Maternal and Child Health Services Title V Block Grant

Alabama

FY 2021 Application/ FY 2019 Annual Report

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Table of Contents

I. General Requirements 5

I.A. Letter of Transmittal 5

I.B. Face Sheet 6

I.C. Assurances and Certifications 6

I.D. Table of Contents 6

II. Logic Model 6

III. Components of the Application/Annual Report 7

III.A. Executive Summary 7

III.A.1. Program Overview 7

III.A.2. How Federal Title V Funds Support State MCH Efforts 12

III.A.3. MCH Success Story 12

III.B. Overview of the State 13

III.C. Five-Year Needs Assessment Summary (as submitted with the FY 2021 Application/FY 2019 Annual Report) 22

III.C.2.a. Process Description 22

III.C.2.b. Findings 24

III.C.2.b.i. MCH Population Health Status 24

III.C.2.b.ii. Title V Program Capacity 28

III.C.2.b.ii.a. Organizational Structure 28

III.C.2.b.ii.b. Agency Capacity 28

III.C.2.b.ii.c. MCH Workforce Capacity 31

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination 34

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures 36

III.D. Financial Narrative 40

III.D.1. Expenditures 42

III.D.2. Budget 47

III.E. Five-Year State Action Plan 51

III.E.1. Five-Year State Action Plan Table 51

III.E.2. State Action Plan Narrative Overview 52

III.E.2.a. State Title V Program Purpose and Design 52

III.E.2.b. Supportive Administrative Systems and Processes 54

III.E.2.b.i. MCH Workforce Development 54

III.E.2.b.ii. Family Partnership 56

III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts 59

III.E.2.b.iv. Health Care Delivery System 60
III.E.2.c State Action Plan Narrative by Domain 63
Women/Maternal Health 63
Perinatal/Infant Health 89
Child Health 112
Adolescent Health 132
Children with Special Health Care Needs 150
Cross-Cutting/Systems Building 176
III.F. Public Input 197
III.G. Technical Assistance 199
IV. Title V-Medicaid IAA/MOU **200**
V. Supporting Documents **201**
VI. Organizational Chart **202**
VII. Appendix **203**
Form 2 MCH Budget/Expenditure Details 204
Form 3a Budget and Expenditure Details by Types of Individuals Served 212
Form 3b Budget and Expenditure Details by Types of Services 214
Form 4 Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated 217
Form 5 Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V 223
Form 6 Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX 227
Form 7 State MCH Toll-Free Telephone Line and Other Appropriate Methods Data 230
Form 8 State MCH and CSHCN Directors Contact Information 232
Form 9 State Priorities – Needs Assessment Year 235
Form 10 National Outcome Measures (NOMs) 237
Form 10 National Performance Measures (NPMs) 277
Form 10 National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle) 293
Form 10 State Performance Measures (SPMs) 295
Form 10 State Performance Measures (SPMs) (2016-2020 Needs Assessment Cycle) 304
Form 10 Evidence-Based or –Informed Strategy Measure (ESM) 310
Form 10 Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle) 332
Form 10 State Performance Measure (SPM) Detail Sheets 342
Form 10 State Performance Measure (SPM) Detail Sheets (2016-2020 Needs Assessment Cycle) 350
Form 10 State Outcome Measure (SOM) Detail Sheets 355

Form 10 Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets	356
Form 10 Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)	371
Form 11 Other State Data	379

I. General Requirements

I.A. Letter of Transmittal

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

September 15, 2020

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 2019 Annual Report and FY 2021 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. You may reach me at 334-209-5331 or email me at Amanda.Martin@adph.state.al.us.

Sincerely,

Amanda C. Martin, M.S.P.H.
Deputy Director
Bureau of Family Health Services

ACM/TRY

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alabamapublichealth.gov

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 2018 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: December 31, 2020.

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: December 31, 2020.

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 state health agency for the state of Alabama, operating with the mission to promote, protect, and improve Alabama's health. Public health functions are shared by state and local offices using a three-pronged system. 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 most local level, the 66 county health departments (CHD) work to preserve, protect, and enhance the general health and environment of their individual communities.

ADPH's Bureau of Family Health Services (FHS), located in the central office, administers the Maternal and Child Health Services Title V 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 Grant
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- State Perinatal Program (SPP)
- Healthy Childcare Alabama Program
- Cancer Prevention and Control Division
- Pregnancy Risk Assessment Monitoring System (PRAMS) Program
- State Dental Program
- Alabama Childhood Lead Poisoning Prevention Program
- Adolescent Pregnancy Prevention Branch

FHS is also home to the MCH Epidemiology Branch which pairs an analytical staff member with each program within the bureau to provide data tracking and reporting support to the program managers. Title V utilizes several of those staff to support the implementation, monitoring, and evaluation of Title V strategies.

Alabama Title V program staff collaborate with other ADPH, FHS, and ADRS staff, and with a variety of local, state, and federal organizations in order to assess the magnitude of factors impacting the state of health of Alabama's MCH population. Program staff rely on these same partnerships to prioritize needs and create methods of addressing current and emerging needs. Considerations of the social determinants of health are also factors in our work to improve health.

FHS and CRS are leading collaborative statewide projects dedicated to improving the health of the MCH population. As part of a 5-year strategic planning reboot, in 2019 ADPH leadership assembled teams to concentrate on five special projects each year. For 2019 one of those projects was Improving Pregnancy Outcomes. On June 20, 2018, the State of Alabama Infant Mortality Reduction Plan was adopted. This plan convened staff from ADPH, the Alabama Medicaid Agency (Medicaid), Alabama Department of Mental Health (ADMH), Alabama Department of Early Childhood Education (DECE), Office of Minority Affairs, and the Department of Human Resources (DHR), and has made great strides in collaborating to improve birth outcomes. The project was implemented in the three counties with an infant mortality rate higher than the overall state infant mortality rate: Macon, Montgomery, and Russell.

A great accomplishment and result of all the state efforts focused on infant mortality is Alabama's infant mortality rate decreasing to 7.0 infant deaths per 1,000 live births in 2018. This figure is the lowest rate in Alabama's history.

Coronavirus Disease 2019 (COVID-19)

The operations and services of ADPH, ADRS, and their partners have been greatly impacted by COVID-19. Like all HRSA grantees, we have experienced meeting and training cancellations, postponed medical, mental, behavioral, and dental services in the state, and transitioned to virtual applications. However, we have all become quite creative as we were determined to find means that would allow us to serve the needs of our communities. We continue to seek guidance from our funders and partners, discover new best practices implemented by our fellow HRSA grantees, and implement new policies and protocols as this pandemic rages on and evolves. We have highlighted the manner in which ADPH and ADRS programs, and the citizens of Alabama are adjusting to new ways of living, learning, and working.

The Oral Health Office's (OHO) initiatives have slowed, mainly because of the closing of dental offices, schools, and Head Start programs. Numerous activities and campaigns, such as the annual Oral Cancer Awareness Month ("Watch Your Mouth") campaign, were cancelled. One significant impact involves the inability of our grant recipient, HandsOn River Region / Pay It Forward, to utilize a large portion of their funds due to the lack of ability to appoint clients in (closed) dental offices. The most significant hindrance that COVID-19 caused is the inability to proceed with the Basic Screening Survey of Alabama kindergarten and third graders on a predictable timeline. The uncertainty of virtual vs in-class learning has resulted in the likely postponement of the survey until predictable in-class scheduling and coordination is feasible later in the academic year.

All Well Woman (WW) Program initial/new enrollment visits were postponed on March 17, 2020, due to COVID-19 responses. Also, implementation of the WW program expansion to Marengo county planned for FY20 was postponed due to the pandemic. WW social workers and nutritionists provided virtual education on the topics of nutrition, physical activity, tobacco cessation, achieving a healthy weight, prevention and management of hypertension and diabetes, bone health and ways to deal with stress and depression. An increased number of eligible participants have been inquiring about the WW program; the program's social work staff are keeping a list of those eligible candidates who desire to join the program once initial visits resume. The social workers are staying connected with the current WW participants via phone and by virtual means to verify that the WW participants are maintaining the goals they established during their initial visits and to inquire about any clinical services needed, such as birth control methods and/or other resource needs such as unemployment or local food bank information. WW staff have provided monthly support group meetings via the Zoom platform and hosted fitness classes via Facebook. Also, ADPH nurse practitioners are refilling medications for WW participants by performing telehealth/phone consult visits and face to face visits for those with critical needs.

WIC has continued to enroll new clients and certify existing clients throughout the COVID-19 pandemic via remote means, with electronic food benefits available statewide. Alabama received permission to implement several COVID-19 waivers through September 30, 2020. Current COVID-19 waivers include: 1) physical presence, 2) remote benefit issuance, 3) separation of duties, 4) food package size modifications for whole grain bread due to limited availability, and 5) compliance investigations due to travel limitations. These waivers have been crucial to ensure benefits continue while supporting participant health and social distancing. By implementing COVID-19 waivers, WIC participation remained steady with more than 117,000 participants receiving WIC benefits in June 2020. The updated USDA WIC income eligibility guidelines went into effect in Alabama on June 15, 2020, increasing financial eligibility and making WIC available to more women, infants, and children. Alabama's WIC program will continue remote issuance as it looks for ways to safely reopen WIC clinics to the public.

ADPH has taken a leading role in responding to COVID-19. ADPH developed webpages to educate visitors about COVID-19. The pages cover topics such as data and surveillance, symptoms and risks, prevention and treatments, and contact tracing, as well as information specific to schools K-12, healthcare providers, health care facilities, and correctional facilities. Visitors can also read the latest COVID-19 news releases which inform the public about upcoming testing sites. There is also a webpage that provides information and resources in Spanish. ADPH staff continue to assist ADPH with COVID-19 response efforts. Staff conduct case investigations and contact tracing, assist with COVID-19 test kit assembly and delivery, provide support for confidential mail notifications, assist in the operation of statewide COVID-19 hotline and e-mail account, deliver test kits and PPE to CHDs, deliver Remdesivir to hospitals, and acquire/distribute KN95 masks and face shields.

MCH Needs

Between 2014-2015 the Needs Assessment for Alabama's Title V program was collaboratively conducted by ADPH and ADRS, through FHS and CRS, respectively. FHS' tasks pertained to assessing needs of infants, children and youth, women of childbearing age, and their families. CRS' activities focused on assessing needs of CYSHCN and their families. The goals of the assessment and related key tasks comprised the framework for the 2015 Statewide Needs Assessment. An analysis of quantitative and qualitative data gathered through 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 several advisory committee meetings, national priority areas and state needs were identified.

ADPH Highlights

The following information is a summary of 2015-2020 priority needs, strategies and accomplishments.

NPM 1-Well-Woman Visit

ESM 1.1 – Increase the proportion of women age 12-55, who report receiving a preventive medical visit in the past 12 months by piloting Well Woman in two county health departments by December 2017.

NPM 3- Risk-Appropriate Perinatal Care

ESM 3.2 - To improve the system of perinatal regionalization statewide in order to increase the number of very low birthweight (VLBW) deliveries at an appropriate level of care facility.

NPM 5-Safe Sleep

ESM 5.1 –To conduct the Direct on Scene Education (DOSE) Train-the-Trainer Program to first responders in order to reduce Alabama's high rate of unsafe sleep-related deaths in infants less than 1 year of age.

NPM 6-Developmental Screening

ESM 6.2 - Establish an agreement with the Alabama Partnership for Children's Help Me Grow (HMG) Program to utilize their online Ages & Stages Questionnaires, Third Edition (ASQ-3) assessment tool so that parents can complete developmental screens prior to child health visits at county health departments.

NPM 10: Adolescent Well-Visit

ESM 10.1- Partner with the University of Alabama at Birmingham (UAB) Leadership Education in Adolescent Health (LEAH) Project to provide training and clinical practice quality improvement on youth-centered care to clinicians and other clinic staff using the Bright Futures model.

NPM #13: Preventive Dental Visit

ESM 13.1 - Increase the proportion of at-risk pregnant women who report receiving a preventive dental visit during pregnancy by piloting the First Steps Program.

ESM 13.2 - Increase the proportion of infants and children, ages 1-17 years, who report receiving a preventive dental visit in the past 12 months by piloting the Home by One Program.

Well Woman Program
- Program expanded and is currently offered in six counties in Alabama (Butler, Dallas, Macon, Montgomery, Russell and Wilcox).
- Enrolled 479 participants in the program and recorded 1,637 total WW visits
- Incorporated Spanish versions of fliers/outreach material to capture Spanish speaking population

Oral Health Program
- 1,299 maternity patients received maternity care coordination services through the ADPH social work program.
- Partnered with Dr. Casey Daniel at USA Health Mitchell Cancer Institute, and several state and local partners for statewide Oral Cancer Awareness Month Campaign. The campaign slogan was "Watch Your Mouth".

Between 2019 and 2020 ADPH and ADRS once again collaborated on Alabama's Title V Program 5-year needs assessment. See section Ⅲ.C for a detailed overview of the 2020 needs assessment.

Children and Youth with Special Health Care Needs

CRS provides clinical medical services, clinical evaluation services, care coordination, information and referral, patient/family education, and parent and youth connection to serve CYSHCN and their families. Family engagement is supported in partnership with Family Voices of Alabama (FVA) and the Family to Family Health Information Center (FVA/F2FHIC). Coordinated health services are delivered via 14 community-based clinics across eight service districts.

CYSHCN MCH Needs

Lack of or inadequate supports for transition to all aspects of adulthood; lack of or inadequate access to health and related services, especially in rural areas and for services identified as difficult to obtain; and "increase family and youth involvement and participation in advisory groups, program development, policy-making, and system-building activities were selected as the state priority needs for 2021-2025. Public/private partnerships, including agreements with the state's two tertiary-level pediatric hospitals, will 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 Children with Special Health Care Needs (CSHCN).

Highlights from the current priority needs:
NPM 11: Medical Home
ESM 11.1 - Percent of enrollees in the state CSHCN program with a comprehensive plan of care.
ESM 11.2 - Percent of providers receiving education/training about family-centered care.
Currently, 7,810 or 66.3 percent, of CYSHCN enrolled in CRS have a current comprehensive plan of care.

NPM 12: Transition
ESM 12.1 - Percent of enrollees in the state CSHCN program with a transition plan in place.
There were 3,589 youth ages 14-21 enrolled in the state CSHCN program and 81.8 percent had a Comprehensive Plan of Care.

SPM: Medical Home
ESM 12.2 - Percent of CYSHCN and their families who report that they share in decision-making and partnerships with health care providers.
In partnership with FVA and the F2FHIC, CRS provided 125 youth, families, and professionals education on family

centered care at the annual Partners in Care Summit.

CRS Highlights

CRS added capability to our current electronic medical record for physicians working clinics to be able to securely access patient records in a customized application. This allows physicians to readily access records in a secure format that complies with all federal and state mandates while improving services. The CRS State Parent Consultant and Youth Consultants continued to promote Family Engagement activities and were actively involved in planning and developing initiatives as members of the CRS Management Team. Local Parent Consultants (LPC) are full time caregivers of CYSHCN and are in most CRS offices. The LPCs held Local Parent Advisory Committees where families provided input into CRS policy and program changes.

The Craniofacial Orthodontia clinic rule was amended so it was no longer restricted to Medicaid as a payer source. This allowed clients with craniofacial diagnoses which warrant intensive orthodontic intervention to be served when otherwise they would be unable to receive services locally. The clinic provides a multidisciplinary team approach, in collaboration with the UAB School of Dentistry, to provide medically necessary orthodontic evaluation and treatment for children with congenital or acquired craniofacial anomalies who are enrolled in CRS.

COVID-19 presented unanticipated challenges for CRS. At the onset of COVID-19 CRS's priority was ensuring that families with CYSHCN and staff were staying safe and healthy. CRS State Office staff and District Supervisors immediately began discussions on how to best serve families while taking the Governor's orders into consideration. Initially clinics were manned by limited staff and other staff were working from home. CRS care coordinators made check-in calls to families. The calls were to ensure that families' needs were being met and assist with needed services. District supervisors worked to implement and provide telehealth services for clinics within Medicaid guidelines. Policies for resuming clinics were developed and implemented to ensure the safety of families with CYSHCN.

III.A.2. How Federal Title V Funds Support State MCH Efforts

Title V funds support personnel and the implementation, monitoring and evaluation of MCH focused activities and data. Staff forge local, state, and federal partnerships to develop, identify, and recommend quality, 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, mortality reviews, and advocacy to increase access to medical and dental care services. Staff provide work 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.

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 individual and family's health. Alabama Title V is able to leverage 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), teen pregnancy prevention, healthy child care, lead exposure, newborn screening, as well as case management and care coordination services for pregnant women, infants, children, and adolescents, including CYSHCN.

III.A.3. MCH Success Story

Trussville native Levi Adams is making strides every day with the help of his loving parents, his siblings, and Children's Rehabilitation Service (CRS). Levi, who is 4, is well on his way to taking his first steps, a feat his parents Dedra and Edward were once told was not a possibility. Levi was referred to CRS from the newborn follow-up clinic for feeding issues with a G-Tube placement. Levi was diagnosed with Down syndrome and 9p deletion syndrome. He has also been diagnosed with failure to thrive, Lennox-Gastaut syndrome, and a variety of other conditions. Through CRS, Levi receives occupational and physical therapy, and he had ear tubes placed to correct his hearing, which is now normal. Dedra said CRS has been a tremendous blessing. "They have been the best resource. Even the emotional support is one of the biggest things I appreciate. Just having somebody who cares, who knows him. He's not just a number. They are invested, and that is what I appreciate more than anything." Levi attends feeding clinic every six months and is making steady progress. He regularly attends orthopedic and seating clinics and has been provided with bracing and medical equipment. Care Coordinator Sandra Bumgardner said she is always excited to see Levi's progress. "Levi has obstacles in life, and he faces them head-on with a huge smile on his face," she said. "He is such a special child that is full of life and determination."

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 in 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 the University of Alabama at Birmingham 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 our 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 county health departments in 66 of Alabama's 67 counties. County health departments 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.

The Alabama Title V program has made great efforts to develop district MCH coordinator positions to lead the charge of developing and implementing programs focused on community-based prevention activities.

ADPH operates on a mission to promote, protect, and improve Alabama's health with a focus on heathy 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 in order 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 health care 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

An additional part of this plan was to assemble teams to concentrate on five special projects. For 2019 those projects were as follows:

1. Improve Pregnancy Outcomes
2. Increase Participation Rates in Obesity and Chronic Disease Prevention Programs
3. Increase Reimbursement for Services Provided in 2018 and 2019
4. Establish a More Unified Workforce
5. Increase the Number of Initiatives Reporting in InsightVision (ADPH's performance management dashboard)

The State of Alabama CSHCN Program is administered by CRS, a division 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 clinics across eight service districts.

Total Population

Based upon the Annual Estimates of the Resident Population produced by the U.S. Census Bureau, the estimated population for the state, as of July 1, 2018, was 4,887,871 according to data retrieved on February 21, 2020. This figure exceeds the 2017 estimate, of 4,875,120, by 12,751 persons.

0-24 Year-Old Residents

Of the most current data available and retrieved on February 21, 2020, for the year 2018, there were 1,542,498 (or 31.7 percent) of the Alabama population, from the age of 0-24 according to the U.S. Census Bureau. The age group breakdown for this calculation was as follows: Under 5 years was 6.0 percent (293,203); 5-9 years was 6.1 percent (297,900); 10-14 years was 6.4 percent (310,495); 15-19 years was 6.5 percent (315,680), and 20-24 years was 6.7 percent (325,220). Of the total population, 4.4 percent of Alabama's population was of Hispanic Origin and 95.6 percent was Not of Hispanic Origin.

Live Births

According to preliminary numbers, retrieved February 27, 2020, from the Alabama Center for Health Statistics, in 2019, there were a total of 58,595 live births to Alabama residents-a slight increase (1.5 percent) from the 57,754 live births in 2018 for the state. There were 4,871 (8.3 percent) live births to mothers of Hispanic origin in the same year. Of the mothers who were non-Hispanic, 63.1 percent were white; 34.6 percent were black; and 2.3 percent were other (including unknown race).

ECONOMIC ENVIRONMENT AND POVERTY LEVELS

Per the U.S. Census Bureau, 2018 American Community Survey 1-Year Estimates Subject Tables, for the year 2018, there were an estimated 800,422 Alabamians below the poverty level. This number accounted for 16.8 percent of Alabamians below poverty level.

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.

For our annual report year 2018, the total number of individuals served under Title V was 139,135. There were 953

pregnant women and 31,059 infants less than 1 year of age served in 2018. The total number of children 1 to 21 years of age, in our 2018 report, was 30,301. There were 10,784 CSHCN and 76,822 “Others” served under Title V in our 2018 report.

CRS continually participates in community awareness and outreach activities in order to educate individuals about CRS services. The following figures represent CYSHCN and families who received services directly from CRS. Specifically, in FY 2016, CRS served 9,858 CYSHCN, which is less than a 1 percent decrease from FY 2015. In FY 2017, CRS served 10,287 CYSHCN, an increase of 4.3 percent over FY 2016. In FY 2018, CRS served 10,784 CYSHCN, an increase of 4.8 percent over FY 2017. The increase may be attributed to the expansion of evaluation clinics in the state.

In FY 2019, CRS served 11,772 CYSHCN, an increase of 9.15 percent over FY 2018. Expansion of Augmentative Communication Clinics to serve children with severe expressive language disorder, opening the Craniofacial Orthodontia Clinic to all payor sources and additional hearing clinics attributed to the increase. In FY 2019, CRS provided information and referrals to 2,066 individuals. For FY 2019, CRS staff reached approximately 62,000 CYSHCN and their families via incoming toll-free calls, information and referrals, Parent and Youth Connection Facebook pages, ADRS/CRS website, local hearing and speech screenings, health fairs, transition expositions, and Family Voices activities.

Issues important to understanding the health needs of the state's population include the health care environment, selected changes in the state’s population, the number of state Title V-served individuals, strategic and funding issues, and special challenges in delivery of services to CYSHCN. Also key to understanding the health needs of the state's Title V populations are salient findings from the current 5-Year Statewide 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 health care 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 concerning the health care environment is summarized here.

Medicaid Managed Care Programs

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

Medicaid Maternity Care Program

Under Medicaid's Maternity Waiver Program that was effective from 1988 through May 1999, ADPH had been the primary provider of prenatal care for 23 of the state's 67 counties and subcontractor for care in many other counties. The department's role in directly providing prenatal care markedly declined with Medicaid's State Plan for Maternity Care, which divided the state into 14 Medicaid maternity districts. With implementation of the plan, ADPH no longer provided maternity services via a direct contract with Medicaid. ADPH gradually withdrew from providing direct prenatal care and, by 2012, provided maternity care coordination in only two counties. Under this plan, the loss of federal matching funds and an increase in the number of eligibles have driven increased demand on the state General Fund.

Legislation passed in 2013 calls for the state to be divided into regions and for a community-led network to coordinate the health care of Medicaid patients in each region, with networks ultimately bearing the risks of contracting with the state of Alabama to provide that care. In FY 2013, Medicaid began working towards the first milestone of establishing Medicaid districts with Regional Care Organization (RCO) provider networks in place. The RCO plan was unsuccessful and discussions began to replace it with the RCO Pivot Plan. The Pivot Plan continued to undergo redesign as Medicaid pursued better ways to transform its delivery system. Throughout the changes at Medicaid, ADPH continued to provide maternity care coordination in 15 of its 67 counties and continues to receive reimbursement for only about half of the services provided.

In FY 2019, ADPH continued to provide maternity care coordination services and only about half of the services were reimbursed by Medicaid. It was determined during FY 2019 that the remaining half of the unpaid services would be covered by MCH funds.

Patient 1st and Case Management/Care Coordination

The Patient 1st Program, a primary care case management program (PCCM), was fully implemented by Medicaid in November 1998. The Patient 1st model assigned all Medicaid recipients to a medical home that managed their health care needs, including referrals for specialty care and pre-authorization of specified Medicaid services. Under Patient 1st, the number of children seen in ADPH clinics declined markedly. PCCM and a prior increase in willingness of private providers to see Medicaid-enrolled patients were thought to be major factors in this decline. The Patient 1st Program originally affected the provision of case management or care coordination by ADPH.

As the provision of direct health care services to children and youth in the CHD setting diminished, the focus shifted from direct services provision to community-based services. This shift gave rise to increased emphasis on provision of care coordination. ADPH provided case management through the Medically at Risk (MAR) Case Management Program with most MAR referrals being for immunizations; dental care; appointments missed for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT); social systems issues; specialty referral coordination; and problems with a medical regimen. In early FY 2004 Patient 1st was discontinued, effective March 1, 2004, because of financial constraints and waiver expiration. When Patient 1st ended, Medicaid-enrolled patients could receive services from any physician who provided services under the Medicaid Program, but Medicaid no longer reimbursed for provision of care coordination for adults. Primary medical providers in the state petitioned Medicaid to restart the managed care program. A task force, which included persons from CRS and ADPH, was established to create a new waiver for a revised managed care program for Medicaid enrollees. The Patient 1st Program was redesigned in December 2004 and all counties were a part of Patient 1st by February 2005.

One change was that Medicaid no longer required a referral from the primary medical provider to provide care coordination. The removal of this barrier allowed ADPH care coordinators to receive referrals from a variety of sources and refer children with select conditions for care coordination by trained CHD staff. Also, CHD care coordinators could provide information and counseling on birth control methods and sexually transmitted diseases (STDs), including HIV infection, to Medicaid-enrolled teens who presented for family planning services. FHS implemented an electronic Care Coordination Referral System (CCRS) which is used for referrals received from the Children's Health Division for children with select conditions. The system is also used for infants referred by Medicaid for care coordination. In FY 2008, ADPH began providing chronic disease case management to asthma and diabetes patients under Medicaid's Together for Quality (TFQ) federal grant. The Patient 1st Care Coordination Program continued to grow; however, growth in the program had created financial concerns for ADPH in regard to the Medicaid match.

In September 2008, Medicaid agreed to pay half of the federal match on any Medicaid-related expansion relative to

FY 2007, after ADPH paid a $2.1 million match in a Medicaid-related expansion of the program. Despite the cost sharing and cost containment, in FY 2009 ADPH determined that it could not maintain the program as then funded and began negotiating with Medicaid for further help with the federal match. Being unsuccessful, ADPH's provision of care coordination under Medicaid's Patient 1st Program decreased. In FY 2010, the Medicaid match dropped but the Governor required that ADPH turn over any savings for distribution to other agencies. In FY 2012, Medicaid expected to be designated by the Centers for Medicare and Medicaid Services (CMS) for participation in Medicaid's "Health Home" option under the Affordable Care Act. Medicaid has since received the Health Home designation and is receiving the enhanced match rate. The number of full-time equivalents (FTEs) providing care coordination in the Patient 1st program has varied yearly. In January of 2019, the RFP was released to transition Medicaid's Patient 1st program to the Alabama Coordinated Health Network (ACHN). This new Medicaid program would move all case management (maternity, Plan First, and Patient 1st) under one entity in seven regions throughout the state. Through negotiations with Medicaid, ADPH would only continue to provide case management services to those infants that did not pass the Newborn Screenings at the hospital and those children with an elevated lead level. Due to the Patient 1st program ending, ADPH faced an impending lay-off at the end of FY 2019. As the staffing plans were being developed, staff were transitioned into different roles throughout the department or found positions with other agencies. Therefore, FY 2019 ended with approximately 45 FTEs in the Patient 1st Program.

Collaboration between CRS and Medicaid

The 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 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 State Parent Consultant (SPC) participate on advisory committees and work groups associated with various Medicaid initiatives.

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 operates these clinics within Medicaid’s Children's Specialty Clinic Services program requirements, which includes the required practitioners credentialed in accordance with Medicaid Administrative Code. CRS clinics employ physicians, nurses, social workers, physical therapists, audiologists, nutritionists, occupational therapists, and speech language pathologists. CRS works with Medicaid to add new specialty clinics or modify existing clinics as needed.

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 requests for ACDs. CRS is the only provider of medically necessary orthodontia for Medicaid recipients. CRS works closely with Medicaid’s Dental Director regarding payment for orthodontia services.

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

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 CMS). This waiver, called "Plan First", expanded Medicaid eligibility for family planning services to 133 percent of Federal Poverty Level (FPL) for women aged 19-55 years of age. Family planning services for adolescents less than 19 years old were already covered by Alabama's State Children's Health Insurance Program (CHIP). Care coordination and outreach were key components of the Family Planning Waiver Proposal.

Effective January 1, 2010, women seeing private Plan First Providers were allowed to take contraceptive prescriptions to the pharmacy. Women receiving services through a CHD continued to obtain their contraceptives on site at the time of their visit, often receiving a 12-month supply. Also, effective January 1, 2010, women applying for Plan First no longer had to provide a birth certificate for proof of citizenship. Under the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, states could now use a data match with the Social Security Administration (SSA) to verify citizenship. In FY 2014, CMS approved the addition of a smoking cessation initiative. This initiative allows waiver recipients to receive smoking cessation products and telephone behavioral counseling through the Alabama Tobacco Quit Line. The Plan First Family Planning Program includes coverage for women ages 19 to 55 up to 141 percent of FPL and coverage for men age 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 was added to SSA by the Balanced Budget Act of 1997. Alabama was the first state in the nation to have a federally approved CHIP plan. Alabama's CHIP program is the result of a partnership between ADPH, Medicaid, and the former Alabama Child Caring Foundation. Alabama's CHIP is administered through ADPH's Bureau of Children's Health Insurance. CHIP provides comprehensive health coverage to eligible children through a separate program known as ALL Kids. As a result of provisions in the Affordable Care Act, in addition to the ALL Kids program, CHIP also funds two groups of Medicaid eligible children (MCHIP).

The Affordable Care Act of 2010 maintains the CHIP eligibility standards in place as of enactment through 2019. Three major activities concerning CHIPRA implementation include: 1) citizenship verification, 2) prospective payments for federally qualified health centers (FQHCs) and rural health centers, and 3) mental health parity. Verification of citizenship relies heavily on coordination with the federal SSA, follow up with parents, and internal tracking. ALL Kids became the sole component of Alabama's CHIP in FY 2004. Persons eligible for Medicaid are not eligible for ALL Kids. Medicaid and ALL Kids continue collaborating on the application process.

The bureau continues to work collaboratively with Medicaid to make enhancements to the dual eligibility enrollment

system. This collaboration will ensure a streamlined application process that is easy for applicants to navigate. As of September 2019, there were 172,747 children enrolled in CHIP with 85,265 enrolled in ALL Kids and 87,482 enrolled in MCHIP. CHIP also developed the ALL Babies program, a pilot in Macon, Montgomery, and Russell counties. ALL Babies provides comprehensive health coverage and case management services for low-income pregnant women who are uninsured and do not qualify for Medicaid pregnancy coverage. The goal of this initiative is to positively impact pregnancy outcomes and reduce infant mortality.

The Alabama Department of Early Childhood Education

DECE was created in 2015 to expand upon the duties of the former Department of Children's Affairs and to include the development of a cohesive and comprehensive system of high quality early learning and care experiences for Alabama's children from birth to eight years of age. DECE's mission is to provide state leadership that identifies, promotes, and coordinates services for children, their families, and communities.

DECE is the state designee for the federally mandated Early Childhood Advisory Council (designated as the Alabama Children's Policy Council in 2015), home of the Alabama Head Start Collaboration Office, coordinator of Alabama's state and local Children's Policy Councils, administrator of the Children First Trust Fund, lead agency for early learning and home visiting programs, and developer and operator of the nationally-recognized First Class Pre-K Program. DECE has also designed and coordinated the state plan for developing a continuum of home visiting services for children from prenatal to age five, including all relevant state agencies.

DECE receives and disperses any funds appropriated by state and federal sources for the establishment, operation, and administration of its programs. DECE is responsible for coordinating and organizing all efforts for the federal Preschool Development Grant and serves as its fiscal agent. DECE was awarded a $70 million ($17.5 million per year for four years) federal preschool development grant in 2014 to expand access to quality First Class Pre-K. In 2018 the Alabama Legislature approved an $18.5 million expansion for First Class Pre-K, increasing the FY 2019 program budget to $96 million. For the 2018-2019 school year, 18,720 children were enrolled in 1,040 classrooms in all 67 counties, serving 33 percent of the state's eligible 4-year-old population. Since 2012, investment in First Class Pre-K has grown from $19 to $100 million, more than 420 percent. There has been a 380 percent increase in additional classrooms and the number of students served during the same period.

Alabama is nationally recognized as a leader in quality early childhood education and care. DECE leadership and staff are regularly called upon to provide leadership and assistance to other states that look to Alabama as the national leader in quality early learning and care, regularly serving as a model and mentor to other states. The First Class Pre-K program maintains the program's nationally recognized quality standards. The National Institute for Early Education Research (NIEER) recognizes Alabama as one of only three states in the nation to have a state pre-kindergarten program that meets all of the quality standards benchmarks.

DECE is frequently invited to present on the national level and share Alabama's successes in pre-k programs while maintaining high quality developmentally appropriate programming.

CRS Services to Certain Medicare Enrollees

In FY 2019, CRS served 47 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 addresses their needs and to help them locate Medicare pharmacies for factor treatment of bleeding disorders. In FY 2019, CRS paid insurance premiums for 23 clients with bleeding disorders.

Emergency Preparedness: ADPH and CRS

ADPH and CRS continue to be involved in emergency preparedness. ADPH has a key role in promptly responding to potential man-made disasters and potential weather-related disasters during which the department's role is to coordinate the health and medical response during any emergency event.

Special Challenges in Delivery of Services to CYSHCN

Addressing the service delivery needs of Alabama's CYSHCN presents special challenges. The state is largely rural, with greater population concentrations surrounding 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. Also, comprehensively meeting the needs of CYSHCN in rural areas is 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. Though 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.

The CSHCN program faces some financial challenges as well. Due to fluctuation in funding from federal MCH Block Grant monies and level funding in state appropriations, significant budget shortfalls have faced the state CSHCN program. CRS has been able to maintain its purchased services program for families with annual taxable incomes up to 300 percent of FPL despite state level funding for the past seven FYs. The budget shortfall continues with level funding in FY 2020.

CRS staff members work to ensure CYSHCN and their families continue to receive high quality services in their local communities and have helped identify resources for additional support. CRS leadership has sought innovative partnerships to maximize the program’s impact. Leadership continues to monitor staffing and budgets to assure program efficiency. Continued funding challenges will make it more important for CRS to re-define its role in meeting the needs of CYSHCN and their families. CRS is currently participating in the National MCH Workforce Development Center 2020 cohort to address service delivery improvement.

The State’s Fiscal Situation

The Alabama Legislature approved a 2021 general fund budget of $2.4 billion which increased spending over the current year by $170 million. The COVID-19 pandemic has stalled the economy putting more than 400,000 Alabamians out of work. Despite the massive economic shutdown that has crippled the state economy and thousands of businesses, there will not be any need to prorate either the General Fund (GF) or the Education Trust Fund (ETF) budgets in 2020.

Alabama has two budgets: ETF, which pays for education in the state, and the GF, which provides money for other

state services. State agencies, most notably Medicaid, also get federal funding. A downturn in the economy would harm both the ETF and General Fund budgets. The $7.1 billion ETF gets about 63 percent of its revenue from state income taxes and about 28 percent from sales taxes. Both are growth revenues that are sensitive to economic conditions. The House Ways and Means Education committee has approved a $7.2 billion ETF for fiscal year 2021, a $91 million increase over current year. The $2.4 billion General Fund gets revenue from about three dozen sources. The Alabama Senate has approved a $2.4 billion General Fund budget which is smaller than the one proposed by the governor before the coronavirus pandemic but larger than the 2020 budget. The General Fund is still healthy, and projections indicate the slowdown caused by the pandemic will reduce growth in tax revenues but not force overall cuts.

Most agencies would receive about the same amount as this year. Three agencies would receive increases requested in the governor's budget. The largest increase from the General Fund would go to Medicaid, which provides some levels of service to almost a million Alabamians. Medicaid would receive $94 million more than this year, a total of $820 million. Public Health would receive a $35 million increase, which will be to $106 million. A portion of this money will cover an increase in the state's share of the Children's Health Insurance Program, ALL Kids. Mental Health would receive a $26 million increase, a total of $154 million.

In FY 2020, Alabama's Title V MCH Program received $11,401,820 and will be budgeted at this level for the FY 2021 application.

III.C. Five-Year Needs Assessment Summary
(as submitted with the FY 2021 Application/FY 2019 Annual Report)

III.C.2.a. Process Description

PROCESS

Every 5 years, each MCH Title V Block Grant to States Program is required to conduct and submit a formal assessment of their State's MCH needs. The FY 2019-20 MCH Needs Assessment for Alabama's Title V Program was collaboratively conducted by ADPH, through FHS, and ADRS, through CRS. FHS's tasks pertained to assessing needs of infants, children and youth, women of childbearing age, and their families. CRS's activities focused on assessing needs of CYSHCN and their families.

GOALS, FRAMEWORK AND METHODOLOGY

Goals - The primary goal of the statewide Needs Assessment is to improve MCH outcomes and to strengthen its state, local and community partnerships for addressing the needs of its MCH population. The goals of the FY 2019-20 MCH Needs Assessment were to: (a) Engage stakeholders to assure collaboration among key stakeholders, (b) Assess needs and identify desired outcomes and mandates by conducting studies that collect qualitative primary data, (c) Analyze pertinent existing databases or reports, (d) Examine strengths and capacity, (e) Select MCH priority needs, and (f) Develop a State Action Plan.

Framework - The goals of the FY 2019-20 MCH Needs Assessment and related key tasks comprised the framework for the Statewide Needs Assessment.

Methodology: ADPH - The main components of FHS's process were as follows: 1) entrance into a contractual agreement with UAB School of Public Health's Applied Evaluation and Assessment Center's Department of Health Care Organization and Policy to administer three web-based surveys (survey of families, also available in Spanish and print copy; survey of healthcare providers serving women of childbearing age, children, youth, and their families; and survey of adolescents between ages 13 and 25), to convene seventeen Focus Group Meetings through partnership with the Alabama Network of Family Resource Centers (ANFRC), and to complete twenty-two Key Informant Interviews to facilitate the collection of qualitative data; 2) utilization of FHS's MCH Epidemiology Branch (MCH Epi) to make presentations compiled from the Federally Available Data (FAD) Resource Document made available by the Maternal and Child Health Bureau (MCHB); 3) assemblage of and identification of priority needs from the MCH Needs Assessment Advisory Group; 4) assemblage of and selection of the state's priority MCH needs from the FHS Bureau Management Team; and 5) development of a State Action Plan that will guide Alabama's Title V Program efforts during the next 5 year grant cycle.

Methodology: CRS - The main components of CRS's process were as follows: 1) enter into an agreement with the UAB School of Public Health's Applied Evaluation and Assessment Center's Department of Health Care Organization and Policy to develop, analyze, and report on data collected from Alabama families, practitioners, and other stakeholders 2) enter into agreement with Family Voices of Alabama (FVA) to assist in generating family involvement 3) administer two web-based surveys (families and youth), convene five focus groups, and seventeen key informant interviews 3) convene the CRS Needs Assessment Advisory Committee to assist with the process and prioritizing the identified needs 4) convene CRS Needs Assessment Leadership Team to select priority needs for CSHCN and the development of a State Action Plan that will guide Alabama's CSHCN Title V Program efforts during the next 5 year grant cycle.

LEVEL AND EXTENT OF STAKEHOLDER INVOLVEMENT

Engaging key stakeholders from the initial onset of the Needs Assessment process and keeping them engaged throughout the entire process is a crucial part of a state's ability to accurately assess the needs of their MCH population.

ADPH - The primary ways in which FHS involved stakeholders consisted of: 1) convening the Needs Assessment

Leadership Team to determine the methods and goals of the FY 2019-20 Needs Assessment; 2) advertising via a press release to encourage Alabama families to participate in the web-based survey; 3) seeking assistance from CHD staff to encourage clients at the local health departments to participate in the web-based survey, including providing select locations with the printed, Spanish version for completion by clients seeking services; 4) identifying non-medical organizations to participate in key informant interviews; 5) convening the MCH Needs Assessment Advisory Group to ensure that a variety of MCH stakeholders were included in the ranking of the state's priority MCH needs; 6) convening the FHS Bureau Management Team, which consists of FHS Division Directors, to select the state's priority MCH needs in consideration of MCH Program Capacity as well as to complete the State Action Plan Table.

CRS - The primary ways in which CRS involved stakeholders consisted of: 1) convening the CRS Needs Assessment Advisory Committee; 2) utilizing CRS staff at the local level to encourage Alabama families to participate in the web-based survey; 3) identifying key informants and populations for focus groups 4) convening the CRS Needs Assessment Advisory Committee to ensure that a variety of MCH stakeholders were included in ranking priority needs; 5) reconvening the CRS Needs Assessment Leadership Team to select the priority needs in consideration of MCH Program Capacity as well as to complete the State Action Plan Table.

Due to the COVID-19 crisis and quarantine, the scheduled in-person advisory committee prioritization meeting was canceled. CRS worked with UAB to develop an online format for presentation of findings and prioritization, including recorded YouTube video presentations embedded within a Qualtrics survey. Over 3 days in April 2020, CRS and UAB made available an asynchronous online portal for advisory committee members to view findings, provide input, and rate needs to assist with the prioritization of identified maternal and child health needs for CYSHCN.

QUANTITATIVE AND QUALITITATIVE METHODS USED

ADPH - In order to complete quantitative data analysis to assess the strengths and needs of each of the MCH population domains, FAD from MCHB was used. Through a contractual agreement with UAB, three web-based surveys were administered; 17 focus groups were convened; and 22 Key Informant Interviews were completed in order to facilitate the collection of qualitative data.

CRS - Quantitative data used included FAD from the MCHB. UAB collected qualitative data by conducting five focus groups and 17 key informant interviews, and administering two surveys in both online and paper format for families and youth.

DATA SOURCES USED

Data sources that were used to inform the Needs Assessment process were comprised of those used to compile the FAD, web-based surveys, key informant interviews and focus groups.

INTERFACE BETWEEN DATA COLLECTION, FINALIZATION OF PRIORITY NEEDS, AND DEVELOPMENT OF STATE ACTION PLAN

ADPH - FHS' MCH Epi staff are a common element in all aspects of the Needs Assessment process: 1) Two MCH Epi staff members are a part of the Needs Assessment Leadership Team, 2) MCH Epi staff made presentations compiled from the FAD Resource Document and presented their findings at the Needs Assessment Advisory Group Meeting during which the state's MCH priority needs were identified and ranked, 3) As part of the Bureau Management Team, MCH Epi staff were again involved in the selection of the state's MCH priority needs and the development of the State Action Plan Table. Because MCH Epi staff prepare the MCH annual applications/reports and are responsible for monitoring ongoing needs assessment activities, integration of the staff in all phases of the Needs Assessment process is ensured.

CRS - UAB used the data collected to capture the perceptions of families/caregivers of CSHCN, YSHCN, and other stakeholders across the state to increase the knowledge base and assist in identifying maternal and child health needs specific to CYSHCN. Bringing this information together with the FAD allowed CRS and stakeholders to

evaluate the issues and general findings across broad cultural and socioeconomic groups. Based on all the data collected UAB developed 15 need statements for CSHCN. CRS used a two-phased process to prioritize the needs. The first phase occurred during the April 2020 online asynchronous sessions, when the CRS Needs Assessment Advisory Committee completed the rating and final rankings. The second phase occurred when the CRS Needs Assessment Leadership team met virtually to select the final priority needs. CRS leadership utilized knowledge of agency capacity and feasibility considerations, along with input obtained from stakeholders, in order to reach a consensus on the final priority needs.

III.C.2.b. Findings

III.C.2.b.i. MCH Population Health Status

MCH POPULATION HEALTH STATUS

Based on the quantitative and qualitative analyses conducted as part of the FY 2019-20 MCH Needs Assessment for Alabama's Title V Program, the health status of Alabama's MCH population can be described for each population health domain. The findings from this statewide assessment of needs serve to inform strategic planning, decision-making and resource allocation efforts and provide a framework against which progress can be assessed during the 5 year reporting period.

Women/Maternal Health - Overview of Health Status

In consideration of the national priority areas related to the Women/Maternal Population Health Domain as depicted by data from the FAD resource document, Alabama is performing either about the same or worse than the nation but has been trending better for most.

Table 1. Federally Available Data related to Maternal/Women's Health

Maternal/Women's Health Indicators	Value	How does Alabama compare to the U.S.?	How has Alabama been doing?
Well-woman visit	66.3%	About the same	About the same
Low-risk cesarean delivery (first births)	28.2%	Worse	Trending better
Preventive dental visit – during pregnancy	40.6%	Worse	About the same
Smoking – during pregnancy	9.6%	Worse	Trending better
Postpartum depression	16.3%	Worse	Trending better
Early prenatal care	71.5%	Worse	About the same
Early elective delivery	1.0%	About the same	Trending better
Teen births	27 per 1,000	Worse	Trending better

MCH Strengths/Needs

An assessment of the needs through web-based surveys, focus groups, and key informant interviews yielded a variety of issues for the Women/Maternal Population Health Domain. Based on stakeholder perceptions, issues were identified in the following areas: health and wellness; mental health; reproductive health; smoking, substance, and alcohol use; health care access, cost, and insurance; oral health care access, cost, and insurance; and maternal mortality.

Successes, Challenges and Gaps Related to Major Morbidity, Mortality, Health Risks or Wellness

Need statements for the Women/Maternal Population Health Domain, based upon FAD and stakeholder input, developed for use in choosing the state's priority needs for the coming 5-year cycle are as follows:

1) Discrimination, bias, and differences in quality of care based on race/ethnicity, socioeconomic status, marital status, age, disability status, insurance status/type, primary language, sexual orientation, and gender identity
2) Lack of or inadequate access to supports for health and wellness, including education; affordable and safe options for physical activity; and healthy foods
3) Lack of or inadequate access to comprehensive, family-centered, and culturally-competent reproductive and well-woman health care and education, including for LGBTQ populations and women with disabilities
4) Insufficient or inadequate translated educational materials and timely interpreter services for individuals whose primary language is not English
5) Lack of or inadequate access to comprehensive mental health services (prevention, crisis care, postpartum)
6) Lack of or inadequate substance abuse treatment (smoking, alcohol, and drugs) and prevention education, including detox, addiction, and rehabilitation/recovery services
7) Inadequate or lack of comprehensive, affordable health and dental insurance
8) High levels of maternal mortality

Selected State Needs and Identified National MCH Priority Areas

In consideration of the national priority areas, the issues identified, desired outcomes, required mandates, existing capacity, and a reasonable opportunity for a focused programmatic effort to lead to improved outcomes for the Women/Maternal Population Health Domain, "**High levels of maternal mortality**" and "**Lack of preventive dental**

visits across all Title V populations, especially for those uninsured“ were selected as the state priority needs.

Perinatal/Infant Health - Overview of Health Status

Table 2. Federally Available Data related to Perinatal/Infant Health

Perinatal/Infant Health Indicators	Value	How does Alabama compare to the U.S.?	How has Alabama been doing?
Risk-appropriate perinatal care – very low birth weight babies born in hospitals with Level III+ NICU	84.1%	NA	Trending better
Breastfeeding – ever	68.1%	Worse	About the same
Breastfeeding – exclusively through 6 months	20.6%	Worse	Trending better
Safe sleep – infant placed on back	71.3%	Worse	About the same
SUID mortality	216.4 per 100,000	Worse	Trending worse
Infant mortality	9.0 per 1,000	Worse	Mixed
Preterm birth	12.0%	Worse	About the same
Low birth weight	10.3%	Worse	About the same
Early elective delivery	1.0%	About the same	Trending better

In consideration of the national priority areas related to the Perinatal/Infant Population Health Domain as depicted by data from the FAD resource document, Alabama is performing either about the same or worse than the nation for most.

MCH Strengths/Needs

An assessment of the needs through web-based surveys, focus groups, and key informant interviews yielded a variety of issues for the Perinatal/Infant Population Health Domain. Based on stakeholder perceptions, issues were identified in the following areas: pregnant and parenting teens and young families/new parents; safe sleep education; breastfeeding; infant mortality; mental health; reproductive health; smoking, substance, and alcohol use; and health/dental care access, cost, and insurance.

Successes, Challenges and Gaps Related to Major Morbidity, Mortality, Health Risks or Wellness

Need statements for the Perinatal/Infant Population Health Domain, based upon FAD and stakeholder input, developed for use in choosing the state’s priority needs for the coming 5-year cycle are as follows:

1) Inequitable access to health resources (including delivery hospitals) based on race/ethnicity, socioeconomic status, geographic location, and education
2) Discrimination, bias, and differences in quality of care based on race/ethnicity, socioeconomic status, marital status, age, insurance status/type, and primary language
3) Lack of or inadequate access to comprehensive reproductive health care
4) Lack of supports for pregnant and parenting teens and young/new parents
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 or inadequate access to breastfeeding supports
8) Lack of or inadequate access to comprehensive mental health services (prevention, crisis care, postpartum)
9) Lack of or inadequate substance abuse treatment (smoking, alcohol, and drugs) and prevention education, including detox, addiction, and rehabilitation/recovery services
10) Inadequate or lack of comprehensive, affordable health and dental insurance

Selected State Needs and Identified National MCH Priority Areas

In consideration of the national priority areas, the issues identified, desired outcomes, required mandates, existing capacity, and a reasonable opportunity for a focused programmatic effort to lead to an improved outcome for the Perinatal/Infant Population Health Domain, “**High levels of infant mortality (and associated factors of preterm birth and low birth weight)**” and “**High levels and worsening trends of sleep-related/SUID deaths**“ were selected as the state priority needs.

Child Health - Overview of Health Status

In consideration of the national priority areas related to the Child Population Health Domain as depicted by data from the FAD resource document, Alabama is performing either about the same or worse than the nation for most but better on one.

Table 3. Federally Available Data related to Child Health

Child Health Indicators	Value	How does Alabama compare to the U.S.?	How has Alabama been doing?
Developmental screening – 9-35 months	26.6%	Worse	Trending better
Physical activity (everyday)	28%	About the same	NA
Preventive dental visit – child (6-11years)	91.5%	Better	About the same
Child mortality	24.6 per 100,000	Worse	Trending better
Obesity – 2-4 years	16.3%	Worse	Trending worse
Child vaccination – 19-35 months	71.2%	About the same	Trending better

MCH Strengths/Needs

An assessment of the needs through web-based surveys, focus groups, and key informant interviews yielded a variety of issues for the Child Population Health Domain. Based on stakeholder perceptions, issues were identified in the following areas: health and wellness; pregnant and parenting teens and young families/new parents; child mental health; health and oral health care access, cost, and insurance; and health and developmental screening.

Successes, Challenges and Gaps Related to Major Morbidity, Mortality, Health Risks or Wellness

Need statements for the Child Population Health Domain, based upon FAD and stakeholder input, developed for use in choosing the state's priority needs for the coming 5-year cycle are as follows:

1) Inequitable access to health resources based on race/ethnicity, socioeconomic status, geographic location, and
2) education
3) Lack of comprehensive, family-centered, and culturally-competent health care
4) Lack of or inadequate access to mental health services that are comprehensive and age-appropriate
5) Lack of or inadequate smoking, alcohol, and substance use prevention education
6) Lack of or inadequate access to affordable and safe options for physical activity
7) Lack of awareness of healthy nutrition guidelines and portion sizes
8) Lack of timely, appropriate, and consistent health and developmental screenings
9) Lack of access to quality early childhood programs that are safe and affordable, especially for children with disabilities
10) High levels and worsening trends for childhood obesity

Selected State Needs and Identified National MCH Priority Areas

In consideration of the national priority areas, the issues identified, desired outcomes, required mandates, existing capacity, and a reasonable opportunity for a focused programmatic effort to lead to an improved outcome for the Child Population Health Domain, "**Lack of timely, appropriate, and consistent health and developmental screenings**" and "**Lack of preventive dental visits across all Title V populations, especially for those uninsured**" were selected as the state priority needs.

Adolescent Health - Overview of Health Status

In consideration of the national priority areas related to the Adolescent Population Health Domain as depicted by data from the FAD resource document, Alabama is performing either about the same or worse than the nation for most but better on two.

Table 4. Federally Available Data related to Adolescent Health

Adolescent Health Indicators	Value	How does Alabama compare to the U.S.?	How has Alabama been doing?
Physical activity (everyday)	20.6%	Worse	NA
Bullying (victimization)	19.6%	About the same	NA
Adolescent well-visit	76.3%	About the same	About the same
Preventive dental visit – adolescent	88.0%	Better	About the same
Adolescent mortality	46.9 per 100,000	Worse	About the same
Adolescent motor vehicle death	25 per 100,000	Worse	Trending better
Adolescent suicide	9.1 per 100,000	Better	Trending worse
HPV vaccination	58.0%	Worse	Trending better
Obesity – ages 10-17	18.2%	Worse	Trending worse
Teen births	27.0 per 1,000	Worse	Trending better

MCH Strengths/Needs

An assessment of the needs through web-based surveys, focus groups, and key informant interviews yielded a variety of issues for the Adolescent Population Health Domain. Based on stakeholder perceptions, issues were identified in the following areas: pregnant and parenting teens; reproductive and sexual health education; adolescent mental health; adolescent smoking, substance, and alcohol use; physical activity; and the need for trusted adult role models and mentors, which some adolescents perceived they did not have.

Successes, Challenges and Gaps Related to Major Morbidity, Mortality, Health Risks or Wellness

Need statements for the Adolescent Population Health Domain, based upon FAD and stakeholder input, developed for use in choosing the state's priority needs for the coming 5-year cycle are as follows:

1) Inequitable access to health resources based on race/ethnicity, socioeconomic status, geographic location, and education
2) Discrimination, bias, and differences in quality of care based on race/ethnicity, socioeconomic status, marital status, age, insurance status/type, sexual orientation, and gender identity
3) Lack of or inadequate access to affordable and safe options for physical activity, exercise, and recreation
4) Lack of or inadequate access to comprehensive reproductive health care, including for LGBTQ populations and adolescents with disabilities
5) Inadequate and insufficient health and sexual health education
6) Lack of or inadequate access to mental health services that are comprehensive and age-appropriate
7) Lack of or inadequate substance abuse treatment (smoking, alcohol, drugs) and prevention education
8) Lack of supports for pregnant and parenting teens
9) Inadequate or insufficient preparation, information, and resources to support transition to adulthood
10) Limited access to adult role models and mentors

Selected State Needs and Identified National MCH Priority Areas

In consideration of the national priority areas, the issues identified, desired outcomes, required mandates, existing capacity, and a reasonable opportunity for a focused programmatic effort to lead to an improved outcome for the Adolescent Population Health Domain, "**Lack of timely, appropriate, and consistent health and developmental screenings**", "**Lack of preventive dental visits across all Title V populations, especially for those uninsured**", and "**Lack of supports for pregnant and parenting teens**" were selected as the state priority needs.

Cross-Cutting/Systems Building

In regards to health equity and disparities, several themes noted across all domains were as follows: indicator data

show differences in outcomes based on race, ethnicity, and socioeconomic status; and stakeholders expressed differences in access to services, treatment experiences, and perception of quality of care based on race, ethnicity, socioeconomic status, marital status, insurance status and type, sexual orientation, and gender identity.

Selected State Needs

In consideration of the issues identified, desired outcomes, existing capacity, and a reasonable opportunity for a focused programmatic effort to lead to an improved outcome focused on health equity for the Cross-Cutting/System Building Domain, "**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**" was selected as the state priority need.

***CSHCN* - Overview of Health Status**

Per the 2017-2018 NSCH-CSHCN data Alabama is trending slightly worse in Transition and Medical Home indicators but trending slightly better in Systems of Care. NSCH-CSHCN data indicates 37 percent of Alabama CSHCN receive care within a medical home compared to 42.7 percent nationwide and 15 percent of YSHCN receive the services necessary to make appropriate transitions to adult healthcare, work, and independence compared to 18.9 percent nationwide. NSCH-CSHCN data indicates 16.3 percent of Alabama CSHCN receive care in a well-functioning system compared to 15.7 percent nationwide. In FY2019, CRS had an enrollment of 11,772 CYSHCN; provided 13,497 clinic visits; responded to 2,066 requests for information and referral; and had 154,784 client encounters.

MCH Strengths/Needs

An assessment of the needs through web-based surveys, focus groups, and key informant interviews yielded a variety of issues for the CSHCN Domain. Based on stakeholder perceptions, issues were identified in the following areas: access to health and health-related care; lack of transportation; workforce shortage, location, and distance to providers; inadequate insurance coverage and cost; strict program qualifications; access to community-based services; accessibility and accommodations; safe, affordable, and inclusive child care and preschool programs; transition to adulthood and adult health care; family supports and respite care; special education; navigation of system of care; technology, electronic medical records, and lack of data; and healthy behaviors.

Successes, Challenges and Gaps Related to Major Morbidity, Mortality, Health Risks or Wellness

Needs statements for the CSHCN domain, based upon FAD and stakeholder input, developed for use in choosing the state's priority needs for the coming 5-year cycle are as follows:

1) Insufficient special education services
2) Lack of or inadequate access to health and related services, especially in rural areas and for services identified as difficult to obtain
3) Lack of or inadequate supports for transition to all aspects of adulthood
4) Lack of or inadequate access to comprehensive medical homes
5) Increase family and youth involvement and participation in advisory groups, program development, policy-making, and system-building activities
6) Lack of provider workforce that is knowledgeable about CYSHCN, especially in rural areas and for adult services
7) Lack of or inadequate access to community services and supports, especially in rural areas and for services identified as difficult to obtain
8) Lack of access to quality early childhood programs that are safe and affordable, especially for children with disabilities
9) Lack of or inadequate accessibility and accommodation supports, including physical environment, interpreter services, and materials
10) Lack of integrated technology, medical records, and data to support continuity of care and data-informed decision-making for program planning and evaluation
11) Inadequate assistance for families to navigate the system of care, including identifying providers, family supports, and community resources
12) YSHCN are not meeting guidelines for physical activity and nutrition
13) Inadequate insurance including cost and benefit coverage issues
14) Support shared decision-making and partnerships between families and health and related professionals
15) Lack of or inadequate transportation for accessing health and community services.

Selected State Needs and Identified National MCH Priority Areas

In consideration of the national priority areas, the issues identified, desired outcomes, required mandates, existing capacity, and a reasonable opportunity for a focused programmatic effort to lead to an improved outcomes for the CSHCN domain, "lack of or inadequate supports for transition to all aspects of adulthood," "lack of or inadequate access to health and related services, especially in rural areas and for services identified as difficult to obtain" and "increase family and youth involvement and participation in advisory groups, program development, policy-making, and system-building activities" were selected as the state priority needs.

III.C.2.b.ii. Title V Program Capacity

III.C.2.b.ii.a. Organizational Structure

ORGANIZATIONAL STRUCTURE

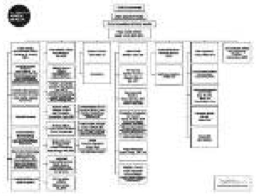
ADPH ORGANIZATIONAL STRUCTURE

The Alabama Department of Public Health (ADPH) and Alabama Department of Rehabilitation Services (ADRS) are not cabinet-level agencies. As their respective boards appoint the heads of these departments, they have experienced more stability and continuity in leadership, enabling a more consistent program direction. However, compared to agencies having a commissioner appointed by the Governor, ADPH and ADRS have relatively less access to the Governor. Linkage for communication and organizational cooperation exists on two levels for ADRS and ADPH. The State Health Officer and the ADRS Commissioner work together on matters of mutual concern, as do the Children's Rehabilitation Service (CRS) and Bureau of Family Health Services (FHS or Bureau) Directors. Staff members from CRS and FHS meet three times a year to discuss programmatic and administrative issues regarding MCH services. ADPH operates under the direction of the State Board of Health and is not under the direct authority of the Governor. ADPH's FHS, located in the central office, administers the Maternal and Child Health Services Title V Block Grant. ADPH contracts with CRS to administer services to children and youth with special health care needs (CYSHCN). ADPH is responsible for the administration of programs carried out with allotments under Title V. ADPH funds are further divided between the Perinatal Health Division, the Oral Health Program, the Women's and Children's Health Division, Consultants-Pediatric Division, the Office of Women's Health, and the public health districts. Other programs administered by FHS include the Title X Family Planning Grant; the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); the State Perinatal Program (SPP); the Healthy Childcare Alabama Program; ADPH's Cancer Prevention and Control Program; the Pregnancy Risk Assessment Monitoring System (PRAMS) Program; and the State Dental Program.

ADRS ORGANIZATIONAL STRUCTURE

The Alabama Board of Rehabilitation Services, whose members are appointed by the Governor, oversees ADRS, which consists of four major programs: Alabama's Early Intervention System (EI), CRS, Vocational Rehabilitation Service (VRS), and the State of Alabama Independent Living/Homebound Service (SAIL). The board appoints a Commissioner of ADRS to oversee and direct the department. CRS, a division of ADRS, has administrative responsibility for the State Title V CSHCN Program and the Alabama Hemophilia Program. 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.

Current organizational charts for ADPH, FHS, ADRS, and CRS are attached to this section.



III.C.2.b.ii.b. Agency Capacity

AGENCY CAPACITY

ADPH Agency Capacity

The Title V Program has substantial capacity to provide services to– promote and protect the health of—all mothers, infants, children and youth, and pregnant women. Through the organizational structure of FHS and the programs administered by FHS, the Title V Program has the capacity to provide Title V services for four of the five population health domains, with CRS providing services for the fifth population health domain, CSHCN. Programs and activities of the Office of Women's Health Branch of FHS's Women's Health Division directly impact the Women/Maternal population health domain. Subsequently, the programs and activities of the Child and Adolescent Health Division directly impact the Adolescent and Child population health domains. The Perinatal/Infant population health domain is impacted by the programs and activities of FHS's Perinatal Health Division.

To maintain capacity, ADPH, including FHS, has periodically adapted to budgetary constraints imposed by factors beyond the department's control. Such factors, as well as the department's adaptation to resultant budgetary constraints, have been critical to maintenance of MCH capacity and illustrate the resilience of the State's Title V Program through difficult times. The Alabama Legislature approved a 2021 General Fund budget of $2.4 billion which increased spending over the current year by $170 million. The COVID-19 pandemic has stalled the economy putting more than 400,000 Alabamians out of work. Despite the massive economic shutdown that has crippled the state economy and thousands of businesses, there will not be any need to prorate either the General Fund or the Education Trust Fund budgets in 2020. The Alabama Senate has approved a $2.4 billion General Fund budget which is smaller than the one proposed by the governor before the coronavirus pandemic but larger than the 2020 budget. The General Fund is still healthy, and projections indicate the slowdown caused by the pandemic will reduce growth in tax revenues but not force overall cuts. Most agencies would receive about the same amount as this year. Three agencies would receive increases requested in the governor's budget. The largest increase from the General Fund would go to Medicaid, which provides some levels of service to almost a million Alabamians. Medicaid would receive $94 million more than this year, a total of $820 million. Public Health would receive a $35 million increase, to $106 million. A portion of this money will cover an increase in the state's share of the Children's Health Insurance Program, ALL Kids. Mental Health would receive a $26 million increase, to $154 million. The budget for the fiscal year starts October 1st.

The Title V Program, as well as other programs administered by FHS, serves all of the State's 67 counties. FHS Program managers monitor all aspects of program administration in order to ensure a statewide system of services, that reflect the components of comprehensive, community-based, coordinated and family-centered care. Because funds from other sources help to pay for services to Title V populations, Title V Program staff stay abreast of those programs and continue to collaborate with other state agencies, health services entities, and private organizations to support health services delivery at the community level and intervene, if necessary. Late in FY 2003, for example, the State Health Officer asked FHS to reduce FY 2004 projected expenditures of MCH Services Block Grant funds (MCH Title V funds) on FHS programs in order to increase MCH Title V support of CHDs, that faced inadequate local support and decreased availability of state funds. Such use of MCH Title V dollars supported local infrastructure, so that CHDs could continue serving the state's low-income maternal and child population. In FY 2003, FHS was informed that state dollars previously available to support the SPP and the State Dental Program would no longer be available. Accordingly, FHS's Deputy Director and Division Directors scrutinized projected expenditures for savings. Consequently, FHS was able to redirect funds to assure continuance of the SPP and the Dental Program.

Current collaborations with other state agencies, health services entities, and private organizations must be maintained and strengthened and new opportunities explored in order to support health services delivery at the community level. FHS continues to aim to partner with Medicaid and the Alabama Hospital Association at every available opportunity. FHS routinely attends meetings with both agencies, sits on committees with common goals, and invites them to participate in all statewide MCH programs. FHS has several programs that collaborate closely with Medicaid. The Title X Program works closely with MCH to ensure that contraception and other family planning needs are met. The growth of ADPH's telehealth capabilities and partnerships continues and includes additional

MCH telehealth initiatives. The state MCH Title V Program must continue to use its Title V funds to support CHDs which helps to support the local communities of which the CHDs are a part. FHS must look for opportunities to use Title V funds to coordinate with other community health service providers and with health components of community-based systems in order to ensure continuity of care for all mothers and children, including CSHCN.

CRS Agency Capacity

The Title V CSHCN Program administrated by CRS ensures the capacity to promote and protect the health of CSHCN in our state. CRS's 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 clinics across eight service districts. CRS staff members 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 is organized in 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. State staff administer three state advisory committees (Parent, Youth, and Hemophilia). Collaborative planning through partnerships with public and private agencies occurs at the state level to develop and enhance systems of services for CYSHCN and their families. These enhanced systems are achieved via interagency agreements, data sharing, coordinated training events, task force and interagency committees, and state legislation.

CRS continues its interagency agreement with Medicaid to provide Children's Specialty Clinics and facilitates service planning via its advisory role regarding the unique needs of CYSHCN and their families. CRS works closely with the state's two tertiary-level pediatric hospitals to provide community-based care coordination, family support activities, and financial assistance to CRS-eligible children receiving care at these institutions. This coordination ensures that children are referred and receive appropriate services from all providers. CRS maintains continuous communication with these providers to assure that needs are identified and comprehensive services are received. The eight service districts are each led by a supervisor responsible for personnel, service implementation, and office operations. CRS district offices function as powerful resource networks in local communities. The fourteen local offices around the state provide community-based services to CSHCN and their families through outpatient specialty medical clinics; care coordination activities; home, school, and community visits; and agency consultations. Specialized medical staff are recruited from the public and private sector to serve CYSHCN. Medical staff may provide services in their home community or travel to CRS clinic sites in rural areas where specialty services are not otherwise available. Local CRS staff participate in county-level Children's Policy Councils (CPC) to represent CYSCHN and their families. CPCs address coordination of a wide array of children's services, including education and primary, specialty, home health, and mental health services at the community level. The goal of these partnerships is to provide a community based, comprehensive, coordinated system of care. Financial assistance and family participation are determined by the program's sliding fee scale. Families with incomes at or below 300 percent of FPL and children, who are insured through Medicaid or ALL Kids, are eligible for full financial assistance. CRS also partners to implement an enhanced benefits package for CYSHCN through ALL Kids Plus, provided through the SCHIP. Referrals for children evaluated for SSI are received in the State Office from the State Disability Determination Units (DDUs) in Birmingham and Mobile and are directed to the appropriate local office. Families

referred by the DDU are contacted regarding CRS services, including care coordination. Flyers with the state toll-free number and a listing of CRS services are distributed through the SSA local offices.

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

Clinical Medical - Medical and rehabilitative services provided through CRS clinics. Care is based on a treatment plan and delivered by way of a multidisciplinary team.

Clinical Evaluation - Specialized clinical evaluation services, including follow-up as appropriate, through multidisciplinary teams.

Care Coordination- Assist clients and families in identifying, accessing, and utilizing community resources to effectively meet their needs. Care coordination is the process that links CSHCN and their families to services and resources in a coordinated effort to maximize their potential and provide them with optimal health care.

Care coordinators, typically nurses or social workers, travel within their assigned counties to meet families, arrange services, and maintain relationships with providers and community organizations. They work to improve the state's system of care by identifying local providers with expertise related to CYSHCN and working with community groups on issues concerning CYSHCN. The agency provides specialized training to selected care coordinators that serve as transition specialists in all eight districts. These specialists provide targeted, comprehensive transition services to CRS-enrolled youth.

Information and Referral - Provide appropriate educational materials and/or information about available resources at the state and community level.

Patient/Family Education - Provide information to clients and their families necessary to carry out prescribed treatment as well as to enable clients/families to make informed choices about the services that best meet their needs. Patient/family education is provided in a culturally competent form, respecting the values, culture, and language needs of the patient/family.

Parent Connection- Family-to-family support and family involvement with policy development and decision-making at all levels. Local Parent Advisory Committees meet in every district office to ensure consumer and provider input into the program.

Youth Connection– Youth-to-youth connections which support youth involvement in policy development and decision making and promote transition services for YSHCN in all aspects of adult life.

III.C.2.b.ii.c. MCH Workforce Capacity

MCH Workforce Capacity

It is through an adequately sized and skilled workforce that the Alabama MCH Title V Program is able to carry out the core public health functions in order to achieve increased accountability through ongoing performance measurement and monitoring to ensure that program goals are met. Alabama Title V Program staff continue to seek guidance and assistance from the National MCH Workforce Development Center and apply for training opportunities presented by the Center, AMCHP, and HRSA to ensure its workforce has the tools necessary for effective program planning and implementation. It is through filling positions in a timely manner and offering the necessary training to help staff work productively that the Alabama MCH Title V Program seeks to maintain staffing and respond to any projected shifts in

the workforce over the 5-year reporting period.

ADPH: MCH Workforce Capacity

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 help pay for services to Title V populations.

Excluding WIC cost centers, 409.6 FTEs served Title V populations in FY 2019, down 3.6 percent (or 15.5 FTEs) since FY 2018. In FY 2019, the 409.6 total non-WIC FTEs serving Title V populations were distributed as follows: 76.6 percent at the county level, 0.1 percent at the Public Health District level, and 23.3 percent at the state level. The positions accounting for 5 percent or more of the total non-WIC FTEs serving Title V populations were aides (6.2 percent), social workers (17.3 percent), nurses (28.5 percent), Administrative Support Assistants (ASAs) (17.0 percent), Nurse Practitioners/Midwife (7.7 percent), and mobile employees (13.2 percent). In FY 2019, 231.8 FTEs were devoted to WIC, decreasing by 0.3 percent (or 0.8 FTE) since FY 2018. In FY 2019, 1.0 FTE were devoted to SSDI.

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

Grace H.A. Thomas, MD, FACOG, joined FHS in May 2005 as Medical Director for Women's Health. Beginning in 2011 until present, she serves as the Medical Officer for FHS where she assists with agency wide strategic planning, development and management of policies, programs, and finances. Before joining FHS, Dr. Thomas worked as a private practitioner for over 10 years. Academic credentials include an undergraduate degree in Biology and a medical degree specialized in Obstetrics and Gynecology.

Amanda Martin, MSPH, Title V Director, started with ADPH in 2001 as a Health Educator. In 2008, she joined FHS's Women, Infants and Children (WIC) Division and was later appointed State WIC Director in September 2013. Ms. Martin now serves as the Deputy-Director of FHS. Ms. Martin previously served as the state Health Professional Shortage Area Coordinator and as a health educator in health promotion. Academic credentials include an undergraduate degree in Environmental Science and a graduate degree in public health.

Meredith Adams, LCSW, PIP, joined ADPH in September 2006 as a Social Work Consultant. She joined FHS in 2011 as the Director of Training for case management/care coordination and was appointed Social Work Director in April 2014. She now serves as the Director of the Child and Adolescent Health Division. Academic credentials include an undergraduate degree in Human Development and Family Studies and a graduate degree in Social Work.

Beth Allen, FNP-C, MSN, CRNP, joined FHS in 2012 and now serves as the Women's Health Division Director and Nurse Practitioner Director. Prior to joining FHS, she served in various capacities at the county and area level. Ms. Allen's background includes experience as a college instructor and as a private practitioner. Academic credentials include undergraduate degrees in biology and nursing and graduate degrees in nursing and nursing practice.

Jessica Hardy, MPH, DNP, APRN, ACNS-BC, a Robert Wood Johnson Foundation Public Health Nurse Leader, serves as the ADPH Telehealth Consultant and the Director of the Office of Women's Health and the Assistant Director of FHS's Women's Health Division. Dr. Hardy joined ADPH over 25 years ago and joined FHS in the Fall of 2016. Academic credentials include undergraduate degrees in nursing and graduate degrees in nursing and nursing practice.

Allison Hatchett, BS, MPH, has been with ADPH 14 years. She transferred from the Office of HIV Prevention and Care to the Bureau of Family Health Services on May 1 and now serves as the WIC Division Director. Academic credentials include an undergraduate degree in Biology and Physical Science and a graduate degree in Epidemiology.

Samille Jackson, MSPH, began her career with ADPH in 2007 and transferred to FHS in September 2017, as the first Maternal and Child Health (MCH) Coordinator. She has prior experience in health promotion, chronic disease

programs, and injury prevention. Academic credentials include an undergraduate degree in environmental science and a graduate degree in public health.

Tommy Johnson, DMD, joined FHS in November 2017 as the ADPH State Dental Director. Before joining FHS, Dr. Johnson worked as a private practitioner for over 28 years. Academic credentials include a medical degree specialized in Dentistry.

Dan Milstead, BS, MBA, joined ADPH in January 1989 as Director of the WIC Division's Financial Management Branch. In 1998, Mr. Milstead transferred to the Bureau of Financial Services as the Director of Third Party Collections but returned to FHS in July 2000. In April 2005, he assumed directorship of FHS's Administrative Division. Academic credentials include an undergraduate degree in accounting and a graduate degree in business administration.

Janice M. Smiley, MSN, RN, has been with ADPH since 1996, and joined FHS in 2007. In May 2014, she was appointed as the Director of the Perinatal Health Division. Ms. Smiley's background includes 35 years of experience in maternal child nursing and worksite wellness. Academic credentials include an undergraduate degree in nursing and a graduate degree in nursing and nursing administration.

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

Tammie R. Yeldell, BS, MPH, joined ADPH in October 1993 as a Statistician with the Center for Health Statistics. Ms. Yeldell joined FHS in December 1999 and is now an Epi Supervisor who serves as the Director of the MCH Epidemiology Branch. Academic credentials include an undergraduate degree in Applied Mathematics and a graduate degree in maternal and child health.

CRS: MCH Workforce Capacity

As of May 2020, 205.1 FTEs are in the field: eight district supervisors, .60 custodial worker, 56 ASAs, 52 social workers, 30 nurses, 15 rehabilitation assistants, 7 nutritionists, eight audiologists, eight local parent consultants (LPC), 7 PTs, 7 SLPs, five OTs, and 1.5 rehabilitation counselors. Twenty-one budgeted vacancies are available: three ASAs, one audiologist, five social workers, one OT, two PTs, one SLP, one Rehab Counselor, two staff nurses, two Rehab Assistants, and three parent consultants.

As of May 2020, 17 FTEs are at the State Office: 13 administrative and four clerical staff. Administrative staff include one Assistant Commissioner, one Assistant Director, one health services administrator, two nurses, one SLP, one audiologist, one state parent consultant (SPC), two youth consultants, one social worker, and two patient account managers.

Through a contract with Easter Seals of Central Alabama, CRS has on staff eight parents of CYSHCN as LPCs and one SPC. Easter Seals employs these individuals and provides benefits. The SPC is based in CRS's state office and advises in collaborative interagency efforts, recruits additional parent participation, facilitates the State Parent Advisory Committee, coordinates the parent-to-parent network and publishes the Parent Connection newsletter. CRS supports State and Local Parent Advisory Committee activities.

Brief biographies of key Title V CRS personnel follow.

Jane Elizabeth Burdeshaw is the ADRS Commissioner. She began her career with ADRS in 1998 as a rehabilitation counselor for SAIL, and then for Vocational Rehab Service. She served as rehab specialist from 2001-09 coordinating staff training and development. She was promoted in 2009 to serve as the director of Human Resources Dept. until her appointment as ADRS commissioner in in 2016. Her academic credentials include an

undergraduate degree in psychology and a graduate degree in counseling and human development.
Cathy Caldwell, BS, MPH, Director of CRS and the Assistant Commissioner of ADRS. She has 20 years previous experience with ADPH, serving as the Director of Alabama's Children's Health Insurance Program (CHIP). Her academic credentials include an undergraduate degree in psychology and a graduate degree in public health.
Kim McLaughlin, BS, M. Ed, serves as the Assistant Director of CRS and the Hemophilia Program Coordinator. Ms. McLaughlin has over 20 years' experience as a CRS State Office staff member. Her academic credentials include an undergraduate degree in vocational evaluation and graduate degree in rehabilitation counseling.
Stacey Neumann, LGSW, joined CRS in October 2019 and serves as the Maternal and Child Coordinator. She was previously the Director of the Vendor Management Branch for WIC and has 17 years' experience in public health. Her academic credentials include an undergraduate degree in human development and family studies and a graduate degree in social work.
Susan Colburn, BS, serves as the State Parent Consultant. She has over 25 years' experience advocating for CSHCN. She serves on a variety of statewide boards, councils and committees, and is a member of the national Association of Maternal and Child Health Programs, including currently serving as a member of the AMCHP Board of Directors. Her academic credentials include a B.S. degree from Auburn University.
Kimberly Lewis, MSW, LICSW, PIP, serves as the CRS Care Coordination Program Specialist. Ms. Lewis joined the CRS State Office in 2014. She has over 21 years of social work experience. Her academic credentials include an undergraduate and graduate degree in social work.

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

PARTNERSHIPS, COLLABORATION, AND COORDINATION

The Title V program fosters relationships with programs both internal to FHS and within ADPH which are not funded by the state Title V program but which serve the legislatively-defined MCH populations thereby helping to contribute to and expand the state Title V program's capacity and reach in meeting the needs of its MCH population. The Title V program's ongoing commitment and efforts to build, sustain and expand partnerships, to work collaboratively and to coordinate with other MCH-serving organizations occurs in the context of FHS and CRS seeking to accomplish their respective missions and identify priority MCH needs, rather than under a particular plan to coordinate with certain programs, some of which are administered by FHS. Following are highlights of selected collaborations in which FHS or CRS engage.

SELECTED COLLABORATIONS INVOLVING BOTH FHS AND CRS

- interagency meetings
- MCH reports/applications
- 5-year MCH needs assessments (Advisory Groups and reports)
- State Newborn Screening Advisory Committee
- State Newborn Hearing Screening Advisory Committee
- State Early Hearing Detection and Intervention Committee

ADPH COLLABORATIONS: INTERNAL AND WITH OTHER ADPH ENTITIES
Collaborations occur within FHS and among FHS staff and other ADPH staff.

- Title X Family Planning
- WIC
- State Perinatal Program
- Social Work Program
- Oral Health Branch
- Adolescent Pregnancy Prevention Program
- Newborn Screening Program
- Lead Program
- Early Childhood Comprehensive Systems (ECCS)
- SSDI
- CoIIN
- Healthy Child Care Alabama Program
- FHS's Medical Consultant Branch
- Fetal and Infant Mortality (FIMR) Program
- Alabama Maternal Mortality Review Program
- Alabama Child Death Review System
- Alabama Pregnancy Risk Assessment Monitoring System (PRAMS)
- CHIP
- ADPH Immunization Division
- The Bureau of Health Promotion and Chronic Disease
- ADPH HIV/AIDS Prevention and Control Division
- Bureau of Disease Control's STD Control Division
- Bureau of Clinical Laboratories
- Vital Statistics
- Center for Health Statistics
- Public Health Nursing Section
- Offices of Women's Health
- Office of Minority Health
- Injury Prevention Division
- County Health Departments
- Public Health District (PHD) Administrators
- PHD Social Work Directors
- PHD Nutrition Directors

ADPH COLLABORATIONS: EXTERNAL ENTITIES

FHS Staff collaborate with many statewide and community groups and governmental and private organizations to address various issues, such as with:

- Medicaid
- Alabama Chapter of the March of Dimes (AMOD)
- State Perinatal Advisory Committee (SPAC)
- Regional FIMR Teams
- Department of Mental Health (DMH)
- State Department of Education
- Hospital Facilities
- Private Physicians
- Gift of Life (a Healthy Start Grantee)
- Department of Human Resources (DHR)
- Children's of Alabama (headquartered in Birmingham and includes the Children's Hospital)
- The Alabama Campaign to Prevent Teen Pregnancy
- Alabama Farmer's Market Authority
- Alabama Cooperative Extension System
- Poarch Band of Creek Indians (PCI)

CRS COLLABORATIONS: INTERNAL AND WITH OTHER ADRS ENTITIES

Collaborations occur within CRS and among CRS and other ADRS programs.

- CRS Needs Assessment Leadership Team
- State Interagency Transition Team
- Youth Leadership Forum Steering Committee
- State Parent Advisory Committee
- Youth Advisory Committee
- Hemophilia Advisory Board
- Alabama's Early Intervention System
- Vocational Rehabilitation Service
- State of Alabama Independent Living Service

CRS COLLABORATIONS: EXTERNAL ENTITIES

- Alabama Medicaid Agency
- Children's Hospital of Alabama
- UAB Pediatric Pulmonary Center Advisory Committee
- UAB Civitan International Research Consumer Advisory Committee
- UAB SOPH MCH Leadership and Policy Advisory Committee
- University of South Alabama Health - Strada Pediatric Complex Care Clinic
- Emergency Preparedness Special Population Taskforce
- Department of Mental Health Children's Taskforce
- UCP Advisory Board
- Alabama Obesity Taskforce
- Children's Justice Taskforce
- Oral Health Coalition of Alabama
- Partners in Project Excellence Advisory Committee
- Young Child Wellness Coalition
- Alabama Child Health Improvement Alliance (ACHIA)
- Alabama Head Injury Task Force
- Hudson Alpha Institute for Biotechnology
- Alabama Respite Coalition
- Children's Policy Councils
- Alabama MCH Partnership
- One Strong Voice, Disability Leadership Coalition
- Covering Alabama's Kids/Families Coalition
- Family Voices of Alabama's Family-to-Family Health Information Center
- Alabama Lifespan Respite Network Sharing the Care Public Awareness Committee
- AMCHP: Board of Directors, Family and Youth Leadership Committee

CRS staff collaborate with many statewide and community groups and governmental and private organizations to address various issues, such as with:

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

After a thorough examination of the findings from the FYs 2019-20 Needs Assessment, the ten highest priority needs, which address the five MCH Population Health Domains, selected by the state's Title V program for the FYs 2021-2025 reporting cycle are detailed below. The numbers assigned are used for listing and do not rank the priorities.

ADPH: State Selected Priorities

The ADPH Priority Needs for the FYs 2021 – 2025 reporting cycle are as follows:
1) High levels of maternal mortality; 2) High levels of infant mortality (and associated factors of preterm birth and low birth weight); 3) High levels and worsening trends of sleep-related/SUID deaths; 4) Lack of timely, appropriate, and consistent health and developmental screenings; 5) Lack of supports for pregnant and parenting teens;
6) Lack of preventive dental visits across all Title V populations, especially for those uninsured; and 7) 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.

ADPH: How Priority Needs Were Determined

Qualitative data collected through web-based surveys, focus groups, and key informant interviews, in addition to quantitative data from the FAD Resource Document, were analyzed and the findings presented at the MCH Needs Assessment Advisory Group Meeting. At this meeting, suggested priority needs were identified. Individuals in breakout groups representing each of the four MCH Population Health Domains, upon which ADPH would focus, rated each need according to: a) Importance, b) Alignment, and c) Effective Interventions. The broad set of identified needs for each of the domains was ranked by group members in consideration of: a) Importance for community/population based on data: The extent or scope based on all data; how important is this issue or need based on what you have heard from the data presentation (i.e. Importance); b) Aligns with other priorities and initiatives in the state: The extent to which the issue/need aligns with other priorities and initiatives in the state (i.e. Alignment); and c) Effective interventions or potential solutions: The extent to which evidence-based or evidence-informed solutions and interventions exist to address the issue or need (i.e. Effective Interventions). An assessment of the needs from the data analyses yielded a variety of issues that were specific to each of the domains. When reviewing the issues specific to each of the domains, group members also identified strengths/needs that crossed all three legislatively-defined groups as well as strengths/needs that related to health equity and disparities. A complete listing of all the domain-specific strengths/needs identified for each MCH Population Health Domain is described in greater detail in the MCH Population Health Status section (III.C.2.b.i) within the Five-Year Needs Assessment Summary of this application/annual report.

ADPH: Process for Selecting State Priority Needs

Following the rating and final rankings that the broader stakeholders completed at the MCH Needs Assessment Advisory Group Meeting, FHS's Bureau Management Team (BMT) convened (via webinar and online survey in response to the ongoing COVID-19 pandemic) to reach consensus on the final priority needs identified in the 2020 Needs Assessment Process. The BMT rated all priority needs in their domains of focus on five criteria while concurrently considering current program activities, collaborations, partnerships, and the capacity available to address the need. The BMT selected strengths/needs for which they felt ADPH was better able to address during the upcoming five-year reporting cycle.

ADPH: State Selected Priorities Compared to Previous Five-Year Priorities

An assessment of the needs from the data analyses yielded a variety of issues that were specific to each of the MCH Population Health Domains in addition to ones that crossed all three legislatively-defined groups as well as strengths/needs that related to health equity and disparities. Included in these identified strengths/needs were the priority needs or some version of these needs, from the previous 5-year cycle. In consideration of the national performance priority areas and the NOMs that would be impacted by the selection of a particular NPM, the BMT selected its final seven priorities. None of ADPH's priorities from the previous 5-year reporting cycle were continued. However, except for two instances, the priority needs selected for each domain related to the previous priority need such that the linked NPM remained the same. For the Women/Maternal domain, "High levels of maternal mortality" replaced "Lack of or inadequate access to comprehensive reproductive and well woman health care" and is linked to NPM #1: Well-woman visit. For the Perinatal/Infant domain, "High levels of infant mortality (and associated factors of preterm birth and low birth weight" replaced "Desire to maintain and strengthen regionalized perinatal care" and is linked to NPM #3: Risk-appropriate perinatal care. As well, "High levels and worsening trends of sleep-related/SUID deaths" replaced "Lack of awareness of and trust in safe-sleep recommendations" and is linked to NPM #5: Safe Sleep. For the Child Health domain, "Lack of timely, appropriate, and consistent health and developmental screenings" replaced "Low rates of preventive health and developmental screening for children" and is linked to NPM #6: Developmental screening. For the Adolescent Health domain, "Lack of timely, appropriate, and consistent health and developmental screenings" replaced "Low rates of preventive health and developmental screening for adolescents" and is linked to NPM #10: Adolescent well-visit. For the strengths/needs that crossed all three legislatively-defined groups, "Lack of preventive dental visits across all Title V populations, especially for those uninsured" replaced both "Inadequate and insufficient health education and outreach pertaining to oral health" and "Inadequate health and dental insurance for all Title V populations" and is linked to NPM #13: Preventive dental visit. For the Adolescent Health domain, another priority need, "Lack of support for pregnant and parenting teens" was also selected. For the Cross-cutting/Systems Building domain, "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" was selected.

CRS: State Selected Priorities

The CSHCN Priority Needs for the 2021 – 2025 reporting cycle for CRS are as follows: 8) Lack of or inadequate supports for transition to all aspects of adulthood; 9) Lack of or inadequate access to health and related services, especially in rural areas and for services identified as difficult to obtain; and 10) Increase family and youth involvement and participation in advisory groups, program development, policy-making, and system-building activities.

CRS: How Priority Needs Were Determined

Qualitative data collected through web-based surveys, focus groups, and key informant interviews, in addition to quantitative data from existing databases and national surveys, were analyzed and the findings presented to the CRS Needs Assessment Advisory Committee. Due to the COVID-19 crisis and quarantine, the scheduled in-person advisory committee meeting was canceled. As previously mentioned, an online format was used to rate the 15

identified MCH needs for CYSHCN. Advisory committee members could work at their own pace over a 3-day period to view findings, provide input, and assign an individual rating for each need. Individual group members rated each need according to the following three separate criteria: 1) Importance based on data /Impact on population, 2) Aligns with other priorities and initiatives in Alabama, and 3) Effective interventions or potential solutions. Individual ratings for criteria scores were summed to yield a total score for each need to assign rank order for needs.

CRS: Process for Selecting State Priority Needs

Following the rating and final rankings that the broader stakeholders completed during the April 2020 online asynchronous sessions, the CRS Needs Assessment Leadership Team met virtually to reach consensus on the final priority needs. CRS leadership utilized knowledge of Agency capacity and feasibility considerations, along with input obtained from stakeholders, in order to reach a consensus on the final priority needs. CRS leadership discussed each need through the lens of five criteria to reach agreement on a rating according to the scale provided. Additional consideration was given to whether the need was rated in the top three on the community stakeholder rankings from the virtual prioritization process. The group also considered current program activities, collaborations, partnerships, and the capacity available to address the need. The top three priority needs for CYSHCN were finalized based on internal discussion and rating.

CRS: State Selected Priorities Compared to Previous Five-Year Priorities

The needs assessment process yielded a variety of issues that were specific to the CSHCN Domain. Though the additional 12 identified needs are not included in the final list, the CRS Needs Assessment Leadership Team recognized that through the two newly developed SPMs many of the other priority needs could be addressed directly or indirectly. Lack of inadequate supports for transition to all aspects of adulthood (NPM #12) was the only CSHCN priority retained from the 2016-2020 needs assessment cycle. Through the addition of a new ESM and revised objectives and strategies, CRS will continue to enhance transition services for YSHCN.

III.D. Financial Narrative

	2017		2018	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$11,315,300	$11,264,929	$11,315,300	$11,411,388
State Funds	$30,602,749	$32,943,966	$17,818,117	$27,113,028
Local Funds	$0	$0	$0	$0
Other Funds	$1,638,969	$775,151	$2,041,819	$1,060,312
Program Funds	$54,105,614	$48,978,741	$62,194,456	$54,375,230
SubTotal	$97,662,632	$93,962,787	$93,369,692	$93,959,958
Other Federal Funds	$144,823,257	$135,088,675	$136,719,366	$136,255,926
Total	$242,485,889	$229,051,462	$230,089,058	$230,215,884

	2019		2020	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$11,264,929	$11,401,820	$11,411,388	
State Funds	$32,943,966	$25,173,350	$27,113,028	
Local Funds	$0	$0	$0	
Other Funds	$1,536,572	$1,223,021	$1,536,572	
Program Funds	$48,718,812	$54,401,167	$32,697,532	
SubTotal	$94,464,279	$92,199,358	$72,758,520	
Other Federal Funds	$135,224,143	$131,593,753	$136,326,832	
Total	$229,688,422	$223,793,111	$209,085,352	

	2021	
	Budgeted	**Expended**
Federal Allocation	$11,401,820	
State Funds	$24,722,324	
Local Funds	$0	
Other Funds	$1,571,751	
Program Funds	$32,132,060	
SubTotal	$69,827,955	
Other Federal Funds	$131,634,427	
Total	$201,462,382	

III.D.1. Expenditures

ADPH

As per Block Grant requirements, the budget for each reporting year was set 2 years' prior in the application (i.e. FY 2019 budget was set in the FY 2017 Annual Report). The level funding methodology for budgeting has been used in the application. Over time, actual expenditures appear to give a more accurate reflection of funds expected instead of making estimates for a future budget environment two years out.

/2021/ Effective 10/01/2019, as reported in the previous application ADPH lost substantial care coordination revenue with the coming of Medicaid's new Alabama Coordinated Health Network (ACHN). Programs affected were Family Planning Care Coordination, EPSDT Care Coordination, and Patient 1st Care Coordination. The loss of revenue has been reflected in the narrative.

The state should document and explain how the reported expenditures comply with the 30 percent-30 percent-10 percent 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 percent-30 percent-10 percent 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 51.35 percent; transfer to Children's Rehabilitation Services met the federally required minimum of 30 percent of the Block Grant; and the Administrative cost capped at 10 percent.

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.

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. In order 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 Program services. Medicaid is billed on 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 2019 Annual Report Expended of $11,401,820 was more than the FY 2017-2019 application's budgeted Grant Award of $11,264,929, a difference of $136,891. The MCH grant is available for two

years and some spending can overlap fiscal years.

Line 1A. (Preventive and Primary Care for Children) – FY 2019 Annual Report expended of $5.85m increased from the FY 2019 Application Budget amount of $4.58m, a difference of $1.27m or 27.71 percent. In 2017, when the budget was developed for 2019 the children served made up 40.69 percent of the total cost compared to the actual expended in 2019 of 51.35 percent. The higher percentage increases the cost associated with children.

Line 3. (State MCH Funds) - FY 2019 Annual Report Expended decreased to $25.2m from the FY 2019 Application Budgeted amount of $32.9m, a difference of $7.7m or -23.59 percent. When the FY 2019 budgeted amount was developed in FY 2017, the Other Support earned income was $54.6m compared to the 2019 actual support income of $62.3m, an increase of $7.7m. ADPH Earned Income programs showing increases EPSDT CC ($2.2m), Family Planning Medicaid ($1.3m), Family Planning Care Coordination ($1.2m), Patient 1st Care Coordination ($320k), DHR Healthy Child Care ($834k) and CRS ($631k). The increase in earned income of $7.7m and virtually no increase in cost are factors that determine the level of state support needed. In this case the net increase in earned income reflects a reduction in need for State support. These increases are reflection of current operations in 2019 and going forward income from care coordination activities will be eliminated, as a result, of Medicaid's ACHN networks providing services and the phasing out of ADPH as a provider.

Line 5. (Other Funds) – CRS FY 2019 Annual Report Expended was $1.22m which is a decrease from the FY 2019 Application Budget number reported of $1.54m, a difference of $313k or -20.41 percent decrease. See CRS explanation.

Line 6. (Program Income) - FY 2019 Annual Report Expended of $54.4m increased from the FY 2019 Application Budgeted amount of $48.7m, a difference of $5.7m or 11.67 percent. When the FY 2019 budget was developed in FY 2017, the ADPH actual total program income was reported at $35.9m compared to the FY 2019 actual income earned of $40.8m, a net increase of $4.9m or 13.65 percent. The programs that showed substantial increases were Family Planning Medicaid ($1.3m), Family Planning Care Coordination ($1.2m), and EPSDT Care Coordination ($2.2m) and Patient 1st Care Coordination ($320k). These increases are reflection of current operations in 2019 and going forward will be eliminated, as a result, of Medicaid's ACHN networks providing services and the phasing out of ADPH as a provider.

Form 2 (+/- 10% Variance)				
MCH Bud/Expenditure Details	Budget FY 2019	Expended FY 2019	Difference	+/-10% Variance
Preventive/Primary Care for Children	$4,583,943	$5,854,378	$1,270,435	27.71%
State MCH Funds	32,943,966	25,173,350	-7,770,616	-23.59%
Other Funds	1,536,572	1,223,021	-313,551	-20.41%
Program Income	48,718,812	54,401,167	5,682,355	11.66%
Totals	**$87,783,293**	**$86,651,916**	**-$1,131,377**	**-1.29%**

Line 9. (Other Federal Funds)

Early Head Start Program - FY 2019 Annual Report Expended of $433k was more than the FY 2017-2019 application's budgeted amount of $329k, a difference of $104k or 31.45 percent. Changes were made to protocol designed to increase the services provided to the enrolled children. With the additional services to be provided, there was an increase in the amount of time spent with each child which increased the expenditures.

Abstinence Education Program – FY 2019 Annual Report Expended decreased $794k from the FY 2017-2019

application's budgeted amount of $1.01m, a difference of $218k or -21.56 percent. Three factors contributing to the decrease in expenditures: (1) decreases in staffing, (2) several sub-grantees stopped providing services and (3) a Request for Proposal (RFP) was released in FY 19 to allow for county health departments to apply to provide services, however, an award was not made.

Personal Responsibility Education Program (PREP) – FY 2019 Annual Report Expended decreased $651k from the FY 2017-2019 application's budgeted amount of $726k, a difference of $75k or -10.26 percent. The same factors that affected Abstinence contributed to PREP's decrease in expenditures: (1) decreases in staffing, (2) several sub-grantees stopped providing services, and (3) a Request for Proposal (RFP) was released in FY 19 to allow for county health departments to apply to provide services, however, an award was not made.

Wise Women Program – FY 2019 Annual Report Expended of $640k deceased from the FY 2019 Application Budgeted amount of $911k, a difference of $271k or -29.77 percent. Fiscal year 2019 was the first year of a 5-year grant cycle. Patient Services did not begin until March, although the starting date, according to the grant, was October 1st. Delay was due to CDC waiting for OMB approval resulting in a 5-month delay. Also, in FY 2017 when the 2019 budget was developed the Wise Women program was at the end of the 5-year cycle. Also, at issue was a change in grant year beginning dates from April 1 to October 1.

Well Women Program – FY 2019 Annual Report Expended of $536k increased from the FY 2019 Application Budgeted amount of $121k, a difference of $415k or 344.2 percent. Well Woman program was implemented in January 2017 in three counties, Butler, Dallas and Wilcox. Currently, the program reach has increased and is currently offered in six counties in Alabama (Butler, Dallas, Macon, Montgomery, Russell and Wilcox) with program implementation pending in a seventh county (Marengo). Between implementation and 2019 program staffing increased, with the most recent increase by 12.9 FTEs to cover staffing in the three 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 2019 Annual Report Expended of $1.44m decreased from the FY 2019 Application Budget amount of $1.83m, a difference of $394k or -21.46 percent. During the reporting period, Mobile County Maternity Program experienced a reduction of 4.0 FTEs that accounts for $177k of the cost and the balance is the reduction that occurs from the cost allocation process which is based on the programs decrease in salaries.

Line 5. (All Others) -- FY 2019 Annual Report Expended of $3.095m increased from the FY 2019 Application Budgeted amount of $1.61m, a difference of $1.48m or 92 percent. Part of the increase is the addition of two programs that did not exist in 2017: (1) Fetal Infant Mortality Review Expansion Nurse Abstractors with $230k and (2) Well-Women program with $476k. Increased growth occurred in the following: Dental program increase in personnel costs associated with the hiring of a Dentist that had been vacant $353k and $140k growth in the PRAMS program. A total of seven FTEs and two cost of living increases were added to these programs. The balance is considered routine costs associated with the administration of the MCH program, i.e., merit raises, healthcare and retirement costs.

Form 3a (+/- 10% Variance)				
	Budget	Expended		+/-10%
Individuals Served	FY 2019	FY 2019	Difference	Variance
Pregnant Women	$1,834,963	$1,441,214	-$393,749	-21.46%
Infants< 1 Year	8,777,739	8,903,777	126,038	1.44%
Children 1-22 Years	52,432,124	47,657,793	-4,774,331	-9.11%
CSHCN	29,807,501	31,101,435	1,293,934	4.34%
All Others	1,611,952	3,095,141	1,483,190	92.01%
Totals	$94,464,279	$92,199,360	-$2,264,919	-2.398%

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

Line 1. (Direct Services) - FY 2019 Annual Report Expended of $45.13m decreased from the FY 2019 Application Budgeted amount of $51.70m, a difference of $6.57m or -12.70 percent. In FY 2017 more resources were used in providing direct services. The trend over this time-period has been more emphasis on redirecting these resources to Enabling and Public Health Services which is reflected in the table below. Respectively, ADPH and CRS makes up $5.8m and $738k of the change.

Line 2. (Enabling Services) - FY 2019 Annual Report Expended of $10.38m decreased from the FY 2019 Application Budgeted amount of $11.63m, a difference of $1.25m or -10.76 percent. Programs that made up the net decrease Family Planning Care Coordination $730k and the loss of the Health Beginnings Contract $108k. CRS share of the increase is $365k. (See CRS explanation).

Line 3. (Public Health Services) - FY 2019 Annual Report Expended of $36.68m increased from the FY 2019 Application Budgeted amount of $31.13m, a difference of $5.55m or 17.83 percent. The table below reflects the movement of cost from Direct Services $6.56m, Enabling Services $1.2m to Public Health Services (PHS) which increased by $5.52m during FY 2019. ADPH notable net increases total $3.46m: Central Office which carries out the activities that benefit the programs increased ($1.4m), as well as EPSDT Care Coordination ($689k), DHR Healthy Child Care ($468k), Well Woman ($415k) and Dental Services ($384k). CRS share of the increase is $2.09m. (See CRS explanation). //2021//

Form 3b (+/- 10% Variance)				
	Budget	Expended		+/-10%
Individuals Served	FY 2019	FY 2019	Difference	Variance
Direct Services	$51,699,379	$45,134,884	-$6,564,495	-12.70%
Enabling Services	11,631,462	10,379,919	-1,251,543	-10.76%
Public Health Services	31,133,438	36,684,557	5,551,119	17.83%
Totals	$94,464,278	$92,199,360	-$2,264,918	-2.40%

CRS

As per Block Grant requirements, the Budget for each reporting year is set 2 years' prior in the application (i.e. FY 2019 budget was set in the FY 2017 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 2019 Annual Report Expended were $1.22m which is a 20.41 percent decrease from the FY 2019 Application Budget. 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 Bud/Expenditure Details	Budget FY 2019	Expended FY 2019	Difference	+/-10% Variance
State MCH Funds	$12,085,537	$12,716,913	$631,376	5.22%
Other Funds	1,536,572	1,223,021	-313,551	-20.41%
Program Income	12,805,914	13,620,429	814,515	6.36%
Totals	$26,428,023	$27,560,363	$1,132,340	4.28%

Line 9. (Other Federal Funds) – CRS FY 2019 Annual Report Expended were $93,334 for CMC Boston University which is a 30.86 percent decrease from the FY 2019 Application Budget of $135,000.00. This decrease is a result of CRS expending less due to staff vacancies.

Form 3b: Budget and Expenditure Detail by Types of Service (IIA. Federal and IIB. Non-Federal MCH Block Grant)

Line 2. (Enabling Services) FY 2019 Annual Report Expended of $2,222,020 decreased from the FY 2019 Application Budgeted amount of $2,587,601 a difference of -14.13 percent. This decrease is due to the application budget being an estimate and an emphasis on redirecting resources to Public Health Services. Therefore, the FY 2019 expenditures are a more accurate reflection of how CRS allocated resources by services.

Line 3. (Public Health Services) FY 2019 Annual Report Expended of $15,298,402 increased from the FY 2019 Application Budgeted amount of $13,210,987 a difference of 15.80 percent. This increase is due to the application budget being an estimate and an emphasis on redirecting resources to Public Health Services. Therefore, the FY 2019 expenditures are a more accurate reflection of how CRS allocated resources by services. //2021//

Form 3b (+/- 10% Variance)				
Individuals Served	Budget FY 2019	Expended FY 2019	Difference	+/-10% Variance
Direct Services	$ 14,008,913	$ 13,271,013	$ (737,900)	-5.27%
Enabling Services	2,587,601	$ 2,222,020	(365,581)	-14.13%
Public Health Services	13,210,987	$ 15,298,402	2,087,415	15.80%
Totals	$ 29,807,501	$ 30,791,435	$ 983,934	3.301%

III.D.2. Budget

ADPH

/2021/ The Alabama Legislature approved a 2021 general fund budget of $2.4 billion which increased spending over the current year by $170 million. The COVID-19 pandemic has stalled the economy putting more than 400,000 Alabamians out of work. Despite the massive economic shutdown that has crippled the state economy and thousands of businesses, there will not be any need to prorate either the General Fund or the Education Trust Fund budgets in 2020.

Alabama has two budgets: The Education Trust Fund (ETF), which pays for education in the state, and the General Fund, which provides money for other state services. State agencies, most notably Medicaid, also get federal funding. A downturn would harm both budgets. The $7.1 billion ETF gets about 63 percent of its revenue from state income taxes and about 28 percent from sales taxes. Both are growth revenues that are sensitive to economic conditions. The House Ways and Means Education committee has approved a $7.2 billion ETF for fiscal year 2021, a $91 million increase over current year. The $2.4 billion General Fund gets revenue from about three dozen sources. Yet it has fewer growth revenues and it isn't immune to an economic downturn. Still, the General Fund increased by $170 million.

The Alabama Senate has approved a $2.4 billion General Fund budget which is smaller than the one proposed by the governor before the coronavirus pandemic but larger than the 2020 budget. The General Fund is still healthy, and projections indicate the slowdown caused by the pandemic will reduce growth in tax revenues but not force overall cuts.

Most agencies would receive about the same amount as this year. Three agencies would receive increases requested in the governor's budget. The largest increase from the General Fund would go to Medicaid, which provides some levels of service to almost a million Alabamians. Medicaid would receive $94 million more than this year, a total of $820 million. Public Health would receive a $35 million increase, to $106 million. A portion of this money will cover an increase in the state's share of CHIP, ALL Kids. Mental Health would receive a $26 million increase, to $154 million. The budget for the fiscal year starts October 1.

In FY 2020, Alabama's Title V MCH Program received $11,401,820 and will be budgeted at this level for the FY 2021 application. The Title X Family Planning Program was awarded in FY 2021 a total of $7,200,000 which included a $1,900,000 supplemental for implementation of a new community outreach and education program pilot.

Medicaid is pursuing a new initiative to transform the Medicaid delivery system through a flexible and more cost-efficient effort which builds off the agency's current 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 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.

ADPH is the current provider of the Medicaid Patient 1st and Plan First case management programs. With implementation of the ACHN, ADPH will lose these two programs, resulting in a revenue reduction of $21.6 million. The impact of this revenue reduction could cause citizens to go unserved, the closure of CHDs, and significant layoffs of ADPH staff. The proposed ACHN model has a decreased emphasis on low risk family planning case management and does not support adherence to selected birth control methods. This could potentially have a

negative impact on the unintended pregnancy rate, including the teenage pregnancy rate. The lack of family planning case management for low risk patients could potentially increase Alabama's infant mortality rate. 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 Newborn Screening, Newborn Hearing Screening, and an elevated lead level. This will result in an approximately $1 million in revenue for the department. The ACHN model has a decreased emphasis on family planning case management and does not support adherence to selected birth control methods with limited patient contact being reimbursable. This decreased support for birth control methods and case management could potentially have a negative impact on the unintended pregnancy rate, including the teenage pregnancy rate.

As a safety net provider for the citizens of Alabama, ADPH facilitates a centralized statewide referral system for all providers including Children's of Alabama Hospital. This electronic referral system saves tax payer money by identifying children that are non-compliant with prescribed treatment plans. ADPH's seamless referral process will be discontinued with the ACHN implementation.

The Title X Family Planning Program continues to provide access to family planning and related health services, giving priority to Alabama's low-income population. The numbers of clients served by the program have trended downward over the last several years, mirroring a nationwide trend among family planning providers. The Congressional Research Service, in "Family Planning Program Under Title X of the Public Health Service Act" (2018), cited numerous factors contributing to declining numbers: staff shortages, increased costs of providing services, higher numbers of insured clients seeking care from private providers, revised clinical guidelines, and increased client uptake of long-acting reversible contraceptive methods. Additionally, the COVID-19 pandemic has drastically altered service delivery models across the country. In Alabama, COVID-19 has caused temporary clinic closures and staff reassignments, which will certainly affect Family Planning numbers. However, COVID-19 also has allowed for (temporary) implementation of telehealth family planning visits, and clinical providers report significantly increased visit numbers as a result. Additionally, the Family Planning Program was successful in securing supplemental funding for FY20 to pilot a Community Health Advisor program, which includes targeted outreach and case management in 13 counties. Program staff are hopeful that the pilot interventions will positively impact reproductive health outcomes and increase the numbers of clients and clinic visits in these counties and support expansion of the program into additional counties.

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 Populations based services. Without these funding sources, services would be severely limited for individuals served and 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 change to ACHN provider services).

The cost accounting system of the ADPH is a very critical operation. It is the process by which we track the amount of money spent for 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 cost and services provided through the Block Grant Program. The current cost system was designed to capture cost 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 in order 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. In order 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.

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

The state should describe how the 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 Finance by 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. 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. 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.

CRS

ADPH contracts with the ADRS/ Division of CRS, to provide services for CSHCN and allocates Title V dollars to

CRS for this effort. ADPH allocated the required 30 percent, approximately $3.4 million to the CSHCN Program in FY 2019. In FY 2019 CRS received a state allocation of $12 million, a state allocation for the Alabama Hemophilia Program of $1.2 million and program income from third party reimbursements of $12.2 million. CRS received approximately $26,200 from MCHB as 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 Collaborative Improvement and Innovation Network to Advance Care (CoIIN) for Children with Medical Complexity (CMC). All of these funds are utilized to serve CYSHCN.

During FY 2019 CRS expended $658,433 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. The COVID-19 pandemic could have an impact in future years as it stalled the economy putting more than 400,000 Alabamians out of work. Another area where CRS was unable to expend all the allocated funds was in our CoIIN project. This was due to two staff vacancies in the project during FY 2019. CRS was able to fill one position in March of 2019. The other position was vacant for the remainder of FY 2019.

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 you will find the State Action Plan Narrative by Domain.

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 2019 and FY 2020 CRS received level funding from the State ETF and General Fund budgets. CRS anticipates receiving level funding from the state for FY 2021 which ensures we can continue to meet the match. In FY 2019, 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). //2021//

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, the Oral Health Program, the Women's and Children's Health Division, Consultants-Pediatric Division, the Office of Women's Health, 66 county health departments in eight public health districts, and other sub-grantees and partner projects.

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

FHS maintains partnerships with local and state agencies including, but not limited to, Medicaid, Department of Human Resources, Department of Mental Health, and local agencies participating in the Healthy Start Initiative. Staff participate on and lead state committees and initiatives, such as the Alabama Opioid Misuse in Women/Neonatal Abstinence Syndrome (OMW/NAS) Taskforce and the Alabama Infant Mortality Reduction Initiative**,** to ensure we consistent collaboration with stakeholders that can help strategically align our goals and activities. ADPH convenes partners and funds projects to enact public health policies, plans, laws, and implement quality improvement projects. Most recently those efforts are exemplified through the establishment of the MMRC and the continued involvement with the Alabama Perinatal Quality Collaborative (ALPQC). In addition to local 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, 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 evidenced based resources, an opportunity for creative thinking and constructive critique, as well as training that supports staff in work to improve the health status of the MCH population. FHS will continue identifying new stakeholders and working toward collective impact that support the goals of Title V.

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

FHS collaborates with stakeholders to leverage program capacity to identify priority needs of mothers, children, and families across the state and to develop strategies to meet those needs. 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 proving direct services though the CHDs. The six public health districts under the umbrella of ADPH do receive Title V funding for core staff and infrastructure, which allows them to serve the immediate needs of the MCH population within the 67 CHDs. Mobile CHD and Jefferson CHD 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 on new procedures within districts, that will address local health needs, NPMs, NOMs, and the seven ESMs. In the future, these MCH services and programs will be coordinated through FHS district staff mobilizing community leaders and facilitating partnerships between those leaders, policy makers, health care providers, and the community members.

CRS

The State of Alabama CSHCN Program is administered by CRS, a division of the ADRS. CRS provides clinical medical services, clinical evaluation services, care coordination, information and referral, patient/family education, and parent and youth connection to serve CSHCN and their families. Family engagement is supported in partnership with Family Voices of Alabama and the Family to Family Health Information Center (FVA/F2FHIC). 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, and coordinated system of services. Coordinated health services are delivered via 14 community- based clinics across eight service districts.

CRS maintains partnerships with statewide and community groups and governmental and private organizations including, but not limited to, Medicaid, DMH, Family Voices of Alabama, UAB, DECE, Alabama Child Health Improvement Alliance (ACHIA) and local Children's Policy Councils. CRS maintains a national partnership with AMCHP and has a staff member serving on the AMCHP Family and Youth Leadership Committee. CRS is currently participating in the 2020 Cohort of the National MCH Workforce Development Center. These national partnerships provide CRS with evidenced based resources as well as training to strengthen and promote the needs of CYSHCN. CRS will continue identifying new stakeholders and developing partnerships to provide quality health care services for CYSHCN in Alabama.

CRS has incorporated the AMCHP Standards of Systems of Care for Children and Youth with Special Health Care Needs in development of the activities in the State Action Plan for the CSHCN domain. Specifically, around two newly developed SPMs addressing Care Coordination and strengthening and enhancing Family/Youth Partnerships and the NPM addressing transition to adult health care.

III.E.2.b. Supportive Administrative Systems and Processes

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

ADPH

ADPH workforce development is primarily coordinated by the Bureau of Professional and Support Services. This bureau houses the Workforce Development Program (WDP) and Performance Management and Quality Improvement (PMQI) Department. WDP offers training programs 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. WDP's 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 development of appropriate training programs and opportunities. PMQI Department leadership and staff worked together to develop a 5-year Strategic Plan and a 2019 Annual Plan. QI training continues to be provided to departmental staff, utilizing new training methods to meet departmental needs. The PMQI Department encourages ADPH bureaus and districts to complete at least one QI project annually that focuses on analyzing and improving processes, programs, or interventions directly related to a strategic priority. To enhance the ability to provide culturally competent services, the Office of Minority Health facilitates local and state level partnerships to address health disparities in Alabama. Grant funds through the Federal Office of Minority Health provides support to the state efforts to improve the health of racial and ethnic minorities.

FHS program directors gather weekly for a program management meeting, during which staff outline program goals and objectives, discuss opportunities for linkages between bureau programs, and work through challenges common across programs. The same process occurs monthly during the district staff meeting. ADPH staff at the district meetings include the Alabama State Health Officer, other senior staff, ADPH District Administrators, and all other ADPH bureau directors. In addition to sharing pertinent program information, addressing public health challenges, and celebrating program successes, the statewide meetings provide an opportunity to update staff on departmental operations, procedures and policies. Additionally, the State Health Officer hosts a monthly ADPH statewide staff meeting. This meeting is presented as a satellite conference, live webcast, and is available to all ADPH employees in the central office, districts, counties, and at the state laboratory. This meeting is used to update all employees on the emerging issues within the state and health department. Topics range from state budget, new programs, observances, and any departmental changes or successes.

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 allow for interns who are currently students in nursing, public heath, epidemiology, and other disciplines. These interns are encouraged to apply to the state personnel employment register so that they may be hired permanently upon graduation.

Alabama Tile V leadership continue to seek guidance and assistance from National MCH Workforce Development Center and apply for training opportunities presented by the Center, AMCHP, and HRSA to ensure our workforce has the tools necessary for effective program planning and implementation.

CRS

The Staff Development and Training Division of ADRS coordinates education, training, and professional development activities for all ADRS programs including CRS. This division is available to work with CRS staff to identify training needs, develop training resources, and provide training opportunities. They also assist in organizing and planning workforce development retreats. 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 five-year State Action Plan.

Training is on-going for CSHCN staff supported by the MCH Title V Block Grant and state funds. CRS collaborates with ADPH, FVA, DHR, UAB, and other partners to provide training for MCH staff. CRS Program Specialists assist multi-disciplinary staff with determining relevant training needs to specifically address the needs of CRS clients. Some of these include: Speech and Hearing Association of Alabama Convention, Alabama Conference of Social Work, Alabama Transition Conference, Partners in Care Summit, and the AMCHP National Conference.

CRS state 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 any program challenges that need to be discussed. 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 which impact the individual divisions as well as the agency as a whole.

In February 2020 CRS began participating in the National MCH Workforce Development Center 2020 cohort. Workforce development and ensuring staff receive training and support are key factors in working with the Center. As part of working with the Center, a Workforce Development subcommittee has been formed. The subcommittee will analyze current practices and identify areas for improvement. The overall goal of the subcommittee is to identify the best ways to support staff and provide them with the tools and resources needed to succeed in their position.

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

ADPH

ADPH continues exploring opportunities to involve families, youth, and fathers in more MCH activities. For the 2020 needs assessment, we developed an adolescent survey and conducted a focus group exclusive to adolescents and young adults to ensure we heard their voices on what they saw as problems and needs in their communities. We also conducted a focus group exclusive to fathers. Furthermore, due to the success of a key connection established during the needs assessment that assisted us with hosting focus groups, we have begun discussions with UAB SOPH for plans to continue our partnership with Alabama Network of Family Resource Centers. Our aim is for the centers to connect us 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 wants 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 quality improvement activities.

CYSHCN

For nearly 25 years, CRS has made a significant investment in family partnerships by employing those with lived experience. CRS staff includes a full time SPC and part time LPCs in most of our offices. These positions are filled by parents who are full time caregivers of CYSHCN. CRS also employees two part time Youth Consultants (YCs) both of whom have received services from CRS.

Advisory Committees

The SPC coordinates the state Parent Advisory Committee, which brings together representatives from the 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 LPCs each coordinate a Local Parent Advisory Committee (LPAC). These groups offer families the opportunity to provide input to policy and program changes in CRS and to interact with local staff members. LPACs also are opportunities for community partners to share information and for families to find mutual support from coming together with other families in their area. Some topics addressed in LPAC meetings included Respite Options and the importance of caring for caregivers; Medicaid Waivers, including finding the most appropriate waiver as well as how to apply; Special Education, the importance of parents being involved in their children's education, including Individualized Education Programs and 504 Plans. Training was also provided by the Alabama Parent Education Center, the state's Parent Training and Information Center.

Many LPACs held meetings focused on transition topics, including guardianship options, employment opportunities for youth with disabilities shared by Vocational Rehabilitation Service, and information from the Full Life Ahead Foundation, all of which align with the work on NPM 12 (Transition). Social media has helped the LPCs to expand their connection to families who are not able to attend a traditional workshop or training opportunity. Some have used Facebook Live to host meetings and discussion groups. Social media will likely become a more important tool in the coming year, as face to face gatherings will be limited by concerns about COVID-19. The LPACs also sponsored events for families in their communities such as Wheelchair Washes, Resource Fairs, and holiday gatherings, including a combined Trunk or Treat /Resource Fair. Another LPAC held a "viewing party" for the film "Intelligent Lives," with invited guests including families and professionals involved in the lives of youth with disabilities.

The YCs continue to reach out to youth and young adults with special health care needs and have a growing network across the state known as the YAC (Youth Advisory Committee) which met twice this year. Both continue to share information and connect with peers utilizing social media. The YCs present at conferences and workshops around the state including the Partners in Care Summit and the Youth Leadership Forum. One YC is serving as a Governor appointed member of the State Independent Living Council.

Strategic and Program Planning

The SPC and YC are involved in planning and developing initiatives for CRS as members of the Management Team. The LPCs are included in these activities in the local offices. All participated in a meeting with the CRS director in early 2019 to review the current Administrative Code pertaining to CRS and decide on proposed changes to the code, which were submitted and approved during 2019.

Quality Improvement/Workforce Development and Training

CRS includes families in all training for staff to strengthen the partnership between families and professionals and to reinforce the concepts of Family-Centered Care. New staff in local CRS offices spend time in orientation with the LPC to learn more about their roles and the principles of family centered care.

The SPC and LPCs have provided training to groups including the national Family Voices Leadership Conference, UAB students at the School of Public Health (SOPH), the UAB Pediatric Pulmonary Center trainees, along with the delegates attending The Governors Youth Leadership Forum, as well as their families. In addition, training has been provided at the annual Partners in Care Summit, the AL Early Intervention & Preschool Conference, the AL Association for Persons in Supported Employment Conference, on Alabama Care Facebook Live broadcasts, and to University of AL students majoring in Special Education, as well as various other community organizations. The SPC and three of the LPCs serve on the statewide steering committee for the Community of Practice for Supporting Families of Individuals with Intellectual and Developmental Disabilities.

The SPC and CRS Assistant Commissioner are members of the ACHIA steering committee, which is the state improvement partnership program working with the AL Chapter of the AAP and pediatric practices across the state. The SPC is serving on the Continuous Quality Improvement Committee, which is charged with reviewing possible topics for future learning collaboratives coordinated by ACHIA. The SPC was a faculty member for the recently completed learning collaborative on adolescent well visits and has shared information about family engagement in the medical home.

The SPC and some LPCs are members of the team participating in the National MCH Workforce Development Center project and are members of the Alabama CMC CoIIN team.

Block Grant Development and Review

The SPC, LPCs, and YCs were all involved in the Five-Year Needs Assessment process, including serving as members of the CRS Needs Assessment Leadership Team.

Materials Development/Program Outreach and Awareness
The SPC, LPCs, and YCs are involved in the development and updating of any printed and web-based materials pertaining to CRS.

LPCs serve on many state and local committees and task forces, including the Alabama Disabilities Advocacy

Program (ADAP) Protection and Advocacy for Persons with Developmental Disabilities Council, Alabama State Department of Education Special Education Advisory Panel, Medicaid's ACHN Consumer Advisory group, Early Hearing Detection and Intervention Learning Community, Community of Practice for Supporting Families State Team, Alabama Council on Developmental Disabilities (ACDD), Sparks/Civitan Consumer Advisory Committee, Lifespan Respite Network, Statewide Autism Workgroup, Early Intervention District Coordinating Council, Children's Policy Councils, Alabama Institute for Deaf and Blind Advisory Board (Mobile) Individual and Family Support Councils, the local Governor's Committees on Employment, Parents as Teachers Advisory Board, and the local planning groups for various events targeted at families who have CYSHCN. They also represent CRS at many community events across the state, such as health fairs and expos, and provide training for various university classes, the Pediatric Pulmonary Center trainees, and statewide conferences. LPCs coordinated the submission of nominees from each office for the "Hero of the Month" Award, presented by the Kids Wish Network.

The SPC is a member of several statewide committees and task forces including the ADPH Newborn Screening Advisory Committee, the UAB PPC Advisory Committee, the Young Child Wellness Council and Project Launch steering committee, the Functional and Access Needs in Disaster Task Force, and One Strong Voice Disability Leadership Coalition. She also just completed her service as a member of the AMCHP Board of Directors. In June 2017, the SPC was appointed to serve as a Public Health Practitioner Affiliate with the UAB SOPH. This appointment will be for 3 years. In 2019 she was appointed to the SouthSeq Community Advisory Board, working with Hudson Alpha Institute of Biotechnology and addressing ways to share news of genetic test results with families of young children in Alabama, Louisiana, and Mississippi.

Family Voices Partnership

CRS has maintained a strong partnership with Family Voices of Alabama (FVA), home of Alabama's F2FHIC. The CRS LPCs also 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 F2FHIC project which strengthens the Parent to Parent program. CRS is partnering with FVA to maintain licenses and training needs for the data system. Information and assistance was provided in the areas of the six core outcomes, with the highest number of requests coming in the area of Community Services, followed by Partnering with Professionals, and Financing of Health Services. A significant collaboration has been support of the Partners in Care Summit, a project of the F2FHIC. CRS's support has helped the conference to grow and allowed for national speakers to present on topics related to medical home, transition to adulthood, and family/professional partnerships. This conference has been attended by families, CRS staff from across the state, and other partners. Unfortunately, the 2020 Summit had to be cancelled due to the COVID-19 crisis.

III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts

The purpose of the State Systems Development Initiative (SSDI) Grant Program is to develop, enhance and expand State Title V Maternal and Child Health (MCH) data capacity. Evidence-based strategy measures 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. Currently, SSDI project staff submits the MCH Block Grant annual report/application by the July deadline.

ADPH's broad capacity to provide data-based information about MCH is critical to FHS access to policy and program relevant information. The collaborative relationships that SSDI Project staff have with other ADPH entities strengthen the data capacity of FHS in general and of the SSDI Project in particular. By linking data from multiple sources the state's MCH data systems can be utilized to readily address longitudinal research questions as well as track and follow MCH populations across multiple programs. This arrangement allows the resultant program data to be used to address important questions in a comprehensive manner.

FHS partners with many various organizations, such as Medicaid and the Alabama Chapter of March of Dimes, to assure achievement of the overall purpose of the federal SSDI program. FHS staff and CRS staff collaborate to coordinate the annual MCH Block Grant report. ADPH's Center for Health Statistics provides access to the state's vital statistics data (births, deaths and fetal deaths) which is utilized by staff members to contribute to the MCH Block Grant through statistical analysis. SSDI staff are working in collaboration with other FHS staff members to identify barriers to timely annual access to linking data. With each MCH Block Grant application/reporting year, there are lags with data reporting on specific performance measures and indicators where an external data source is relied upon. Although we recognize this barrier to reporting, there are still apparent needs that are beyond FHS's scope where assistance with data reporting is needed. For instance, Alabama currently does not have a hospital discharge database. Although the MCH Epidemiology Branch Director has been in consultation with the Alabama Hospital Association, the 2020 legislative session ended early due to COVID-19 and the hospital discharge database legislation never got introduced, as was planned.

By performing program evaluation activities around the NPMs, state MCH programs can monitor if they are achieving the goals and objectives that were identified for programmatic focus. This knowledge allows the state MCH programs to make adjustments, as needed, to ensure that they are making progress towards successfully achieving their intended goals. Currently, Title V and SSDI project staff lack evaluation knowledge and experience necessary to accurately evaluate current MCH programs. As SSDI Project Staff support MCH programs, there is growing need for a skillset that we currently do not possess. SSDI Project staff will hopefully obtain the knowledge, skills, and abilities necessary to provide evaluation support efforts, over the next 4 years, which will allow for improved program development and effectiveness. In the interim, the SSDI Consultant (Branch Director of MCH Epidemiology and Assistant Director of Perinatal Health Division) has participated in work group meetings with the National MCH Workforce Development Center to complete tasks related to the Governor's Plan to Reduce Infant Mortality. That plan is working to complete a “Single State” Project on infant mortality reduction. Staff from the Workforce Development Center team, alongside the SSDI Consultant, provided onsite assistance/guidance to strategy teams to assist them in their effort to complete program specific initiatives. The project consultant believes that she has gleaned knowledge from the meetings that may assist with monitoring and evaluating program activities.

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

In January of 2019, the RFP was released to transition Medicaid's Patient 1st program to ACHN. Medicaid instituted ACHNs effective October 1, 2019 in an effort to transform the Medicaid delivery system and become more cost-efficient. The new single care coordination delivery system is designed to link patients, providers, and community resources in seven newly-defined ACHN regions. Delivery of medical services is not part of ACHN.

This new Medicaid program moved all case management (maternity, Plan First, and Patient 1st) under one entity in seven regions throughout the state. ADPH was the provider of the Medicaid Patient 1st and Plan First case management programs. Those programs are no longer under ADPH and resulted in a loss of $21.6 million for the department and significant layoff of ADPH social workers. Through negotiations with Medicaid, ADPH only provides case management services to those infants that did not pass the newborn screenings at the hospital and those children with an elevated lead level. FY 2019 ended with approximately 45 FTEs in the Patient 1st Program.

ACHN has a decreased emphasis on low risk family planning case management and does not support adherence to selected birth control methods. This model could potentially have a negative impact on the unintended pregnancy rate including the teenage pregnancy rate. The lack of family planning case management for low risk patients could potentially increase Alabama's infant mortality rate. ADPH was the safety net provider for the citizens of Alabama, facilitating a centralized statewide referral system for all providers, including Children's Hospital. In the past, ADPH was able to identify children that are non-compliant with prescribed treatment plans. That referral process was discontinued with the ACHN implementation.

Added to the changes at Medicaid are the federal and state budget cuts that most agencies have experienced in recent years. These cuts have greatly affected Alabama hospitals. Many hospitals face challenges with recruiting patients and sustaining the funds to provide the necessary services, especially when most are operating in the red. These challenges have resulted in a fragile health care system, particularly in the rural communities. A recent report by the Alabama Hospital Association(AHA) stated that since 2011, thirteen hospitals have closed in Alabama and seven of those hospitals were in rural areas. Patients must travel farther and farther to receive what some would consider a basic service, such as a safe place to deliver a healthy baby. Safe deliveries are especially important in Alabama where the infant mortality rate remains among the highest in the nation.

To combat some of these problems, FHS continues to aim to partner with Medicaid and AHA at every available opportunity. FHS routinely attends meetings with both agencies, sits on committees with common goals, and invites them to participate in all statewide MCH programs. FHS has several programs that collaborate closely with Medicaid. Title X Program works closely with MCH to ensure that contraception and other family planning needs are met. In 2019 ADPH and Medicaid developed new contracts to address billing for EPSDT clinical, EPSDT case management, the lead program, immunizations, and Plan First.

In 2012, the telemedicine service was established to address the lack of HIV care in rural areas of the state. ADPH bureau collaborations further expanded the reach of telemedicine in rural Alabama by funding start-up costs for the necessary equipment in select county health departments. ADPH actively began engaging medical partners who wanted to offer health care services utilizing telemedicine technology and health care providers, transmission of images, and remote monitoring of vital signs. Telemedicine services were first available in only four county health departments. The Telemedicine Program has grown exponentially in recent years. Sixty-five county health departments have telehealth carts and 15 healthcare agencies collaborate with the Telehealth Program. Telehealth equipment is also used for meetings and training.

The growth of ADPH's telehealth capabilities and partnerships continues. Blue Cross Blue Shield of Alabama began

reimbursing providers for all telehealth encounters with previously covered specialties in 2018. Governor Kay Ivey convened a workgroup to develop recommendations for proposed telehealth legislation by January 2019. A grant began in October 2018 with the Alabama Department of Mental Health and Children's of Alabama to allow adolescents to receive behavioral health services through telehealth. Additional MCH telehealth initiatives include the following: 1) Pediatric Neurology; objective is to empower pediatric neurologists to use telecommunications; 2) Maternal-Fetal Medicine with UAB and the University of South Alabama; two programs each with unique features; 3) Pediatric Nephrology; 4) Family Planning: EVAs for enhanced visualization and development of colposcopy services; 5) Developmental-Behavioral Health (Autism).

ADPH’s Office of Primary Care and Rural Health (OPCRH) facilitates and participates in activities to improve access to health care services for all rural Alabamians with special concern for children, the elderly, minorities and other medically underserved vulnerable populations. Fifty-five out of 67 of Alabama's counties are considered rural and 2,031,229 residents, or 43.6 percent of the entire Alabama population, live in rural areas. Currently, 63 of Alabama’s 67 counties have areas designated as medically underserved for primary care. Between 2018 and 2019, nine new rural health clinics were established, for a current total of 113. OPCRH works very closely with the Alabama Rural Health Association, AHA, the Alabama Primary Health Care Association, and departmental bureaus to address health issues affecting those living in rural areas. Some of the major programs employed by the OPCRH include the recruitment and retention of healthcare professionals and technical assistance to small rural hospitals, and health providers in transitioning to a new value-based healthcare system. Per the ADPH Annual Report, OPPCRH utilizes national programs to recruit health professionals into medically underserved areas. Currently, there are over 150 healthcare providers delivering medical care to rural and medically underserved Alabamians under these programs. The OPCRH also assists communities in establishing CMS certified rural health clinics.

CRS Health Care Delivery System

CRS is involved in several collaborative efforts with other federal, state, and non-governmental partners to ensure access to quality health care and needed services for the CSHCN population. CRS, in conjunction with Children’s Hospital of Alabama (COA) and Medicaid, held the first in a series of Pediatric Care Coordination Curriculum trainings. The trainings are funded by a grant from the Alabama Department of Early Childhood Education. CRS is also an active member of ACHIA which is the state improvement partnership program working with the AL Chapter of the AAP and pediatric practices across the state. The CRS Assistant Commissioner and SPC are members of the ACHIA steering committee. The SPC serves on the Continuous Quality Improvement Committee, which is charged with reviewing possible topics for future learning collaboratives coordinated by ACHIA. Other members of ACHIA include Medicaid, CHIP, Title V, and COA. CRS is also the lead agency for the Alabama CMC CoIIN, which is a collaboration of several entities including Medicaid, University of South Alabama Pediatric Complex Care Clinic, and COA. Through the placement of a care coordinator at the USAPCCC the CoIIN project has created a multidisciplinary group dedicated to providing comprehensive, well-coordinated care for Children with Medical Complexity and their families at the University of South Alabama Pediatric Complex Care Clinic.

CRS Medicaid Partnership

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 also 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 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. CRS and Medicaid state staff also collaborate to hold statewide joint meetings regarding collaboration and service delivery. ACHN staff participated in the previously mentioned Pediatric Care Coordination Curriculum training and will continue to participate in future trainings.

Medicaid has a wide variety of Home and Community-Based Waiver programs for which CYSHCN may be eligible. CRS care coordinators and Parent Consultants 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 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 payment for orthodontia services.

CRS serves in an advisory role to Medicaid for program and policy decisions likely to affect CYSHCN and its sub-group, CMC, 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 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 will make a determination for which program the child is eligible. Alabama has a low uninsured rate for children, which is due to the focus on education and outreach to all uninsured children. CRS also works with private insurers to ensure coverage for services for CYSHCN.

CRS continues to work towards joining Alabama's One Health Record. The One Health Record® system was created as Alabama's health information exchange (HIE) through a federal grant awarded to the state in 2009. Under the guidance of the Alabama Health Information Commission, One Health Record® has emerged as an interoperable, two-way data exchange system between providers, hospitals and others within Alabama and in other states. Participating providers can query the interoperable, two-way data exchange from within their electronic health record system to access patient health data from other providers. Interfacing CRS's current EMR to One Health Record® will save CRS time and money. CRS will be able to provide an electronic copy of the medical portion of a child's clinic report of visit (ROV) to each physician involved in their care. CRS program physicians will have the capability to send and receive laboratory and x-ray orders electronically and it will provide the ability to send electronic prescriptions.

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

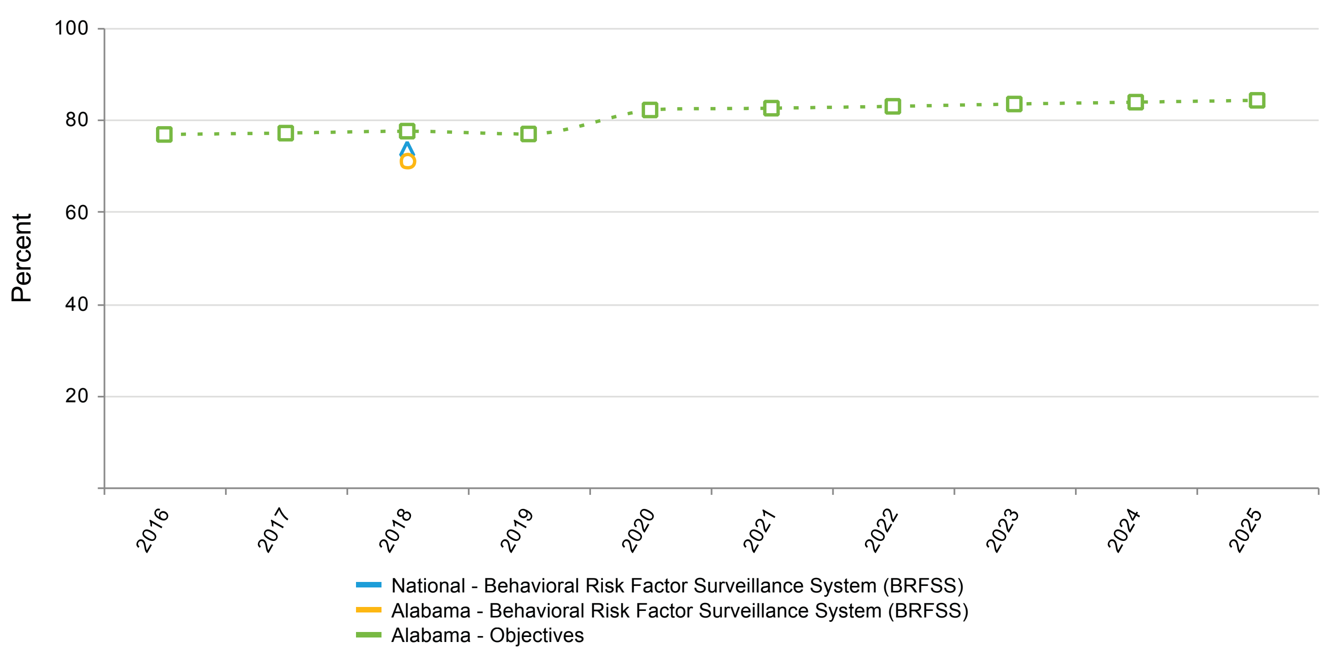
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID	Data Not Available or Not Reportable	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2014_2018	28.5	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2018	10.7 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2018	12.5 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2018	28.0 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2017	7.2	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	7.4	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2017	4.3	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2017	3.1	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2017	232.4	NPM 1
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	PRAMS-2015	5.0 %	NPM 1
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births	SID	Data Not Available or Not Reportable	NPM 1
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2017_2018	12.2 %	NPM 13.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	88.1 %	NPM 13.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2018	25.2	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2017	19.9 %	NPM 1

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)				
	2016	**2017**	**2018**	**2019**
Annual Objective	76.7	77	77.4	76.8
Annual Indicator	65.8	65.4	66.3	70.8
Numerator	552,796	550,090	560,384	599,429
Denominator	840,350	840,780	845,315	846,286
Data Source	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017	2018

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	82.0	82.4	82.8	83.3	83.7	84.1

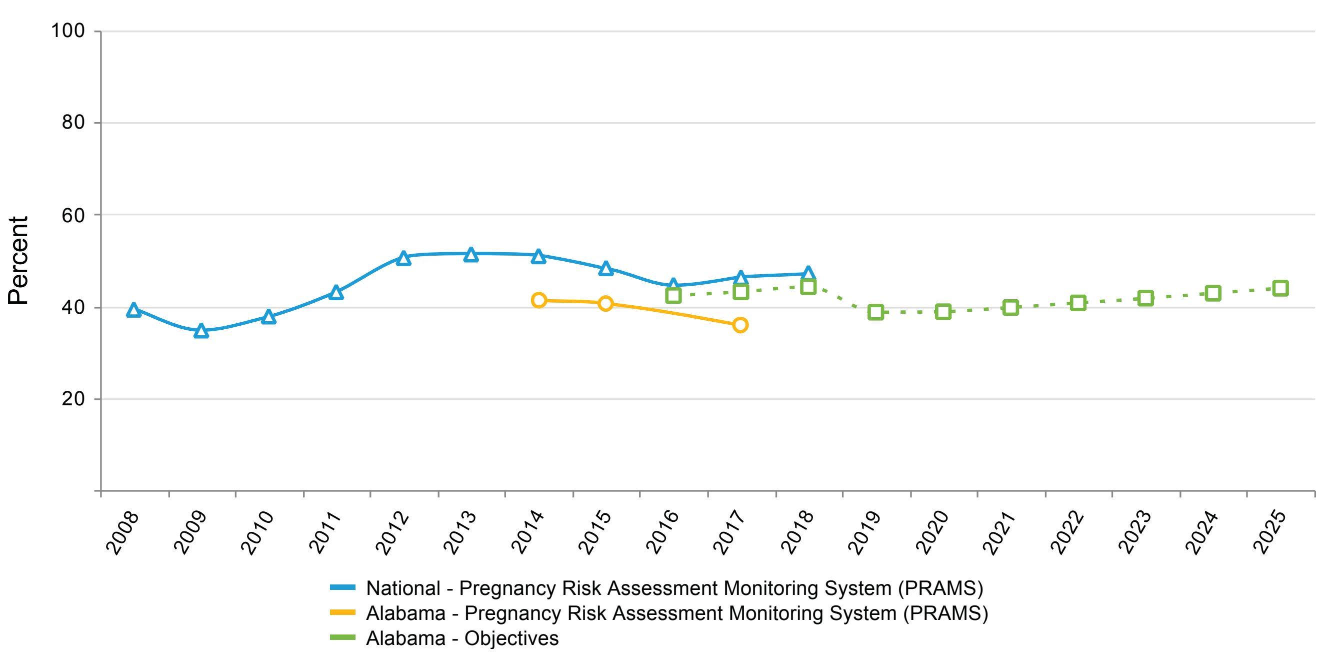
Evidence-Based or –Informed Strategy Measures

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 2 points annually.

Measure Status:	Active			
State Provided Data				
	2016	2017	2018	2019
Annual Objective		44	44.5	44.9
Annual Indicator	43.2	43.2	43.2	43.2
Numerator	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
Data Source	BRFSS and U.S. Census Bureau, Population Division	BRFSS and U.S. Census Bureau, Population Division	BRFSS and U.S.Census	BRFSS and U.S.Census
Data Source Year	2015	2015	2015	2015
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	45.4	45.8	46.2	46.7	47.1	47.5

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)

	2016	2017	2018	2019
Annual Objective	42.3	43.1	44.2	38.7
Annual Indicator	41.2	40.6	40.6	36.0
Numerator	22,302	22,286	22,286	19,726
Denominator	54,138	54,955	54,955	54,751
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2015	2017

Annual Objectives

	2020	2021	2022	2023	2024	2025
Annual Objective	38.8	39.7	40.7	41.7	42.8	43.9

Evidence-Based or –Informed Strategy Measures

ESM 13.1.1 - Proportion of at-risk pregnant women who report receiving a preventive dental visit during pregnancy by piloting the First Steps Program.

Measure Status:	Active

State Provided Data				
	2016	2017	2018	2019
Annual Objective		28	27.7	28.1
Annual Indicator	27.9	27.6	28	28.8
Numerator	288,998	286,146	292,658	300,040
Denominator	1,036,378	1,036,378	1,045,740	1,041,996
Data Source	Alabama Medicaid Agency and U.S. Census	Alabama Medicaid Agency and U.S. Census	Alabama Medicaid, U.S. Census	Alabama Medicaid, U.S. Census
Data Source Year	2016	2016/17	2017/2018	2018/2019
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	28.9	29.1	29.2	29.4	29.5	29.7

ESM 13.1.2 - Proportion of at-risk pregnant women who are educated about the importance of receiving preventive dental care during pregnancy and assist with linking Medicaid insured to needed dental services by piloting the First Steps Program.

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			50
Annual Indicator			0
Numerator			0
Denominator			7
Data Source			Alabama Medicaid, ADPH Oral Health Branch
Data Source Year			2019
Provisional or Final ?			Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	75.0	75.0	50.0	50.0	50.0	50.0

State Performance Measures

SPM 4 - Percent of women who smoke during pregnancy

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	8.7
Numerator	
Denominator	
Data Source	ADPH Center for Health Statistics
Data Source Year	2018
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	8.6	8.5	8.4	8.3	8.2

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

Increase the number of uninsured expectant mothers that receive preventive dental care to decrease the likelihood of low birthweight babies.

Strategies

Provide access to dental care through a value-based collaboration with the Pay It Forward Program.

ESMs	Status
ESM 13.1.1 - Proportion of at-risk pregnant women who report receiving a preventive dental visit during pregnancy by piloting the First Steps Program.	Active
ESM 13.1.2 - Proportion of at-risk pregnant women who are educated about the importance of receiving preventive dental care during pregnancy and assist with linking Medicaid insured to needed dental services by piloting the First Steps Program.	Active

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

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

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

Increase the percentage of expectant mothers receiving preventive dental visits.

Strategies

Promote preventive dental visits through ads placed on Standeez displays to be placed in all county health departments.

ESMs	Status
ESM 13.1.1 - Proportion of at-risk pregnant women who report receiving a preventive dental visit during pregnancy by piloting the First Steps Program.	Active
ESM 13.1.2 - Proportion of at-risk pregnant women who are educated about the importance of receiving preventive dental care during pregnancy and assist with linking Medicaid insured to needed dental services by piloting the First Steps Program.	Active

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

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

State Action Plan Table (Alabama) - Women/Maternal Health - Entry 3

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 2 points annually.	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 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

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

2016-2020: National Performance Measures

Well Woman Program

NPM 1: Percent of women with a past year preventive medical visit

ESM 1.1 - Increase the proportion of women age 15-55, who report receiving a preventive medical visit in the past 12 months by piloting Well Woman in 2 county health departments by December 2017.

The WW program operates under the Office of Women's Health and in 2018 was included as a part of the Governor's initiative on Infant Mortality Reduction for the state of Alabama. The program allows for women to receive a preventive wellness screening, an opportunity to participate in behavioral changes regarding chronic diseases, food choices, physical activity, and referrals for smoking cessation. The WW program focuses on women of childbearing age to improve their overall health before becoming pregnant and after the delivery of a newborn. The program reach has increased and is currently offered in six counties in Alabama (Butler, Dallas, Macon, Montgomery, Russell and Wilcox).

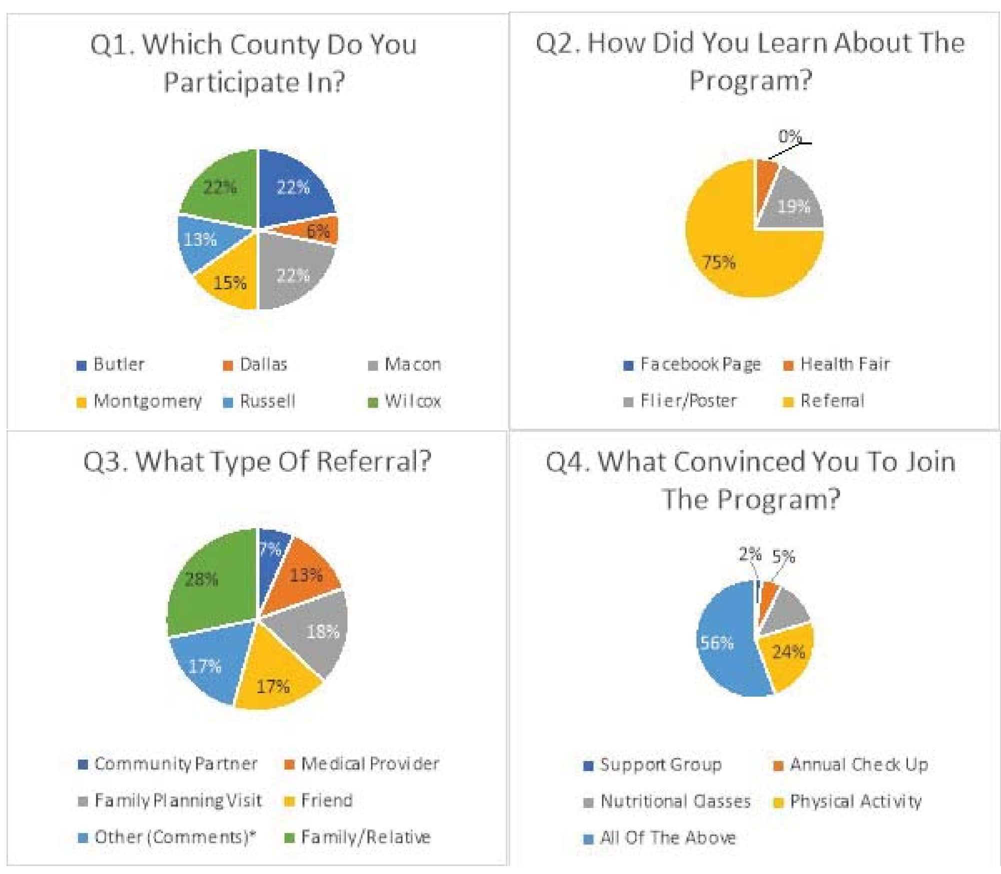
Program objectives:

The WW program provides a well clinic visit that includes the following:

- Cardiovascular disease risk factor screenings to determine risk factors – includes blood pressure and cholesterol screening
- Risk reduction counseling to help women understand their risks
- Healthy life/reproductive health planning to include inter-conception and preconception care
- Health coaching, nutritional counseling and support to help women discover healthy lifestyle behaviors
- Vision and oral screenings
- Physical activity encouragement/incentives, such as YMCA memberships

Program achievements:

- Enrolled 479 participants in the program and 1,637 total WW visits made at the CHDs in FY2019 (visits include initial visits and revisits/follow-up visits)
- Hired a nutritionist to provide nutritional education to participants in Macon, Montgomery and Russell counties
- Sponsored a 2-day training course for the program's social worker staff on motivational interviewing skills which offered 12.5 social work ethics continuing education hours
- Hosted a student intern from UAB for summer 2019 through the Pathways to Practice Scholars student fields placement program
- Referral process developed to collaborate with community partners for referrals into the program
- Incorporated Spanish version fliers/outreach material to capture Spanish speaking population
- Development of WW Alabama Facebook page/social media access
- Social media was used to survey program participants in all six counties during the summer of 2019. Four questions were asked with the following results: 75 percent of respondents learned about the program through a referral by a family member or friend; and 56 percent reported joining the program for all parts (support group, physical activity, nutritional and screenings/check-ups)



Program challenges:

Majority of data collected manually by program coordinator. Will continue to work with the electronic health record team to resolve and solicit assistance from ADPH MCH epidemiology staff

Staffing resources for nutritionist at state and district level is challenging for new counties participating in the WW program.

Oral Health Office

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy
ESM 13.1-Increase the proportion of at-risk pregnant women who report receiving a preventive dental visit during pregnancy by piloting the First Steps Program.

OHO continues its partnership with the maternity care coordination program using ADPH case managers to promote dental visits during pregnancy. In August of 2019 there was a presentation to ADPH social workers on oral health partnerships for home visitors. Dental data continued to be collected. Educational material and oral hygiene kits continued to be shipped to all care coordinators. Patients needing a dental home were referred to local dental providers. As a part of the patient assessment process, the patients were educated about the importance of accessing dental care. If specific dental needs were identified, such as locating a dental provider, social workers assisted patients with appointment scheduling, monitored appointment compliance, and linked patients to community resources to help overcome barriers in remaining compliant with oral health care services. Patients were also given access to oral health kits for themselves, children residing in the home, as well as any other member of the household. In the 16 counties targeted from October 2018 through November 2019, 1,299 maternity patients received maternity care coordination services through the ADPH social work program. A total of 1,246 Nonmedicaid/Uninsured maternity patients

received care coordination services in the same counties during the same period. These services were funded through the MCH Title V Block Grant. A video conference is being planned with case managers to further develop the program.

OHO provided the following items to the Medicaid Maternity Care Program

- 25 Now You're Brushing for Two Posters (English)
- 25 Now You're Brushing for Two Posters (Spanish)
- 250 Infant Oral Health Infographic (Spanish)
- 1,000 Infant Oral Health Infographic (English)
- 1,000 Provider Guides (English)
- 100 Provider Guides (Spanish)
- 1,000 Protect Tiny Teeth Flyers (English)
- 250 Protect Tiny Teeth Flyers (Spanish)
- 1,000 Prenatal Oral Health Infographic (English)

Program research was also done during this same time period to assess how maternity patients insured through private insurance companies were being educated about the importance of accessing oral health services during pregnancy. The main purpose of this research was to learn from our community partners, in the private and public sectors about successful efforts they were utilizing in educating maternity patients about the importance of accessing oral health services.

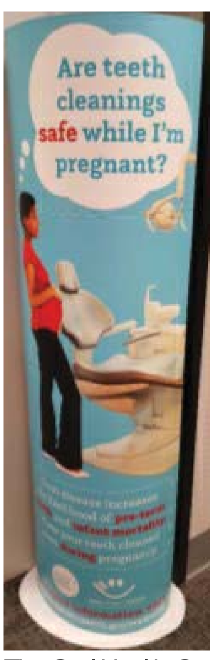
OHO continues to partner with ADPH internal programs, such as WIC, Perinatal Health, Women's Health, and external programs, such as Gift of Life (GOL), Head Start, and Pay It Forward, that serve or connect with pregnant women to increase oral health awareness and to promote routine dental visits, even during pregnancy.

OHO and ADPH marketing division staff developed floor clings, bus windows decals, and billboards advocating preventative dental visits for pregnant women during pregnancy citing the correlation between low birth weight and infant mortality with mothers exhibiting periodontal disease. The ads promoting dental visits for pregnant women continued to appear on local buses and bus stops in Montgomery throughout FY 2019. OHO also purchased Standeez promoting preventive dental visits for pregnant women and HPV that were placed in 30 Dollar General stores, grocery stores, and pharmacies around the state in August 2019.

Ads created to promote dental visits for pregnant women continued to be featured in "Oh, Baby!" magazine which is placed in all delivering hospitals throughout the state as well as OB/GYN offices. The 2019 ad featured two of the materials from the "Tiny Teeth" materials.

A new pamphlet was created to compliment the OHO fluoridation toolkit. The flyer is available online and was distributed to all public water systems along with the toolkit.

The OHO director, Tommy Johnson, DMD, presented at the Gulf Coast OB/GYN Conference on the importance of preventive dental visits for pregnant women regarding low birth weight babies. The conference was attended by approximately 125 people. Dr. Johnson gave similar presentations at various other venues including the Montgomery Area Dietetic Association, Medicaid, etc. on overall physical health and pregnancy as they relate to oral health.



The Oral Health Coalition of Alabama (OHCA) work group continued to meet to develop Alabama's first State Oral Health Plan. The new 5-year state plan includes an objective and strategy linked to promoting preventive dental visits for pregnant women. Alabama's first State Oral Health Plan was completed in the late summer/ early fall of 2019. In November of 2019 OHO held a dedication and reveal program for the oral health plan.

ADPH's Northern Public Health District continued to partner with OHO to provide healthy habits "gifts" to children in immunization clinics and also at appropriate health fair venues. OHO provided the district with 3,500 additional oral health kits. In addition to providing a toothbrush, toothpaste, and dental floss in a "gift bag", county staff are using it as an opportunity to provide outreach, especially for WIC services, but also for other health department services such as family planning, additional immunization, breast and cervical cancer program, etc. Home health staff are also assisting in outreach by providing the "gifts" and information in homes where there are family members that may also need these services.

Sarrell Dental, which managed several dental clinics within CHDs, has moved those clinics to free standing buildings. While no longer connected to ADPH, these clinics continue to provide dental homes for a significant number of Medicaid children and their families. Family Health Dental operates clinics in Mobile CHD which provide dental services via community health center-managed dental programs, which included dental services for uninsured or underinsured adults. The only ADPH operated dental clinic that remains is located within the Tuscaloosa CHD. Free oral hygiene supplies, educational material, and other assistance were provided to the Tuscaloosa CHD as requested and OHO plans to assist the CHD by funding the update of its radiology equipment in 2020.

GOL serves women, infants and children who are at a greater risk for infant mortality. They help program participants reduce barriers to success, related to economic, social and health disparities. Through one aspect of GOL, case managers and nurses provide dental health education and promote dental visits for their clients and their families. OHO provided dental health education material and oral hygiene supplies for the 500 maternity patients seen annually. The following supplies/educational material were sent to GOL:

- 1,000 toothbrushes, toothpaste, spools of dental floss
- 500 plastic promotional bags for patients
- 500 each of "Prevent Pregnancy-Related Gum Disease"
- 500 each of "A Healthy Smile for Your Baby"

- 500 each of "Two Healthy Smiles"
- 500 each of "Healthy Habits for Happy Smiles"
- 100 each of "Healthy Habits for Happy Smiles"(Spanish Version)

The Pay It Forward program, administered by HandsOn River Region, was awarded a $25,000 grant from OHO in 2019 to continue its program and support the salary of a coordinator. The program is a value-based program whereas uninsured / under-insured clients can receive dental treatment by logging volunteer hours with any of more than 200 volunteer sites within the River Region. The program coordinator is responsible for recruiting new volunteer dentists, orientation of new patients who enroll in Pay It Forward, scheduling appointments, overseeing ADPH grant funds, exploring new modes of transportation for clients, and identifying additional partners for new clients. Pay It Forward originally only allowed GOL mothers to participate; fathers have since been added. Additionally, the program expanded the organizations through which clients could be vetted and enrolled. The following organizations were added:

- Hope Inspired Ministries -- Hope Inspired Ministries serves low-skilled, poorly educated, and chronically unemployed men and women by preparing them to obtain and maintain employment.
- Nehemiah Center -- The mission of Nehemiah Center is to equip and enable the children and adults they serve with lasting skills enabling them to abundantly sustain themselves physically, spiritually and emotionally.
- Communities of Transformation -- The mission of Communities of Transformation is to move families from surviving to thriving by developing personal leadership skills and building authentic relationships.
- Transformation Montgomery – Transformation Montgomery is a nonprofit organization that seeks to transform lives one person, one family, one neighborhood at a time through holistic life skills training, relational community renewal, and affordable housing.
- Aid to Inmate Mothers -- Aid to Inmate Mothers provides services to Alabama's incarcerated women with emphasis on enhancing personal growth and strengthening the bonds between inmate mothers and their children.
- Friendship Mission -- Demonstrating love in action, Friendship Mission, Inc. provides a faith-centered place of refuge for the River Region's homeless and poor that exemplifies compassion, promotes self-sufficiency and offers the tools to achieve this goal.

ADPH's collaboration with Pay It Forward is featured in the Best Practice Approach Report (BPAR) on State Oral Health Programs and Collaborative Partnerships with the Association of State and Territorial Dental Directors.

Each year OHO purchases and creates educational resources and promotional items with plans to distribute during oral health month and by request of its partners. Below is a partial list of those efforts in 2019.

OHO provided the following materials to SPP

- 1,000 Prenatal Oral Health Infographic (English)
- 1,000 Provider Guides (English)
- 20 Now You're Brushing for Two posters (English)
- 20 Now You're Brushing for Two posters (Spanish)

OHO provided the following materials to Medicaid Maternity Care Program

- 25 Now You're Brushing for Two Posters (English)
- 25 Now You're Brushing for Two Posters (Spanish)
- 250 Infant Oral Health Infographic (Spanish)
- 1,000 Infant Oral Health Infographic (English)
- 1,000 Provider Guides (English)

- 100 Provider Guides (Spanish)
- 1,000 Protect Tiny Teeth Flyers (English)
- 250 Protect Tiny Teeth Flyers (Spanish)
- 1,000 Prenatal Oral Health Infographic (English)

OHO provided the following materials to GOL

- 25 Provider Guides (English)
- 200 Prenatal Oral Health Infographic (English)
- 300 Infant Oral Health Infographic (English)

OHO mailed a sample of the Tiny Teeth custom materials to each of the 66 CHDs to inform them of new items that they could order for their oral health education needs.

Other ADPH Women/Maternal Health Programs

Family Planning

The APDH Family Planning 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. Services include reproductive life planning, contraceptive counseling, breast and cervical cancer screenings and follow up, and screening and treatment for sexually transmitted infections. Clients have access to a broad range of contraceptive methods, including long-acting reversible contraceptives.

The ADPH Family Planning Program continued providing family planning clinical services to Alabama Medicaid Plan First patients under the CMS-approved 1115 Plan First Family Planning Waiver.

The Family Planning Program also renewed an MOU with Alabama Department of Human Resources to continue DHR funding of non-surgical contraceptive supplies for low-income Family Planning clients.

To increase access to services and remove barriers to care for women in need of reproductive health care, the ADPH Family Planning Program completed a successful IUD insertion pilot in four counties (Morgan in the north, Shelby and Montgomery in central Alabama, and Baldwin in the south) that launched in October 2018. Nurse Practitioners began IUD insertion and removal training to support statewide expansion of IUD availability in every public health district over the next year, significantly increasing patient access to long acting reversible contraceptives. Family Planning physicians also began providing colposcopy services in some CHDs; clinics were strategically selected to support ease of access for patients within surrounding geographic areas comprising multiple counties. Family Planning physicians travel to these CHDs on a rotating schedule to provide the procedure. However, plans are in development for Nurse Practitioners to receive colposcopy training; upon completion, the NPs will utilize mobile colposcopy equipment and existing telehealth capability in the CHDs, giving physicians the ability to diagnose and treat patients remotely. The addition and expansion of this critical procedure greatly facilitates continuity of care for patients who require timely follow up of cervical cancer screenings.

In 2019, the ADPH Family Planning Program and its sub-recipients, Jefferson County Department of Health and Mobile County Health Department, served 71,415 clients in 141,515 visits. More than half of the clients served were uninsured. Almost 39,000 clients reported incomes of 100 percent or less of Federal Poverty Level.

FY 2019 ended with approximately 45 FTEs in the Patient 1st Program.

FHS expanded the use of its hotline from helping pregnant women access providers and educational materials about pregnancy, to a resource of information on all bureau services. In 2018, a total of 733 calls were received on the line.

Special Supplemental Nutrition Program for Women, Infants, and Children

The WIC Program implemented eWIC statewide during the calendar year 2019. The change to eWIC allows families to purchase their food benefits electronically in place of paper checks. One of the flexibilities of eWIC is that families may purchase foods as they need the food each month. eWIC improves the family shopping experience and reduces the stigma associated with assistance programs. Families are allowed to contact their clinic in months when they do not have a required face to face appointment, and their benefits can be loaded remotely without the parent driving to the clinic.

The free Alabama WIC app is available for participants to access on Apple and Android devices. The WIC app features appointment and benefit expiration reminders, a searchable WIC approved food list, recipes, nutrition and breastfeeding education, and more. Staff are encouraged to download the app, explore what it offers and share this information with participants.

The WIC program continues to offer electronic nutrition education as a partner with wichealth.org. This arrangement allows low risk participants to complete nutrition education lessons via a web application. The nutrition education lessons directly interface with the Crossroads Management Information System, so that clinics can confirm completion of these lessons. Nutrition staff are also conducting nutrition education visits via telephone to reduce the number of visits that the family must make to the clinic.

The WIC program has been focusing nutrition education efforts on the health benefits of WIC foods to reduce the incidence of obesity, heart disease, cancer, and diabetes for the past 2 years. The FY 2020 - 2021 Nutrition Education Plan continues to expand on these efforts. The plan includes new recipes incorporating WIC approved foods, new information about shopping tips to spread WIC benefits throughout the month and how to plan meals. Families are provided incentive items in the form of a shopping list and a nut butter scraper in an effort to educate and encourage WIC participants about the health benefits of WIC foods. The WIC program will continue to monitor food benefit redemption data to determine if the education provided regarding health benefits of the WIC food package increases redemption of WIC foods, including fresh fruits and vegetables.

WIC continued to increase public awareness of the importance of breastfeeding. The WIC Programs in Dallas and Walker counties were recipients of the Loving Support Award of Excellence for exemplary breastfeeding promotion and support activities. The WIC Breastfeeding Coordinator provided breastfeeding information for ADPH's *Alabama's Health* newsletter. The Breastfeeding Coordinator and other members of the Alabama Breastfeeding Committee (ABC) participated in CDC's State Breastfeeding Coalition teleconference calls. The WIC Breastfeeding Coordinator continued training WIC staff and offering breastfeeding education to staff from Alabama hospitals. She served on the board of the Alabama Lactation Consultant Association, which continued to meet. Also, the coordinator served on the board of ABC, which continued to meet. Nurses, doctors, lactation consultants, and various other health professionals are members of ABC, which focuses on encouraging, supporting, and protecting breastfeeding in Alabama. The WIC State Breastfeeding Coordinator participated as a member of the Central Alabama Breastfeeding Task Force.

The Breastfeeding Resource Guide was updated for ADPH's website. Materials were distributed to CHDs to promote Breastfeeding Awareness Month. As of September 2019, there were a total of 70 active peer counseling sites. Training was provided for the Breastfeeding Peer Counseling Program. Expansion of the Breastfeeding Peer

Counseling Program continues.

A WIC Alabama Breastfeeding Enrollment Report is available for Public Health District Nutrition Directors. The report provides breastfeeding initiation and duration rates for each clinic and district.

Pregnancy Risk Assessment Monitoring System

The PRAMS Project began collecting data in 1992 and was designed to help state health departments establish and maintain a surveillance system of selected maternal behaviors and experiences. The Centers for Disease Control (CDC) collaborated with Alabama, other states, and the District of Columbia to implement this system. The Alabama PRAMS Project was transferred to the FHS from the Center for Health Statistics (CHS) on May 1, 2016. The CHS continues to provide the required data to the BFHS to carry out the PRAMS grant activities.

Through the relocation of the PRAMS Project to the BFHS, staff now have direct access to Alabama PRAMS data. Alabama PRAMS is positioned to collaborate with other partners and key stakeholders for maternal and child health in the state. Alabama PRAMS works with the Alabama MCH Title V Program, which fosters relationships with programs both internal and external to the BFHS and with many statewide and community groups and governmental and private organizations to address various issues. As such, Alabama PRAMS works to collaborate with WIC, Medicaid Maternity Care Providers, birthing facilities, health care providers (obstetricians/gynecologists, pediatricians, nurses, etc.), Healthy Child Care staff, the Alabama Chapter of March of Dimes (MOD), other BFHS and ADPH program staff, and other key stakeholders, as deemed appropriate. These collaborations provide opportunities to promote the awareness of and benefits of participating in the survey, if selected.

The Alabama PRAMS Project seeks to help improve the health of mothers and babies in Alabama. To perform these tasks, the PRAMS questionnaire asks mothers questions about their behaviors and experiences around the time of their pregnancy to determine why some babies are born healthy and some are not. Each year, approximately 1,450 Alabama mothers are randomly selected from the state birth certificate registry to receive the questionnaire, via mail or phone, for completion. In 2018, 811 Alabama mothers participated in PRAMS.

In the future, there will be an option to answer the PRAMS survey via a web application, which the Alabama PRAMS Project will seek to implement once available. With improved rewards and increased brand recognition, Alabama PRAMS improved recent response rates, which have exceeded the CDC response rate threshold. Maternal behavior and pregnancy outcomes have been strongly associated, thus, the impetus for seeking to improve efforts to understand contributing factors to infant mortality and low birth weight. Topics of PRAMS questions include, but are not limited to, the following: breastfeeding, contraception, infant sleep environment, prenatal care, and maternal mental health.

Since Healthy People 2020 goals and objectives include numerous maternal and child health indicators, Alabama PRAMS data will be used to measure the status of the maternal and child health related indicators, as applicable. Alabama PRAMS data will also be used by Alabama’s Title V MCH program to monitor progress related to the National Performance Measures selected for programmatic focus during the current funding cycle.

The Alabama PRAMS Project is currently participating in the supplemental opioid research that began in May 2019 and will continue until further notice. The main goal of the Alabama PRAMS Opioid Supplement is to use the existing PRAMS methodology to assess maternal behaviors and experiences related to opioid use among women before, during, and after pregnancy in the United States.

Office of Women's Health

The Office of Women's Health (OWH) was created by Alabama Legislature Act 2002-141 to be an advocate for women's health issues. The purpose of the office as described in the legislation is as follows:

- To educate the public and be an advocate for women's health by establishing appropriate forums to educate the public regarding women's health, with an emphasis on preventive health and healthy lifestyles.
- To assist the state health officer in identifying, coordinating, and establishing priorities for programs, services, and resources the state should provide for women's health issues and concerns.
- To serve as a clearinghouse and resource for information regarding women's health data, services, and programs that address women's health issues.
- To provide an annual report on the status of women's health and activities of the office to the Governor and the Legislature.

The law provides for an advisory committee for the office. The Steering Committee consists of the following:

- Three physicians appointed by the Medical Association of the State of Alabama
- Three nurses appointed by the Alabama State Nurses Association
- Three pharmacists appointed by the Alabama Pharmacy Association
- Three employers appointed by the Business Council of Alabama
- One consumer appointed by the Governor, one appointed by the Lieutenant Governor, and one appointed by the Speaker of the House
- Three members appointed by the Alabama Hospital Association
- Three registered dietitians appointed by the Alabama Dietetic Association

Women on Wellness

The Women on Wellness (WOW) Speakers Bureau was developed by the OWH Steering Committee to promote the health of women throughout the state by facilitating and coordinating evidence-based information and education about women's health. The WOW Speakers Bureau features great public communicators who are experts in women's health and focus on specific issues affecting women's health through the lifespan. WOW speakers are physicians, nurses, dietitians, pharmacists, social workers, community health advocates, and other healthcare providers who are qualified expert speakers available for any audience interested in learning more about specific women's health issues.

Single Mothers Empowerment Conference

Single mothers were invited to the Sixth Annual Single Mothers Empowerment Conference on Saturday, June 22, 2019, at the McWane Science Center in Birmingham. The theme was "Revive & Refresh , Stronger Together!" and topics included finances, healthy relationships, life transitions, legal concerns, and much more. The event provided a constellation of information, resources, mentorship, a strong network of support and motivation for single parent women of all walks of life. It was designed to empower single mothers to address the challenges and obstacles they face as family leaders while helping them to renew their hopes, dreams and goals.

Women's Health Update

The OWH Twelfth Annual Women's Health Update was held Friday, August 2, 2019, at the Grandview Medical Center Auditorium in Birmingham, Alabama. The theme was: Innovations in Women's Health: A Focus on Technology. The event was a continuing education offering for registered nurses, nurse practitioners, pharmacists, social workers, dietitians, and other health care providers. The purpose of the annual conference is to disseminate scholarly work that is aimed at improving the health status of all women. Topics included Telehealth, cardiovascular health, weight management, nutrition, complementary and alternative medicine, preconception care, mental health issues,

community involvement, and health policy; each topic included the use of technology for assistance with health care needs across communities. The conference provided a venue for scholars from various disciplines to share their latest projects and research findings with colleagues.

Opioids

The Alabama OMW/NAS Taskforce continues to meet quarterly in March, June, September, and December. The goal of the taskforce, formed through an ADPH Office of Women's Health partnership with the AAP, Alabama Chapter, is to target the misuse of opioids in Alabama among women and address the growing trend of infants born addicted to drugs (NAS), by introducing preventative strategies and proposing standardized screening protocols to address early identification in women, and in babies exhibiting NAS after delivery. Midyear 2018, the three core subcommittee teams - legal, protocol, and education - were expanded to include the treatment, resources & recovery committee. The target population continues to be girls/women (including incarcerated women) and NAS infants.

Committee members participated in a panel discussion with the Executive Director of the Alabama Office of Prosecution Services/Alabama District Attorneys Association in 2019, at the AAP, Alabama Chapter meeting, to discuss the Alabama child endangerment law and criminalization of mothers who use illegal substances during pregnancy. Mothers continue to be charged with chemical endangerment of the child. Discussions are ongoing for the development of a position statement that would include decriminalization for women in treatment programs. The taskforce hopes to develop the basis for a communication piece for the State of Alabama that stresses, that if the mother gets treatment during pregnancy, she will not be charged. The document would carry logos of the Attorney General, the AAP, Alabama Chapter, and ADPH. Draft language for the position statement flyer was submitted for literacy level review by staff at UAB.

The taskforce is working to address universal testing of all mothers in labor and delivery units and reduce variation in treatment of opioid exposure. Data is needed for comparison of outcomes and translation into better care. A comparison of three years of data from Huntsville/Madison hospitals (which test all mothers), to UAB and St. Vincent's data (which do not test all mothers), is being explored. Challenges include the fact that providers keep circling back to fear of prosecution if the baby tests positive for opioids.

Maternal Mortality Review Program

ADPH established the Maternal Mortality Review Program (MMRP) in March 16, 2018. The purpose of the Program is to understand how a wide array of social, economic, health, educational, environmental, and safety issues relate to maternal death. The goal is to do an in-depth look into the circumstances of each case of maternal death to understand how to prevent them. An additional goal is to promote change among individuals, communities, and health care systems in order to improve the well-being of women of childbearing age, infants, and families. The maternal mortality review process begins with the ADPH nurse abstractor gathering information about a maternal death and synthesizing the information into a case summary. The de-identified case summary is presented to the Maternal Mortality Review Committee (MMRC). The MMRC is a multidisciplinary team which reviews cases of maternal death that occur during pregnancy or within one year of pregnancy and makes recommendations that will lead to a more effective and efficient statewide maternal care system.

The Alabama MMRC convened for the first time on December 7, 2018 for a mock case review. ADPH and a team from the Centers for Disease Control and Prevention (CDC) provided information on the importance of conducting maternal death reviews and oriented members about the role they each play on the committee. The MMRP has consulted and collaborated with the Division of Reproductive Health National Center for Chronic Disease Prevention

and Health Promotion Centers for Disease Control and Prevention in the implementation and operations of the Alabama MMRP. On Friday, February 8, 2019, the Alabama MMRC conducted its first case review meeting with more than 45 professionals from across the state in attendance. During the year, the MMRC met quarterly and reviewed all of the 36 maternal deaths selected for review out of 56 maternal deaths that occurred in 2016. Support for the MMRC was provided by the American College of Obstetricians and Gynecologists.

Currently, the MMRP staff is abstracting 2017 maternal deaths. The MMRC is meeting quarterly to review the 2017 case summaries and make recommendations. An abbreviated report of the 2016 findings is being prepared and scheduled to be published by the end of 2020.

In FY 21, the MMRC will continue to meet quarterly to review cases. The MMRP will be provided state funds through the general fund budget. These funds were secured through the efforts of the March of Dimes and the Medical Association of the State of Alabama. The funds will be used to hire additional MMRP staff and provide funding for autopsies. The program will incorporate interviews from family members, a process similar to FIMR, to gain a better understanding of the factors that contribute to maternal deaths. Maternal deaths that are COVID-19 related will be reviewed, abstracted and presented to the MMRC. So that, prevention efforts can be disseminated to mitigate these deaths.

State of Alabama Infant Mortality Reduction Plan

In December 2017, Governor Kay Ivey convened the Children's Cabinet to address the issue of infant mortality in Alabama. A subcommittee was created to develop an action plan. This subcommittee was comprised of leaders and staff from DECE, DHR, DMH, ADPH, Medicaid, and OMA. Title V funded program managers and MCH Epi staff developed and implemented strategies and data support for governor's initiative.

Home Visiting

DECE contracted with two programs to provide evidence-based home visitation, using the Parents as Teachers and Nurse-Family Partnership (NFP) models of service delivery. Newly hired staff were required to complete NFP required and DECE required new home visitor trainings. Following the training period, recruitment ensued. Though the narrow eligibility requirements of NFP proved to be a challenge, the team met half of their year 1 targets in the first three quarters. By the end of quarter three, more than 50 families (across all pilot counties) were enrolled in the program, illustrating rapid growth of participant enrollment. This upward trend is anticipated to increase by the end of year one. Funding from a variety of sources, in addition to matched funds by Medicaid, allowed home-visiting services to be expanded to 66 of 67 counties in Alabama. The strategy team will continue to use the two models as a basis for continuous program growth and advancement.

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

The SBIRT tool can be a useful instrument in identifying, reducing, and preventing substance use, domestic violence, and depression. Research has been completed on best practices in providing services among pre-pregnancy, prenatal, and post-partum women. Additionally, training strategies and outreach models have been explored to determine the optimal ways to effectively provide screenings. In this way, a training program and support for providers may increase the number of screenings that take place. The SBIRT committee began meeting to develop a working plan as to how to accomplish the goal of implementing SBIRT in the designated counties. After developing the plan, the lengthy contractual process further delayed plan implementation; thus, significantly delaying the progress in the team's proposed objectives. However, the team selected a project coordinator, who began in September 2019, to provide oversight for the anticipated activities. The integral role of the project coordinator in the activities throughout the remaining years in the initiative will be imperative to the program's success. The lead agency for SBIRT was the Alabama Department of Mental Health.

Preconception and Inter-Conception Care

The WW program provides preconception and inter-conception care to women of child- bearing ages (15-55 years), as a foundation for wellness, identification of chronic diseases, and the adoption of a healthier lifestyle. In the first year of the initiative, a referral process was developed and initiated for enrollment into the program. The program boasts a 45 percent increase over the target enrollment of participants (total number by August 26, 2019 = 291). Of those enrolled in the program, at least 78 percent had controlled blood pressure at nearly the end of year one and 93 percent had blood glucose levels controlled inside the target range.

This program continues to be encouraged throughout the pilot counties and nearly seven thousand promotional materials have been distributed, in addition to social media postings. Community partnerships established in year 1 with organizations, such as GOL and Small Wonders, is projected to increase participant enrollment and improve health outcomes of women.

Perinatal Regionalization

Enhancing perinatal regionalization is a priority of the State of Alabama Infant Mortality Reduction Plan. For several years, the team has been working and continues to work to implement a fully coordinated system of perinatal regionalized care in Alabama. The foundation for such a system will be dependent upon relevant data that the workgroup began collecting in year 1. Furthermore, the workgroup, in collaboration with the Alabama Hospital Association and the State Health Planning and Development Agency (SHPDA), has worked to identify the level of neonatal care of delivering hospitals through self-declaration of the facilities. Baseline data for self-declared neonatal level of care was received from the SHPDA, and pertinent data was requested from the Center for Health Statistics. In March 2019, a conference call was convened with Dr. Wanda Barfield, OB/GYN and Rear Admiral with CDC, to discuss recommendations for engaging providers. In May 2019, Dr. Whit Hall, Neonatologist at the University of Arkansas, traveled to Alabama and met with staff and providers at the three delivering hospitals in Montgomery to discuss opportunities, options, challenges, and barriers. Review of the aforementioned data and support from CDC and experts will further advance the efforts underway to develop a perinatal regionalization system in the state.

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. The ESM supporting activities for each NPM will be implemented as described below.

Well Woman Program

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 2 points annually.

For 2021, WW plans to continue the implementation and monitoring progress of programs in the existing six counties by implementing quarterly conference calls with district administrative staff and WW administrative staff for county staff engagement and to discuss challenges, progress, and continual updates of the program. Program implementation is pending in a seventh county, Marengo. The program objectives include the following:

- Recruitment of women ages 15-55 for enrollment in program and encourage current participants to have their annual re-screening wellness visit
- Target underinsured and/or uninsured women to enroll in the program
- Train 100 percent of relevant staff in each county participating in the program
- Increase public awareness about the program through social media and the distribution of marketing materials to promote the preventative visit
- Increase percentage of referrals from providers in the community annually
- Decrease the percentage of women with blood pressure readings greater than the target range (<130/80) on initial assessment compared to blood pressure readings on follow-up/return visits or annual wellness visit
- Decrease the percentage of women with an unhealthy BMI (greater than 30) on initial assessment compared to BMI on follow-up/revisits or annual wellness visit

WW has been challenged with data collection due to the majority of data being collected manually by the program coordinator. WW will continue to work with the EHR team to resolve and solicit assistance from ADPH MCH epidemiology staff.

Oral Health Office

ESM 13.1.1 - Proportion of at-risk pregnant women who report receiving a preventive dental visit during pregnancy by piloting the First Steps Program.

ESM 13.1.2 - Proportion of at-risk pregnant women who are educated about the importance of receiving preventive dental care during pregnancy and assist with linking Medicaid insured to needed dental services by piloting the First Steps Program.

OHO anticipates the partnership with HandsOn River Region supporting the Pay It Forward Program to continue in 2021. Additional organizations continue to be recruited to participate in the Pay It Forward Program; additional providers are being sought as well.

OHO will continue to fulfill CHD orders for the custom “Tiny Teeth” materials.

The office is planning to conduct oral health screenings for early Early Headstart sites, collaborate with Auburn University Early Headstart Home programs for oral health education and screenings, and create an instructional video on the use of the ADPH Oral Health Flip book that will be used in training centers for daycare

homes and Headstart training centers.

Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2017	7.2	NPM 3
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	7.4	NPM 3 NPM 5
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2017	4.3	NPM 3
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2017	3.1	NPM 5
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2017	232.4	NPM 3
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2017	191.7	NPM 5

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				
	2016	2017	2018	2019
Annual Objective	85.2	75.9	84.5	84.2
Annual Indicator	75.7	84.3	84.1	83.5
Numerator	892	958	913	949
Denominator	1,179	1,136	1,086	1,137
Data Source	Alabama Center for Health Statistics	Alabama Center for Health Statistics	Alabama Center for Health Statistics	Alabama Center for Health Statistics
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Provisional	Provisional	Provisional

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	83.6	83.8	84.0	84.1	84.3	84.5

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
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	46
Data Source	Alabama State Perinatal Program Data
Data Source Year	2020
Provisional or Final ?	Final

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	15.0	25.0	35.0	50.0	65.0

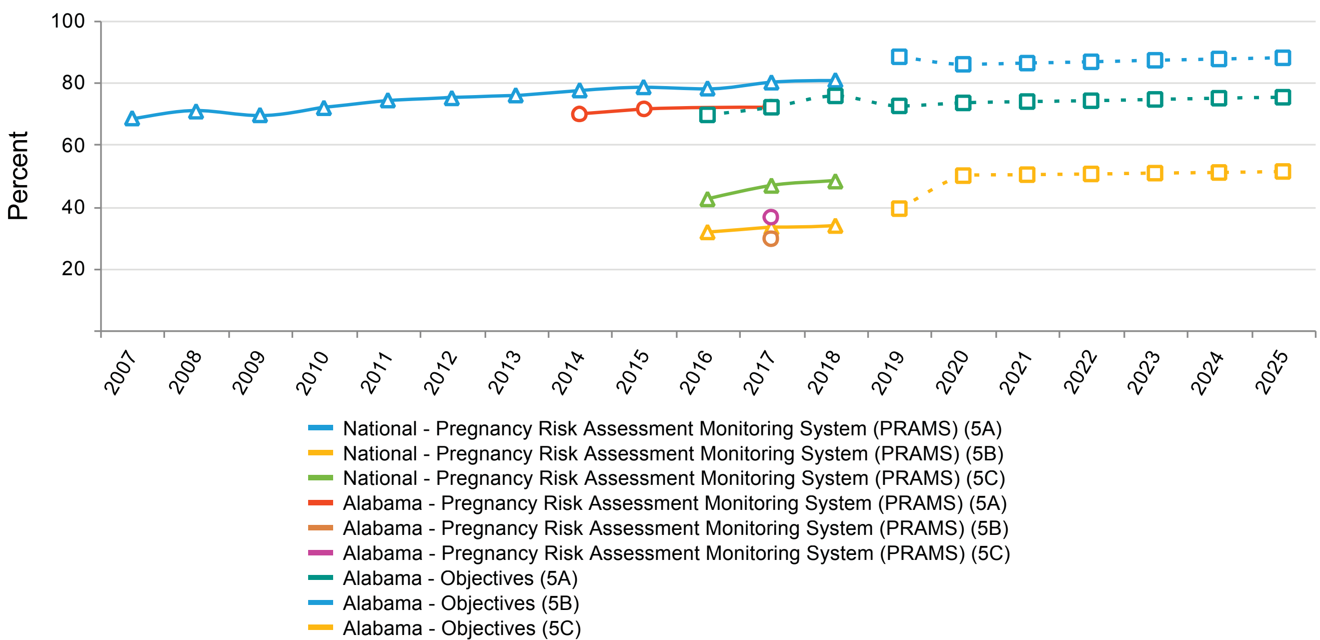
ESM 3.2 - Number of steps of the CDC's Level of Care Assessment Tool (LOCATe) Process completed in order to design and align the Alabama Perinatal Regionalization System Guidelines with the national criteria for the Maternal Levels of Care

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Alabama State Perinatal Program Data
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	1.0	1.0	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)				
	2016	**2017**	**2018**	**2019**
Annual Objective	69.4	71.9	75.5	72.3
Annual Indicator	69.5	71.3	71.3	72.1
Numerator	37,350	38,245	38,245	37,735
Denominator	53,710	53,663	53,663	52,309
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2015	2017

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	73.3	73.7	74.0	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
Annual Objective	88.1
Annual Indicator	29.8
Numerator	15,619
Denominator	52,446
Data Source	PRAMS
Data Source Year	2017

State Provided Data			
	2017	**2018**	**2019**
Annual Objective			88.1
Annual Indicator	86.7	86.7	
Numerator	533	533	
Denominator	615	615	
Data Source	PRAMS	PRAMS	
Data Source Year	2016	2016	
Provisional or Final ?	Provisional	Provisional	

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	85.7	86.1	86.5	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
Annual Objective	39.3
Annual Indicator	36.7
Numerator	19,218
Denominator	52,355
Data Source	PRAMS
Data Source Year	2017

State Provided Data			
	2017	2018	2019
Annual Objective			39.3
Annual Indicator	38.7	38.7	
Numerator	235	235	
Denominator	608	608	
Data Source	PRAMS	PRAMS	
Data Source Year	2016	2016	
Provisional or Final ?	Provisional	Provisional	

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	49.9	50.2	50.4	50.7	50.9	51.2

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - Percent of WIC prenatal participants placing their infants to sleep on their backs

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	71.3
Numerator	38,245
Denominator	53,663
Data Source	Alabama PRAMS
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	72.0	72.7	73.4	74.1	74.8

ESM 5.2 - Number of sleep-related infant deaths

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	70
Numerator	
Denominator	
Data Source	ADPH Center for Health Statistics
Data Source Year	2018
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	68.0	66.0	64.0	62.0	60.0

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

Measure Status:	Active

State Provided Data

	2019
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Alabama State Perinatal Program Documentation
Data Source Year	2020
Provisional or Final ?	Final

Annual Objectives

	2021	2022	2023	2024	2025
Annual Objective	12.0	15.0	19.0	24.0	29.0

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 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	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 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	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% 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 - Percent of WIC prenatal participants placing their infants to sleep on their backs	Active
ESM 5.2 - Number of sleep-related infant deaths	Active
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	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 - Sleep-related 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% 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 - Percent of WIC prenatal participants placing their infants to sleep on their backs	Active
ESM 5.2 - Number of sleep-related infant deaths	Active
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	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 - Sleep-related 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% 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 - Percent of WIC prenatal participants placing their infants to sleep on their backs	Active
ESM 5.2 - Number of sleep-related infant deaths	Active
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	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 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Perinatal/Infant Health - Annual Report

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 3.2 - To improve the system of perinatal regionalization statewide in order to increase the number of very low birthweight (VLBW) deliveries at an appropriate level of care facility.

Alabama continued to focus on preterm births with the ESM to address improving the system of perinatal referral and transfer for high risk mothers and infants. SPP staff worked to establish the comprehensive system of regionalized perinatal care in Alabama. AHA and ADPH continued to meet with State Health Planning and Development Agency (SHPDA), to ensure the questions related to perinatal levels of care were include in the annual hospital survey. The questions corresponded with the Alabama Perinatal Regionalization System Guidelines. The survey was provided to all delivering hospitals to self-declare their neonatal level of care as a baseline assessment. In May 2019, Dr. Richard W. Hall, University of Arkansas Neonatologist, a national expert in perinatal regionalization implementation provided an overview of the steps taken to implement perinatal regionalization in Arkansas. Dr. Hall shared the importance of data to depict the true picture of the problem, utilization, processes, and policies required to develop an evidence-based system of regionalized care. A total of 27 people attended the sessions, that included healthcare providers and hospital women services staff. The attendees discussed the challenges, barriers, and obstacles associated with the current regionalized system of perinatal care and suggestions of how to improve the system.

NPM 5-Percent of infants placed to sleep on their backs
ESM 5.1 -To conduct the Direct on Scene Education (DOSE) Train-the-Trainer Program to first responders in order to reduce Alabama's high rate of unsafe sleep-related deaths in infants less than one year of age

Activities related to the DOSE Train-the-Trainer Program remained stagnant in FY 2019.

In 2018, there were 70 SUID deaths in Alabama. That number was a decrease of 47 sleep related deaths from 2017. ADPH continues to provide pack-n-plays and safety kits to families in Alabama who are in need of a safe sleep environment for their infant.

Alabama Safe Sleep Outreach Project

ADPH continued to collaborate with the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD). In August 2018, the NICHD extended the Alabama Safe Sleep Outreach Project. The Perinatal Regional Coordinators continue to provide quarterly education to hospital women service's nurse managers. NICHD has provided Safe to Sleep Campaign materials in bulk to the state to utilize in its promotion of safe sleep and are to be provided to all county health departments. The materials are housed in the ADPH warehouse and can be obtained by electronically requesting the materials. The Safe Sleep Team/Taskforce continues to meet quarterly and provide community outreach. The taskforce participates in health fairs, faith-based events, conferences and other events to raise awareness of the importance of a safe sleep environment for infants. In August 2019, the NICHD, Palladian Partners and ADPH collaborated to coordinate a photo shoot featuring Alabama infants less than one year of age in their safe sleep environment. In March 2019, 2014-2018 infant mortality data was analyzed to determine zip codes with the high rates of SUID. The information will be utilized to determine areas of targeted infant sleep education to the public and healthcare providers. The agency continues to distribute the Sleep Safe and Snug books both in English and

Spanish to women that deliver within the state. The books are provided to the delivering hospitals to be provided to the parents before discharge. These books are shipped on a quarterly basis to the delivering hospitals. One challenge encountered with this initiative has been one hospital declined to participate indicating that the book was against Baby Friendly guidelines because one picture in the book shows an infant with a pacifier in his mouth. The books in this county are now being distributed through the Medicaid Maternity Care Providers to parents.

Alabama Baby Box Initiative

The statewide initiative was launched in March 2016. DHR is the lead agency for Alabama. ADPH has collaborated with the project from initiation by identifying education topics and presenters for the educational videos. The Baby Box funders committed to 100,000 free boxes for Alabama participants in the original conversations; however, the funder now has committed to as many baby boxes as needed indefinitely to Alabama participants. As of November 2019, the Baby Boxes were no longer available for free to parents. The parents will have to pay to receive the box and are not required to view the educational videos to obtain a baby box. DHR has purchased Baby Boxes to make them available for free to parents who view the educational videos. The Baby Box liaison employee continues to provide safe sleep education to obstetrics and gynecology offices, delivering hospitals, and collaborating agencies throughout the state.

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

Early Elective Deliveries - Ongoing education efforts to reduce the number of non-medically indicated early elective deliveries continued statewide.

FIMR-In 2019 State Perinatal Program staff abstracted and reviewed a total of approximately 200 fetal and infant deaths.

In September 2018, ADPH repealed and replaced the Fetal, Infant, and Maternal Mortality Review Administrative Rule which was approved by the State Committee of Public Health. In 2018, the State Perinatal Program was expanded to include nurse abstractors for FIMR. These abstractors continue to focus on abstracting all infant deaths that occur within their regions. In 2019, FIMR case review teams (CRT) continued to meet at a minimum quarterly to review infant deaths and make recommendations to improve infant health and reduce infant mortality.

Collaborating Partners and Initiatives for the MCH Population

ABC -ADPH continued to collaborate with the ABC on initiatives to promote and increase breastfeeding statewide. Several ADPH staff served as board members on the ABC.

Babypalooza - Babypalooza is an annual statewide event that educates and informs new or expecting parents about community resources and is held in the five largest cities in Alabama. The event is free to the public and focuses on maternity wellness, child safety, and early learning. The state perinatal coordinators exhibited a booth at each of the events and provided educational literature on an array of perinatal topics that aim to improve birth outcomes, reduce morbidity and mortality, and support healthy moms, infants, and families.

Exhibits - Annually, SPP staff travel to conferences, summits, health-fairs, and other exhibiting opportunities such as the Alabama Chapter-American Academy of Pediatrics, Alabama Chapter-March of Dimes Perinatal Conference, Alabama Section-American Congress of Obstetricians and Gynecologists, Medical Association State of Alabama, the Association of Women's Health, and Obstetric and Neonatal Nurses Conference to provide outreach education and collaboration on perinatal issues that are pertinent to strategies being addressed in Alabama.

Alabama Perinatal Quality Collaborative –In March 2017, the Alabama Perinatal Excellence Collaborative transitioned to the Alabama Perinatal Quality Collaborative.

State of Alabama Infant Mortality Reduction Plan

In December 2017, Governor Kay Ivey convened the Children's Cabinet to address the issue of infant mortality in Alabama. A subcommittee was created to develop an action plan. This subcommittee was comprised of leaders and staff from DECE, DHR, DMH, ADPH, Medicaid, and OMA. Title V funded program managers and MCH Epi staff developed and implemented strategies and data support for the plan.

Perinatal Regionalization

Enhancing perinatal regionalization is a priority of the State of Alabama Infant Mortality Reduction Plan. For several years, the team has been working and continues to work on implementing a fully coordinated system of perinatal regionalization care in Alabama. The foundation for such a system will be dependent upon relevant data that the workgroup began collecting in year 1. Furthermore, the workgroup, in collaboration with the Alabama Hospital Association and SHPDA, has worked to identify the level of neonatal care of delivering hospitals through self-declaration of the facilities. Baseline data for self-declared neonatal level of care was received from the SHPDA, and pertinent data was requested from the Center for Health Statistics. In March 2019, a conference call was convened with Dr. Wanda Barfield, OB/GYN and Rear Admiral with CDC, to discuss recommendations for engaging providers. In May 2019, Dr. Whit Hall, Neonatologist at the University of Arkansas, traveled to Alabama and met with staff and providers at the three delivering hospitals in Montgomery to discuss opportunities, options, challenges, and barriers. Review of the aforementioned data and support from CDC and experts will further advance the efforts underway to develop a perinatal regionalization system in the state.

Safe Sleep

DHR led the safe sleep education efforts. With sleep-related infant deaths among the top three contributors of overall infant mortality in Alabama, the need for heightened education is evident. The Safe Sleep Campaign was created to provide safe sleep education at the community level to parents, healthcare providers, elected officials, and the general public. A workgroup was created as a part of the initiative to inform safe sleep efforts and is comprised of partners in academia, state government, and healthcare. As part of this initiative, the team proposed to have at least 11 members in the workgroup, yet surpassed this goal in quarter one alone by 36 percent. Future efforts are underway to include in the workgroup representatives from Blue Cross Blue Shield and the American Association of Retired Persons. In addition, the workgroup has provided quarterly updates at the Children's Policy Council meetings in the targeted counties. In fiscal year one, education was disseminated as outlined below.

- 138,878 Postcards in all counties
- 865 Baby boxes in all counties
- 5 Billboards posted in Montgomery and Macon counties
- 2 Bus wraps displayed in Montgomery county

The team will continue to expand the workgroup and promote safe sleep using effective educational strategies.

Breastfeeding

The hallmark of the breastfeeding initiative has been the utilization of existing and new alliances to increase and advance breastfeeding awareness. A multidisciplinary breastfeeding workgroup was established and includes partners from 18 different agencies. This interagency approach, coupled with multiple views of which to share insight,

will strengthen the workforce to tackle issues that inhibit breastfeeding efforts. The team collaborated with the Alabama Extension Office and the Alabama Partnership for Children to implement a Breastfeeding Friendly Childcare Certification Program, which aims to recognize childcare providers who offer welcoming environments within their facilities for breastfeeding mothers. As of September 1, 2019, five childcare centers were certified in Montgomery and Lee counties. Education of pregnant and postpartum mothers is key in communicating the benefits of breastfeeding. As such, a variety of educational outreach methods were implemented throughout the pilot counties, including fliers, social media posts, and ads in Oh Baby!, a published book that is given to expectant mothers. This workgroup will continue to provide diverse perspectives to further advance the team's objective to use breastfeeding as a way to reduce infant morbidity and mortality in the target counties and statewide.

Increase Utilization of 17P

The use of 17P in women with previous spontaneous singleton preterm births has proven to reduce the incidence of subsequent preterm births. The strategies for the 17P program are to identify the baseline utilization of 17P; provide education to both providers and patients; identify barriers to access and/or adherence to the medication; and expand and facilitate access to 17P. Data collection of 17P claims and research on other states' approaches to 17P expansion remain underway. Targeted interviews of priority stakeholders (e.g., obstetric providers, medical assistants) were completed to map the processes that providers and patients undergo to prescribe, acquire, and administer 17P. Table 3 outlines the identified problem areas, which indicate a need for programmatic and policy changes. As a result, activities throughout the remaining fiscal years of the initiative will align with implementing solutions to these issues.

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

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

In collaboration with AHA, meetings will be held in the three delivering hospitals, in the pilot counties to discuss a plan to improve the system of perinatal care in Alabama. Data, strategies, and objectives will be presented to the administrators and healthcare providers in the three delivering hospitals in the pilot counties. The Perinatal Regionalized system protocols will be created and will be modeled after the existing Trauma Stroke system. Additional planned activities include working to analyze baseline level of care as self-declared by delivering hospitals on the annual SHPDA survey. SPP will continue to provide education, resources, and training to facilities regarding the adopted Alabama Perinatal Regionalization System Guidelines.

ESM 5.1 - Percent of WIC prenatal participants placing their infants to sleep on their backs

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 agency has created MCH Coordinators for each public health district. Thus, the momentum for safe sleep is beginning to grow again at the district, county and community level. The West Central District and the East Central Districts are planning to host DOSE trainings in the upcoming months.

Other Perinatal/Infant Health Activities

SPP plans to continue marketing safe sleep messages and promoting the breastfeeding education campaign in FY 2021.

SPP to implement a Breastfeeding Friendly Office campaign to engage obstetricians/gynecologists and pediatricians to promote breastfeeding and to support families that choose to breastfeed in FY2021.

SPP plans to create the Perinatal Regionalized System Protocols and pilot the implementation in the three pilot counties in FY2021.

SPP plans to continue to promote safe sleep messages and breastfeeding education in FY2021.

The SPP partnerships will remain with Medicaid, DHR, and DMH as we continue to implement SBIRT in CHDs.

SPP staff will continue to abstract and review fetal and infant deaths.

Activities associated with the State of Alabama Infant Mortality Reduction Plan will continue in FY 2021. Those activities impact home visiting, safe sleep, breastfeeding, perinatal regionalization, and the utilization of 17P.

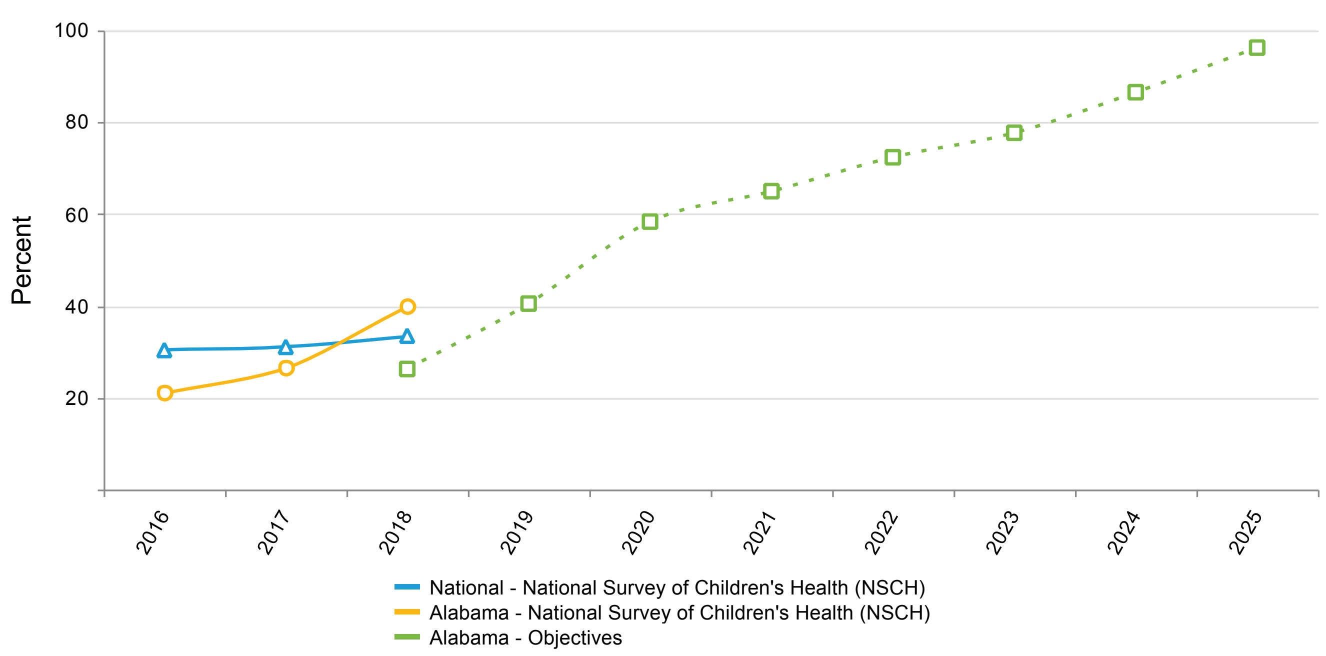
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2017_2018	12.2 %	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	88.1 %	NPM 6 NPM 13.2

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)

	2016	2017	2018	2019
Annual Objective			26.3	40.5
Annual Indicator		21.2	26.6	39.8
Numerator		32,690	38,521	53,496
Denominator		154,509	145,031	134,315
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives

	2020	2021	2022	2023	2024	2025
Annual Objective	58.3	64.9	72.3	77.6	86.4	96.1

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:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	1.0	2.0	3.0	4.0	5.0

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:	Active
State Provided Data	
	2019
Annual Objective	
Annual Indicator	1.8
Numerator	22,363
Denominator	1,219,436
Data Source	APC and U.S. Census Bureau Population Estimates
Data Source Year	2018
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	1.9	1.9	1.9	1.9	1.9

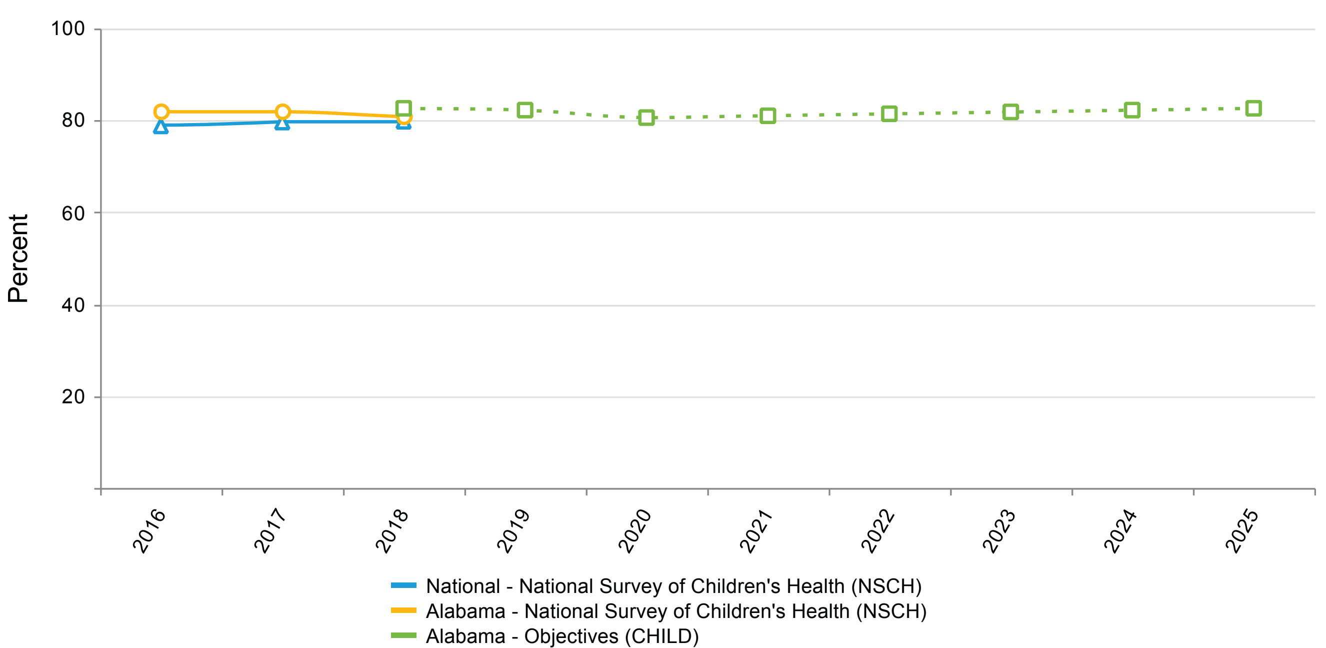
ESM 6.3 - Proportion of children aged 12 & 24 months that have a reported blood lead screening in the past year

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	54.6
Numerator	33,751
Denominator	61,836
Data Source	Alabama Medicaid
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	55.1	55.7	56.2	56.8	57.4

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



NPM 13.2 - Child Health

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH)				
	2016	**2017**	**2018**	**2019**
Annual Objective			82.5	82.1
Annual Indicator		81.7	81.7	80.7
Numerator		837,585	836,024	830,091
Denominator		1,025,822	1,023,434	1,028,454
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	80.5	80.9	81.3	81.7	82.1	82.5

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - Proportion of infants and children, ages 1 through 17 years, who report receiving a preventive dental visit in the past 12 months by piloting the Home by One Program.

Measure Status:	Active

State Provided Data				
	2016	2017	2018	2019
Annual Objective		0	5	10
Annual Indicator	0	27.6	28.2	26.4
Numerator		286,146	292,658	273,684
Denominator		1,036,378	1,036,378	1,036,378
Data Source	PRAMS, Medicaid, RCOs, Social Work Program Data	Medicaid, Census	Medicaid, Census	Medicaid, Census
Data Source Year	2017	2017	2018,2017	2019,2010
Provisional or Final ?	Provisional	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	15.0	20.0	25.0	30.0	30.0	30.0

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:	Active

State Provided Data

	2016	2017	2018	2019
Annual Objective		54.3	53.3	73
Annual Indicator	53.7	52.8	72.2	54.6
Numerator	34,296	33,970	32,124	33,751
Denominator	63,812	64,372	44,467	61,836
Data Source	Alabama Medicaid Agency EPSDT data	Alabama Medicaid Agency EPSDT data	Alabama Medicaid	Alabama Medicaid Agency EPSDT data
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives

	2020	2021	2022	2023	2024	2025
Annual Objective	55.1	55.7	56.2	56.8	57.4	57.9

SPM 4 - Percent of women who smoke during pregnancy

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	8.7
Numerator	
Denominator	
Data Source	ADPH Center for Health Statistics
Data Source Year	2018
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	8.6	8.5	8.4	8.3	8.2

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

Increase percentage of children ages 1-17 years old receiving preventive dental visits

Strategies

Increase awareness of importance of preventive dental visits and promote visits by the "Share Your Smile With Alabama" smile contest.

ESMs	Status
ESM 13.2.1 - Proportion of infants and children, ages 1 through 17 years, who report receiving a preventive dental visit in the past 12 months by piloting the Home by One Program.	Active

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

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 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

Increase percentage of children ages 1-17 years old receiving preventive dental visits

Strategies

Promote preventive dental visits through ads placed on Standeez displays to be placed in all county health departments.

ESMs	Status
ESM 13.2.1 - Proportion of infants and children, ages 1 through 17 years, who report receiving a preventive dental visit in the past 12 months by piloting the Home by One Program.	Active

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

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 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	Active
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	Active
ESM 6.3 - Proportion of children aged 12 & 24 months that have a reported blood lead screening 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.

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	Active
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	Active
ESM 6.3 - Proportion of children aged 12 & 24 months that have a reported blood lead screening 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 5

Priority Need

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

SPM

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

Objectives

Increase by 1% the number of children aged 12 & 24 months that have a reported blood lead screening

Strategies

Increase the number of children aged 12 & 24 months that have a reported blood lead screening

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

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 county's that do not offer EPSDT.

State Action Plan Table (Alabama) - Child Health - Entry 7

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.

2016-2020: National Performance Measures

2016-2020: State Performance Measures

2016-2020: SPM 4 - Number of school districts assessed regarding current mental health services

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		0	5	10
Annual Indicator	0	0	33.8	43.2
Numerator			47	60
Denominator			139	139
Data Source	Medicaid, CHIP, Dept. of Ed, Dept. of MH, Schools	Medicaid, CHIP, Dept. of Ed, Dept. of MH, Schools	State Department of Education	Alabama Department of Mental Health
Data Source Year	2017	2017	2018	2019
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

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 6.2 - Establish an agreement with the Alabama Partnership for Children's Help Me Grow (HMG) Program to utilize their online Ages & Stages Questionnaires, Third Edition (ASQ-3) assessment tool so that parents can complete developmental screens prior to child health visits at county health departments.

SPM 2-Increase the percentage of Alabama Medicaid- eligible children who receive a blood lead screening test.

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-Increase the proportion of infants and children, ages 1-17 years, who report receiving a preventive dental visit in the past 12 months by piloting the Home by One Program.

Dr. Ric Simpson continued to serve as a liaison between the Oral Health Coalition and the Alabama Chapter of the Academy of Pediatric Dentistry (AAPD) and shares OHO activities to promote programs/activities designed to reach very young children and their parents regarding the importance of a dental home. OHO Director successfully recruited new members for OHCA including the President and Executive Director of the Board of Dental Examiners of Alabama and Director of WIC, to name a few.

OHO assisted AAP staff in applying for a DentaQuest grant to fund a statewide " Brush, Book, Bed" program to targeted children ages 0-3 years. The grant promoted interprofessional collaboration between pediatricians and pediatric dentists and promoted good oral health concepts through 12 pediatric practice sites statewide. Pediatric staff provided parent education using videos, flip charts, etc. and distributed education material (books, brochures, stickers, etc).

The "Brush, Book, Bed" campaign successfully concluded in 2019. While the program was not renewable, ADPH purchased 566 "Pony Brushes His Teeth" books, printed BBB bookmarks and posters, and distributed them through Early Headstart, essentially keeping the campaign going independently of DentaQuest. While OHO adapted to early head start instead of pediatric dental offices, the program remained focused on the 0-3 age group.

Schools and other entities were able to submit a material request via the OHO webpage. OHO will continue to print and distribute as requests are made. Each of the items above continue to be available by request to schools and other entities via the webpage.

A total of 22,386 oral health kits were distributed to children and adults that were victims of the Lee County, AL tornadoes and Hurricane Michael through partnerships with CHDs, local churches, and a local pediadontist.

New brochures and fliers featuring and promoting oral health topics and programs were developed on an ongoing basis.

In February 2019, the OHO requested Governor Kay Ivey sign a proclamation declaring February as Children's Dental Health Month in Alabama-bringing recognition to the importance of children's oral health to their overall well- being.

In February 2019, the 2nd annual "Share Your Smile with Alabama" campaign was launched for third grade children in public, private, and home schools statewide to bring attention to National Children's Dental Health Month. Two children, one girl and one boy, were selected from photo submissions as the overall winners of the "Share Your Smile with Alabama" campaign. Prizes of oral health products and a photo shoot in the RSA studio were met with accolades from children's families as well as the ADPH staff. The winners appeared at a live news conference from Montgomery and were featured in OHO marketing campaigns to promote children's oral health in the state throughout the year. The campaign is designed to increase awareness about the importance of good oral health and the value of a great smile. OHO advertisements have been published statewide in Birmingham Parent Magazine, Montgomery Parents, River Region's Journey, River Region's Boom, Auburn-Opelika Parents, Mobile Bay Parents, Eastern Shore Parents, Anniston Star, and Lagniappe (Mobile / Eastern Shore). In the first magazine ad, not only are the children featured, ESM 13.2 was also highlighted.

In FY19, the OHO Director coordinated a partnership with Father Purcell's (Pediatric) Nursing Home. OHO supplied quarterly shipments of oral health kits for all 53 residents of the facility. Additional shipments were requested when numerous patients experience flu or other contagious illnesses.

Other ADPH Child Health Programs

Youth Suicide Prevention

Suicide is the eleventh leading cause of death in the state, with 836 citizens lost to suicide in 2017. In 2019, ADPH's Alabama Youth Suicide Prevention Program began its third year working to reduce the rate of suicides and suicide attempts for youth ages 10 to 24. The program provides grants to crisis centers, the state suicide prevention coalition, and colleges and universities to provide education, outreach, screenings, and referrals to promote suicide prevention, awareness, and services in communities throughout the state. Grantees implement three evidence based- curriculums, QPR (Question-Persuade-Refer), Response, and Kognito. In 2019, suicide prevention program partners conducted 426 trainings, resulting in 13,008 individuals trained as gatekeepers to identify and refer individuals at risk for suicide. Evidence-based bullying prevention curriculum are also taught by the crisis centers participating in the Rape Prevention and Education Program

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 the BPPS (ADPH) received a grant from the Alabama Department of Economic and Community Affairs, which allowed that bureau to develop the Alabama Child Passenger Safety Program. The goals of the Alabama Child Passenger Safety Program are to educate Alabamians on the safe use of child passenger restraints, provide training for individuals to become certified Child Passenger Safety technicians, and establish new car seat fitting stations. With the grant, ADPH established 18 new car seat fitting stations around the state that are managed by six local public health district coordinators.

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.

Oral Health Office

ESM 13.2.1 - Proportion of infants and children, ages 1 through 17 years, who report receiving a preventive dental visit in the past 12 months by piloting the Home by One Program.

The OHO Registered Dental Hygienist will continue conversations with DECE in an attempt to reinstate fluoride varnish programs in the Early Head Start Program.

OHO will continue to distribute the "Pony Brushes His Teeth" book along with oral health kits through DHR. RDH planning an October 2021 presentation to HCCA nurses that work in the Early Head Start childcare centers. The focus of the training is childhood oral health care and nutrition. The training will also be available for on-demand access.

OHO will continue to partner with HCCA to provide free oral hygiene supplies and education material.

In 2021, OHO will continue its partnership with WIC, providing oral health kits to children enrolled in the program in black belt counties.

OHO will continue to develop, print, and ship oral hygiene kits, coloring books, and activity pages to Alabama public schools, upon request. In February 2021, OHO plans to continue the Children's Dental Health Month activities that have been implemented in the prior two years. Alabama is discussing ways to expand Alabama's Share Your Smile Contest to other areas of womens and childrens health, such as dental care during pregnancy and childhood injury prevention. Plans are underway to expand smile contest to other groups.

OHO will continue to explore possible ways, with the help of Family Voices, to include CSHCN in promoting ESM 13.2.

OHO finalized a funding mechanism to conduct Basic Screening Survey (BSS) beginning in Fall 2020. Fifty schools have been selected by ASTDD for screenings of kindergarten and third grade students.

OHO plans to continue its partnership with Father Purcell's (Pediatric) Nursing Home, providing oral health supplies, in 2021.

Children's Health Branch

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

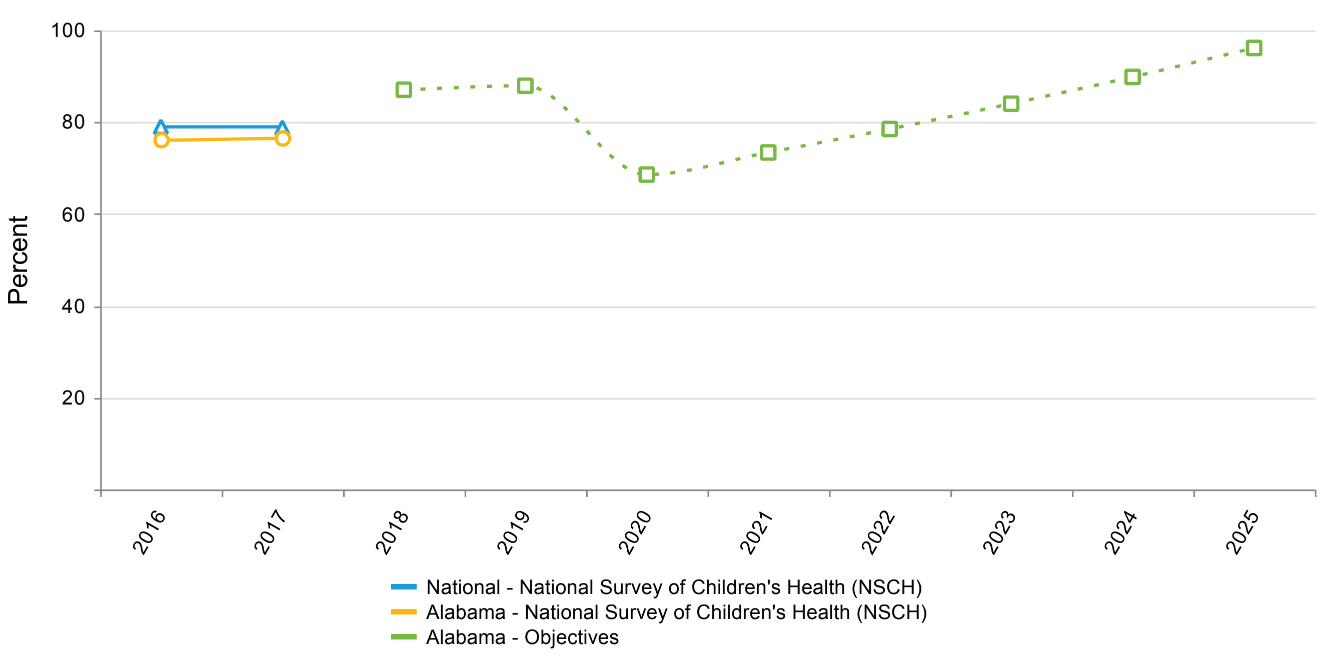
ESM 6.3 - Proportion of children aged 12 & 24 months that have a reported blood lead screening in the past year

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2017_2018	12.2 %	NPM 13.2
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2018	46.2	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2016_2018	25.0	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2016_2018	10.3	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2017_2018	50.5 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	88.1 %	NPM 10 NPM 13.2
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)	NSCH-2017_2018	16.1 %	NPM 10
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)	WIC-2016	16.3 %	NPM 10
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)	YRBSS-2015	16.2 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2018_2019	60.7 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2018	64.7 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2018	89.4 %	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2018	80.0 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2018	25.2	NPM 10

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)

	2016	2017	2018	2019
Annual Objective			86.9	87.8
Annual Indicator		75.9	76.3	76.3
Numerator		267,488	279,668	279,668
Denominator		352,368	366,499	366,499
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives

	2020	2021	2022	2023	2024	2025
Annual Objective	68.5	73.3	78.4	83.9	89.7	96.0

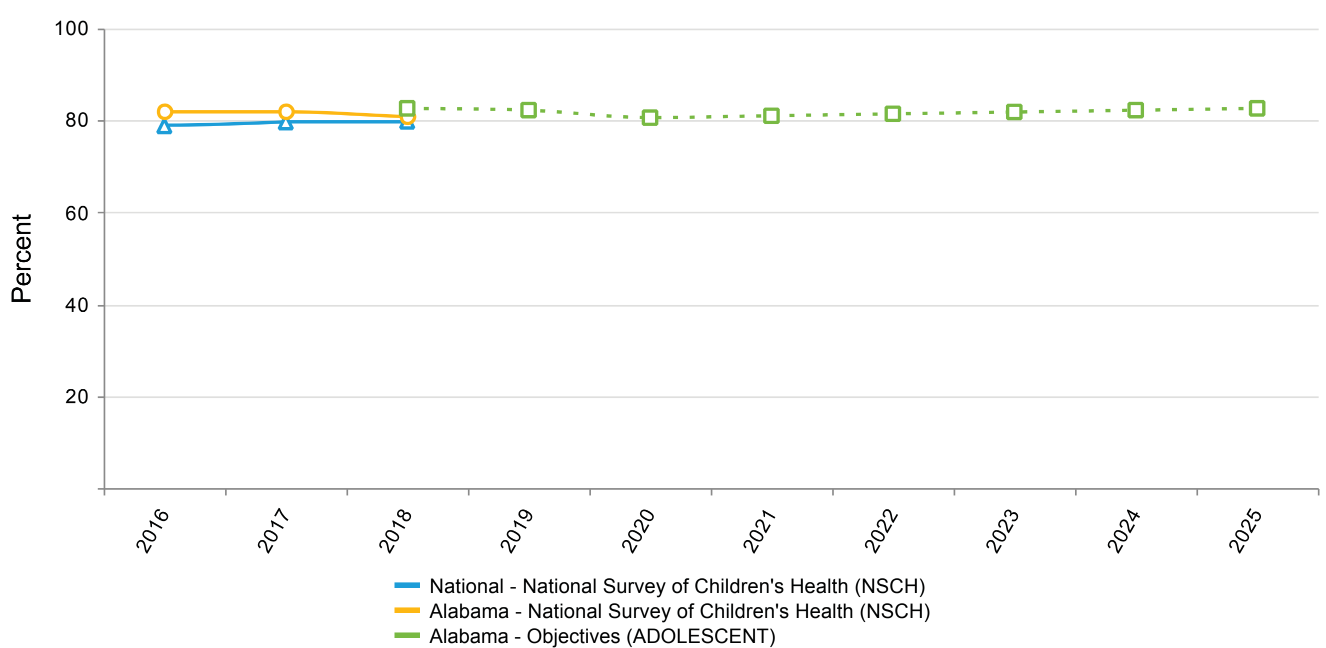
Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	76.3
Numerator	279,668
Denominator	366,499
Data Source	NSCH
Data Source Year	2016-17
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	77.1	77.9	78.7	79.5	80.3



NPM 13.2 - Adolescent Health

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH)				
	2016	**2017**	**2018**	**2019**
Annual Objective			82.5	82.1
Annual Indicator		81.7	81.7	80.7
Numerator		837,585	836,024	830,091
Denominator		1,025,822	1,023,434	1,028,454
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

ℹ Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

State Provided Data				
	2016	2017	2018	2019
Annual Objective			82.5	82.1
Annual Indicator		81.7		
Numerator		837,585		
Denominator		1,025,822		
Data Source		NSCH		
Data Source Year		2016		
Provisional or Final ?		Final		

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	80.5	80.9	81.3	81.7	82.1	82.5

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - Proportion of infants and children, ages 1 through 17 years, who report receiving a preventive dental visit in the past 12 months by piloting the Home by One Program.

Measure Status:	Active

State Provided Data				
	2016	2017	2018	2019
Annual Objective		0	5	10
Annual Indicator	0	27.6	28.2	26.4
Numerator		286,146	292,658	273,684
Denominator		1,036,378	1,036,378	1,036,378
Data Source	PRAMS, Medicaid, RCOs, Social Work Program Data	Medicaid, Census	Medicaid, Census	Medicaid, Census
Data Source Year	2017	2017	2018,2017	2019,2010
Provisional or Final ?	Provisional	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	15.0	20.0	25.0	30.0	30.0	30.0

State Performance Measures

SPM 4 - Percent of women who smoke during pregnancy

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	8.7
Numerator	
Denominator	
Data Source	ADPH Center for Health Statistics
Data Source Year	2018
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	8.6	8.5	8.4	8.3	8.2

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

Increase percentage of children ages 1-17 years old receiving preventive dental visits

Strategies

Increase awareness of importance of preventive dental visits and promote visits by the "Share Your Smile With Alabama" smile contest

ESMs	Status
ESM 13.2.1 - Proportion of infants and children, ages 1 through 17 years, who report receiving a preventive dental visit in the past 12 months by piloting the Home by One Program.	Active

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

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 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

Increase percentage of children ages 1-17 years old receiving preventive dental visits

Strategies

Promote preventive dental visits through ads placed on Standeez displays to be placed in all county health departments.

ESMs	Status
ESM 13.2.1 - Proportion of infants and children, ages 1 through 17 years, who report receiving a preventive dental visit in the past 12 months by piloting the Home by One Program.	Active

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

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

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

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% the total number of EPSDT screenings performed in county health departments annually

Strategies

Increase EPSDT sreenings 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	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 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

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

Priority Need

Lack of support for pregnant and parenting teens.

SPM

SPM 4 - Percent of women who smoke during pregnancy

Objectives

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

Strategies

Offer more prenatal classes in WIC in counties with higher rates of teen pregnancy than the state rate or in at least 5 counties.

2016-2020: National Performance Measures

2016-2020: State Performance Measures

2016-2020: SPM 3 - Develop a comprehensive Adolescent Health Program Strategic Plan.

Measure Status:				**Active**
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		2	22	23
Annual Indicator	1	22	0	0
Numerator				
Denominator				
Data Source	Checklist Criteria Screening Tool	Checklist Criteria Screening Tool	Checklist Criteria Screening Tool	Checklist Criteria Screening Tool
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

2016-2020: SPM 4 - Number of school districts assessed regarding current mental health services

Measure Status:				**Active**
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		0	5	10
Annual Indicator	0	0	33.8	43.2
Numerator			47	60
Denominator			139	139
Data Source	Medicaid, CHIP, Dept. of Ed, Dept. of MH, Schools	Medicaid, CHIP, Dept. of Ed, Dept. of MH, Schools	State Department of Education	Alabama Department of Mental Health
Data Source Year	2017	2017	2018	2019
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

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-Increase the proportion of infants and children, ages 1-17 years, who report receiving a preventive dental visit in the past 12 months by piloting the Home by One Program.

In 2019, OHO again requested that Governor Kay Ivey sign a proclamation declaring February as Children's Dental Health Month in Alabama to bring recognition to the importance of children's oral health and their overall well-being. Additional Children's Dental Health Month recognition included OHO launching its 2nd annual "Share Your Smile with Alabama" campaign for third grade children in public, private, and home schools statewide to bring attention to National Children's Dental Health Month. Two children, one girl and one boy, were selected from photo submissions as the overall winners of the "Share Your Smile with Alabama" campaign. Prizes of oral health products and a photo shoot in the RSA studio were met with accolades from children's families as well as the ADPH staff. The winners appeared at a live news conference from Montgomery and were featured in OHO marketing campaigns to promote children's oral health in the state throughout the year. The campaign is designed to increase awareness about the importance of good oral health and the value of a great smile. OHO advertisements have been published statewide in Birmingham Parent Magazine, Montgomery Parents, River Region's Journey, River Region's Boom, Auburn-Opelika Parents, Mobile Bay Parents, Eastern Shore Parents, Anniston Star, and Lagniappe (Mobile / Eastern Shore). In the first ad, not only are the children featured, ESM 13.2 was also highlighted.

New brochures and fliers highlighting the need for/importance of good oral hygiene were developed on an ongoing basis.

Oral Cancer Awareness Month

OHO partnered with Dr. Casey Daniel at USA Health Mitchell Cancer Institute for statewide Oral Cancer Awareness Month Campaign. The campaign slogan was “Watch Your Mouth” and activities were promoted by the following collaborators:

- Jefferson County Health Department
- UAB School of Dentistry, Oral and Facial Surgery
- ADPH Immunization
- Alabama Adolescent Task Force
- Alabama Comprehensive Cancer Control Coalition
- Tuscaloosa CHD
- Alabama Dental Association
- ADPH Oral Health Office
- Alabama Chapter—American Academy of Pediatrics
- OHCA
- Tobacco Prevention and Control Program, ADPH
- Sarrell Dental
- DentaQuest
- USA Health Mitchell Cancer Institute
- Mobile CHD
- Franklin Primary Health Center

- Alabama Board of Dental Examiners

The campaign consisted of designing, printing, and distributing oral health resources/educational materials to include posters, brochures, and shower cards featuring messages regarding HPV, HPV vaccination sites, oral cancers, and oropharyngeal cancer. A summary of what was created and distributed is as follows:

- 600 11 x 17 posters
- 10,500 laminated oral cancer self-exam cards (waterproof)
- 1,250 HPV infocards
- 5,000 oral cancer brochures
- 5,000 oral cancer fliers

Prior to his death in 2019, Coach Pat Sullivan partnered with OHO to create a YouTube public service announcement focusing on his battle with oral cancer for use in future oral cancer awareness campaigns.

OHO purchased Standeez promoting HPV vaccines and they were placed in 30 grocery stores, drug stores, and dollar stores around the state in September 2019.

Other ADPH Adolescent Health Programs

Adolescent Pregnancy Prevention Branch

The Adolescent Pregnancy Prevention Branch (APPB) works to reduce the incidence of unplanned pregnancies and sexually transmitted infections (STIs) among Alabama youth ages 10-19. APPB's work is made possible through federal grants awarded to ADPH from the Department of Health and Human Services, Administration on Children, Youth, 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 19, APPB provided programming to youth in 10 Alabama counties.

The Alabama Sexual Risk Avoidance Education Program (ASRAE) provides evidence-based abstinence education

to middle and high school aged youth in school and community settings. The purpose of ASRAE is to support decisions to abstain from or delay sexual activity. Three community-based organizations that are supported with ASRAE funds deliver evidence-based education programming to youth in six Alabama counties. The evidence-based 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 youths in community settings. The goal of APREP is to reduce pregnancy and STIs, including HIV, among teens by using effective evidence-based programming. One community-based organization funded through APREP 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 four counties. The project utilizes the evidence-based curricula, *Making Proud Choices: An Adaptation for Youth in Out-of-Home Care*, and *Seventeen Days*, plus adulthood preparation lessons taken from *Love Notes* and *Money Habitudes 2 for At-Risk Youth*. Adulthood preparation programming is designed to promote successful transition to young adulthood.

Public awareness efforts are key to successful teen pregnancy prevention. APPB partnered with Family Planning on media opportunities throughout the state in FY 2019. Approximately $200,000 was utilized to place ads and posters promoting abstinence, birth control, and STI reduction in schools, community organizations, youth recreational facilities, local health departments, and statewide publications. In addition, posters and brochures are shared at community and school events.

Rape Prevention

The Rape Prevention and Education Program, a CDC-funded program, provides prevention of sexual violence (SV) perpetration and victimization by decreasing SV risk factors and increasing SV protective factors for the general population in 40 Alabama counties through grants to the Alabama Coalition Against Rape (ACAR) and nine rape crisis centers. The Public Health and Human Services Block Grant provides prevention education and awareness to the public and support through the promotion of public awareness and general assistance to victims of sex offenses within the state in 29 counties through grants to ACAR and six rape crisis centers. Through this work, more than 20,000 youth and young adults have been reached.

Youth Suicide Prevention

Suicide is the eleventh leading cause of death in the state, with 836 citizens lost to suicide in 2017. In 2019, ADPH's Alabama Youth Suicide Prevention Program began its third year working to reduce the rate of suicides and suicide attempts for youth ages 10 to 24. The program provides grants to crisis centers, the state suicide prevention coalition, and colleges and universities to provide education, outreach, screenings, and referrals to promote suicide prevention, awareness, and services in communities throughout the state. Grantees implement three evidence based- curriculums: QPR (Question-Persuade-Refer), Response, and Kognito. In 2019, suicide prevention program partners conducted 426 trainings, resulting in 13,008 individuals trained as gatekeepers to identify and refer individuals at risk for suicide.

As of December 2019, there were 173,363 children enrolled in CHIP, where 85,926 were enrolled in ALL Kids and 87,437 were enrolled in MCHIP. Of the ALL Kids enrollees, 32,345 were 13-18 years of age. Of the MCHIP enrollees, 61,179 were 13-18 years of age.

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

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

ADPH, UAB LEAH, the Alabama Chapter of AAP, and ACHIA will continue to partner as part of the StayWell initiative. The Adolescent Well Visit Learning Collaborative will continue to promote the healthcare provider training modules.

Oral Health Office

ESM 13.2-Proportion of infants and children, ages 1-17 years, who report receiving a preventive dental visit in the past 12 months by piloting the Home by One Program.

OHO will continue promoting oral cancer awareness and HPV vaccines for adolescents.

There will be a revised oral cancer awareness month campaign in 2021.

In 2021, OHO plans to again request that Governor Kay Ivey sign a proclamation declaring February as Children's Dental Health Month in Alabama to bring renewed attention to the importance of oral health and overall health of one of the state's most vulnerable populations.

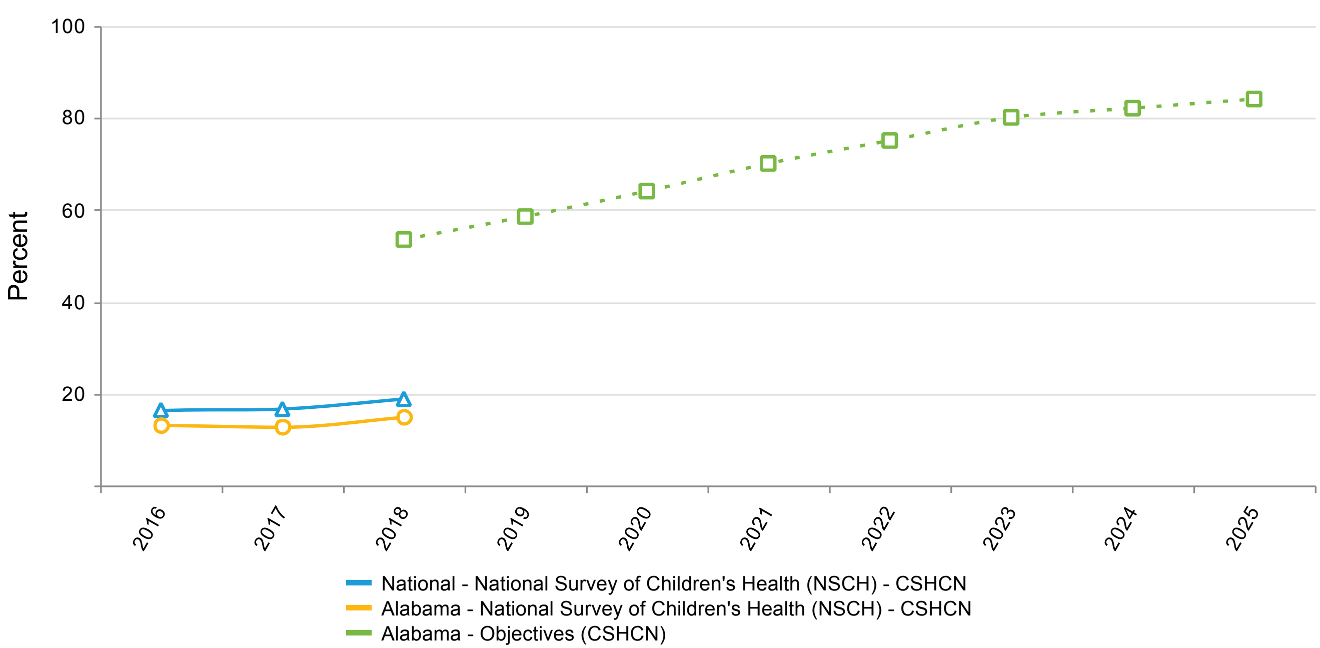
Children with Special Health Care Needs

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2017_2018	13.2 %	NPM 11 NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2017_2018	50.5 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	88.1 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year	NSCH-2017_2018	2.4 %	NPM 11

National Performance Measures

NPM 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
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				
	2016	**2017**	**2018**	**2019**
Annual Objective			53.5	58.5
Annual Indicator		13.2	12.9	15.0
Numerator		13,335	13,867	14,975
Denominator		101,361	107,738	99,967
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

State Provided Data				
	2016	2017	2018	2019
Annual Objective			53.5	58.5
Annual Indicator	44.3	51.5	77.9	81.9
Numerator	1,255	1,400	2,753	2,938
Denominator	2,830	2,718	3,532	3,589
Data Source	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	64.0	70.0	75.0	80.0	82.0	84.0

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Percent of YSHCN enrolled in the State CSHCN program with a transition plan in place.

Measure Status:	Active

State Provided Data

	2016	2017	2018	2019
Annual Objective		35.5	52	55
Annual Indicator	44.3	51.5	77.9	81.9
Numerator	1,255	1,400	2,753	2,938
Denominator	2,830	2,718	3,532	3,589
Data Source	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

Annual Objectives

	2020	2021	2022	2023	2024	2025
Annual Objective	57.0	60.0	62.0	65.0	67.0	69.0

ESM 12.2 - Percent of YSHCN enrolled in State CSHCN program who report satisfaction with their transition experience to adulthood.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives

	2021	2022	2023	2024	2025
Annual Objective	50.0	58.0	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

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	8.0	12.0	16.0	20.0	24.0

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

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	50.0	58.0	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 necessary to make transitions to adult health care

Objectives

By 2025, increase the score of each of the Six Core Elements of Healthcare Transition activities to at least a level 3. By 2025, increase the percentage of eligible YSCHN that attend a CRS Teen Transition clinic.

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 ages 21-26.

ESMs	Status
ESM 12.1 - Percent of YSHCN enrolled in the State CSHCN program with a transition plan in place.	Active
ESM 12.2 - 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% 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

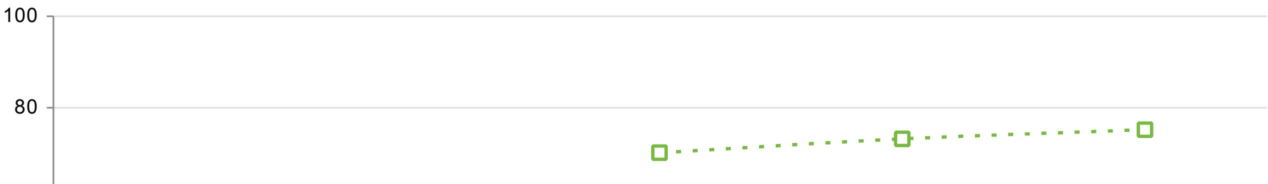
By 2025 Family/Youth partnerships with internal and external partners are reflective of the four domains of Family Engagement; representation, transparency, impact and commitment. By 2025 the first cohort of participants will have completed the Family Youth Leadership Training Institute.

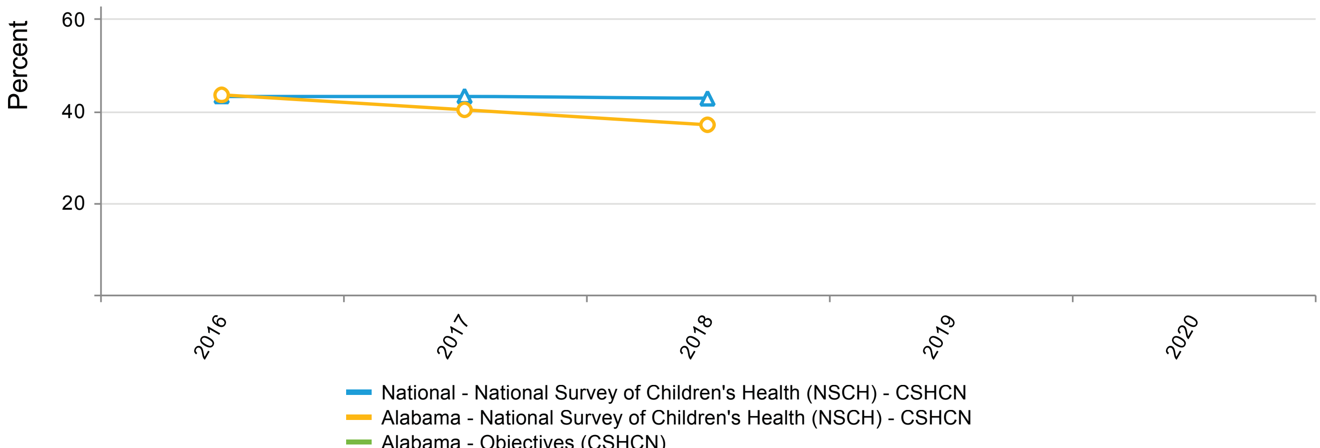
Strategies

Incorporate the four domains of Family Engagement into staff development activities. Employ the Family Engagement in Systems Assessment Tool (FESAT) towards assessing progress on strengthening family/youth engagement. Utilize alternative methods to include 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/youth 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 materials at professional conferences and other community events to educate healthcare providers and health related professionals about the importance of engaging families/youth in the decision making process.

2016-2020: National Performance Measures

2016-2020: NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home
Indicators and Annual Objectives





2016-2020: NPM 11 - Children with Special Health Care Needs

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CSHCN				
	2016	**2017**	**2018**	**2019**
Annual Objective			70	73
Annual Indicator		43.3	40.1	37.0
Numerator		102,023	99,230	90,678
Denominator		235,517	247,758	245,036
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective			70	73
Annual Indicator	36.2	65.8	71.9	73
Numerator	3,567	6,766	7,754	8,594
Denominator	9,858	10,287	10,784	11,772
Data Source	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 11.1 - Percent of enrollees in the State CSHCN program with a comprehensive plan of care.

Measure Status:				Active
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		51	70	65
Annual Indicator	56.5	65.8	65.9	66.3
Numerator	5,567	6,766	7,103	7,810
Denominator	9,858	10,287	10,784	11,772
Data Source	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

2016-2020: ESM 11.2 - Percent of providers receiving education/training about family-centered care.

Measure Status:			Active
State Provided Data			
	2017	**2018**	**2019**
Annual Objective	50	42	45
Annual Indicator	40	54.8	49.2
Numerator	200	274	246
Denominator	500	500	500
Data Source	CSHCN Program	CSHCN Program	CSHCN Program
Data Source Year	2017	2018	2019
Provisional or Final ?	Provisional	Provisional	Provisional

2016-2020: State Performance Measures

2016-2020: SPM 1 - Percent of CYSHCN and their families who report that they share in decision-making and partnerships with their health care providers.

Measure Status:				**Active**
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		5	27	28
Annual Indicator	40	78.8	76.7	80
Numerator	18	26	23	24
Denominator	45	33	30	30
Data Source	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

NPM 11 - Medical Home (The percent of children with special health care needs having a medical home) *(CSHCN Survey)*

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through17, who receive care in a well-functioning system.

Strategies: 1) The State CSHCN program staff, including the parent consultant, will provide health care services that encourage the family to share in decision making and provide necessary feedback on services provided; 2) The state CSHCN program staff, including the parent consultant, will maintain and update a comprehensive, integrated plan of care that has been developed with the family and other members of a team that addresses family care and that is shared with families and among and between providers; 3)The state CSHCN program staff, including the parent consultant, will link families without a medical home to appropriate community primary care physicians (PCP); 4) The state CSHCN program staff, including the parent consultant, will establish an EHR system to increase consistent communication with primary care physicians and sub- specialists who provide care for CYSHCN; 5)The state CSHCN program staff, including the parent consultant, will partner with Medicaid RCOs or managed care companies to receive appropriate referrals to facilitate services for CYSHCN; and 6)The state CSHCN program staff, including the parent consultant, will collaborate with FVA, Family to Family Health Information Center Grant, the Alabama Chapter of the AAP, and ACHIA to provide medical home and family centered care training to providers.

Objectives (NPM 11):

1. By 2020, increase, by 5 percent, the number of CYSHCN who have access to a medical home.
2. By 2020, increase, by 5 percent, the number of CYSHCN who report that they have a comprehensive plan of care.
3. By 2020, increase, by 5 percent, the number of PCPs who provide care to children and youth with special health care needs.
4. By 2020, increase, by 10 percent, the number of contacts made between CRS staff and Medicaid RCOs or managed care company representatives.
5. By 2020, increase, by 5 percent, the number of activities to support CYSHCN and their families in self-management of the child's health and health care.
6. By 2020, increase, by 5 percent, the number of providers who receive medical home and family centered care training.
   (See Activity Sheet for NPM 11)

ESMs:

11.1 - Percent of enrollees in the State CSHCN program with a comprehensive plan of care.

11.2 - Percent of providers receiving education/training about family-centered care.

Activities	Pyramid Level of Service		
	DS	ES	PHSS
1. Work cooperatively with Medicaid and/or Medicaid Managed Care entities to assure that eligible CSHCN have access to a medical home.	x		x
2. Modify and continually update plan of care for CSHCN enrolled in the CRS program.	x	x	
3. Share plan of care with clients, families, PCPs and sub-specialists.	x	x	
4. Work collaboratively with other agencies to support efforts around medical home and CSHCN quality improvement projects.			x
5. Host or directly provide patient-centered medical home and family engagement/professional partnerships trainings.			x
6. Implement EHR in the CRS program.	x		x
7. Maintain a data base of PCPs who provide care for CYSHCN	x		x
8. Collaborate with FVA and the F2F HIC to provide support and training on navigating the system of care for CYSHCN and their families.	x		x

Direct Services:

CRS maintained 14 clinic sites to provide clinical medical services, care coordination, and family support services to enrolled CYSHCN.

CRS continued efforts to maintain and enhance the EMR. CRS continued efforts to develop an EHR that will interface with Alabama's One Health Record. The One Health Record® system was created as Alabama's health information exchange (HIE).

CRS staff held 3,440 medical and evaluation clinics. CRS staff completed 9,713 current plans of care for enrolled CYSHCN.

CRS staff made 529 hospital visits, 637 home visits, and 1,386 school visits to provide enrollment and follow-up care to CYSHCN.

CRS staff served 406 clients without insurance coverage.

CRS enrollment forms were made available on the public website; and referrals were accepted via phone, email, fax, or hard copy.

CRS continued to partner with Hudson Alpha Institute for Biotechnology to provide genetic services to enrolled CYSHCN. This partnership provides unique and cutting-edge medical care for CYSHCN and their families in the state of Alabama by expanding access to genomic medicine.

Enabling Services:
CRS continued to provide clinic services and respond to requests for information and referral for CYSHCN and their families. See www.rehab.alabama.gov for CYSHCN success stories.

CRS maintained and enhanced its EMR. The EMR task force held regularly scheduled meetings regarding the EMR components that are unique to the CSHCN program. Updates included modifying EMR software for CRS to capture an entire report of visit (ROV) for CRS clinics. This new area in CHARMS software for capturing data was designed

by specialties such as: audiology, neurology, feeding, PT, OT, etc. In addition, the capability was added to our electronic health record for physicians working clinics to be able to access the CHARMS software via Citrix XenApp.

CRS continued efforts to develop an EHR that will interface with Alabama's One Health Record. One Health Record® system was created as Alabama's HIE.

CRS continued efforts to identify community PCPs willing to accept CYSHCN as patients. CRS staff assisted families without medical homes to locate appropriate community PCPs. CRS staff maintained a database of PCPs of CRS enrollees to facilitate identification of local providers with experience in providing services to CYSHCN.

CRS through the CMC CoIIN project designed and implemented a Shared Plan of Care (SPoC). As part of the project the SPoC is being tested through a Plan-Do-Study-Act cycle and modified as needed.

CRS program staff conducted hearing screenings at community health fairs, schools, daycare centers, and Migrant Head Start programs.

CRS program staff provided care coordination, referrals, translation, and outreach to CYSHCN.

CRS provided transportation assistance to eligible CYSHCN.

Public Health System and Services:

In FY 2019, Medicaid implemented a consolidated Care Coordination system through a Section 1915 (b) Waiver, which 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.

CRS, in partnership with FVA and the F2FHIC, provided education on family-centered care to youth, families, and professionals at the annual Partners in Care Summit.

CRS partnered with ACHIA, The UAB Pediatric Pulmonary Center, FVA/F2FHIC, and AL AAP to provide medical training to providers, staff, and families of CSHCN.
Constructs of a Service System for CYSHCN

The interagency group, comprised of the CRS Advisory Committee, key state-level stakeholders, youth with special health care needs, and families of CYSHCN (through the advisory committee, surveys, and focus groups), will continue its ongoing participation in the CYSHCN needs assessment process.

State Program Collaboration: CRS

Many collaborative mechanisms continued to exist at the state level to coordinate state services available to CYSHCN. CRS continued to represent the Title V CSHCN Program in numerous efforts; discussion of which follows.

Support for Several Programs: CRS

CRS continued to collaborate with UAB Sparks Clinic, Alabama's LEND Program, on behalf of CYSHCN. CRS provided Title V funding support to FVA and the F2FHIC which provides education and training for clients, families, and health professionals including physicians.

Alabama Children's Policy Council

Under the coordination of the Department of Early Childhood Education, each local Children's Policy Council (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 continued to serve as a member of the State Children's Policy Council, and ADRS staff members continued participation in local Children's Policy Councils in all 67 counties within the state. CRS staff provide expertise related to the unique needs of CYSHCN during CPC meetings. This partnership continues to raise awareness of the importance of the specialized needs of CYSHCN and the implications that these needs have for resources in a local community. It also supports the inclusion of CYSHCN at the local level.

Alabama Head Injury Task Force

ADRS continued its role as the lead state agency for serving individuals with traumatic brain injury. Task force members include public and private agencies. This group planned for the development and implementation of a statewide, community-based system of services for children and adults with traumatic brain injury. Data sharing, financial issues, interagency training, and coordinated policies were addressed by the task force.

Alabama SCHIP

CRS continued to participate both as a provider of ALL Kids Plus services and as an advocate for the unique needs of CYSHCN in policy development for general benefits packages. CRS continued meeting on an as-needed basis with ALL Kids staff to discuss program and policy issues likely to affect CYSHCN.

CRS helped its 310 ALL Kids enrollees with annual renewal as needed. CRS also used Title V funds to pay insurance premiums for coverage accessible through employment, the Consolidated Omnibus Budget Reconciliation Act and ALL Kids for 28 enrolled clients.

Alabama Medicaid

CRS continued its interagency agreement with Medicaid to provide Children's Specialty Clinic Services. 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 reviewed all statewide requests to Medicaid for augmentative communication devices (ACDs) and housed all Medicaid prior authorization requests for ACDs. CRS is the only provider of medically necessary orthodontia for Medicaid recipients. CRS works closely with Medicaid's Dental Director regarding payment for orthodontia services. Members of the CRS state office staff, including the SPC, met quarterly with Medicaid staff members to discuss program and policy decisions likely to affect CYSHCN.

Family Voices of Alabama

CRS continues to maintain a strong partnership with FVA, home of Alabama's F2FHIC. FVA members are active participants in both CRS's State and Local Advisory Committees. The FVA co-director is the CRS State Parent Consultant. CRS continued partnering with FVA and the F2FHIC on programmatic and grant activities. FVA provided support for youth and families of CSHCN to participate in CRS-sponsored activities including needs assessment activities. CRS, in collaboration with FVA and the F2FHIC, provided medical home and family centered care training

to approximately 246 providers.

Alabama Parent Education Center

The Alabama Parent Education Center (APEC) provides services and support to assist families particularly those underserved including minority, low-income, and those with children with disabilities. APEC provides families with the training, information, and support they need to help them ensure that their children become productive, well-educated citizens. This group provided families with training, information and support through programs such as the Parent Training and Information Center, the Youth Transition Project, School Improvement Services, Programs of Adult and Community Education, and Fathers Forward. APEC staff members continued to provide training for CRS Local Parent Advisory Committees.

State Support for Communities: CRS

Community support was provided through several local planning processes; discussion of which follows.

Local Children's Policy Councils

As previously noted, ADRS staff continued to participate in each county's Local Children's Policy Council to provide a voice for CYSHCN in needs assessments, community planning, and resource mapping activities conducted by the CPC.

CRS Local Parent Advisory Committees

The LPCs each coordinate a LPAC. These groups offer families the opportunity to provide input to policy and program changes in CRS and to interact with local staff members. LPACs are opportunities for community partners to share information with families. They also allow for families to provide mutual support from other families in their area. Representatives from each LPAC committee make up the State Parent Advisory Committee, which continued to advise CRS administrators on program and policy issues concerning family-centered care.

CRS Local Offices

Each district office continued its support of local, district, and regional health planning initiatives. Staff members served on local councils that address health and youth and children's issues. CRS Title V MCH Block Grant funds supported their involvement financially and through performance standards. Additionally, each district office functioned as a powerful resource network within its local community, responding to numerous requests for information regarding CYSHCN and available services.

Coordination of Health Components of Community-Based Systems: CRS

Coordination within community-based systems was achieved through several means; listing and discussion of which follows:

Maternal and Child Health

As previously discussed, CRS administrative staff members and program specialists met quarterly with staff from Family Health Services and several other MCH stakeholders, to assure coordination of initiatives.

Memorandums of Understanding with Tertiary Children's Hospitals

Memorandums of understanding were maintained between CRS and the two-tertiary care pediatric hospitals in the state and are essential to the coordination of health components of community-based systems.

The Alabama Hemophilia Program

This program continued to be administered by CRS. Persons of any age with bleeding disorders are eligible to participate. Treatment centers in Birmingham and Mobile provide evaluation, treatment, patient education, care coordination, and allied health services. CRS received MCHB funds through a contract with Hemophilia of Georgia to promote comprehensive care for this population.

Coordination of Health Services with Other Services at the Community Level

The state made great advances toward coordinating community-based services for CYSHCN through the agreements with tertiary-level providers, credentialing of local vendors for allied health services, and service agreements with community providers and hospitals. The development of further public and private partnerships continues.

CRS, as a division of ADRS, is co-located with EIS, VRS, and the SAIL Program in most locations throughout the state. This relationship continues to promote the coordination of program planning and service delivery at all levels.

CRS staff members volunteered their time to provide their specialized skills for various camps, including Camp G.I.F.T.E.D., a theater camp for young people with special needs hosted by Alabama State University.

CRS promoted the development of community-based systems of care through its network of 14 district offices, which work with every county in the state to enhance local services for CYSHCN.

EHDI Learning Community

CRS audiologists participate in the ADPH EHDI learning community to increase awareness of the Joint Committee on Infant Hearing guidelines.

Supporting families of Deaf/Hard of Hearing Children/Youth

The SPC worked with AL's Early Intervention System Director to develop a process where all families who are referred to EI after a second-tier hearing screen will be asked if they would like to be connected to a LPC for family to family support, which will include the newly developed Guide By Your Side program which is a project of Hands & Voices.

Quality Assurance and Systems Development: CRS

Quality assurance and systems development activities by CRS continued in FY 2019.

Formal monitoring procedures for clinical sites and Quality Care Guidelines for specific diagnostic conditions were accomplished by the Quality Improvement Teams, which included the local parent consultant in CRS districts. The teams continued to meet periodically to identify service delivery areas that need improvement and to formulate an

improvement plan to address that need.
Standards of care implemented for each specialty medical and evaluation clinic were reviewed and updated as needed. The CRS policy and procedure manual and the CRS bill payer manual were updated as needed. These manuals are available on the ADRS internal website.

A credentialing process was used for enrolling specialty physicians, dentists, allied healthcare providers, and durable medical equipment providers. Clinic and care coordination dictation were regularly reviewed by the appropriate staff therapist, program specialist, and medical consultant to ensure quality and appropriateness of coding for reimbursement.

Staff performance appraisals, based on pre-identified responsibilities and expected results, were conducted biannually.

CMC CoIIN

In FY 2019 CRS was in Year 3 of the 4-year HRSA funded Collaborative to Advance Care for Children with Medical Complexity. CRS is the lead for the Alabama CoIIN initiative. The goal is to increase services from a single locus of care management (a medical home) and utilization of a Shared Plan of Care. The medical home can be either the University of South Alabama Pediatric Complex Care Clinic or with community-based pediatric providers. Past year accomplishments include hiring a CRS Care Coordinator to provide Care Coordination services onsite at the University of South Alabama Pediatric Complex Care Clinic. These Care Coordination services had a positive impact on the quality of life for the Children with Medical Complexity and their families. As previously mentioned, a SPoC was developed in conjunction with the staff at the University of South Alabama Pediatric Complex Care Clinic and CRS as well as input from families utilizing the SPoC.

NPM 12: Transition **(**The percentage of children with special health care needs who received services necessary to make transitions to adult health care). (*CSHCN Survey)*

NOM - Percent of children and youth with special health care needs, ages 14-21, who receive transition services.

Strategies: 1) The state CSHCN program staff, including the parent consultant, will develop a policy that describes the process for transition preparation and planning for YSHCN and their families as they prepare to move from pediatric to adult health care. The policy will be shared with clinic staff, YSHCN, and their families. 2) The state CSHCN program staff, including the parent consultant, will maintain an electronic medical system for identifying transitioning YSHCN, ages 14-21, to track receipt of each of the Six Core Elements of Health Care Transition. 3) 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. 4) 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. 5) The state CSHCN program staff, including the parent consultant, will identify adult providers to accept CRS patients and will complete a transfer package (including the transition readiness assessment, plan of care, medical summary and emergency care plan) for youth leaving CRS and will communicate with the new adult provider/subspecialist confirming transfer completion and the need for consultation, with health care providers and community systems. 7) The state CSHCN program staff, including the parent consultant, will obtain feedback on the transition experiences of young adults ages 21-26.

Objectives (NPM 12):

1. By 2020, increase the number of clinic staff, transitioning YSHCN and families who received a written transition policy to Level 2.
2. By 2020, increase the number of transitioning YSHCN in the CRS Program identified via an electronic system to Level 3.
3. By 2020, increase the level of transition of YSHCN in the CRS Program who received transition preparation and planning to Level 3.
4. By 2020, increase the number of YSHCN in the CRS Program who attended teen transition clinic.
5. By 2020, increase the number of young adults who provided feedback about their experiences when transitioning to adult services to Level 3. *(See Activity Sheet for NPM 12)*

ESMs:
12.1 - Percent of YSHCN enrolled in State CSHCN Program with a transition plan in place.

12.2 – Percent of the State CSHCN Program clinics who adopt the Six Core Elements of Health Care Transition.

Activities	Pyramid Level of Service		
	DS	ES	PHSS
1.Develop transition policy for the CSHCN program.	x		x
2. Share transition policy with CRS clinic staff, youth and families.	x		
3. Establish and maintain an electronic system for identifying transitioning YSHCN, ages 14-21.			x
4. Conduct transition readiness assessment on all YSHCN starting at age 14.	x		
5. Provide teen transition clinic at three CRS clinic sites.	x		
6. Incorporate transition planning in 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.	x	x	
7. Work collaboratively with other agencies or health care entities to identify adult providers who will accept CRS clients and will complete a transfer package for youth leaving the CRS program.	x	x	x
8. Communicate with new adult provider confirming completion of transfer of YSHCN and need for consultation.	x		
9. Elicit anonymous consumer feedback about previous CRS client's transition experience.	x		x
10. Conduct educational sessions with CRS clinic staff to guide the implementation of Six Core Elements of Health Care Transition.			x

Direct Services:

CRS continued to utilize the customized transition policy from the Six Core Elements of Health Care Transition (www.GotTransition.org). CRS continued to post the transition policy at all fourteen clinic sites (See picture below).

CRS continued to support staff social work positions focused on transition. At 14 years of age, CRS youth are transferred to their district's Social Work Transition Specialist.

CRS staff, including local parent consultants and transition social workers, received continued education on how to use the Six Core Elements of Health Care Transition in CRS teen transition clinics and with other transition age

YSHCN.

CRS staff completed the transition readiness assessment tool on 174 clients, age 14 and older. CRS staff identified 367 enrolled youth, age 14, via its current electronic medical record system. CRS staff saw 41 YSHCN in teen transition clinics.
The ADRS Continuum of Transition focused on strengthening the continuum of services provided by each division. Transition liaisons were identified from both divisions for each district office, and ongoing training was provided.

CRS care coordinators completed 9,713 plans of care for enrolled YSHCN. The plan covered health/medical issues, educational needs and planning, developmental and independent living skills, and future planning issues. The plan is updated annually with families and youth.

CRS State Office Staff, including the State Office Parent Consultant, worked with the CRS Program staff to modify strategies and objectives for NPM 12.

Enabling Services:

CRS program staff continued providing care coordination, translation, and referral services to transitioning YSHCN. CRS provided transportation assistance to enrolled, eligible YSHCN. Program staff participated in transition team meetings with local school districts and participated in High School Transition Fairs to educate families and community members about CRS transition services.

CRS program staff have assisted with planning and participating in Transition Resource Fairs in their local communities to promote awareness to students, caregivers, and educational, medical, and other community stakeholders. Some of the topics included navigating complex medical transitions, becoming a better self-advocate, transitions to high school and college, Medicaid waivers, and employment.

CRS Social Work Transition Specialists attended the Alabama Transition Conference. This yearly conference is a joint 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 health care needs.

CRS supported youth who have leadership training through the annual Alabama Governor's Youth Leadership Forum (YLF).

CRS has two part-time Youth Consultants that work to increase outreach to youth and young adults across the state. Both YCs are consistently using social media to increase connections with YSHCN in Alabama and have also created a page on the ADRS SharePoint site to share youth resources with CRS staff.

Public Health Systems and Services:

Coordination of Health Services with Other Services at the Community Level

CRS staff continued to work individually with YSHCN to ensure linkages with adult healthcare providers and community service systems. CRS continued to fill vacant social work staff positions focused specifically on transition. These specialists continued to provide targeted, comprehensive transition services to help CRS-enrolled youth and their families plan for adulthood.

CRS had 144-page views (hits) on its program website for the AMCHP Standards for Systems of Care for CYSHCN. Version 2.0 was uploaded to the program website.

CRS adopted the Six Core Elements of Health Care Transition used with clients attending CRS Teen Transition Clinics and with transition YSHCN (www.GotTransition.org).

CRS and VRS staff have continued to collaborate on issues and challenges in the referral and transition process. CRS and VRS staff continued to meet and hold conference calls, assuring that YSHCN receive timely and appropriate services to assist them locally with health, education and employment- related goals.

SPM 1: Percent of CYSHCN and their families who report that they share in decision-making and partnerships with their health care providers.

State Priority Need: Family professional partnerships for CYSHCN.
Measure: Promote shared decision-making and partnerships between families and health related professionals.

Strategies: 1) The state CSHCN program staff, including the Parent Consultant, will develop and provide training for families of CYSHCN on how to improve communication with their health care providers. 2) The state CSHCN program staff, including the Parent Consultant, will collaborate with family organizations and other federal, state, and community partners to provide health care services that encourage families to share in decision making and provide feedback on services provided.

Objective

By 2020, increase by 5 percent, the percent of families with CYSHCN who report that they shared in the decision making at all levels.

CRS identified increasing the capacity to promote shared decision-making and partnerships between families and health and related professionals as a state priority for 2016-2020. This priority addressed several activities in each of the following two areas:

1. CRS/CSHCN Data Collection and Support
2. FVA/F2FHIC

See CSHCN Data Action Plan for SPM 1 2016-2020 Five-Year Needs Assessment in the attachment section.

CRS/CSHCN Data Collection and Support:

CRS maintained and enhanced its EMR. The EMR task force held regularly scheduled meetings regarding the EMR components that are unique to the CSHCN program. Updates included modifying EMR software for CRS to capture an entire ROV for CRS clinics. This new area in CHARMS software for capturing data was designed by specialties such as: audiology, neurology, feeding, PT, OT, etc. In addition, the capability was added to our electronic health record for physicians working clinics to be able to access the CHARMS software via Citrix XenApp.

CRS continued efforts to develop an EHR that will interface with Alabama's One Health Record. One Health Record® system was created as Alabama's HIE. Developing this interface will be of great benefit to CRS clients, their families and program staff.

FVA/F2FHIC:

CRS LPCs in collaboration with FVA and the F2FHIC collected data about the needs expressed by families in the state and the types of information shared with them. CRS continues to use this data to help assess the needs of CSHCN and their families. CRS collaborated with FVA in supporting the Partners in Care Summit, a project of the F2FHIC.

Children with Special Health Care Needs - Application Year

An assessment of the needs through web-based surveys, focus groups, key informant interviews, and analyses of quantitative data from national surveys yielded a variety of issues for the CSHCN domain. In consideration of the national priority areas, the issues identified, desired outcomes, existing capacity, and a reasonable opportunity for a focused programmatic effort to lead to an improved outcome, the following three priority needs were identified for CSHCN: Lack of or inadequate supports for transition to all aspects of adulthood; lack of or inadequate access to health and related services, especially in rural areas and for services identified as difficult to obtain; and increase family and youth involvement and participation in advisory groups, program development, policy-making, and system-building activities. Though the additional identified needs are not included in the final list, the CRS Needs Assessment Leadership Team recognized that through two newly developed SPMs many of the other priority needs could be addressed directly or indirectly. Lack of or inadequate supports for transition to all aspects of adulthood (NPM 12) was the only CSHCN priority retained from the 2016-2020 needs assessment cycle.

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. Through the addition of a new ESM and revised objectives and strategies, CRS will continue activities to enhance transition services for YSHCN.

ESM 12. 1 (Continued) - Percent of YSHCN enrolled in State CSHCN Program with a transition plan in place.

ESM 12.2 (New) - Percent of YSHCN enrolled in State CSHCN Program who report satisfaction with their transition experience to adulthood.

For 2021, CRS will focus on developing a survey to address the newly created ESM 12.2 and continue transition activities from the 2016-2020 needs assessment cycle.

The transition activities include:
Continuing 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.

Continuing to educate staff, including social workers, on how to use the Six Core Elements of Health Care Transition in Teen Transition Clinic and with transitioning YSHCN and their families.

Continuing to provide care coordination and information and referral services to transitioning YSHCN.

Continuing to collaborate with VRS staff on the referral and transition process.

Continue including the Six Core Elements of Health Care Transition into clinical processes such as EHR templates, care plans, and ROVs.

The CRS Needs Assessment Leadership Team developed two new SPMs to encompass several priority needs. Although each SPM is tied to one specific priority need the objectives and strategies will have a positive impact on other priority needs.

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 CSHCN Checklist Criteria Scoring Tool for SPM 2 2021-2025 Five-Year Needs Assessment in the attachment section for a complete list of activities.

For 2021, CRS will build internal capacity to advance Family/Youth involvement and participation by incorporating the four domains of Family Engagement into staff development activities.

These activities include:

Begin development of a fact sheet on the four domains of Family Engagement and begin educating staff about the four domains.

Employ the Family Engagement in Systems Assessment Tool (FESAT) towards assessing progress on strengthening family/youth engagement. During 2021 CRS will administer the FESAT to determine a baseline score and identify domains for improvement. For more information about the FESAT visit https://familyvoices.org/familyengagementtoolkit/.

CRS will begin the initial research for developing a family/youth leadership training institute.

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.

For 2021, CRS will develop and administer the CRS Care Coordination Family Survey to measure that CRS is providing comprehensive care coordination services to families.

Develop a Care Coordination Program fact sheet and begin educating families on the importance of care coordination and its value in improving health care outcomes for CYSHCN.

Identify outreach opportunities to promote public awareness of CRS Care Coordination Services within the medical community and among families of CYSHCN.
Conduct a training for CRS care coordinators regarding utilizing a family and person-centered approach to care plan development.

Throughout the upcoming year, the CRS Needs Assessment Leadership Team will meet quarterly or on a more periodic basis if deemed necessary to review progress on the Action Plan for the CSHCN domain.CRS staff will provide status updates on the progress or lack thereof of efforts to address the identified measures. Updates will address activities, accomplishments resulting from those activities, challenges encountered while attempting to carry out the activities, and any necessary revisions to the current activities in place. CRS staff will also continue to collaborate with current partners and seek to identify new partners to address the identified priority needs.

Cross-Cutting/Systems Building

State Performance Measures

SPM 5 - Percent of women, ages 18-44, with follow up Colposcopy visit when indicated, in the past year

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	43.2
Numerator	1,081,373
Denominator	2,505,795
Data Source	BRFSS and U.S. Census
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	45.8	46.2	46.7	47.1	47.5

SPM 6 - 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.

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	6
Data Source	Program Data
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	0.2	0.3	0.5	0.7	0.8

SPM 7 - Percent of staff trained at day care provider/centers on CPR/First Aid

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	28.6
Numerator	6,157
Denominator	21,514
Data Source	Healthy Childcare Alabama Training Data
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	28.9	29.2	29.5	29.8	30.1

SPM 8 - Number of modules of the University of Wisconsin-Madison's Population Health Initiative's Health Equity Training Modules completed in order to advance health equity in the Alabama MCH Title V Block Grant Program

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Alabama MCH Title V Program Documentation
Data Source Year	2020
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	1.0	1.0	2.0	2.0	3.0

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 - Percent of women, ages 18-44, with follow up Colposcopy visit when indicated, in the past year

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 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.

SPM

SPM 6 - 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.

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 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.

SPM

SPM 7 - Percent of staff trained at day care provider/centers on CPR/First Aid

Objectives

Increase the number of staff at early childhood programs that receive health and safety training including CPR/First Aid.

Strategies

Provide education on health and safety to early childhood programs.

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.

SPM

SPM 8 - Number of modules of the University of Wisconsin-Madison's Population Health Initiative's Health Equity Training Modules completed in order to advance health equity in the Alabama MCH Title V Block Grant Program

Objectives

Advance efforts to address health disparities in the state’s maternal and child population by utilizing the University of Wisconsin-Madison's Population Health Initiative's Health Equity Training Modules to train Alabama MCH Title V staff

Strategies

Train Alabama MCH Title V staff to advance health equity in the Alabama MCH Title V Block Grant Program by utilizing the University of Wisconsin-Madison's Population Health Initiative's Health Equity Training Modules.

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

Increase, annually, ABCCEDP screening in CHDs and statewide to address the well-woman visit

Strategies

Increase ABCCEDP screening in CHDs and statewide to address the well-woman visit

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, annually, WISEWOMAN screenings statewide to address the well-woman visit

Strategies

Increase WISEWOMAN screenings statewide to address the well-woman visit

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

Annually, in Alabama's Cancer Prevention and Control Plan, continue to advocate for equitable access for cancer screening and education to address the well-woman visit

Strategies

In Alabama's Cancer Prevention and Control Plan, continue to advocate for equitable access for cancer screening and education to address the well-woman visit

State Action Plan Table (Alabama) - Cross-Cutting/Systems Building - Entry 8

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

Annually, increase WISEWOMAN screenings statewide to address smoking

Strategies

Increase WISEWOMAN screenings statewide to address smoking

State Action Plan Table (Alabama) - Cross-Cutting/Systems Building - Entry 9

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 Well Woman visits performed at the local county health departments; Increase public awareness of program via social media & marketing materials

Strategies

Increase the proportion of Well Woman (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 10

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

Year 1: Maintain 10 active NPI numbers for county health departments; Year 2-5 increase the number of county health departments with an active NPI number by one per year.

Strategies

Increase the availability of EPSDT screenings in the county health departments

State Action Plan Table (Alabama) - Cross-Cutting/Systems Building - Entry 11

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 membership, 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 12

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 & 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 13

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

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 14

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.

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Cross-Cutting/Systems Building - Application Year

All Alabama communities benefit when we reduce health disparities through policies, practices, and organizational systems.

Promoting health equity and reducing health disparities was a guiding principle for the ADPH and the Title V MCH Needs Assessment. All elements of the data collection plan were designed to be accessible and encourage participation from a diverse population.

- Surveys: 1) By providing family surveys in English and Spanish, paper and online (including mobile-friendly layouts)
- Focus Groups: 1) Intentional recruitment in urban and rural areas. 2) Engaging partners who are trusted members of the communities that serve to host and recruit participants. 3) Providing participant incentives including compensation as well as food, childcare, and/or transportation. 4) Hosting groups for special populations hosted and facilitated by trusted partners.

Furthermore, in keeping with the processes' guiding principle of promoting health equity and reducing disparities, several themes were noted across all domains.

- Indicator data show differences in outcomes based on race, ethnicity, and socioeconomic status.
- Stakeholders expressed differences in access to services, treatment experiences, and perception of quality of care based on race, ethnicity, socioeconomic status, marital status, insurance status and type, sexual orientation, and gender identity.

Final selection of priority needs was done in a two-phase process. It was a priority of FHS to include broad stakeholder input on the developed need statements prior to making any decisions. Following stakeholder input, FHS leadership was able to be informed by stakeholder opinions while incorporating their knowledge of agency capacity and other feasibility considerations.

Phase 1: Stakeholder Input

In March 2020, ADPH convened domain-specific meetings of key constituents and consumers to serve as an advisory committee and to assist with the prioritization of identified maternal and child health needs. Each session included an overview of Title V and the needs assessment process. The Federally Available Data related to the domain was shared along with summaries of the qualitative data collected from the community. In each session, the domain's list of needs was presented for consideration and participants were divided into small groups for discussion and individual rating.

Phase 2: Leadership Rating and Final Decisions
Following the rating and final rankings that the broader stakeholders completed at the March 2020 meetings, the Bureau Management Team (BMT) convened (via webinar and online survey in response to the ongoing COVID-19 pandemic) to reach consensus on the final priority needs identified in the 2020 Needs Assessment Process. The BMT rated all priority needs in their domains of focus on 5 criteria (described below). The average of these scores were then calculated. If the priority need was rated in the top 3 on the community stakeholder rankings from Phase 1, it received an additional point.

Selected State Needs

In consideration of the issues identified, desired outcomes, existing capacity, and a reasonable opportunity for a focused programmatic effort to lead to an improved outcome focused on health equity for the Cross-Cutting/System Building Domain, "**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" was selected as the state priority need.

The original version of this priority need, which was compiled from several individual needs but shortened due to character limitations in TVIS, read as follows:

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.

A review of publications from CDC as well as a publication from the Robert Wood Johnson Foundation's Vulnerable Population Portfolio, "A New Way to Talk About the Social Determinants of Health", in addition to others helped in the development of the wording that was chosen in a manner to aid discussions amongst groups which may think and believe differently.

Over the next 5-year reporting cycle for the MCH Title V Block Grant, ADPH staff will seek to advance efforts to address health disparities for the state's maternal and child population.

III.F. Public Input

The Alabama Title V MCH Block Grant Program is administered by 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-Bureau of Family Health Services

As part of the fiscal years 2019-2020 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 an advisory group meeting convened for the MCH needs assessment.

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

FHS no longer convenes the advisory group for the Early Childhood Comprehensive Systems Planning Grant. The group is now convened by the Alabama Partnership for Children, but FHS continues to participate and receives input on its implementation of early childhood system initiatives.

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

Further, two key ways that FHS seeks input on MCH issues are through collaboration with the State Perinatal Advisory Committee and the Regional Perinatal Advisory Committees.

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

FHS Cancer Prevention and Control Division obtains public input through two roundtable groups. The Breast Cancer Roundtable meets annually to assist in program decisions. Representatives include the Susan G. Komen for The Cure, North Central Alabama, which represents constituents in northern Alabama; The Joy to Life Foundation, which represents constituents in southern Alabama; the American Cancer Society; several hospitals across the state; cancer centers in the state; other community organizations; and survivors of cancer.

WIC serves women who are pregnant, who recently had a baby, or who are breastfeeding; infants; and children up to the age of 5 years. To qualify to receive WIC benefits, the applicant must meet income guidelines and have at least one nutrition risk documented. Benefits provided by the WIC Program include quality nutrition education and services, breastfeeding promotion and support, referrals to Maternal and Child Health care services and other assistance agencies, and supplemental foods prescribed as a monthly food package. The Alabama WIC Program is federally funded by the United States Department of Agriculture. 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.

The bureau maintains a State Title V MCH webpage (which is part of ADPH's main web site, www.alabamapublichealth.gov) that informs viewers about the Federal-State Title V partnership. A link to the "Survey of Families" web-based survey that was conducted during the Needs Assessment was posted on the site. A link to obtain a copy of the Executive Summary Report from the FY 2014-15 MCH Title V Statewide Needs Assessment can be accessed from the site as well. The MCH Epi Branch will continue to update the State Title V MCH web site 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 always email comments directly to other FHS programs using their induvial webpages on the ADPH site as well. Furthermore, ADPH utilizes several sources of social media which are always open to public comment. WW takes full advantage of the availability of social media outlets by allowing each WW location to have its own separate Facebook page. These pages facilitate open and public communication directly between the district WW staff, partners, and program participants.

Children's Rehabilitation Service

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, seventeen key informant interviews, and convening the CRS Needs Assessment Advisory Committee. In order to ensure family and youth input the survey was promoted through the CRS website, SPC and YC Facebook pages, and at the local CRS clinics. 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.

CRS seeks input from families and youth on an ongoing basis through the State Parent Advisory Committee, Local Parent Advisory Committees, and Youth Advisory Committee. These advisory groups allow stakeholders to provide input regarding policy development and program activities. Families and youth are compensated for participation on 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. Parent Consultants provide input into CRS special projects such as serving on the National MCH Workforce Development Team and as a core team member on the CMC CoIIN project. CRS also holds an annual Hemophilia Advisory Committee meeting to seek input into policy issues surrounding Hemophilia.

III.G. Technical Assistance

ADPH

FHS is seeking technical assistance with developing initiatives focused on youth engagement and empowerment, family and consumer engagement, and supplementary development of the 2021-2025 State Action Plan. Additional technical assistance will be requested as further needs are identified throughout the year.

CRS

CRS will utilize technical assistance from AMCHP and its New Director Leaders Cohort.

CRS will utilize technical assistance from Strengthening the Evidence Base for MCH Programs Initiative to assist with developing and implementing evidence-based or evidence-informed State Action Plans and in responding to the National Outcome Measures, National Performance Measures, and State Performance Measures.

CRS will utilize the technical expertise of National Family Voices and Family Voices of Alabama in the performance of activities associated with our newly created CSHCN SPM around strengthening and enhancing family/youth partnerships, involvement, and engagement. CRS will utilize technical assistance from National Family Voices on the use of the FESAT as part of this SPM.

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 in obtaining coverage.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - TITLE V_MEDICAID MOU_AL_FY2021 APPLICATION_FY2019 ANNUAL REPORT.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - CSHCN Data Action Plan for SPM 2016-2020.pdf

Supporting Document #02 - CSHCN Checklist Criteria Scoring Tool for SPM 2.pdf

Supporting Document #03 - AL FY 2021 APPLICATION_FY 2019 ANNUAL REPORT_Acronyms.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - MCH FY 2021 APPLICATION_FY 2019 ANNUAL REPORT_ORG CHARTS_ADPH_CRS.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Alabama

	FY 21 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 11,401,820	
A. Preventive and Primary Care for Children	$ 5,854,378	(51.3%)
B. Children with Special Health Care Needs	$ 3,420,546	(30%)
C. Title V Administrative Costs	$ 1,140,181	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 10,415,105	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 24,722,324	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 1,571,751	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 32,132,060	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 58,426,135	
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)	$ 69,827,955	
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)	$ 131,634,427	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 201,462,382	

OTHER FEDERAL FUNDS	FY 21 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Early Head Start - Child Care Partnerships (EHS-CC) Grant	$ 432,850
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 794,286
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 651,395
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 160,319
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program	$ 640,002
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Zika Surveillance Systems Grant Program	$ 98,073
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 104,542
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH	$ 56,066
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 127,999,214
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Well Woman	$ 536,480
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > CMC-COIIN BOSTON UNIVERSITY	$ 135,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > CRS HEMOPHILL OF GEORGIA	$ 26,200

	FY 19 Annual Report Budgeted		FY 19 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 11,264,929		$ 11,401,820	
A. Preventive and Primary Care for Children	$ 4,583,943	(40.7%)	$ 5,854,378	(51.3%)
B. Children with Special Health Care Needs	$ 3,379,479	(30%)	$ 3,420,546	(30%)
C. Title V Administrative Costs	$ 1,126,492	(10%)	$ 1,140,181	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 9,089,914		$ 10,415,105	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 32,943,966		$ 25,173,350	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 1,536,572		$ 1,223,021	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 48,718,812		$ 54,401,167	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 83,199,350		$ 80,797,538	
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)	$ 94,464,279		$ 92,199,358	
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)	$ 135,224,143		$ 131,593,753	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 229,688,422		$ 223,793,111	

OTHER FEDERAL FUNDS	FY 19 Annual Report Budgeted	FY 19 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Early Head Start - Child Care Partnerships (EHS-CC) Grant	$ 329,294	$ 432,850
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 1,012,637	$ 794,286
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 725,840	$ 651,395
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program	$ 911,302	$ 640,002
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 164,498	$ 160,319
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 101,492	$ 104,542
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH	$ 56,052	$ 56,066
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 131,641,044	$ 127,999,214
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > National Hemophilia Program	$ 26,200	$ 27,192
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Zika Surveillance Systems Grant Program		$ 98,073
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Well Woman	$ 120,784	$ 536,480
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > CMC-COIIN Boston University	$ 135,000	$ 93,334

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: Line 1. (Federal Allocation) – FY 2019 Annual Report Expended $11,401,820 was more than the FY 2017-2019 application's budgeted Grant Award of $11,264,929, a difference of $136,891. The MCH grant is available for 2 years and some spending can overlap fiscal years.	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: Line 1A. (Preventive and Primary Care for Children) – FY 2019 Annual Report expended of $5.85m increased from the FY 2019 Application Budget amount of $4.58m, a difference of $1.27m or 27.71 percent. In 2017, when the budget was developed for 2019 the children served made up 40.69 percent of the total cost compared to the actual expended in 2019 of 51.35 percent. The higher percentage increases the cost associated with children.	
3.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: Line 3. (State MCH Funds) - FY 2019 Annual Report Expended decreased to $25.2m from the FY 2019 Application Budgeted amount of $32.9m, a difference of $7.7m or -23.59 percent. When the FY 2019 budgeted amount was developed in FY 2017, the Other Support earned income was $54.6m compared to the 2019 actual support income of $62.3m, an increase of $7.7m. ADPH Earned Income programs showing increases EPSDT CC ($2.2m), Family Planning Medicaid ($1.3m), Family Planning Care Coordination ($1.2m), Patient 1st Care Coordination ($320k), DHR Healthy Child Care ($834k) and CRS ($631k). The increase in earned income $7.7m and virtually no increase in cost are factors that determine the level of state support needed. In this case the net increase in earned income reflects a reduction in need for state support. These increases are reflection of current operations in 2019 and going forward income from care coordination activities will be eliminated, as a result of Medicaid's ACHN networks.	
4.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**

Field Note:
Line 5. (Other Funds) – CRS FY 2019 Annual Report Expended was $1.22m which is a decrease from the FY 2019 Application Budget number reported of $1.54m, a difference of $313k or -20.41 percent decrease. See CRS explanation.

5.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**

Field Note:
Line 6. (Program Income) - FY 2019 Annual Report Expended of $54.4m increased from the FY 2019 Application Budgeted amount of $48.7m, a difference of $5.7m or 11.67 percent. When the FY 2019 budget was developed in FY 2017, the ADPH actual total program income was reported at $35.9m compared to the FY 2019 actual income earned of $40.8m, a net increase of $4.9m or 13.65 percent. The programs that showed substantial increases were Family Planning Medicaid ($1.3m), Family Planning Care Coordination ($1.2m), and EPSDT Care Coordination ($2.2m) and Patient 1st Care Coordination ($320k). These increases are reflection of current operations in 2019 and going forward will be eliminated, as a result, of Medicaid's ACHN networks providing services and the phasing out of ADPH as a provider.

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:	**2019**
	Column Name:	**Annual Report Expended**

Field Note:
Line 9. (Other Federal Funds) Early Head Start Program - FY 2019 Annual Report Expended $433k was more than the FY 2017-2019 application's budgeted amount $329k, a difference of $104k or 31.45 percent. Changes were made to protocol designed to increase the services provided to the enrolled children. With the additional services to be provided, there was an increase in the amount of time spent with each child which increased the expenditures.

7.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**

Field Note:
Line 9. (Other Federal Funds) Abstinence Education Program – FY 2019 Annual Report Expended decreased $794k from the FY 2017-2019 application's budgeted amount $1.01m, a difference of $218k or -21.56 percent. Three factors contributing to the decrease in expenditures: (1) decreases in staffing, (2) several sub-grantees stopped providing services and (3) a Request for Proposal (RFP) was released in FY 19 to allow for county health departments to apply to provide services, however, an award was not made.

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: **2019**

Column Name: **Annual Report Expended**

Field Note:
Line 9. (Other Federal Funds) Personal Responsibility Education Program (PREP) – FY 2019 Annual Report Expended decreased $651k from the FY 2017-2019 application's budgeted amount $726k, a difference of $75k or -10.26 percent. The same factors that affected Abstinence contributed to PREP's decrease in expenditures: (1) decreases in staffing, (2) several sub-grantees stopped providing services, and (3) a Request for Proposal (RFP) was released in FY 19 to allow for county health departments to apply to provide services, however, an award was not made.

9. **Field Name:** **Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program**

Fiscal Year: **2019**

Column Name: **Annual Report Expended**

Field Note:
Line 9. (Other Federal Funds) Wise Women Program – FY 2019 Annual Report Expended of $640k decreased from the FY 2019 Application Budgeted amount of $911k, a difference of $271k or -29.77 percent. Fiscal year 2019 was the first year of a 5-year grant cycle. Patient Services did not begin until March, although grant began October 1st. Delay was due to CDC waiting for OMB approval resulting in a 5-month delay. Also, in FY 2017 when the 2019 budget was developed the Wise Women program was at the end of the 5-year cycle. Also, at issue was a change in grant year beginning dates from April 1st to October 1.

10. **Field Name:** **Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Well Woman**

Fiscal Year: **2019**

Column Name: **Annual Report Expended**

Field Note:
Line 9. (Other Federal Funds) Well Women Program - FY 2019 Annual Report Expended of $536k increased from the FY 2019 Application Budgeted amount of $121k, a difference of $415k or 344.2 percent. Well Woman program was implemented in January 2017 in three counties: Butler, Dallas and Wilcox. The program reach has increased and is currently offered in six counties in Alabama (Butler, Dallas, Macon, Montgomery, Russell and Wilcox) with program implementation pending in a seventh county (Marengo). Between implementation and 2019 program staffing increased, with the most recent increase by 12.9 FTEs to cover staffing in the three new counties.

11. **Field Name:** **Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > CMC-COIIN Boston University**

Fiscal Year: **2019**

Column Name: **Annual Report Expended**

Field Note:

Line 9. (Other Federal Funds) CMC-COIIN Boston University - FY 2019 Annual Report Expended $93.3k decreased from the FY 2019 Application Budgeted amount of $135k, a difference of $41.7k or -30.86 percent. The decrease is a result of staff vacancies.

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 21 Application Budgeted	FY 19 Annual Report Expended
1. Pregnant Women	$ 137,464	$ 137,464
2. Infants < 1 year	$ 849,251	$ 849,251
3. Children 1 through 21 Years	$ 5,854,378	$ 5,854,378
4. CSHCN	$ 3,420,546	$ 3,420,546
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 10,261,639	$ 10,261,639

IB. Non-Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Pregnant Women	$ 1,303,749	$ 1,303,749
2. Infants < 1 year	$ 4,510,976	$ 8,054,526
3. Children 1 through 21 Years	$ 22,840,201	$ 41,803,414
4. CSHCN	$ 28,567,259	$ 27,680,889
5. All Others	$ 2,344,131	$ 3,095,141
Non-Federal Total of Individuals Served	$ 59,566,316	$ 81,937,719
Federal State MCH Block Grant Partnership Total	$ 69,827,955	$ 92,199,358

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:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: Line 1. (Pregnant Women) – FY 2019 Annual Report Expended of $1.44m decreased from the FY 2019 Application Budget amount of $1.83m, a difference of $394k or -21.46 percent. During the reporting period, Mobile County Maternity Program experienced a reduction of 4.0 FTE's that accounts for $177k of the cost and the remaining expenditures is the reduction that occurs from the cost allocation process which is based on the programs decrease in salaries.	
2.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: See IA. Federal MCH Block Grant explanation.	
3.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: Line 5. (All Others) -- FY 2019 Annual Report Expended of $3.095m increased from the FY 2019 Application Budgeted amount of $1.61m, a difference of $1.48m or 92 percent. Part of the increase is the addition of two programs that did not exist in 2017: (1) Fetal Infant Mortality Review Expansion Nurse Abstractors with $230k and (2) Well-Women program with $476k. Increased growth occurred in the following: Dental program increase in personnel costs associated with the hiring of a Dentist that had been vacant $353k and $140k growth in the PRAMS program. A total of seven FTEs and two cost of living increases were added to these programs. The balance is considered routine costs associated with the administration of the MCH program, i.e., merit raises, healthcare and retirement costs.	

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 21 Application Budgeted	FY 19 Annual Report Expended
1. Direct Services	$ 2,059,820	$ 4,431,909
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 851,359	$ 2,005,475
B. Preventive and Primary Care Services for Children	$ 898,461	$ 2,116,434
C. Services for CSHCN	$ 310,000	$ 310,000
2. Enabling Services	$ 1,720,670	$ 1,065,673
3. Public Health Services and Systems	$ 7,621,330	$ 5,904,238
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		$ 161,456
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 2,613
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Other		
CRS: Purchased Services, Health Insurance		$ 145,930
ADPH: CH Assess & Primary Care Program Support		$ 4,121,910
Direct Services Line 4 Expended Total		$ 4,431,909
Federal Total	$ 11,401,820	$ 11,401,820

IIB. Non-Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Direct Services	$ 28,672,153	$ 40,702,975
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 7,286,522	$ 13,346,760
B. Preventive and Primary Care Services for Children	$ 7,689,667	$ 14,085,202
C. Services for CSHCN	$ 13,695,964	$ 13,271,013
2. Enabling Services	$ 7,223,749	$ 9,342,729
3. Public Health Services and Systems	$ 22,530,233	$ 30,751,834
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		$ 1,357,865
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 2,255,565
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Other		
ADPH: Non-Federal program cost for MCH support		$ 37,089,545
Direct Services Line 4 Expended Total		$ 40,702,975
Non-Federal Total	$ 58,426,135	$ 80,797,538

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. Direct Services**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**

Field Note:
Line 1. (Direct Services) - FY 2019 Annual Report Expended of $45.13m decreased from the FY 2019 Application Budgeted amount of $51.70m, a difference of $6.57m or -12.70 percent. In FY 2017 more resources were used in providing direct services. The trend over this time-period has been more emphasis on redirecting these resources to Enabling and Public Health Services which is reflected in the table below. ADPH makes up $5.8m and CRS $738k of the change

2.	**Field Name:**	**IIA. Federal MCH Block Grant, 2. Enabling Services**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**

Field Note:
Line 2. (Enabling Services) - FY 2019 Annual Report Expended of $10.38m decreased from the FY 2019 Application Budgeted amount of $11.63m, a difference of $1.25m or -10.76 percent. Programs that made up the net decrease are Family Planning Care Coordination ($730k) and the loss of the Health Beginnings Contract ($108k). CRS share of the increase is $365k. (See CRS explanation).

3.	**Field Name:**	**IIA. Federal MCH Block Grant, 3. Public Health Services and Systems**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**

Field Note:
Line 3. (Public Health Services) - FY 2019 Annual Report Expended of $36.68m increased from the FY 2019 Application Budgeted amount of $31.13m, a difference of $5.55m or 17.83 percent. The table below reflects the movement of cost from Direct Services ($6.56m), Enabling Services ($1.2m) to Public Health Services (PHS) which increased by $5.52m during FY 2019. ADPH notable net increases total $3.46m: Central Office which carries out the activities that benefit the programs increased; EPSDT Care Coordination ($689k); DHR Healthy Child Care ($468k), Well Woman ($415k) and Dental Services ($384k). CRS' share of the increase is $2.09m. (See CRS explanation).

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Alabama

Total Births by Occurrence: 57,813 **Data Source Year: 2019**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Screen	(B) Aggregate Total Number Presumptive Positive Screens	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	57,813 (100.0%)	3,018	169	168 (99.4%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	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				

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Newborn Hearing	57,813 (100.0%)	2,210	52	51 (98.1%)

3. Screening Programs for Older Children & Women

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Alabama Childhood Lead Poisoning Prevention Program	39,404	430	430	296
Alabama Breast and Cervical Cancer Early Detection Program - Mammogram Screening	7,653	1,027	101	101
Alabama Breast and Cervical Cancer Early Detection Program-Cervical Cancer Screening	4,371	616	136	136

4. Long-Term Follow-Up

The Alabama Newborn Screening Program is limited in the long-term follow up it provides to individuals affected with a newborn screening disorder. Long-term follow up is directly monitored by the primary care physician (PCP) and the specialty care center. The Sparks Clinic at the University of Alabama at Birmingham provides and manages metabolic foods for individuals with metabolic disorders. The Alabama Department of Public Health does provide care coordination services if requested by the specialty care center or the PCP for compliance with specialty appointments and long-term follow up.

Form Notes for Form 4:

Total births by occurrence and the following program names data are based upon calendar year information (January 1, 2019- December 31, 2019): Core RUSP conditions and newborn hearing, and Childhood lead poisoning data was based on calendar year information (January 1, 2018-December 31, 2018). The following program names in the Screening Programs for Older Children & Women section are based upon fiscal year information (October 1, 2018-September 30, 2019): Alabama Breast and Cervical Cancer Early Detection Program-Mammogram Screening & Alabama Birth and Cervical Cancer Early Detection Program-Cervical Cancer Screening data.

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2019**
	Column Name:	**Total Births by Occurrence Notes**

Field Note:
The provisional estimate, as of February 27, 2020, of the number of live births that occurred in Alabama in calendar year (CY) 2019 was 57,210. As of June 16, 2020, the final number, based upon the vital statistic file, of live births occurring in the state in CY 2019 was not available.
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.
The number of first time newborn screening samples from children received by the Alabama Department of Public Health Bureau of Clinical Laboratories for CY 2019 was 57,813. When the provisional estimate is less than the number of children receiving at least one newborn screening, TVIS traditionally flags this field. We are setting the births by occurrence to match the number of children receiving at least one screening to validate Form 4.

2.	**Field Name:**	**Core RUSP Conditions - Receiving At Least One Screen**
	Fiscal Year:	**2019**
	Column Name:	**Core RUSP Conditions**

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 2019.

3.	**Field Name:**	**Core RUSP Conditions - Positive Screen**
	Fiscal Year:	**2019**
	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). This brings the total number of newborn screening conditions to 31 out of 35 recommended for Alabama.

4.	**Field Name:**	**Core RUSP Conditions - Confirmed Cases**
	Fiscal Year:	**2019**
	Column Name:	**Core RUSP Conditions**

Field Note:
The number in this section excludes babies who were born in Alabama but lived out of state.

5.	**Field Name:**	**Core RUSP Conditions - Referred For Treatment**
	Fiscal Year:	**2019**
	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.

6.	**Field Name:**	**Newborn Hearing - Receiving At Least One Screen**
	Fiscal Year:	**2019**
	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) 2019.

7.	**Field Name:**	**Newborn Hearing - Confirmed Cases**
	Fiscal Year:	**2019**
	Column Name:	**Other Newborn**

Field Note:
Data results based on date of birth per CY.

8.	**Field Name:**	**Newborn Hearing - Referred For Treatment**
	Fiscal Year:	**2019**
	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.

9.	**Field Name:**	**Alabama Childhood Lead Poisoning Prevention Program - Receiving At Least One Screen**
	Fiscal Year:	**2019**

	Column Name:	**Older Children & Women**

Field Note:
Lead data is reported according to date processed (i.e., not real time data). Date in which specimen collected may differ from data processing day. All data processed dates in our submission this year are from calendar year 2018. This is the most currently available data.

10.	**Field Name:**	**Alabama Childhood Lead Poisoning Prevention Program - Positive Screen**
	Fiscal Year:	**2019**
	Column Name:	**Older Children & Women**

Field Note:
The number of confirmed cases for the Alabama Childhood Lead Poisoning Prevention Program reported by the Alabama Department of Public Health Director of Children's Health was 470. This number may include people who have been tracked for years. Therefore, duplicates were included in this total count. Since this number is greater than the number who received at least one screening, TVIS flagged this field. Consequently, we are setting the number of children with presumptive positive screens to match the number who were confirmed cases to validate Form 4.

11.	**Field Name:**	**Alabama Childhood Lead Poisoning Prevention Program - Confirmed Cases**
	Fiscal Year:	**2019**
	Column Name:	**Older Children & Women**

Field Note:
The number of confirmed cases for the Alabama Childhood Lead Poisoning Prevention Program reported by the Alabama Department of Public Health Director of Children's Health was 470. This number may include people who have been tracked for years. Therefore, duplicates were included in this total count. Since this number is greater than the number who received at least one screening, TVIS flagged this field. Consequently, we are setting the number of children with presumptive positive screens to match the number who were confirmed cases to validate Form 4.

12.	**Field Name:**	**Alabama Childhood Lead Poisoning Prevention Program - Referred For Treatment**
	Fiscal Year:	**2019**
	Column Name:	**Older Children & Women**

Field Note:

Currently, there is a partial county that does not use the same reporting system as all other counties, therefore, at this time their data is not trackable. Being unable to track data is a possible reason for the lower “Number Referred for Treatment” than confirmed cases.

The number of presumptive positive screens for the Alabama Childhood Lead Poisoning Prevention Program reported by the Alabama Department of Public Health Director of Children’s Health was 430. This number may include people who have been tracked for years. Therefore, duplicates were included in this total count. Since this number is less than the number who received at least one screening, TVIS flagged this field. Consequently, we are setting the number of children with presumptive positive screens to match the number who were confirmed cases to validate Form 4.

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 2019

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	707	64.6	0.0	5.7	29.7	0.0
2. Infants < 1 Year of Age	31,621	42.0	0.0	55.7	2.2	0.1
3. Children 1 through 21 Years of Age	29,621	74.6	2.3	6.0	17.1	0.0
3a. Children with Special Health Care Needs	11,772	73.0	3.6	19.9	3.5	0.0
4. Others	71,402	50.6	0.6	21.1	27.7	0.0
Total	133,351					

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	57,761	Yes	57,761	100	57,761	707
2. Infants < 1 Year of Age	56,504	Yes	56,504	95	53,679	31,621
3. Children 1 through 21 Years of Age	1,288,751	Yes	1,288,751	6	77,325	29,621
3a. Children with Special Health Care Needs	301,568	Yes	301,568	25	75,392	11,772
4. Others	3,542,381	Yes	3,542,381	3	106,271	71,402

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Form Notes for Form 5:

Alabama Department of Public Health (ADPH) does not currently have a mechanism in place to correctly identify or accurately estimate the types of individuals served in Form 5a (i.e., inclusion of unduplicated, direct enabling non-reimbursed individuals served). We acknowledge this limitation and are actively working toward solutions (e.g., hiring staff and creation of an electronic health record system). Effective with FY 2018 data, a condensed versions of insurance payment category was utilized in preparation for the transition to utilization of the Electronic Health Record (EHR) system, consequently numbers in this section may not be comparable to previous years.

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2019**
	Field Note: Currently, to our knowledge, Mobile County is the only county which provides pregnant women data. Due to the fact that a patient's insurance status may change throughout the reporting period, the numbers provided may represent a duplicate patient count. At this time unduplicated and statewide numbers for this section are unavailable, however if this information becomes available we will make the appropriate updates to this section. "Title XIX %" includes Medicaid and Plan 1st; "Title XXI %" includes All Kids; "Private/Other" % includes Private and Other Insurances; "None %" includes Private Pay.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2019**
	Field Note: The numbers in this section are based upon occurrence data for calendar year 2019 for mothers 25-34 years of age, retrieved May 31, 2020, and based upon Alabama year 2014 revised birth certificate layout. There is no Title XXI code option for payment source in the Alabama 2014 birth certificate layout. Consequently, there is a 0 percent for this category. "Title XIX %" includes Medicaid only. "Private/Other %" includes the following insurance types: Private, Indian Health Service, Champus/Tri-care, Other Government, and Other. "None%" includes self pay only. The age range evaluated was based upon the National Vital Statistics Reports ("Births: Final Data for 2017"). In which case Alabama residential birth rates (births per 1,000 women in the population) by age of mother was 80.0 or greater (25-29 years' rate =98.0; 30-34 years' rate =100.3). Data in this section is not comparable to reports prior to 2019 submission due to changes in reporting.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2019**

Field Note:
In this section, Jefferson County Department of Health numbers include an unduplicated factor for calculation purposes. Mobile County Health Department numbers were received in an unduplicated format. All additional counties for the Alabama Department of Public Heath were, to our knowledge, received in duplicated format. At this time unduplicated numbers for all counties are not available, however if this information becomes available, we will make the appropriate updates.

Beginning in the application submission year of 2020 (data report 2019), the age range grouping in Jefferson County for this category. Consequently, data from the year 2019 forward may not be comparable to previous years. In FY 2018, there was a transition to the utilization of a new tracking system for insurance type at ADPH for Child Health Visit/ Patient Count. Numbers provided for FY 2018 are estimates and lower than in previous years.

4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2019**

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 percentage is calculated by dividing the number of distinct cases by each insurance status by the total number of distinct cases.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2019**

Field Note:
Due to the fact that a patient’s insurance status may change throughout the reporting period, the numbers provided may represent a duplicate patient count. At this time unduplicated numbers for this section are unavailable, however if this information becomes available we will make the appropriate updates to this section. “Title XIX%” includes All Kids; “Private/Other” % includes Private and Other Insurances; “None %” includes Private Pay.

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2019**

Field Note:
The numerator for the data in this section is based upon provisional residential data of mothers 15-44 years of age for calendar year (CY) 2019; retrieved February 27, 2020, from the Alabama Center of Health Statistics birth files (58,595). The denominator for the data in this section was retrieved from the Reference Data (National Vital Statistics System) on July 1, 2020 for CY 2018 Residential Live Birth Provisional Data (57,761). The exact percent is slightly higher than 100 percent (101 percent) however, to address the validation issue (excluding decimal percentage), 100 percent is reported in this section. This is possibly due to evaluation of different CY data. Also, due to the change in the reporting methods beginning in year 2017 submission, percent served instead of total served, data in this section is not comparable to previous year report.

2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2019**

Field Note:
The numerator for the data in this section is based upon occurrent data of mothers ages 25-34 years, for calendar year (CY) 2018; retrieved March 31, 2020 from the Alabama Center of Health Statistics birth files (31,621). Also, included in the numerator is the number of Unique Page Views to our Perinatal Program website (11,020) and Newborn Screening Program website (10,814) which provide public information and education. The denominator for the data in this section was retrieved from the National Vital Statistics System on July 7, 2020, for CY 2018 Occurrent Live Birth Data (56,504).

In review of our notes from last year, we noticed a human error in updates to this section post face to face. The correct information for last year was 83.755 percent (84 percent). Consequently, the numbers this year may not be comparable to previous years.

3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2019**

Field Note:
The numerator for this section is based upon FY 2019 data for the following: estimates of Tuscaloosa County preschool-2nd grade screenings and/or educational programs and UAB Dental School West Central District screenings and educational program (~867), WIC participants 1 to 5 years (56,259), Patient 1st children who were not referred by newborn screening (24,036), Healthy Child Care Nurse Consultant services provided (including first aid and CPR) (1,196) {(950+58,317+24,026+1,196)}. The denominator was provided by HRSA in Form 5b Reference Data from the US Census Bureau Population Estimates, CY 2018 (1,292,158).

4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2019**

Field Note:
The numerator is the number of children reached by CRS for FY 2019 (62,283). The denominator is the estimated number of CSHCN in Alabama from the NSCH-CSHCN 2017-2018 combined data (245,036). The numerator divided by the denominator calculates the Total percent Served.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2019**

Field Note:
The numerator for the data in this section is the number of mothers served in the state for fiscal year 2019 (71, 415) according to Family Planning data provided to MCH Epidemiology Staff. The denominator for the data in this section was provided by HRSA in Form 5b Reference Data from the US Census Bureau Population Estimates, CY 2017, Data (3,542,381). Note, the numerator and denominator data are based upon the latest, known, available date from both sources; which is based upon different years. This percentage is less than 3 percent (2.016 percent) and TVIS would not accept our inputted numbers. To address this validation issue, 3 percent is reported in this section. Also, due to the change in the reporting methods beginning in year 2017 submission, percent served instead of total served, data in this section is not comparable to previous year reports.

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Alabama

Annual Report Year 2019

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	64,019	38,185	18,942	4,906	207	1,027	5	0	747
Title V Served	842	172	445	135	3	24	18	0	45
Eligible for Title XIX	32,848	15,423	12,721	3,721	126	292	1	0	564
2. Total Infants in State	62,926	37,788	18,529	4,759	207	1,021	4	0	618
Title V Served	59,489	36,578	16,893	4,566	160	761	9	0	522
Eligible for Title XIX	41,512	14,462	14,898	2,412	0	0	0	0	9,740

Form Notes for Form 6:

Data in this section included content from Alabama Medicaid. Beginning with the year 2017 dataset, the methodologies utilized by Alabama Medicaid to calculate eligibility numbers based upon age transitioned from evaluating by age at any point during the year to ages as of the end of the calendar year. In the year 2020, the Medicaid Agency “noticed some errors within the eligibility section in the reports submitted for FY 2018 and FY 2019 time-periods. The eligibility data submitted earlier has duplicate members in the files. The agency now utilizes selective methods for de-duplication of the eligible population.” The data in this section is based upon the corrected Medicaid reports. Consequently, content in this section may not be comparable to previous years due to different calculation methods.

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2019**
	Column Name:	**Total**

Field Note:
Beginning in the year 2014, method of payment for the fetal death files from Alabama's Center for Health Statistics was no longer an option for file completion.

Starting in the year 2014, we utilized new in state race coding. Persons whose race code was listed as Bridged White are in the White race category. Persons whose race code was listed as Bridged Black, Bridged American Indian/Alaska, or Bridged Asian/Pacific Islander are in the Other/Unk race category.

2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2019**
	Column Name:	**Total**

Field Note:
Beginning in the year 2014, method of payment for the fetal death files from Alabama's Center for Health Statistics was no longer an option for file completion.

Starting in the year 2014, we utilized new in state race coding. Persons whose race code was listed as Bridged White are in the White race category. Persons whose race code was listed as Bridged Black, Bridged American Indian/Alaska, or Bridged Asian/Pacific Islander are in the Other/Unk race category.

3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2019**
	Column Name:	**Total**

Field Note:
Beginning in the year 2014, method of payment for the fetal death files from Alabama's Center for Health Statistics was no longer an option for file completion.

Starting in the year 2014, we utilized new in state race coding. Persons whose race code was listed as Bridged White are in the White race category. Persons whose race code was listed as Bridged Black, Bridged American Indian/Alaska, or Bridged Asian/Pacific Islander are in the Other/Unk race category.

4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2019**
	Column Name:	**Total**

Field Note:
Beginning in the year 2014, method of payment for the fetal death files from Alabama's Center for Health Statistics was no longer an option for file completion.

Starting in the year 2014, we utilized new in state race coding. Persons whose race code was listed as Bridged White are in the White race category. Persons whose race code was listed as Bridged Black, Bridged American Indian/Alaska, or Bridged Asian/Pacific Islander are in the Other/Unk race category.

5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2019**
	Column Name:	**Total**

Field Note:
Beginning in the year 2014, method of payment for the fetal death files from Alabama's Center for Health Statistics was no longer an option for file completion.

Starting in the year 2014, we utilized new in state race coding. Persons whose race code was listed as Bridged White are in the White race category. Persons whose race code was listed as Bridged Black, Bridged American Indian/Alaska, or Bridged Asian/Pacific Islander are in the Other/Unk race category.

6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2019**
	Column Name:	**Total**

Field Note:
Beginning in CY 2016, Alabama Medicaid switched from ICD9 to ICD10 codes and implemented a new Eligibility and Enrollment System. As a result of the new system, the decision was made to develop a new reporting system for eligibility that utilizes eligibility from the fiscal agent system. Information from this new reporting system was provided to ADPH for use in the Title V Maternal and Child Health Services Block Grant Reporting. Hopefully, in the future the system can provide a more detailed breakdown by race.

In review of our notes from last year, we noticed a human error in data entry in the “Hispanic” count. The correct information for last year was 2,695. Consequently, the numbers this year may not be comparable to previous years.

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Alabama

A. State MCH Toll-Free Telephone Lines	2021 Application Year	2019 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"	Meredith Adams	Meredith Adams
4. Contact Person's Telephone Number	(334) 206-3897	(334) 206-3897
5. Number of Calls Received on the State MCH "Hotline"		1,205

B. Other Appropriate Methods	2021 Application Year	2019 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"		2,593
3. State Title V Program Website Address	http://www.rehab.alabama.gov/crs http://www.alabamapublichealth.gov/mch	http://www.rehab.alabama.gov/crs http://www.alabamapublichealth.gov/mch
4. Number of Hits to the State Title V Program Website		18,034
5. State Title V Social Media Websites	Parent Connection and Youth Connection Facebook	Parent Connection Facebook and Youth Connection Facebook Pages
6. Number of Hits to the State Title V Program Social Media Websites		10,845

Form Notes for Form 7:

Effective January 1, 2019, The Healthy Beginnings number is also the Bureau of Family Health Services and Maternal and Child Health information line. This number can be used on all printed material and media buy for the following programs: Adolescent Pregnancy Prevention, the Dental Program, Family Planning, Office of Women’s Health, Perinatal Program and the WIC program.

The State Title V Program website address includes the Alabama Department of Rehabilitation Service/Children’s Rehabilitation Service (CRS) and the Alabama Department of Public Health (ADPH) Maternal and Child Health (MCH) Services Program website.

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-15,589 and ADPH MCH – 2,445).

Effective June 26, 2017, the State Title V Program Website Address for MCH was updated to the following: http://www.alabamapublichealth.gov/mch

The previous website address was as follows: http://www.adph.org/mch

All of our ADPH websites have seen a reduction in the amount of page views reported since we switched to the Cascade system. We attribute this to the fact that Cascade uses a different method (Google Analytics) to capture the data than the old Learning Content Management System (LCMS). We feel this is a more accurate reflection of activity on the website.

Number of Hits to the State Title V Program Social Media Websites - FY 2019 numbers are reflective of actual numbers of people reached by posts on the Parent Connection Facebook and Youth Connection Facebook pages.

Form 8
State MCH and CSHCN Directors Contact Information

State: Alabama

1. Title V Maternal and Child Health (MCH) Director	
Name	Amanda C. Martin
Title	Deputy Director, Bureau of Family Health Services
Address 1	P O Box 303017
Address 2	
City/State/Zip	Montgomery / AL / 36130
Telephone	(334) 206-5331
Extension	
Email	amanda.martin@adph.state.al.us

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Cathy Caldwell
Title	Assistant Commissioner
Address 1	Alabama Department Rehabilitation Services
Address 2	602 S. Lawrence St.
City/State/Zip	Montgomery / AL / 36104
Telephone	(334) 293-7049
Extension	
Email	cathy.caldwell@rehab.alabama.gov

3. State Family or Youth Leader (Optional)	
Name	Susan Colburn
Title	CSHCN State Office Parent Consultant
Address 1	Alabama Department of Rehabilitation Services
Address 2	602 S. Lawrence St.
City/State/Zip	Montgomery / AL / 36104
Telephone	(334) 293-7041
Extension	
Email	susan.colburn@rehab.alabama.gov

Form Notes for Form 8:

Effective March 1, 2020, Chris Haag retired from his position as Deputy Director of the Bureau of Family Health Services. Effective February 1, 2020, Amanda Martin was appointed the position of Deputy Director of the Bureau of Family Health Services.

Form 9
State Priorities – Needs Assessment Year

State: Alabama

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 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 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
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	
	2019
Annual Indicator	10,000.0
Numerator	1
Denominator	1
Data Source	Bureau of Family Health Services MCH Epi Director
Data Source Year	2019

NOM 2 - Notes:

At this time, Alabama does not have a hospital discharge database to track this information. 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 a hospital discharge database becomes available, we will update this section in future submissions.

Data Alerts: None

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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
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

State Provided Data

	2019
Annual Indicator	42.7
Numerator	25
Denominator	58,595
Data Source	Center for Health Statistics
Data Source Year	2019

NOM 3 - Notes:

Data in this section were based upon analysis of Alabama's Center for Health Statistics Vital Records Birth and Death files. The specific Maternal Mortality ICD-10 codes evaluated are as follows: A34, O00-O95, O98-O99. Note: This data is provisional.

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
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
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
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
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 %			
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
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
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
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
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
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 - Sleep-related 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
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 - The percent of infants born with fetal alcohol exposure 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 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

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

State Provided Data	
	2019
Annual Indicator	1,000.0
Numerator	1
Denominator	1
Data Source	Center for Health Statistics
Data Source Year	2019

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
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
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
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

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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
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
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
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
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
2017_2018	3.2 %	0.7 %	29,568	927,968
2016_2017	3.1 %	0.7 %	28,645	909,975
2016	2.2 % ϟ	0.8 % ϟ	19,716 ϟ	882,862 ϟ

Legends:

⚑ Indicator has an unweighted denominator <30 and is not reportable

ϟ 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
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
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
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
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 <50 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
2015	16.2 %	1.4 %	33,648	208,340
2013	17.2 %	1.3 %	35,758	207,938
2011	17.1 %	1.8 %	35,378	207,117
2009	13.2 %	1.1 %	23,206	175,351
2005	14.7 %	0.9 %	30,947	211,112

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
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
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, ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	79.3 %	2.9 %	67,707	85,380
2017	71.2 %	3.5 %	61,479	86,295
2016	77.3 %	3.5 %	66,107	85,544
2015	70.6 %	3.6 %	59,298	84,042
2014	77.0 %	4.3 %	64,987	84,458
2013	77.0 %	4.0 %	65,160	84,627
2012	71.3 %	3.5 %	62,125	87,099
2011	68.8 %	3.1 %	61,952	90,063
2010	58.2 %	3.1 %	54,195	93,100
2009	47.3 %	4.2 %	43,575	92,187

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
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
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
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
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
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
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 not able to obtain needed health care in the last year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	2.4 % ϟ	0.7 % ϟ	26,027 ϟ	1,094,670 ϟ
2016_2017	2.8 %	0.7 %	30,968	1,101,322
2016	3.5 % ϟ	1.0 % ϟ	39,076 ϟ	1,104,799 ϟ

Legends:

⚑ Indicator has an unweighted denominator <30 and is not reportable

ϟ 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)				
	2016	**2017**	**2018**	**2019**
Annual Objective	76.7	77	77.4	76.8
Annual Indicator	65.8	65.4	66.3	70.8
Numerator	552,796	550,090	560,384	599,429
Denominator	840,350	840,780	845,315	846,286
Data Source	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017	2018

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	82.0	82.4	82.8	83.3	83.7	84.1

Field Level Notes for Form 10 NPMs:

1. **Field Name:** **2020**

Column Name: **Annual Objective**

Field Note:
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 2018, 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 “2018”. This query on May 14, 2020 provided Alabama with a baseline for 2018 of roughly 81.2 percent of females indicating a routine checkup within the past year. Objectives from 2019 forward have been set to require an annual increase of 0.5 percent from the 2018 baseline.

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				
	2016	2017	2018	2019
Annual Objective	85.2	75.9	84.5	84.2
Annual Indicator	75.7	84.3	84.1	83.5
Numerator	892	958	913	949
Denominator	1,179	1,136	1,086	1,137
Data Source	Alabama Center for Health Statistics	Alabama Center for Health Statistics	Alabama Center for Health Statistics	Alabama Center for Health Statistics
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Provisional	Provisional	Provisional

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	83.6	83.8	84.0	84.1	84.3	84.5

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Alabama's Center for Health Statistics provided the data for this performance measure. In the year 2016 (January 1st-December 15th), 75.7 percent of very low birth weight infants were born in an Alabama hospital with a Level III or IV facility. The objective settings for subsequent years was set to require a slight increase; specifically, 0.2 percent per year, from the 2016 baseline. At this time the data provided is final as of June 19, 2017.

2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Alabama’s Center for Health Statistics provided the data for this performance measure. In the year 2017, (January 1st- December 31st), 84.3 percent of very low birth weight infants were born in an Alabama hospital with a Level III or IV facility. The objective settings for subsequent years was set to require a slight increase; specifically, 0.2 percent per year, from the 2017 baseline. At this time the data provided is provisional as of June 12, 2018.

3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Alabama’s Center for Health Statistics provided the data for this performance measure. In the year 2018, (January 1st- December 31st), 84.1 percent of very low birth weight infants were born in an Alabama hospital with a Level III or IV facility. The objective settings for subsequent years was set to require a slight increase; specifically, 0.2 percent per year, from the 2018 baseline. At this time the data provided is provisional as of May 10, 2019.

4.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**

Field Note:
Alabama’s Center for Health Statistics provided the data for this performance measure. In the year 2019, (January 1st- December 31st), 83.5 percent of very low birth weight infants were born in an Alabama hospital with a Level III or IV facility. The objective settings for subsequent years was set to require a slight increase; specifically, 0.2 percent per year, from the 2018 baseline. At this time the data provided is provisional as of July 9, 2020.

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

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	69.4	71.9	75.5	72.3
Annual Indicator	69.5	71.3	71.3	72.1
Numerator	37,350	38,245	38,245	37,735
Denominator	53,710	53,663	53,663	52,309
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2015	2017

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	73.3	73.7	74.0	74.4	74.8	75.1

Field Level Notes for Form 10 NPMs:

1. **Field Name:** **2020**

Column Name: **Annual Objective**

Field Note:
The Pregnancy Risk Assessment and Monitoring System (PRAMS) is the data source for this (5A) National Performance Measure 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's PRAMS coordinator (2017 results); indicated there were 72.2 percent of Alabama infants who were placed on their backs to sleep. Objectives for 2018 forward have been set to require an annual improvement of 0.5 percent from the baseline. Note, previous years reports are not comparable due to the utilization of a historical data set (Year 2013 PRAMS publication).

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
Annual Objective	88.1
Annual Indicator	29.8
Numerator	15,619
Denominator	52,446
Data Source	PRAMS
Data Source Year	2017

State Provided Data			
	2017	2018	2019
Annual Objective			88.1
Annual Indicator	86.7	86.7	
Numerator	533	533	
Denominator	615	615	
Data Source	PRAMS	PRAMS	
Data Source Year	2016	2016	
Provisional or Final ?	Provisional	Provisional	

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	85.7	86.1	86.5	87.0	87.4	87.8

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
The Pregnancy Risk Assessment and Monitoring System (PRAMS) is the data source for this (B) National Performance Measure 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. This question was not asked in the previous year (2014) survey publication. As of September 4, 2018, per communication forwarded by Alabama's Interim PRAMS coordinator, the 2016 data was available for PRAMS question 67a ("How did your new baby usually sleep in the past 2 weeks?").

2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Data in this section reflects the most recently available information (year 2016) provided directly from the Alabama's Interim PRAMS coordinator.

3.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**

Field Note:
The Pregnancy Risk Assessment and Monitoring System (PRAMS) is the data source for this (B) National Performance Measure 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's PRAMS coordinator; who indicated there were 84.4 percent of Alabama infants 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. This question was not asked in the previous year (2014) survey publication. Consequently, the response to this question is not comparable to previous years submission.

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
Annual Objective	39.3
Annual Indicator	36.7
Numerator	19,218
Denominator	52,355
Data Source	PRAMS
Data Source Year	2017

State Provided Data			
	2017	**2018**	**2019**
Annual Objective			39.3
Annual Indicator	38.7	38.7	
Numerator	235	235	
Denominator	608	608	
Data Source	PRAMS	PRAMS	
Data Source Year	2016	2016	
Provisional or Final ?	Provisional	Provisional	

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	49.9	50.2	50.4	50.7	50.9	51.2

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
The Pregnancy Risk Assessment and Monitoring System (PRAMS) is the data source for this (C) National Performance Measure 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's Interim PRAMS coordinator. This question was not asked in the previous year (2014) survey publication. Consequently, information in this section is not comparable to previous years.

2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
The Pregnancy Risk Assessment and Monitoring System (PRAMS) is the data source for this (C) National Performance Measure 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's Interim PRAMS coordinator. This question was not asked in the previous year (2014) survey publication. Consequently, information in this section is not comparable to previous years.

3.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**

Field Note:
The Pregnancy Risk Assessment and Monitoring System (PRAMS) is the data source for this (C) National Performance Measure 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's PRAMS coordinator. This question was not asked in the previous year (2014) survey publication. Consequently, information in this section is not comparable to previous years.

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)				
	2016	**2017**	**2018**	**2019**
Annual Objective			26.3	40.5
Annual Indicator		21.2	26.6	39.8
Numerator		32,690	38,521	53,496
Denominator		154,509	145,031	134,315
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	58.3	64.9	72.3	77.6	86.4	96.1

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**

Field Note:
The National Survey of Children's Health (NSCH) 2016 report was utilized for the National Performance Measure 6 data source for determining annual objectives. Specifically, we queried the NSCH website by survey and topic for the year 2016 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: Developmental screening, age 9-35 months." This query on July 10, 2020 provided Alabama with a baseline for 2018 of 47.1% of parents completing a developmental screening tool during the past 12 months of children ages 9 through 35 months. Utilizing NSCH 2018 as a baseline for this performance measure, we set an annual improvement of 11.3% for objectives in subsequent years. Previous year reports are not comparable due to the utilization of historical data sets (Year 2016, 2011-2012 or prior). Previous year reports are not comparable due to the utilization of historical data sets.

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)				
	2016	**2017**	**2018**	**2019**
Annual Objective			86.9	87.8
Annual Indicator		75.9	76.3	76.3
Numerator		267,488	279,668	279,668
Denominator		352,368	366,499	366,499
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	68.5	73.3	78.4	83.9	89.7	96.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**

Field Note:
The National Survey of Children's Health (NSCH) 2017 report was utilized for the National Performance Measure (NPM) 10 data source for determining annual objectives. Specifically, we queried the NSCH website by survey and topic for the year 2016 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 12-17 years, with a preventive medical visit in the past year." This query on July 10, 2020, provided Alabama with a baseline for 2018 of 59.8 percent of adolescents with one or more preventive medical visits in the past year. Utilizing NSCH 2018 as a baseline for this performance measure, we set an annual improvement of 0.07 percent for objectives in subsequent years. Previous year reports are not comparable due to the utilization of historical data sets.

NPM 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 - Children with Special Health Care Needs

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CSHCN				
	2016	**2017**	**2018**	**2019**
Annual Objective			53.5	58.5
Annual Indicator		13.2	12.9	15.0
Numerator		13,335	13,867	14,975
Denominator		101,361	107,738	99,967
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective			53.5	58.5
Annual Indicator	44.3	51.5	77.9	81.9
Numerator	1,255	1,400	2,753	2,938
Denominator	2,830	2,718	3,532	3,589
Data Source	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	64.0	70.0	75.0	80.0	82.0	84.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
This data represent ESM 12.1
The data source for this indicator is the CSHCN Program. The numerator is the number of YSHCN with a comprehensive plan of care in place. This number does not include those enrollees with a health and medical plan of care. The denominator is the number of YSHCN 14-21 enrolled in the State CSHCN Program.

2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
This data represents ESM 12.1
The data source for this indicator is the CSHCN Program. The numerator is the number of YSHCN with a plan of care in place. The denominator is the number of YSHCN 14-21 enrolled in the State CSHCN Program.

3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Denominator: Number of 14-21 yrs of age, both open and closed between 10/1/17 - 9/30/18.

Numerator= Number of Children 14-21 yrs of age, both open and closed between 10/1/17-9/30/18, who have a comprehensive plan of care.

2753= Number of 14-21 year old who have transition plan.

4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Denominator = Number of children 14-21 years of age, both open and closed between 10/1/2018 and 9/30/2019.
Numerator = Number of children 14-21 years of age, both open and closed between 10/1/2018 and 9/30/2019 who have a Comprehensive Plan of Care.

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)				
	2016	**2017**	**2018**	**2019**
Annual Objective	42.3	43.1	44.2	38.7
Annual Indicator	41.2	40.6	40.6	36.0
Numerator	22,302	22,286	22,286	19,726
Denominator	54,138	54,955	54,955	54,751
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2015	2017

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	38.8	39.7	40.7	41.7	42.8	43.9

Field Level Notes for Form 10 NPMs:

1. **Field Name:** **2020**

   Column Name: **Annual Objective**

   Field Note:
   The Pregnancy Risk Assessment and Monitoring System (PRAMS) is the data source for this (13.1) National Performance Measure 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)				
	2016	**2017**	**2018**	**2019**
Annual Objective			82.5	82.1
Annual Indicator		81.7	81.7	80.7
Numerator		837,585	836,024	830,091
Denominator		1,025,822	1,023,434	1,028,454
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	80.5	80.9	81.3	81.7	82.1	82.5

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**

Field Note:
The National Survey of Children's Health (NSCH) 2017 report was utilized for National Performance Measure 13.2 data source for determining annual objectives. Specifically, we queried the NSCH website by survey and topic for the year 2018 for the state of Alabama. The starting point/topic selected was Title V Block Grant Measures and the specific National Performance Measure selected was "13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year." This query on July 10, 2020, provided Alabama with a baseline for 2018 of 79.7 percent of children, age 1-17 years, who had a preventive dental visit in the past year. Utilizing the NSCH 2018 as a 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.

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

State Provided Data				
	2016	2017	2018	2019
Annual Objective			82.5	82.1
Annual Indicator		81.7		
Numerator		837,585		
Denominator		1,025,822		
Data Source		NSCH		
Data Source Year		2016		
Provisional or Final ?		Final		

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	80.5	80.9	81.3	81.7	82.1	82.5

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:

The National Survey of Children's Health (NSCH) 2016 report was utilized for National Performance Measure 13.2 data source for determining annual objectives. Specifically, we queried the NSCH website by survey and topic for the year 2016 for the State of Alabama. The starting point/topic selected was Title V Block Grant Measures and the specific National Performance Measure selected was "13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year." This query on May 25, 2018, provided Alabama with a baseline for 2016 of 81.7 percent of children, age 1-17 years, who had a preventive dental visit in the past year. Utilizing the NSCH 2016 as a baseline for this performance measure, we set an annual improvement of 0.006 for objectives in subsequent years. Note, previous year reports are not comparable due to the utilization of historical data sets (Year 2011-2012 or prior).

2.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**

Field Note:

At this time, we are unaware of a data source for Alabama Adolescents in the 12-25-year age group who completed dental preventive visits in the past year for this section. To prevent a TVIS error code, the results in the child section was included for adolescents since the age groups overlapped. When we become aware that such data is available we will ensure that future publications utilize this data source.

Form 10
National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

State: Alabama

2016-2020: NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CSHCN				
	2016	**2017**	**2018**	**2019**
Annual Objective			70	73
Annual Indicator		43.3	40.1	37.0
Numerator		102,023	99,230	90,678
Denominator		235,517	247,758	245,036
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective			70	73
Annual Indicator	36.2	65.8	71.9	73
Numerator	3,567	6,766	7,754	8,594
Denominator	9,858	10,287	10,784	11,772
Data Source	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
This data represents ESM 11.1
The comprehensive plan of care data source for this indicator is the CSHCN Program. The numerator does not include enrolled clients with a health/medical plan of care.
There are 3,462 enrolled CYSHCN with a health/medical plan of care in place.

2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
This data represents ESM 11.1
The comprehensive plan of care data source for this indicator is the CSHCN Program. The numerator includes enrolled clients with a plan of care.
There are 6,766 enrolled CYSHCN with a current plan of care in place.

3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Denominator=Number of Children in CSHCN Program.
Numerator= Number of Children Served With Medicaid and/or Medicaid and private insurance.

4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Denominator = Number of children in CSHCN Program.
Numerator = Number of Children Served w/ Medicaid and/or Medicaid and Private Insurance.

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:	Active

State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		54.3	53.3	73
Annual Indicator	53.7	52.8	72.2	54.6
Numerator	34,296	33,970	32,124	33,751
Denominator	63,812	64,372	44,467	61,836
Data Source	Alabama Medicaid Agency EPSDT data	Alabama Medicaid Agency EPSDT data	Alabama Medicaid	Alabama Medicaid Agency EPSDT data
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	55.1	55.7	56.2	56.8	57.4	57.9

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Data guiding annual objectives for this state performance measure comes from the FY 2016 Alabama Medicaid Agency Early and Periodic Screening, Diagnostic and Treatment (EPSDT) report. In FY 2016, of the 63,812 total eligible receiving at least one initial or periodic screening for ages 1-2 years, 34,296 blood lead was screened/tested for persons in this age group. This, for FY 2016, represented 53.7 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:**	**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 persons in this age group blood lead was screened/tested. This 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.

3.	**Field Name:**	**2018**
	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 2018, of the 44,467 total eligible receiving at least one initial or periodic screening for ages 1-2 years, 32,124 persons in this age group blood lead was screened/tested. This 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 1.0 percent from this baseline.

4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Data guiding annual objectives for this state performance measure comes from the FY 2019 Alabama Medicaid Agency Early and Periodic Screening, Diagnostic and Treatment (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 persons in this age group blood lead was screened/tested. This for FY 2018, 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 1.0 percent from this baseline.

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

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	8.0	12.0	16.0	20.0	24.0

Field Level Notes for Form 10 SPMs:

None

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

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	50.0	58.0	67.0	77.0	89.0

Field Level Notes for Form 10 SPMs:

None

SPM 4 - Percent of women who smoke during pregnancy

Measure Status:	Active

State Provided Data

	2019
Annual Objective	
Annual Indicator	8.7
Numerator	
Denominator	
Data Source	ADPH Center for Health Statistics
Data Source Year	2018
Provisional or Final ?	Final

Annual Objectives

	2021	2022	2023	2024	2025
Annual Objective	8.6	8.5	8.4	8.3	8.2

Field Level Notes for Form 10 SPMs:

1. **Field Name:** **2019**

   Column Name: **State Provided Data**

   Field Note:
   Based upon the ADPH Center for Health Statistics, Percent of Births with Maternal Smoking, 2018 (8.7 percent).

   Objectives set for a 1 percent annual decrease from the 2018 benchmark of 8.7 percent of births with maternal smoking.

SPM 5 - Percent of women, ages 18-44, with follow up Colposcopy visit when indicated, in the past year

Measure Status:	Active

State Provided Data

	2019
Annual Objective	
Annual Indicator	43.2
Numerator	1,081,373
Denominator	2,505,795
Data Source	BRFSS and U.S. Census
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives

	2021	2022	2023	2024	2025
Annual Objective	45.8	46.2	46.7	47.1	47.5

Field Level Notes for Form 10 SPMs:

1. **Field Name:** **2019**

   Column Name: **State Provided Data**

   Field Note:
   This is a new measure set to complement work on measure ESM 1.1.

   Benchmark data and objectives have been set equal to those in ESM 1.1.

SPM 6 - 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.

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	6
Data Source	Program Data
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	0.2	0.3	0.5	0.7	0.8

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 are set to increase by one program out of the six (e.g. 1/6=0.17) annually.

This measure is based upon the total number of Program Partners participating in the Early Head Start Child Care Partnership 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 Auburn University Hub.

SPM 7 - Percent of staff trained at day care provider/centers on CPR/First Aid

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	28.6
Numerator	6,157
Denominator	21,514
Data Source	Healthy Childcare Alabama Training Data
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	28.9	29.2	29.5	29.8	30.1

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Objectives are set to increase 1 percent annually from the benchmark value of 28.6 percent.

SPM 8 - Number of modules of the University of Wisconsin-Madison's Population Health Initiative's Health Equity Training Modules completed in order to advance health equity in the Alabama MCH Title V Block Grant Program

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Alabama MCH Title V Program Documentation
Data Source Year	2020
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	1.0	1.0	2.0	2.0	3.0

Field Level Notes for Form 10 SPMs:

None

Form 10
State Performance Measures (SPMs) (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 1 - Percent of CYSHCN and their families who report that they share in decision-making and partnerships with their health care providers.

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		5	27	28
Annual Indicator	40	78.8	76.7	80
Numerator	18	26	23	24
Denominator	45	33	30	30
Data Source	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
The observed status of this indicator is based on a checklist of several activities in three areas which identified the need for the CSHCN Program to increase its capacity to promote shared decision-making and partnerships between families and health and related professionals as a state priority. The scoring will be measured yearly for increase or decrease from prior year.

2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
The observed status of this indicator is based on a checklist of several activities in two areas which identified the need for the CSHCN Program to increase its capacity to promote shared decision-making and partnerships between families and health and related professionals as a state priority. The scoring will be measured yearly for increase or decrease from prior year.

3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Based upon Data Action Plan for SPM (Scoring Chart)

4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
The observed status of this indicator is based on a checklist of several activities in three areas which identified the need for the CSHCN Program to increase its capacity to promote shared decision-making and partnerships between families and health and health-related professionals as state priority. The scoring is measured annually for an increase or decrease from the prior year. See CSHCN Data Action Plan for SPM 1 2016-2020 Five-Year Needs Assessment in the attachment section.

2016-2020: SPM 3 - Develop a comprehensive Adolescent Health Program Strategic Plan.

Measure Status:				Active
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		2	22	23
Annual Indicator	1	22	0	0
Numerator				
Denominator				
Data Source	Checklist Criteria Screening Tool	Checklist Criteria Screening Tool	Checklist Criteria Screening Tool	Checklist Criteria Screening Tool
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Annual Progress will be tracked utilizing a Checklist Criteria Scoring Tool which was created to monitor progress towards development of a strategic plan for an Adolescent Health Program to respond to the changing health priorities routinely faced by children and youth. The annual indicator for the fiscal year 2016 was established as one. An annual fiscal year increase of one count was established for each proceeding year.

2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
UAB has been actively working on this measure since June 2015. ADPH staff and other contributing partners began collaborating thereafter. Youth interviews took place in the summer of 2017. The Adolescent Health Plan was drafted by LEAH short-term trainees from May to June of 2018. The Adolescent Health Plan draft is currently by LEAH director Dr. Tina Simpson.

3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Objectives from 2018 through 2023 have been adjusted to reflect activities that have been ongoing since 2015. UAB LEAH has reported no additional progress on the Adolescent Health Plan during 2018.

4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Objectives from 2019 through 2023 have been adjusted to reflect activities that have been ongoing since 2015. UAB LEAH has reported no additional progress on the Adolescent Health Plan during 2019.

2016-2020: SPM 4 - Number of school districts assessed regarding current mental health services

Measure Status:				Active
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		0	5	10
Annual Indicator	0	0	33.8	43.2
Numerator			47	60
Denominator			139	139
Data Source	Medicaid, CHIP, Dept. of Ed, Dept. of MH, Schools	Medicaid, CHIP, Dept. of Ed, Dept. of MH, Schools	State Department of Education	Alabama Department of Mental Health
Data Source Year	2017	2017	2018	2019
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Currently, ADPH has an established collaborative effort, with the Montgomery County Public School System, in which ADPH Social Work (SW) staff work with the school's SW staff to assist referred children. At this point, ADPH has been unable to expand available services outside of Montgomery County and has been unable to focus on providing training to educational staff about available services. The MCH Title V Program will continue to seek means to move this effort forward.

2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Currently, 47 school systems have been reported to have active school-based mental health collaboration partners. These systems receive services as part of a collaboration between the Alabama Department of Mental Health and Alabama State Department of Education. During 2018, the Governor staffed a task force to improve safety in Alabama Schools, part of this initiative will be to secure funding for mental health services in schools. The MCH Title V Program will continue to seek means to move this effort forward.

3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
The annual indicator for the year 2019 (43.2) is an estimate. Year 2019 data source was Alabama Department of Mental Health. ADPH staff met with the board of the School Superintendents of Alabama to discuss services available through the department. Behavioral Health in school age children living in rural areas can access services through telehealth. Further discussions are planned.

Form 10
Evidence-Based or –Informed Strategy Measure (ESM)

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 2 points annually.

Measure Status:	Active

State Provided Data

	2016	2017	2018	2019
Annual Objective		44	44.5	44.9
Annual Indicator	43.2	43.2	43.2	43.2
Numerator	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
Data Source	BRFSS and U.S. Census Bureau, Population Division	BRFSS and U.S. Census Bureau, Population Division	BRFSS and U.S.Census	BRFSS and U.S.Census
Data Source Year	2015	2015	2015	2015
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives

	2020	2021	2022	2023	2024	2025
Annual Objective	45.4	45.8	46.2	46.7	47.1	47.5

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
We used the BRFSS question regarding “Last Checkup” for data year 2015, as our baseline, which referred to a routine checkup in the last year by gender. This query on May 24, 2017, provided a baseline of roughly 76.2% of females. Objectives from 2017 forward have been set to require an annual increase of 0.5% 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% of the total female population. Also, using the 76.2% 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% of the target population. The year 2015 baseline was set at 43.2% with an annual improvement of 1.0% objectives. Note, Well Woman data was based upon 15-55 years of age.

2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
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 of 1.0 percent objectives. Note, Well Woman data was based upon 15-55 years of age.

3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
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 of 1.0 percent objectives. Note, Well Woman data was based upon 15-55 years of age.

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
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	46
Data Source	Alabama State Perinatal Program Data
Data Source Year	2020
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	15.0	25.0	35.0	50.0	65.0

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2019**

   Column Name: **State Provided Data**

   Field Note:
   This measure is new and serves to track the number of birthing hospitals meeting with Alabama State Perinatal Program staff to share data and discuss the Alabama Perinatal Regionalization System Guidelines.

   Objectives are set to represent the percentage of birthing hospitals that have met to date in the given calendar year. The objectives are based upon the benchmark total of 46 birthing hospitals at the time of this report.

2. **Field Name:** **2021**

   Column Name: **Annual Objective**

   Field Note:
   Objectives are set to represent the percentage of birthing hospitals that have met, to date, in the given calendar year. The objectives are based upon the benchmark total of 46 birthing hospitals at the time of this report.

   Thus, in 2021, 15 percent of 46=7 birthing hospitals would have met, to date.

3. **Field Name:** **2022**

	Column Name:	**Annual Objective**

Field Note:
Objectives are set to represent the percentage of birthing hospitals that have met, to date, in the given calendar year. The objectives are based upon the benchmark total of 46 birthing hospitals at the time of this report.

Thus, in 2022, 25 percent of 46=12 birthing hospitals would have met, to date.

4.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
Objectives are set to represent the percentage of birthing hospitals that have met, to date, in the given calendar year. The objectives are based upon the benchmark total of 46 birthing hospitals at the time of this report.

Thus, in 2023, 35 percent of 46=16 birthing hospitals would have met, to date.

5.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**

Field Note:
Objectives are set to represent the percentage of birthing hospitals that have met, to date, in the given calendar year. The objectives are based upon the benchmark total of 46 birthing hospitals at the time of this report.

Thus, in 2024, 50 percent of 46=23 birthing hospitals would have met, to date.

6.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**

Field Note:
Objectives are set to represent the percentage of birthing hospitals that have met, to date, in the given calendar year. The objectives are based upon the benchmark total of 46 birthing hospitals at the time of this report.

Thus, in 2025, 65 percent of 46=30 birthing hospitals would have met, to date.

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

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Alabama State Perinatal Program Data
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	1.0	1.0	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 is a new measure which serves to track implementation of the CDC's Level of Care Assessment Tool (LOCATe) Process which is being utilized to align the Alabama Perinatal Regionalization System Guidelines with the national criteria for the Maternal Levels of Care.

Objectives are based upon the number of steps of the CDC LOCATe Process completed in the specified year.

ESM 5.1 - Percent of WIC prenatal participants placing their infants to sleep on their backs

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	71.3
Numerator	38,245
Denominator	53,663
Data Source	Alabama PRAMS
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	72.0	72.7	73.4	74.1	74.8

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
This is a new measure for which actual program data is not available at the time of this report.
In order to meet reporting requirements, data from the Alabama PRAMS Program for 2015, found in the FAD resource document for NPM 5A,has been entered.

Objectives are based upon the 2015 indicator and set for a 1 percent increase annually.

ESM 5.2 - Number of sleep-related infant deaths

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	70
Numerator	
Denominator	
Data Source	ADPH Center for Health Statistics
Data Source Year	2018
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	68.0	66.0	64.0	62.0	60.0

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 3 percent, are based upon the benchmark year 2018, during which SUID was responsible for 70 of the 405 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

Measure Status:	Active

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

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	12.0	15.0	19.0	24.0	29.0

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2019**

   Column Name: **State Provided Data**

   Field Note:
   This is a new measure which serves to track 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

   Objectives are based upon the number of trainings facilitated in the specified year and set to increase 25 percent annually.

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	1.0	2.0	3.0	4.0	5.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Objectives based upon the 676 visits statewide in county health departments in 2020 to children birth to 19 and set to increase 1 percent annually.

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:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	1.8
Numerator	22,363
Denominator	1,219,436
Data Source	APC and U.S. Census Bureau Population Estimates
Data Source Year	2018
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	1.9	1.9	1.9	1.9	1.9

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:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
Annual object set for a 1 percent annual increase from the 2018 Benchmark:
22,363/1,219,436*100=1.83 percent
1% Increase = 1.85 percent (2021)

3.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**

Field Note:
Annual object set for a 1 percent annual increase from the 2018 Benchmark:
22,363/1,219,436*100=1.83 percent
1% Increase = 1.87 percent (2022)

4.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
Annual object set for a 1 percent annual increase from the 2018 Benchmark:
22,363/1,219,436*100=1.83 percent
1% Increase = 1.89 percent (2023)

5.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**

Field Note:
Annual object set for a 1 percent annual increase from the 2018 Benchmark:
22,363/1,219,436*100=1.83 percent
1% Increase = 1.91 percent (2024)

6.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**

Field Note:
Annual object set for a 1 percent annual increase from the 2018 Benchmark:
22,363/1,219,436*100=1.83 percent
1% Increase = 1.93 percent (2025)

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
Annual Objective	
Annual Indicator	54.6
Numerator	33,751
Denominator	61,836
Data Source	Alabama Medicaid
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	55.1	55.7	56.2	56.8	57.4

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 Early and Periodic Screening, Diagnostic and Treatment (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 persons in this age group blood lead was screened/tested. This for FY 2018, 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 1.0 percent from this baseline.

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

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	76.3
Numerator	279,668
Denominator	366,499
Data Source	NSCH
Data Source Year	2016-17
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	77.1	77.9	78.7	79.5	80.3

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2019**

Column Name: **State Provided Data**

Field Note:
Based upon the NSCH 2016-17 indicator of 76.3 percent.

Objectives set for a 1 percent annual increase from the 2016-17 benchmark indicator of 76.3 percent.

ESM 12.1 - Percent of YSHCN enrolled in the State CSHCN program with a transition plan in place.

Measure Status:	Active

State Provided Data				
	2016	2017	2018	2019
Annual Objective		35.5	52	55
Annual Indicator	44.3	51.5	77.9	81.9
Numerator	1,255	1,400	2,753	2,938
Denominator	2,830	2,718	3,532	3,589
Data Source	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	57.0	60.0	62.0	65.0	67.0	69.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
The data source for this indicator is the CSHCN Program.

2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
This data represents ESM 12.1
The data source for this indicator is the CSHCN Program. The numerator is the number of YSHCN with a plan of care in place. The denominator is the number of YSHCN 14-21 enrolled in the State CSHCN Program.

3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
The data source for this indicator is the CSHCN Program.

Numerator=The Number of Children 14-21 Yrs of age, Both open and closed between 10/1/17- 9/30/18, who have a comprehensive plan of care.

Denominator - The Number of Children 14-21 Yrs of age, Both open and closed between 10/1/17-9/30/18.

4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
The data source for this indicator is the CSHCN Program.
Numerator = The Number of Children 14-21 Yrs. of Age - Both open and closed between 10/01/18 - 09/30/19 who have a comprehensive plan of care.
Denominator = The Number of Children 14-21 Yrs. of Age - Both open and closed between 10/01/18 - 09/30/19.

ESM 12.2 - Percent of YSHCN enrolled in State CSHCN program who report satisfaction with their transition experience to adulthood.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	50.0	58.0	67.0	77.0	89.0

Field Level Notes for Form 10 ESMs:

None

 Created on 9/15/2020 at 4:21 PM

ESM 13.1.1 - Proportion of at-risk pregnant women who report receiving a preventive dental visit during pregnancy by piloting the First Steps Program.

Measure Status:	Active

State Provided Data

	2016	2017	2018	2019
Annual Objective		28	27.7	28.1
Annual Indicator	27.9	27.6	28	28.8
Numerator	288,998	286,146	292,658	300,040
Denominator	1,036,378	1,036,378	1,045,740	1,041,996
Data Source	Alabama Medicaid Agency and U.S. Census	Alabama Medicaid Agency and U.S. Census	Alabama Medicaid, U.S. Census	Alabama Medicaid, U.S. Census
Data Source Year	2016	2016/17	2017/2018	2018/2019
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives

	2020	2021	2022	2023	2024	2025
Annual Objective	28.9	29.1	29.2	29.4	29.5	29.7

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Beginning with the year 2016 data we utilized Alabama Medicaid data to determine the numerator and the U.S. Census American Fact Finder to determine the denominator. We set an annual improvement of 0.5 percent for objectives in subsequent years.

2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Beginning with the year 2016 data we utilized the most recently available Alabama Medicaid data to determine the numerator and the U.S. Census American Fact Finder to determine the denominator. As of May 25, 2018, the most recent U.S. Census American Fact Finder data according to specific age group breakdown was for the year 2016. The most recent Alabama Medicaid data was for FY 2017. We set an annual improvement of 0.5 percent for objectives in subsequent years. Note, previous year data is not comparable due to differing year data sources.

3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Beginning with the year 2016 data we utilized the most recently available Alabama Medicaid data to determine the numerator and the U.S. Census American Fact Finder to determine the denominator. As of May 5, 2019 the most recent U.S. Census American Fact Finder data according to specific age group breakdown was for the year 2017. The most recent Alabama Medicaid data was for FY 2018. We set an annual improvement of 0.5 percent for objectives in subsequent years. Note, previous year data is not comparable due to differing year data sources.

4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Beginning with the year 2016 data we utilized the most recently available Alabama Medicaid data to determine the numerator. Due to the American FactFinder being decommissioned and no longer available, beginning in the year 2020, we began utilizing the American Community Survey to determine the denominator. As of May 7, 2020, the most recent U.S. Census data according to specific age group breakdown was for the year 2018. The most recent Alabama Medicaid data was for FY 2019. We set an annual improvement of 0.5 percent for objectives in subsequent years. Note, previous year data is not comparable due to differing year data sources.

5.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**

Field Note:
During FY 2018, 1323 maternity patients in 15 counties received care coordination services through the ADPH Social Work program. Staff educated maternity patients about the importance of receiving routine and preventive dental care. Information was made available to these patients about available dental services that in their local communities that offered care on a sliding scale or at no cost. Oral Hygiene kits were also provided to patients and family members. Staff assisted patients with locating dental providers, if needed.

ESM 13.1.2 - Proportion of at-risk pregnant women who are educated about the importance of receiving preventive dental care during pregnancy and assist with linking Medicaid insured to needed dental services by piloting the First Steps Program.

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			50
Annual Indicator			0
Numerator			0
Denominator			7
Data Source			Alabama Medicaid, ADPH Oral Health Branch
Data Source Year			2019
Provisional or Final ?			Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	75.0	75.0	50.0	50.0	50.0	50.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Alabama Medicaid Agency is transforming their Maternity Health Care Coordination services to utilize Maternity Care Providers instead of ADPH Social Work staff. ADPH Oral Health Branch program staff will collaborate with Medicaid to educate and train maternity providers in regard to the importance of patients receiving preventive oral health care services.

In 2019, there were a total of 7 Alabama Coordinated Health Networks (ACHN) providers statewide.

ESM 13.2.1 - Proportion of infants and children, ages 1 through 17 years, who report receiving a preventive dental visit in the past 12 months by piloting the Home by One Program.

Measure Status:	Active

State Provided Data

	2016	2017	2018	2019
Annual Objective		0	5	10
Annual Indicator	0	27.6	28.2	26.4
Numerator		286,146	292,658	273,684
Denominator		1,036,378	1,036,378	1,036,378
Data Source	PRAMS, Medicaid, RCOs, Social Work Program Data	Medicaid, Census	Medicaid, Census	Medicaid, Census
Data Source Year	2017	2017	2018,2017	2019,2010
Provisional or Final ?	Provisional	Final	Final	Final

Annual Objectives

	2020	2021	2022	2023	2024	2025
Annual Objective	15.0	20.0	25.0	30.0	30.0	30.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
At this point, due to data collection restraints, we are unable to provide accurate data that reflects the total number of preventive dental visits among the 1,253 maternity patients who have received or who are currently receiving maternity care coordination services.

It is anticipated social work staff will begin enter data electronically into the ACORN system, the ADPH social work documentation system on/before 10/1/2018. We anticipate that for FY 2018, quarterly and yearly data will be available that reflects the total number of maternity patients assessed and of those patients the number who had a preventive dental visit.

2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
The numerator is based upon the Alabama Medicaid Agency's Form CMS-416: Annual EPSDT Participation Report. The denominator is based upon the 2010 U.S. Census of population.

3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
The numerator is based upon the Alabama Medicaid EPSDT FY 2018 data. The denominator is based upon U.S. Census American Fact Finder data. As of May 17, 2019 the most recent U.S. Census American Fact Finder data according to specific age group breakdown was for the year 2017.

4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
In 2024, if ADPH is providing the same maternity care services as are being provided today to women in 15 counties, the estimated percentage would be 30%.

If the services are being provided by Alabama Medicaid through the ACHN Program, ADPH’s annual objective would be 0 and the ESM would need to be made inactive.

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 3.2 - To improve the system of perinatal regionalization statewide in order to increase the number of very low birthweight (VLBW) deliveries at an appropriate level of care facility.

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			79.6
Annual Indicator			83.5
Numerator			949
Denominator			1,137
Data Source			Center for Health Statistics
Data Source Year			2019
Provisional or Final ?			Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
The Perinatal Division aims to develop strategies to improve the system of Perinatal Regionalization statewide. We aim to promote awareness of the Alabama Perinatal Regionalization System Guidelines statewide. Our goal is to reduce preterm and very low birthweight births in Level 1 and Level 2 hospitals. For this ESM we evaluated the number of very low birth weight delivers in Level 3 and 4 hospitals vs. the number of very low birth weight births statewide.

2016-2020: ESM 5.1 - To conduct the Direct on Scene Education (DOSE) Train-the-Trainer Program to first responders in order to reduce Alabama's high rate of unsafe sleep-related deaths in infants less than one year of age.

Measure Status:				**Active**
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		2.6	2.7	2.5
Annual Indicator	2.6	1.7	2.5	2.5
Numerator	300	215	314	314
Denominator	11,640	12,605	12,660	12,660
Data Source	Office of EMS, Alabama Perinatal Program Director	Office of EMS, Alabama Perinatal Program Director	Office of EMS, The Alabama State Perinatal Program	Office of EMS, The Alabama State Perinatal Program
Data Source Year	2016-2017	2017-2018	2018	2018
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2016**

   Column Name: **State Provided Data**

   Field Note:
   We went from doing a train-the-trainer with the 6 EMS regional directors to educating EMS/EMT personnel statewide and there are 11, 640 EMS/EMTs certified statewide. We have managed to train only 300 of the certified EMS/EMTs across the state to date. As of May 2017, approximately 300 EMS/EMTs in Alabama have been trained to conduct the DOSE Program in their local communities with additional trainings scheduled in the months of June and July. A goal is to train 50 percent of the licensed EMS/EMTs in Alabama on the DOSE program.

2. **Field Name:** **2017**

   Column Name: **State Provided Data**

Field Note:
We are educating EMS/EMT personnel statewide and there are 12,605 EMS/EMTs certified statewide. Per information obtained from our State Perinatal Program Director, as of March 2018 we have managed to train 515 EMS/EMTs (300 in data source years 2016-2017 and 215 in data source years 2017-2018) in Alabama to conduct the Direct on Scene Education (DOSE) Program in their local community. The number of EMS/EMTs trained to conduct the program has been smaller than expected. The collaborating partner, Emergency Medical Services, provides training funds to their regional directors to travel and conduct outreach education to certified EMS and EMTs statewide.

Unexpectedly, the EMS Program funding was decreased thus resulting in less funding for travel and trainings for the regional directors. Collaboration to promote the DOSE Program continues along with several other safe sleep initiatives across the state. A goal is to train 50% of the licensed EMS/EMTs in Alabama on the DOSE program.

3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
We are educating EMS/EMT personnel statewide and there are 12,605 EMS/EMTs certified statewide. Per information obtained from our State Perinatal Program Director, in the year 2018 we managed to train 314 EMS/EMTs in Alabama to conduct the Direct on Scene Education (DOSE) Program in their local community. The number of EMS/EMTs trained to conduct the program has been smaller than expected. The collaborating partner, Emergency Medical Services, provides training funds to their regional directors to travel and conduct outreach education to certified EMS and EMTs statewide.
Unexpectedly, the EMS Program funding was decreased thus resulting in less funding for travel and trainings for the regional directors. Collaboration to promote the DOSE Program continues along with several other safe sleep initiatives across the state. A goal is to train 50% of the licensed EMS/EMTs in Alabama on the DOSE program.

4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
We are educating EMS/EMT personnel statewide and as of 2/21/2020 there were 12,835 EMS/EMTs certified statewide. Per information obtained from our State Perinatal Program Director, in the year 2018 we trained 314 EMS/EMTs in Alabama to conduct the Direct on Scene Education (DOSE) Program in their local community. The number of EMS/EMTs trained to conduct the program has been smaller than expected. The collaborating partner, Emergency Medical Services, provides training funds to their regional directors to travel and conduct outreach education to certified EMS and EMTs statewide.
Unexpectedly, the EMS Program funding was decreased thus resulting in less funding for travel and trainings for the regional directors. Collaboration to promote the DOSE Program continues along with several other safe sleep initiatives across the state. A goal is to train 50% of the licensed EMS/EMTs in Alabama on the DOSE program.
The year 2018 data is the most recently available DOSE training data.

2016-2020: ESM 6.2 - To establish an agreement with the Alabama Partnership for Children's Help Me Grow Program to utilize their online ASQ-3 assessment tool so that parents can complete developmental screens prior to child health visits at county health departments.

Measure Status:		**Active**	
State Provided Data			
	2017	**2018**	**2019**
Annual Objective	5	10	15
Annual Indicator	100	100	100
Numerator	536	23,761	27,494
Denominator	536	23,761	27,494
Data Source	Alabama Medicaid Agency	Alabama Medicaid Agency	Help Me Grow
Data Source Year	2017	2018	2019
Provisional or Final ?	Final	Provisional	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
In order to calculate the number of parents who completed an ASQ3 developmental screening checklist, we added the number of initial and periodic screenings for children 5 and under. This is based upon Appendix A of the January 2018 EPSDT Well Child Check-Up Guidelines distributed by the Alabama Medicaid Agency. No data is available to measure the exact number of parents. This data represents one parent for every child, birth to 5 years of age, seen in the local health departments .

2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
The change to the EHR resulted in no capacity to interface with Alabama Partnership for Children's Help Me Grow (HMG) Program to utilize their online ASQ-3 assessment tool. HMG has agreed to share statewide data. During CY 2018 HMG, First Class Pre-K classrooms statewide, child care centers, family home providers and 4 pediatric practices utilized the online assessment tool to provide 22, 363. Utilizing the same procedure as CY 17 – adding the number of initial and periodic screenings from children 5 and under, 1, 398 ASQ 3 developmental screenings were provided in local health departments through October 31, 2018.

3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
The Alabama Partnership, Help me Grow program reports a total of 27,494 ASQ 3 screenings provided during CY 201.

All ASQ-3 Assessment Tool results are uploaded to the Enterprise Database.

2016-2020: ESM 10.1 - Partner with the University of Alabama at Birmingham (UAB) LEAH Project to provide training and clinical practice quality improvement on youth-centered care to clinicians and other clinic staff using the Bright Futures model.

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		0	5	10
Annual Indicator	0	0	0	0
Numerator		0	0	0
Denominator		900	900	900
Data Source	UAB LEAH Program Evaluation Tools	UAB LEAH Program Evaluation Tools	UAB Leah ACHIA Program Evlauation Tools	UAB LEAH ACHIA Program Evaluation Tools
Data Source Year	2017	2017	2018	2019
Provisional or Final ?	Provisional	Provisional	Provisional	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
The training that is planned as part of implementation is scheduled for a future date. Data will be entered during the next opportunity to report.

2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
There are approximately 900 Alabama Association of Pediatricians (AAP) members, which includes retired members.

3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
There are approximately 900 Alabama Association of Pediatricians (AAP) members, which includes retired members. UAB LEAH, ADPH MCH/Children’s Health and the Alabama Child Health Improvement Alliance (ACHIA) has partnered to develop a Quality Improvement Initiative to train pediatricians about evidence-based practice, coding, difficult conversations, privacy and developmental indicators to increase adolescent well visits.

4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Alabama Association of Pediatricians (AL AAP) continued to make resources available to pediatricians to increase adolescent well visits.

2016-2020: ESM 11.1 - Percent of enrollees in the State CSHCN program with a comprehensive plan of care.

Measure Status:				Active
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		51	70	65
Annual Indicator	56.5	65.8	65.9	66.3
Numerator	5,567	6,766	7,103	7,810
Denominator	9,858	10,287	10,784	11,772
Data Source	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
The data source for this indicator is the CSHCN Program.

2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:

The comprehensive plan of care data source for this indicator is the CSHCN Program. The numerator does not include enrolled clients with a plan of care.

3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
The data represent ESM 11.1.

The comprehensive plan of care data source for this indicator is the CSHCN Program. The numerator does not include enrolled clients with a health/medical plan of care.

4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
The comprehensive plan of care data source for this indicator is the CSHCN Program.
Numerator = Cases with a comprehensive plan of care. The numerator does not include enrolled clients with a health/medical plan of care.
Denominator = Total enrolled.

2016-2020: ESM 11.2 - Percent of providers receiving education/training about family-centered care.

Measure Status:			Active
State Provided Data			
	2017	**2018**	**2019**
Annual Objective	50	42	45
Annual Indicator	40	54.8	49.2
Numerator	200	274	246
Denominator	500	500	500
Data Source	CSHCN Program	CSHCN Program	CSHCN Program
Data Source Year	2017	2018	2019
Provisional or Final ?	Provisional	Provisional	Provisional

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2017**

   Column Name: **State Provided Data**

   Field Note:
   The observed status of this indicator is based on a checklist of several activities in two areas which identified the need for the CSHCN Program to increase its capacity to provide training/in-service to families and health and related professionals about family-centered care. The scoring will be measured yearly for increase or decrease from prior year.

2. **Field Name:** **2018**

   Column Name: **State Provided Data**

   Field Note:
   Beginning with the year 2018 data, we utilized CSHCN Program, FVA (PICS), F2F Training, and Med. Aspects to determine the numerator.

3. **Field Name:** **2019**

   Column Name: **State Provided Data**

   Field Note:
   Beginning with FY 2018, data used from the CSHCN Program included FVA Partners in Care Summit, F2F Training, and Med Aspects to determine the numerator. FY 2019 did not have Med Aspects.

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

Measure Status:	Active
Goal:	Increase the proportion of children aged 12 and 24 months that have a reported blood lead screening.
Definition:	**Numerator:** Number of Alabama children aged 12 and 24 months that have a reported blood lead screening **Denominator:** Number of Alabama children aged 12 and 24 months **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Eliminating EBLLs among children is one of the Healthy People 2020 U.S. national health objectives
Data Sources and Data Issues:	Alabama Department of Public Health Lead Program Data
Significance:	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 blood lead levels above five micrograms per deciliter, the reference level at which CDC recommends public health actions be initiated. No safe blood lead level 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 elevated blood lead levels (EBLLs) than those non-enrolled children, according to national studies.

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 and healthcare providers and related health professionals.
Definition:	**Numerator:** Annual Score on the Checklist Criteria Scoring Tool **Denominator:** Total Possible Points on the Checklist Criteria Scoring Tool **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	MICH-31: Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, and coordinated systems.
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, thus, inaccurate monitoring of progress on meeting the goals and objectives of the measure.
Significance:	Partnerships with individuals/families/family-led organizations is one of the guiding principles in developing the MCH Block Grant. The Title V Maternal and Child Health 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:	**Numerator:** Number of respondents who report receiving comprehensive care coordination services. **Denominator:** Number of survey respondents. **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	MICH-31: Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, coordinated systems.
Data Sources and Data Issues:	Data Source: CRS Care Coordination Family Survey will be developed to measure that comprehensive care coordination services are provide to families. Comprehensive Care Coordination is 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 Children and Youth with Special Health Care Needs 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 as a system domain and a component of the Medical Home and integrated with Community-Based Services.

SPM 4 - Percent of women who smoke during pregnancy
Population Domain(s) – Women/Maternal Health, Child Health, Adolescent Health

Measure Status:	Active
Goal:	To decrease the number of women who smoke during pregnancy.
Definition:	**Numerator:** Number of women who report smoking during pregnancy **Denominator:** Number of live births **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Related to Tobacco Use (TU) Objective 6: Increase smoking cessation during pregnancy (Target: 30.0%)
Data Sources and Data Issues:	WIC Class Participation Data
Significance:	Women who smoke during pregnancy are more likely to experience a fetal death or deliver a low birth weight baby. Adverse effects of parental smoking on children have been a clinical and public health concern for decades. Children have an increased frequency of ear infections; acute respiratory illnesses and related hospital admissions during infancy; severe asthma and asthma-related problems; lower respiratory tract infections; and SIDS. The Health Consequences of Smoking—50 Years of Progress. A Report of the Surgeon General. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014. https://www.surgeongeneral.gov/library/reports/50-years-of- progress/index.html

SPM 5 - Percent of women, ages 18-44, with follow up Colposcopy visit when indicated, in the past year
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Increase the proportion of women ages 18-44 who report receiving a follow up Colposcopy visit when medically indicated, in the past 12 months
Definition:	**Numerator:** Number of women ages 18-44 who report receiving a follow up Colposcopy visit when medically indicated, in the past 12 months **Denominator:** Number of women ages 18-44 **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Related to Access to Health Services (AHS) Developmental Objective 7.0: Increase the proportion of persons who receive appropriate clinical preventive services
Data Sources and Data Issues:	Well Woman Program Data
Significance:	A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. For example, screening and management of chronic conditions such as diabetes, and counseling to achieve a healthy weight and smoking cessation, can be advanced within a well woman visit to promote women's health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes. The annual well-woman visit is recommended by the American College of Obstetrics and Gynecologists (ACOG). http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/Well-Woman-Visit

SPM 6 - 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.
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% of their population with children with special needs.
Definition:	**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 **Unit Type:** Percentage **Unit Number:** 100
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 Early Head Start 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 7 - Percent of staff trained at day care provider/centers on CPR/First Aid
Population Domain(s) – Cross-Cutting/Systems Building

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percent of staff trained at day care provider/centers on CPR/First Aid in the past year</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of staff trained at day care provider/centers on CPR/First Aid in the past year</td></tr>
<tr><td>Denominator:</td><td>Number of staff trained at day care provider/centers in the past year</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Healthy Childcare Alabama Training Data</td></tr>
<tr><td>Significance:</td><td>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 Early Head Start 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</td></tr>
</table>

SPM 8 - Number of modules of the University of Wisconsin-Madison's Population Health Initiative's Health Equity Training Modules completed in order to advance health equity in the Alabama MCH Title V Block Grant Program
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Advance health equity in the Alabama MCH Title V Block Grant Program by utilizing the University of Wisconsin-Madison's Population Health Initiative's Health Equity Training Modules to train Alabama MCH Title V staff
Definition:	**Numerator:** Number of modules of the University of Wisconsin-Madison's Population Health Initiative's Health Equity Training Modules completed **Denominator:** Number of modules of the University of Wisconsin-Madison's Population Health Initiative's Health Equity Training Modules completed **Unit Type:** Count **Unit Number:** 3
Data Sources and Data Issues:	Alabama MCH Title V Block Grant Program Documentation
Significance:	All Alabama communities benefit when health disparities are reduced through policies, practices, and organizational systems. Promoting health equity and reducing health disparities should be encouraged as a guiding principle for the Alabama Title V Program. Over the next 5 year reporting cycle for the MCH Title V Block Grant, ADPH staff will seek to advance efforts to address health disparities for the state's maternal and child population. HEALTH EQUITY TRAINING MODULES HEALTH EQUITY MODULE 1 | INTRODUCTION: The first module begins with an introduction to health equity. It discusses how health is more than just sickness or its absence, and that health inequities are more than just differences in health outcomes. HEALTH EQUITY MODULE 2 | HEALTH & POWER: The second module explores the relationship between health and power, considering what it means to suggest that "the root cause of health inequity is powerlessness." HEALTH EQUITY MODULE 3 | OPERATIONALIZE HEALTH EQUITY: The third module discusses ideas for operationalizing health equity in practice, and specifically looks at opportunities to expand the definition of health, strategically use data, assess and influence the policy context, and strengthen community capacity to act on health inequities.

Form 10
State Performance Measure (SPM) Detail Sheets (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 1 - Percent of CYSHCN and their families who report that they share in decision-making and partnerships with their health care providers.
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	Promote shared decision-making and partnerships between families and health and related professionals
Definition:	**Numerator:** 33 **Denominator:** 33 **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Measurement checklist based on annual data from FVA and the F2F HICs grant, the State CSHCN Program, and Medicaid
Significance:	Based on the findings from Alabama's 2015 Title V MCH Needs Assessment for CSHCN .

2016-2020: SPM 3 - Develop a comprehensive Adolescent Health Program Strategic Plan.
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	Partner with medical professional organizations, schools, and various youth-serving community partners to develop a comprehensive adolescent health strategic plan that will serve to effectively increase the health of Alabama's adolescent population.
Definition:	**Numerator:** Annual Score on the Checklist Criteria Scoring Tool **Denominator:** Total Possible Points on the Checklist Criteria Scoring Tool **Unit Type:** Count **Unit Number:** 24
Healthy People 2020 Objective:	One of the goals of the Healthy People 2020 is to improve the healthy development, safety, and well-being of adolescents and young adults. In particular, AH-1: Increase the proportion of Adolescents who had a wellness checkup in the last 12 months.
Data Sources and Data Issues:	Data Source: Annual Progress will be tracked utilizing a Checklist Criteria Scoring Tool which was created to monitor progress towards development of a strategic plan for an Adolescent Health Program to respond to the changing health priorities routinely faced by children and youth. Criteria on which this measure is rated follows: 1. Identify the strategic planning committee 2. Develop a conceptual framework that describes and defines adolescent health 3. Develop a vision for healthy adolescents 4. Assess needs, assets, and resources 5.Use the results of the FY 2014-15 and ongoing MCH Title V Needs Assessment to identify the specific areas that need to be addressed in order to significantly improve adolescent health 6. Identify strategic issues that need to be addressed to improve adolescent health 7. Formulate recommendations and strategies to address strategic issues 8. Create, disseminate, and implement the strategic plan Note: Criteria will be rated as follows: 0 - Not Met; 1- Partially Met; 2 - Mostly Met; 3 - Completely Met Annually, the criteria will be scored (0-24) and the total score for the year will be entered on Form 10b. Data Issues: Failure to accurately document action on the criteria could lead to inaccurate annual scoring and, thus, inaccurate monitoring of progress on meeting the goals and objectives of the measure.
Significance:	The Adolescent Pregnancy Prevention Branch at the Alabama Department of Public Health (ADPH) currently works to promote healthy adolescent choices during the unique time period in the life cycle that takes one from childhood to adulthood. Staff work to provide resources and presentations to parents, community groups and educators to promote positive youth

	development; collaborate with community action groups to analyze data trends regarding adolescent risk behaviors; provide resources through grants to reduce adolescent pregnancy and sexually transmitted disease rates; and provide information about successful adolescent health initiatives. An Adolescent Health Program is proposed for development in Alabama to respond to the changing health priorities routinely faced by children and youth. The creation of this program in the Alabama Department of Public Health's Bureau of Family Health Services (Bureau) will facilitate coordination of independent programs and services provided to children, youth, and families by multiple organizations into one coherent program in the state. Many components of the infrastructure that is needed to support this program's development contains the basic underlying framework of refined organizational and communication channels that will be needed for the program to become established and sustainable. To build upon the infrastructural component of a successful Adolescent Health Program in the state, it would need to entail: a) Establishment of a Planning Team, b) Assessment of Health Problems and Service Needs, c) Identification of Goals and Objectives, d) Development of Action Plan, e) Implementation of Action Plan, and f) Evaluation of Effectiveness.

2016-2020: SPM 4 - Number of school districts assessed regarding current mental health services
Population Domain(s) – Child Health, Adolescent Health

Measure Status:	Active
Goal:	The goal is to partner with schools and community organizations throughout the state that provide youth-centered services to the child and adolescent populations in order to increase access to appropriate mental health and preventive health services.
Definition:	**Numerator:** Number of school districts assessed regarding current mental health services **Denominator:** Number of school districts in the state **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Mental Health and Mental Disorders: MHMD-6: Increase the proportion of children with mental health problems who receive treatment and MHMD-11.2: Increase the proportion of primary care physician office visits where youth aged 12 to 18 years are screened for depression.
Data Sources and Data Issues:	Data Sources: Alabama Medicaid and Children's Health Insurance Program (CHIP) Data Alabama Department of Education Alabama Department of Mental Health Data from School Systems ADPH Care Coordination Data Data Issues: Possible data issues may include lack of willingness of schools and parents to participate in the program. Additionally, a shortage of mental health providers in the counties coupled with compliance issues may create errors when reporting data.
Significance:	The goals of this measure will be to: * Increase access to appropriate mental and preventive health services through partnership with educators, mental health providers, and other health care providers, as well as community organizations that provide services to children enrolled in the fifth through twelfth grades. * Work collaboratively with these entities to assess appropriate mental health and preventive health services in the school districts. These goals will be accomplished through: 1. Assessing the current mental health services within each school district as well as school staff's knowledge of available services. 2. Educating and training school staff to increase knowledge and understanding of available mental health services as well as other necessary resources in the community. The significance of this measure is to collaborate with community providers, educators, and parents to increase the overall level of understanding within the school systems as it pertains to accessing mental health services for the aforementioned populations.

	The lack of adequate mental and preventive health services for children in the fifth through twelfth grades is a significant problem that needs to be addressed before said children and youth reach adulthood. Partnerships with the above mentioned organizations will increase the number of children who receive needed mental and preventive health services. Accomplishing the previously mentioned goals will increase parents' and educators' understanding of the importance of managing and treating mental health issues. These accomplishments in turn will further facilitate a more positive learning environment for children to be more successful in all aspects of their development and education.

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 2 points annually.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase the proportion of women age 15-55 who report receiving a preventive medical visit in the past 12 months
Definition:	**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 **Unit Type:** Percentage **Unit Number:** 100
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 Well Woman protocol, we can not only monitor the number of women who receive preventive medical visits, but we can also help improve the health outcomes for women and children.

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:	**Numerator:** Number of delivering hospitals represented at the meeting **Denominator:** Number of delivering hospitals in Alabama **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Alabama's State Perinatal Program's 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 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

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:	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
Definition:	**Numerator:** Number of steps of the CDC's Level of Care Assessment Tool (LOCATe) Process completed **Denominator:** Number of steps of the CDC's Level of Care Assessment Tool (LOCATe) Process completed **Unit Type:** Count **Unit Number:** 3
Data Sources and Data Issues:	Alabama Perinatal Regionalization System Data
Significance:	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 our state. 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.

ESM 5.1 - Percent of WIC prenatal participants placing their infants to sleep on their backs
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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>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</td></tr>
<tr><td>Definition:</td><td><table>
<tr><td>Numerator:</td><td>Number of WIC prenatal participants placing their infants to sleep on their backs</td></tr>
<tr><td>Denominator:</td><td>Number of WIC prenatal participants</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table></td></tr>
<tr><td>Data Sources and Data Issues:</td><td>WIC program data or other applicable data sources</td></tr>
<tr><td>Significance:</td><td>Increasing safe sleep education to WIC participants before the birth of the infant helps to raise awareness of safe sleep recommendations and practices thereby increasing the likelihood of the infants being placed on their backs and in safe sleep environments for sleep after delivery.</td></tr>
</table>

ESM 5.2 - 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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>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.</td></tr>
<tr><td>Definition:</td><td><table><tr><td>Numerator:</td><td>Number of sleep-related infant deaths</td></tr><tr><td>Denominator:</td><td>Number of sleep-related infant deaths</td></tr><tr><td>Unit Type:</td><td>Count</td></tr><tr><td>Unit Number:</td><td>200</td></tr></table></td></tr>
<tr><td>Data Sources and Data Issues:</td><td>ADPH's Center for Health Statistics</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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 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:	**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:** 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 **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	Alabama's 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:	Active
Goal:	Increase the proportion of children birth to age 19 that received a well child appointment in the past year.
Definition:	**Numerator:** Number of EPSDT screenings performed in the county health departments in the past year **Denominator:** Number of children birth to age 19 who received services in the county health departments in the past year **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	County Health Departments Electronic Health Records
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:	Active
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:	**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 **Unit Type:** Percentage **Unit Number:** 100
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:	**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 **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Lead program data from the HHLPPPS database
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:	Active
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:	**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 **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Electronic Health Records from County Health Departments
Significance:	Early identification of developmental disorders is critical to the well-being of adolescents and their families.

ESM 12.1 - Percent of YSHCN enrolled in the State CSHCN program with a transition plan in place.
NPM 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

Measure Status:	Active
Goal:	Improve the percentage of CYSHCN ages 14-21 who receives transition services.
Definition:	**Numerator:** The number of youth with special health care needs ages 14-21 receiving transition services. **Denominator:** The total number of youth with special health care needs requiring transition services. **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	2011-2016 indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are not comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.
Significance:	Based on the findings of the Title V Needs Assessment for CSHCN and ongoing challenges in Alabama.

ESM 12.2 - 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 necessary to make transitions to adult health care

Measure Status:	Active
Goal:	To improve the transition experience.
Definition:	**Numerator:** Number of youth that indicate satisfaction regarding their transition experience. **Denominator:** Total number of youth surveyed. **Unit Type:** Percentage **Unit Number:** 100
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. 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 Children and Youth with Special Health Care Needs 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 quality improvement measures to drive program development that supports the achievement of successful outcomes.

ESM 13.1.1 - Proportion of at-risk pregnant women who report receiving a preventive dental visit during pregnancy by piloting the First Steps Program.
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Active
Goal:	To assist identified at-risk women in having healthy pregnancies to avoid poor birth outcomes by obtaining the health, dental, and social services needed.
Definition:	**Numerator:** At-risk pregnant women in need of health, dental, and social services who receive needed services. **Denominator:** At-risk pregnant women in need of health, dental, and social services. **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Data Sources: ADPH PRAMS Data Alabama Medicaid Agency Alabama Social Services Program Data Data Issues: Data issues will vary depending upon the data source in use.
Significance:	By implementing the First Steps Program, comprehensive healthcare services will be promoted for low-income pregnant women. The program's goal will be to assist identified at-risk women in having healthy pregnancies, to avoid poor birth outcomes, and to assist mothers in obtaining the health, dental, and social services that they need.

ESM 13.1.2 - Proportion of at-risk pregnant women who are educated about the importance of receiving preventive dental care during pregnancy and assist with linking Medicaid insured to needed dental services by piloting the First Steps Program.
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Active	
Goal:	To identify maternity health care providers serving Medicaid insured maternity patients. Train and educate 25% of these health care providers about the importance of maternity patients receiving preventative oral health services during pregnancy.	
Definition:	**Numerator:**	The total number of currently established Maternity Care Districts in which ADPH staff have provided care coordination. Goal: Two of the 14 Maternity Care Districts.
	Denominator:	The total number of currently established Maternity Care Districts that provide maternity care services throughout the state. There are 14 established Maternity Care Districts.
	Unit Type:	Percentage
	Unit Number:	100
Data Sources and Data Issues:	Alabama Medicaid, ADPH Programs providing services to Medicaid insured maternity patients.	
Significance:	Through the implementation of the First Steps Program, maternity health care providers will have increased knowledge of the importance of maternity patients receiving preventive oral health care services. The identified providers will educate their maternity patients with this information and assist their maternity patients with accessing preventive oral health services. In September 2017, Alabama Medicaid released a Request for Proposal (RFP) for Maternity Health Care Coordination for the 15 counties currently receiving maternity care coordination services from ADPH social work staff. Once Medicaid identifies a Maternity Care Provider, it is anticipated ADPH will transfer any open maternity case to the selected provider. Ongoing Oral Health education to maternity patients insured by Medicaid is one of the required components of the RFP. This component helps to insure maternity patients continue to receive oral health education and the importance of at least a preventive visit during their pregnancy. As of March 2018, Medicaid has not finalized their plans for Maternity Care Coordination services for Medicaid insured maternity patients. Currently, ADPH social work staff is continuing to provide maternity care coordination services in 15 counties throughout the state. ADPH staff will continue to provide education in regard to the importance of accessing preventive oral health care services and linking patients to needed services. Until Medicaid's plans are finalized, the Office of Oral Health staff and other ADPH social work program staff will collaborate with Medicaid about continuing to educate and train maternity providers in regard to the importance of patients receiving preventive oral health care services.	

ESM 13.2.1 - Proportion of infants and children, ages 1 through 17 years, who report receiving a preventive dental visit in the past 12 months by piloting the Home by One Program.
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Increase the proportion of Alabama's at-risk infants and children, ages 1-17 years, who had a preventive dental visit during the past 12 months.
Definition:	**Numerator:** Number of infants/children ages 1-17 years who received a preventive dental visit in the past 12 months. **Denominator:** Number of infants/children ages 1-17 years in Alabama. **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Data Sources: Alabama Medicaid Agency Utilization Rate Data (for preventive dental visits); Alabama Children's Health Insurance Program (CHIP) Utilization Rate Data (for preventive dental visits); and Alabama Blue Cross Blue Shield Utilization Rate Data (for preventive dental visits). Data Issues: Data issues will vary depending upon the data source in use.
Significance:	The implementation of the Home by One Program can increase the proportion of infants/children in Alabama who have established dental homes and are accessing routine preventive dental visits.

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 3.2 - To improve the system of perinatal regionalization statewide in order to increase the number of very low birthweight (VLBW) deliveries at an appropriate level of care facility.
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:	To improve the system of perinatal regionalization statewide in order to increase the number of very low birthweight (VLBW) deliveries at an appropriate level of care facility.
Definition:	**Numerator:** VLBW deliveries in Level 3 and Level A hospitals **Denominator:** Number of VLBW births statewide **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Alabama Department of Public Health's Center for Health Statistics
Significance:	Alabama continues to focus on preterm births with the selection of a new ESM to address improving the system of perinatal referral and transfer for high risk mothers and infants. In collaboration with the CoIIN Perinatal Regionalization Workgroup, the Alabama Hospital Association, the Alabama Chapter-American Academy of Pediatrics, the Alabama Section-American Congress of Obstetricians and Gynecologists, and others the Alabama Perinatal Regionalization System Guidelines were established. The State Perinatal Advisory Committee made a recommendation to the State Health Officer in August 2017 to endorse the Alabama Perinatal Regionalization System Guidelines as best practice for providing care to high risk women and infants. In September 2017, the State Committee of Public Health approved and signed a Resolution that acknowledged the Guidelines as best practice. In December 2017, a small subset of the CoIIN work group met to determine next steps in moving the initiative forward. A data collection tool was created for Level 1 and Level 2 hospitals to collect information on the number of VLBW infants born in their facility. Utilizing the Alabama Public Health Training Network, Dr. Scott Harris, State Health Officer, recorded a five minute video reviewing the four neonatal levels of care. The Alabama Hospital Association has developed a one page informational flyer and survey to allow all delivering hospitals in Alabama to self-declare their neonatal level of care. Hospitals will be provided the data collection tool and asked to complete the tool for any infant born in a Level 1 or Level 2 hospital that weighs less than 1,500 grams or is less than 32 weeks gestation. This tool is for hospital use only. Alabama is a state that does not regulate delivering hospital's neonatal levels of care. Annually the hospitals are surveyed by SHPDA, and self-declare the neonatal level of care. ADPH will collaborate with SHPDA.

2016-2020: ESM 5.1 - To conduct the Direct on Scene Education (DOSE) Train-the-Trainer Program to first responders in order to reduce Alabama's high rate of unsafe sleep-related deaths in infants less than one year of age.
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:	Train 50 percent of registered Emergency Medical Responders and Emergency Medical Technicians to conduct the Direct On Scene Education (DOSE) Program in local communities across Alabama.
Definition:	**Numerator:** The number of licensed Emergency Medical Responders and Emergency Medical Technicians who have received DOSE training. **Denominator:** The total number of Emergency Medical Responders and Emergency Medical Technicians licensed by the Office of Emergency Medical Services and Trauma in Alabama. **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Data Source: Office of Emergency Medical Services reports Data Issues: EMSC data updated annually and may not account for new employees or changes in work certification status.
Significance:	Training EMSC regional coordinators who can then train first responders within their region to conduct activities associated with the DOSE Program will provide the EMSC regional coordinators with tools necessary to assess and provide education related to reducing the risks of unsafe sleep environments in the homes of families with pregnant women and infants less than one year of age. Additionally, reducing sleep-related infant deaths would address three of the Healthy People 2020 goals: MICH-1.3: Reduce the rate of infant deaths from sudden unexpected infant death (includes SIDS, unknown cause, and accidental suffocation and strangulation in bed). First responders have a unique opportunity that nurses, physicians, and other providers of care do not; namely, they are able to see families in their home environment and visually assess an infant's sleeping environment while educating, not just the mother, but the whole family, on ways to reduce risk factors associated with SIDS/SUID, asphyxia, suffocation, and/or strangulation.

2016-2020: ESM 6.2 - To establish an agreement with the Alabama Partnership for Children's Help Me Grow Program to utilize their online ASQ-3 assessment tool so that parents can complete developmental screens prior to child health visits at county health departments.
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:	To establish an agreement with the Alabama Partnership for Children's (APC) to utilize the ASQ-3 online assessment tool for parents to complete a developmental screening during child health visits at county health departments.
Definition:	**Numerator:** The total number of parents, who bring their children to Well-Child Clinics at county health departments, who complete online developmental screening tools prior to child health visits. **Denominator:** The total number of parents, who bring their children to Well-Child Clinics at county health departments. **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	The Ages and Stages Questionnaire (ASQ-3) Online Enterprise Tool which is an evidence-based, parent-completed tool for developmental screening. Aggregate data and reports will be obtained from the APC. Data Issues: Potential issues to ensure that the numerator and denominator are captured accurately include the following: ADPH must establish a Business Associates Agreement (BAA) with APC's Help Me Grow (HMG) Program and Brookes Publishing Company, the owner of the ASQ-3 assessment tool. This system will be interfaced with the ADPH Electronic Health Record system. HMG is working with early childhood system partners to build upon existing efforts and infrastructure to ensure Alabama can more effectively coordinate, improve, and track developmental screenings and referrals for young children across Alabama. The ASQ-3 Online management system increases the accuracy of reporting and efficiency of processes through automation.
Significance:	A public health issue, across the state of Alabama and across the nation, is the low rates of preventive health and developmental screening of children. Additionally, Alabama's FY 2014-15 5-Year Statewide Needs Assessment revealed that there is a perceived lack of resources and support to promote parenting skills and child development among new parents of young children. Through this strategy measure, both aforementioned issues can be combatted by transforming the lives of vulnerable families and ensuring that those families get hands-on support and access to developmental screening from birth to age 2. To foster a collaborative spirit and to integrate with already-established programs, ADPH staff plans to work closely with Help Me Grow in this initiative. Alabama developed its Help Me Grow Initiative in 2012 and, in 2015, received funding to expand services statewide. By working through the state's 2-1-1 System, Help Me Grow has developed a single point of entry for families and service providers to access screening, referral, and case management services. Help Me Grow recently purchased the ASQ-3 Online Enterprise Tool, allowing care

	providers, teachers, and parents easy access to evidence-based developmental screening instruments. This online system carries with it the capacity for Help Me Grow to amass, analyze, and report on children's developmental status in Alabama. Thus, through linkage with Help Me Grow, ADPH's own access to data would be strengthened. Furthermore, since Nurse Family Partnership only follows families through age 2 of the child, linkage with Help Me Grow would allow that entity to continue to follow up with families through 71 months of age. That is, after age 2, the family would be referred to Help Me Grow. The Help Me Grow Program would then continue to be the point of contact for those families in the coming years to continue to move the needle on Alabama's positive contribution towards NPM 6.

2016-2020: ESM 10.1 - Partner with the University of Alabama at Birmingham (UAB) LEAH Project to provide training and clinical practice quality improvement on youth-centered care to clinicians and other clinic staff using the Bright Futures model.

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 capacity for training and quality improvement efforts on adolescent-centered care to clinicians and other clinic staff, using the Bright Futures model, through a partnership established with the HRSA-funded UAB LEAH project.</td></tr>
<tr><td>Definition:</td><td><table><tr><td>Numerator:</td><td>Number of Healthcare Providers Trained</td></tr><tr><td>Denominator:</td><td>Number of Healthcare Providers in Alabama</td></tr><tr><td>Unit Type:</td><td>Percentage</td></tr><tr><td>Unit Number:</td><td>100</td></tr></table></td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Sources:

UAB Leadership and Education in Adolescent Health (LEAH) Program Evaluation Tools
NSCH (National Survey of Children's Health) data for Alabama

Data will be collected through the aforementioned partnership using the UAB LEAH program evaluation tools. This data will measure the number of healthcare providers trained through this partnership.

Additionally, NSCH Alabama data will be used to establish a baseline of the percentage of adolescents who received at least 1 well visit in the last year. Once the strategic plan is in the implementation phase, the baseline percentage will be the measure against which improvement in NPM 10 is tracked.

Data Issues:

Issues may include: difficulty integrating with the database maintained by the UAB LEAH Project in order to keep an accurate account of the number of healthcare providers who are trained through this partnership, difficulty identifying and reaching all healthcare providers who need to receive the training; and difficulty getting providers to agree to be trained via this partnership.</td></tr>
<tr><td>Significance:</td><td>Today's adolescents struggle with a wide range of health care needs related to a variety of social, economic, and environmental factors. Adolescents in the southeastern U.S., of which Alabama is a part, are particularly plagued by these health concerns. Over 21 percent of Alabama's adolescents aged 12-17 had no preventive medical care visits in 2011-12 compared to 18.3 percent nationally.

Adolescence provides a unique opportunity to invest in the health and well-being of youth. Good health (physical, emotional, social, and spiritual) enables young people to make the most of their teenage years, while laying a strong foundation for adult life. Lifestyle behaviors developed during adolescence often continue into adulthood and influence long-term prospects for health and risk for chronic disease. Yet, improving the health and well-being of adolescents is a challenging endeavor. UAB LEAH is committed to improving the health status of adolescents, particularly those in the southeastern region of the U.S. To improve adolescent health and build capacity among healthcare providers statewide, collaboration between ADPH and the UAB LEAH is necessary.</td></tr>
</table>

2016-2020: ESM 11.1 - Percent of enrollees in the State CSHCN program with a comprehensive plan of care.
2016-2020: NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Promote Medical Home
Definition:	**Numerator:** 100 **Denominator:** 100 **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	2011-2016, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are not comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.
Significance:	Based on findings from the 2015 Title V Needs Assessment for CSHCN and on-going challenges in the State of Alabama.

2016-2020: ESM 11.2 - Percent of providers receiving education/training about family-centered care.
2016-2020: NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Promote Medical Home
Definition:	**Numerator:** 100 **Denominator:** 100 **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	The State CSHCN Program, Family Voices of Alabama, and the Family-to-Family Health Information Center
Significance:	Based on findings from the 2015 Title V Needs Assessment for CSHCN and on-going challenges in the State of Alabama.

Form 11
Other State Data

State: Alabama

The Form 11 data are available for review via the link below.

Form 11 Data

State of Alabama
Maternal and Child Health Services Block Grant
2019 Annual Report/2021 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.	Assurances and Certifications
Supporting Document #01	Organizational Charts
Supporting Document #02	Acronyms and Abbreviated Names

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

September 15, 2020

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

To Whom It May Concern:

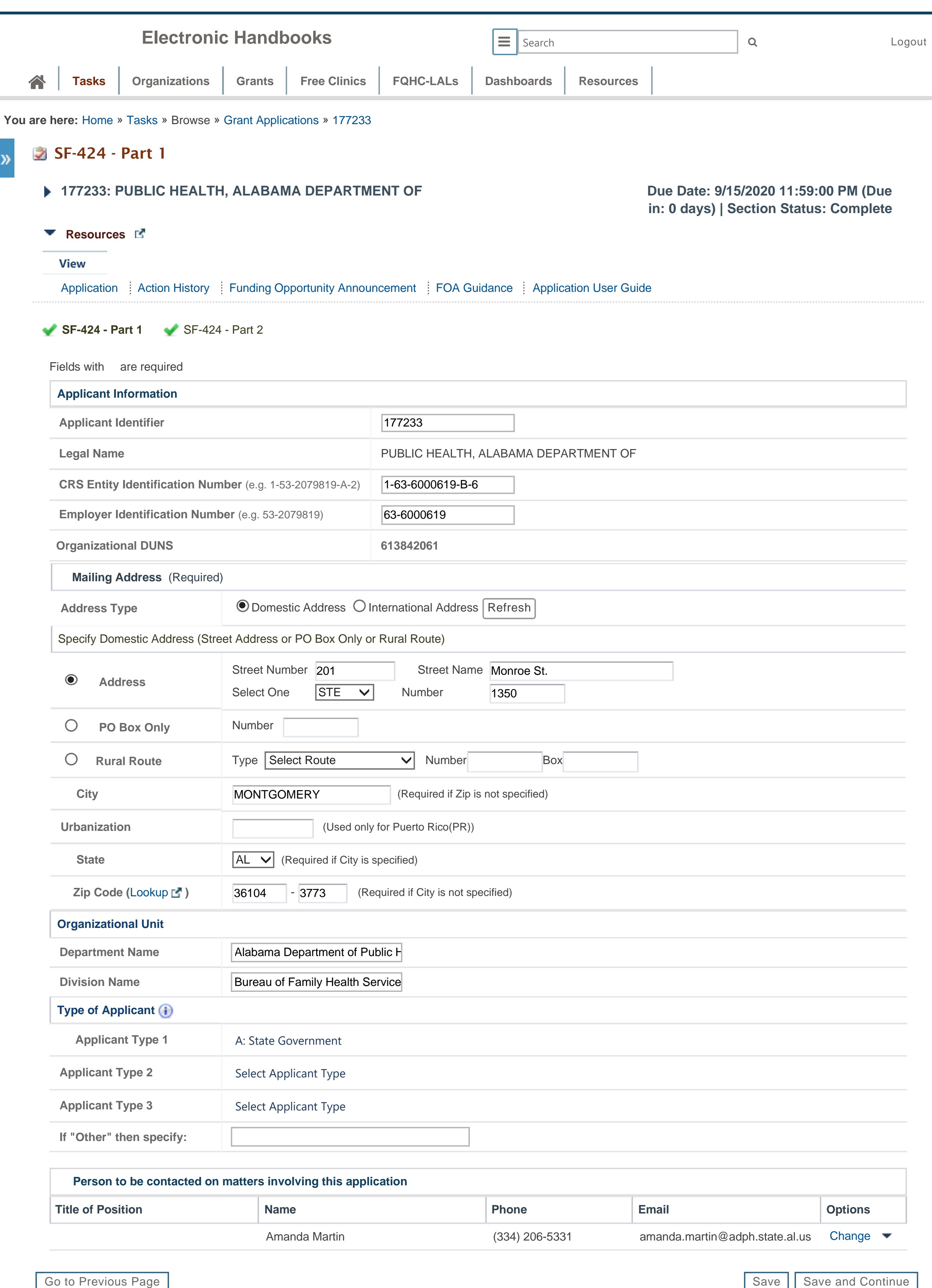
On behalf of the Alabama Department of Public Health, I am submitting the State of Alabama's Maternal and Child Health Services Block Grant FY 2019 Annual Report and FY 2021 Application. The document is being submitted electronically using the web-based application format for the document. Per our understanding 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. You may reach me at 334-209-5331 or email me at Amanda.Martin@adph.state.al.us.

Sincerely,

Amanda C. Martin, M.S.P.H.
Deputy Director
Bureau of Family Health Services

ACM/TRY



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SF-424 - Part 1

177233: PUBLIC HEALTH, ALABAMA DEPARTMENT OF

Due Date: 9/15/2020 11:59:00 PM (Due in: 0 days) | Section Status: Complete

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SF-424 - Part 1 SF-424 - Part 2

Fields with are required

Applicant Information

Applicant Identifier	177233
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 DUNS	613842061

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
	Amanda Martin	(334) 206-5331	amanda.martin@adph.state.al.us	Change

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Product: EHBs

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SF-424 - Part 2

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Information entered on the 'Part 1' page was saved successfully. The Section status is **Complete**.

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Due Date: 9/15/2020 11:59:00 PM (Due in: 0 days) | Section Status: Complete

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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

Congressional Districts

Applicant	AL-02
Program/Project	AL-All Districts

Additional Program/Project Congressional Districts (Maximum 1) Attach File

No documents attached

Proposed Project Period

Start Date	10/1/2020
End Date	9/30/2022

Estimated Funding

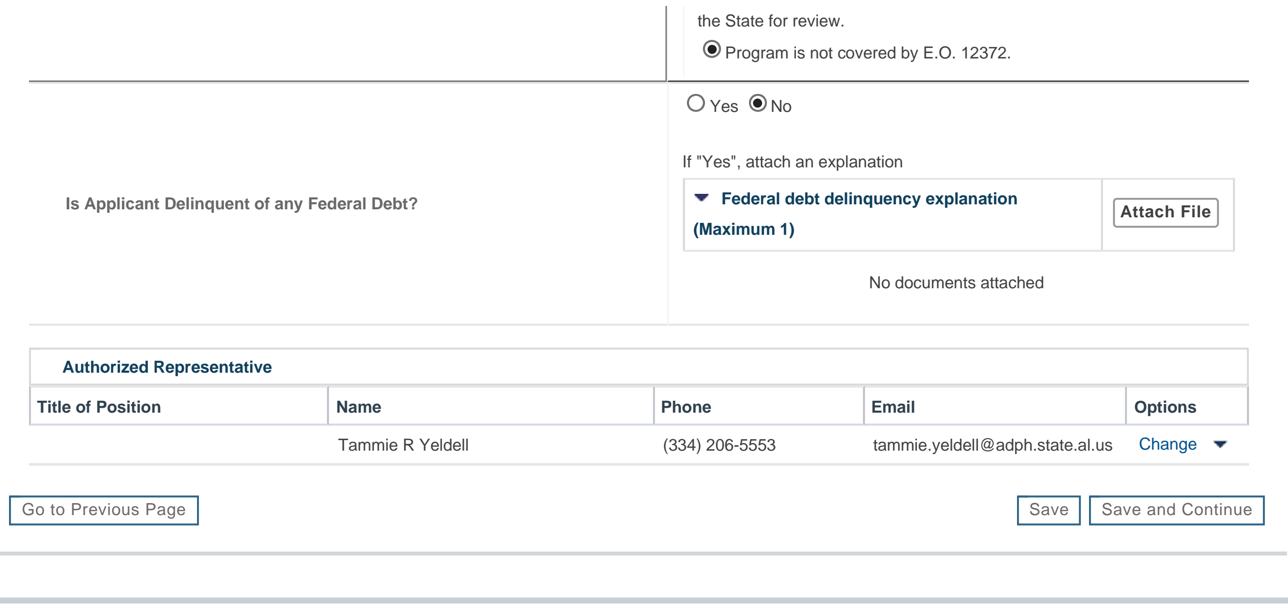
Federal (This amount is populated from Budget Section A - Total Federal New or Revised Budget.)	$11,401,820.00
Applicant (This amount is populated from Budget Section C - Non Federal Resources.)	$0.00
State (This amount is populated from Budget Section C - Non Federal Resources.)	$24,722,324.00
Local (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.)	$1,571,751.00
Program Income (This amount is populated from Budget Section C - Non Federal Resources.)	$32,132,060.00
Total	$69,827,955.00

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
	Tammie R Yeldell	(334) 206-5553	tammie.yeldell@adph.state.al.us	Change

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CERTIFICATIONS

OMB Approval No. 0990-0317

1. CERTIF1CATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIF1CATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The authorized official signing for the applicant organization certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The official signing agrees that the applicant organization will comply with the HHS terms and conditions of award if a grant is awarded as a result of this application.

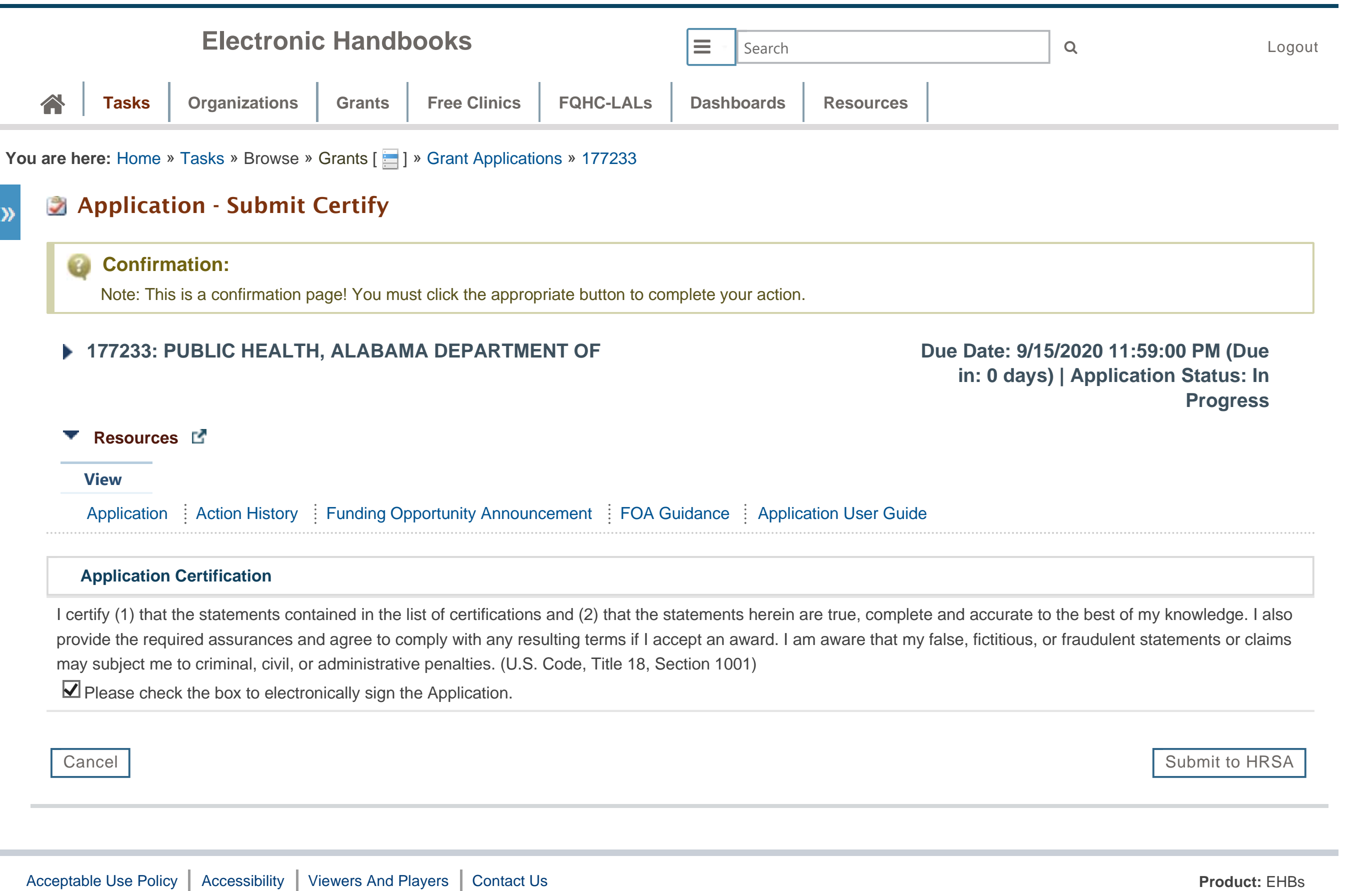
3. CERTIF1CATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defmed by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

HHS strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the HHS mission to protect and advance the physical and mental health of the American people.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Due Date: 9/15/2020 11:59:00 PM (Due in: 0 days) | Application Status: In Progress
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Application User Guide
Application Certification
I certify (1) that the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances and agree to comply with any resulting terms if I accept an award. I am aware that my false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 18, Section 1001)
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Supporting Document

Topic	Page
Organizational Charts	Attachment

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, J.D.
  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**
- **Health Statistics** — Nicole Rushing
  Administrative Services, Quality Assurance and Registration, Record Services, Special Services, Statistical Analysis
- **Information Technology** — Regina Patterson
  Administration, Business and Information Architecture, Clinical Systems, Database Administration, Logistics, Project Management Support, Systems Development and Integration, Technical Support
- **Centralized Billing Unit** — Arnita Shepherd

Chief Medical Officer
Mary McIntyre, MD, MPH

- **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** — Grace Thomas, MD
  - **Family Health Services** — Grace Thomas, MD
    Administration, Cancer Prevention and Control, Oral Health, Perinatal Health, Women's and Children's Health, WIC
- **Medical Director (Acting), Health Provider Standards** — Mary McIntyre, MD, MPH
  - **Health Provider Standards** — Dennis Blair
    Assisted Living, Medicare Other, Nursing Home, CLIA, Licensure, Certification
- **Home and Community Services** — Shelia Duncan
  Accounts Payable, Accounts Receivable, Budget and Personnel, Home Care Services
- **HIV Prevention and Care** — Sharon Jordan, BS, MPH

General Counsel
Brian Hale, JD

- **Compliance**

Chief of Staff
Michele Jones, MS

- **Emergency Medical Services** — Stephen Wilson, BS, NRP
- **Environmental Services** — Sherry Bradley, MPA
  Community Environmental Protection, Food/Milk Lodging
- **Prevention, Promotion, and Support** — Jamey Durham, MBA
  Chronic Disease, Emergency Preparedness, Health Behavior, Health Media and Communications, Management Support, Minority Health, Nutrition and Physical Activity, Performance Management and Accreditation, 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** — Gavin Graf
- **Telehealth** — April Golson

Governmental Affairs and Community Relations
Carolyn Bern, MPA

Scott Harris

Bureau of Family Health Services
Director - Grace Thomas (PHPD)

Assistant to Bureau Director
D'Tanja Brock (ASA 3)

Medical Director
Vacant (PHPS)

Deanah Maxwell (PHPS)
Lynda Gilliam (PHPS)

Assistant to Bureau Deputy Director
Tarina Moores (ASA 3)
Ruthie Spencer (RSE)

Deputy Director - Amanda Martin (HSA 4)

Administrative Division

Director
Dan Milstead (HSA 3)
Assistant Director
Claudia Cauthen (SR ACCT)

Tarina Moores (ASA 3)

Financial Management
Dan Milstead (HSA 3)
Claudia Cauthen (SR ACCT)
Crystal Duckworth (ACCT)
Greg Roberts (AT)

Contract Management
Vacant (HSA 1)

Pediatric Consultant
Karen Landers (PHPD)

Oral Health
Tommy Johnson (DD)
Jennifer Morris (RDH)
Summer Macias (PI Spec)
Jessica Durham (ASA 2)

Cancer Prevention and Control Division

Director
Nancy Wright (HSA 3)
Assistant Director
Amy Stratton (NM)

Misty Price (ASA 3)

Cancer Prevention
Vacant (HSA 2)
Stephen Jaye (HSA 1)
Carol Garrett (HSA 1)
Vacant (PHE)
Vanessa Motley (HSA 1)

Cancer Epidemiology
Justin George (Epi Sup)
Tim Feuser (Epi)
Edana Huffman (Epi)
Mirwais Zhuben (Epi)
Linda Forney (RSE)

Cancer Registry
Aretha Bracy (HSA 2)
Vacant (PHRA 2)
Mark Jackson (CTR Sr)
Farzana Salimi (PHRA 2)
Diane Hadley (PHRA 2)
Angela Gaston (PHRA 2)
Vacant (PHRA 1)
Cassandra Glaze (PHRA 2)
Elaine Wooden (PHRA 1)
Vacant (ASA 3)
Katelynn Thompson (PHRA Trainee)

Breast and Cervical Cancer
Amy Stratton (NM)
Kay Mathews (HSA 2)
Kelli Hardy (NC)
Rhonda Hollon (SW Sr)
Maxine Hawthorne (ASA 2)
Kelsey Thomas (ASA 2)
Caroline Jones (ASA 2)
Janet Sudduth (ASA 2)
Shandra Graham (ASA 2)
Hazel Cunningham (SW Sr)
Jackie Wilson (HSA1)
Vonda Buckhault (NC)
Elaine Goodman (NC)
Cindy Brewer (NC)

Perinatal Health Division

Director
Janice Smiley (HSA 3)
Assistant Director
Tammie Yeldell (Epi Sup)

Daphne Buskey (ASA 3)

State Perinatal
Vacant (NM)
Lisa Carter (NS)
Pamela Farris (NC)
Trendle Samuel (NS)
Janise Norman (NC)
Cathy Nichols (NS)
Toni Beasley (NC)
Tonya Troncalli (NC)
Vacant (NS)
Shirley Daniel (NS)
Vacant (NC)
Deborah Davis (RSE)
Lindsay Harris (NC)
Vacant (ASA 2)

MCH Epidemiology
Tammie Yeldell (Epi Sup)
Alice Irby (Epi Sr)
Miranda Daniels (Epi)
Julie Nightengale (PHRA 3)
William Duncan (PHRA 2)
Fu Zhao (PHRA 3)
Kristen Johnson (Epi)
Taishayla McKitt (Epi)
Tara Harriel (ASA 3)

MCH Coordinator
Samille Jackson (HSA 2)

Newborn Screening
Rachael Montgomery (NM)
Mary Ellen Whigham (NS)
Vacant (NS)
Leanna Rambo (NS)
Nancy Strong (NC)
Stephanie Rhodes (NC)
Lynne Landry (ASA 2)

Infant Mortality Prevention
Tracie West (SW Sr)

Child and Adolescent Health Division

Director
Meredith Adams (HSA 3)
Assistant Director
Sandy Powell (NM)

Javette Jones-Gadson (ASA 3)
Bronett Terrell (ASA 1)

Children's Health
Sandy Powell (NM)
Anna Moore (ASA 2)

Lead
Seratia Johnson (NS)
Mallory Rigsby (HSA 1)
Erika Denny (ASA 2)
Anna Moore (ASA 2)

Healthy Child Care Alabama
Thresa Dix (NS)
Julie Till (NS)
Nona Smith (ASA 2)
Katie Brent (ASA 2)
Gwen Kennedy (NC)
Sheila Davis (NC)
Daphne Pate (NC)
Vacant (NC)
Ann Fox (NC)
Karen Cobb (NC)
Ginger Letson (NC)
Crystal Page (NC)
Alicia Boykin (NC)
Marsha Galloway (NC)
Judy Cunningham (NC)
Teresa Goad (NC)
Deborah Weaver (NC)
Pamela Senters (NC)
Vacant (NC)
Vacant (NC)

Social Work
Carolyn Miller (SWM)
Vacant (SW Sup)
Dianne Chandler (SW Sup)
Melissa Godwin (SW Sup)
Pamela Foster (SW Sr)
Rebekah Smay (SW Sr)
Vacant (SW Sr)
Charlena Freeman (RSE)

Adolescent Health

Adolescent Pregnancy Prevention
Valerie Lockett (HSA 2)
Jasmine Abner (PHES)
Chelsei Martin (PHE)
Vacant (SW Sr)
Kimberly Cole (ASA 2)

WIC Division

Director
Allison Hatchett (HSA 3)
Assistant Director
Vacant (Nutr A)

Vacant (ASA 3)
Yolanda Johnson (ASA 2)

Nutrition Services
Vacant (Nutr A)
Janie Clay (NAA)
Margaret Stone (NAA)
Mandy Darlington (NAA)
Twanna Brown (NAA)
Angela McCormick (NAA)
Michell Grainger (NS)

WIC Training Clinic
Twanna Brown (NAA)
Carmalita Green (Nutr Sr)
Christine Long (ASA 3)
Vacant (ASA 2)

Breastfeeding/Peer Counseling
Michell Grainger (NS)
Vacant (Nutr Sr)

Vendor Management
Ashley Johnson (HSA 2)
Debbie Free (AT)
Vacant (HSA 1)
Vacant (Spec Inv)
Charlie Martin (Spec Inv)
Kenny Thomas (Spec Inv)

Operations Branch
Kimberly Smith (HSA 2)
Deanna Maddox (HSA 1)
Austin Atkins (HSA 1)
Phil Tucker (ASA 2)
Larry Harris (St Clk)

Crossroads State Agency Model (SAM) Project
Kimberly Smith (HSA 2)
Maggie Gates-Kilgore (PC-CE)

Women's Health Division

Director
Beth Allen (NPD)
Assistant Director
Jessica Hardy (NA)
(Telehealth Consultant)

Toni Russell (ASA 3)
Jessa Powell (ASA 3)

State Clinical Operations
DaJuna Tatom (NPS)
Neysa Hernandez (NPS)
Stephanie Phillips (NPS)
Krysta Hood (NPS)
Vacant (NM)
Thelma McDade (NC)

Office of Women's Health
Jessica Hardy (NA)
Jessa Powell (ASA 3)
Likhita Raparti (Stu Aide)

Well Woman
Sabrina Horn (NC)

Family Planning Plan First/Title X

Clinical
Laurie Gregory (NM)
Nikki Kiefer (HSA 1)
Vacant (ASA 2)

Administrative
Chelsea McLaurine (HSA 2)
Dechete Gordon (PHES)

Abbreviations:

ACCT - Accountant
ACCT Clk - Account Clerk
ASA - Administrative Support Assistant
AT - Account Technician
Cler Aide - Clerical Aide
CTR Sr - Certified Tumor Registrar Senior
DD - Dental Director
Epi - Epidemiologist
Epi Sr - Epidemiologist Senior
Epi Sup - Epidemiologist Supervisor
HSA - Health Services Administrator
NA - Nurse Administrator
NAA - Nutritionist, Assistant Administrator
NC - Nurse Coordinator
NM - Nurse Manager
NPD - Nurse Practitioner Director
NPS - Nurse Practitioner Senior
NS - Nurse Supervisor
Nutr A - Nutritionist, Administrator
Nutr Sr - Senior Nutritionist
PC-CE - Project Coordinator (Contract Employee)
PHE - Public Health Educator
PHES - Public Health Educator Senior
PHPD - Public Health Physician Director
PHPS - Public Health Physician Senior
PHRA - Public Health Research Analyst
PI Spec - Public Information Specialist
PM-CE - Project Manager (Contract Employee)
RDH - Registered Dental Hygienist
RSE - Retired State Employee
Spec Inv - Special Investigator
Spec Inv Chief - Special Investigator Chief
SR ACCT - Senior Accountant
St Clk - Stock Clerk
SPT - State Professional Trainee
Stu Aide - Student Aide
SW Sr - Social Worker Senior
SW Sup - Social Worker Supervisor
SWM - Social Worker Manager
TC - Training Coordinator

Grace Thomas MD (signature)

Grace Thomas | June 1, 2020
Date

Alabama Department of Rehabilitation Services Organizational Chart

Governor of Alabama

Alabama Board of Rehabilitation Services

Commissioner

Internal Audit
Audit Manager

Communications and Information
Governmental Relations Manager

Computer Services
Chief Information Officer

Human Resource Development
HR Director
- Personnel
- Recruiting and Diversity
- Staff Development and Training

Finance Division
Chief Financial Officer
- Accounting
- Purchasing
- Supply

Legal Division
Staff Attorney

Early Intervention
State Coordinator
State Office Staff
Field Staff

SAIL/Homebound
State Coordinator
State Office Staff
Field Staff

Business Relations
State Coordinator
State Office Staff

Children's Rehabilitation
Assistant Commissioner
- Field Supervision
  - Field Staff
- State Office Staff

Vocational Rehabilitation-General
Assistant Commissioner
- Field Supervision
  - Field Staff
- State Office Staff

Vocational Rehabilitation-Blind/Deaf
Assistant Commissioner
- Field Supervision
  - Field Staff
- State Office Staff

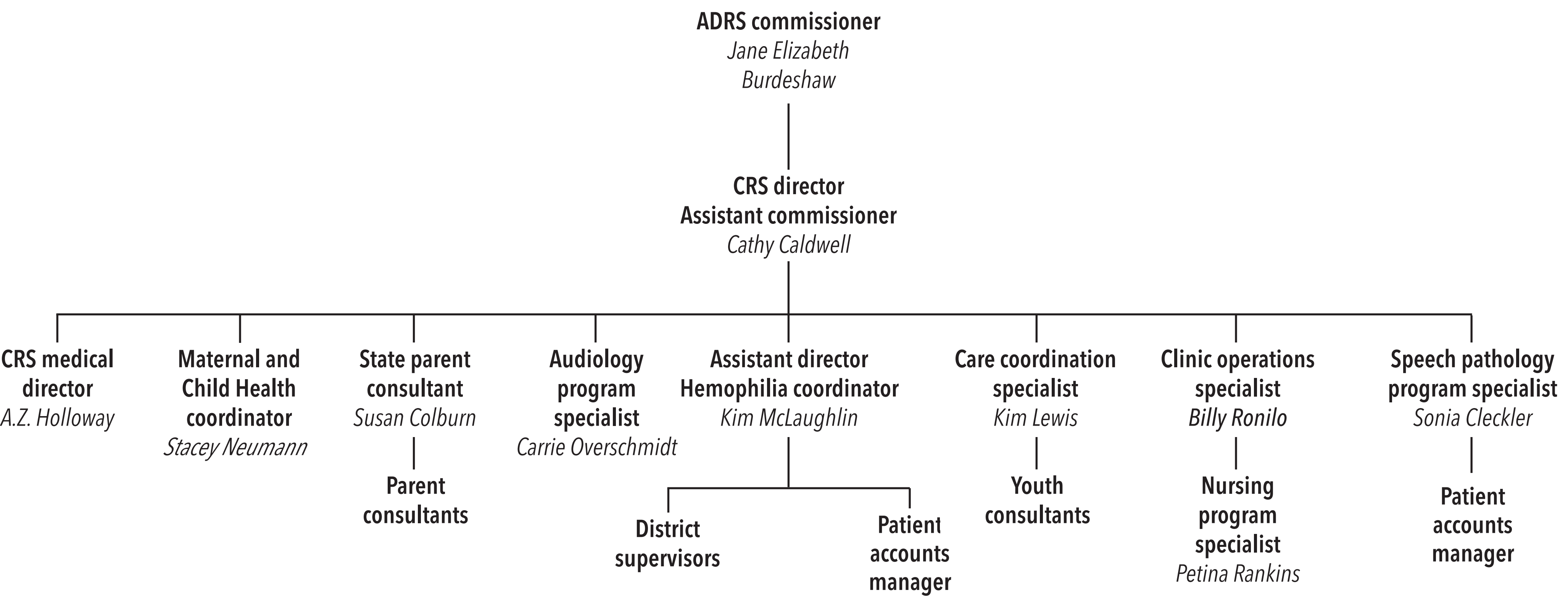
Dec. 9, 2016

Commissioner, Alabama Department of Rehabilitation Services

Alabama's children and adults with disabilities

Children's Rehabilitation Service

Organizational Chart



06/19

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	The 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
AFF	American FactFinder
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
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
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
Census	U.S. Census, U. S. Census Bureau
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
CI	Confidence Interval
CJIC	Criminal Justice Information Center
CMC CoIIN	Children with Medical Complexity (CMC) Collaborative Improvement and Innovation Network (CoIIN)
CMS	Centers for Medicare and Medicaid Services (located in the U.S. Dept. of Health and Human Services)
COA	Children's Hospital of Alabama
COBRA	Consolidated Omnibus Budget Reconciliation Act
COIIN	Collaborative Improvement and Innovation Network to Reduce Infant Mortality
CPC	Children's Policy Council
CRS	Children's Rehabilitation Service
CRT	Case Review Team
CSHCN	Children with Special Health Care Needs
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
DMH	Alabama Department of Mental Health
DOSE	Direct On Scene Education
ECCS	Early Childhood Comprehensive Systems
ECHD	Escambia County Health Department
e.g.	For Example
EHBs	Electronic Handbooks
EHCC	Eco-Healthy Child Care
EHS	Early Head Start
EI	Early Intervention Program
EIS	Alabama Early Intervention System
EBLL	Elevated Blood Lead Level
EMSC	Emergency Medical Services for Children
EMST	Emergency Medical Services and Trauma
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment; Early Periodic Screening, Diagnosis, and Treatment
ESMs	Evidence-Based or –Informed Strategy Measures
ETF	Education Trust Fund

EWSE	Every Woman Southeast
F2FHIC	Family to Family Health Information Center
FAD	Federally-Available Data
Family Planning	Alabama Department of Public Health's Family Planning Program
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
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
HIV	Human Immunodeficiency Virus
HIPAA	Health Insurance Portability and Accountability Act
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
ImmPrint	Immunization Provider Registry with Internet Technology, Immunization on Provider Registry with Internet Technology
IMR	Infant Mortality Rate
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
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)
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
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
Medicaid	Alabama Medicaid Agency
MMA	Methylmalonic Acidemia
MOU	Memorandum of Understanding
NASHP	National Academy for State Health Policy
NCQA	National Committee for Quality Assurance
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
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
NPM	National Performance Measure
NSCH	National Survey of Children's Health
NSCH-CSHCN	National Survey of Children with Special Health Care Needs
NSP	Newborn Screening Program
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
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
PKU	Phenylketonuria
Plan First	Family Planning Medicaid Waiver
PRAMS	Pregnancy Risk Assessment Monitoring System
PREP	Personal Responsibility Education Program
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
RPACs	Regional Perinatal Advisory Councils
RWJ	Robert Wood Johnson
SAIL	State of Alabama Independent Living Program
SAM	Crossroads State Agency Model
SAMHSA	Substance Abuse and Mental Health Services Administration
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
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
SPC	State Parent Consultant
SPM	State Performance Measure
SPP	State Perinatal Program
SPTF	Alabama State Suicide Prevention Task Force
SSA	Social Security Administration
SSDI	State Systems Development Initiative
SSI	Supplemental Security Income
STAR	Alabama's Assistive Technology Resource Program
State	State of Alabama
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
SUID	Sudden Unexpected Infant Death
SUDI	Sudden Unexpected Death in Infancy
SRV	Secure Remote Viewer
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
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
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
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