabilities
ACDRS	Alabama Child Death Review System
ACHIA	Alabama Child Health Improvement Alliance
ACHN	Alabama Coordinated Health Network
ACLPP	Alabama Childhood Lead Poisoning Prevention
ACMG	American College of Medical Genetics
ACOG	American College of Obstetricians and Gynecologists
ACS	American Community Survey
Adolescent Health Program	Adolescent and School Health Program (located in Family Health Services)
ADAP	Alabama Disabilities Advocacy Program
ADPH	Alabama Department of Public Health
ADRS	Alabama Department of Rehabilitation Services
AEAC	Applied Evaluation and Assessment Collaborative
AEMA	Alabama Emergency Management Agency
AFF	American Fact Finder
AHP	Adolescent Health Program
AIDS	Acquired Immune Deficiency Syndrome
Alabama Medicaid	Alabama Medicaid Agency
Alabama River Region	Montgomery, Lowndes, Autauga, Elmore, and Macon counties; central Alabama
AlaHA	Alabama Hospital Association
ALDA	Alabama Dental Association
ALL Kids	Alabama's State Children's Health Insurance Program
ALPQC	Alabama Perinatal Quality Collaborative
AMCHP	Association of Maternal and Child Health Programs
AMOD	Alabama Chapter of the March of Dimes
AOTF	Alabama Obesity Task Force
APEC	Alabama Parent Education Center
APPB	Adolescent Pregnancy Prevention Branch
APREP	Alabama Personal Responsibility Education Program
Area	Public Health Area
ARMS	Alabama Resource Management System
ARRA	American Recovery and Reinvestment Act
ASA	Administrative Support Assistant
ASCCA	Alabama's Special Camp for Children and Adults
ASL	American Sign Language
ASPARC	Alabama Suicide Prevention and Resource Coalition
ASQ-3	Ages and Stages Questionnaire
ASRAE	Alabama Sexual Risk Avoidance Education Program
ASTDD	Association of State and Territorial Dental Directors
ASTHO	Association of State and Territorial Health Officials
ATR	Alabama Trauma Registry
AYSPAP	Alabama Youth Suicide Prevention and Awareness Program
BAHA	Bone anchored hearing aid
BCBS	Blue Cross and Blue Shield of Alabama, Blue Cross Blue Shield of Alabama
BCL	Bureau of Clinical Laboratories

BI	Business Intelligence
Block Grant	MCH Title V Block Grant to States Program
BMI	Body Mass Index
BMT	Bureau of Family Health Services' Management Team
BPAR	Best Practice Approach Report
BPSS	Bureau of Prevention, Promotion & Support
BRFSS	Behavioral Risk Factor Surveillance System
BSS	Basic Screening Survey
Bureau	Bureau of Family Health Services
CAHMI	Child and Adolescent Health Measurement Initiative
CAHPS	Consumer Assessment of Healthcare Providers and Systems (r)
CAST-5	Capacity Assessment for State Title V
CAT	Community Action Team
CBER	Center for Business and Economic Research
CCHD	Critical Congenital Heart Disease
CCRS	Centralized Care Coordination Referral System, Care Coordination Referral System
CDC	U.S. Centers for Disease Control and Prevention
CDH	Child Death Review
Census	U.S. Census, U. S. Census Bureau
CEP	Center for Emergency Preparedness
CER	Comparative Effectiveness Research
CHARMS	Children's Health and Resource Management System
CHD	County Health Department
CHIP	Federal Children's Health Insurance Program, Alabama's State Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act
CHS	Center for Health Statistics
CHW	Community Health Workers
CI	Confidence Interval
CJIC	Criminal Justice Information Center
CMC CoIIN	Children with Medical Complexity Collaborative Improvement and Innovation Network
CMS	Centers for Medicare and Medicaid Services (located in the U.S. Dept. of Health and Human Services)
CPoC	Comprehensive Plan of Care
COA	Children's Hospital of Alabama
COBRA	Consolidated Omnibus Budget Reconciliation Act
COIIN	Collaborative Improvement and Innovation Network to Reduce Infant Mortality
COOP	Continuity of Operations Plan
COVID-19	Coronavirus Disease 2019
CPC	Children's Policy Council
CRS	Children's Rehabilitation Service
CRT	Case Review Team
CSHCN	Children with Special Health Care Needs
CVB	Cash Value Benefit
CY	Calendar Year
CYSHCN	Children and Youth with Special Health Care Needs
Data Resource Center	Data Resource Center for Child & Adolescent Health
DCA	Department of Children's Affairs
DCCs	District Coordinating Councils
DDU	Disability Determination Unit
DECA	Department of Economic and Community Affairs
DECE	Alabama Department of Early Childhood Education
Department	Alabama Department of Public Health
DHHS	U.S. Department of Health and Human Services
DHR	Alabama Department of Human Resources
Dietary Guidelines	Dietary Guidelines for America
DME	Durable Medical Equipment
DMH	Alabama Department of Mental Health
DOSE	Direct On Scene Education
EBT	Electronic Benefit Transfer
ECCS	Early Childhood Comprehensive Systems

ECD	East Central Public Health District
e.g.	For Example
EHBs	Electronic Handbooks
EHCC	Eco-Healthy Child Care
EHS	Early Head Start
EHSCCP	Early Head Start Child Care Partnership
EI	Early Intervention Program
EIS	Alabama Early Intervention System
EBLL	Elevated Blood Lead Level
ECD	East Central Public Health District
EMSC	Emergency Medical Services for Children
EMST	Emergency Medical Services and Trauma
EOP	Emergency Operations Plan
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment; Early Periodic Screening, Diagnosis, and Treatment
ESMs	Evidence-Based or –Informed Strategy Measures
ESF	Emergency Support Functions
ETF	Education Trust Fund
EWSE	Every Woman Southeast
F2F HIC	Family to Family Health Information Center
FAD	Federally-Available Data
FAND	Functional and Access Needs in Disasters
FDO	From Day One
FES	Family Engagement in Systems
FESAT	Family Engagement in Systems Assessment Tool
FH	Family Health
FHS	Bureau of Family Health Services, Family Health Services
FIMR	Fetal/Infant Mortality Review, Fetal and Infant Mortality Review Program
FIT	Fecal Immunochemical Test
FMAP	Federal Medical Assistance Percentages
Form SF424	The Face Sheet
FP	ADPH Family Planning Program
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FTE	Full Time Equivalent
FTP	File Transfer Protocol
FVA	Family Voices of Alabama
FY	Fiscal Year
FY 2014-15 Needs Assessment	FY 2014-15 5-Year Statewide MCH Needs Assessment
GAL	Get a Healthy Life Campaign, Get a Life
GPRA	Government Performance and Results Act
Governor	Governor of the State of Alabama
HBsAg	An antigen produced by the hepatitis B virus
HBWW	Healthy Babies are Worth the Wait
HCCA	Healthy Child Care Alabama
HCFA	Health Care Financing Administration
Health Homes	Medicaid Networks
HEDIS	Health Plan Employer Data and Information Set
HI-5	U.S. Census Bureau's Historical Health Insurance Table 5, original version
HIA-5	U.S. Census Bureau's Historical Health Insurance Table 5, revised version
HIE	Health Information Exchange
HIV	Human Immunodeficiency Virus
HIPAA	Health Insurance Portability and Accountability Act
HOH	Hard of Hearing
House	Alabama House of Representatives
HPCD	Bureau of Health Promotion and Chronic Disease, Health Promotion and Chronic Disease
HPSAs	Health Professionals Shortage Areas
HPV	Human Papillomavirus Vaccines
HRSA	U.S. Health Resources and Services Administration

HSCI	Health Systems Capacity Indicator
HSI	Health Status Indicator
ICC	Interagency Coordinating Council
i.e.	That Is
IEP	Individualized Education Plan
IFSP	Individualized Family Service Plan
ImmPrint	Immunization Provider Registry with Internet Technology, Immunization on Provider Registry with Internet Technology
IMR	Infant Mortality Rate
IBCLC	International Board Certified Lactation Consultants
IT	Information Technology
IUD	Intrauterine Device
JCDH	Jefferson County Department of Health
JCIH	Joint Committee on Infant Hearing
LEAH	Leadership and Education in Adolescent Health
LPACs	Local Parent Advisory Committees, CRS Local Parent Advisory Committees
LARCs	Long-Acting Reversible Contraceptives
LGBTQ	Lesbian, Gay, Bisexual, Transgender, or Questioning
LOCATe	Level of Care Assessment Tool
LPC	Local Parent Consultant
MAR	Medically at Risk
MCADD	Medium-chain Acyl-CoA Dehydrogenase Deficiency
MCH	Maternal and Child Health
MCHB	Maternal and Child Health Bureau (located in federal Health Resources and Services Administration)
MCHD	Mobile County Health Department
MCH Epi	MCH Epidemiology Branch
MCH Epi Branch	Maternal and Child Health Epidemiology Branch (located in the Bureau of Family Health Services)
MCH Leadership Team	MCH Needs Assessment Leadership Team
MCH Needs Assessment Report	Statewide 5-Year Maternal and Child Health Needs Assessment Report, Alabama, FY 2009-10 MCH
MCTF	Mass Care Task Force
Pyramid	Pyramid developed by MCHB, depicting 4 levels of service
MCH Reports/Applications	Maternal and Child Health Block Grant Services Reports/Applications
MCH Title V funds	Maternal and Child Health Services Block Grant funds, MCH Services Block Grant Funds
MCH 2009 Report/2011 Application	Alabama Maternal and Child Health Services Block Grant FY 2009 Annual Report/FY 2011 Application
MCHD	Mobile County Health Department
Medicaid	Alabama Medicaid Agency
MMA	Methylmalonic Acidemia
MMRC	Maternal Mortality Review Committee
MOU	Memorandum of Understanding
NASHP	National Academy for State Health Policy
NCQA	National Committee for Quality Assurance
NED	Northeastern Public Health District
Needs Assessment Report	Statewide 5-Year Maternal and Child Health Needs Assessment Report, Alabama, FYs 2009-10 Needs Assessment/2009-10 Needs Assessment State of Alabama FYs 2009-10 Maternal and Child Health Needs Assessment
NFP	Nurse Family Partnership
NICHD	Eunice Kennedy Shriver National Institute of Child Health and Human Development
NICU	Neonatal Intensive Care Unit
NIEER	National Institute for Early Education Research
NOM	National Outcome Measure
NP	Nurse Practitioner
NPM	National Performance Measure
NSCH	National Survey of Children's Health
NSCH-CSHCN	National Survey of Children with Special Health Care Needs
NBHS	Newborn Hearing Screening
NBS	Newborn Screening
NFP	Nurse Family Partnership

OHB	Oral Health Branch
OHCA	Oral Health Coalition of Alabama
OHO	Oral Health Office
OMW/NAS	Alabama Opioid Misuse in Women/Neonatal Abstinence Syndrome
OPCRH	Office of Primary Care and Rural Health
OT	Occupational Therapist
OWH	Office of Women's Health
PAT	Parents as Teachers
PC	Parent Consultants
PCCM	Primary Care Case Management
PCI	Poarch Band of Creek Indians
PCOR	Patient Centered Outcome Research
PCP	Primary Care Provider
PCOS	Poly Cystic Ovarian Syndrome
PCRH	The Office of Primary Care and Rural Health
PedNSS	Pediatric Nutrition Surveillance System
PHA	Public Health Area
PHALCON	Public Health of Alabama County Operations Network
PHE	Public Health Emergency
PKU	Phenylketonuria
Plan First	Family Planning Medicaid Waiver
PoC	Plan of Care
PPE	Personal Protective Equipment
PRAMS	Pregnancy Risk Assessment Monitoring System
PREP	Personal Responsibility Education Program
Project HOPE	Project Harnessing, Opportunity for Positive, Equitable early childhood development
PT	Physical Therapist
QPR	Question -Persuade-Refer
RCO	Regional Care Organization, Medicaid Reform
RDH	Registered Dental Hygienist
RNPC	Regional Nurse Perinatal Coordinator
ROSE	Reaching Our Sisters Everywhere
ROV	Record of Visit
RPACs	Regional Perinatal Advisory Committees
RWJ	Robert Wood Johnson
SAIL	State of Alabama Independent Living Program
SAIMRP	State of Alabama Infant Mortality Reduction Plan
SAM	Crossroads State Agency Model
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SCHIP	State Children's Health Insurance Program (also called ALL Kids)
School of Dentistry	University of Alabama School of Dentistry in Birmingham
SCID	Severe Combined Immunodeficiency
SDE	State Department of Education
SED	Southeastern Public Health District
SHARP	Sexual Health and Adolescent Risk Prevention
SHPDA	State Health Planning and Development Agency
SIDS	Sudden Infant Death Syndrome
SLPs	Speech Language Pathologists
SNAP	State Nutrition Action Plan
SOAP	Subjective, Objective, Assessment, and Plan
SOBRA	Sixth Omnibus Budget Reconciliation Act
SOM	State Outcome Measure
SOPH	School of Public Health
SPAC	State Perinatal Advisory Committee
SPAC	State Parent Advisory Committee
SPC	State Parent Consultant
SPM	State Performance Measure
SPoC	Shared Plan of Care

SPP	State Perinatal Program
SPTF	Alabama State Suicide Prevention Task Force
SRV	Secure Remote Viewer
SSA	Social Security Administration
SSDI	State Systems Development Initiative
SSI	Supplemental Security Income
STAR	Alabama's Assistive Technology Resource Program
State	State of Alabama
STEP	Staging Transition for Every Patient
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
SUID	Sudden Unexpected Infant Death
SUDI	Sudden Unexpected Death in Infancy
SWD	Southwestern Public Health District
TANF	Temporary Assistance to Needy Families
TBI	Traumatic Brain Injury
Tdap	Tetanus-diphtheria-acellular pertussis vaccine
TFQ	Together for Quality Grant, administered by the Alabama Medicaid Agency
Title V	MCH Title V
TM	Trademark
TMS	Tandem Mass Spectrometry
TTC	Teen Transition Clinic
TVIS	Title V Information System
UAB	University of Alabama at Birmingham
UCP	United Cerebral Palsy
UNHS	Universal Newborn Hearing Screening
U.S.	United States of America
USA	University of South Alabama
USA PCCC	University of South Alabama Pediatric Complex Care Clinic
USDA	United States Department of Agriculture
VFC	Vaccines for Children
VLBW	Very Low Birth Weight
VLCAD	Very Long–chain Acyl-CoA Dehydrogenase Deficiency
VRS	Vocational Rehabilitation Service
WCD	West Central Public Health District
WIC	Special Supplemental Nutrition Program for Women, Infants and Children; Women, Infants, and Children
WOW	Women on Wellness
WW	Well Woman
YAC	Youth Advisory Committee
YC	Youth Consultants
YLF	Youth Leadership Forum
YRBSS	Youth Risk Behavior Survey System
YSHCN	Youth with Special Health Care Needs
2009-10 MCH Needs Assessment Report	Statewide 5-Year Maternal and Child Health Needs Assessment Report, Alabama, FYs 2009-10
2009-10 Needs Assessment	State of Alabama FYs 2009-10 Maternal and Child Health Needs Assessment
2009-10 Needs Assessment Report	Statewide 5-Year Maternal and Child Health Needs Assessment Report, Alabama, FYs 2009-10
2009-10 Nutrition Education Plan	FY 2009-10 WIC Nutrition Education Plan
2011-12 Nutrition Education Plan	FY 2011-12 WIC Nutrition Education Plan
416 Report	Form CMS-416: Annual EPSDT Participation Report, provided by the Alabama Medicaid Agency

Supporting Document

Topic	Page
State Action Plan Table	Attachment

Alabama State Action Plan Table 2024 Application/2022 Annual Report

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
Women/Maternal Health					
Lack of preventive dental visits across all Title V populations, especially for those uninsured.	Educate and reach out to oral health providers to improve understanding of preventive dental visits during pregnancy and through ads utilizing television, streaming, and social media platforms. Promote HPV education, and HPV vaccine education, promotion and referral using the #WATCHYOURMOUTH campaign developed through a partnership with Mitchell Cancer Institute.	By 2025, increase the percentage of dental providers who receive education on the importance of preventive dental visits for expectant mothers by 10 percent. By 2025, increase the percentage of dental providers who are provided education and support on the provision/referral for HPV vaccine by 10 percent. (create a provider Services survey and gather baseline data.)	NPM 13.1: Percent of women who had a preventive dental visit during pregnancy	ESM 13.1.1: Percentage of dental providers receiving information/education regarding importance of preventive dental visits for expectant mothers ESM 13.1.2: Percentage of dental providers that received information/education regarding their perinatal patients about the FDA-approved HPV vaccine in order to reduce the risk of oropharyngeal, cervical, and other HPV-related cancers	NOM 14: Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 19: Percent of children, ages 0 through 17, in excellent or very good health
High levels of maternal mortality.	Offering more classes for women participants in WIC in counties with higher rates of maternal mortality than the state rate or in at least 5 counties.	Provide routine classes, to women participants, that promote health, breastfeeding, safe sleep, and make referrals to other programs that impact maternal mortality.	NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	***Inactive -*** *ESM 1.1: Proportion of women age 15-55 who report receiving a preventive medical visit in the past 12 months by increasing total enrollment percentage*	NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations NOM 3: Maternal mortality rate per 100,000 live births NOM 4: Percent of low birth weight

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
				in the Well Woman Program by 2 points annually. ESM 1.2: Increase the percentage of women receiving both FP services and WW services by 2 percent within active WW counties.	deliveries (<2,500 grams) NOM 5: Percent of preterm births (<37 weeks) NOM 6: Percent of early term births (37, 38 weeks) NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.4: Preterm-related mortality rate per 100,000 live births NOM 10: Percent of women who drink alcohol in the last 3 months of pregnancy NOM 11: Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females NOM 24: Percent of women who experience postpartum depressive symptoms following a recent live birth

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
Perinatal/Infant Health					
High levels of infant mortality (and associated factors of preterm birth and low birth weight).	Convene the delivering hospitals to share data and discuss the Alabama Perinatal Regionalization System Guidelines.	Increase the percent of delivering hospitals convened at a meeting to share data and discuss the Alabama Perinatal Regionalization System Guidelines.	NPM 3: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)	ESM 3.1: Percent of delivering hospitals convened at a meeting to share data and discuss the Alabama Perinatal Regionalization System Guidelines ESM 3.2: Number of steps of the CDC's LOCATe process completed in order to design and align the Alabama Perinatal Regionalization System Guidelines with the national criteria for the maternal levels of care	NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate per 1,000 live births NOM 9.4: Preterm-related mortality rate per 100,000 live births
High levels of infant mortality (and associated factors of preterm birth and low birth weight).	Implement the CDC's Level of Care Assessment Tool (LOCATe) process in order to align and implement the national criteria for the maternal levels of care.	Complete the steps of the CDC's Level of Care Assessment Tool (LOCATe) process in order to design and align the Alabama Perinatal Regionalization System Guidelines with the national criteria for the maternal levels of care.	NPM 3: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)	ESM 3.1: Percent of delivering hospitals convened at a meeting to share data and discuss the Alabama Perinatal Regionalization System Guidelines ESM 3.2: Number of steps of the CDC's LOCATe process completed in order to design and align the Alabama Perinatal	NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate per 1,000 live births NOM 9.4: Preterm-related mortality rate per 100,000 live births

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
				Regionalization System Guidelines with the national criteria for the maternal levels of care	
High levels and worsening trends of sleep-related/SUID deaths.	Provide safe sleep education to WIC prenatal participants in order to increase the percent placing their infants to sleep on their backs.	Increase by 5 percent annually, the percentage of WIC prenatal participants placing their infants to sleep on their backs by providing safe infant sleep education.	NPM 5: A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding	***Inactive -*** *ESM 5.1: Number of sleep-related infant deaths* ESM 5.2: Number of trainings facilitated to assist healthcare professionals and first responders, who interact with expecting and new mothers, with being trained on safe sleep recommendations	NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.5: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births
High levels and worsening trends of sleep-related/SUID deaths.	Implement targeted consistent safe sleep education to caregivers, child health providers, health care providers, and hospital systems.	Decrease by 3 percent annually, the number of sleep-related infant deaths by implementing targeted consistent safe sleep education to caregivers, child health providers, health care providers, and hospital systems.	NPM 5: A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding	***Inactive -*** *ESM 5.1: Number of sleep-related infant deaths* ESM 5.2: Number of trainings facilitated to assist healthcare professionals and first responders, who interact with expecting and new mothers, with being trained on safe sleep recommendations	NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.5: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births
High levels and worsening trends of sleep-	Facilitate trainings to assist healthcare professionals and first responders, who interact with expecting and new mothers, with being trained on safe sleep recommendations.	Increase by 25 percent annually, the number of trainings facilitated to assist healthcare professionals and first responders, who interact	NPM 5: A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a	***Inactive -*** *ESM 5.1: Number of sleep-related infant deaths*	NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
related/SUID deaths.		with expecting and new mothers, with being trained on safe sleep recommendations.	separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding	ESM 5.2: Number of trainings facilitated to assist healthcare professionals and first responders, who interact with expecting and new mothers, with being trained on safe sleep recommendations	rate per 1,000 live births NOM 9.5: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births
Child Health					
Lack of preventive dental visits across all Title V populations, especially for those uninsured.	Provide educational preventive dental materials and oral health kits to patients and providers, and promotion of importance of preventive dental visits via the annual “Share Your Smile with Alabama” smile contest. Promote HPV education, and HPV vaccine education, promotion, and referral using the #WATCHYOURMOUTH campaign developed through a partnership with Mitchell Cancer Institute.	By 2025 increase the number of dental providers who receive education on the importance of preventive dental visits for children ages 1-17 years by 10 percent. By 2025, increase the percentage of dental providers who are provided education and support on the provision/referral for HPV vaccine by 10 percent. (create a provider Services survey and gather baseline data.)	NPM 13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	ESM 13.2.1: Percentage of providers receiving information/education regarding importance of preventive dental visits for children ages 1-17 years of age ESM 13.2.2: Percentage of dental providers that received information/education regarding informing their families of patients at 9 years of age about the FDA-approved HPV vaccine in order to prevent future oropharyngeal, cervical, and other HPV-related cancer	NOM 14: Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 19: Percent of children, ages 0 through 17, in excellent or very good health
Lack of timely,	Increase EPSDT sreenings in the county health departments.	Increase by 1 percent the total	NPM 6: Percent of	***Inactive -*** *ESM 6.1:*	NOM 13: Percent of children

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
appropriate, and consistent health and developmental screenings.		number of EPSDT screenings performed in county health departments annually.	children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	*Proportion of children birth to age 19 that received a well child appointment in the past year* ***Inactive -*** *ESM 6.2: Proportion of children birth to age 19 that received a developmental screening in conjunction with a well-child appointment in the past year* ESM 6.3: Proportion of children aged 12 & 24 months that have a reported blood lead screening in the past year ESM 6.4: Proportion of children birth to age 19 that received a well child appointment in the past year	meeting the criteria developed for school readiness (DEVELOPMENTAL) NOM 19: Percent of children, ages 0 through 17, in excellent or very good health
Lack of timely, appropriate, and consistent health and developmental screenings.	Partner with Alabama Partnership for Children (APC) and Help Me Grow to monitor the number of developmental screenings.	Increase by 1% the total number of children birth to age 5 that receive the ASQ-3.	NPM 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	***Inactive -*** *ESM 6.1: Proportion of children birth to age 19 that received a well child appointment in the past year* ***Inactive -*** *ESM 6.2: Proportion of children birth to age 19 that*	NOM 13: Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) NOM 19: Percent of children, ages 0 through 17, in excellent or very good health

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
				received a developmental screening in conjunction with a well-child appointment in the past year ESM 6.3: Proportion of children aged 12 & 24 months that have a reported blood lead screening in the past year ESM 6.4: Proportion of children birth to age 19 that received a well child appointment in the past year	
Lack of timely, appropriate, and consistent health and developmental screenings.	Consistently referring children in health departments where EPSDT is provided or to their health care provider in countries that do not offer EPSDT.	Ensure that all WIC participants benefit from EPSDT.			
Lack of timely, appropriate, and consistent health and developmental screenings.	Due to the increasing numbers of suicide in children/adolescents and failure to identify mental health concerns in children and adolescents proactively, partner with Suicide Prevention to incorporate questions related to mental health in initial and updated medical history questionnaires in an effort to identify potential mental health concerns.	Intervene/refer patients identified as having mental health concerns/suicidal tendencies to appropriate healthcare professionals.			
Lack of timely, appropriate, and consistent health and developmental screenings.	Increase the percentage of two year old children who were screened for lead poisoning at their 12 and 24 month follow-up visit.	Until more data is available, to maintain the percentage of two year old children who have received two blood lead tests at 12 and 24 months as recommended by the Alabama Childhood Lead Poisoning Prevention Program to	SPM 9: Percent of 2 year old children who have received two blood lead tests at 12 and 24 months as recommended by the ACLPP Program		

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
		at least 20 percent.			
Adolescent Health					
Lack of preventive dental visits across all Title V populations, especially for those uninsured.	Promote HPV education and HPV vaccine education, promotion, and referral using the #WATCHYOURMOUTH campaign developed through a partnership with Mitchell Cancer Institute.	By 2025 increase the number of dental providers who receive education on the importance of preventive dental visits for children ages 1-17 years by 10 percent. By 2025, increase the percentage of dental providers who are provided education and support on the provision/referral for HPV vaccine by 10 percent. (create a provider Services survey and gather baseline data.)	NPM 13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	ESM 13.2.1: Percentage of providers receiving information/education regarding importance of preventive dental visits for children ages 1-17 years of age ESM 13.2.2: Percentage of dental providers that received information/education regarding informing their families of patients at 9 years of age about the FDA-approved HPV vaccine in order to prevent future oropharyngeal, cervical, and other HPV-related cancer	NOM 14: Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 19: Percent of children, ages 0 through 17, in excellent or very good health
Lack of timely, appropriate, and consistent health and developmental screenings.	Increase EPSDT screenings in the county health departments.	Increase by 1 percent the total number of EPSDT screenings performed in county health departments annually.	NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.	***Inactive -*** *ESM 10.1: Proportion of adolescents, aged 12 to 19, that received an adolescent well visit in the past year* ESM 10.2: Proportion of adolescents, aged 12 to 19, that received	NOM 16.1: Adolescent mortality rate ages 10 through 19, per 100,000 NOM 16.2: Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 NOM 16.3: Adolescent suicide rate, ages 15 through 19, per

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
				an adolescent well visit in the past year	100,000 NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling NOM 19: Percent of children, ages 0 through 17, in excellent or very good health NOM 20: Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) NOM 22.2: Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza NOM 22.3: Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine NOM 22.4: Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine NOM 22.5: Percent of adolescents,

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
					ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females
Children with Special Health Care Needs					
Lack of or inadequate access to services necessary for CSHCN to transition to all aspects of adult life.	The state CSHCN program staff, including the Parent Consultant, will conduct a transition readiness assessment at age 14 using a standardized tool, administered periodically, and discuss needed self-care skills and changes in adult-centered care. The state CSHCN program staff, including the Parent Consultant, will incorporate transition planning into their existing plan of care, starting at age 14 partnering with youth and families in developing transition goals and preparing and updating a medical summary and emergency care plan. Provide education to families about Teen Transition clinic and the benefits of attending. Provide education to staff to guide implementation of transition strategies. The state CSHCN program staff will identify adult providers to accept program clients, complete a transfer package for youth leaving the program and follow-up with the provider regarding the YSHCN's transfer status. Obtain feedback on transition experience of young adults.	By 2025, increase the total score on the Six Core Elements of Health Care Transition™ 3.0 Current Assessment of Health Care Transition Activities for Transitioning Youth to an Adult Health Care Clinician from baseline to 90% (Baseline = FY 2020 total score of 68.75%). By 2025, increase the number of attendees at CRS Teen Transition clinic by 25% (Baseline = FY 2020 total attendees of 54).	NPM 12: Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care	ESM 12.1: Percent of YSHCN enrolled in State CSHCN program who report satisfaction with their transition experience to adulthood.	NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
Lack of or inadequate access to health and related services, especially in rural areas and for services identified as difficult to obtain.	Develop and implement a survey for families to assess the comprehensiveness of and satisfaction with CRS Care Coordination services and connection to community resources. Utilize information from the surveys to improve the quality of care coordination for CYSHCN. Educate families on the importance of care coordination and its value in improving health care outcomes for CYSHCN through developing a Care Coordination Program fact sheet. Train CRS care coordinators to use a family and person-centered approach to care plan development. Ensure that families of CYSHCN have access to and are educated about the importance of connection to a medical home. Expand outreach activities to promote public awareness of CRS Care Coordination Services within the medical community and among families of CYSHCN. Develop an internal tracking mechanism for referrals to community resources for CYSHCN not enrolled with CRS.	By 2025, increase by 10 percent the number of families of CYSHCN in the program who report receiving comprehensive care coordination.	SPM 3: Increase the capacity of families to connect CYSHCN to the health and human services they require for optimal behavioral, developmental, health, and wellness outcomes through our Care Coordination Program.		
Increase family and	Administer the FESAT to assess progress on strengthening family/youth engagement within CRS. Incorporate the four domains of Family	By 2025, increase the Engagement Score on the Family Engagement	SPM 2: Strengthen and enhance family/youth		

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
youth involvement and participation in advisory groups, program development, policy-making, and system building activities.	Engagement into staff development activities through the development of a Family Engagement Quality Improvement Initiative action plan within each CRS District. Conduct ongoing monitoring of District action plans to ensure incorporation of the four domains of Family Engagement. Utilize alternative methods to increase parent and youth involvement in advisory groups and program development i.e. Zoom meetings, Facebook Live meetings, and conference calls. Develop and conduct a Family Leadership Training Institute. Develop or modify a Family/Youth Partnership outreach campaign aimed at healthcare providers and related professionals to teach about the importance of engaging families/youth in the decision-making process. Utilize the Family/Youth Partnership outreach campaign materials at professional conferences and other community events.	in Systems Assessment Tool (FESAT) by 10% above the baseline (baseline to be established in FY 2021). By 2025 the first cohort of participants will have completed the Family Leadership Training Institute.	partnerships, involvement and engagement in advisory groups, program development, policymaking, and system-building activities to support shared decision making between families and health-related professionals.		
Cross-Cutting/Systems Building					
Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they live, learn, work, and play.	Increase the proportion of WW preventative visits in all program specific counties for women ages 15-55 and educating the public in all program specific counties of available WW services.	Increase the number of WW visits performed at the local county health departments; Increase public awareness of program via social media & marketing materials.			
Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they	Recruit women ages 15-55 to the WW program for cardiovascular disease risk factor screenings, healthy life/reproductive health planning (interconception and preconception care), health coaching and nutritional counseling.	Each county participating in WW program will establish a particular day of the week to offer WW services at the county health departments; WW staff will continue to assist identified at-risk women in having healthy pregnancies to avoid poor birth outcomes.			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
live, learn, work, and play.					
Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they live, learn, work, and play.	WW program will provide risk reduction counseling to help clients understand their risks, health coaching to set goals for behavioral change, and offer nutritional counseling and support to WW participants to help discover healthy lifestyle behaviors.	Program will continue to offer monthly support group meetings coordinated by social workers; nutritional classes per registered dietitian; and physical activity incentives, such as YMCA memberships, and through partnership with ADPH Nutrition and Physical Activity Division.			
Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they live, learn, work, and play.	Program will recruit all women aged 15-55 residing in counties participating in the WW program via marketing materials and social media.	Continue to partner with community partners in selected counties for referrals into the program; increase the number of community partners in all counties participating in WW program to increase enrollment and broaden ethnicity of participants.			
Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life	WW Program will continue to use Spanish speaking marketing materials to recruit population and offer Spanish literature for education and healthy lifestyle behaviors.	Increase & continue distribution of Spanish marketing materials to recruit Spanish speaking women aged 15-55.			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
where they live, learn, work, and play.					
Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they live, learn, work, and play.	Target underinsured and/or uninsured women, ages 15-55, to enroll in WW program.	Encourage/provide wellness visit to women, ages 15-55, who report not having a preventative visit in the last year regardless of insurance status.			
Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they live, learn, work, and play.	Increase the number of early head start programs that accept children with disabilities.	Increase the number of early head start programs that accept children with disabilities by one provider per year.	SPM 5: Increase the proportion of EHS programs participating in the EHSCCP grant program that maintain 10 percent of their population with children with special needs.		