Maternal and Child Health Services Title V Block Grant

Alabama

FY 2022 Application/ FY 2020 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

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

August 27, 2021

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 2020 Annual Report and FY 2022 Application. The document is being submitted electronically using the Web-based application format for the document. Per our understanding of the federal guidance, the document is now submitted entirely via the Web, and no paper copies of this letter or any part of the application are required.

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

Sincerely,

Jessica Hardy

Jessica Hardy, M.P.H., D.N.P
Director, Office of Women's Health
Director, Maternal and Child Health

JH/JP

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I.B. Face Sheet

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

I.C. Assurances and Certifications

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

I.D. Table of Contents

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

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

The Alabama Department of Public Health (ADPH) is the primary 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 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
- Alabama's Early Intervention System
- Vocational Rehabilitation Service
- State of Alabama Independent Living Service

FHS is also home to the MCH Epidemiology Branch which pairs an analytical staff member with programs within the bureau to provide data tracking and reporting support. Title V utilizes several epi staff to support the implementation, monitoring, and evaluation of Title V strategies. Furthermore, Alabama Title V program staff collaborate with other ADPH and ADRS staff and with a variety of local, state, and federal stakeholders in order to assess the magnitude of factors impacting the state of health of Alabama's MCH population. Program staff rely on these partnerships to prioritize population health needs and create methods of addressing current and emerging needs.

Coronavirus Disease 2019 (COVID-19)

The operations and services of ADPH, ADRS, and their partners continued to be greatly impacted by COVID-19 throughout 2020. While many public and private offices and businesses transitioned to proving services through virtual applications, the state has experienced staff shortages, and meeting, training, and program cancellations, closure of healthcare clinics, and postponed medical, mental, behavioral, and dental services. Alabama Title V continues 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 the pandemic and the worldwide response evolve.

COVID-19 presented unanticipated challenges for CRS. In response to the Governor's mandates, CRS operated

most of the second quarter of FY 2020 with a hybrid of on-site service delivery, teleworking, and telemedicine. CRS' priority was ensuring that families with CYSHCN and staff were staying safe and healthy. On May 1, 2020, CRS District Office and State Office staff returned to on site work. On May 4, 2020, CRS clinics resumed operations per guidance provided through the CRS Re-Open Task Force and CDC.

CRS staff members continue to ensure CYSHCN and their families receive high quality services in their local communities while identifying resources for families to address issues created by the impacts of COVID-19. Our mission has always been to provide quality clinical services to CYSHCN and their families and we were able to continue meeting their needs even during a time of extreme limitations.

MCH Needs

Needs Assessments for Alabama's Title V program are 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 statewide needs assessment. An analysis of quantitative and qualitative data gathered through paper and web-based surveys, focus groups, key informant interviews, and from select databases and national surveys yielded a variety of issues for the population health domains. After convening advisory committee meetings, national priority areas and state needs were identified.

ADPH Highlights

The following information is a summary of 2015-2020 priority needs, strategies and accomplishments. See section III.E.2.c. State Action Plan Narrative by Domain for additional information.

NPM 1-Well-Woman Visit

ESM 1.1 – 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.

Accomplishments

The Well Woman Program enrolled 371 participants in the program and 361 patients were seen in the colposcopy clinic, despite delays and complications due to COVID-19.

The State Dental Program's FY2019 FY fluoridation awards went to 109 wells and plants per CDC standards and guidelines—a 21% increase over the previous year. The FY2020 FY fluoridation awards will go to 121 wells and plants per CDC standards and guidelines—a 10% increase over 2019. The program partnered with the City of Troy (Alabama) and the Alabama Department of Emergency (ADEM) Management to host its first ever Oral Health and Community Water Fluoridation Conference. The conference was held in October 2020 using a virtual platform and provided four free CE hours to 187 water plant operators. State dental directors and college instructors were also among the diverse group of attendees. Representatives from CDC, the National Fluoridation Society, City of Troy, and Hand Aqua Products presented at the conference.

SPP continued to provide cribs. SPP staff and partners continued to review maternal, fetal and infant mortality cases, and implement plans of action to address identified needs. SPP was a member of the core leadership team on the Project Harnessing, Opportunity for Positive, Equitable early childhood development (Project HOPE), which provided aid to children and families in Montgomery and Macon counties through the purchase of cloth masks, bottles of hand sanitizer, Chromebooks, Amazon Fire tablets, and Teach My Learning kits.

County Health Departments

In November of 2019 Alabama Title V leadership worked with the ADPH district administrators to identify and train six district MCH coordinators, whose roles would be to manage the replication of evidence-based central office programs in their local communities. ADPH also worked with program coordinators at the Jefferson County Department of Health (JCDH) and Mobile County Health Department (MCHD) to expand their community evidence-based programs. District projects were designed to focus on counties with adverse health outcomes in an effort to reduce the health disparities in our state. For FY20 the ADPH, MCHD, and JCDH coordinators designed projects that focused on access to oral health care, expansion of the Well Woman services, safe sleep outreach and education, infant injury prevention, increasing EPSDT visits, and suicide prevention. COVID-19 caused numerous disruptions and delays during FY 2020.

CRS

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.

CRS continues to operate seven service programs to serve CYSHCN and their families. Services provided in each of these programs are funded in full or in part by Title V funds. The seven programs are: Clinical Medical; Clinical Evaluation; Hemophilia; Care Coordination; Information and Referral; Parent Connection; and Youth Connection. Family engagement is supported in partnership with Family Voices of Alabama (FVA) and the Family to Family Health Information Center (FVA/F2F HIC). Coordinated health services are delivered via 14 community-based clinics across eight service districts.

CSHCN Needs

The state priority needs, selected for 2021-2025, are as follows: 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 increases in family and youth involvement and participation in advisory groups, program development, policy-making, and system-building activities. 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).

CRS Highlights

The following information is a summary of 2015-2020 priority needs, strategies, and accomplishments. See section III.E.2.c. State Action Plan Narrative by Domain CSHCN Annual Report for additional information.

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.

NPM 12: Transition

ESM 12.1 - Percent of enrollees in the state CSHCN program with a transition plan in place.

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

Accomplishments

The CRS State Care Coordination Program Specialist convened a group of CRS staff members that included Care Coordinators, Social Work Specialists, Physical Therapists, Computer Services, Nurses, and State Office Staff including the State Parent Consultant to focus on improving the Comprehensive Plan of Care (CPoC). Major changes that resulted from the workgroup include allowing a multidisciplinary team to document in the CPoC and automatically send the plan of care to the child’s medical home.

CRS had 54 YSHCN participate in Teen Transition Clinic (TTC). This number was a 29 percent increase from FY 2019. The increase is attributed to more CRS clients and their families being educated about TTC, consistent use of transition readiness assessments, development of transition plans of care, and access to additional evaluation resources. TTC is a specialized clinic that helps YSHCN make the transition to adult life. There are five TTCs located throughout the state.

CRS collaborated with Family Voices of Alabama (FVA) as part of the Collaborative Improvement and Innovation Network to Advance Care for Children with Medical Complexity (CMC CoIIN) project to provide individuals participating in the CMC CoIIN a FVA Care Notebook. Recognizing the importance of empowering families to communicate with healthcare providers and health related professionals FVA developed the Care Notebook. It is designed to help parents/caregivers maintain an ongoing record of a child's care, services, providers, and notes.

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.

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

Title V funds strategically support personnel and the implementation, monitoring and evaluation of MCH focused activities, data collection, and program evaluation. Staff forge local, state, and federal partnerships to develop, identify, and recommend quality and equitable, preventive, educational, and early treatment strategies to prevent illness, injury, disease and death and to eliminate disparities. Title V funds support breastfeeding, well visits, community water fluoridation, developmental screenings, transition, fetal, infant, and maternal mortality review committees, and advocacy to increase equity and improve access to quality medical and dental care services. Staff 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 health and their families' 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, and 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.

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

III.A.3. MCH Success Story

The Winston family of Florence understands the importance of advocacy and steps to the front of the line when it is time to raise awareness. Rachel, whose daughter Ava was born at 24 weeks and diagnosed with cerebral palsy, knows first-hand how important it is for families of disabled children to receive the support they need. Rachel said Ava remained in the hospital for six months in Birmingham after she was born. But before they were discharged, she was connected to Early Intervention and United Cerebral Palsy Center by a case worker and later learned about additional ADRS services.

“When Ava came along, I realized that there was so much that I did not know,” said Rachel. “I was very happy to find out that there were programs and services to help my family learn how to best care for Ava and how to gain access to the resources she needs to reach her potential.”

Ava began making immediate progress, Rachel said, and the same was true when they transitioned to Children’s Rehabilitation Service. Ava’s current CRS Social Worker Victoria Weatherby has a relationship with the family that goes beyond the walls of CRS. “I really got to know them well when we used to do respite care. It was called ‘Break Time,’” Victoria said. “It was like a support group for special needs children where we did respite care one Friday night a month.”

Ava now attends CRS seating and feeding clinics along with orthopedic clinics, and she and Rachel always arrive in great spirits. “You never see her without a smile on her face,” Victoria said. “She is just awesome.” Rachel has an even bigger platform to advocate for children and adults with disabilities as a nursing professor at the University of North Alabama and recently elected member of the Florence City School Board. She often sings the praises of ADRS programs when she has a chance to discuss services with other parents. “I would tell them that ADRS can provide a wealth of services, resources, and access that your child needs to reach his or her potential,” she said. “ADRS is also full of knowledgeable and compassionate providers who can help you navigate your way through the process of caring for a child with special needs.”

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.

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

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

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, 2019, was 4,903,185 according to data retrieved on March 29, 2021. This figure exceeds the 2018 estimate, of 4,887,681, by 15,504 persons.

0-24 Year-Old Residents
Of the most current data available and retrieved on March 29, 2021, for the year 2019, there were 1,538,530 (or 31.4 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 approximately 6.0 percent (294,357); 5-9 years was approximately 6.1 percent (297,968); 10-14 years was approximately 6.3 percent (310,498); 15-19 years was approximately 6.4 percent (313,615); and 20-24 years was approximately 6.6 percent (322,092). Of the total population, approximately 4.6 percent of Alabama's population was of Hispanic Origin and approximately 95.4 percent was Not of Hispanic Origin.

Live Births
According to numbers, retrieved March 29, 2021, from the National Center for Health Statistics website, in 2019, there were a total of 58,615 live births to Alabama residents-a slight increase (approximately 1.5 percent) from the 57,761 live births in 2018 for the State. There were 4,910 (approximately 8.4 percent) live births to mothers of Hispanic origin in the same year. Of the mothers who were non-Hispanic, approximately 57.0 percent were white; 31.0 percent were black; 1.5 percent were Asian; approximately 0.3 percent were American Indian or Alaska Native and 0.06 percent were Native Hawaiian or Other Pacific Islander.

ECONOMIC ENVIRONMENT AND POVERTY LEVELS
Per the U.S. Census Bureau, 2019 American Community Survey Poverty Status In The Past 12 Months, for the year 2019, there were an estimated 739,108 or 15.5% of Alabamians below the 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 2019, there were 707 pregnant women and 31,621 infants less than one year of age

served. There were 11,772 CSHCN and 71,402 “Others” served under Title V in our 2019 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 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. In FY 2019, CRS served 11,772 CYSHCN, an increase of 9.15 percent over FY 2018. The 2019 increase is attributed to 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.

In FY 2020, CRS served 12,091 CYSHCN, a slight increase of 2.17 percent over FY 2019. This number was the lowest increase over the past several years and is attributed to impacts surrounding the pandemic. In FY 2020, CRS provided information and referrals to 2,230 individuals. For FY 2020, CRS staff reached approximately 57,560 CYSHCN and their families via incoming toll-free calls, information and referrals, Parent and Youth Connection Facebook pages, ADRS/CRS website, outreach activities, health fairs, transition expositions, local hearing screenings, and Family Voices of Alabama (FVA) 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 called 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, receiving 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. ADPH did not provide maternity care coordination services in FY 2020.

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 Request for Proposals (RFP) was released to transition Medicaid's Patient 1st program to the Alabama Coordinated Health Network (ACHN). This new Medicaid program moved all case management (maternity, Plan First, and Patient 1st) under one entity in seven regions throughout the state. Through negotiations with Medicaid, ADPH continued to only 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. In FY 2020 ADPH provided case management services to those children that did not pass the Newborn Screening or Newborn Hearing Screening at birth and those children with an elevated lead level. FY 2020 ended with 7 FTEs providing services to the identified infants and children.

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 special health care needs. 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.

Throughout the COVID pandemic, CRS worked closely with Alabama Medicaid to discuss the needs of therapists and Medicaid recipients, both in and out of ADRS, to maintain a continuum of service delivery for all recipients in the state. Medicaid communicated with CRS program specialists regarding therapeutic codes and service delivery options to ensure all Medicaid recipients could be served appropriately. Medicaid recognized the need for covering Speech Therapy, Occupational Therapy, and Physical Therapy via telemedicine visits which allowed CRS to continue providing services during the pandemic to families that would have otherwise been unable to receive needed services. Upon notification of coverage CRS began researching methods of delivery for telemedicine. This involved testing various methods and discussing options while considering efficacy of delivery, HIPAA, and service provision equivalents.

Alabama Medicaid communicates changes via Alerts. During COVID-19 CRS assisted with the distribution of these Alerts to many partners (Durable Medical Equipment (DME) companies, etc.) to ensure individuals were apprised of temporary changes to Medicaid policy in response to the pandemic. All forms of DME continued to be delivered to clients with training provided via tele-means, when needed, to prevent gaps in service.

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. During the COVID-19 shutdown, Prior Authorization requests for ACDs continued to be submitted and reviewed to prevent delay in receipt of equipment.

CRS is the only provider of medically necessary orthodontia for Medicaid recipients. CRS works closely with Medicaid's Dental Director regarding coverage for medically necessary orthodontia services. During the pandemic CRS worked with orthodontists at UAB School of Dentistry to approve teledentistry codes to ensure clients in active orthodontia were still followed by their orthodontist for their plan of care to prevent patient abandonment.

CRS has an ongoing collaboration with Medicaid to meet Health Insurance Portability and Accountability Act (HIPAA) standards for privacy and billing. CRS staff have access to Medicaid eligibility data for confirming coverage as outlined in the Provider Agreement between Medicaid and ADRS.

Medicaid Family Planning Waiver and Related Issues

The 1115(a) Family Planning Waiver Proposal, submitted by ADPH and Medicaid to the Health Care Financing Administration (HCFA) in FY 1999, was implemented in October 2000 (HCFA became 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 2020, 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 2020, CRS paid insurance premiums for 16 clients with bleeding disorders.

Emergency Preparedness: ADPH and CRS

ADPH and CRS continue to be involved in emergency preparedness response. 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 due to CYSHCN often needing services from multiple systems. Service delivery can be further compounded by barriers to accessing care such as a family's financial circumstances, geographic location, and low health literacy. These barriers became even more apparent during the pandemic.

In response to the Governor's mandates, CRS operated most of the second quarter of FY 2020 with a hybrid of on-site service delivery, teleworking, and telemedicine. Even during the Stay at Home order, CRS staff continued activities to support the needs of children, youth, and families by paying copays, authorizing medications, providing needed services, and equipment. CRS staff worked diligently to contact families to assess needs and reassure them that CRS was continuing to serve them through innovative ways until it was again safe to reopen clinics. In the interim, several telemedicine clinics were provided including Seating, Cerebral Palsy/Neuromotor, Teen Transition, and Limb Deficiency.

On May 1, 2020, CRS District Office and State Office staff returned to on site work. On May 4, 2020, CRS clinics resumed operations per guidance provided through the CRS Re-Open Task Force and CDC. Safety practices included wearing Personal Protective Equipment (PPE), utilizing screening procedures (questions and temperature), managing waiting areas, reducing clinic numbers, and holding telemedicine clinics when appropriate. Of course, all staff maintained recommended social distancing, wearing face coverings, and diligently washing their hands.

CRS has utilized CMS/Medicaid's lessened restrictions on telemedicine visits during the pandemic. Several CRS

Evaluation clinics began to meet as telemedicine clinics over secure Zoom accounts even before offices reopened to staff. Clients were provided the multidisciplinary team evaluation they were accustomed to receiving even though the visit occurred via telemedicine. Offices reopened on May 4, 2020, and additional Evaluation and Medical clinics were developed to deliver multidisciplinary clinical services via telemedicine. These include Adult Hemophilia, Augmentative Communication & Technology, Cystic Fibrosis, Feeding, Neurology, Pediatric Hemophilia Seizure, and Seating/Positioning/Mobility Clinic. During the COVID-19 crisis, CRS audiologists continued to serve clients by providing curbside assistance when possible for hearing aid troubleshooting, providing batteries, and providing audiological counseling and education.

CRS staff members continue to ensure CYSHCN and their families receive high quality services in their local communities while identifying resources for families to address issues created by the impacts of COVID-19. Our mission has always been to provide quality clinical services to CYSHCN and their families and we were able to continue meeting their needs even during a time of extreme limitations.

In addition to the COVID-19 crisis, CRS faced continued challenges in rural areas. The state is largely rural, with greater population concentrations surrounding three larger urban areas (Mobile, Birmingham, and Huntsville). In rural areas, more risk factors exist that could potentially increase the percentage of CYSHCN in the general child population, such as higher poverty levels and lower education levels. According to the USDA Economic Research Service the poverty rate in rural Alabama is 18.5 percent compared with 14.8 percent in urban areas of the state and 18.8 percent of the rural population has not completed high school.

Comprehensively meeting the needs of CYSHCN in rural areas is even more difficult due to transportation barriers and limited access to providers with specialized experience in treating complicated health issues. Specialists and allied health professionals with pediatric experience are mainly located in the larger urban areas, necessitating travel to access them. In general, the state has poor public transportation systems. 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 State’s Fiscal Situation

The COVID-19 pandemic stalled the economy putting more than 400,000 Alabamians out of work. Despite the massive economic shutdown that 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 2022. The General Fund provides funding for most non-education programs in the state. The $2.4 billion General Fund budget which was approved will increase spending 3.6% over the current year 2021 by $90.6 million.

The General Fund got a break this year as federal matching dollars for the state Medicaid program and the Children’s Health Insurance (CHIP) were higher than usual. That means, while actual funding won’t increase, the state will spend $51 million less on Medicaid and $12 million less on CHIP. Medicaid’s state funding will fall from $820 million to $769 million, however, carryover funds combined with and increased federal match will make up the difference. Most agencies would receive about the same amount as the current year. These three agencies would receive budget increases: Alabama Pardons and Paroles, Alabama Department of Corrections and Alabama

Department of Mental Health. Public Health would receive departmental funding of $47.7 million, a $1.9 million increase over FY 2021.

In FY 2020, Alabama's Title V MCH Program received $11,482,727 and will be budgeted at this level for the FY 2022 application.

III.C. Needs Assessment
FY 2022 Application/FY 2020 Annual Report Update

Please see the MCH Title V Block Grant to States FY 2021 Application/FY 2019 Annual Report for more details regarding the process, goals, framework, methodology, level and extent of stakeholder involvement, quantitative and qualitative methods, data sources used, data collection, finalization of priority needs, and development of the state action plan for the 5-year assessment of needs, as originally submitted.

Ongoing Needs Assessment Activities

In an effort to address the ongoing needs of the state's maternal and child population, the Alabama MCH Title V program staff members continue to engage stakeholders and to assess necessary changes and emerging issues as we continue to develop and implement ESMs and SPMs, along with the activities outlined in the state's 5-year action plan during the FY 2021-FY 2025 reporting cycle. There have been a few emerging issues within Alabama and some areas HRSA has asked states to focus on as new strategies are implemented.

CRS engages in ongoing needs assessment activities to assess for emerging needs, changing conditions, and system capacity. As part of the 2021-2025 Five-Year State Action Plan CRS is soliciting feedback and seeking input regarding our Transition and Care Coordination services. The UAB School of Public Health, Applied Evaluation and Assessment Collaborative administers the surveys and analyzes the survey data. CRS values public input from individuals with lived experiences and seeks input from families and youth on an ongoing basis through the State Parent Advisory Committee, Local Parent Advisory Committees, and Youth Advisory Committee. CRS also holds an annual Hemophilia Advisory Committee meeting to seek input into programmatic and policy issues related to the Alabama Hemophilia Program administered by CRS. Information collected during the various advisory committees allows CRS leadership to continually assess health needs of CYSHCN and the system capacity to address these needs. An additional effort to solicit ongoing feedback is a series of Staff and Community Partner surveys around access to services. These surveys are also being administered and analyzed by UAB.

Health Status and Needs of the MCH Population

General Overview of Health Status
Based on Census population estimates, the population in Alabama in 2019 was 4,903,185. According to the Center for Health Statistics, for Alabama residents in 2019, there were: 58,615 live births; 54,109 deaths; 449 infant deaths; and 525 fetal deaths

The following is an update of the overview of the health status of the population per domain.

Women/Maternal Health
In 2019, there were 58,615 residential live births in Alabama with the rate of black and other births being slightly higher than white births; at 13.6 and 11.2 per 1,000 population respectively. When comparing Alabama residential live births from 2019 to those from 2018, there was a decrease of 861 births, overall.

Perinatal/Infant Health
In 2019, 449 infants expired before their first birthday yielding an infant mortality rate of 7.7 infant deaths per 1,000 live births. The infant mortality rate in Alabama still continued to exceed the national rate. The black to white disparity continued with a larger number of black infants dying than their white counterparts

Child Health
In 2018, 89 children, 1-4 years of age, and 107 children, 5-14 years of age, expired with "accidents" as the leading cause of death in both age groups. For decedents less than 1 year of age, "congenital malformations, deformations, and abnormalities" was the leading cause of death.

Children with Special Health Care Needs
Per 2018-2019 National Survey of Children with Special Health Care Needs (NSCH-CSHCN) data Alabama is trending slightly better in Transition and trending slightly worse in Medical Home and Systems of Care indicators. NSCH-CSHCN data indicate 23.8 percent of YSHCN receive the services necessary to make appropriate transitions to adult health care compared to 22.9 percent nationwide. NSCH-CSHCN data indicate 37.4 percent of Alabama CSHCN have a medical home compared to 42.3 percent nationwide and 12.9 percent of Alabama CSHCN receive care in a well-functioning system compared to 14.1 percent nationwide. The medical home indicator has declined slightly from the 2016-2017 NSCH-CSHCN data which indicated 40.1 percent of Alabama CSHCN had a medical home compared to 43.2 percent nationwide. Despite NPM 11 not being selected for the 2021-2025 Five-Year State Action Plan CRS recognizes the need to continue educating CYSHCN and their families on the benefits of a medical home and will do this through a SPM focused on Care Coordination and another one on Family Engagement.

Adolescent Health
In 2018, 238 adolescents aged 15-19 years expired with accidents as the leading cause of death followed by homicides. Births to teens, 10-19 years of age, continued to decline to an all-time low of 7.3 percent in Alabama in 2017.

Title V Program Capacity Organizational Structure

Please see the **MCH Title V Block Grant to States FY 2021 Application/FY 2019 Annual Report** for more details regarding "ADPH's Organizational Structure" and "ADRS's Organizational Structure" for the 5-year assessment of needs, as originally submitted. The following are updates reflecting changes that have occurred since the original submission.
Current organizational charts for ADPH, FHS, ADRS, and CRS are attached to this section and as attachments to this document.

Agency Capacity

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

ADPH Program Capacity

As part of MCH Title V transformation, ADPH has moved to a more collaborative model for delivering Title V services. Title V staff have developed structures and processes to facilitate collaboration between state and county offices. These processes necessitate that state and CHD staff work together to design strategies and plans to improve community health. Resources have always been allocated to the CHDs departments where we know services were delivered to those in great need. This new effort is to ensure the appropriate partners are involved as we assess the communities' needs and develop programs to improve the health of the population.

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

MCH Workforce Capacity

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

ADPH

There have been major changes in FHS' program capacity with several positions now vacant. While FHS is without vital epidemiology and perinatal staff, FHS has been able to create and fill new positions in the new district MCH initiative and maternal mortality to assist with the implementation of the state action plan. The FIMR program has expanded and there are FIMR abstractors in four of the five districts. The responsibilities of the abstractors include: 1) abstracting, reviewing, processing, and presenting FIMR data; 2) collaborating with delivering hospitals to provide staff and family education; and 3) fostering and enhancing collaborations with community agencies to identify the perinatal needs and to increase the perinatal health knowledge of each region; and 4) promoting perinatal health outreach in order to improve outcomes for babies throughout the region. A Maternal Mortality Review Program Coordinator was hired in August 2019 with the main responsibilities of coordinating all activities of the MMRP and abstracting maternal mortality cases for committee review. In November of 2019 Alabama Title V leadership worked with the ADPH district administrators to identify and train six district MCH coordinators. There are currently four social workers in the role of district MCH coordinator. The coordinators' responsibilities include: 1) coordinating district MCH activities in conjunction with ADPH program managers to plan and implement innovative MCH strategies; 2) facilitating district MCH advisory committees, and fostering collaborations with community agencies to identify the local MCH needs; and 3) developing and implementing communication and outreach plans to promote health equity and the elimination of disparities.

ADPH cost center data provided by ADPH's Bureau of Financial Services was used to estimate the number of ADPH FTEs devoted to serving Title V populations. FTEs reported here are not limited to those paid for by Title V, because funds from other sources also assist in paying for services to Title V populations. Excluding WIC cost centers, 350.67 FTEs served Title V populations in FY 2020, down 14.4 percent (or 58.9 FTEs) since FY 2019. The

positions accounting for 5 percent or more of the total non-WIC FTEs serving Title V populations were aides (5.2 percent), social workers (6.2 percent), nurses (32.1 percent), Administrative Support Assistants (ASAs) (19.9 percent), Nurse Practitioners/Midwife (9.2 percent), and mobile employees (11.0 percent). In FY 2020, 210.05 FTEs were devoted to WIC, decreasing by 9.4 percent (or 16.75 FTEs) since FY 2019. In FY 2020, .98 FTE were devoted to SSDI.

CRS

There have been no changes in CRS's organizational structure or leadership. Data provided by the ADRS Personnel and Human Resources Division was used to provide the number of CRS FTE's devoted to serving CYSHCN. FTEs reported here are not limited to those paid for by Title V, because funds from other sources also assist in paying for services to CYSHCN.

As of March 2021, 200.1 FTEs are in the field: eight District Supervisors, 0.6 Custodian, 54 Administrative Support Assistants (ASAs), 53 Social Workers, 30 Nurses, 14 Rehabilitation Assistants, seven Nutritionists, ten Audiologists, eight Physical Therapists (PT), eight Speech Language Pathologists (SPL), five Occupational Therapists (OT), and two 2.5 Rehabilitation Counselors. There are also six Local Parent Consultants (LPCs) in the field under the Easter Seals of Central Alabama contract. Fifteen budgeted vacancies are available: four ASAs, four Social Workers, one OT, one PT, one SLP, two staff Nurses, two Rehabilitation Assistants. There are four vacant LPC positions.

As of March 2021, 15 FTEs are at the State Office: 11 administrative and four clerical staff. Administrative staff include one Assistant Commissioner, one Assistant Director, one Health Services Administrator, one SLP, one Audiologist, one Nurse, one OT, one State Parent Consultant (SPC), one Social Worker, and two Patient Account Managers. There are also two part time Youth Consultants (YCs) at the State Office under the Easter Seals of Central Alabama contract. One of the part time YC positions is currently vacant.

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. In addition, there are two part time YCs under the Easter Seals contract. The individuals employed through the Easter Seals contract are included above.

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 birthweight 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 education
2) Lack of comprehensive, family-centered, and culturally-competent health care
3) Lack of or inadequate access to mental health services that are comprehensive and age-appropriate
4) Lack of or inadequate smoking, alcohol, and substance use prevention education
5) Lack of or inadequate access to affordable and safe options for physical activity
6) Lack of awareness of healthy nutrition guidelines and portion sizes
7) Lack of timely, appropriate, and consistent health and developmental screenings
8) Lack of access to quality early childhood programs that are safe and affordable, especially for children with disabilities
9) 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:

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

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$11,315,300	$11,411,388	$11,264,929	$11,401,820
State Funds	$17,818,117	$27,113,028	$32,943,966	$25,173,350
Local Funds	$0	$0	$0	$0
Other Funds	$2,041,819	$1,060,312	$1,536,572	$1,223,021
Program Funds	$62,194,456	$54,375,230	$48,718,812	$54,401,167
SubTotal	$93,369,692	$93,959,958	$94,464,279	$92,199,358
Other Federal Funds	$136,719,366	$136,255,926	$135,224,143	$131,593,753
Total	$230,089,058	$230,215,884	$229,688,422	$223,793,111

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

	2022	
	Budgeted	Expended
Federal Allocation	$11,482,727	
State Funds	$31,724,878	
Local Funds	$0	
Other Funds	$1,566,690	
Program Funds	$26,066,122	
SubTotal	$70,840,417	
Other Federal Funds	$123,892,360	
Total	$194,732,777	

III.D.1. Expenditures

ADPH

As per Block Grant requirements, the budget for each reporting year was set two years' prior in the application (i.e. FY 2020 budget was set in the FY 2018 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.

/2022/ 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. 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

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

Alabama Maternal and Child Health Services Title V Block Grant has met the 30%-30%-10% requirement as specified in Section 504(d) and Section 505(a)(3). As indicated in Form 2, all MCH cost centers spending on Preventive and Primary Care for Children was 49.25%; transfer to Children's Rehabilitation Services met the federally required minimum of 30% of the Block Grant; and the administrative cost capped at 10%.

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

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

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

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

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

Form 2: MCH Budget/Expenditures Details

Line 1. (Federal Allocation) – FY 2020 Annual Report Expended of $11,482,727 was more than the FY 2018-2020 application's budgeted Grant Award of $11,411,388, a difference of $71,339. The MCH grant is available for two years and some spending can overlap fiscal years.

Line 1A. (Preventive and Primary Care for Children) – FY 2020 Annual Report expended of $5.79m increased from the FY 2020 Application Budget amount of $4.58m, a difference of $1.20m or 26.25%. In 2018, when the budget

was developed for 2020 the children served made up 40.21% of the total program cost compared to the actual expended in FY 2020 of 50.45%. The higher percentage increases the cost in programs that see children.

Line 3. (State MCH Funds) - FY 2020 Annual Report Expended increased to $32.35m from the FY 2020 Application Budgeted amount of $27.11m, a difference of $5.24m or 19.32%. When the FY 2020 budgeted amount was developed in FY 2018, the other support income was $39.4m compared to the 2020 actuals of $34.5m, a decrease of $5.2m. During this period, 2018 actual cost was adjusted downward for the loss of care coordination services. Revenue from lost services was projected to be $20.28m. The combination of reduced income and cost reflects a need for more State Support. ADPH's share of this increase was $4.48m and as expected Family Planning programs showed the impact of lost revenue. The remaining increase in State Funds of $749k is related to CRS and is a 6.2% variance for the program. The loss of care coordination and the COVID pandemic continues the downward trend in revenue.

Line 5. (Other Funds) – CRS FY 2020 Annual Report Expended was $1.11m which is a decrease from the FY 2020 Application Budget reported at $1.54m, a decrease of $420k or 27.34%. See CRS explanation.

Line 6. (Program Income) - FY 2020 Annual Report Expended of $26.8m decreased from the FY 2020 Application Budgeted amount of $32.7m, a difference of $5.88m or 17.98%. When the FY 2020 budget was developed in FY 2018, the ADPH total program income was reported at $20.1m compared to the FY 2020 actual income earned of $14.8m, a net decrease of $5.3m. Overall, the net decrease of $5.9m in ADPH income was seen in Family Planning related programs (Medicaid). All other ADPH earned income programs had small increases totaling $591k. ADPH delivery of services reflect current operations that have been affected by Medicaid's ACHN networks providing services and the phasing out of ADPH as a provider. Another factor has been the effects of the COVID 19 pandemic on providing client services. CRS program income decreased from a budget amount of $12.6m to 2020 actual income of $12.05m, a decrease of $547k which is 4.3% variance for the program.

Form 2 (+/- 10% Variance)

MCH Bud/Expenditure Details	Budget FY 2020	Expended FY 2020	Difference	+/-10% Variance
Preventive/Primary Care for Children	$4,588,519	5,793,036	$1,204,517	26.25%
State MCH Funds	27,113,028	32,350,502	5,237,474	19.32%
Other Funds	1,536,572	1,116,526	-420,046	-27.34%
Program Income	32,697,532	26,818,653	-5,878,879	-17.98%
Totals	**$65,935,651**	**$66,078,717**	**$143,066**	**0.22%**

Line 9. (Other Federal Funds) – Programs with significant dollar differences comparing FY 2018-2020 Budget versus FY 2020 actual expended.

Early Head Start Program - FY 2020 Annual Report Expended of $995k increased from the FY 2018-2020 application's budgeted amount of $357k, a difference of $638k or 179.05%. 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 caused the increase in expenditures from 2018 to 2020.

Abstinence Education Program – FY 2020 Annual Report Expended of $887k decreased from the FY 2018-2020 application's budgeted amount of $1.19m, a difference of $301k or 25.33%. 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 2020 Annual Report Expended of $380k decreased from the FY 2018-2020 application's budgeted amount of $903k, a difference of $523k or 57.87%. 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.

Well Women Program – FY 2020 Annual Report Expended of $1.30m increased from the FY 2020 Application Budgeted amount of $277k, a difference of $1.02m or 369.16%. Well Woman program was implemented in January 2017 in three counties: Butler, Dallas, and Wilcox. The program reach has been extended and Well Woman is currently offered in six counties in Alabama (Butler, Dallas, Macon, Montgomery, Russell, and Wilcox) with program implementation pending in three additional counties (Marengo, Henry, and Barbour). Between implementation and 2020 program support and staffing increased, with the most recent increase to 14.4 FTEs to cover staffing at the state office and program support in the three new counties. Plans are under discussion to add an additional three counties (Greene, Hale, and Perry) beginning fiscal year 2022.

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 2020 Annual Report Expended of $656k decreased from the FY 2020 Application Budget amount of $1.83m, a difference of $1.18m or 64.22%. During 2018, Mobile and Cullman County had a Maternity Program totaling $1.38m and in 2020 these programs totaled $475k. As reported in the previous application, Medicaid's new Alabama Coordinated Health Network (ACHN) will eliminate ADPH care coordination including maternity services revenue.

Line 2. (Infants<1 year) – FY 2020 Annual Report Expended of $5.48m decreased from the FY 2020 Application Budgeted amount of $8.77m, a difference of $3.30m or 37.57%. From 2018 to 2020, the activity declined by 2,446 for infants, a decrease of 25.25%. As expected, these services have been affected by Medicaid's Alabama Coordinated Health Network (ACHN).

Line 3. (Children 1-22 Years) – FY 2020 Annual Report Expended of $34.3m decreased from the FY 2020 Application Budget amount of $52.4m, a difference of $18.10m or 34.53%. From 2018 to 2020, the activity declined for children by 17,954, a decrease of 28.36%. As expected, these services have been affected by Medicaid's Alabama Coordinated Health Network (ACHN).

Form 3a (+/- 10% Variance)				
	Budget	Expended		+/-10%
Individuals Served	FY 2020	FY 2020	Difference	Variance
Pregnant Women	$1,834,963	$656,612	-$1,178,351	-64.22%
Infants< 1 Year	8,777,739	5,480,367	-3,297,372	-37.57%
Children 1-22 Years	52,432,124	34,328,192	-18,103,932	-34.53%
CSHCN	29,807,501	29,689,464	-118,037	-0.40%
All Others	1,611,952	1,613,774	1,822	0.11%
Totals	$94,464,279	$71,768,408	-$22,695,870	-24.026%

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 2020 Annual Report Expended of $39.53m increased from the FY 2020 Application Budgeted amount of $33.26m, a difference of $6.27m or 18.83%. By comparing recent expended amounts to each other, as opposed to the budgeted number from 2018, is more insightful: Instead of looking at budget to actual the numbers indicate the overall trend for Direct Services has continued downward, Expended for 2018 at $44.5m and for 2020 at $39.5m, a $5m decline.

Line 2. (Enabling Services) - FY 2020 Annual Report Expended of $3.77m decreased from the FY 2020 Application Budgeted amount of $9.76m, a difference of $5.99m or 61.40%. As reported earlier ADPH lost substantial care coordination services with the coming of Medicaid's Alabama Coordinated Health Network (ACHN). Programs impacted were Family Planning Care Coordination, EPSDT Care Coordination, and Patient 1st Care Coordination. CRS FY 2020 enabling services expended of $2.198m decreased from the FY 2020 Budgeted amount of $2.250m, a difference of $52k.or 2.30% variance for the program. //2022//

Form 3b (+/- 10% Variance)				
	Budget	Expended		+/-10%
Individuals Served	FY 2020	FY 2020	Difference	Variance
Direct Services	$33,268,198	$39,533,882	$6,265,684	18.83%
Enabling Services	9,759,967	3,767,014	-5,992,954	-61.40%
Public Health Services	29,730,355	28,467,512	-1,262,843	-4.25%
Totals	$72,758,520	$71,768,407	-$990,113	-1.36%

CRS

As per Block Grant requirements, the Budget for each reporting year is set 2 years prior in the application (i.e. FY 2020 budget was set in the FY 2018 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 2020 Annual Report Expended of $1.1m decreased from the FY 2020 Application Budgeted of amount of 1.5m, a difference of 420k or 27.34 percent. This decrease is a result of CRS expending less from the Hemophilia State Allocation due to an increase in the number of hemophilia clients with insurance coverage.

Form 2 (+/- 10% Variance)

MCH	Budget	Expended		+/-10%
Budget/Expenditure Details	FY 2020	FY 2020	Difference	Variance
State MCH Funds	$12,085,537	$12,834,829	$749,292	6.20%
Other Funds	1,536,572	1,116,526	-420,046	-27.34%
Program Income	12,595,766	12,048,759	-547,008	-4.34%
Totals	$26,217,875	$26,000,114	$217,761	-0.83%

III.D.2. Budget

ADPH

/2022/ 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 2021.

The General Fund provides funding for most non-education programs in the state. The $2.4 billion General Fund budget which was approved will increase spending 3.6% over the current year 2021 by $90.6 million. The General Fund got a break this year as federal matching dollars for the state Medicaid program and the Children's Health Insurance (CHIP) were higher than usual. That means, while actual funding won't increase, the state will spend $51 million less on Medicaid and $12 million less on CHIP. Medicaid's state funding will fall from $820 million to $769 million, however, carryover funds combined with and increased federal match will make up the difference.

Most agencies would receive about the same amount as the current year. These three agencies would receive budget increases: Alabama Pardons and Paroles, Alabama Department of Corrections and Alabama Department of Mental Health. Public Health would receive departmental funding of $47.7 million, a $1.9 million increase over FY 2021.

In FY 2020, Alabama's Title V MCH Program received $11,482,727 and will be budgeted at this level for the FY 2022 application. The Title X Family Planning Program was awarded for FY 2022 a total of $7,200,000 which included a $1,900,000 supplemental for implementation of a new community outreach and education program pilot.

The Alabama Medicaid Agency has implemented a Medicaid delivery system which provides for a flexible and more cost-efficient effort which builds off the agency's current case management program structure. 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. ACHNs were implemented on October 1, 2019 but did not begin providing services until November 1, 2019.

The Patient 1st and Plan First case management programs ended on September 30, 2019. ADPH continues to provide care coordination services to children identified with an abnormal Newborn Screening, Newborn Hearing Screening, and an elevated lead level. Revenue generated from these services will result in an approximately $1 million 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 cast 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 facilitated a centralized statewide referral system for all providers including Children's of Alabama Hospital. The electronic referral system saved taxpayer money by identifying children that were non-compliant with prescribed treatment plans. ADPH's seamless referral process was discontinued with the ACHN implementation.

The Title X Family Planning Program provides access to quality family planning and related health services, giving priority to Alabama's low-income population. Undeniably, onset of the COVID-19 pandemic posed an immediate

and serious threat to resources and capacity of Alabama's health care infrastructure. For patient and staff safety, routine, in-person family planning services in the county health departments were unavailable for a number of months; however, some exceptions were made for acute or time-sensitive health care needs, including follow up diagnostics for women with high-risk, abnormal pap smears. The pandemic response also necessitated intermittent reassignments of family planning clinic and administrative personnel, well into FY21, to assist in development and implementation of response plans, to staff COVID-19 phone lines and vaccination clinics, and to support data management. Further, COVID-19 funding supported implementation of new Infectious Disease and Outbreaks strike teams in each district, offering new opportunities for existing clinic staff. Consequently, limited clinic staff impacted the timing and speed at which county health departments could resume routine family planning services.

Although the COVID-19 pandemic drastically altered family planning service delivery models across the country, the pandemic also presented ADPH an opportunity that not only allowed uninterrupted statewide patient access to essential family planning services, but also demonstrated the program's capacity for expansion into a new service delivery model. Alabama Medicaid's approval of telehealth family planning visits for Medicaid recipients, on a month-to-month basis since March 2020, facilitated ADPH's implementation of family planning visits by telephone. Through telephone visits and subsequent curbside pick-up of contraceptive supplies, ADPH nurse practitioners provided continuity of care and met essential family planning needs of low-income patients across the state. Many family planning patients utilized this new visit model; as a result, telephone visits exceeded typical numbers of in-person provider visits. Because remote visit models remove many barriers to care, ADPH initiated a discussion with Alabama Medicaid regarding continuation of telephone family planning visits, as well as virtual on-screen visits after expiration of the public health emergency. Existing ADPH technology supports virtual on-screen visits through the department's electronic health record.

Finally, the Family Planning Program collaborated with the UAB O'Neal Comprehensive Cancer Center to pilot a Community Health Advisor (CHA) initiative, which included targeted outreach and education focusing on cervical cancer screening and prevention and provided case management in 13 counties. Despite event cancellations caused by COVID-19, the UAB community workers reported many successful outreach encounters, which included distribution of ADPH Family Planning educational resources. Family Planning social workers also provided case management for almost 900 ADPH patients in 2,375 separate encounters. During FY21, the Family Planning Program began hiring ADPH Public Health Educators and additional social work staff to expand the CHA initiative to seven 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 to better capture the full “reach” of the MCH Population. As an example, ADPH has sought to include estimates which now include consideration of educational programs and training in this effort. To better link the provision of services with the funding, 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 funds 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 two 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 two-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% 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

The State of Alabama CSHCN Program is administered by CRS, a division of ADRS. ADPH contracts with CRS, to provide services for CSHCN and allocates Title V dollars to CRS for this effort. ADPH allocated the required 30 percent, approximately $3.4 million to the CSHCN Program in FY 2020. In FY 2020 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 $12.5 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 Children with Medical Complexity (CMC) Collaborative Improvement and Innovation Network to Advance Care (CoIIN). All these funds are utilized to serve CYSHCN.

During FY 2020 CRS expended $745,378 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. CRS expenditures for the CMC CoIIN project exceeded the allocated $135,000 due to receiving approval from Boston University to spend carryover funds.

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 2020 and FY 2021 CRS received level funding from the State ETF and General Fund budgets. CRS anticipates receiving level funding from the state for FY 2022 which ensures we can continue to meet the match. In FY 2020, 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). //2022//

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, State Perinatal Advisory Councils, the Oral Health Coalition of Alabama (OHCA), and the State of Alabama Infant Mortality Reduction Plan**,** to ensure we consistently collaborate 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 MMRP 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 towards 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 meet 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 providing direct services through 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 66 CHDs. MCHD and JCDH are independent; however, both departments receive sub-awards to support MCH activities.

Through the MCH Transformation and the emphasis on performance and accountability, work continues 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 ADRS. CRS provides clinical medical services, clinical evaluation services, care coordination, information and referrals, parent connections, and youth connections to serve CSHCN and their families. 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. Family engagement is supported in partnership with FVA and the Family to Family Health Information Center (F2F HIC).

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

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

CRS has incorporated the AMCHP Standards for 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, the standards are being used to strengthen the existing Care Coordination Program and address the transition process. Per the above mentioned standards CRS is working to ensure the plan of care is jointly developed, shared, and implemented among CYSHCN and their family, primary care provider and/or the specialist serving as the principal coordinating physician and members of the health care team. In accordance with the standards CRS is implementing a system to elicit feedback on the transition process. CRS has built its transition program around Got Transition's Six Core Elements of Health Care Transition™ framework.

Recognizing the importance of delivering quality health care services to CYSHCN, the Assistant Commissioner made the decision to apply for the National MCH Workforce Development Center 2020 Cohort. CRS was accepted and began working with the Center in February 2020. Since that time a team of CRS staff and outside partners have been analyzing the current service delivery model to identify opportunities to improve access to services and improve the quality of services provided. It is imperative to include health equity as part of the analysis and incorporate a goal of building an internal capacity to act on the social determinants that impact the health of Alabama's CYSHCN. A focus on equity and social determinants includes identifying barriers CYSHCN and their families face that impact their ability to receive services and recognizing barriers vary from community to community by culture, geography, financial status, and educational factors.

CRS completed the 2020 cohort in August 2020 and applied for and was accepted in a Single State Intensive project with the Center. This collaboration with the Center has allowed us to continue working on our Health Transformation Project with National MCH Workforce Development Center experts and receive focused support.

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

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.

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 the National MCH Workforce Development Center and apply for training opportunities presented by the Center, AMCHP, HRSA and other state and federal partners to ensure our workforce has the knowledge and tools necessary for effective program planning and implementation. Addressing equity was identified as a need during the 2020 Needs Assessment cycle, thus in March 2020 FHS Title V staff participated in the National MCH Workforce Development Center's skills institute, Strengthening Skills for Health Equity. Equity focused training and other training for all staff supported by the MCH Title V Block Grant is accessed as needed.

CRS

CRS is committed to ensuring a highly qualified diverse workforce that is equipped with the knowledge and skills to provide quality services to CYSHCN and their families. In February 2020 CRS began participating in the National MCH Workforce Development Center 2020 cohort. As a result of working with the Center, CRS identified Workforce Development as a key area of focus. A Workforce Development Subcommittee analyzed current practices and identified areas for improvement. These areas included Professional Development, Quality Improvement, and Family Engagement. We are continuing to identify the best ways to support staff and provide them with the tools and resources needed to succeed in their positions. A Workforce Development staff survey will be launched late August 2021 to assess training needs, identify ways to improve the orientation process, and strengthen employee skills. The data collected from the survey will allow CRS leadership to develop a strategic plan ensuring a highly qualified and supported MCH workforce.

CRS collaborates with the ADRS Staff Development and Training Division which coordinates education, training, and professional development activities for all ADRS programs. Division staff have worked with CRS to identify training needs, develop training resources, and provide training opportunities that strengthen our MCH workforce. CRS utilizes the expertise available through the Staff Development and Training Division to ensure that staff are equipped with the resources and knowledge base to implement the 2021-2025 State Action Plan.

CRS management encourages staff participation in learning opportunities. Collaborations with ADPH, FVA, DHR, UAB, COA, and other partners allows for the identification of professional development and learning opportunities that ensure highly skilled and qualified staff. CRS State Office Program Specialists also assist multi-disciplinary staff in identifying relevant learning opportunities to specifically address the needs of CYSHCN and their families. These opportunities include the following annual events: Speech and Hearing Association of Alabama Convention, Alabama Conference of Social Work, Alabama Transition Conference, Partners in Care Summit, Autism Matters Conference, Alabama Traumatic Brain Injury Conference, Alabama Autism Conference, Assistive Technology Industry Association Conference, and the Early Intervention Preschool Conference. In addition to state sponsored training opportunities, CRS State Office staff participate in opportunities provided by national partnerships such as AMCHP, the MCH Federal/State Title V Partnership, and the Skills Institutes offered by the National MCH Workforce Development Center.

CRS is committed to recruiting qualified staff to ensure we continue providing quality services to CYSHCN and their families. CRS has developed strong partnerships with colleges and universities within the state to recruit perspective employees. Current CRS staff either exhibit or present to the following groups and at the following annual events: University of Alabama Health Sciences Job Fair, University of Alabama Career Fair, Tuskegee University Career Fair, Auburn University Audiology Doctoral Students, Troy University Rehabilitation Counselor Program, University of South Alabama OT students, Samford Speech Language Pathology School, and Jacksonville State Social Work Day. CRS SLPs present to university speech programs statewide and teach some SPL courses.

To further ensure CRS has a workforce that is adequate in size, effectively trained, and properly supported, 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. The ADRS Commissioner is committed to ensuring a quality workforce and meets quarterly with the Assistant ADRS Commissioner and State Office Program Specialists to hear updates and discuss issues surrounding service delivery including workforce development.

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

ADPH

ADPH continues exploring opportunities to involve families, youth, and fathers in more MCH activities. 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 has sought guidance from state and national partners on strategies to collaborate with community leaders and groups as well as families of every background in every step of program implementation, including needs and assets assessments, program planning, service delivery, program monitoring and quality improvement activities.

CRS

ADRS and CRS have a deep and long-standing commitment to family engagement and the principles of family-centered care. For nearly three decades this commitment has impacted every part of the CRS division, including the direct services provided as well as the infrastructure building and population health work which is undertaken. CRS makes a significant investment in family partnerships by employing those with lived experience. CRS staff includes a full time SPC and part time LPCs in many of our offices. These positions are filled by parents who are full time caregivers of CYSHCN. CRS also employees two part time YCs that facilitate youth involvement in policy development and decision making.

In FY 2020, CRS was awarded a grant from ADPH to hire a parent consultant dedicated to working with families statewide who have children who are Deaf/Hard of Hearing. One of our current LPCs moved into this role. Data is transferred from ADPH on babies who do not pass the Newborn Hearing Screening, and the PC contacts those families (as well as others) to offer support and information.

COVID-19 greatly impacted many aspects of our work to engage families. Due to the effort to limit face-to-face contacts when families visited the local offices, LPCs were not able to interact with families in the waiting and exam rooms as they had always done. The lack of interaction was also true for the clinics CRS holds in community partner locations. The SPC and LPCs created innovative ways to connect with families. A one-page list of “Conversation Starters” was developed to make the most of brief interactions and to try to identify needs the families may have been experiencing because of COVID-19. The “Conversation Starters” were utilized as LPCs made phone contacts before and after clinics in place of face-to-face contacts. Since March of 2020 there have been no in-person family meetings, which includes our Parent Advisory Committees (PACs). Some virtual PAC meetings have taken place, and been successful, but most families participating have expressed that it does not feel the same as gathering in person and interacting with each other as well as CRS Leadership.

One new initiative has been the implementation of monthly webinars coordinated by the CRS PCs and designed for families. PCs were trained on how to host a Zoom Training and utilize the ADRS Zoom Account. These webinars are called “Family Connections” and have covered a wide range of topics including Respite, Emergency Preparedness, Medicaid Waivers, Mental Health, and Sibling Issues. In the first few weeks of the pandemic, it was clear that families were facing significant challenges. Working with the Family Resource Specialists from the F2F HIC, a private

Facebook group was created entitled “AL Special Needs Parent Support Group.” It immediately took off and began growing; to date, there are 716 members of the group, and it has become a wonderful community where people ask questions and share information freely with each other. There have also been opportunities for families to share supplies or equipment with each other, all facilitated by the connections in the group.

Advisory Committees

The SPC coordinates the state PAC, which brings together representatives from the Local Parent Advisory Committees (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 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 Alternatives to Guardianship, The Enable Savings Plan, Special Education and IEP development, SSI, Community Respite Options, and various mental health related topics including the importance of self-care during this year.

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). In FY 2020, YAC meetings were held via Zoom and specifically addressed the impacts of COVID-19 and strategies to address these impacts. Topics included ways to cope during COVID. The YCs encouraged YSHCN to listen to music, spend time outdoors, and to talk on the phone with friends since they could not spend time face-to-face. Other Zooms focused on accessibility in the community. YC and YSHCN discussed accessibility issues pertaining to public buildings and private vehicles. They also provided information and resources via the Youth Connection Facebook page regarding COVID-19 and virtual education resources specifically for YSHCN as they adapted to virtual education platforms.

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.

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 UAB students at the School of Public Health (SOPH), the UAB Pediatric Pulmonary Center trainees, and the Medicaid ACHN staff’s introductory Care Coordinator training. In addition, LPCs have been interviewed on Alabama Cares Facebook Live broadcasts and presented to University of Alabama 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 has had multiple opportunities to present during webinars sponsored by AMCHP and the CMC CoIIN.

The SPC and CRS Assistant Commissioner are members of the ACHIA steering committee, which is the state improvement partnership program working with the Alabama Chapter of the American Academy of Pediatrics (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 and some LPCs are members of the team participating in the CRS National MCH Workforce Development Center project and are members of the Alabama CMC CoIIN team. The SPC was the co-lead for the CoIIN sponsored affinity group for Title V leaders. In addition, CRS has just completed a six-month project sponsored by national Family Voices, the Collaborative Action Team for Diverse Family Engagement. The CRS Assistant Commissioner and the SPC co-lead this team made up of CRS staff and FVA staff.

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. The SPC and a LPC are part of the Block Grant State Action Plan workgroup that meets monthly to discuss progress on Block Grant State Action Plan activities.

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 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), Lifespan Respite Network, 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, although these activities have been curtailed during the pandemic. They do provide training for various university classes, the UAB 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 Project Launch 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 is also a member of the AMCHP Legislative and Finance Committee. In June 2017, the SPC was appointed to serve as a Public Health Practitioner Affiliate with the UAB SOPH, and this appointment was renewed in 2020. 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 FVA, home of Alabama's F2F HIC. 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 F2F HIC project which strengthens the Parent to Parent program. CRS is partnering with FVA to maintain licenses and training needs for the data system. Information and assistance were 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 Medical Home. A significant collaboration has been support of the Partners in Care Summit, a project of the F2F HIC. CRS's support has helped the conference to grow and allowed for national speakers to present on topics related to medical homes, transition to adulthood, and family/professional partnerships. This conference has been attended by families, CRS staff from across the state, and other community partners. Unfortunately, the 2020 and 2021 Partners in Care Summit had to be cancelled due to the COVID-19 crisis.

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

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

MCH Epidemiology Workforce

There have been major changes in the epidemiology program capacity within the last year resulting in several vacancies needing to be filled. In an effort to continue to adequately serve programs until vacancies are filled, FHS has initiated a partnership with UAB to support our epidemiology and data analysis needs. 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 epidemiology workforce has the tools necessary for effective program monitoring and evaluation. Currently, epi staff are seeking training from agencies with a higher level of analytical expertise and experience directly related to MCH needs, specifically in the areas of statistical analysis. Brief biographies of Title V MCH Epi personnel in 2020 follow.

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. She supports all MCH epidemiology and evaluation needs including serving as the coordinator for the Title V MCH Block Grant and Title V Five-year Needs Assessment and supporting epi staff and MCH program managers as needs arise. Academic credentials include an undergraduate degree in Applied Mathematics and a graduate degree in maternal and child health.

Julie Nightengale, MPH, is a Research Analyst and has worked with public health for 11 years. She joined FHS' MCH Epidemiology Branch in 2017. Ms. Nightengale currently supports the FIMR, Alabama Newborn Screening, EHDI Programs. She also participates in the State Perinatal Advisory Committee, and supports other programs funded by CDC. Academic credentials include an MPH in Epidemiology.

William V. Duncan, BS, has 21 years of experience with ADPH. He works as a Public Health Research Analyst in the MCH Epidemiology Branch supporting the Family Planning, Well Woman, and Childhood Lead Poisoning Prevention Programs. Academic credentials include an undergraduate degree in Commerce and Business Administration.

Alice Irby, MPH, MS, joined FHS in 2016 and serves as the State Systems Development Initiative (SSDI) Coordinator. She is an MCH Epidemiologist, and currently, her major work involves federal grant management efforts related to MCH issues. Subjects of her work at ADPH have included Vital Records, the Zika Pregnancy Registry, and most recently COVID-19 pandemic efforts. Academic credentials include graduate degrees in biology and public health.

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

The purpose of the SSDI Grant Program is to develop, enhance and expand state Title 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 and varied organizations, such as Alabama 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 (birth, death and fetal death) 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' 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, there is not enough support of a hospital discharge database at this time.

By performing program evaluation activities around the NPMs, state MCH programs can monitor whether or not 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 epidemiology and SSDI project staff members have limited evaluation knowledge and experience necessary to accurately evaluate current MCH programs. Additionally, SSDI and MCH Epidemiology staff have also experienced challenges with SAS® Studio which is utilized for analytical purposes. These challenges compounded with the SSDI coordinator also being assigned the task of assisting with COVID-19 pandemic efforts limited the amount of time that could be dedicated to training to further develop skills. 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 and statistical support efforts, over the next year, which will allow for improved program development and effectiveness. In the interim, project staff will work with Georgetown University staff to complete Technical Assistance activities related to supporting program evaluation activities around NPMs and develop ideas related to products that demonstrate the use of data to inform decision making process. Our Perinatal Health Division director has indicated that she will request program evaluation training for all MCH Epi Branch members (which includes SSDI staff).

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

FHS MCH Epidemiology Brach staff support several programs funded by Title V. Those programs include Lead Poising Prevention, Well Woman, and SPP. Staff create data reports, complete data requests submitted by individuals within and outside ADPH and participate in evaluation projects. FHS MCH epidemiology staff access data from sources such as the Electronic Health Record system, the Healthy Housing and Lead Poisoning Surveillance System, FIMR, and the Center for Health Statistics. The work of the epidemiology branch supports program managers as they develop local, state, and federal reports, leading contributing factors to mortality, and recommendations for community and state programs. Their support in necessary in order to implement effective and evidence-based maternal and child health strategies in an effort to prevent or reduce disease, injury, disability and mortality. Staff also supported activities of the 2020 Title V Needs Assessment.

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

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

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

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

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

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

No Title V program staff were involved or consulted in the planning and development of the Alabama EOP. Title V leadership is not included in the state's emergency preparedness planning before a disaster; however, Title V staff are consulted in the response when pregnant women and children are impacted. Title V leadership is not currently a part of the Incident Management Structure (IMS); however, the Title V director was included in the past.

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

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

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

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

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

The Title V program fosters relationships with programs both internal to FHS and across 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. Similarly, the Title V program partners with public and private organizations in the state and across the nation, leveraging federal and state program resources to improve and expand the service delivery capacity of the program. 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.

ADPH

Current collaborations with other state public health and social service agencies, health services entities and practitioners, private organizations, and community partners must be maintained and strengthened, and new opportunities explored in order to support population-based health services delivery. The public and private partnerships allow ADPH, to leverage federal and state program resources, thereby contributing to the service delivery capacity of the Alabama Title V program. These partnerships expand the design and implementation of strategies aimed at improving the outcomes of the MCH population, particularly strategies addressing health inequities and supporting families and communities.

FHS continues to aim to partner with Medicaid, AHS, state advocacy agencies, and others at available opportunities. FHS staff routinely attend meetings with its partners and stakeholders, sits on committees with common goals, and invites them to participate in all statewide MCH programs. The Alabama Title V MCH Program has implemented a plan to extend its partnerships into the local community through the employment of District MCH Coordinators. These coordinators are tasked with developing strategic community partnerships to address local inequities. FHS also continues to 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 CYSHCN.

ALL Babies, a collaborative effort between CHIP and FHS, provides medical coverage to women who are not eligible for insurance and therefore unable to access prenatal care. FHS social workers provide case management services to the women and their infants for one year to ensure a medical home and dental home are established.

The State Dental Program partners with local governments, ADEM, and advocacy groups to support community water fluoridation regulation and infrastructure. Since 2018 the program has awarded over 300 water wells and plants fluoridation grants to purchase new or additional fluoridation equipment, ensuring hundreds of thousands of Alabamians have access to fluoridated water.

SPP, AHA, SHPDA, GOL, Birmingham Healthy Start plus, and other partners continue to work to implement a fully coordinated system of perinatal regionalized care in Alabama. The first step is assessing the current level of services offered by Alabama's delivering hospitals, followed by statewide compliance with the Alabama Perinatal Regionalization Guidelines.

Title V staff lead the State of Alabama Infant Mortality Reduction Plan, a collaboration between leaders and staff from

DECE, DHR, ADMH, ADPH, Medicaid, and OMA. These partners have developed and implemented activities and data support to address expanding current systems of care in areas such as mental health, safe sleep, home visiting, and breastfeeding.

Title V leadership and staff have been active partners in ALPQC since its inception. ALPQC began the Birth Certificate Accuracy Initiative (BCAI) project in 2018 with the purpose of improving the accuracy of birth registry data collected in the state for surveillance and future quality improvement work. After the completion of BCAI, ALPQC introduced the Maternal Hypertension (HTN) Initiative; the purpose is to assist hospitals in establishing protocols and processes and developing education to ensure pregnant and postpartum patients with hypertension/preeclampsia are quickly identified and managed.

FHS partners with Alabama educational intuitions and the National Maternal Child Health Workforce Development Center to recruit and host interns, providing them with direct training in the leveraging of funds, partnerships, and services for the benefit of the MCH population. Learning these skills before they enter the workforce, is vital preparation for future MCH professionals.

CRS

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. In February 2020 CRS began participating in the National MCH Workforce Development Center 2020 cohort. The focus has been to assess our current service delivery model to identify opportunities to improve access to services for those underserved and improve the quality of services provided. Utilizing data analytics, we can determine where we are as an agency and what other service models would look like in our agency. CRS completed the cohort in August and applied for and was accepted in a Single State Intensive project with the Center. Participating in this cohort has allowed us to continue working with the National MCH Workforce Development Center.

CRS is participating in the National Care Coordination Academy. The Academy is offered in partnership with the Departments of Accountable Care and Clinical Integration and the Department of Continuing Education, at Boston Children's Hospital. A team of CRS staff and outside partners including representatives from Medicaid and COA are participating in this unique learning opportunity. As part of its work with the Academy the Alabama team is focusing on exploring the benefits of a tiered system of care coordination for CYSHCN. By working with the Academy, we are learning how best to implement and evaluate a tiered system of care coordination to determine its efficiency and effectiveness and identify any needed changes for service delivery.

CRS is the lead agency for the Alabama Children with Medical Complexity (CMC) Collaborative Improvement and Innovation Network (CoIIN) to test and spread promising care delivery strategies for CMC. CRS in collaboration with Medicaid, University of South Alabama Pediatric Complex Care Clinic (USAPCCC), COA, and FVA have worked to create a service delivery model that provides comprehensive and well-coordinated care for CMC and their families. This provision of care for CMC is being accomplished through the implementation of a comprehensive care coordination program to improve outcomes for CMC. The focus is on establishment of a patient-centered medical home model and the use of Shared Plans of Care to improve communication among providers and families.

At the State level CRS is an active member of ACHIA which is the state improvement partnership program working with the Alabama 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.

In FY 2020 the CRS Social Work Transition Specialist in Birmingham began serving on the UAB/COA transition clinic Steering committee to assist with the development of a hospital wide transition policy. The meetings occur quarterly and moved to a Zoom format at the start of the pandemic. The goal of the committee is to develop a global transition policy and build relationships between hospital disciplines and the new Staging Transition for Every Patient (STEP) program. The STEP program at UAB started in September 2020 to help with the transition to adult care. It is the first formal program of its kind in Alabama and the surrounding region.

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

FHS

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

CRS

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

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

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

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

CRS serves in an advisory role to Medicaid for program and policy decisions likely to affect CYSHCN and its sub-group, 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 the SPC, participate on advisory committees and work groups associated with various Medicaid initiatives.

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

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

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

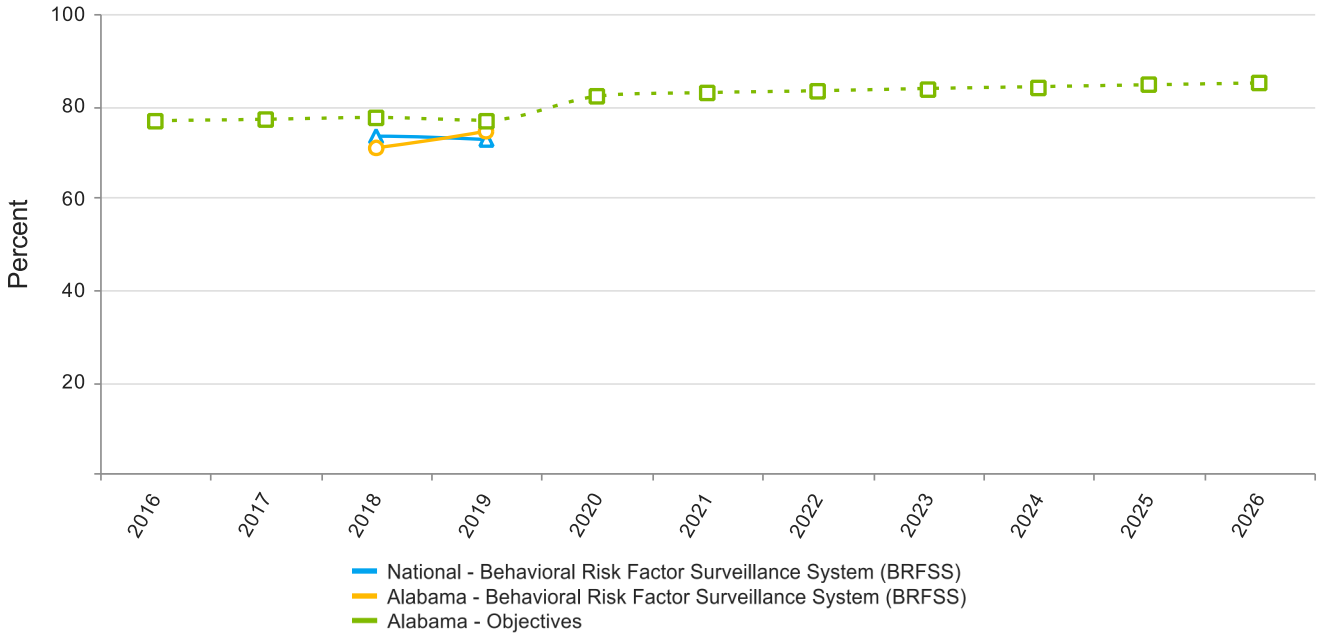
Women/Maternal Health

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-2015_2019	34.3	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2019	10.5 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2019	12.5 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2019	29.4 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2018	6.9	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	6.9	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	4.4	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	2.6	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	249.3	NPM 1
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy	PRAMS-2015	5.0 %	NPM 1
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations	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-2018_2019	13.4 %	NPM 13.1
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-2018_2019	12.9 %	NPM 13.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	87.6 %	NPM 13.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	25.6	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2019	23.5 %	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**	**2020**
Annual Objective					82
Annual Indicator				70.8	74.4
Numerator				599,429	629,176
Denominator				846,286	846,056
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	82.8	83.2	83.7	84.1	84.5	84.9

Evidence-Based or –Informed Strategy Measures

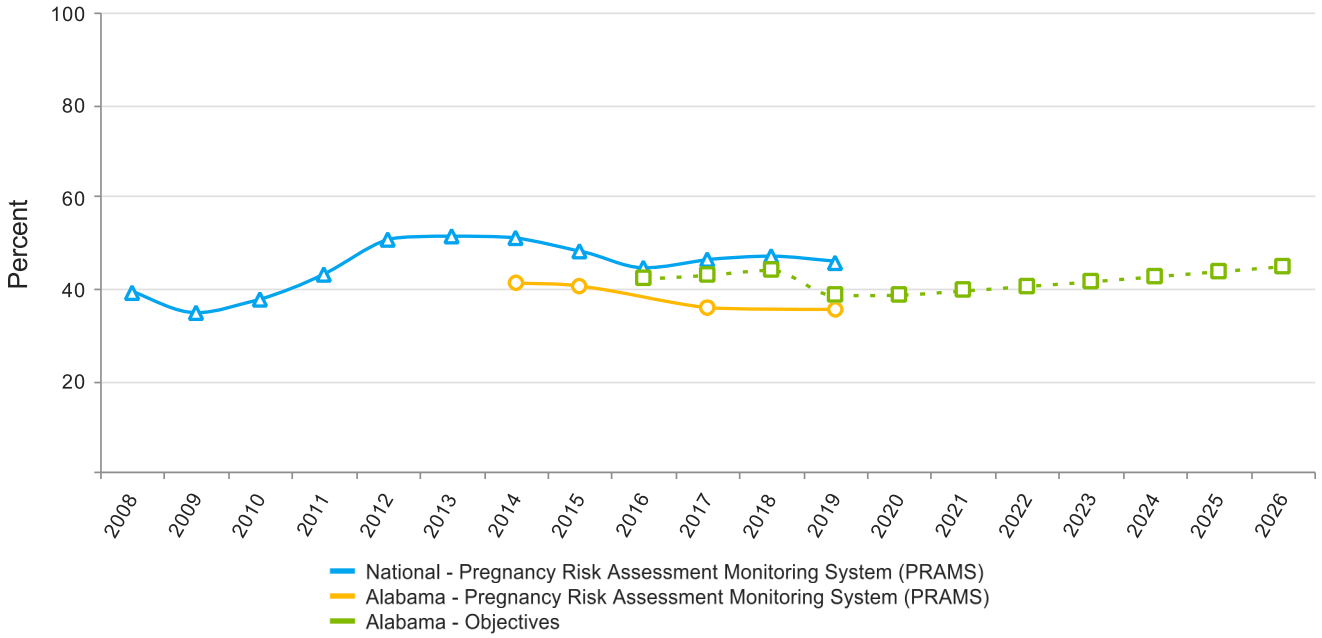
ESM 1.1 - Proportion of women age 15-55 who report receiving a preventive medical visit in the past 12 months by increasing total enrollment percentage in the Well Woman Program 2 points annually.

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		44	44.5	44.9	45.4
Annual Indicator	43.2	43.2	43.2	43.2	43.2
Numerator	1,081,373	1,081,373	1,081,373	1,081,373	1,081,373
Denominator	2,505,795	2,505,795	2,505,795	2,505,795	2,505,795
Data Source	BRFSS and U.S. Census Bureau, Population Division	BRFSS and U.S. Census Bureau, Population Division	BRFSS and U.S.Census	BRFSS and U.S.Census	BRFSS and U.S.Census
Data Source Year	2015	2015	2015	2015	2015
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	45.8	46.2	46.7	47.1	47.5	48.0

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**	**2020**
Annual Objective	42.3	43.1	44.2	38.7	38.8
Annual Indicator	41.2	40.6	40.6	36.0	35.4
Numerator	22,302	22,286	22,286	19,726	19,451
Denominator	54,138	54,955	54,955	54,751	54,884
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2015	2017	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	39.7	40.7	41.7	42.8	43.9	45.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active
State Provided Data	
	2020
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	500
Data Source	Oral Health Program
Data Source Year	2020
Provisional or Final ?	Final

Annual Objectives					
	2022	**2023**	**2024**	**2025**	**2026**
Annual Objective	3.0	6.0	9.0	10.0	10.0

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

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	500
Data Source	Oral Health Program
Data Source Year	2020
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	3.0	6.0	9.0	10.0	10.0

State Performance Measures

SPM 4 - Percent of women who smoke during pregnancy

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	8.7	8
Numerator		
Denominator		
Data Source	ADPH Center for Health Statistics	ADPH Center for Health Statistics
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	7.8	7.8	7.7	7.6	7.5	7.5

State Action Plan Table

State Action Plan Table (Alabama) - Women/Maternal Health - Entry 1	
Priority Need	
Lack of preventive dental visits across all Title V populations, especially for those uninsured.	
NPM	
NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy	
Objectives	
By 2025, increase the percentage of dental providers who receive education on the importance of preventive dental visits for expectant mothers by 10%.	
By 2025, increase the percentage of dental providers who are provided education and support on the provision/referral for HPV vaccine by 10%. (create a provider Services survey and gather baseline data.)	
Strategies	
Educate and reach out to oral health providers to improve understanding of preventive dental visits during pregnancy, and through ads utilizing television, streaming, and social media platforms.	
Promote HPV education, and HPV vaccine education, promotion and referral using the #WATCHYOURMOUTH campaign developed through a partnership with Mitchell Cancer Institute.	
ESMs	**Status**
ESM 13.1.1 - Percentage of dental providers receiving information/education regarding importance of preventive dental visits for expectant mothers	Active
ESM 13.1.2 - Percentage of dental providers that received information/education regarding their perinatal patients about the FDA approved HPV vaccine in order to reduce the risk of oropharyngeal, cervical, and other HPV-related cancers	Active
NOMs	
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	
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) - Women/Maternal Health - Entry 2

Priority Need

High levels of maternal mortality.

NPM

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

Objectives

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

Strategies

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

ESMs	Status
ESM 1.1 - Proportion of women age 15-55 who report receiving a preventive medical visit in the past 12 months by increasing total enrollment percentage in the Well Woman Program 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 - Percent of women who drink alcohol in the last 3 months of pregnancy

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

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

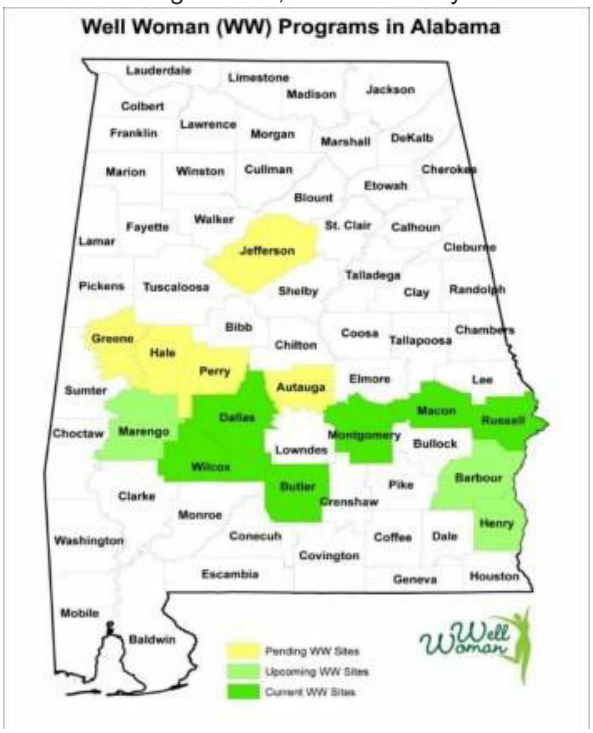
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Well Woman Program

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

ESM 1.1: Increase the proportion of women age 15-55 who report receiving a preventive medical visit in the past 12 months

The ADPH Well Woman program creates the opportunity for women ages 15-55 to receive preventative health screenings and management of chronic diseases. The program is an evidence-based program that utilizes the New Leaf intervention modules which were developed at the University of North Carolina at Chapel Hill. The goal of the program is to provide preconception and interconception care to women of child-bearing age as a foundation for wellness, identification of chronic diseases and planning to adopt a healthier lifestyle. The program started in 2017 as a pilot program in Wilcox, Butler and Dallas counties. The successes of the program in those three counties lead to an expansion. In October 2018, ADPH received funds from the governor's imitative to decrease infant mortality. With the funding of the governor's initiative and MCH funds, the program expanded to the 3 new counties- Macon, Montgomery and Russell. The program is currently in 6 counties (Butler, Dallas, Macon, Montgomery, Russell and Wilcox). For fiscal year 2020, we were fortunate to expand to Marengo county. Due to COVID and staffing issues, the program hasn't started in Marengo county yet. In fiscal year 2021, we have plans to implement the program in Henry and Barbour counties and discussions are underway to implement a traveling Well Woman team in West Central district covering Greene, Hale and Perry counties. Well Woman sites are illustrated on the Alabama map below.



Our mission is to provide a healthy living, prevention & early detection of diseases program, and to increase the quality of life for women ages 15-55. We encourage self-referrals, referrals from community partners, local physicians, and other programs within Alabama Department of Public Health like the Family Planning and STD clinics. Our ideal participant is the uninsured and/or underinsured but we will not deny services to any qualifying participant. The program enhances access to preventative screenings for cardiovascular disease, wellness checks, and vision and oral screenings. We offer services to address issues like obesity, hypertension, high cholesterol and

diabetes. Also, we focus on counseling before and after pregnancies to improve birth outcomes in the state of Alabama.

Program staff consists of a variety of professional staff members. An administrative assistant enrolls the participant by ensuring the consent form is signed and by entering the referral source, if noted. A clinic aide performs the biometric testing which includes weight, height, waist measurements, two B/P readings and lab results for the lipid panel and glucose levels. A registered nurse initiates the initial visit by completing the health and physical assessment and initial counseling to discuss prescreening lab results. The Nurse Practitioner completes the risk reduction counseling which consists of reviewing initial lab results and educating the client on ways to adopt a healthier lifestyle. The social worker is the driver of the program responsible for the case management of participants; coordinating health coaching sessions with participants either face to face or by phone and spearheading monthly support group meetings on a variety of topics; and reinforcing education provided by the registered nutritionist and Nurse Practitioner. Also, the program offers monthly nutritional education to participants by a registered nutritionist.

Clinic visits were postponed in the second quarter of fiscal year 2020 and resumed in the fourth quarter on August 27, 2020. The program enrolled 371 participants in fiscal year 2020. Though new clients could not be enrolled, existing clients continued to receive services via telehealth phone visits and virtual means. Telehealth/telemedicine was incorporated into protocols, which allowed continuation of services, such as health and nutrition coaching sessions, risk assessment and counseling, as well as other educational opportunities. New protocols for safety measures were put into place to ensure the well-being and protection of staff and clients. These new safety measures included provision of personal protective equipment to both staff and clients, social distancing and screenings for COVID related symptoms. Nurse practitioners conducted risk assessments by reviewing the participant's history and physical and lab results. Treatment was initiated, if needed, and the participant was counseled on any identified conditions (such as hypertension). Web cameras were purchased for social workers and the nutritionist to host and participate in virtual opportunities. Participants benefitted from the web cameras also, with nutritional classes held twice weekly with a registered nutritionist. As physical activity is an important component of ensuring health, partnerships with local communities allowed multiple daily exercise classes to be offered via Facebook and other virtual platforms. The program hosted a virtual, three-day course for its second annual training for social workers. The training focused on motivational interviewing.

Near the final quarter of the fiscal year, the Well Woman Program was selected to host two student interns for summer 2020 through the National Maternal Child Health Workforce Development Center. The internship ran from June 8 through July 31. The interns worked with the program virtually and in-person to increase client awareness/understanding about the program and to identify and develop ways to collect and analyze data on program participants, including blood pressure readings, weight, current health issues, and reproductive and medical history. The interns also helped to develop an electronic version of the quarterly newsletters sent to staff for program updates, which allowed for easy dissemination. Through manual data collection remains a challenge, program staff work closely with the epidemiology division for assistance, with increased usage of data available in the ADPH electronic health record system. In subsequent years, improved data collection and analyses will likely have a long-term positive effect for quality improvement of the program and patient care.

Program Success Story:

One participant, from Russell county, joined the Well Woman program in February 2019. She desired to lose weight and become healthier. She was determined to reach her goals from the start and continued her journey throughout the pandemic by participating in daily virtual exercise classes. She has lost over 20 pounds and is committed to her goals.

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.

The Oral Health Office (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. These partners receive oral health kits containing pamphlets, toothbrushes, toothpaste, floss, hand sanitizer and lip balm SPF rated to prevent oral cancers. Partners may submit requests to OHO for oral health kits throughout the year.

Promotion of preventive dental visits for expectant mothers was achieved by design and creation of EuroFit Wall Stands. One hundred of these displays were obtained and distributed to CHDs in each of the six public health districts, UABSOD, ADPH family planning clinics, and some FQHCs.

A 30 second Spectrum cable television and streaming advertisement began showing in September 2020 and ran through the month of October, National Dental Hygiene Month. The ad promoted preventive dental visits for expectant mothers and children ages 1-17, in addition to the newly FDA approved (age appropriate) HPV vaccine, for expectant mothers and children ages 9-17 years. The following summarizes the public reach of the Spectrum advertisement.

Television Overview
1,006 Airings
31 Networks
12 Zones

Streaming TV Overview
95,067 Impressions
93,727 Completions
98.59% Completion Rate

Ongoing activities in Alabama to improve oral health:

The only ADPH operated dental clinic that remains is located within the Tuscaloosa County.
The Tuscaloosa County Health Department (TCHD) provides preventive and restorative care for children, young adults, and pregnant women under the age of 21 who are covered by Medicaid, ALLKids, or Alabama Blue Cross Blue Shield. OHO utilized Title V funds to equip the Tuscaloosa County Health Department's dental clinic with new digital radiography equipment. Free oral hygiene supplies, educational material, and other assistance were provided to TCHD as requested. In 2020 there were a total of 1,672 patient visits to TCHD dental clinic. Of that total, 1,299 were preventive dental visits and 10 were pregnant women.

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. Northern Public Health District 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.

Community Water Fluoridation

OHO awards Fluoridation Grants totaling $100,000 (maximum $25,000 per site) by way of RFPs for purpose of replacing or updating fluoridation equipment to offer uninterrupted Community Water Fluoridation, as well as initiation of fluoridation. OHO provided grants totaling $57,396 to water plants for purchase of new or additional fluoridation equipment. These public water systems serve a total population of 123,998.

Annual CDC Fluoridation Quality Awards are presented (one year in arrears) to water plants that consistently maintain the optimal 0.7 ppm fluoride level on a monthly basis. The FY2019 FY fluoridation awards went to 109 wells and plants per CDC standards and guidelines—a 21% increase over the previous year. The FY2020 FY fluoridation awards will be presented to 121 wells and plants per CDC standards and guidelines—a 10% increase over 2019.

The OHO fluoridation toolkit pamphlet was updated to indicate observance of the 75th year of Community Water Fluoridation in the U.S. The toolkit and pamphlet continue to be available through the ADPH website and was the pamphlet distributed to all public water systems and included in the OHO oral health toolkits after the redesign. The pamphlet was also distributed at health fairs.

OHO hosted its first ever Oral Health and Community Water Fluoridation Conference, a goal of the director of the OHO since 2017. Using a virtual platform, OHO partnered with the City of Troy (Alabama) and the Alabama Department of Emergency (ADEM) Management to host the conference and provide four free CE hours to 187 water plant operators. In addition to the operators, state dental directors and college instructors were among the diverse group of attendees. Speakers for the conference were from the CDC (National Fluoridation Engineer), National Fluoridation Society (President), City of Troy (Utilities Engineer), and Hand Aqua Products (sales representative). The Oral Health Office partnered once again with the City of Troy for an in-person conference in Troy, Alabama. This conference provided seven free ADEM approved CE hours to 85 water plant operators and environmentalists.

Approximately 721,699 residents will be positively impacted from the educational information provided by the conference.

Community and State Partnerships

OHO initiated a collaboration with Life on Wheels, a non-denominational faith-based organization offering free pregnancy tests and ultrasounds in the River Region and Birmingham areas. Through this partnership, oral health kits and educational materials about oral health during and after pregnancy are provided to clients. Since the organization's inception in 2016, 3,926 free pregnancy tests and 3,531 ultrasounds have been provided.

The Pay It Forward program, administered by HandsOn River Region, was awarded a $25,000 grant from OHO in 2020 to continue its program and support the salary of a coordinator. The program is a value-based program where uninsured / under-insured clients (mothers and fathers) 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. The following organizations partner with HandsOn River Region to enroll clients:

- Gift of Life — Gift of Life serves expectant and parenting moms and dads and children who are at a greater risk for infant mortality by reducing barriers to success, related to economic, social and health disparities and to improved birth outcomes
- 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.
- HOLA – Hispanic Outreach Leadership and Action - HOLA is a local non-profit that serves the Hispanic community in the river region.

The COVID pandemic had great impact on the Pay it Forward program due to the closure of dental offices and hesitancy of its clients to complete community service and dental visits for fear of contracting the virus. Orientation of new clients was affected as well, although, in person and ZOOM orientations are now underway.

Even with the numerous obstacles of COVID, Pay it Forward managed the following accomplishments for 2020:

- Number of orientations scheduled - 7
- Approximate number of people oriented - 41
- Number of appointments made - 3
- Number of successful appointments - 3

- Approximate number of volunteer hours by participants - 90
- Number of participating dentists - 7
- Number of visits/calls made to potential dentists to recruit for program – 1

In spite of all the obstacles of the last several months, the program continues to serve the underserved who otherwise might never have the opportunity to receive dental care.

County Health Department MCH Projects

ADPH, JCDH and MCHD coordinators submitted MCH proposals in 2020 to address needs within the Women/Maternal Health Domain, with projects focused on access to oral health care, expansion of the Well Woman services, and suicide prevention. While COVID-19 caused numerous disruptions and delays during FY 2020, the coordinators had begun implementing some projects, and were able to establish partnerships, purchase equipment and take other steps that would propel other activities in FY21 once clinics and other agencies reopened.

Highlights

- *West Central P*ublic Health *District*: Two QPR suicide curriculum trainings were facilitated and suicide prevention resources and promotional items were provided to residents in Perry, Pickens and Tuscaloosa counties.

- *JCDH*: Coordinator facilitated the From Day One Program, a comprehensive patient centered program with a mission to improve pregnancy and birth outcomes. From October 2019-September 2020, Community Health Workers (CHWs) and other community agencies hosted of four baby safety showers, providing health and safety education and resources to 38 maternity clients, along with 24 family members.

- *MCHD*: provided referral services and linkages to preventive care and immunization services for 71 participants in the Family Support/Home Visitation program for pregnant and parenting teens in Mobile County as well as participants in the Fatherhood Initiative.

- *Northern District*: Developed partnerships with local agencies, including Community Services Planning Council (CPSC), County Interagency Councils, Caring Connection of the Shoals, Alabama Society of Health Care Social Workers, Children's Policy Councils, hosted dental health awareness days in all 12 northern district counties, providing education and incentives for pregnant women and children. The MCH coordinator presented QPR training to 96 individuals and provided suicide prevention resources to community partners such as meals on wheels, North Central Alabama Regional Council of Governments (NARCOG), and North West Alabama Council of Local Governments (NACOLG).

Barriers

- *West Central P*ublic Health *District*: COVID-19 caused numerous disruptions and delays during FY 2020, therefore, the coordinator was not able to fully implement this dental plan or QPR and Response trainings as planned

- *JCDH*: Due to COVID 19 restrictions and guidelines, the Baby Safety Shower format had to be reevaluated and changed to virtual presentations, with a touchless pickup system. Lack of experience with virtual platforms for program managers, agency volunteers, and program participants. Language barriers caused delays in hosting the Baby Safety Showers which were previously inclusive of English and Spanish speaking

clients.

- *MCHD*: The Covid-19 pandemic caused significant changes in the functions of the agency and the delivery of MCH services. Family Support/Home Visitation and Fatherhood programs saw some declines due to the Covid 19 pandemic. Some participants were out of work and trying to navigate the closure of daycares and schools. In-person education classes were replaced with virtual education and follow-up, which introduced new barriers for participants such as a lack of adequate phones, computers, internet services and other technology. The number of participants for virtual activities experienced a drop compared to the in-person meetings.

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. In CY 2020, the ADPH Family Planning Program and its sub-recipients, Jefferson County Department of Health and Mobile County Health Department, served 45,497 clients in 99,137 visits. Over 23,000 clients reported incomes of 100 percent or less of Federal Poverty Level, and more than half of the clients served during CY 2020 were uninsured. However, ADPH also provides family planning services to patients insured by Alabama Medicaid (Plan First and/or full Medicaid) or Blue Cross Blue Shield of Alabama.

ADPH Family Planning services include reproductive life planning, contraceptive counseling, breast and cervical cancer screenings and follow up, screening and treatment for sexually transmitted infections. Clients also receive referrals for health care services outside the scope of family planning, through partnerships with other ADPH programs, such as the Alabama Breast and Cervical Early Detection Program, and external entities, such as Alabama Department of Human Resources, contracted professional services providers, and Alabama Coordinated Healthcare. Clients have access to a broad range of contraceptive methods, including long-acting reversible contraceptives (LARC). During CY 2020, just over 31 percent of clients selected a LARC method, as compared to just over 34 percent during FY 2019.

During CY 2020, Family Planning Program clients and service provision were dramatically impacted by the onset of the COVID-19 pandemic. With Alabama Medicaid's approval, ADPH implemented a virtual visit model, which allowed continued provision of essential family planning services. Beginning in March 2020, Alabama Medicaid extended approval for telehealth family planning visits on a month-to-month basis. Telehealth visits are especially beneficial to ADPH clients whose access to services may be limited by barriers, such as lack of transportation, inability to fit in-person visits into hourly work schedules, and lack of childcare.

In 2019, Family Planning physicians began providing colposcopy services, traveling to selected CHDs on a rotating schedule, in order to facilitate easier access for patients within surrounding multi-county geographic areas. The addition and expansion of this critical procedure greatly facilitates continuity of care for patients who require follow up of abnormal cervical cancer screening results. As with other clinical services, colposcopies were necessarily limited during 2020.

However, a continuation plan, including use of personal protective equipment for patients and providers, was implemented to ensure timely access to this critical diagnostic procedure for high-risk and/or emergent cases that could not be safely postponed. Plans are in development for ADPH nurse practitioners (NPs) to receive colposcopy

training, beginning in the next fiscal year. Upon completion of training, the NPs will utilize mobile colposcopy equipment and existing telehealth capacity to transmit live colposcopy imaging, allowing physicians to diagnose and recommend treatment options remotely.

Special Supplemental Nutrition Program for Women, Infants, and Children

Alabama's WIC Program implemented eWIC statewide during 2019. The transition to eWIC allows families to purchase their food benefits using an electronic benefits transfer (EBT) eWIC card 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. The transition to eWIC also enabled Alabama's WIC Program to quickly respond to the federally declared COVID-19 public health emergency. Several WIC waivers were implemented during 2020 to promote social distancing and keep Alabama's WIC participants safe. Physical presence and remote benefits issuance waivers allow benefits to be loaded remotely without requiring a face to face appointment. During COVID-19, most WIC participants receive benefits automatically through auto issuance; certain participant groups require a monthly remote telephone visit to receive benefits.

To assist with communication during COVID-19, text messaging was launched providing appointment reminders and auto issuance notifications. Another ongoing outreach activity that has helped during COVID-19 is the Alabama WIC app. The free Alabama WIC app is available for participants to access on Apple and Android devices. The WIC app features a clinic locator, appointment and benefit expiration reminders, notification pushes to share pertinent information, a searchable WIC approved food list, a bar code scanner to determine if specific food items are WIC approved, nutritious recipes, education focused on nutrition and breastfeeding, and more. WIC participants are encouraged to download the app and explore what it offers.

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 website. The nutrition education lessons directly interface with Alabama's WIC Crossroads Management Information System, so that clinics can confirm completion of these lessons. WIC providers also conduct nutrition education visits via telephone to reduce the number of visits that the family must make to the clinic.

During 2020, Alabama's WIC program focused nutrition education efforts on improving the oral health of WIC participants as part of the FY 2021-2022 Nutrition Education Plan. The WIC Nutrition Education Plan supports these efforts with nutritious recipes incorporating WIC approved foods, tips for increasing dairy intake, education on high calcium and high phosphorus foods, and dental hygiene reminders. Families are provided incentive items in the form of a clear zipper pouch containing a toothpaste squeezer and a tooth brush sand timer to educate and encourage WIC participants about the oral health benefits of WIC foods. Alabama's WIC program will continue to monitor food benefit redemption data to determine if the education provided increases redemption of calcium and phosphorus rich WIC approved foods.

WIC continues to increase public awareness of the importance of breastfeeding. In 2019, 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 virtually during COVID-19. 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 Alabama Breastfeeding Resource Guide was updated for ADPH's website. Materials were distributed to county health departments to promote Breastfeeding Awareness Month in August. As of September 2020, there were a total of 70 breastfeeding peer counseling sites. Although COVID-19 has slowed some activities, efforts to expand Alabama's WIC Breastfeeding Peer Counseling Program continue. During 2020, virtual training was offered for the Breastfeeding Peer Counseling Program. To monitor its effectiveness, 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 2019, 798 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.

Women's Health Update

The OWH Twelfth Annual Women's Health Update was cancelled in 2020 due to COVID and scheduled to resume virtually in FY21.

Opioid Misuse in Women and Neonatal Abstinence Syndrome

The OMW/NAS Taskforce continued to meet quarterly in March, July, 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 trend of infants born addicted to drugs (NAS/ NOWS), by

introducing preventative strategies and proposing standardized screening protocols to address early identification in women and in babies exhibiting NAS after delivery. In 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/NOWS 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, 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 MMRP in March 16, 2018. The purpose of MMRP 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). 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 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 2018 maternal deaths. The MMRC is meeting quarterly to review the 2018 case summaries and make recommendations. An abbreviated report of the MMRC findings is being prepared and scheduled to be published by the end of 2021. The MMRP was provided state funds through the general budget to hire additional staff and provide funding to perform maternal death autopsies. Two additional nurse abstractors and an administrative support assistant were added to the staff in October 2020. Contracts have been secured with the UAB to perform the autopsies and the Steele City Mortuary Transport to transport the decedents to and from UAB. A student

intern is working with the MMRP to research and develop a process to incorporate interviews from the next of kin. The interviews will assist the MMRP in gaining a better understanding of the factors that contribute to maternal 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. Following is an overview of the initiative's maternal health strategies.

Home Visiting
The Alabama Department of Early Childhood Education (DECE) contracted with two programs to provide home visiting services in the three original target areas, Macon, Montgomery, and Russel counties, using the Parents as Teachers (PAT) and Nurse Family Partnership (NFP) models of service delivery. The programs began the year fully staffed and trained. However, throughout the year staff turnover caused new staff to go through the processes of becoming both model and DECE trained, which usually takes at least a few months. During and after the training period, staff members continued to work to gain public awareness in the communities and recruit families to participate. Despite the challenge of staff turnover, the goal to serve 100 families across the target counties was achieved, with 145 active families in FY2020.

State funding was blended with federal (Health Resources & Services Administration Maternal, Infant, and Early Childhood Home Visiting) funding which allowed more families to be served. Additionally, matched funding from the Alabama Medicaid Agency, funds from the Department of Human Resources, and increased research and training allowed DECE to expand home visiting to all counties in the state. One of the models provided phones and service plans to families who were without these means. These provisions allowed home visitors to continue to maintain contact with families and refer them to resources for necessities, such as housing and food. Some of the screenings and assessments were completed virtually and allowed the continuation of data collection. Collectively, 190 screenings were provided, which assessed child development, parent-child interaction, and intimate partner violence. Additionally, five women were referred for tobacco cessation services.

There were many challenges to overcome during this year. The narrow eligibility requirements for NFP of first-time mothers prior to 28 weeks gestation, made it difficult to find enrollees. When eligible mothers were identified, it was challenging to get them to reschedule after the initial visit. This challenge is typical in communities where there is limited awareness about a new program. It is hoped that with increased enrollment, more mothers will find out about the program through word of mouth, which is often the best form of advertisement. Similarly, receipt of referrals from usual sources decreased with business closures and staff transitioned to working from home. Program staff continued to reach out to establish new referral sources.

Reliable referral sources for the program were more difficult to locate, due to the location of one of the pilot counties and the impact of the COVID-19 pandemic. The program using PAT only serves Russell County, which is large, both urban and rural, and with a transient military community. It also borders Georgia, where some families choose to receive medical and other services. Many families choose physicians and delivering hospitals in Georgia (who accept Alabama insurances), and the programs have to rely on them for referrals. Regarding the effects of the COVID-19 pandemic, it was difficult to identify new referral sources due to limited travel and the inability to go into offices and meet with staff in person. Many agencies and programs transitioned to providing services remotely, making referrals an afterthought in dealing with the demands of virtual service delivery. However, both programs

serving Russell County reported progress, new partnerships, and referral sources over the past year.

The novel coronavirus (COVID-19) pandemic presented the most significant challenge this year. However, both models of home visiting were quick to provide guidance on how to continue visiting families virtually. The transition was almost seamless, and the programs were able to retain most of the families. This transition resulted in positive movement on team goals. Figures 3a – 3c depict select performance measures and outcome indicators, with targets where applicable, for the second year. At least 50 percent of primary caregivers in Montgomery and Russell counties reported safe sleep practices. More than half of the mothers who delivered during the time period initiated breastfeeding in all three counties. The percentage of infants born preterm varied by county.

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.

To increase the number of providers who use SBIRT, the team worked diligently throughout this year to construct an Alabama-specific, online training module. After extensive research into evidence-based literature was conducted, the content of the training was drafted. The process towards production remained ongoing, which involved working with a software development company to solidify plans to bring the project to fruition. The team also explored different opportunities to involve other partners whose clients may benefit from the screening tool. This exploration resulted in discussions and implementation of virtual SBIRT training with ADPH staff involved in the ALL Babies and Family Planning programs. Moreover, coordination was initiated with the Alabama Medicaid Agency on the ways in which Alabama Coordinated Health Network (ACHN) case managers may use the SBIRT model with pregnant women. In this way, more at-risk women may be identified and receive appropriate follow-up care. Grant funds will be used to help offset costs for ACHNs on incorporating the screening tool into their electronic health records system. To further increase awareness of the model and its relevance, the team plans to present at a conference in the next fiscal year for healthcare professionals, introducing them to the model and process in OB/GYN practices.

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 project year started off strong for the Well Woman team, with a total of 120 participants enrolled in the pilot counties within the first quarter. However, the onset of the COVID-19 pandemic in the second quarter was particularly challenging for the Well Woman team, which serves clients who are at increased risk of severe outcomes. Groups at risk include those with underlying health conditions, such as obesity, hypertension, diabetes, high cholesterol, and heart disease. The goal to enroll 500 women across all six counties during FY2020 (which averages to approximately 83 enrollees per county) was not met, as a result of the pandemic. However, 371 participants were enrolled across all six counties, 221 of which were in the pilot counties. Among those enrolled, 59 (27 percent) women were hypertensive and underscored the need for chronic condition management and healthy lifestyle adjustment.

Clinic visits were postponed in the second quarter and resumed in the fourth quarter on August 27. Though new clients could not be enrolled, existing clients continued to receive services via telehealth phone visits and virtual means. Telehealth/telemedicine was incorporated into protocols, which allowed continuation of services, such as health and nutrition coaching sessions, risk assessment and counseling, as well as other educational opportunities. New protocols for safety measures were put into place, to ensure the well-being and protection of staff and clients.

These new safety measures included provision of personal protective equipment to both staff and clients, social distancing, and screenings for COVID-related symptoms. Nurse practitioners conducted risk assessments reviewing the participant's history and physical and lab results. Treatment was initiated, if needed, and the participant was counseled on any identified conditions (such as hypertension). Web cameras were purchased for social workers and the nutritionist to host and participate in virtual opportunities. Participants benefitted from the web cameras also, with virtual nutritional classes held twice weekly with a registered nutritionist. As physical activity is an important component of ensuring health, partnerships with local communities allowed multiple daily exercise classes to be offered via Facebook. The team hosted a virtual, 3-day course for its second annual training for social workers. This training focused on motivational interviewing.

Near the final quarter of the fiscal year, the Well Woman program was selected to host two student interns for summer 2020 through the National Maternal Child Health Workforce Development Center. The internship ran from June 8 through July 31. The interns worked with the program virtually and in-person to increase client awareness/understanding about the program and to identify and develop ways to collect and analyze data on program participants, including blood pressure readings, weight, current health issues, and reproductive and medical history. The interns also helped to develop an electronic version of the periodic newsletters sent to staff for program updates, which allowed for easy dissemination. Though manual data collection remains a challenge, program staff work closely with the epidemiology division for assistance, with increased usage of data available in the ADPH electronic health record system. In subsequent years, improved data collection and analyses will likely have a long-term positive effect for quality improvement of the program and patient care.

Perinatal Regionalization

Enhancing perinatal regionalization (PR) 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.

During this fiscal year, epidemiologists and research analysts analyzed pertinent data to create an evidence base upon which to act. These analyses included information on birth characteristics and outcomes in the state. Unfortunately, loss of staff during the fiscal year, coupled with the reassignment of team members to COVID response efforts, hindered the anticipated progression of PR activities. Moving forward, efforts will continue in order to effectively communicate the findings of the analyses, such that stakeholders may begin implementation of the PR model. Once the PR model is adopted, trainings will be provided to hospital administrators and staff, as well as Emergency Medical Services workers. In this way, those involved in the care and transport of at-risk mothers will have all the resources needed to ensure transport to the appropriate level of care hospital, which consequently will improve maternal and child health.

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 by 2 points annually.

For 2022, WW plans to expand and implement the program in Henry and Barbour counties and discussions are underway to implement a traveling Well Woman team in the West Central district, covering Greene, Hale, and Perry counties.

At this time, Title V funds do not support the colposcopy project, so it has been removed as an SPM. FHS will continue to report progress on the project as part of the Family Planning Program.

Oral Health Office

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

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

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

The OHO will distribute educational resources to dental providers through direct mailings and the promotion of awareness campaigns related to oral hygiene, oral cancer, and HPV.

OHO and OCHA will develop and promote educational opportunities for dental providers on the importance of dental visits during pregnancy through ads utilizing television, streaming, and social media platforms.

OHO anticipates the partnership with HandsOn River Region supporting the Pay It Forward Program to continue in 2022. Additional organizations continue to be recruited to participate in the Pay It Forward Program; additional providers are being sought as well.

In addition to the new radiographic equipment purchased with MCH funds, TCHD was able to obtain portable dental chairs and delivery systems to equip two operatories (treatment rooms) in the Greene County Health Department to begin operation by FY2022. These new operatories are significant in that Greene County does not have a dentist. The intent is to initially provide preventive dental appointments for the MCH target population, provide preventive dental visits to expectant mothers as a result of the increased Medicaid eligibility age. The clinic will be staffed by the TCHD dental team, as well as allow UABSOD students the opportunity to do rotations there. Eventually, the plan is to expand to restorative procedures as well. Patients needing restorative procedures can referred to the TCHD or other nearby facilities.

Maternal Mortality Review Program

In FY 22, the MMRC will continue to meet quarterly to review cases. State funds through the general fund budget will continue for the MMRP. These funds were secured through the efforts of the March of Dimes and the Medical Association of the State of Alabama. The program will incorporate next of kin interviews from family members, and identity a process for including a community representative on the MMRC. 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.

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-2018	6.9	NPM 3
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	6.9	NPM 3 NPM 5
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	4.4	NPM 3
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	2.6	NPM 5
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	249.3	NPM 3
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	117.7	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	2020
Annual Objective	85.2	75.9	84.5	84.2	83.6
Annual Indicator	75.7	84.3	84.1	83.5	83.5
Numerator	892	958	913	949	949
Denominator	1,179	1,136	1,086	1,137	1,137
Data Source	Alabama Center for Health Statistics	Alabama Center for Health Statistics	Alabama Center for Health Statistics	Alabama Center for Health Statistics	Alabama Center for Health Statistics
Data Source Year	2016	2017	2018	2019	2019
Provisional or Final ?	Final	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	83.8	84.0	84.1	84.3	84.5	84.6

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data		
	2019	2020
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	2026
Annual Objective	0.0	10.9	21.7	32.6	43.5	54.3

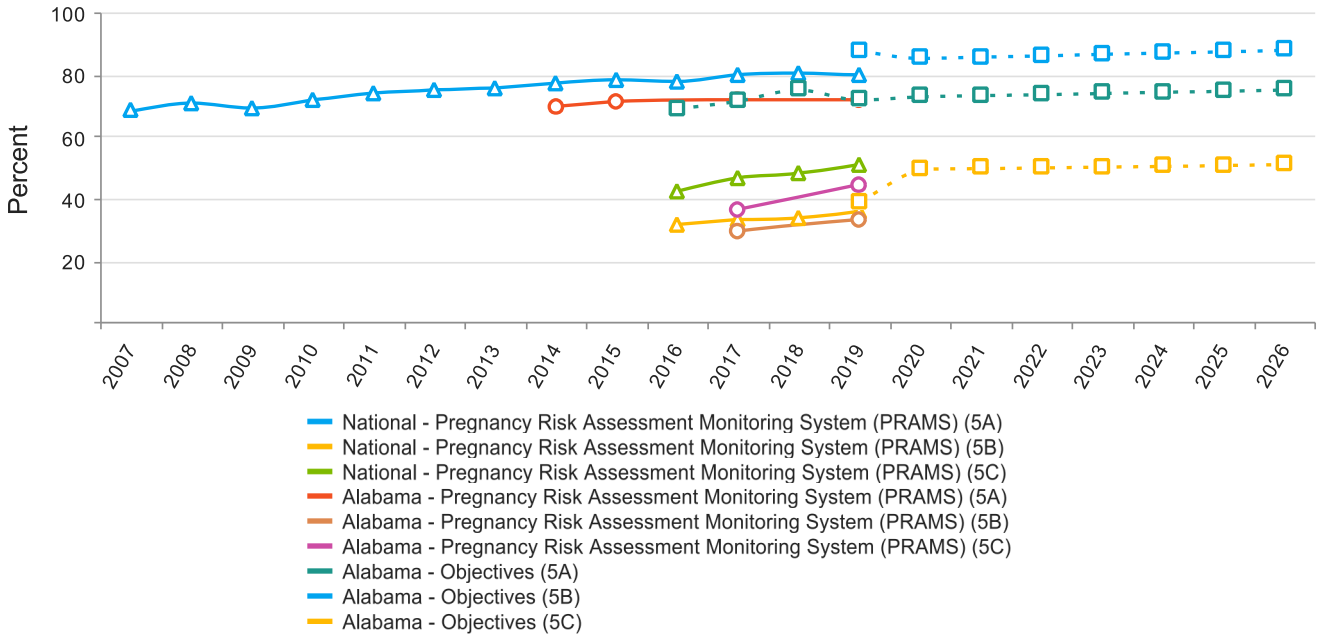
ESM 3.2 - Number of steps of the CDC's Level of Care Assessment Tool (LOCATe) Process completed in order to design and align the Alabama Perinatal Regionalization System Guidelines with the national criteria for the Maternal Levels of Care

Measure Status:	Active

State Provided Data		
	2019	2020
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	2026
Annual Objective	1.0	1.0	2.0	2.0	3.0	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**	**2020**
Annual Objective	69.4	71.9	75.5	72.3	73.3
Annual Indicator	69.5	71.3	71.3	72.1	72.0
Numerator	37,350	38,245	38,245	37,735	37,266
Denominator	53,710	53,663	53,663	52,309	51,781
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2015	2017	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	73.7	74.0	74.4	74.8	75.1	75.5

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

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2019	**2020**
Annual Objective	88.1	85.7
Annual Indicator	29.8	33.3
Numerator	15,619	16,967
Denominator	52,446	50,878
Data Source	PRAMS	PRAMS
Data Source Year	2017	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			88.1	85.7
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						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	86.1	86.5	87.0	87.4	87.8	88.3

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

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2019	**2020**
Annual Objective	39.3	49.9
Annual Indicator	36.7	44.4
Numerator	19,218	22,734
Denominator	52,355	51,234
Data Source	PRAMS	PRAMS
Data Source Year	2017	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			39.3	49.9
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						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	50.2	50.4	50.7	50.9	51.2	51.5

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - Number of sleep-related infant deaths

Measure Status:	Active

State Provided Data		
	2019	2020
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	2026
Annual Objective	63.9	62.0	60.1	58.3	56.6	54.9

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

Measure Status:	Active

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

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	2.5	3.1	3.9	4.9	6.1	7.6

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

NOMs

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

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

Priority Need

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

NPM

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

Objectives

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

Strategies

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

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

NOMs

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

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

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

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

Priority Need

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

NPM

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

Objectives

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

Strategies

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

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

NOMs

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

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

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

State Perinatal Program

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

ESM 3.2 - 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 included 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 and 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.

In 2020, to inform the perinatal regionalization (PR) strategy, epidemiologists and research analysts analyzed pertinent data to create an evidence base upon which to act. These analyses included information on birth characteristics and outcomes in the state. Unfortunately, loss of staff during the fiscal year, coupled with the reassignment of team members to COVID response efforts, hindered the anticipated progression of PR activities.

The percent of VLBW infants delivered at the appropriate facility is included in the agency's improving birth outcomes strategic plan. Monthly VLBW delivery data for Macon, Montgomery, and Russell counties were reviewed at the monthly strategic plan meetings. Evidence-based strategies to increase the number of VLBW within the pilot counties were reviewed with the goal to identify and select the appropriate strategy/strategies that could be implemented in the pilot counties.

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

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.

In 2020, the 2019 infant mortality data was released. In 2019 Alabama experienced an increase of 29 SUID; for a total of 99 SUIDS. ADPH provided 127 pack-n-plays and safety kits to families in Alabama to provide a safe sleep environment. Outreach and training related to DOSE remained stagnant in part due to the pandemic.
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 which were to be provided to all county health departments. The materials were housed in the ADPH warehouse and could be obtained by electronically requesting the materials. The Safe Sleep Team/Taskforce continued to meet quarterly and provide community outreach. The taskforce participated 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 was to be utilized to determine areas of targeted infant sleep education to the public and healthcare providers. The agency continued to distribute the Sleep Safe and Snug books both in English and Spanish to women that deliver within the state. The books were provided to the delivering hospitals to be distributed to the parents before discharge. These books were 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.

In 2020, the agency continued to provide the Sleep Baby Safe and Snug board books in both English and Spanish to women that deliver within the state. The books continued to be shipped quarterly to the delivering hospitals statewide to 45 of the 46 delivering hospitals.

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.

In 2020, DHR continue to provide free Baby Boxes in all of the 67 counties within the state and plan to do so in 2022.

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 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.

In 2020, FIMR activities continued even during the COVID-19 pandemic. The State Perinatal Program Staff abstracted and reviewed 331 fetal and infant deaths. Nurse abstractors contacted appropriate entities to request needed records for case abstraction. The records were received via fax, electronic mail, or postal mail. The ability to receive the needed records versus in person record abstraction, which was impossible due to the pandemic, allowed the nurse abstractors to continue case abstraction uninterrupted and continue the FIMR process. Consequently, FIMR CRTs were able to continue to meet, virtually, instead of in person meetings, at a minimum quarterly to review infant deaths and make recommendations to mitigate infant death.

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.

In 2020, Babypalooza events were not held due to the COVID-19 pandemic.

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.

In 2020, the SPP staff did not attend annual summits, health-fairs and other exhibiting opportunities due to the COVID-19 pandemic.

Alabama Perinatal Quality Collaborative - In 2020, ADPH staff continued to participate in the ALPQC steering committee meetings virtually. The staff participated in the planning of and presented at the annual ALPQC Summit that was held on February 27, 2020. Staff also participated in the launching of the neonatal opioid withdrawal syndrome and maternal hypertension initiatives.

The Wellness Coalition- The coalition provides health care access services primarily to the River Region’s non-elderly adults who have chronic diseases (diabetes, heart disease, asthma, obesity and others) and no health insurance. They provide community health and wellness interventions in other venues such as churches and community agencies. In 2020, the SPP participated as a member of the Wellness Coalition Racial and Ethnic Approaches to Community Health (REACH) advisory committee and collaborated in a breastfeeding public awareness campaign targeted for women of color within the region.

Alabama Partnership for Children- SPP participated in several initiatives that originated with the Alabama Partnership for Children, which is a non-profit organization created to develop, design, and implement a unified approach for improving outcomes of children from birth to age five in Alabama. SPP was a member of the core leadership team on the Project HOPE, sponsored by the Robert Wood Johnson Foundation and implemented by the BUILD Initiative since 2019. Project Hope is designed to generate real progress toward equitable outcomes for young children (prenatal to five) and their families by building the capacity of local communities, state leaders, cross

sector state teams, and local coalitions to prevent social adversities in early childhood and promote child wellbeing. Between November 2019 and April 2020, processes and plans were put into place to frame the specifics for improving access and quality of services to children and families. Specifics included confirming the equity challenges faced by beneficiaries and identifying and selecting at least one policy, practice, or funding vehicle, which upon modification may lead to anticipated changes. Throughout the implementation of this project, continuous feedback, communication, and evaluation has facilitated progress towards the team's goals. The project targeted six zip codes, based on disparities in data around infant mortality, in Macon County and one zip code 36108 in Montgomery County. Ten emerging equity challenges were identified during the beneficiary voice visits. These challenges were the focus of phase three of four of the project.

In 2020, in light of the COVID-19 pandemic, up to $30,000 in direct aid was provided to children and families in Montgomery and Macon counties. In Macon County, the following items were purchased: 900 cloth masks, 252 quart-sized bottles of hand sanitizer, 90 Amazon Fire tablets, and 25 Teach My Learning kits. In Montgomery County (West), 66 Chromebooks were delivered to children entering kindergarten in fall 2020. Additionally, the local school district equipped school buses with Wi-Fi, to serve as hot spots in locations around the county for areas with limited internet access. Provision of these items in both counties allowed the safe continuation of learning and allowed disadvantaged students to have equitable access to technology. With the pandemic in 2020, the project had to revise its plans. SPP will continue to collaborate until the project ends in October 2021.

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 governor's initiative. Following is an overview of the initiative's strategies impacting perinatal and infant health.

Home Visiting
DECE contracted with two programs to provide home visiting services in the three original target areas, Macon, Montgomery, and Russel counties, using PAT and NFP models of service delivery. The goal to serve 100 families across the target counties was achieved, with 145 active families in FY2020.

State funding was blended with federal (Health Resources & Services Administration Maternal, Infant, and Early Childhood Home Visiting) funding which allowed more families to be served. Additionally, matched funding from the Alabama Medicaid Agency, funds from the Department of Human Resources, and increased research and training allowed DECE to expand home visiting to all counties in the state. One of the models provided phones and service plans to families who were without these means. These provisions allowed home visitors to continue to maintain contact with families and refer them to resources for necessities, such as housing and food. Some of the screenings and assessments were completed virtually and allowed the continuation of data collection. Collectively, 190 screenings were provided, which assessed child development, parent-child interaction, and intimate partner violence.

There were many challenges to overcome during this year. The narrow eligibility requirements for NFP, of first-time mothers prior to 28 weeks gestation, made it difficult to find enrollees. When eligible mothers were identified, it was challenging to get them to reschedule after the initial visit. This challenge is typical in communities where there is limited awareness about a new program. It is hoped that, with increased enrollment, more mothers will find out about the program through word of mouth, which is often the best form of advertisement. Similarly, receipt of referrals from usual sources decreased with business closures and staff transitioned to working from home. Program staff

continued to reach out to establish new referral sources.

Reliable referral sources for the program were more difficult to locate, due to the location of one of the pilot counties and the impact of the COVID-19 pandemic. The program using PAT only serves Russell County, which is large, both urban and rural, and with a transient military community. It also borders Georgia, where some families choose to receive medical and other services. Many families choose physicians and delivering hospitals in Georgia (who accept Alabama insurances), and the programs have to rely on them for referrals. Regarding the effects of the COVID-19 pandemic, it was difficult to identify new referral sources due to limited travel and the inability to go into offices and meet with staff in person. Many agencies and programs transitioned to providing services remotely, making referrals an afterthought in dealing with the demands of virtual service delivery. However, both programs serving Russell County reported progress, new partnerships, and referral sources over the past year.

The COVID-19 pandemic presented the most significant challenge this year. However, both models of home visiting were quick to provide guidance on how to continue visiting families virtually. The transition was almost seamless, and the programs were able to retain most of the families. This transition resulted in positive movement on team goals. At least 50 percent of primary caregivers in Montgomery and Russell counties reported safe sleep practices. More than half of the mothers who delivered during the time period initiated breastfeeding in all three counties. The percentage of infants born preterm varied by county.

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.

To increase the number of providers who use SBIRT, the team worked diligently throughout this year to construct an Alabama-specific, online training module. After conducting extensive research into evidence-based literature, the content of the training was drafted. The process towards production remained ongoing, which involved working with a software development company to solidify plans to bring the project to fruition. The team also explored different opportunities to involve other partners whose clients may benefit from the screening tool. This exploration resulted in discussions and implementation of virtual SBIRT training with ADPH staff involved in the ALL Babies and Family Planning programs. Moreover, coordination was initiated with Medicaid on the ways in which ACHN case managers may use the SBIRT model with pregnant women. In this way, more at-risk women may be identified and receive appropriate follow-up care. Grant funds will be used to help offset costs for ACHNs on incorporating the screening tool into their electronic health records system. To further increase awareness of the model and its relevance, the team plans to present at a conference in the next fiscal year for healthcare professionals, introducing them to the model and process in OB/GYN practices.

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 project year started off strong for the Well Woman team, with a total of 120 participants enrolled in the pilot counties within the first quarter. However, the onset of the COVID-19 pandemic in the second quarter was particularly challenging for the Well Woman team, which serves clients who are at increased risk of severe outcomes. Groups at risk include those with underlying health conditions, such as obesity, hypertension, diabetes, high cholesterol, and heart disease. The

goal to enroll 500 women across all six counties during FY2020 (which averages to approximately 83 enrollees per county) was not met, as a result of the pandemic. However, 371 participants were enrolled across all six counties, 221 of which were in the pilot counties. Among those enrolled, 59 (27 percent) women were hypertensive and underscored the need for chronic condition management and healthy lifestyle adjustment.

Clinic visits were postponed in the second quarter and resumed in the fourth quarter on August 27. Though new clients could not be enrolled, existing clients continued to receive services via telehealth phone visits and virtual means. Telehealth/telemedicine was incorporated into protocols, which allowed continuation of services, such as health and nutrition coaching sessions, risk assessment and counseling, as well as other educational opportunities. New protocols for safety measures were put into place, to ensure the well-being and protection of staff and clients. These new safety measures included provision of personal protective equipment to both staff and clients, social distancing, and screenings for COVID-related symptoms. Nurse practitioners conducted risk assessments by reviewing the participant's history and physical and lab results. Treatment was initiated, if needed, and the participant was counseled on any identified conditions (such as hypertension). Web cameras were purchased for social workers and the nutritionist to host and participate in virtual opportunities. Participants benefitted from the web cameras also, with virtual nutritional classes held twice weekly with a registered nutritionist. As physical activity is an important component of ensuring health, partnerships with local communities allowed multiple daily exercise classes to be offered via Facebook. The team hosted a virtual, 3-day course for its second annual training for social workers. This training focused on motivational interviewing.

Near the final quarter of the fiscal year, the Well Woman program was selected to host two student interns for summer 2020 through the National Maternal Child Health Workforce Development Center. The internship ran from June 8 through July 31. The interns worked with the program virtually and in-person to increase client awareness/understanding about the program and to identify and develop ways to collect and analyze data on program participants, including blood pressure readings, weight, current health issues, and reproductive and medical history. The interns also helped to develop an electronic version of the periodic newsletters sent to staff for program updates, which allowed for easy dissemination. Though manual data collection remains a challenge, program staff work closely with the epidemiology division for assistance, with increased usage of data available in the ADPH electronic health record system. In subsequent years, improved data collection and analyses will likely have a long-term positive effect for quality improvement of the program and patient care.

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 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.

During this fiscal year, epidemiologists and research analysts analyzed pertinent data to create an evidence base upon which to act. These analyses included information on birth characteristics and outcomes in the state. Unfortunately, loss of staff during the fiscal year, coupled with the reassignment of team members to COVID response efforts, hindered the anticipated progression of PR activities. Moving forward, efforts will continue in order

to effectively communicate the findings of the analyses, such that stakeholders may begin implementation of the PR model. Once the PR model is adopted, trainings will be provided to hospital administrators and staff, as well as Emergency Medical Services workers. In this way, those involved in the care and transport of at-risk mothers will have all the resources needed to ensure transport to the appropriate level of care hospital, which consequently will improve maternal and child health.

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.

Activities continued throughout the year to increase safe sleep education throughout the pilot counties. This year, the team took a different approach to educational outreach. Social media and digital educational campaigns were initiated. The team worked to place digital media ads and articles within newspapers throughout the counties. In the fourth quarter, nearly 170,000 destination URL links were displayed in the three counties (for example, via Google, Facebook, and Instagram), corresponding to a total of 233 viewers who selected the links for additional information. In Montgomery County, an additional 52 indoor digital screens were displayed. These numbers are indicative of the success of using mixed media to reach a broader audience for increased awareness. The team will continue to utilize social media platforms for digital placement of educational materials to increase awareness of safe infant sleep practices. In addition to the educational outreach, DHR continues to be a distribution site for Baby Boxes and ADPH continues to be the provider for the Cribs for Kids program. 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, 2020, five childcare centers were certified in Montgomery and Lee counties and 38 were certified statewide. 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!, and a published book that is given to expectant mothers.

Throughout the second year, the breastfeeding team worked towards efforts which emphasized the benefits of breastfeeding primarily through education and partnerships. To further support educational outreach, a media campaign was launched statewide, with both online and printed educational materials geared towards parents, caregivers, and communities. The framework for a new Baby Friendly Provider Program, led by ADPH, was established. The program will provide obstetricians, pediatricians, and other professionals the opportunity to undergo trainings to support optimal breastfeeding practices. After successful completion of these teachings,

participants will obtain certification and receive materials to support their own professional knowledge. Toolkits will also be distributed through the program and will include materials for both providers and patients to ensure mothers receive information to support healthy infant nutrition through breastfeeding.

A satellite webcast conference was broadcasted on September 16, 2020 statewide for nurses, social workers, physicians, and other partcipants. Conference topics included the following: identification of political, economic, and social barriers to successful breastfeeding; risks posed by formula feeding; breastfeeding barriers, resources, and supportive strategies in different clinical settings; and an introduction to the Baby Friendly Provider Program. Conference faculty included staff of the Simon Williamson Clinic, Reaching Our Sisters Everywhere, and ADPH. There were 131 participants in attendance. This session allowed a diverse audience, who frequently work with maternal clients, to gather information for use in practice.

By joining forces with the Wellness Coalition, outreach was extended to a broader population, increasing awareness of this imperative topic. Additionally, continued collaboration with partners on the Breastfeeding Workgroup improved understanding of the work of each participating organization. Meaningful discussions provoked thoughts about the ways in which resources could be mobilized for this portion of the initiative.

As with other strategy teams, a key challenge during this second project year was staff turnover. Though new staff was brought on later in the year, a considerable amount of time was required to ensure adequate training. As additional team members are hired, it is hoped that staff preparation and retention will aid in advancing future breastfeeding efforts. 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.

Strategy members worked throughout the year to develop and distribute a survey to providers. Completed in the third quarter, the survey was sent to obstetricians and assessed beliefs, practices, and challenges pertaining to 17P. The survey captured pertinent factors that both aid and hinder 17P prescribing and usage for eligible women. The low response rate (21 percent) inhibited the team from drawing major conclusions. Among those who responded, only one provider indicated a need for assistance to increase use of 17P. Additionally, other ways the physicians noted as proven and effective ways to reduce preterm births included family support, early and adequate prenatal care, and other medications.

Alabama Newborn Screening Program

The Alabama Newborn Screening Program (ANSP) is a part of the Perinatal Health Division within the Bureau of Family Health Services and is a coordinated system encompassing newborn screening, birth defects, care coordination, evaluation, diagnosis, intervention, and management of conditions. The newborn screen includes the bloodspot screen, newborn hearing screen, and pulse oximetry screen to detect critical congenital heart defects. The goal of the ANSP is to identify certain genetic and congenital disorders early to reduce infant morbidity, death,

intellectual disability, and other developmental disabilities.

Newborn screening is mandated by public health law and is a collaborative effort between the Bureau of Clinical Laboratories, which performs blood analysis of approximately 150,000 specimens each year, and the Bureau of Family Health Services, which performs follow-up and education activities. Currently, Alabama screens for 31 of 35 nationally recommended conditions as part of the Recommended Uniform Screening Panel (RUSP), with plans to add four additional conditions to include Pompe disease, Mucopolysaccharidosis type 1, X-linked Adrenoleukodystrophy, and Spinal Muscular Atrophy. The program works in partnership with pediatric subspecialists throughout the state to ensure all babies identified with presumptive positive results receive appropriate follow-up. The program's subspecialists participate in provider education webinars and on the Alabama Newborn Screening Advisory Committee. Additionally, six community-based sickle cell organizations provide counseling services and follow-up for children identified with sickle cell disease or trait.

The Alabama Early Hearing Detection and Intervention (EHDI) Program, *Alabama's Listening*, ensures that all infants receive a hearing screening prior to hospital discharge, and that they are referred for further testing and intervention if they do not pass the screening. The Alabama's Listening program is federally funded. The goal of the program is to follow the Joint Committee on Infant Hearing guidelines, which is screening by one month of age, diagnostic hearing evaluation by three months of age, and referral to early intervention by six months of age to ensure optimal language acquisition, academic achievement, and social and emotional development.

The Alabama EHDI Program is supported by the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) Universal Newborn Hearing Screening grant. The purpose of the CDC hearing grant project is to support states that have routinely identified infants who are deaf or hard of hearing, and work to provide and document recommended follow-up testing and intervention services. The CDC Early Hearing Detection and Intervention (EHDI) project focuses on optimization of the EHDI information system and standardized collection, reporting and analysis of hearing data to ensure infants receive timely diagnostic and intervention services. The purpose of the HRSA hearing grant project is to support EHDI programs to engage stakeholders, expand hearing screening in children up to 3 years of age, strengthen family support services, educate health professionals, and improve care coordination services for children who are deaf or hard of hearing.

In 2020, the ANSP had a total of 2,560 lab referrals, initial failed hearing results, and failed pulse oximetry results reported to the follow-up program; the ANSP also confirmed the diagnosis of 223 infants with a primary newborn screening condition (Table 1). Infant lives were saved and improved through early screening and detection.

Table 1

2020 NBS Screening Disorders Based on Date of Birth for Calendar Year 2020	**Number of Lab Referrals, Initial Failed Hearing Results, and Failed Pulse Ox Results Reported to the Follow-up Program**	**Number of Confirmed Diagnoses**	**Number Referred for Intervention/Specialty Care**
3-Hydroxy-3-methyglutaric aciduria	0	0	0
3MCC	8	1	1

Argininosuccinic aciduria	0	0	0
Beta Ketothiolase deficiency	0	0	0
Biotinidase deficiency	1	1	1
Carnitine uptake defect (CUD)	45	1	1
Citrullinemia type 1	32	0	0
Classic Galactosemia	30	2	2
Classical Phenylketonuria (PKU)	22	2	2
Congenital Adrenal Hyperplasia	23	5	5
Congenital Hypothyroidism	89	47	47
Critical Congenital Heart Disease	9	1	1
Cystic Fibrosis	249	17	17
Glutaric acidemia type 1	2	0	0
Hearing Loss	1734	89	89
Holocarboxylase Synthase Deficiency	0	0	0
Homocystinuria	53	0	0
Isovaleric acidemia	2	0	0
LCHAD (Long-chain)	1	0	0
Maple Syrup Urine Disease	15	0	0
MCADD (Medium-chain)	14	1	1
***Methylmalonic acidemia (Cbl A, B)** ***Methylmalonic acidemia mutase** ***Propionic acidemia**	35	3	3
Multiple Carboxylase Deficiency	0	0	0
Severe Combined Immunodeficiency	49	0	0
S Beta thalassemia	4	4	4
SC disease	13	13	13
SS Disease	35	35	35
Trifunctional protein deficiency	0	0	0
Tyrosinemia Type I	91	0	0
VLCAD (very long chain)	4	1	1
TOTALS	2560	223	223

There were significant challenges in 2020 for the ANSP. In September 2020, the program relocated from Montgomery to the new state health laboratory in Prattville. Co-location of newborn screening follow-up staff and

laboratory staff was recommended by an external review panel with the purpose to improve and strengthen communication, understanding of issues affecting each other's area, and overall program functioning. Additionally, the emergency response to the COVID-19 pandemic redirected program staff to COVID-19 activities such as contact tracing and preparing specimen kits for shipment. The pandemic also affected timely follow-up services received by families such as outpatient diagnostic hearing evaluations. Many outpatient audiology testing facilities were closed during the pandemic and were delayed in re-opening, which delayed hearing diagnostic and intervention services.

Infant Mortality Awareness Activities

ADPH held its third Infant Mortality Awareness Summit, virtually, on Wednesday, September 9, 2020. The summit was sponsored by ADPH, Birmingham Heathy Start Plus (BHSP), and The Gift of Life Foundation, Inc. The theme of the summit was the Examining the Roots: The Impact of Maternal Mortality and Infant Mortality. The goal and objectives of the summit were as follows:
Goal - To raise awareness of infant mortality and maternal mortality, and the impacts on families, communities, and the state.
Objective #1 - To discuss infant mortality and maternal mortality and the impacts in Alabama.
Objective #2 – To identify factors that impact infant mortality.
Objective #3 - Discuss infant and maternal mortality advocacy and evidence based-programs.
Objective #4 Provide education on the contributions of physical and mental health, community support, inequity, and disparities to pregnancy outcomes.
Objective #5 Address knowledge gaps, and the ways in which communities, agencies, and providers can work collaboratively to improve pregnancy and birth outcomes.

Congresswoman Terri A. Sewell of Alabama's 7th Congressional District provided opening remarks speaking on national efforts to address maternal and infant health, specifically, the Black Maternal Health Momnibus Act and other legislative work of the US congress. Dr. Joia Crear Perry, of the National Birth Equity Collaborative, moderated a panel of health care providers. The panelists included a local pediatrician, psychiatrist, and two OB/GYNs discussing services offered, patients' barriers to care, and their ideas for partnership and change. In addition to the panel sessions, there were three additional presentation on the following topics: health equity and birth justice by Dr. Monica R. McLemore of the University of California, San Francisco, School of Nursing, Pregnancy Discrimination Act delivered by Mrs. Eddie Abdulhaqq of the U.S. Equal Employment Opportunity Commission (EEOC), and an overview of an obstetrics telemedicine project implemented by Dr. Lilanta Joy Bradley, of the University of Alabama. The summit ended with panel discussion on Maternal, Fetal, and Infant Loss The panelists (mothers and sisters) shared the details of their losses and then went on to discuss how those losses affected their families and how they continue to cope while helping others before, during, and after similar situations through their counseling services and foundations.

Perinatal/Infant Health - Application Year

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

State Perinatal Program

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

ESM 3.2 - 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.

Currently, the percent of VLBW infants delivered at the appropriate facility is included in the agency's improving birth outcomes strategic plan. Evidence-based strategies to increase the number of VLBW within the pilot counties are being reviewed with the goal to identify and select the appropriate strategy/strategies that can be implemented in the pilot counties.

In 2022, with pertinent staff positions filled, education of the findings of the analyses will be shared with stakeholders. Through the sharing of the finding and the depiction of better outcomes for infants delivered at appropriate facilities implementation of the PR model will begin in the delivery hospitals within the three pilot counties; thus, shortly after statewide adoption will occur. A review of regional referral systems that are currently in place, which were incorporated in the late 1970's, is needed to determine if revisions are needed based on the changes that have occurred within the delivering hospitals within the last decade.

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

Other Perinatal/Infant Health Activities

We will continue to provide the *Sleep Baby Safe and Snug* board books in both English and Spanish to the delivering hospitals quarterly in 2022.

In 2022, DHR plans to continue to provide free Baby Boxes in all of the 67 counties within the state.

In 2022, if the annual statewide Babypalooza events are held SPP staff will participate to educate on an array of perinatal topics and inform pregnant and new parents.

In 2022, the staff will continue to attend the quarterly steering committee meetings and to collaborate with the ALPQC.
In 2022, collaboration with the Wellness Coalition will continue.

All activities of the State of Alabama Infant Mortality Reduction Plan will continue, with a few minor plans for expansion of work group activities.

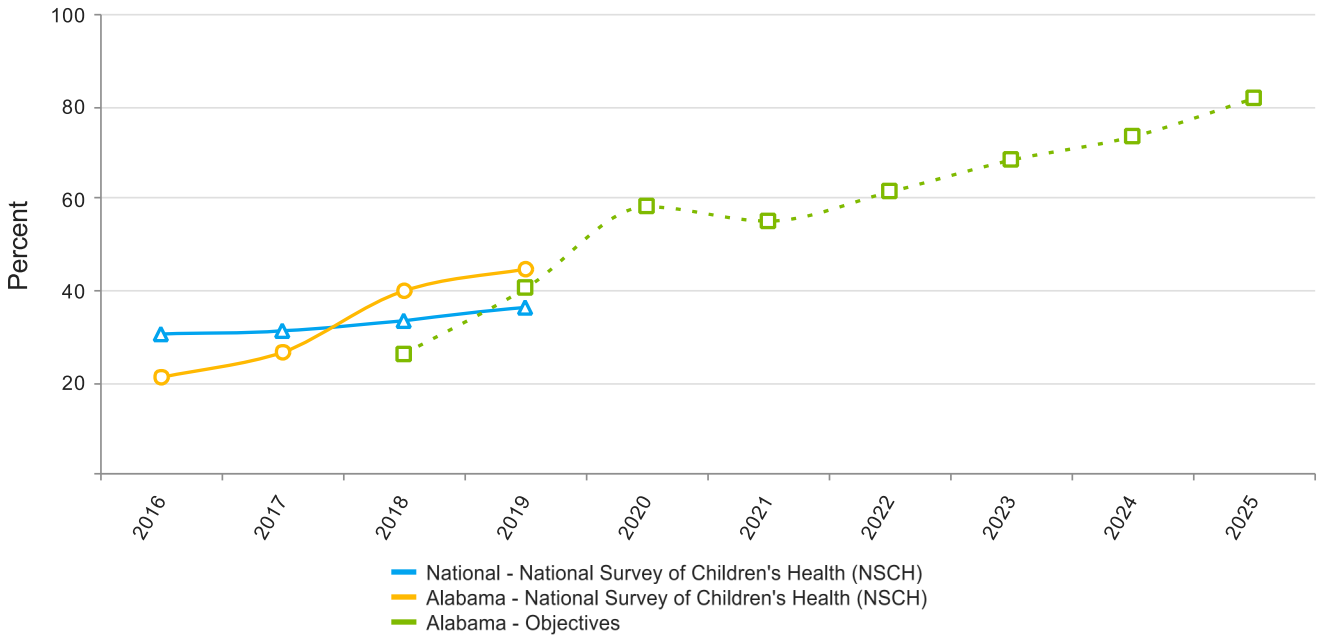
Child Health

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-2018_2019	13.4 %	NPM 13.2
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-2018_2019	12.9 %	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	87.6 %	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**	**2020**
Annual Objective			26.3	40.5	58.3
Annual Indicator		21.2	26.6	39.8	44.6
Numerator		32,690	38,521	53,496	54,906
Denominator		154,509	145,031	134,315	122,972
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	55.2	61.5	68.4	73.5	81.8	91.0

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	2026
Annual Objective	1.0	2.0	3.0	4.0	5.0	6.0

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	2020
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	

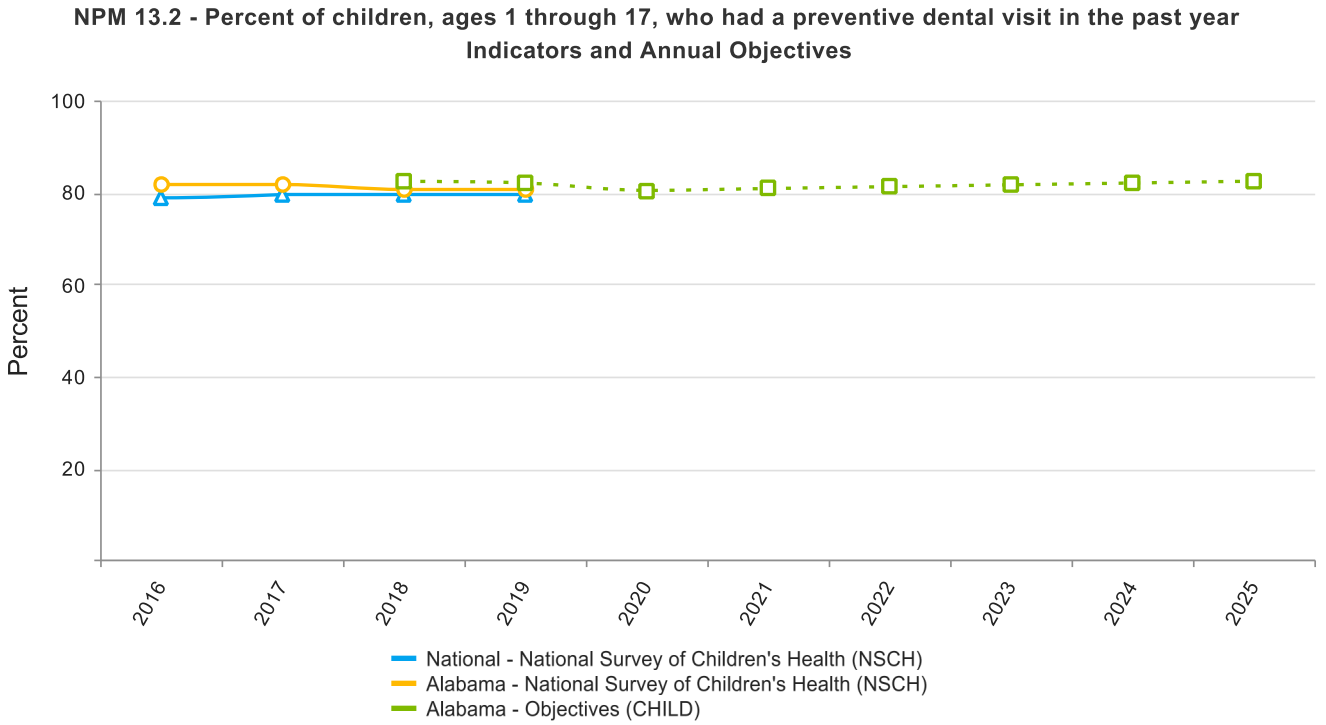
Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	1.9	1.9	1.9	2.0	2.0	2.0

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	54.6	56.2
Numerator	33,751	32,982
Denominator	61,836	58,688
Data Source	Alabama Medicaid	Alabama Medicaid
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	56.8	57.3	57.9	58.5	59.1	59.7



NPM 13.2 - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			82.5	82.1	80.5
Annual Indicator		81.7	81.7	80.7	80.8
Numerator		837,585	836,024	830,091	838,606
Denominator		1,025,822	1,023,434	1,028,454	1,037,949
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	80.9	81.3	81.7	82.1	82.5	82.9

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active
State Provided Data	
	2020
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	500
Data Source	Oral Health Program
Data Source Year	2020
Provisional or Final ?	Final

Annual Objectives					
	2022	**2023**	**2024**	**2025**	**2026**
Annual Objective	3.0	6.0	9.0	10.0	10.0

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

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	500
Data Source	Oral Health Program
Data Source Year	2020
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	3.0	6.0	9.0	10.0	10.0

State Performance Measures

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

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		54.3	53.3	73	55.1
Annual Indicator	53.7	52.8	72.2	54.6	56.2
Numerator	34,296	33,970	32,124	33,751	32,982
Denominator	63,812	64,372	44,467	61,836	58,688
Data Source	Alabama Medicaid Agency EPSDT data	Alabama Medicaid Agency EPSDT data	Alabama Medicaid	Alabama Medicaid Agency EPSDT data	Alabama Medicaid Agency EPSDT data
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	56.8	57.3	57.9	58.5	59.1	59.7

SPM 4 - Percent of women who smoke during pregnancy

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	8.7	8
Numerator		
Denominator		
Data Source	ADPH Center for Health Statistics	ADPH Center for Health Statistics
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	7.8	7.8	7.7	7.6	7.5	7.5

State Action Plan Table

State Action Plan Table (Alabama) - Child Health - Entry 1	
Priority Need	
Lack of preventive dental visits across all Title V populations, especially for those uninsured.	
NPM	
NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	
Objectives	
By 2025 increase the number of dental providers who receive education on the importance of preventive dental visits for children ages 1-17 years by 10%.	
By 2025, increase the percentage of dental providers who are provided education and support on the provision/referral for HPV vaccine by 10%. (create a provider Services survey and gather baseline data.)	
Strategies	
Provide educational preventive dental materials and oral health kits to patients and providers, and promotion of importance of preventive dental visits via the annual “Share Your Smile with Alabama” smile contest.	
Promote HPV education, and HPV vaccine education, promotion and referral using the #WATCHYOURMOUTH campaign developed through a partnership with Mitchell Cancer Institute.	
ESMs	**Status**
ESM 13.2.1 - Percentage of providers receiving information/education regarding importance of preventive dental visits for children ages 1-17 years of age	Active
ESM 13.2.2 - Percentage of dental providers that received information/education regarding informing their families of patients at 9 years of age about the FDA approved HPV vaccine in order to prevent future oropharyngeal, cervical and other HPV-related cancer	Active
NOMs	
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	
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) - Child Health - Entry 2

Priority Need

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

NPM

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

Objectives

Increase by 1% 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 3

Priority Need

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

NPM

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

Objectives

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

Strategies

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

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

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 5

Priority Need

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

Objectives

Ensure that all WIC participants benefit from EPSDT.

Strategies

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

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

Priority Need

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

Objectives

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

Strategies

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

Children's Health Branch

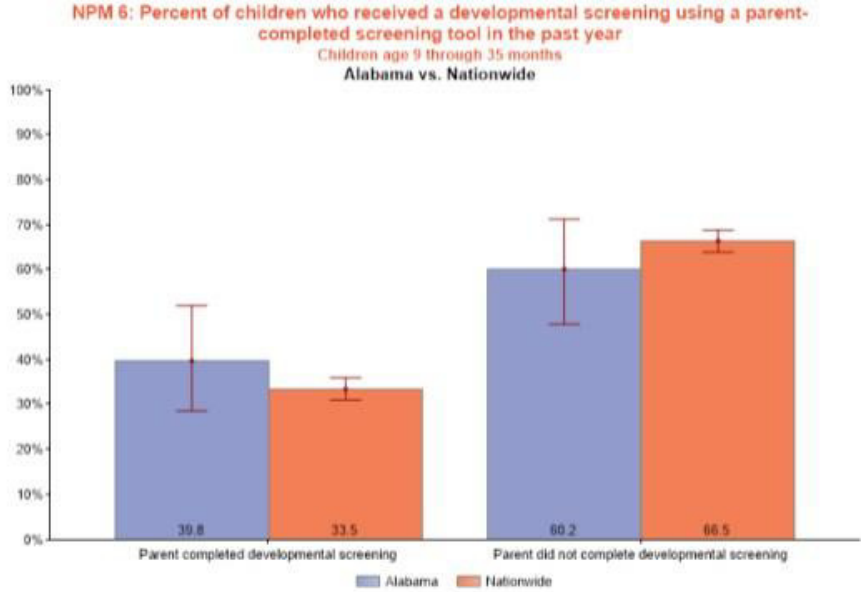
NPM 6-Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent completed screening tool

ESM 6.2 - 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.

According to the Child and Adolescent Health Measurement Initiative (CAHMI), in 2017-2018 39.8 percent (53,496) of Alabama's children age 9-35 months received a developmental screening using a parent completed tool; 60.2% (80,818) of the developmental screenings were not completed by the parent.

Again, according to CAHMI, Alabama fared better than the national average of 33.5 parent completed vs. 66.5 parent did not complete the developmental screening.

According to the Alabama State Department of Education (ALSDE), in 2017-18, Alabama had 1,473 public schools in a total of 137 local school systems. The Alabama Department of Mental Health is collaborating with the ALSDE and local education agencies to ensure children and adolescents have access to high quality mental health services, early intervention and treatment services. Fifteen mental health centers will receive additional funds for the expansion of School- Based Mental Health services with $750,000 in FY21. Currently 71 school systems and all 19 community mental health centers participating in the School Based Mental Health Collaboration Program.



Oral Health Office

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

National Dental Hygiene Month

A 30 second Spectrum cable television and streaming advertisement began showing in September 2020 and ran through the month of October, National Dental Hygiene Month. The ad promoted preventive dental visits for expectant mothers and children ages 1-17, in addition to the newly FDA approved (age appropriate) HPV vaccine, for expectant mothers and children ages 9-17 years. The following summarizes the public reach of the Spectrum advertisement.

Television Overview
1,006 Airings
31 Networks
12 Zones

Streaming TV Overview
95,067 Impressions
93,727 Completions
98.59% Completion Rate

Ongoing activities in Alabama to improve oral health:

OHO hosted its first ever Oral Health and Community Water Fluoridation Conference, virtually. This event provided four free CE hours to 187 water plant operators. OHO partnered once again with the City of Troy for an in-person conference in Troy, Alabama. This conference provided seven free ADEM approved CE hours to 85 water plant operators and environmentalists. Approximately 721,699 residents will be positively impacted from the educational information provided by the conference.

OHO provided grants totaling $100K to water plants for purchase of new or additional fluoridation equipment and the OHO fluoridation toolkit pamphlet was updated to indicate observance of the 75th year of Community Water Fluoridation in the U.S. The toolkit and pamphlet continue to be available through the ADPH website and was the pamphlet distributed to all public water systems after the redesign.

In accordance with the State Oral Health Plan, Goal 4.1.1: Conduct a statewide Basic Screening Survey (BSS) for K and 3rd grade children, OHO initiated this project in 2020. Fifty schools were selected by the Association of State and Territorial Dental Directors (ASTDD) to have students screened during the 2021-2022 school year. In addition to an oral exam, height and weight will be collected so as to report BMI. Also, each child received an oral health kit and school nurses and counselors receive OHO backpacks with resources highlighting HPV vaccination, community water fluoridation, tobacco cessation, and more.

TCHD provides preventive and restorative care for children, young adults, and pregnant women under the age of 21 who are covered by Medicaid, ALLKids, or Alabama Blue Cross Blue Shield. OHO utilized Title V funds to equip TCHD's dental clinic with new digital radiography equipment. Free oral hygiene supplies, educational material, and other assistance were provided to TCHD as requested. In 2020 there were a total of 1,672 patient visits to TCHD dental clinic. Of that total, 1,299 were preventive dental visits.
TCHD is currently in the fourth year of the a HRSA grant with UAB School of Dentistry. This grant focuses on increasing the dental student's clinical experience with children under the age of six. Two or three fourth-year dental students rotate through the clinic three days per week during their academic year. The students provide preventive and restorative care and participate in screenings/educational programs. Pediatric dental residents treat patients two days per month under the supervision of a pediatric dentist. Because of the COVID19 pandemic the 2020 rotations ended in March. The students resumed their rotations in August 2020. Due to scheduling issues related to the pandemic, the residents/UAB faculty were unable to resume rotations. As part of the HRSA grant, the fourth-year dental students rotate one day per week through the WIC clinic. The students provide counseling, which addresses

establishing a dental home by age one and the importance of dental care during pregnancy. They also distribute dental educational materials and supplies. If the WIC patient does not have an established dentist, they are given a referral. Many patients elect to schedule an appointment in the TCHD clinic, and often are seen the same day.

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.

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. Furthermore, new patients of Sarrell Dental are identified through screenings by ADPH in collaboration with Sarrell. 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.

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. OHO provided 2,200 oral health kits and educational materials to Head Start and Early Head Start. OHO provided, to schools and multiple agencies, 4,300 oral heal kits and educational materials during Children's Dental Health Month.

The office conducted oral health screenings for early Early Headstart sites and created an Oral Health Flip book that will be used in training for daycare homes and Headstart training centers.

OHO continued to partner with HCCA to provide free oral hygiene supplies and education material. There were 3,040 oral health kits and educational materials distributed to HCCA in 2020.

OHO continues to mail "Tiny Teeth" custom education materials to each of the 66 CHDs and others by request.

OHO continued its partnership with WIC, providing oral health kits to children enrolled in the program. The distribution is now more widespread. There were 5,000 oral health kits and educational materials, including "Tiny Teeth", provided to WIC clinics in 2020.

OHO continues to promote "Brush, Book, Bed" program, targeted to children ages 0-3 years. The American Academy of Pediatrics program provides partners with resources (brochures, stickers, etc). to promote good oral health through a repeatable and repetitive nighttime routine.

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

Oral Cancer Awareness Month

In April 2020, the OHO requested Governor Kay Ivey sign a proclamation declaring April as Oral Cancer Awareness Month in Alabama.

In February 2020, the 3nd 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. The partnership continued in FY20 with OHO supplying quarterly shipments of oral health kits for all residents of the facility. This partnership continues to grow and be appreciated by Father Purcell's. OHO increased the supplies to allow more frequent changing of toothbrushes during the COVID-19 pandemic.

County Health Departments

District MCH Coordinators submitted plans in 2020 to address needs within the Child Health Domain, with several projects focused on access to oral health care, increasing EPSDT visits, injury prevention and suicide prevention. While COVID-19 caused numerous disruptions and delays during FY 2020, the coordinators were able to establish partnerships, purchase equipment and take other steps that would propel the projects in FY21 once schools and clinics reopened.

Highlights

- *West Central Public Health District*: Developed a dental referral system. TCHD dieticians screened 940 children, referred 522, and 73 were examined by a dentist. MCH Coordinator assisted TCHD dental staff with dental screenings for Pre-K children at a local elementary school. Promotional dental items and resources, such as pamphlets, tooth brushes, tooth paste, and t-shirts were distributed during community events to bring about awareness of preventive dental care in Perry, Pickens and Tuscaloosa counties. Two QPR (Question, Persuade, and Refer) Gatekeeper Training for Suicide Prevention curriculum trainings were facilitated and suicide prevention resources and promotional items were provided to residents in Perry, Pickens and

Tuscaloosa counties.

- *Northeastern Public Health District:* Developed a dental referral system; 6,459 WIC children were screened for oral health needs, 3,595 children were referred to local dentists, and 250 exams completed during the fiscal year 2020.

- *Mobile County Health Department*: Provided referral services, linkages to preventive care and immunization services, and education on car seat safety for participants in the Family Support/Home Visitation program for pregnant and parenting teens in Mobile County as well as participants in the Fatherhood Initiative.

- *Northern District*: Developed partnerships with local agencies, including CPSC, County Interagency Councils, Caring Connection of the Shoals, Alabama Society of Health Care Social Workers, Children's Policy Councils, hosted dental health awareness days in all 12 northern district counties, providing education and incentives for pregnant women and children. The MCH coordinator presented QPR training to 96 individuals and provided suicide prevention resources to community partners such as meals on wheels, NARCOG, and NACOLG.

Barriers

- *West Central P*ublic Health *District*: COVID-19 caused numerous disruptions and delays during FY 2020, therefore, the coordinator was not able to fully implement this dental plan or QPR and Response trainings as planned.

- *MCHD*: The Covid-19 pandemic caused significant changes in the functions of the agency and the delivery of MCH services. Family Support/Home Visitation and Fatherhood programs saw some declines due to the Covid 19 pandemic. Some participants were out of work and trying to navigate the closure of daycares and schools. In-person education classes were replaced with virtual education and follow-up, which introduced new barriers for participants such as a lack of adequate phones, computers, internet services and other technology. The number of participants for virtual activities experienced a drop compared to the in-person meetings.

Other ADPH Child Health Programs

Youth Suicide Prevention

Suicide is the eleventh leading cause of death in the state, with 804 citizens lost to suicide in 2018. In 2020, ADPH's Alabama Youth Suicide Prevention Program began its fourth 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, Response, and Kognito. In 2020, suicide prevention program partners conducted 129 trainings, resulting in 2,237 individuals trained as gatekeepers to identify and refer individuals at risk for suicide.

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. Due to COVID-19 and the temporary reassignment of program staff as a result, this program was on hiatus for the majority of 2020.

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

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

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

The OHO will distribute educational resources to dental providers through direct mailings and the promotion of awareness campaigns related to preventive dental visits and HPV.

OHO and OCHA will develop and promote educational opportunities for dental providers on the importance of preventive dental visits through ads utilizing television, streaming, and social media platforms.

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

OHO will continue its partnership with WIC, providing oral health kits to children enrolled in the program .

OHO will continue to develop, print, and ship oral hygiene kits, coloring books, and activity pages to Alabama public schools, upon request. In February 2022, 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 women's and children's health, such as dental care during pregnancy and childhood injury prevention. Plans are underway to expand the 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.

Alabama's BSS began in the Fall of 2020. Fifty schools were selected by ASTDD for screenings of kindergarten and third grade students. OHO has requested 10 additional schools be added to the screening list to ensure a more representative sample of oral health in Alabama. A total of 3,238 students have been screened and BSS will continue in FY22.

OHO plans to continue its partnership with Father Purcell's (Pediatric) Nursing Home, providing oral health supplies, in 2022.

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

The Children's Health Branch will continue to monitor the proportion of children birth to age 19 that received a well child appointment and of children birth to age 19 that receive developmental screenings. ACLPPP will continue to work with local providers, the Environmental Lead Certification Program and the Social Work Branch to increase blood lead testing and reduce lead exposure among children less that 6 years of age.

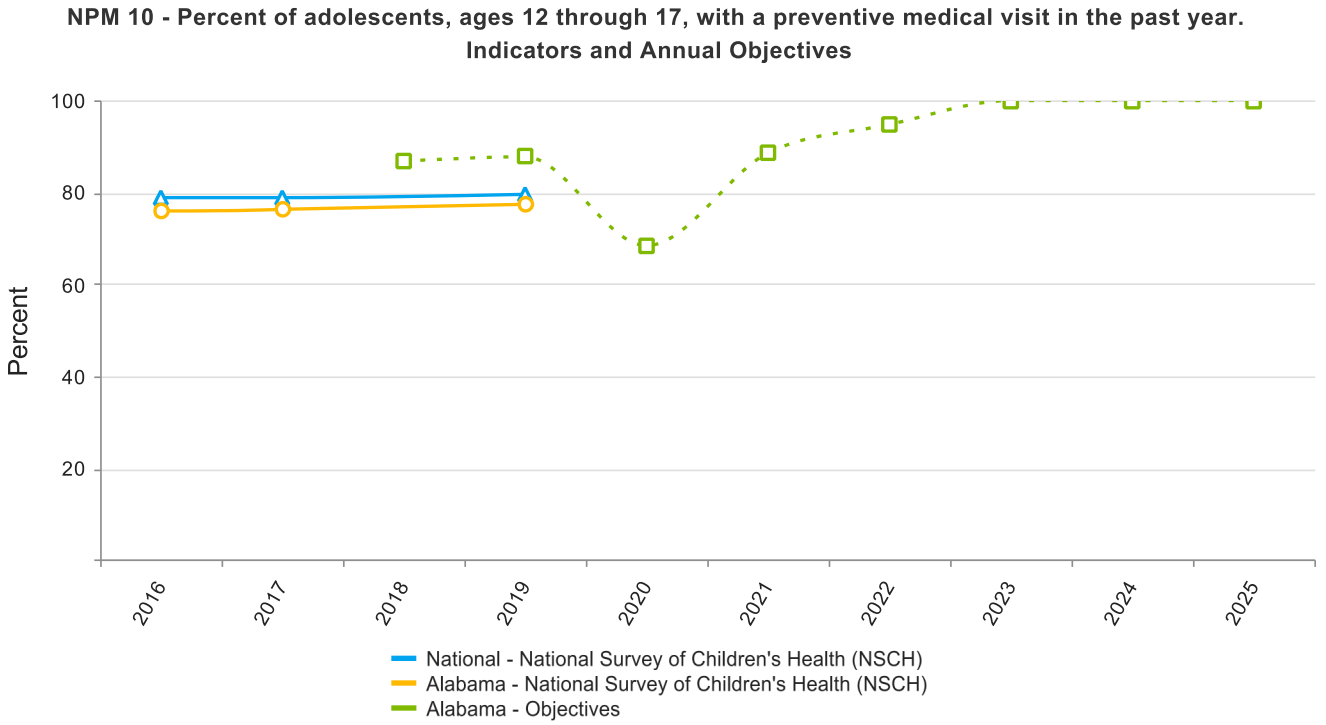
Adolescent Health

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-2018_2019	13.4 %	NPM 13.2
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2019	48.2	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2017_2019	22.9	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2017_2019	10.7	NPM 10
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-2018_2019	12.9 %	NPM 10 NPM 13.2
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	52.4 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	87.6 %	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-2018_2019	17.3 %	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)	WIC-2018	16.2 %	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-2019	17.2 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2019_2020	57.8 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2019	65.6 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2019	91.8 %	NPM 10

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2019	86.8 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	25.6	NPM 10

National Performance Measures



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			86.9	87.8	68.5
Annual Indicator		75.9	76.3	76.3	77.4
Numerator		267,488	279,668	279,668	253,566
Denominator		352,368	366,499	366,499	327,459
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017	2019

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						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	88.6	94.8	100.0	100.0	100.0	100.0

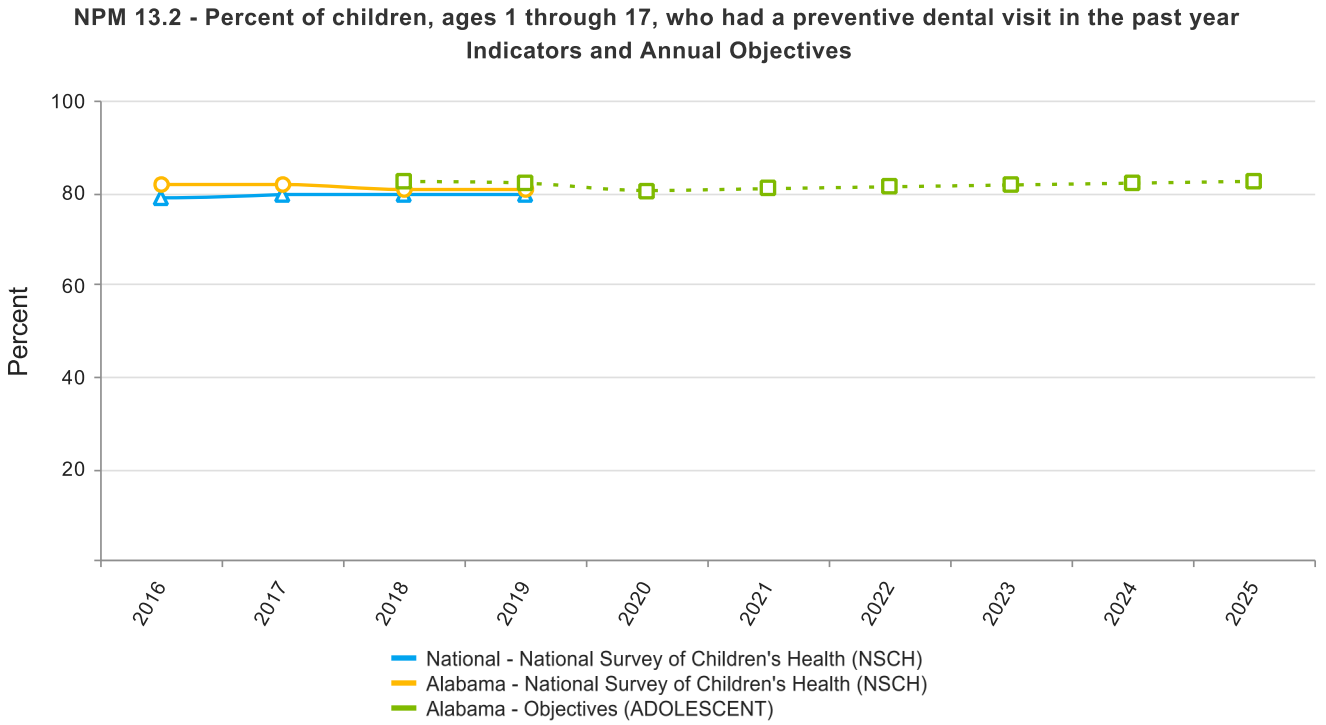
Evidence-Based or –Informed Strategy Measures

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	2020
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	2026
Annual Objective	77.1	77.8	78.6	79.4	80.2	81.0



NPM 13.2 - Adolescent Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			82.5	82.1	80.5
Annual Indicator		81.7	81.7	80.7	80.8
Numerator		837,585	836,024	830,091	838,606
Denominator		1,025,822	1,023,434	1,028,454	1,037,949
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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	2020
Annual Objective			82.5	82.1	80.5
Annual Indicator		81.7			
Numerator		837,585			
Denominator		1,025,822			
Data Source		NSCH			
Data Source Year		2016			
Provisional or Final ?		Final			

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	80.9	81.3	81.7	82.1	82.5	82.9

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active
State Provided Data	
	2020
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	500
Data Source	Oral Health Program
Data Source Year	2020
Provisional or Final ?	Final

Annual Objectives					
	2022	**2023**	**2024**	**2025**	**2026**
Annual Objective	3.0	6.0	9.0	10.0	10.0

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

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	500
Data Source	Oral Health Program
Data Source Year	2020
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	3.0	6.0	9.0	10.0	10.0

State Performance Measures

SPM 4 - Percent of women who smoke during pregnancy

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	8.7	8
Numerator		
Denominator		
Data Source	ADPH Center for Health Statistics	ADPH Center for Health Statistics
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	7.8	7.8	7.7	7.6	7.5	7.5

State Action Plan Table

State Action Plan Table (Alabama) - Adolescent Health - Entry 1	
Priority Need	
Lack of preventive dental visits across all Title V populations, especially for those uninsured.	
NPM	
NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	
Objectives	
By 2025 increase the number of dental providers who receive education on the importance of preventive dental visits for children ages 1-17 years by 10%.	
By 2025, increase the percentage of dental providers who are provided education and support on the provision/referral for HPV vaccine by 10%. (create a provider Services survey and gather baseline data.)	
Strategies	
Promote HPV education and HPV vaccine education, promotion, and referral using the #WATCHYOURMOUTH campaign developed through a partnership with Mitchell Cancer Institute.	
ESMs	**Status**
ESM 13.2.1 - Percentage of providers receiving information/education regarding importance of preventive dental visits for children ages 1-17 years of age	Active
ESM 13.2.2 - Percentage of dental providers that received information/education regarding informing their families of patients at 9 years of age about the FDA approved HPV vaccine in order to prevent future oropharyngeal, cervical and other HPV-related cancer	Active
NOMs	
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	
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) - Adolescent Health - Entry 2	
Priority Need	
Lack of timely, appropriate, and consistent health and developmental screenings.	
NPM	
NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.	
Objectives	
Increase by 1% 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

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) - Adolescent Health - Entry 3

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.

Children's Health Branch

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

ESM 10.1 Partner with the University of Alabama at Birmingham to provide training and clinical practice quality improvement on youth-centered care to clinicians and other clinic staff using the Bright Futures mode.

Data combined for 2016-2017 from the Data Resource Center for CAHMI reveals 76.3 percent (279,668) of adolescents, ages 12 through 17, had a preventive medical visit in the past year. The national average is 78.7 percent and the range across states is 67.9 percent to 90.9 percent. The rate for Alabama's adolescents ages 12 through 17 ranked lower than the U.S.'s rate but not statistically significant. For 2019, the latest year for which Medicaid data is available, approximately 164,401 10-14 year olds and 110,596 15- 18 year olds were eligible for EPSDT screenings. The total number of 10-18 year olds eligible was 274,997. According to the FY2019 Medicaid data, 80,012 10-14 year olds and 42,099 15-18 year olds were screened. If this data is consistent, older adolescents may be less likely to seek well visits.

The Branch Director continued working with the UAB LEAH. The LEAH Director assisted with the Title V Needs Assessment by participating in the stakeholder interviews and the needs assessment prioritization meetings for both child and adolescent health. Products related to the Adolescent Well Child Visit campaign (#StayWell) that were developed as part of the Title V, ACHIA, and UAB LEAH partnership are currently being disseminated through the AL AAP Quality Improvement Initiative designed to strengthen pediatrician-school nurse collaborations. Additionally, one educational focus of the AL AAP pediatrician-school nurse initiative is on e-cigarette use. We have provided web resources to be used as a part of this initiative.

For professionals, in partnership with UAB LEAH and Alabama Chapter of AAP, an Adolescent Well Visit Learning Collaborative was formed. Members of ACHIA developed training modules which were recorded by the ADPH Distance Learning/Video Communications Branch, to educate physicians on adolescent health issues. The modules were made available to pediatricians and family physicians for CE credit and to meet quality assurance performance measures. The Adolescent and Child Health branch will continue to partner with UAB LEAH and the Alabama Chapter of the AAP.

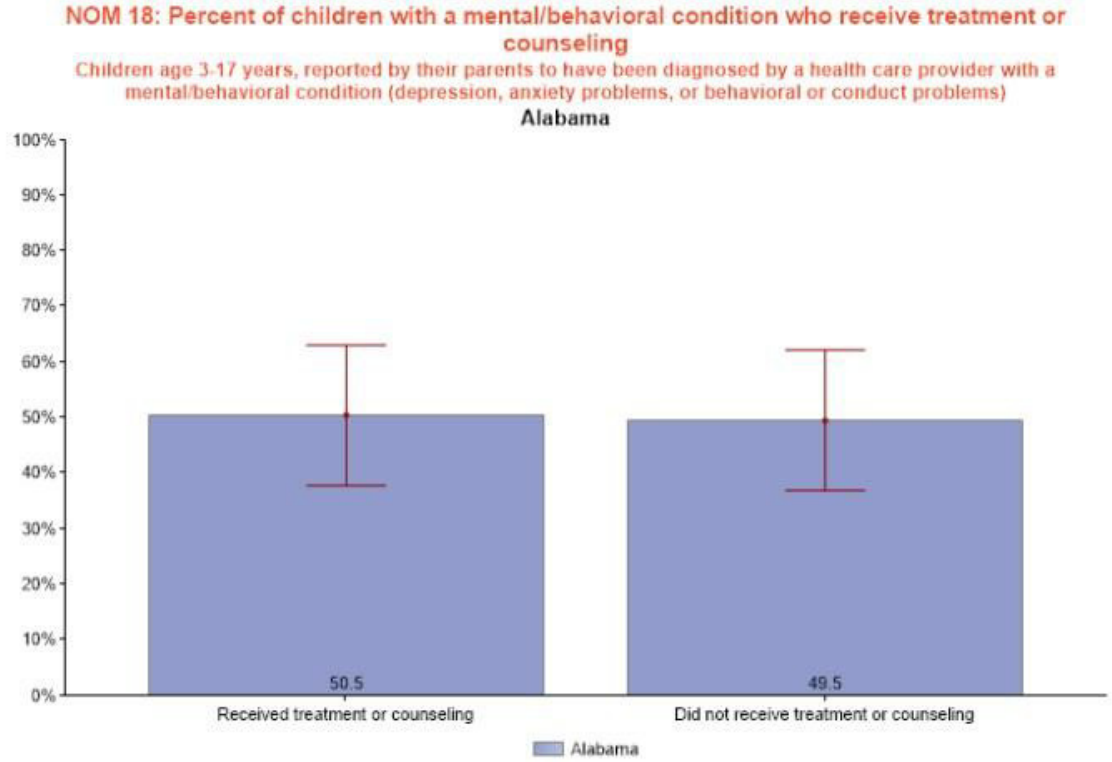
SPM 4- Number of school districts assessed regarding current mental health services.

According to CDC, one in six children aged 2-8 has a mental, behavioral, or developmental disorder. Mental health issues often co-occur with substance abuse, violence, anxiety, depression and child suicide. About eight in ten children aged 3-17 years with depression also have anxiety (59.3 percent). More than one in three children aged 3-17 have behavioral problems; more than 1 in 3 have anxiety (36.6 percent); and about 1 in 5 also have depression (20.3 percent). In 2017 Governor Kay Ivey authorized a council to recommend strategies to increase school safety. As a result, the council recommended strategies to increase school safety emphasizing physical security, threat assessments and mental health, and coordinated training and planning by state agencies.

According to the Data Resource CAHMI, in 2015 50.5 percent (68,245) of Alabama's children, ages 3 through 17, with a mental/behavioral condition received treatment or counseling and 49.5 percent (66,863) did not. Alabama's children, ages 3 through 17,fared slightly better than the national average at 50.3 receiving treatment vs. 49.7 that did not.

According to the Alabama State Department of Education (ALSDE), in 2017-18, Alabama had 1,473 public schools in a

total of 137 local school systems. The Alabama Department of Mental Health is collaborating with the ALSDE and local education agencies to ensure children and adolescents have access to high quality mental health services, early intervention and treatment services. Fifteen mental health centers will receive additional funds for the expansion of School- Based Mental Health services with $750,000 in FY21. Currently 71 school systems and all 19 community mental health centers participating in the School Based Mental Health Collaboration Program.



Oral Health Office

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

ESM 13.2-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.

Oral Cancer Awareness Month

In 2020 OHO again requested that Governor Kay Ivey sign a proclamation declaring April as Oral Cancer Awareness Month in Alabama to raise awareness about oral and oropharyngeal cancers cancer and how they may be prevented or detected early.

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

For the month of April, OHO partnered with Mitchell Cancer Institute and ADPH Family Planning for Oral Cancer Awareness Month. A Spectrum ad, featuring the #WATCHYOURMOUTH campaign materials, ran in various locations throughout the state, on closed circuit televisions at the UABSOD in common areas. and on the following social media platforms: OHCA Facebook page; ADPH Facebook and Twitter accounts; OHO Facebook page; and Mitchell Cancer Institute Facebook page. Television and streaming reach are as follows:

Television Overview
11,399 Airings
51 Networks

Streaming TV Overview
357,264 Impressions
352,180 Completions
98.58 percent Completion Rate

The campaign was hampered by the COVID pandemic, whereas it occurred during the period when dental offices were closed or operating at greatly diminished capacity. Some of the efforts were successfully carried out:

- Light up Alabama Red (various buildings throughout the state illuminated red)
- Dental students, dental faculty, and ADPH staff wearing #WATCHYOURMOUTH Oral Cancer Awareness Month tee shirts for photos (corresponding with Light Up Alabama Red)
- Distribution of updated pamphlets and brochures (2500 each) though various platforms
- Proclamation signed by Gov Ivey (no signing ceremony due to COVID)
- Presentation of the Board of Dental Examiners; 1-hour CE course on HPV education and prevention

Ongoing activities in Alabama to improve oral health:

Merck discovered the #WATCHYOURMOUTH campaign shortly after the FDA approval of the HPV vaccine. A panel of Merck representatives received a presentation of the campaign by ADPH OHO and Mitchell Cancer Institute. Merck, in turn, has shared numerous slide presentations with us and granted permission for us to use them in presentations. Merck has brokered numerous presentations between the OHO and other organizations nationwide to promote the campaign. Merck continues to enthusiastically support the efforts we have put forth.

Some organizations to which the campaign has been presented:

- Alabama Chapter American Academy of Pediatrics
- Alabama Comprehensive Cancer Coalition
- Alabama Cancer Leadership
- Florida Chapter American Academy of Pediatrics
- Association of State and Territorial Dental Directors
- School-Based Health Alliance
- New York City Department of Health
- Georgetown University Maternal and Child Health Division
- American Dental Association
- VAX2STOPCANCER

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

OHO created and purchased new Eurofit wall stands promoting HPV vaccines. The stands were placed in or given to CHDs, Mitchell Cancer Institute, ADPH Family Planning sites, and the Community Dental Health Coordinator (CDHC) program at UAB, beginning in September 2020.

A 30 second Spectrum cable television and streaming advertisement began showing in September 2020 and ran through the month of October, National Dental Hygiene Month. The ad promoted preventive dental visits for expectant mothers and children ages 1-17, in addition to the newly FDA approved (age appropriate) HPV vaccine, for expectant mothers and children ages 9-17 years. The following summarizes the public reach of the Spectrum advertisement.

Television Overview
1,006 Airings
31 Networks
12 Zones

Streaming TV Overview
95,067 Impressions
93,727 Completions
98.59 percent Completion Rate

Ongoing activities in Alabama to improve oral health:

The only ADPH operated dental clinic that remains is located within Tuscaloosa County. TCHD provides preventive and restorative care for children, young adults, and pregnant women under the age of 21 who are covered by Medicaid, ALLKids, or Alabama Blue Cross Blue Shield. OHO utilized Title V funds to equip the Tuscaloosa County Health Department's dental clinic with new digital radiography equipment. Free oral hygiene supplies, educational material, and other assistance were provided to TCHD as requested. In 2020 there were a total of 1,672 patient visits to TCHD dental clinic. Of that total, 1,299 were preventive dental visits.

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.

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 include dental services for uninsured or underinsured adults.

Community Water Fluoridation

The OHO fluoridation toolkit pamphlet was updated to indicate observance of the 75th year of Community Water Fluoridation in the U.S. The toolkit and pamphlet continue to be available through the ADPH website and was the pamphlet distributed to all public water systems after the redesign.

OHO hosted its first ever Oral Health and Community Water Fluoridation Conference in partnership with the City of Troy (Alabama) and ADEM Management. The conference four free CE hours to 187 water plant operators. The Oral Health Office partnered again with City of Troy for an in-person conference in Troy, Alabama. This conference provided seven free ADEM approved CE hours to 85 water plant operators and environmentalists. Approximately 721,699 residents will be positively impacted from the educational information provided by the conference.

OHO provided grants totaling $57,396 to five water plants for purchase of new or additional fluoridation equipment. These pants and public water systems serve a total population of 123,998.

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.

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. Four community-based organizations that are supported with ASRAE funds deliver evidence-based education programming to youth in Alabama. 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 youth in community settings. The goal of APREP is to reduce pregnancy and STIs, including HIV, among teens by using effective evidence-based programming. Two community-based organizations 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, schools and community organizations in Alabama. The project utilizes the evidence-based curricula, *Making Proud Choices: An Adaptation for Youth in Out-of-Home Care*, *Wise Guys* 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.

The COVID-19 pandemic had an adverse effect on programming this grant year due to restrictions of limited face-to-

face interactions with the target population.

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 42 Alabama counties through grants to the Alabama Coalition Against Rape (ACAR) and nine rape crisis centers. Funded centers focused efforts on activities around changing social norms, creating protective environments, and empowering young girls and women. 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 33 counties through grants to ACAR and seven rape crisis centers.

Youth Suicide Prevention

Suicide is the eleventh leading cause of death in the state, with 804 citizens lost to suicide in 2018. In 2020, ADPH's Alabama Youth Suicide Prevention Program began its fourth 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, Response, and Kognito. In 2020, suicide prevention program partners conducted 129 trainings, resulting in 2,237 individuals trained as gatekeepers to identify and refer individuals at risk for suicide.

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

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

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

The OHO will distribute educational resources to dental providers through direct mailings and the promotion of awareness campaigns related to preventive dental visits and HPV.

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

There will be a revised oral cancer awareness month campaign in 2022.

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

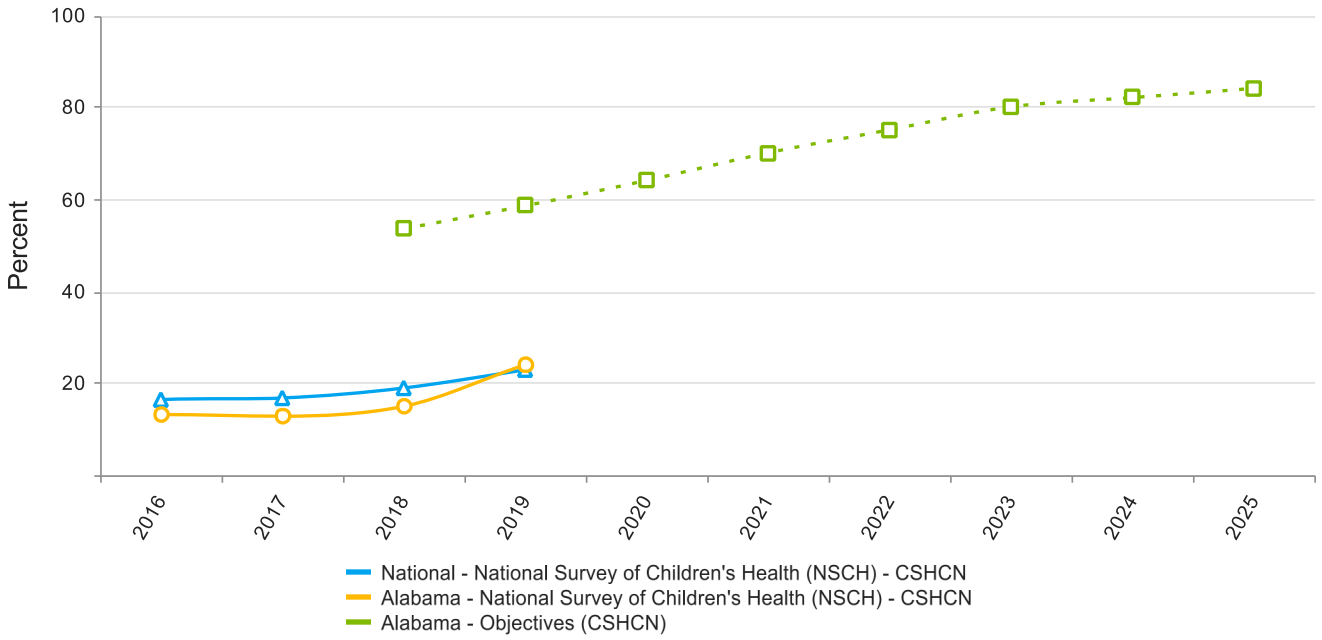
Children with Special Health Care Needs

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-2018_2019	12.9 %	NPM 11 NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	52.4 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	87.6 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	NSCH-2018_2019	2.3 %	NPM 11

National Performance Measures

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care
Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			53.5	58.5	64
Annual Indicator		13.2	12.9	15.0	23.8
Numerator		13,335	13,867	14,975	21,076
Denominator		101,361	107,738	99,967	88,591
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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	2020
Annual Objective			53.5	58.5	64
Annual Indicator	44.3	51.5	77.9	81.9	89.4
Numerator	1,255	1,400	2,753	2,938	3,171
Denominator	2,830	2,718	3,532	3,589	3,548
Data Source	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	70.0	75.0	80.0	82.0	84.0	92.0

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Percent of YSHCN enrolled in State CSHCN program who report satisfaction with their transition experience to adulthood.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	58.0	67.0	77.0	89.0	100.0

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	2026
Annual Objective	33.0	50.0	67.0	88.0	100.0	100.0

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	58.0	67.0	77.0	89.0	100.0

State Action Plan Table

State Action Plan Table (Alabama) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Lack of or inadequate access to services necessary for CSHCN to transition to all aspects of adult life.	
NPM	
NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care	
Objectives	
By 2025, increase the total score on the Six Core Elements of Health Care Transition™ 3.0 Current Assessment of Health Care Transition Activities for Transitioning Youth to an Adult Health Care Clinician from baseline to 90% (Baseline = FY 2020 total score of 68.75%). By 2025, increase the number of attendees at CRS Teen Transition clinic by 25% (Baseline = FY 2020 total attendees of 54).	
Strategies	
The state CSHCN program staff, including the Parent Consultant, will conduct a transition readiness assessment at age 14 using a standardized tool, administered periodically, and discuss needed self-care skills and changes in adult-centered care. The state CSHCN program staff, including the Parent Consultant, will incorporate transition planning into their existing plan of care, starting at age 14 partnering with youth and families in developing transition goals and preparing and updating a medical summary and emergency care plan. Provide education to families about Teen Transition clinic and the benefits of attending. Provide education to staff to guide implementation of transition strategies. The state CSHCN program staff will identify adult providers to accept program clients, complete a transfer package for youth leaving the program and follow-up with the provider regarding the YSHCN's transfer status. Obtain feedback on transition experience of young adults.	
ESMs	Status
ESM 12.1 - Percent of YSHCN enrolled in State CSHCN program who report satisfaction with their transition experience to adulthood.	Active
NOMs	
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	

State Action Plan Table (Alabama) - Children with Special Health Care Needs - Entry 2

Priority Need

Lack of or inadequate access to health and related services, especially in rural areas and for services identified as difficult to obtain.

SPM

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

Objectives

By 2025, increase by 10% the number of families of CYSHCN in the program who report receiving comprehensive care coordination.

Strategies

Develop and implement a survey for families to assess the comprehensiveness of and satisfaction with CRS Care Coordination services and connection to community resources. Utilize information from the surveys to improve the quality of care coordination for CYSHCN. Educate families on the importance of care coordination and its value in improving health care outcomes for CYSHCN through developing a Care Coordination Program fact sheet. Train CRS care coordinators to use a family and person-centered approach to care plan development. Ensure that families of CYSHCN have access to and are educated about the importance of connection to a medical home. Expand outreach activities to promote public awareness of CRS Care Coordination Services within the medical community and among families of CYSHCN. Develop an internal tracking mechanism for referrals to community resources for CYSHCN not enrolled with CRS.

State Action Plan Table (Alabama) - Children with Special Health Care Needs - Entry 3

Priority Need

Increase family and youth involvement and participation in advisory groups, program development, policy-making, and system building activities.

SPM

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

Objectives

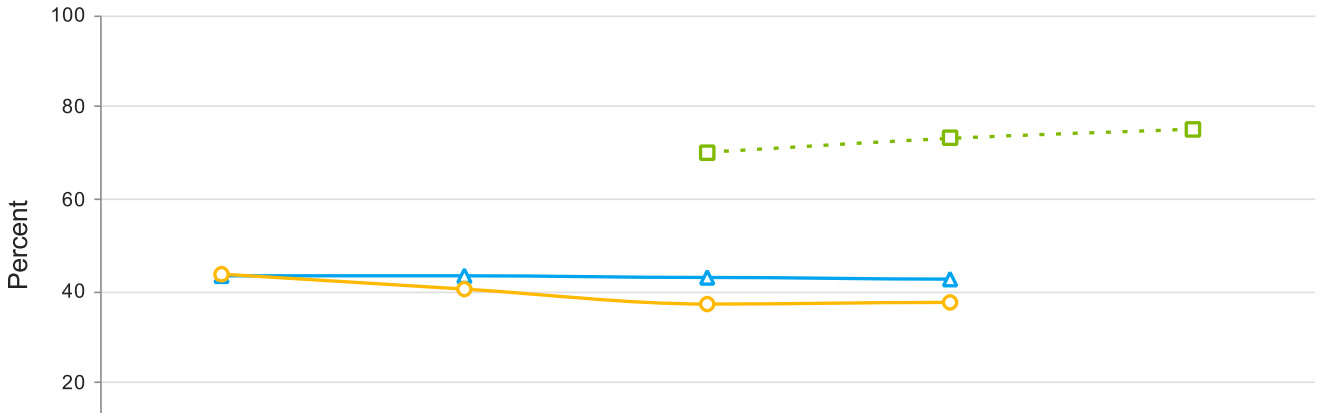
By 2025, increase the Engagement Score on the Family Engagement in Systems Assessment Tool (FESAT) by 10% above the baseline (baseline to be established in FY 2021). By 2025 the first cohort of participants will have completed the Family Leadership Training Institute.

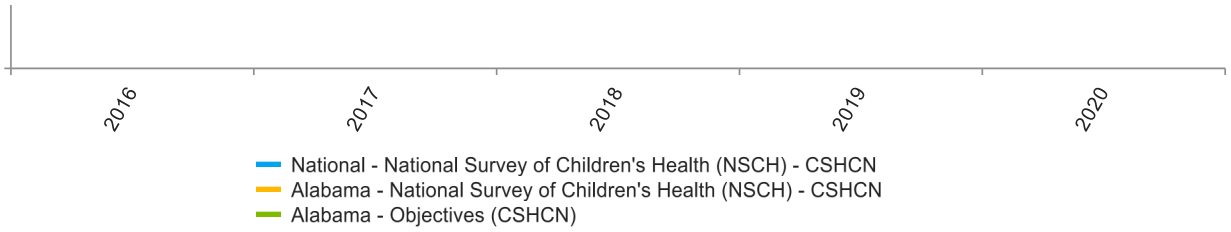
Strategies

Administer the FESAT to assess progress on strengthening family/youth engagement within CRS. Incorporate the four domains of Family Engagement into staff development activities through the development of a Family Engagement Quality Improvement Initiative action plan within each CRS District. Conduct ongoing monitoring of District action plans to ensure incorporation of the four domains of Family Engagement. Utilize alternative methods to increase parent and youth involvement in advisory groups and program development i.e. Zoom meetings, Facebook Live meetings, and conference calls. Develop and conduct a Family Leadership Training Institute. Develop or modify a Family/Youth Partnership outreach campaign aimed at healthcare providers and related professionals to teach about the importance of engaging families/youth in the decision-making process. Utilize the Family/Youth Partnership outreach campaign materials at professional conferences and other community events.

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**	**2020**
Annual Objective			70	73	75
Annual Indicator		43.3	40.1	37.0	37.4
Numerator		102,023	99,230	90,678	88,885
Denominator		235,517	247,758	245,036	237,911
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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**	**2020**
Annual Objective			70	73	75
Annual Indicator	36.2	65.8	71.9	73	73.8
Numerator	3,567	6,766	7,754	8,594	8,923
Denominator	9,858	10,287	10,784	11,772	12,091
Data Source	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

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**	**2020**
Annual Objective		51	70	65	66
Annual Indicator	56.5	65.8	65.9	66.3	70.4
Numerator	5,567	6,766	7,103	7,810	8,516
Denominator	9,858	10,287	10,784	11,772	12,091
Data Source	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

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

Measure Status:	Active			
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective	50	42	45	47
Annual Indicator	40	54.8	49.2	50.4
Numerator	200	274	246	252
Denominator	500	500	500	500
Data Source	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

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**	**2020**
Annual Objective		5	27	28	29
Annual Indicator	40	78.8	76.7	80	96.7
Numerator	18	26	23	24	29
Denominator	45	33	30	30	30
Data Source	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Medical Home

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

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.

FY 2020 is the final reporting year for NPM 11 as it was not selected to continue in the 2021-2025 reporting cycle. Although it was not selected, CRS embraces the philosophy of providing family-centered, coordinated, ongoing comprehensive care within a medical home. Activities conducted through two new SPMs will ensure CRS continues building on the work done throughout the 2016-2020 reporting cycle. See section III.E. Five -Year State Action Plan for additional information on the new SPMs.

In FY 2020, CRS continued to provide clinic services and respond to requests for information and referral for CYSHCN and their families. CRS maintained 14 clinic sites to provide clinical medical services, care coordination, and family support services to enrolled CYSHCN. CRS staff held 2,883 medical and evaluation clinics. The total number of clinics conducted in FY2020 is a decrease of 16.2 percent from FY 2019 due to clinics being closed for 6 weeks because of COVID-19. CRS staff completed 9,713 current plans of care for enrolled CYSHCN.

CRS staff made 240 hospital visits, 721 home visits, and 649 school visits to provide enrollment and follow-up care to CYSHCN. CRS staff served 363 clients without insurance coverage. In comparison to the FY 2019 numbers all these activities decreased due to COVID-19 except for an increase in home visits. The increase in home visits is attributed to being unable to visit children at school either due to COVID restrictions or children choosing to attend virtual school from their home.

Through the CRS Care Coordination program, staff provided comprehensive care coordination that included referrals for services, translation assistance, and conducting outreach activities to serve CYSHCN. CRS Care Coordinators provided transportation assistance to eligible CYSHCN and completed the Medicaid NET Request Form electronically to expedite reimbursement for transportation to medical appointments. Ensuring CYSHCN and their families have a medical home and that the CRS Care Coordinator is communicating with the medical home is a key component to providing Care Coordination services. CRS Care Coordinators and LPCs continued assisting families without medical homes to locate appropriate community primary care physicians (PCPs).

In FY 2020, the CRS State Care Coordination Program Specialist convened a group of CRS staff members that included Care Coordinators, Social Work Specialists, Physical Therapists, Computer Services, Nurses, and State Office Staff including the State Parent Consultant to focus on improving the Comprehensive Plan of Care (CPoC). Major changes that resulted from the workgroup include allowing a multidisciplinary team to document in the CPoC and automatically send the plan of care to the child's medical home. The group also focused on ensuring the CPoC is jointly developed with the family and shared with the caregiver.

CRS continued efforts to identify community PCPs willing to accept CYSHCN as patients. Local CRS staff work to build relationships with PCPs that serve CYSHCN to establish referral services through outreach activities and participating in community events. Pre COVID-19 CRS staff made office visits to medical practices to share information on how to refer to CRS. As a result of COVID-19 restrictions staff switched to conducting outreach activities via conference calls or Zoom meetings. CRS staff continue to maintain a database of PCPs of CRS enrollees to facilitate identification of local providers with experience in providing services to CYSHCN.

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. In FY 2020 the EMR was updated to allow for CRS Parent Consultants to document in the record. The system was also opened to allow all disciplines to enter a progress note in the Record of Visit (ROV) section. Ensuring all disciplines enter progress notes in the ROV allows for uniform and consistent communication resulting in quality care for CYSHCN. In addition, CRS continued efforts to interface with Alabama's One Health Record. The One Health Record® system was created as Alabama's health information exchange (HIE).

CRS, in collaboration with FVA, F2F HIC, UAB Pediatric Pulmonary Center, Alabama Chapter of the AAP and ACHIA, continued to provide medical home and family centered care training to approximately 252 providers. Due to COVID-19 some of the training opportunities previously offered were cancelled. The Partners in Care Summit held in partnership with FVA and the F2F HIC, that provides education on family-centered care to youth, families, and professionals, was not held in FY 2020 due to COVID-19. CRS in conjunction with COA held the Pediatric Care Coordination Curriculum training for staff from CRS, COA, Medicaid, and USA Health Systems. This training was held prior to the onset of COVID-19.

The following section outlines the numerous ways that CRS state and local staff fostered relationships and built new partnerships to ensure a system of community-based services are provided to CYSHCN and their families. The state made great advances toward coordinating community-based services for CYSHCN through collaboration with payers, agreements with tertiary-level providers, and collaboration with other community partners.

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 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 coverage 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.

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.

Alabama CHIP (known as ALL Kids)
CRS continued to participate as an ALL Kids provider utilizing the ALL Kids Plus component to provide an enhanced array of services for the unique needs of CYSHCN. CRS continued meeting on an as-needed basis with ALL Kids staff to discuss program and policy issues likely to affect CYSHCN. CRS assisted its 447 ALL Kids enrollees with annual renewal as needed.

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.

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 and provides a voice for CYSHCN in needs assessments, community planning, and resource mapping activities conducted by the CPC. Due to COVID-19 the CPC's met virtually during FY 2020.

Family Voices of Alabama
CRS continues to maintain a strong partnership with FVA, home of Alabama's F2F HIC. FVA members are active participants in both CRS' State and Local Parent Advisory Committees. The FVA co-director is the CRS State Parent Consultant. CRS continued partnering with FVA and the F2F HIC 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 Local Parent Advisory Committees
The LPCs each coordinate a Local Parent Advisory Committee (LPAC). These groups offer families the opportunity to provide input in CRS policy and program changes and to interact with local staff members. LPACs are opportunities for community partners to share information and for families to find mutual support from coming together with 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.

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 LPAC.

Alabama MCH Partnership Meeting
These meetings consist of representatives of all Alabama's Title V funded programs as well as other MCH-related programs. CRS State Office Specialists represent CRS at the quarterly MCH Partnership meeting. Other MCH stakeholders include Alabama Department of Public Health, Family Voices of Alabama, UAB Pediatric Pulmonary Center, Medicaid, Gift of Life, Department of Children's Affairs, and Alabama Early Intervention.

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.

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.

EHDI Learning Community
CRS audiologists participate in the ADPH EHDI learning community to increase awareness of the Joint Committee on Infant Hearing guidelines. CRS program staff conducted hearing screenings at community health fairs, schools, daycare centers, and Migrant Head Start programs.

Hudson Alpha Institute for Biotechnology
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.

Children with Medical Complexity (CMC) Collaborative Improvement and Innovation Network (CoIIN)
In FY 2020, CRS continued participation in the HRSA funded CMC CoIIN. CRS is the lead for the Alabama CMC 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 (SPoC). The medical home can be either the University of South Alabama Pediatric Complex Care Clinic (USAPCCC) or with community-based pediatric providers. Accomplishments include providing Care Coordination services onsite at the USAPCCC. These Care Coordination services had a positive impact on the quality of life for children with medical complexity and their families. Clinic staff continued the use of the SPoC that was developed as part of the project. The SPoC was developed in conjunction with the staff at the USAPCCC and CRS as well as input from families utilizing the SPoC. The SPoC has received positive feedback from families and providers.

Quality Assurance and Systems Development: CRS
Quality assurance and systems development activities by CRS continued in FY 2020.

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.

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

ESM 12.1 Percent of YSHCN enrolled in State CSHCN Program with a transition plan in place.

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

Ensuring YSHCN are equipped with the skills and tools necessary to transition to adult health care has always been a priority for CRS. Although FY 2020 is the final reporting year for the 2016-2020 needs assessment cycle CRS will continue to enhance transition services as NPM 12 was continued for the 2021-2025 reporting cycle. See section III.E. Five -Year State Action Plan to learn more about a new ESM to address transition as well as revised objectives and strategies for the 2021-2025 cycle.

For the 2016-2020 needs assessment cycle CRS has worked to successfully develop and implement policy utilizing the Got Transition's Six Core Elements of Health Care Transition™ approach. CRS utilizes the Six Core Elements of Health Care Transition™ Transition Readiness Assessment for Youth and the Transition Readiness Assessment for Parents/Caregivers starting at age 14 and older. In FY20, we continued to focus on conducting transition readiness assessments and incorporating transition planning into existing plans of care starting at age 14.

At 14 years of age, CRS youth are transferred to their district's transition social worker. In FY 2020 these specialists continued to provide targeted, comprehensive transition services to help CRS-enrolled youth and their families plan for adulthood. These services included providing care coordination, translation, transportation assistance, and referral services to enrolled, eligible transitioning YSHCN. CRS staff also participated in transition team meetings with local school districts to assist in transition planning. In FY 2020 there were 23 CRS transition social workers serving YSHCN. These social workers ensure that YSHCN have a Comprehensive Plan of Care (CPoC) in place. The plan covers health/medical issues, educational needs, developmental and independent living skills, and planning for transition. The plan is updated annually with families and youth.

CRS had 3,548 YSHCN enrolled in FY 2020 and out of these 3,171 had a CPoC in place. The FY 2020 total CPoC for YSHCN is a 7.5 percent increase over FY 2019. We believe this increase is due to continued focus on transition planning and ensuring that staff are complying with policies and procedures through monitoring electronic records and reviewing reports.

In addition to these activities CRS offers YSHCN ages 12 to 21 the opportunity to participate in Teen Transition Clinic (TTC). This specialized clinic helps YSHCN make the transition to adult life. There are five TTCs located throughout the state. YSHCN attending TTC are given a pre-vocational evaluation where the results are used to assist in planning additional services and seeking supports and accommodations that may be needed after high school. During clinic, the attendee and their family work together with a team to explore and address issues and options in planning for the future. Topics include education, independent living, employment, and adaptive equipment among others. Based on the specific needs of the YSHCN that is attending TTC the team may consist of the following: pediatrician; rehabilitation technology specialist; physical therapist; nutritionist; audiologist; SLP; social worker; independent living specialist; parents and other relatives; friends; counselors; and school staff among others. After completing the clinic, the attendee and their family are provided a written summary of information from the clinic visit, along with team members' suggestions and resources for further planning.

In FY 2020, CRS had 54 YSHCN participate in Teen Transition Clinic. This total was a 29 percent increase from FY 2019. The increase is attributed to more CRS clients and their families being educated about TTC, consistent use of transition readiness assessments, development of transition plans of care, and access to additional evaluation resources.

One mother describes their CRS TTC experience as, “Teen Transition clinic has been amazing for my daughter and our family. She has always set high goals for herself knowing up front that her goals would be more difficult to obtain than a typical teen. Teen Transition gives her all the resources she needs to make these goals a reality. In one room she has a support group for all areas of need. We leave Teen Transition clinic with a plan, more resources, and a support group that is always willing to brainstorm solutions as they arise. This clinic makes sure my daughter is successful in obtaining her goals.”

CRS Transition Social Workers continued to build a network of adult healthcare providers for YSHCN. Having a strong network ensures that CRS can link YSHCN to the appropriate adult healthcare provider and community services systems. This activity was impacted by COVID-19 as it is usually completed through both in-person presentations to physicians providing adult healthcare and through staff participation in outreach activities focused on transition.

In FY 2020, the CRS Transition Social Worker in Birmingham began serving on the UAB/COA transition clinic steering committee to assist with the development of a hospital wide transition policy. The meetings occurred quarterly and moved to a zoom format at the start of the COVID pandemic. The goal of the committee is to develop a global transition policy and build relationships between hospital disciplines and the new Staging Transition for Every Patient (STEP) program. The STEP program at UAB started in September 2020 to assist with the transition to adult care. It is the first formal program of its kind in Alabama and the surrounding region.

CRS has long been a champion in Family and Youth engagement. To ensure that YSHCN have a voice CRS employs two part-time Youth Consultants (YCs). The individuals in these positions have lived experience and coordinate outreach efforts to share their experience with transition and other information with YSHCN across the state. They utilize social media to increase connections with YSHCN in Alabama and share information on the ADRS SharePoint for CRS staff. The YCs hold Youth Advisory Committees (YAC) that promote the concept that every YSHCN will have access to services for transition to adulthood. In FY 2020 they held YAC meetings via Zoom specifically addressing the impacts of COVID-19 and strategies to address these impacts. They also provided information and resources via the Youth Connection Facebook page regarding COVID-19 and virtual education resources specifically for YSHCN as they adapted to virtual education platforms.

YCs also present at the Alabama Governor's Youth Leadership Forum (YLF). The YLF is an innovative, intensive, five-day career leadership training program, sponsored by ADRS and hosted by Troy University. The forum helps shape high school students with disabilities through sessions on self-esteem, self-advocacy, career choice, independent living options, and leadership. The YCs present on their transition experience from pediatric to adult healthcare and some of the challenges faced. They utilize a video that demonstrates the preferred way a doctor should talk to a transition-aged patient about their healthcare. A question and answer portion allows for the YCs to address specific questions about their experience. The 2020 YLF was cancelled due to COVID-19.

The Vocational Rehabilitation (VR) program which serves adults is also located within ADRS. A continuum of services is encouraged through regular meetings and consistent communication between CRS transition social workers and VR counselors to ensure that appropriate accommodations are in place for educational and employment success. CRS and VR staff have continued to collaborate on issues and challenges in the referral and transition process. In FY 2020 CRS and VR staff continued to meet virtually and hold conference calls, assuring that YSHCN received timely and appropriate services to assist them locally with health, education, and employment-related challenges faced due to COVID-19.

Another strong collaboration to enhance transition services for YSHCN needs in Alabama is with the local school systems. Representatives from CRS work with schools to plan and participate in Transition Resource Fairs in their

local communities. These events promote awareness to students, caregivers, educational, medical, and other community stakeholders. Some of the topics presented included navigating complex medical transitions, becoming a better self-advocate, transitioning from high school to college, Medicaid waivers, and employment.

Enhancing the knowledge and skills of CRS transition social workers and other CRS care coordinators is critical to providing quality services. This knowledge enhancement is done through internal and external training opportunities. CRS staff, including LPCs and CRS transition social workers, received continued education on how to use the various components of the Six Core Elements of Health Care Transition™ 3.0. As the majority of FY 2020 was impacted by COVID-19 travel restrictions, training was conducted by existing CRS Social Work Administrators and Social Work Specialists or conducted virtually.

CRS transition social workers attended the annual Alabama Transition Conference Training Series. This conference is a partnership between ADRS and Auburn University and provides attendees with updates regarding state and national transition policies and best practices when working with youth and young adults with special health care needs. In FY 2020 the conference was held the first week in March prior to the impacts of COVID-19.

In FY 2020, the Central Alabama Transition Team held Hot Topics in Transition where educators, parents, and agencies met to listen to expert presenters and gain helpful information about topics of interest in transition. As Hot Topics in Transition was a pre COVID-19 event CRS staff were able to attend.

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

FY 2020 is the final reporting year for SPM 1 as it was not selected to continue in the 2021-2025 Five - Year State Action Plan. Although it was not selected, CRS will continue promoting shared decision-making and partnerships between families and health care providers through the creation of two new SPMs. See section III.E. Five - Year State Action Plan for additional information on the new SPMs.

Activities outlined in the CSHCN Data Action Plan for SPM 1 2016-2020 Five-Year Needs Assessment included improving data collection and support and working with FVA/F2F HIC. In FY 2020 the overall score increased to 29 out of 30 versus a score of 24 out of 30 in FY 2019. Outlined below are the activities that occurred in FY 2020 to increase the overall score. See section V. Supporting Documents to review the FY 2020 scored CSHCN Data Action Plan.

CRS/CSHCN Data Collection and Support:

CRS maintained and enhanced its EMR in FY 2020 to ensure accurate data collection. The EMR task force held regularly scheduled meetings regarding the EMR components that are unique to the CSHCN program. Priority was given to establishing e-prescribing through NewCrop and creating an electronic growth chart.

CRS continues to work toward 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' 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.

In February 2020, CRS began participating in the National MCH Workforce Development Center 2020 cohort. As a result of working with the Center, CRS identified data as one of three key areas of focus. The data subcommittee analyzed current practices and identified areas for improvement. These included improving efficiency within our data collection systems, identifying ways to interpret data to improve services, and collecting data from external partners. As part of the project a series of Staff Surveys are being conducting by UAB School of Public Health Applied Evaluation and Assessment Collaborative (AEAC) on behalf of CRS. One of the surveys will be focused on collecting information regarding what CRS staff need in relation to data collection, reporting, and training. CRS leadership will use this information to identify quality improvement projects to improve overall data collection.

FVA/F2F HIC:

CRS LPCs in collaboration with FVA and the F2F HIC collect data about the needs expressed by families in the state and the types of information shared with them. The CRS SPC continues to use this data to help assess the needs of CSHCN and their families. Information and assistance were provided in the areas of the six core outcomes, with the highest number of requests coming in the areas of Community Services, Partnering with Professionals, and Medical Home. The SPC also shares the information with other CRS State Office Specialists during Management Team meetings.

The Partners in Care Summit is a project of the F2F HIC and provides an opportunity for CRS to collaborate with FVA in providing national speakers that present on the importance of the medical home and sharing in the decision-making process. It also highlights the importance of family/professional partnerships. The Summit is attended by families, CRS staff from across the state, and other partners. Unfortunately, the FY 2020 meeting was cancelled due to COVID-19.

In FY 2020, CRS collaborated with FVA as part of the CMC CoIIN project to provide individuals participating in the CMC CoIIN a FVA Care Notebook. Recognizing the importance of empowering families to communicate with healthcare providers and health related professionals FVA developed the Care Notebook. It is designed to help parents/caregivers maintain an ongoing record of a child's care, services, providers, and notes. It provides parents/caregivers a way to maintain the lines of communication between the many service providers that they encounter. As part of the CMC CoIIN collaboration, a representative of FVA follows up with the families receiving Care Notebooks to ensure they understand the purpose of the Care Notebook, answer parent/caregiver questions, and provide overall support while promoting the importance of shared decision-making.

Children with Special Health Care Needs - Application Year

In the upcoming reporting year CRS will continue to address the three priority needs identified for CSHCN for the 2021-2025 State Action Plan. These are: Lack of or inadequate supports for transition to all aspects of adulthood; increase family and youth involvement and participation in advisory groups, program development, policy-making, and system-building activities; and lack of or inadequate access to health and related services, especially in rural areas and for services identified as difficult to obtain. See section III.E. Five - Year State Action Plan for additional information.

To fully implement the 2021 – 2025 Block Grant State Action Plan CRS created a Block Grant State Action Plan team. The team includes the members of the CRS Needs Assessment Leadership team, a LPC, and a Social Work Transition Specialist. The team originally intended to meet quarterly but quickly recognized the need to meet monthly. Throughout the upcoming year the Block Grant State Action Plan Team will continue monthly meetings to review progress on the Action Plan for the CSHCN domain. During the monthly meetings team members provide status updates on the progress or lack thereof of efforts to address the identified measures. Updates also address activities surrounding the outlined strategies, accomplishments resulting from those activities, challenges encountered while attempting to carry out the activities, and needed revisions to the current activities. CRS staff will also continue to collaborate with current partners and seek to identify new partners to address the identified priority needs.

Outlined below are the activities the Block Grant State Action Plan team identified for FY 2022.

National Performance Measure 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care.

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

For FY 2022, CRS will receive detailed reports of the baseline transition survey data from the UAB School of Public Health, Applied Evaluation and Assessment Collaborative. UAB administered the survey on behalf of CRS and conducted the analysis of the survey results. The CRS Block Grant State Action Plan team will review the results from the baseline Transition survey to identify areas of improvement. CRS will readminister the survey in the final quarter of FY 2022.

The Block Grant State Action Plan team will complete the Six Core Elements of Health Care Transition™ Current Assessment of Health Care Transition Activities for Transitioning Youth to an Adult Health Care Clinician to determine progress being made in the following areas; Transfer of Care; Transfer Completion; Youth/Young Adult and Parent/Caregiver Feedback.

For FY 2022, CRS will continue the following transition activities to strengthen the Six Core Elements of Health Care Transition™ in service delivery:

Continue to identify transitioning youth, starting at age 14, through the EMR. Identified youth will be transferred to the social work transition specialist for coordination of transition activities. This coordination includes incorporating transition planning into their existing plan of care, partnering with youth and families in developing transition goals and preparing and updating a medical summary and emergency care plan.

Continue 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.

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

Continue to collaborate with VR 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.

As part of the 2021-2025 needs assessment cycle CRS developed two new SPMs. Although each SPM is tied to one specific priority need the objectives and strategies will have a positive impact on other needs identified during the needs assessment process.

SPM 2 - Strengthen and enhance family/youth partnerships, involvement and engagement in advisory groups, program development, policymaking, and system-building activities to support shared decision making between families and health-related professionals. See section V. Supporting Documents to review the CSHCN Checklist Criteria Scoring Tool for SPM 2 2021-2025 Five-Year Needs Assessment for a complete list of activities.

For 2022, CRS will readminister the FESAT to assess progress on strengthening family/youth engagement within CRS. We will compare the Engagement Score to the baseline established in FY 2021 and use this information to foster conversations among CRS Management Team and the LPCs regarding the four domains of Family Engagement. The CRS MCH coordinator will conduct ongoing monitoring of District Family Engagement Quality Improvement Initiatives through reviewing action plan development and implementation. CRS staff will utilize the National Family Voices Domains of Family Engagement fact sheets to incorporate FESAT information in staff development activities. For more information about the FESAT visit https://familyvoices.org/fesat/.

CRS will continue analyzing the research collected regarding developing a CRS Family Leadership Training Institute. During FY 2022 CRS will create a detailed action plan outlining the establishment of a CRS Family Leadership Training Institute.

CRS will coordinate with the ADRS Office of Communications and Information to begin developing or modifying a Family/Youth Partnership outreach campaign aimed at healthcare providers and related professionals to teach about the importance of engaging families/youth in the decision-making process.

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

For 2022, CRS will receive detailed reports of the baseline Care Coordination survey data from the UAB School of Public Health, Applied Evaluation and Assessment Collaborative who administered and conducted the analysis of the survey results. The CRS Block Grant State Action Plan Team will review the results from the baseline Care Coordination survey to identify areas of improvement. CRS will readminister the survey in the final quarter of FY 2022.

Utilize the Care Coordination Program fact sheet to educate 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.

Cross-Cutting/Systems Building

State Performance Measures

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	0	40
Numerator	0	2
Denominator	6	5
Data Source	Program Data	Program Data
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	0.6	0.8	1.0	1.0	1.0	1.0

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

Measure Status:	Active

State Provided Data		
	2019	2020
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	2026
Annual Objective	28.9	29.2	29.5	29.8	30.1	30.4

SPM 7 - 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	2020
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	2026
Annual Objective	3.0	3.0	3.0	3.0	3.0	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 - 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 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 - 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 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 - 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 4

Priority Need

Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they live, learn, work, and play.

Objectives

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 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, 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 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

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 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, 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 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

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 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

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 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

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 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

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 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

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 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

Encourage/provide wellness visit to women ages 15-55 who report not having a preventative visit in the last year regardless of insurance status.

Strategies

Target underinsured and/or uninsured women ages 15-55 to enroll in WW program.

Cross-Cutting/Systems Builiding - Annual Report

No content was entered for the Cross-Cutting/Systems Building - Annual Report in the State Action Plan Narrative by Domain section.

Cross-Cutting/Systems Building - Application Year

No content was entered for the Cross-Cutting/Systems Building - Application in the State Action Plan Narrative by Domain section.

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.

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, three key ways that FHS seeks input on MCH issues are through collaboration with the State Perinatal Advisory Committee, the Regional Perinatal Advisory Committees, and the Maternal Mortality Review Committee.

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.

FHS maintains a 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 obtain a copy of the FY 2019-20 MCH Title V Statewide Needs Assessment can be accessed from the site. 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 also 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 open to public comment. Well Woman takes full advantage of the availability of social media outlets by allowing each Well Woman location to have its own separate Facebook page. These pages facilitate open and public communication directly between the district Well Woman 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, 17 key informant interviews, and convening the CRS Needs Assessment Advisory Committee. Input from the CRS Needs Assessment Advisory Committee which consists of key partners and stakeholders was sought during an initial planning meeting and via the April 2020 online prioritization process. The online process allowed Advisory committee members to enter detailed comments which CRS Needs Assessment Leadership Team took into consideration when selecting the priority needs. The CRS 2020 Title V MCH Block Grant Comprehensive Needs Assessment Summary can be accessed from the ADRS website at https://rehab.alabama.gov/news/blog.

CRS values public input from individuals with lived experience and seeks input from families and youth on an ongoing basis through the 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 in order to reduce barriers to participation. CRS assures cultural and linguistic competence and compliance with the Americans with Disabilities Act at all meetings. In addition, the SPC, LPCs and YCs provide input into CRS special projects such as serving on teams for the National MCH Workforce Development Center Health Transformation Project, Care Coordination Academy, and CMC CoIIN.

CRS also holds an annual Hemophilia Advisory Committee meeting to seek input into programmatic and policy issues related to the Alabama Hemophilia Program administered by CRS. The committee consists of individuals with various interests in the hemophilia community, including clients, parents, insurance representatives, physicians, other State agencies, such as Medicaid, and local providers of treatment and medication.

The ADRS Office of Communications & Information maintains the Department’s website which includes CRS’s

webpage (www.rehab.alabama.gov/services/crs). Through the ADRS-Today feature of the website CRS can seek public comment through News Releases, a Media Gallery, and the ADRS blog. The CRS webpage provides a “contact us” feature for the public to email comments directly to CRS; or the public can call a 1-800 number for direct contact. CRS utilizes several sources of social media, which are always open to public comment. Both the SPC and YC utilize social media to foster communication among the general public, CRS staff, partners, and program participants through the Parent Connection and Youth Connection Facebook pages.

III.G. Technical Assistance

ADPH

In 2021 FHS has been receiving technical assistance from the National MCH Workforce Development Center. The purpose of the technical assistance is to support strategic planning and program analysis through the revision of our evidence-based strategies and state performance measures. The Title V staff have participated in two general technical assistance sessions and four domain and program specific sessions. Program directors will continue to work with the Center in FY 2022. FHS in in discussions with UAB SOPH to enter into an agreement to aid with developing initiatives and partnerships based on the needs identified in the 2020 Needs Assessment and activities subsequently developed as part of the 2021-2025 State Action Plan. Additional technical assistance will be requested as further needs are identified throughout the year.

CRS

CRS held a technical assistance session with the MCH Evidence Center to strengthen the 2021-2025 State Action Plan for the CSHCN domain. As a result of the session CRS was able to identify areas of improvement to ensure we implement an evidence-based or evidence-informed State Action Plan. Additional assistance will be requested as needed.

CRS utilized the technical expertise of National Family Voices and FVA in the performance of activities associated with strengthening and enhancing family/youth partnerships, involvement, and engagement. National Family Voices provided technical assistance on the use of the FESAT as part our SPM around strengthening family engagement. Additional assistance will be requested as needed.

CRS will utilize technical assistance from AMCHP and its New Director Leaders Cohort.

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 - ADPH-CRS Medicaid IAA_070921.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - CSHCN Checklist Criteria Scoring Tool for SPM 2.pdf

Supporting Document #02 - CSHCN Data Action Plan for SPM 1 2016-2020.pdf

Supporting Document #03 - AL FY 2022 APPLICATION_FY 2020 ANNUAL REPORT_Acronyms.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - ADPH-CRS Organizational Charts.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Alabama

	FY 22 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 11,482,727	
A. Preventive and Primary Care for Children	$ 5,793,036	(50.4%)
B. Children with Special Health Care Needs	$ 3,444,819	(30%)
C. Title V Administrative Costs	$ 1,148,272	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 10,386,127	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 31,724,878	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 1,566,690	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 26,066,122	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 59,357,690	
A. Your State's FY 1989 Maintenance of Effort Amount $ 15,408,615		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 70,840,417	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 123,892,360	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 194,732,777	

OTHER FEDERAL FUNDS	FY 22 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Early Head Start - Child Care Partnerships (EHS-CC) Grant	$ 995,594
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 887,883
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 380,774
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 179,020
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program	$ 698,009
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 115,245
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH	$ 1,024
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 119,307,681
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > National Hemophilia Program	$ 26,200
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Well Woman	$ 1,300,930

	FY 20 Annual Report Budgeted		FY 20 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 11,411,388		$ 11,482,727	
A. Preventive and Primary Care for Children	$ 4,588,519	(40.2%)	$ 5,793,036	(50.4%)
B. Children with Special Health Care Needs	$ 3,423,417	(30%)	$ 3,444,819	(30%)
C. Title V Administrative Costs	$ 1,141,138	(10%)	$ 1,148,272	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 9,153,074		$ 10,386,127	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 27,113,028		$ 32,350,502	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 1,536,572		$ 1,116,526	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 32,697,532		$ 26,818,653	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 61,347,132		$ 60,285,681	
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)	$ 72,758,520		$ 71,768,408	
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)	$ 136,326,832		$ 124,110,692	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 209,085,352		$ 195,879,100	

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Early Head Start - Child Care Partnerships (EHS-CC) Grant	$ 356,786	$ 995,594
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 1,189,138	$ 887,883
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 903,874	$ 380,774
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 277,504	$ 179,020
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program	$ 803,285	$ 698,009
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 120,864	$ 115,245
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH	$ 59,950	$ 1,024
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 132,176,943	$ 119,307,681
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > National Hemophilia Program	$ 26,200	$ 24,132
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Well Women	$ 277,288	$ 1,300,930
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > CMC-COIIN Boston University	$ 135,000	$ 220,400

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Line 1. (Federal Allocation) – FY 2020 Annual Report Expended of $11,482,727 was more than the FY 2018-2020 application's budgeted Grant Award of $11,411,388, a difference of $71,339. The MCH grant is available for two years and some spending can overlap fiscal years.	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Line 1A. (Preventive and Primary Care for Children) – FY 2020 Annual Report expended of $5.79m increased from the FY 2020 Application Budget amount of $4.58m, a difference of $1.20m or 26.25%. In 2018, when the budget was developed for 2020 the children served made up 40.21% of the total program cost compared to the actual expended in FY 2020 of 50.45%. The higher percentage increases the cost in programs that see children.	
3.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Line 3. (State MCH Funds) - FY 2020 Annual Report Expended increased to $32.35m from the FY 2020 Application Budgeted amount of $27.11m, a difference of $5.24m or 19.32%. When the FY 2020 budgeted amount was developed in FY 2018, the other support income was $39.4m compared to the 2020 actuals of $34.5m, a decrease of $5.2m. During this period, 2018 actual cost was adjusted downward for the loss of care coordination services. Revenue from lost services was projected to be $20.28m. The combination of reduced income and cost reflects a need for more State Support. ADPH's share of this increase was $4.48m and as expected Family Planning programs showed the impact of lost revenue. The remaining increase in State Funds of $749k is related to CRS and is a 6.2% variance for the program. The loss of care coordination and the COVID pandemic continues the downward trend in revenue.	
4.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**

	Field Note: Line 5. (Other Funds) – CRS FY 2020 Annual Report Expended of $1.1m decreased from the FY 2020 Application Budgeted of amount of 1.5m, a difference of 420k or 27.34 percent. This decrease is a result of CRS expending less from the Hemophilia State Allocation due to an increase in the number of hemophilia clients with insurance coverage.	
5.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Line 6. (Program Income) - FY 2020 Annual Report Expended of $26.8m decreased from the FY 2020 Application Budgeted amount of $32.7m, a difference of $5.88m or 17.98%. When the FY 2020 budget was developed in FY 2018, the ADPH total program income was reported at $20.1m compared to the FY 2020 actual income earned of $14.8m, a net decrease of $5.3m. Overall, the net decrease of $5.9m in ADPH income was seen in Family Planning related programs (Medicaid). All other ADPH earned income programs had small increases totaling $591k. ADPH delivery of services reflect current operations that have been affected by Medicaid's ACHN networks providing services and the phasing out of ADPH as a provider. Another factor has been the effects of the COVID 19 pandemic on providing client services. CRS program income decreased from a budget amount of $12.6m to 2020 actual income of $12.05m, a decrease of $547k which is 4.3% variance for the program.	
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:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Early Head Start Program - FY 2020 Annual Report Expended of $995k increased from the FY 2018-2020 application's budgeted amount of $357k, a difference of $638k or 179.05%. 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 caused the increase in expenditures from 2018 to 2020.	
7.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Abstinence Education Program – FY 2020 Annual Report Expended of $887k decreased from the FY 2018-2020 application's budgeted amount of $1.19m, a difference of $301k or 25.33%. 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:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Personal Responsibility Education Program (PREP) – FY 2020 Annual Report Expended of $380k decreased from the FY 2018-2020 application's budgeted amount of $903k, a difference of $523k or 57.87%. 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) > Health Resources and Services Administration (HRSA) > Well Women**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Well Women Program – FY 2020 Annual Report Expended of $1.30m increased from the FY 2020 Application Budgeted amount of $277k, a difference of $1.02m or 369.16%. Well Woman program was implemented in January 2017 in three counties: Butler, Dallas, and Wilcox. The program reach has been extended and Well Woman is currently offered in six counties in Alabama (Butler, Dallas, Macon, Montgomery, Russell, and Wilcox) with program implementation pending in three additional counties (Marengo, Henry, and Barbour). Between implementation and 2020 program support and staffing increased, with the most recent increase to 14.4 FTEs to cover staffing at the state office and program support in the three new counties. Plans are under discussion to add an additional three counties (Greene, Hale, and Perry) beginning fiscal year 2022.	
10.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > CMC-COIIN Boston University**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Line 9. (Other Federal Funds) – CRS FY 20 Annual Report Expended $220,399.98 increased from the FY 20 Annual Report Budgeted amount of $135,000.00. The 63.26 percent increase in the expended amount is a result of HRSA approving the use of carryover funds.	

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 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 117,328	$ 117,328
2. Infants < 1 year	$ 979,272	$ 979,272
3. Children 1 through 21 Years	$ 5,793,036	$ 5,793,036
4. CSHCN	$ 3,444,819	$ 3,444,819
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 10,334,455	$ 10,334,455

IB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 539,284	$ 539,283
2. Infants < 1 year	$ 4,792,614	$ 4,501,095
3. Children 1 through 21 Years	$ 25,105,258	$ 28,535,156
4. CSHCN	$ 28,475,899	$ 26,244,645
5. All Others	$ 1,592,907	$ 1,613,774
Non-Federal Total of Individuals Served	$ 60,505,962	$ 61,433,953
Federal State MCH Block Grant Partnership Total	$ 70,840,417	$ 71,768,408

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:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Line 1. (Pregnant Women) – FY 2020 Annual Report Expended of $656k decreased from the FY 2020 Application Budget amount of $1.83m, a difference of $1.18m or 64.22%. During 2018, Mobile and Cullman County had a Maternity Program totaling $1.38m and in 2020 these programs totaled $475k. As reported in the previous application, Medicaid's new Alabama Coordinated Health Network (ACHN) will eliminate ADPH care coordination including maternity services revenue.	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Line 2. (Infants<1 year) – FY 2020 Annual Report Expended of $5.48m decreased from the FY 2020 Application Budgeted amount of $8.77m, a difference of $3.30m or 37.57%. From 2018 to 2020, the activity declined by 2,446 for infants, a decrease of 25.25%. As expected, these services have been affected by Medicaid's Alabama Coordinated Health Network (ACHN).	
3.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Line 3. (Children 1-22 Years) – FY 2020 Annual Report Expended of $34.3m decreased from the FY 2020 Application Budget amount of $52.4m, a difference of $18.10m or 34.53%. From 2018 to 2020, the activity declined for children by 17,954, a decrease of 28.36%. As expected, these services have been affected by Medicaid's Alabama Coordinated Health Network (ACHN).	

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 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 5,232,168	$ 5,469,383
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 2,416,995	$ 2,534,524
B. Preventive and Primary Care Services for Children	$ 2,461,356	$ 2,581,042
C. Services for CSHCN	$ 353,817	$ 353,817
2. Enabling Services	$ 323,885	$ 299,568
3. Public Health Services and Systems	$ 5,926,674	$ 5,713,776
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		$ 164,555
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 842
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Other		
ADPH:CH Assessment & Primary Care program support		$ 5,107,608
CRS: Purchased Services, Health Insurance		$ 196,378
Direct Services Line 4 Expended Total		$ 5,469,383
Federal Total	$ 11,482,727	$ 11,482,727

IIB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 32,618,359	$ 34,064,498
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 9,495,063	$ 10,733,863
B. Preventive and Primary Care Services for Children	$ 9,669,337	$ 10,930,873
C. Services for CSHCN	$ 13,453,959	$ 12,399,762
2. Enabling Services	$ 3,530,180	$ 3,467,446
3. Public Health Services and Systems	$ 23,209,151	$ 22,753,736
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 833,460
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 1,449,606
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Other		
ADPH: Other Non-Fed program cost for MCH activitie		$ 31,781,432
Direct Services Line 4 Expended Total		$ 34,064,498
Non-Federal Total	$ 59,357,690	$ 60,285,680

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:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Line 1. (Direct Services) - FY 2020 Annual Report Expended of $39.53m increased from the FY 2020 Application Budgeted amount of $33.26m, a difference of $6.27m or 18.83%. By comparing recent expended amounts to each other, as opposed to the budgeted number from 2018, is more insightful: Instead of looking at budget to actual the numbers indicate the overall trend for Direct Services has continued downward, Expended for 2018 at $44.5m and for 2020 at $39.5m, a $5m decline.	
2.	**Field Name:**	**IIA. Federal MCH Block Grant, 2. Enabling Services**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Line 2. (Enabling Services) - FY 2020 Annual Report Expended of $3.77m decreased from the FY 2020 Application Budgeted amount of $9.76m, a difference of $5.99m or 61.40%. As reported earlier ADPH lost substantial care coordination services with the coming of Medicaid's Alabama Coordinated Health Network (ACHN). Programs impacted were Family Planning Care Coordination, EPSDT Care Coordination, and Patient 1st Care Coordination. CRS FY 2020 enabling services expended of $2.198m decreased from the FY 2020 Budgeted amount of $2.250m, a difference of $52k.or 2.30% variance for the program.	

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Alabama

Total Births by Occurrence: 57,210 **Data Source Year: 2019**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	56,573 (98.9%)	2,552	197	197 (100.0%)

Program Name(s)				
3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect	Citrullinemia, Type I
Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease	Cystic Fibrosis
Glutaric Acidemia Type I	Hearing Loss	Holocarboxylase Synthase Deficiency	Homocystinuria	Isovaleric Acidemia
Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)
Primary Congenital Hypothyroidism	Propionic Acidemia	S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)
Severe Combined Immunodeficiences	ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Newborn Hearing	56,573 (98.9%)	1,734	66	66 (100.0%)

3. Screening Programs for Older Children & Women

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Alabama Childhood Lead Poisoning Prevention Program	44,061	464	464	464
Alabama Breast and Cervical Cancer Early Detection Program - Breast Cancer Screening	4,638	693	74	51
Alabama Breast and Cervical Cancer Early Detection Program - Cervical Cancer Screening	2,797	514	106	90

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, childhood lead poisoning, and Core RUSP data are based upon calendar year information (January 1, 2019-December 31, 2019). Newborn hearing data is also based upon calendar year information (January 1, 2020- December 31, 2020). The following programs named in the Screening Programs for Older Children & Women section are based upon fiscal year information (October 1, 2019-September 30, 2020): 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:	**2020**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: As of February 27, 2020 the number of live births that occurred in Alabama in calendar year (CY) 2019 was 57,210 based upon the vital statistic file of living births occuring in the State in CY 2019. Data in this section may not be comparable to previous years due to CY variance. Effective in CY 2018, the table previously utilized for our hospital of occurrence data was discontinued resulting in the use of a comparable table. Consequently, data in this section may not be directly comparable to previous years.	
2.	**Field Name:**	**Core RUSP Conditions - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2020**
	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 2020.	
3.	**Field Name:**	**Core RUSP Conditions - Total Number of Out-of-Range Results**
	Fiscal Year:	**2020**
	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 count brings the total number of newborn screening conditions to 31 out of 35 recommended for Alabama.	
4.	**Field Name:**	**Core RUSP Conditions - Total Number Confirmed Cases**
	Fiscal Year:	**2020**
	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 - Total Number Referred For Treatment**
	Fiscal Year:	**2020**
	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 - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2020**
	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) 2020.	
7.	**Field Name:**	**Newborn Hearing - Total Number Confirmed Cases**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: Data results based on date of birth per CY.	
8.	**Field Name:**	**Newborn Hearing - Total Number Referred For Treatment**
	Fiscal Year:	**2020**
	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 - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2020**
	Column Name:	**Older Children & Women**

	Field Note: In an effort to report more meaningful data, the lead program began reporting real time data in our FY 2022 Application / FY 2020 Annual Report. Consequently, the numbers in this section may not be comparable to historical data. The data reported this year is based upon collection dates in calendar year 2019, instead of date in which specimen was processed. Consequently, numbers received and referral numbers may differ. Confirmed cases will include all persons who have been tracked. Also, this data is the most currently available.	
10.	**Field Name:**	**Alabama Childhood Lead Poisoning Prevention Program - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The number of presumptive positive cases for the Alabama Childhood Lead Poisoning Prevention Program reported by the Alabama Department of Public Health Director of Children's Health was 464. This number may include persons who have been tracked for years. Therefore, duplicates were included in this total count.	
11.	**Field Name:**	**Alabama Childhood Lead Poisoning Prevention Program - Total Number Confirmed Cases**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	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 524. This number may include persons 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 - Total Number Referred For Treatment**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**

	Field Note: The number referred for treatment is based upon when case management was initiated, rather than the date specimen was received. Currently, there is a portion of a county that does not use the same reporting system as all other counties; therefore, at this time their data is not trackable. The number of patients referred for treatment and reported by the Alabama Childhood Lead Poisoning Prevention Program Director, located within the Alabama Department of Public Health, was 554. This number may include persons who have been tracked for years. Therefore, duplicates may appear over the course of multiple years. However, the data in this report is de-duplicated so that each child is only counted once per calendar year. This count includes a very small number of adults (ages 18 to <21) who had elevated blood lead due to occupational exposure. 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.	
13.	**Field Name:**	**Alabama Breast and Cervical Cancer Early Detection Program - Breast Cancer Screening - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2020**
	Column Name:	**Older Children & Women**
	Field Note: The number of cases that received treatment may change as the program continues to obtain data. The Alabama Breast and Cervical Cancer Early Detection Program has been equally impacted by the pandemic and a decline in enrollment, screening and cancer cases has been observed. This program name has been listed in previous publications as "Alabama Breast and Cervical Cancer Early Detection Program - Mammogram Screening"	
14.	**Field Name:**	**Alabama Breast and Cervical Cancer Early Detection Program - Cervical Cancer Screening - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2020**
	Column Name:	**Older Children & Women**
	Field Note: The number of cases that received treatment may change as the program continues to obtain data. The Alabama Breast and Cervical Cancer Early Detection Program has been equally impacted by the pandemic and a decline in enrollment, screening and cancer cases has been observed.	

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Alabama

Annual Report Year 2020

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	1,014	59.7	0.0	9.8	30.5	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	23,634	78.6	0.9	6.8	13.7	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	12,091	73.8	3.7	19.5	3.0	0.0
4. Others	50,969	50.7	0.5	17.8	31.0	0.0
Total	107,238					

Form 5b – Total Percentage of Populations Served by Title V (Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	58,615	Yes	58,615	34.6	20,281	1,014
2. Infants < 1 Year of Age	57,224	Yes	57,224	86.2	49,327	31,621
3. Children 1 through 21 Years of Age	1,288,065	Yes	1,288,065	3.0	38,642	23,634
3a. Children with Special Health Care Needs 0 through 21 years of age^	293,203	Yes	293,203	19.6	57,468	12,091
4. Others	3,558,219	Yes	3,558,219	3.0	106,747	50,969

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2020**

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.

The percent total sections, based upon information provided to us, resulted in a total of 100.1 percentage. This percentage total is possibly due to rounding techniques. Since this total was greater than 100% TVIS would not accept the percentage inputs. To address this validation issue, the percentage of "None" was adjusted from 30.6 to 30.5 to enable us to proceed to the next section.

2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2020**

Field Note:
The numbers in this section are based upon occurrence data for calendar year 2019 for mothers 25-34 years of age and based upon Alabama year 2014 revised birth certificate layout. When more current, analyzed data becomes available we will update this section. There is no Title XXI code option for payment source in the Alabama 2014 birth certificate layout. Consequently, there is a 0% 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). Due to changes in reporting, age range change and occurrence vs residential data in this section are not comparable to submissions prior to the year 2019 due to changes in reporting.

3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2020**

	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 changed to include up to 6 years of age. 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 0 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: The "Primary Source of Coverage" percentages of CSHCN are obtained from the CRS report titled MCH Grant Clients by Insurance Status and County.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	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:	**2020**
	Field Note: The State Perinatal Program distributes "Sleep Baby Safe and Snug” Board Books to moms at delivery hospitals according to their specific region of delivery. During Calendar Year 2020 Regions II, III, IV and V in combination distributed 18, 762 English books and 1, 494 Spanish books for a total of 20,256.	
2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2020**

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 FY (October 1, 2019- September 30, 2020) data for the number of Unique Page Views to our Perinatal Program website (15,486) and Newborn Screening Program website (2,276) which provide public information and education. The denominator for the data in this section was retrieved from the National Vital Statistics System on June 15, 2021 for CY 2019 Occurrent Live Birth Data (57,224). Due to the change in the reporting methods beginning in year 2019 submission, percent served data, instead of total served data, in this section is not comparable to last year report. At this time, to our knowledge, the population based services have been included in this count. When more currently available analyzed date becomes available we will update this section. Additionally, when more recently analyzed statistical data becomes available we will update this section.

3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2020**

Field Note:
Our Oral Health Office awards competitive fluoridation grants to eligible public water systems to initiate, update or expand community water fluoridation efforts. In calendar year 2020, they were able to award five grants to public water systems primarily located in the following Alabama counties: Houston, Cleburne, Crenshaw, Madison and Pike. The goal of the program is to expand to additional counties as funds permit. To our knowledge, their Water Fluoridation Reporting System is unable to provide populations served according to age. Consequently, we utilized the most recently available population census data (American Community Survey, 2019) for the 1-21 age group of these counties to determine an estimation (134,293.8) of the population served. We believe these numbers are an over estimation of the population, however they are the most accurate representation of the 1-21 year age group in these counties that we are aware of at this time. When more accurate/precise numbers become available we will update the data.

This percentage is less than 3% and TVIS would not accept our inputted numbers. To address this validation issue, 3% is reported in this section.

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**

Field Note:
The numerator is the number of children reached by CRS for FY 2020 (57,560). The source of this data is the CSHCN program. The number of children reached is calculated through the following: Toll Free Calls, SS Contacts, Information and Referrals, Facebook (Parent and Youth Connection) reaches, ADRS Website CRS page hits, Local Hearing Screenings, Outreach Reports, FVA contacts, and total served. Reference data was used for the denominator as it is the best estimate for Children with Special Health Care Needs 0 through 21 Years of Age in the State.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**

Field Note:
The numerator for the data in this section is the number of mothers Served in the state for fiscal year 2020 according to Family Planning data (50,969) provided to MCH Epidemiology Staff and the number of calls to the Bureau of Family Health Services & MCH Information hotline (1,560). 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 2019, Data (3,558,219). 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% and TVIS would not accept our inputted numbers. To address this validation issue, 3% 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 2020

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	1,167	278	635	153	3	18	16	0	64
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	58,214	35,794	16,531	4,468	156	745	9	0	511
Eligible for Title XIX	41,239	13,761	14,644	2,626	0	0	0	0	10,208

Form Notes for Form 6:

Data in this section included content from Alabama Medicaid. Beginning with the FY 2020 data, the methodologies utilized by Alabama were modified. The new methodology identifies paid claims with dates of service 10/1/2019 through 9/30/20 using the criteria “aid claims only” and “latest paid claims only” to gain the unduplicated count of recipients. This was in an effort to present more accurate data. Consequently, content in this section may not be comparable to previous years due to different calculation methods. Center for Health Statistic counts in this section are from the most currently analyzed data (2019). When more up to date analyzed data is available we will update this section.

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2020**
	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:	**2020**
	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:	**2020**
	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:	**2020**
	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:	**2020**
	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:	**2020**
	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.	

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Alabama

A. State MCH Toll-Free Telephone Lines	2022 Application Year	2020 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"		1,560

B. Other Appropriate Methods	2022 Application Year	2020 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"		3,539
3. State Title V Program Website Address	https://www.rehab.alabama.gov/services/crs http://www.alabamapublichealth.gov/mch	Https://www.rehab.alabama.gov/services/crs http://www.alabamapublichealth.gov/mch
4. Number of Hits to the State Title V Program Website		14,204
5. State Title V Social Media Websites	Parent Connection and Youth Connection Facebook	Parent Connection and Youth Connection Facebook
6. Number of Hits to the State Title V Program Social Media Websites		13,663

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 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 websites.

The number of hits to the state Title V Program Website consists of a combination of the number of hits that both websites received (CRS-11,960 and ADPH MCH – 2,244).

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 reduction 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.

Effective July 20, 2020 the Alabama Department of Rehabilitation Services/ Children's Rehabilitation Service website was updated to the following: https://www.rehab.alabama.gov/services/crs.

The previous website address was as follows: http://www.rehab.alabama.gov/crs.

Number of Hits to the State Title V Program Social Media Websites – FY 2020 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	Jessica Hardy
Title	Assistant Director of the Women's Health Division and MCH Title V Director
Address 1	P O Box 303017
Address 2	
City/State/Zip	Montgomery / AL / 36130
Telephone	(334) 206-2924
Extension	
Email	jessica.hardy@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. Lawrene 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 602
Address 2	
City/State/Zip	Montgomery / AL / 36104
Telephone	(334) 293-7041
Extension	
Email	Susan.Colburn@rehab.alabama.gov

Form Notes for Form 8:

Effective June 1, 2021 Dr. Jessica Hardy, Assistant Director of the Women's Health Division, began serving as the MCH Title V Director.

Form 9
List of MCH Priority Needs

State: Alabama

Application Year 2022

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 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Lack of or inadequate access to services necessary for CSHCN to transition to all aspects of adult life.	Continued
2.	Lack of or inadequate access to health and related services, especially in rural areas and for services identified as difficult to obtain.	New
3.	Increase family and youth involvement and participation in advisory groups, program development, policy-making, and system building activities.	New
4.	High levels of maternal mortality.	New
5.	High levels of infant mortality (and associated factors of preterm birth and low birth weight).	New
6.	High levels and worsening trends of sleep-related/SUID deaths.	New
7.	Lack of timely, appropriate, and consistent health and developmental screenings.	New
8.	Lack of preventive dental visits across all Title V populations, especially for those uninsured.	New
9.	Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they live, learn, work, and play.	New
10.	Lack of support for pregnant and parenting teens.	New

Form 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.

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.

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
2019	70.6 %	0.2 %	41,128	58,238
2018	70.8 %	0.2 %	40,629	57,415
2017	71.5 %	0.2 %	41,925	58,645
2016	71.8 %	0.2 %	42,282	58,911
2015	72.8 %	0.2 %	43,258	59,393
2014	72.7 %	0.2 %	42,851	58,929

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2020
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

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
2015_2019	34.3	3.4	101	294,125
2014_2018	28.5	3.1	84	294,932

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	10.5 %	0.1 %	6,136	58,590
2018	10.7 %	0.1 %	6,184	57,735
2017	10.3 %	0.1 %	6,038	58,902
2016	10.3 %	0.1 %	6,096	59,127
2015	10.4 %	0.1 %	6,218	59,641
2014	10.1 %	0.1 %	5,989	59,388
2013	10.0 %	0.1 %	5,805	58,134
2012	10.0 %	0.1 %	5,853	58,419
2011	9.9 %	0.1 %	5,896	59,331
2010	10.3 %	0.1 %	6,165	60,023
2009	10.3 %	0.1 %	6,454	62,443

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	12.5 %	0.1 %	7,311	58,586
2018	12.5 %	0.1 %	7,204	57,727
2017	12.0 %	0.1 %	7,090	58,909
2016	12.0 %	0.1 %	7,083	59,120
2015	11.7 %	0.1 %	6,999	59,640
2014	11.7 %	0.1 %	6,926	59,397
2013	11.8 %	0.1 %	6,842	58,140
2012	11.9 %	0.1 %	6,976	58,413
2011	11.9 %	0.1 %	7,032	59,327
2010	12.5 %	0.1 %	7,484	59,990
2009	12.5 %	0.1 %	7,801	62,420

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	29.4 %	0.2 %	17,240	58,586
2018	28.0 %	0.2 %	16,178	57,727
2017	27.0 %	0.2 %	15,927	58,909
2016	26.6 %	0.2 %	15,753	59,120
2015	25.4 %	0.2 %	15,146	59,640
2014	25.0 %	0.2 %	14,841	59,397
2013	25.6 %	0.2 %	14,912	58,140
2012	28.1 %	0.2 %	16,392	58,413
2011	29.3 %	0.2 %	17,410	59,327
2010	31.7 %	0.2 %	19,035	59,990
2009	33.0 %	0.2 %	20,593	62,420

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019/Q1-2019/Q4	2.0 %			
2018/Q4-2019/Q3	2.0 %			
2018/Q3-2019/Q2	2.0 %			
2018/Q2-2019/Q1	1.0 %			
2018/Q1-2018/Q4	1.0 %			
2017/Q4-2018/Q3	1.0 %			
2017/Q3-2018/Q2	1.0 %			
2017/Q2-2018/Q1	1.0 %			
2017/Q1-2017/Q4	2.0 %			
2016/Q4-2017/Q3	2.0 %			
2016/Q3-2017/Q2	2.0 %			
2016/Q2-2017/Q1	2.0 %			
2016/Q1-2016/Q4	2.0 %			
2015/Q4-2016/Q3	1.0 %			
2015/Q3-2016/Q2	1.0 %			
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	3.0 %			
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
2018	6.9	0.4	401	57,970
2017	7.2	0.4	427	59,178
2016	8.3	0.4	494	59,405
2015	8.0	0.4	478	59,921
2014	7.3	0.4	438	59,650
2013	8.5	0.4	499	58,433
2012	8.8	0.4	517	58,721
2011	8.0	0.4	475	59,619
2010	8.6	0.4	516	60,330
2009	7.7	0.4	484	62,733

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	6.9	0.4	401	57,761
2017	7.4	0.4	435	58,941
2016	9.0	0.4	534	59,151
2015	8.3	0.4	496	59,657
2014	8.7	0.4	515	59,422
2013	8.6	0.4	500	58,167
2012	8.9	0.4	519	58,448
2011	8.2	0.4	488	59,354
2010	8.7	0.4	524	60,050
2009	8.3	0.4	517	62,475

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	4.4	0.3	252	57,761
2017	4.3	0.3	254	58,941
2016	5.4	0.3	321	59,151
2015	5.0	0.3	301	59,657
2014	5.1	0.3	305	59,422
2013	5.6	0.3	323	58,167
2012	5.8	0.3	340	58,448
2011	5.2	0.3	309	59,354
2010	5.4	0.3	323	60,050
2009	5.1	0.3	316	62,475

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2018	2.6	0.2	149	57,761
2017	3.1	0.2	181	58,941
2016	3.6	0.3	213	59,151
2015	3.3	0.2	195	59,657
2014	3.5	0.2	210	59,422
2013	3.0	0.2	177	58,167
2012	3.1	0.2	179	58,448
2011	3.0	0.2	179	59,354
2010	3.3	0.2	201	60,050
2009	3.2	0.2	201	62,475

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	249.3	20.8	144	57,761
2017	232.4	19.9	137	58,941
2016	309.4	22.9	183	59,151
2015	283.3	21.8	169	59,657
2014	301.2	22.6	179	59,422
2013	326.6	23.7	190	58,167
2012	296.0	22.5	173	58,448
2011	283.0	21.9	168	59,354
2010	299.8	22.4	180	60,050
2009	312.1	22.4	195	62,475

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	117.7	14.3	68	57,761
2017	191.7	18.1	113	58,941
2016	216.4	19.2	128	59,151
2015	184.4	17.6	110	59,657
2014	181.8	17.5	108	59,422
2013	171.9	17.2	100	58,167
2012	152.3	16.2	89	58,448
2011	143.2	15.5	85	59,354
2010	136.6	15.1	82	60,050
2009	155.3	15.8	97	62,475

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

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

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	5.0 %	0.7 %	2,756	55,187
2014	5.8 %	0.8 %	3,176	55,143

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2020
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
2018_2019	13.4 %	1.6 %	138,913	1,035,959
2017_2018	12.2 %	1.6 %	125,032	1,022,648
2016_2017	11.9 %	1.5 %	120,775	1,016,617
2016	10.6 %	1.6 %	107,793	1,020,682

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	32.3	2.5	173	535,424
2018	26.9	2.3	144	534,364
2017	24.6	2.1	132	536,937
2016	22.9	2.1	123	537,913
2015	23.6	2.1	128	541,244
2014	25.0	2.1	136	543,901
2013	25.3	2.2	138	546,207
2012	26.3	2.2	145	551,124
2011	28.4	2.3	156	549,586
2010	26.0	2.2	144	553,130
2009	26.7	2.2	147	551,483

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	48.2	2.8	301	624,113
2018	46.2	2.7	289	626,175
2017	46.9	2.7	294	627,266
2016	50.4	2.8	316	626,927
2015	44.3	2.7	279	629,274
2014	43.3	2.6	274	632,306
2013	39.4	2.5	251	637,220
2012	45.1	2.7	291	644,819
2011	45.8	2.6	300	655,606
2010	45.4	2.6	301	663,126
2009	45.1	2.6	300	665,683

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2017_2019	22.9	1.6	217	948,102
2016_2018	25.0	1.6	239	955,033
2015_2017	25.0	1.6	240	958,914
2014_2016	24.6	1.6	236	957,959
2013_2015	20.8	1.5	199	958,263
2012_2014	21.5	1.5	207	962,433
2011_2013	22.4	1.5	219	978,412
2010_2012	24.2	1.6	242	1,001,033
2009_2011	24.2	1.5	248	1,023,913
2008_2010	26.2	1.6	271	1,035,662
2007_2009	29.6	1.7	306	1,033,470

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2019	10.7	1.1	101	948,102
2016_2018	10.3	1.0	98	955,033
2015_2017	9.1	1.0	87	958,914
2014_2016	9.1	1.0	87	957,959
2013_2015	8.2	0.9	79	958,263
2012_2014	7.9	0.9	76	962,433
2011_2013	8.5	0.9	83	978,412
2010_2012	8.7	0.9	87	1,001,033
2009_2011	8.0	0.9	82	1,023,913
2008_2010	7.4	0.9	77	1,035,662
2007_2009	6.3	0.8	65	1,033,470

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	21.8 %	1.7 %	237,911	1,089,138
2017_2018	22.4 %	1.7 %	245,036	1,095,255
2016_2017	22.5 %	1.6 %	247,758	1,102,057
2016	21.3 %	1.8 %	235,517	1,106,270

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	12.9 %	2.2 %	30,632	237,911
2017_2018	13.2 %	2.5 %	32,403	245,036
2016_2017	16.3 %	2.7 %	40,287	247,758
2016	17.9 %	3.4 %	42,120	235,517

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	2.9 %	0.8 %	26,467	925,851
2017_2018	3.2 %	0.7 %	29,568	927,968
2016_2017	3.1 %	0.7 %	28,645	909,975
2016	2.2 %	0.8 %	19,716	882,862

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	10.0 %	1.4 %	91,976	917,778
2017_2018	11.8 %	1.5 %	108,519	919,536
2016_2017	14.3 %	1.6 %	129,491	904,244
2016	15.0 %	1.9 %	131,199	876,057

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	52.4 %	6.8 %	53,247	101,640
2017_2018	50.5 %	6.6 %	68,245	135,109
2016_2017	50.4 %	6.1 %	70,843	140,701
2016	45.4 %	6.8 %	52,413	115,425

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	87.6 %	1.5 %	952,023	1,086,836
2017_2018	88.1 %	1.6 %	957,626	1,087,156
2016_2017	88.1 %	1.5 %	963,574	1,093,625
2016	87.2 %	1.8 %	961,065	1,101,823

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

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

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	16.2 %	0.2 %	6,225	38,400
2016	16.3 %	0.2 %	6,937	42,671
2014	16.3 %	0.2 %	7,077	43,509
2012	15.6 %	0.2 %	7,160	45,769
2010	15.8 %	0.2 %	7,246	45,743
2008	14.9 %	0.2 %	6,439	43,267

Legends:

Indicator has a denominator <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
2019	17.2 %	1.3 %	35,281	204,779
2015	16.1 %	1.4 %	33,723	209,650
2013	17.1 %	1.3 %	35,621	208,378
2011	17.0 %	1.8 %	35,387	207,991
2009	13.3 %	1.1 %	23,465	176,530
2005	14.6 %	0.9 %	31,002	211,879

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	17.3 %	2.4 %	81,449	469,615
2017_2018	16.1 %	2.3 %	74,048	458,822
2016_2017	18.2 %	2.3 %	79,213	434,616
2016	18.2 %	2.6 %	75,916	417,095

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	3.1 %	0.3 %	34,038	1,086,191
2018	3.5 %	0.4 %	37,799	1,087,053
2017	2.9 %	0.2 %	31,668	1,091,184
2016	2.3 %	0.3 %	25,705	1,098,459
2015	2.8 %	0.2 %	30,460	1,107,192
2014	3.7 %	0.4 %	40,624	1,106,022
2013	4.5 %	0.4 %	50,076	1,110,389
2012	4.0 %	0.3 %	45,014	1,125,653
2011	5.2 %	0.4 %	58,831	1,123,644
2010	6.0 %	0.5 %	67,911	1,135,416
2009	6.1 %	0.4 %	68,872	1,125,665

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	72.3 %	3.4 %	43,000	59,000
2015	69.5 %	3.8 %	42,000	60,000
2014	73.5 %	3.7 %	44,000	60,000
2013	65.9 %	4.1 %	39,000	60,000
2012	70.4 %	4.6 %	42,000	60,000
2011	74.0 %	4.2 %	44,000	60,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	57.8 %	1.8 %	592,796	1,025,598
2018_2019	60.7 %	1.6 %	624,937	1,029,550
2017_2018	53.8 %	1.5 %	550,063	1,022,626
2016_2017	54.3 %	1.7 %	556,320	1,024,530
2015_2016	61.9 %	2.0 %	640,838	1,035,279
2014_2015	57.0 %	1.8 %	598,882	1,050,301
2013_2014	61.0 %	2.1 %	648,135	1,063,003
2012_2013	52.1 %	2.6 %	557,694	1,070,309
2011_2012	49.4 %	2.7 %	517,288	1,047,833
2010_2011	45.9 %	2.7 %	478,640	1,042,788
2009_2010	41.8 %	2.4 %	444,551	1,063,518

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	65.6 %	3.4 %	203,935	311,072
2018	64.7 %	3.2 %	201,534	311,649
2017	58.0 %	3.0 %	181,483	312,726
2016	51.7 %	3.3 %	162,799	314,880
2015	48.4 %	3.3 %	154,158	318,674

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	91.8 %	2.0 %	285,577	311,072
2018	89.4 %	2.3 %	278,746	311,649
2017	88.7 %	2.0 %	277,479	312,726
2016	91.7 %	1.7 %	288,789	314,880
2015	93.3 %	1.7 %	297,233	318,674
2014	88.6 %	2.1 %	283,448	319,757
2013	87.3 %	2.3 %	279,968	320,759
2012	81.7 %	3.1 %	262,973	321,732
2011	74.4 %	2.7 %	241,457	324,613
2010	68.4 %	3.1 %	217,469	317,811
2009	57.6 %	3.1 %	184,090	319,470

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	86.8 %	2.4 %	270,134	311,072
2018	80.0 %	2.7 %	249,374	311,649
2017	78.3 %	2.5 %	244,987	312,726
2016	72.4 %	2.9 %	227,907	314,880
2015	72.1 %	2.9 %	229,605	318,674
2014	71.6 %	2.9 %	228,967	319,757
2013	69.5 %	3.1 %	222,975	320,759
2012	60.5 %	3.6 %	194,524	321,732
2011	64.3 %	3.0 %	208,632	324,613
2010	47.7 %	3.3 %	151,723	317,811
2009	43.5 %	3.2 %	139,022	319,470

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	25.6	0.4	3,955	154,529
2018	25.2	0.4	3,924	155,697
2017	27.0	0.4	4,241	157,072
2016	28.4	0.4	4,480	158,008
2015	30.1	0.4	4,739	157,380
2014	32.0	0.5	5,009	156,495
2013	34.3	0.5	5,392	157,394
2012	39.2	0.5	6,195	158,036
2011	41.0	0.5	6,609	161,135
2010	44.0	0.5	7,343	166,863
2009	48.3	0.5	8,205	169,867

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

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

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	23.5 %	1.6 %	12,454	53,091
2017	19.9 %	1.5 %	10,710	53,919
2015	16.3 %	1.3 %	8,898	54,491
2014	17.6 %	1.3 %	9,621	54,657

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	2.3 %	0.7 %	24,990	1,086,730
2017_2018	2.4 %	0.7 %	26,027	1,094,670
2016_2017	2.8 %	0.7 %	30,968	1,101,322
2016	3.5 %	1.0 %	39,076	1,104,799

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Alabama

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

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective					82
Annual Indicator				70.8	74.4
Numerator				599,429	629,176
Denominator				846,286	846,056
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	82.8	83.2	83.7	84.1	84.5	84.9

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	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 2019, as our baseline, which referred to a routine checkup in the last year by gender. Specifically, we queried the BRFSS website “Prevalence Data & Data Analysis Tools” data (“Prevalence and Trends Data”). Location was set to “Alabama;” class was set to “Health Care Access/Coverage;” topic was set to “Last Checkup;” and year was set to “2019”. This query on May 7, 2021 provided Alabama with a baseline for 2019 of 82.0 percent of females indicating a routine checkup within the past year. Objectives from 2020 forward have been set to require an annual increase of 0.5 percent from the 2019 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	2020
Annual Objective	85.2	75.9	84.5	84.2	83.6
Annual Indicator	75.7	84.3	84.1	83.5	83.5
Numerator	892	958	913	949	949
Denominator	1,179	1,136	1,086	1,137	1,137
Data Source	Alabama Center for Health Statistics	Alabama Center for Health Statistics	Alabama Center for Health Statistics	Alabama Center for Health Statistics	Alabama Center for Health Statistics
Data Source Year	2016	2017	2018	2019	2019
Provisional or Final ?	Final	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	83.8	84.0	84.1	84.3	84.5	84.6

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 Level III or IV hospital 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 Level III or IV hospital 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 Level III or IV hospital 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:**	**2021**
	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 Level III or IV hospital 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. When more currently analyzed data becomes available we will update this section.	

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**	**2020**
Annual Objective	69.4	71.9	75.5	72.3	73.3
Annual Indicator	69.5	71.3	71.3	72.1	72.0
Numerator	37,350	38,245	38,245	37,735	37,266
Denominator	53,710	53,663	53,663	52,309	51,781
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2015	2017	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	73.7	74.0	74.4	74.8	75.1	75.5

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
The Pregnancy Risk Assessment and Monitoring System (PRAMS) is the data source for this (A) 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	**2020**
Annual Objective	88.1	85.7
Annual Indicator	29.8	33.3
Numerator	15,619	16,967
Denominator	52,446	50,878
Data Source	PRAMS	PRAMS
Data Source Year	2017	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			88.1	85.7
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						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	86.1	86.5	87.0	87.4	87.8	88.3

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:**	**2021**
	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 that 84.4 percent of Alabama infants were placed to sleep in a crib, bassinet or pack and play. Objectives for 2017 forward have been set to require an annual improvement of 0.5 percent from the baseline. 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	**2020**
Annual Objective	39.3	49.9
Annual Indicator	36.7	44.4
Numerator	19,218	22,734
Denominator	52,355	51,234
Data Source	PRAMS	PRAMS
Data Source Year	2017	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			39.3	49.9
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						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	50.2	50.4	50.7	50.9	51.2	51.5

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:**	**2021**
	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**	**2020**
Annual Objective			26.3	40.5	58.3
Annual Indicator		21.2	26.6	39.8	44.6
Numerator		32,690	38,521	53,496	54,906
Denominator		154,509	145,031	134,315	122,972
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	55.2	61.5	68.4	73.5	81.8	91.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
The National Survey of Children's Health (NSCH) 2018-2019 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 two-year combined data (as this data is listed as the most reliable estimate) for the State of Alabama. The starting point/topic selected was Title V Block Grant Measures and the specific National Performance Measure selected was number "6: Percent of children, age 9-35 months." This query on January 6, 2021 provided Alabama with a baseline for 2018-2019 of 44.6% of parents completing a developmental screening tool during the past 12 months of children ages 9 through 35 months. Utilizing NSCH data (2018-2019) as our 2019 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 a historical data sets (Year 2018 or prior).

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**	**2020**
Annual Objective			86.9	87.8	68.5
Annual Indicator		75.9	76.3	76.3	77.4
Numerator		267,488	279,668	279,668	253,566
Denominator		352,368	366,499	366,499	327,459
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017	2019

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						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	88.6	94.8	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 NPMs:

1. **Field Name:** **2021**

   Column Name: **Annual Objective**

   Field Note:
   The National Survey of Children's Health (NSCH) 2019 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 2019 for the state of Alabama. The starting point/topic selected was Title V Block Grant Measures and the specific NPM selected was number "10: Percent of adolescents, age 12 through 17 years, with a preventive medical visit in the past year." This query on May 7, 2021 provided Alabama with a baseline for 2019 of 77.4 percent of adolescents with one or more preventive medical visits in the past year. Utilizing NSCH 2019 as a baseline for this performance measure, we set an annual improvement of 0.07 percent for objectives in subsequent years. This improvement percent will result in over 100% in 2023; consequently, this year and future years are set at 100% for TVIS.

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			53.5	58.5	64
Annual Indicator		13.2	12.9	15.0	23.8
Numerator		13,335	13,867	14,975	21,076
Denominator		101,361	107,738	99,967	88,591
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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**	**2020**
Annual Objective			53.5	58.5	64
Annual Indicator	44.3	51.5	77.9	81.9	89.4
Numerator	1,255	1,400	2,753	2,938	3,171
Denominator	2,830	2,718	3,532	3,589	3,548
Data Source	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	70.0	75.0	80.0	82.0	84.0	92.0

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.	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Denominator = Number of children 14-21 years of age, both open and closed between 10/1/2019 and 9/30/2020. Numerator = Number of children 14-21 years of age, both open and closed between 10/1/2019 and 9/30/2020 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**	**2020**
Annual Objective	42.3	43.1	44.2	38.7	38.8
Annual Indicator	41.2	40.6	40.6	36.0	35.4
Numerator	22,302	22,286	22,286	19,726	19,451
Denominator	54,138	54,955	54,955	54,751	54,884
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2015	2017	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	39.7	40.7	41.7	42.8	43.9	45.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	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**	**2020**
Annual Objective			82.5	82.1	80.5
Annual Indicator		81.7	81.7	80.7	80.8
Numerator		837,585	836,024	830,091	838,606
Denominator		1,025,822	1,023,434	1,028,454	1,037,949
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	80.9	81.3	81.7	82.1	82.5	82.9

Field Level Notes for Form 10 NPMs:

1. **Field Name:** **2021**

Column Name: **Annual Objective**

Field Note:
The National Survey of Children's Health (NSCH) 2018-2019 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 two-year combined data (as this data is listed as the most reliable estimate) for the State of Alabama. The starting point/topic selected was Title V Block Grant Measures and the specific National Performance Measure selected was "13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year." This query on January 6, 2021 provided Alabama with a baseline for 2018-2019 of 80.8 percent of children, age 1-17 years, who had a preventive dental visit in the past year. Utilizing NSCH data (2018-2019) as our 2019 baseline for this performance measure, we set an annual improvement of 0.005 for objectives in subsequent years. Note, previous year reports may not be comparable due to the utilization of historical data sets (Year 2018 or prior).

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

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			82.5	82.1	80.5
Annual Indicator		81.7			
Numerator		837,585			
Denominator		1,025,822			
Data Source		NSCH			
Data Source Year		2016			
Provisional or Final ?		Final			

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	80.9	81.3	81.7	82.1	82.5	82.9

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:**	**2021**
	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**	**2020**
Annual Objective			70	73	75
Annual Indicator		43.3	40.1	37.0	37.4
Numerator		102,023	99,230	90,678	88,885
Denominator		235,517	247,758	245,036	237,911
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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**	**2020**
Annual Objective			70	73	75
Annual Indicator	36.2	65.8	71.9	73	73.8
Numerator	3,567	6,766	7,754	8,594	8,923
Denominator	9,858	10,287	10,784	11,772	12,091
Data Source	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

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.	
5.	**Field Name:**	**2020**
	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**	**2020**
Annual Objective		54.3	53.3	73	55.1
Annual Indicator	53.7	52.8	72.2	54.6	56.2
Numerator	34,296	33,970	32,124	33,751	32,982
Denominator	63,812	64,372	44,467	61,836	58,688
Data Source	Alabama Medicaid Agency EPSDT data	Alabama Medicaid Agency EPSDT data	Alabama Medicaid	Alabama Medicaid Agency EPSDT data	Alabama Medicaid Agency EPSDT data
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	56.8	57.3	57.9	58.5	59.1	59.7

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 leads were screened/tested for persons in this age group. This data 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 leads were screened/tested. This data for FY 2017, represented 52.8 percent of children ages 1-2 years receiving a blood lead screening. Objectives for subsequent years have been set to require an annual increase of 1.0 percent from this baseline.	
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 leads were screened/tested. This data for FY 2018, represented 72.2 percent of children ages 1-2 years receiving a blood lead screening. Objectives for subsequent years have been set to require an annual increase of 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 leads were screened/tested. This data for FY 2019, represented 54.6 percent of children ages 1-2 years receiving a blood lead screening. Objectives for subsequent years have been set to require an annual increase of 1.0 percent from this baseline.	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data guiding annual objectives for this state performance measure comes from the FY 2020 Alabama Medicaid Agency Early and Periodic Screening, Diagnostic and Treatment (EPSDT) report. In FY 2020, of the 58,688 total eligible receiving at least one initial or periodic screening for ages 1-2 years, 32,928 persons in this age group blood leads were screened/tested. This data for FY 2020, represented 56.2% 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% from this baseline.	
6.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
Data guiding annual objectives for this state performance measure comes from the FY 2020 Alabama Medicaid Agency Early and Periodic Screening, Diagnostic and Treatment (EPSDT) report. In FY 2020, of the 58,688 total eligible receiving at least one initial or periodic screening for ages 1-2 years, 32,928 persons in this age group blood leads were screened/tested. This data for FY 2020, represented 56.2% 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% 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	2026
Annual Objective	33.0	50.0	67.0	88.0	100.0	100.0

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	2026
Annual Objective	50.0	58.0	67.0	77.0	89.0	100.0

Field Level Notes for Form 10 SPMs:

None

SPM 4 - Percent of women who smoke during pregnancy

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	8.7	8
Numerator		
Denominator		
Data Source	ADPH Center for Health Statistics	ADPH Center for Health Statistics
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	7.8	7.8	7.7	7.6	7.5	7.5

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 most currently available analyzed data.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Based upon the ADPH Center for Health Statistics, Percent of Births with Maternal Smoking, 2019 (8.0 percent). Objectives set for a 1 percent annual decrease from the 2019 benchmark of 8.0 percent of births with maternal smoking.	
3.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: Based upon the ADPH Center for Health Statistics, Percent of Births with Maternal Smoking, 2019 (8.0 percent). Objectives set for a 1 percent annual decrease from the 2019 benchmark of 8.0 percent of births with maternal smoking.	

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	0	40
Numerator	0	2
Denominator	6	5
Data Source	Program Data	Program Data
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	0.6	0.8	1.0	1.0	1.0	1.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
This measure is new with the goal of tracking the number of EHS that maintain a specified level of CSHCN. Objectives were set to increase by one program out of the six (e.g. 1/6=0.17) annually.

This measure was based upon the total number of Program Partners participating in the 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.

2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Before the end of 2020, there were only five program partners instead of six originally mentioned in this measure. Jefferson County Committee for Economic Opportunity ended its agreement with the Department of Human Resources (DHR) and the slots were transferred to other centers.

In 2020, two of the five centers met their goal of 10% or higher. In 2021, we discovered that Special Needs Children were under reported to DHR. Therefore, the Alabama Department of Public Health (ADPH) added policies to the Care Coordination Protocol to include working with centers to identify children with special needs, assisting in obtaining the Individualized Family Service Plans (IFSP), verifying the number of special needs children monthly at each center, and reporting to DHR children not listed on their monthly report. The desire is that these efforts will help to improve the percentage of children identified with special needs at each center.

Objectives beyond the year 2020 were set to increase by one additional program out of the five (e.g. 3/5=0.60) annually.

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

Measure Status:	Active

State Provided Data		
	2019	2020
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	2026
Annual Objective	28.9	29.2	29.5	29.8	30.1	30.4

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 7 - 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	2020
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	2026
Annual Objective	3.0	3.0	3.0	3.0	3.0	3.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
The program is working on TA and this SPM will be updated in the next FY.

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**	**2020**
Annual Objective		5	27	28	29
Annual Indicator	40	78.8	76.7	80	96.7
Numerator	18	26	23	24	29
Denominator	45	33	30	30	30
Data Source	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

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.	
5.	**Field Name:**	**2020**
	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 a 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 section V Supporting Documents.	

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

Measure Status:	**Active**				
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		2	22	23	24
Annual Indicator	1	22	0	0	0
Numerator					
Denominator					
Data Source	Checklist Criteria Screening Tool	Checklist Criteria Screening Tool	Checklist Criteria Screening Tool	Checklist Criteria Screening Tool	Checklist Criteria Screening Tool
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	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.	
5.	**Field Name:**	**2020**
	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 during 2020 they would like to update and complete the Adolescent Health Plan.	

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

Measure Status:	Active				
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		0	5	10	15
Annual Indicator	0	0	33.8	43.2	50.7
Numerator			47	60	72
Denominator			139	139	142
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	The Alabama Department of Mental Health and the St
Data Source Year	2017	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Final

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 the 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 the Alabama Department of Mental Health. ADPH staff met with the board of the School Superintendents of Alabama to discuss services available through the department. School age children living in rural areas can access Behavioral Health services through telehealth. Further discussions are planned.

4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
The Department of Mental Health Website states that 72 school systems are participating in the School-Based Mental Health Collaboration and they are supposed to receive $750,000 in FY21 to expand the program. The State Department of Education website 2020 Quick Facts states there are now 142 local School Systems which is an increase over the past couple of years.

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Alabama

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

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		44	44.5	44.9	45.4
Annual Indicator	43.2	43.2	43.2	43.2	43.2
Numerator	1,081,373	1,081,373	1,081,373	1,081,373	1,081,373
Denominator	2,505,795	2,505,795	2,505,795	2,505,795	2,505,795
Data Source	BRFSS and U.S. Census Bureau, Population Division	BRFSS and U.S. Census Bureau, Population Division	BRFSS and U.S.Census	BRFSS and U.S.Census	BRFSS and U.S.Census
Data Source Year	2015	2015	2015	2015	2015
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	45.8	46.2	46.7	47.1	47.5	48.0

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.	
4.	**Field Name:**	**2019**
	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% with an annual improvement of 1.0 percent objectives. Note, Well Woman data was based upon 15-55 years of age.	
5.	**Field Name:**	**2020**
	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% with an annual improvement of 1.0 percent objectives. Note, Well Woman data was based upon 15-55 years of age.

At this time the Women's Health Program is planning to work with our Technical Assistance team at Georgetown University to acquire a better understanding of the most appropriate manner to report measures for the MCH Block Grant. The Women's Health Program team plans to rewrite this measure in our next grant submission in a manner that more accurately reflects the efforts of the program.

6.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

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% with an annual improvement of 1.0 percent objectives. Note, Well Woman data was based upon 15-55 years of age.

At this time the Women's Health Program is planning to work with our Technical Assistance team at Georgetown University to acquire a better understanding of the most appropriate manner to report measures for the MCH Block Grant. The Women's Health Program team plans to rewrite this measure in our next grant submission in a manner that more accurately reflects the efforts of the program.

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

Measure Status:	Active

State Provided Data		
	2019	2020
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	2026
Annual Objective	0.0	10.9	21.7	32.6	43.5	54.3

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2019**

Column Name: **State Provided Data**

Field Note:
This measure serves to track the number of birthing hospital meetings with the Alabama State Perinatal Program staff to share data and discuss the Alabama Perinatal Regionalization System Guidelines.

This objective was based upon the year 2020 benchmark total of 46 birthing hospitals. The goal was to increase the number of birthing hospitals meetings by five hospitals per year. This goal would result in an approximately 10.9 percent increase in the year 2021. Unfortunately, due to COVID, we have been unable to move forward with this objective. Our goal is to begin movement on this measure in the year 2022.

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	2020
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	2026
Annual Objective	1.0	1.0	2.0	2.0	3.0	3.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: This measure serves to track implementation of the CDC's Level of Care Assessment Tool (CDC LOCATe) which is being utilized to align the Alabama Perinatal Regionalization System Guidelines with the national criteria for the Maternal Levels of Care. Objectives are set to increase hospital participation by five facilities per year. Unfortunately, due to COVID, we have been unable to move forward with this objective. Our goal is to begin movement on this measure in the year 2022.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Unfortunately, due to COVID, we have been unable to move forward with this objective. Our goal is to begin movement on this measure in the upcoming year. This measure may be revised in future reports based upon the results of the Perinatal Health Division Director Technical Assistance (TA) meeting.	

ESM 5.1 - Number of sleep-related infant deaths

Measure Status:	Active

State Provided Data		
	2019	2020
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	2026
Annual Objective	63.9	62.0	60.1	58.3	56.6	54.9

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

Measure Status:	Active

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

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	2.5	3.1	3.9	4.9	6.1	7.6

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: This measure is a new one, which serves to track the number of trainings facilitated to assist healthcare professionals and first responders, who interact with expecting and new mothers, during training on safe sleep recommendations Objectives are based upon the number of trainings facilitated in the specified year and set to increase 25 percent annually.	
2.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: In the year 2020, due to COVID-19 only two trainings were conducted. These two trainings were virtual. The goal is to continue to increase trainings by 25 percent annually. This measure may be revised in future reports based upon the results of the Perinatal Health Division Director Technical Assistance (TA) meeting.	

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	2026
Annual Objective	1.0	2.0	3.0	4.0	5.0	6.0

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	2020
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	2026
Annual Objective	1.9	1.9	1.9	2.0	2.0	2.0

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 objective 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 (2021)

This measure may be revised in future reports based upon the results of the Child and Adolescent Health Division Director Technical Assistance (TA) meeting.

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	54.6	56.2
Numerator	33,751	32,982
Denominator	61,836	58,688
Data Source	Alabama Medicaid	Alabama Medicaid
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	56.8	57.3	57.9	58.5	59.1	59.7

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Data guiding annual objectives for this measure comes from the FY 2019 Alabama Medicaid Agency 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 levels were screened/tested. For FY 2018, this figure 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.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data guiding annual objectives for this state performance measure comes from the FY 2020 Alabama Medicaid Agency Early and Periodic Screening, Diagnostic and Treatment (EPSDT) report. In FY 2020, of the 58,688 total eligible receiving at least one initial or periodic screening for ages 1-2 years, 32,928 persons in this age group blood lead levels were screened/tested. For FY 2020, this figure represented 56.2% 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% 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	2020
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	2026
Annual Objective	77.1	77.8	78.6	79.4	80.2	81.0

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.

This measure may be revised in future reports based upon the results of the Child and Adolescent Health Division Director Technical Assistance (TA) meeting.

ESM 12.1 - 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	2026
Annual Objective	50.0	58.0	67.0	77.0	89.0	100.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	500
Data Source	Oral Health Program
Data Source Year	2020
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	3.0	6.0	9.0	10.0	10.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: This measure is new and has the goal of tracking increase in dental provider knowledge. The denominator is based upon program estimates of approximately 25% of total Alabama dentists (500 individuals). The fiscal year 2022 baseline is set at 3.0% with a 3.0% annual improvement objective until reaching our overall 10% dental provider reach goal. We aim to implement this measure in the upcoming fiscal year (2022).	
2.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: This measure is new and has the goal of tracking increase in dental provider knowledge. The denominator is based upon program estimates of approximately 25% of total Alabama dentists (500 individuals). The fiscal year 2022 baseline is set at 3.0% with a 3.0% annual improvement objective until reaching our overall 10% dental provider reach goal. We aim to implement this measure in the upcoming fiscal year (2022).	

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

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	500
Data Source	Oral Health Program
Data Source Year	2020
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	3.0	6.0	9.0	10.0	10.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: This measure is new and has the goal of tracking increase in dental provider knowledge. The denominator is based upon program estimates of approximately 25% of total Alabama dentists (500 individuals). The fiscal year 2022 baseline is set at 3.0% with a 3.0% annual improvement objective until reaching our overall 10% dental provider reach goal. We aim to implement this measure in the upcoming fiscal year (2022).	
2.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: This measure is new and has the goal of tracking increase in dental provider knowledge. The denominator is based upon program estimates of approximately 25% of total Alabama dentists (500 individuals). The fiscal year 2022 baseline is set at 3.0% with a 3.0% annual improvement objective until reaching our overall 10% dental provider reach goal. We aim to implement this measure in the upcoming fiscal year (2022).	

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

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	500
Data Source	Oral Health Program
Data Source Year	2020
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	3.0	6.0	9.0	10.0	10.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: This measure is new and has the goal of tracking increase in dental provider knowledge. The denominator is based upon program estimates of approximately 25% of total Alabama dentists (500 individuals). The fiscal year 2022 baseline is set at 3.0% with a 3.0% annual improvement objective until reaching our overall 10% dental provider reach goal. We aim to implement this measure in the upcoming fiscal year (2022).	
2.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: This measure is new and has the goal of tracking increase in dental provider knowledge. The denominator is based upon program estimates of approximately 25% of total Alabama dentists (500 individuals). The fiscal year 2022 baseline is set at 3.0% with a 3.0% annual improvement objective until reaching our overall 10% dental provider reach goal. We aim to implement this measure in the upcoming fiscal year (2022).	

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

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	500
Data Source	Oral Health Program
Data Source Year	2020
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	3.0	6.0	9.0	10.0	10.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: This measure is new and has the goal of tracking increase in dental provider knowledge. The denominator is based upon program estimates of approximately 25% of total Alabama dentists (500 individuals). The fiscal year 2022 baseline is set at 3.0% with a 3.0% annual improvement objective until reaching our overall 10% dental provider reach goal. We aim to implement this measure in the upcoming fiscal year (2022).	
2.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: This measure is new and has the goal of tracking increase in dental provider knowledge. The denominator is based upon program estimates of approximately 25% of total Alabama dentists (500 individuals). The fiscal year 2022 baseline is set at 3.0% with a 3.0% annual improvement objective until reaching our overall 10% dental provider reach goal. We aim to implement this measure in the upcoming fiscal year (2022).	

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**	**2020**
Annual Objective			79.6	79.8
Annual Indicator			83.5	83.5
Numerator			949	949
Denominator			1,137	1,137
Data Source			Center for Health Statistics	Center for Health Statistics
Data Source Year			2019	2019
Provisional or Final ?			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. This section includes the most recently available analyzed data (2019).	
2.	**Field Name:**	**2020**
	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. This section includes the most recently available analyzed data (2019).	

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**	**2020**
Annual Objective		2.6	2.7	2.5	2.5
Annual Indicator	2.6	1.7	2.5	2.5	2.5
Numerator	300	215	314	314	314
Denominator	11,640	12,605	12,660	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	Office of EMS, The Alabama State Perinatal Program
Data Source Year	2016-2017	2017-2018	2018	2018	2018
Provisional or Final ?	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.

5.	**Field Name:**	**2020**
	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**	**2020**
Annual Objective	5	10	15	20
Annual Indicator	100	100	100	100
Numerator	536	23,761	27,494	24,085
Denominator	536	23,761	27,494	24,085
Data Source	Alabama Medicaid Agency	Alabama Medicaid Agency	Help Me Grow	Help Me Grow
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Provisional	Provisional	Final

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.	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: For FY20 the Alabama Partnership for Children, Help Me Grow program provided 24, 085 developmental screenings.	

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**	**2020**
Annual Objective		0	5	10	20
Annual Indicator	0	0	0	0	0
Numerator		0	0	0	0
Denominator		900	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	UAB LEAH ACHIA Program Evaluation Tool
Data Source Year	2017	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Final	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.	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The Quality Improvement Initiative with partners UAB LEAH, ADPH MCH/Children's Health and the Alabama Child Health Improvement Alliance (ACHIA) is completed.	

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**	**2020**
Annual Objective		51	70	65	66
Annual Indicator	56.5	65.8	65.9	66.3	70.4
Numerator	5,567	6,766	7,103	7,810	8,516
Denominator	9,858	10,287	10,784	11,772	12,091
Data Source	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

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.	
5.	**Field Name:**	**2020**
	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**	**2020**
Annual Objective	50	42	45	47
Annual Indicator	40	54.8	49.2	50.4
Numerator	200	274	246	252
Denominator	500	500	500	500
Data Source	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

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.	
4.	**Field Name:**	**2020**
	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. In FY 2020 several events were not held due to COVID-19. These include, FVA Partners in Care Summit and Med Aspects. FY 2020 data includes the Pediatric Care Coordination Curriculum Training as it was held pre COVID-19.	

2016-2020: 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**	**2020**
Annual Objective		35.5	52	55	57
Annual Indicator	44.3	51.5	77.9	81.9	89.4
Numerator	1,255	1,400	2,753	2,938	3,171
Denominator	2,830	2,718	3,532	3,589	3,548
Data Source	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

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.	
5.	**Field Name:**	**2020**
	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 10/01/19 - 09/30/20 who have a comprehensive plan of care. Denominator = The Number of Children 14-21 Yrs. of Age - Both open and closed between 10/01/19 - 09/30/20.	

2016-2020: 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**	**2020**
Annual Objective		28	27.7	28.1	28.9
Annual Indicator	27.9	27.6	28	28.8	22.8
Numerator	288,998	286,146	292,658	300,040	236,219
Denominator	1,036,378	1,036,378	1,045,740	1,041,996	1,037,400
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	Alabama Medicaid, U.S. Census
Data Source Year	2016	2016/17	2017/2018	2018/2019	2020/2019
Provisional or Final ?	Final	Final	Final	Final	Final

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. This measure will be revised in future reports based upon the results of the Oral Health Division Director Technical Assistance (TA) meeting.	
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. This measure will be revised in future reports based upon the results of the Oral Health Division Director Technical Assistance (TA) meeting results.	
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. This measure will be revised in future reports based upon the results of the Oral Health Division Director Technical Assistance (TA) meeting results.

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. This measure will be revised in future reports based upon the results of the Oral Health Division Director Technical Assistance (TA) meeting results.

5.	**Field Name:**	**2020**
	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 June 16, 2021 the most recent U.S. Census data according to specific age group breakdown was for the year 2019. The most recent Alabama Medicaid data was for FY 2020. We set an annual improvement of 0.5% for objectives in subsequent years. Note, previous year data is not comparable dude to differing year data sources. This measure will be revised in future reports based upon the results of the Oral Health Division Director Technical Assistance (TA) meeting results.

2016-2020: 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**	**2020**
Annual Objective			50	75
Annual Indicator			0	0
Numerator			0	0
Denominator			7	7
Data Source			Alabama Medicaid, ADPH Oral Health Branch	Alabama Medicaid, ADPH Oral Health Branch
Data Source Year			2019	2019
Provisional or Final ?			Final	Final

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.

This measure will be revised in future reports based upon the Oral Health Division Director Technical Assistance (TA) meeting results.

2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
This measure will be revised in future reports based upon the Oral Health Division Director Technical Assistance (TA) meeting results.

2016-2020: 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**	**2020**
Annual Objective		0	5	10	15
Annual Indicator	0	27.6	28.2	26.4	26.4
Numerator		286,146	292,658	273,684	273,684
Denominator		1,036,378	1,036,378	1,036,378	1,037,400
Data Source	PRAMS, Medicaid, RCOs, Social Work Program Data	Medicaid, Census	Medicaid, Census	Medicaid, Census	Medicaid, Census
Data Source Year	2017	2017	2018,2017	2019,2010	2019
Provisional or Final ?	Provisional	Final	Final	Final	Final

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. This measure will be revised in future reports based upon the Oral Health Division Director Technical Assistance (TA) meeting results.	
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. This measure will be revised in future reports based upon the Oral Health Division Director Technical Assistance (TA) meeting results.	
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. This measure will be revised in future reports based upon the Oral Health Division Director Technical Assistance (TA) meeting results.	
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. This measure will be revised in future reports based upon the Oral Health Division Director Technical Assistance (TA) meeting results.	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: This measure will be revised in future reports based upon the Oral Health Division Director Technical Assistance (TA) meeting results.	

Form 10
State Performance Measure (SPM) Detail Sheets

State: Alabama

SPM 1 - Percent of children who receive a blood lead screening test at age 12 and 24 months of age
Population Domain(s) – Child Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the proportion of children aged 12 and 24 months that have a reported blood lead screening.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of Alabama children aged 12 and 24 months that have a reported blood lead screening</td></tr>
<tr><td>Denominator:</td><td>Number of Alabama children aged 12 and 24 months</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Alabama Department of Public Health Lead Program Data</td></tr>
<tr><td>Significance:</td><td>Lead is a potent and pervasive neurotoxicant. Elevated blood lead levels (EBBLs) can result in decreased IQ, academic failure, and behavioral problems in children. There are approximately half a million U.S. children ages 1-5 with 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.</td></tr>
</table>

SPM 2 - Strengthen and enhance family/youth partnerships, involvement and engagement in advisory groups, program development, policymaking, and system-building activities to support shared decision making between families and health-related professionals.
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	Strengthen and enhance partnerships between families, youth and healthcare providers and related health professionals.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Annual Score on the Checklist Criteria Scoring Tool **Denominator:** Total Possible Points on the Checklist Criteria Scoring Tool
Data Sources and Data Issues:	Annual Progress will be tracked utilizing a Checklist Criteria Scoring Tool which was created to monitor progress towards meeting the objectives outlined in the action plan. Scoring will be based on a total score (maximum=24) and will be measured yearly for increase or decrease from prior year. Scoring: 0=not started/no progress; 1=initial activity/minimal progress; 2=some activity/moderate progress; 3=completed or sustaining level progress. Data Issues: Failure to accurately document action on the criteria could lead to inaccurate annual scoring and, 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:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of respondents who report receiving comprehensive care coordination services.</td></tr><tr><td>**Denominator:**</td><td>Number of survey respondents.</td></tr></table>
Healthy People 2030 Objective:	MICH-20: Increase the proportion of children and adolescents with special health care needs who receive care in a family-centered, comprehensive, and coordinated system.
Data Sources and Data Issues:	Data Source: CRS Care Coordination Family Survey will be developed to measure that comprehensive care coordination services are being provided to families. Comprehensive Care Coordination is a patient-and-family centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the caregiving capabilities of families. Care coordination addresses interrelated medical, social, developmental, behavioral, educational, and financial needs in order to achieve optimal health and wellness outcomes. Baseline to be determined by 2021. Data Issues: A potential issue when collecting data using a survey format is a limited number of respondents which could impact the outcome.
Significance:	The Standards for Systems of Care for 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 under the Medical Home domain.

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:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women who report smoking during pregnancy **Denominator:** Number of live births
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 - 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:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of EHS programs participating in the EHSCCP grant program that maintain 10% of their population with children with special needs **Denominator:** Number of EHS programs participating in the EHSCCP grant program
Data Sources and Data Issues:	DHR EHS Program Information
Significance:	Head Start is a federally funded, locally administered comprehensive child development program that provides early education and support services to children and families with household incomes up to 130 percent of poverty by federal standards (about $33,000 for a family of four). Head Start serves children ages 3 to 5, while 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 6 - Percent of staff trained at day care provider/centers on CPR/First Aid
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Increase the percent of staff trained at day care provider/centers on CPR/First Aid in the past year
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of staff trained at day care provider/centers on CPR/First Aid in the past year **Denominator:** Number of staff trained at day care provider/centers in the past year
Data Sources and Data Issues:	Healthy Childcare Alabama Training Data
Significance:	Head Start is a federally funded, locally administered comprehensive child development program that provides early education and support services to children and families with household incomes up to 130 percent of poverty by federal standards (about $33,000 for a family of four). Head Start serves children ages 3 to 5, while 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 - 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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>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</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>3</td></tr>
<tr><td>Numerator:</td><td>Number of modules of the University of Wisconsin-Madison's Population Health Initiative's Health Equity Training Modules completed</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Alabama MCH Title V Block Grant Program Documentation</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** 33 **Denominator:** 33
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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>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.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>24</td></tr>
<tr><td>Numerator:</td><td>Annual Score on the Checklist Criteria Scoring Tool</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2020 Objective:</td><td>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.</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>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.</td></tr>
<tr><td>Significance:</td><td>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</td></tr>
</table>

	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:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of school districts assessed regarding current mental health services **Denominator:** Number of school districts in the state
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:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women age 15-55 who report having received a preventive visit in the past year **Denominator:** Number of women age 15-55 in Alabama
Data Sources and Data Issues:	BRFSS Question 3.4 National Survey of Children's Health K4Q20 Issues: State-level samples; NSCH not completed on an annual basis
Significance:	By implementing the 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:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of delivering hospitals represented at the meeting **Denominator:** Number of delivering hospitals in Alabama
Data Sources and Data Issues:	Alabama'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)

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Implement the CDC's Level of Care Assessment Tool (LOCATe) Process in order to align and implement the national criteria for the Maternal Levels of Care</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>3</td></tr>
<tr><td>Numerator:</td><td>Number of steps of the CDC's Level of Care Assessment Tool (LOCATe) Process completed</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Alabama Perinatal Regionalization System Data</td></tr>
<tr><td>Significance:</td><td>Creation of a system that aligns the maternal levels of care with Alabama Perinatal Regionalization System Guidelines utilizing CDC LOCATe ensures that there is a regionalized system for neonates and moms in 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.</td></tr>
</table>

ESM 5.1 - Number of sleep-related infant deaths
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Decrease by 3 percent annually, the number of sleep-related infant deaths by implementing targeted consistent safe sleep education to caregivers, child health providers, health care providers, and hospital systems.
Definition:	**Unit Type:** Count **Unit Number:** 200 **Numerator:** Number of sleep-related infant deaths **Denominator:**
Data Sources and Data Issues:	ADPH's Center for Health Statistics
Significance:	Providing safe sleep education to targeted audiences that provide care to infants helps to ensure that consistent messaging is shared with families with hopes that more families will implement safe sleep recommendations with the ultimate goal of decreasing sleep-related infant deaths.

ESM 5.2 - Number of trainings facilitated to assist healthcare professionals and first responders, who interact with expecting and new mothers, with being trained on safe sleep recommendations
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Increase by 25 percent annually, the number of trainings facilitated to assist healthcare professionals and first responders, who interact with expecting and new mothers, with being trained on safe sleep recommendations
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of trainings facilitated to assist healthcare professionals and first responders, who interact with expecting and new mothers, with being trained on safe sleep recommendations **Denominator:**
Data Sources and Data Issues:	Alabama'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:	**Unit Type:** Percentage **Unit Number:** 100 **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
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:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children birth to age 19 that received a developmental screening in conjunction with a well child appointment in the past year **Denominator:** Number of children birth to age 19
Data Sources and Data Issues:	APC and Help Me Grow Program Data
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families.

ESM 6.3 - Proportion of children aged 12 & 24 months that have a reported blood lead screening in the past year
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Increase the proportion of children aged 12 & 24 months that have a reported blood lead screening in the past year
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children aged 12 & 24 months that have a reported blood lead screening in the past year **Denominator:** Number of children aged 12 & 24 months
Data Sources and Data Issues:	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:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of adolescents aged 12 to 19 that received an adolescent well visit in the county health departments in the past year **Denominator:** Number of adolescents aged 12 to 19
Data Sources and Data Issues:	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 State CSHCN program who report satisfaction with their transition experience to adulthood.
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To improve transition services and the overall transition experience.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of youth that indicate satisfaction regarding their transition experience.</td></tr>
<tr><td>Denominator:</td><td>Total number of youth surveyed.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Survey based on the Six Core Elements of Health Care Transition 2.0 Health Care Transition Feedback Survey for Youth and the State and Local Area Integrated Telephone Survey (SLAITS) 2007 Survey of Adult Transition and Health (SATH). A potential issue when collecting data using a survey format is a limited number of respondents which could impact the outcome.</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

ESM 13.1.1 - Percentage of dental providers receiving information/education regarding importance of preventive dental visits for expectant mothers
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

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:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** 0 **Denominator:** 500
Data Sources and Data Issues:	Oral Health Program Data
Evidence-based/informed strategy:	To our knowledge, there is currently no evidence-based/informed strategy for dental provider training.
Significance:	Oral health is inextricably linked to overall general health and well-being. People with limited access to preventive oral health services are at greater risk for oral diseases that lead to sometimes devastating outcomes. There are profound and consequential oral health disparities within Alabama and the American population, as well as barriers hampering segments of the population from attaining optimal oral health. There are safe and effective measures to prevent the most common dental diseases such as dental caries, as well as more complex oral cavity disease processes. An increase in professionals educated on the need for oral health care and equity for certain populations and the need for collaboration between state and local agencies as well as regulatory bodies will contribute to diverse policies and advocacy for those in need. It is important for providers to receive education on oral health for pregnant women as that is a great unmet need for this population. Potentially profound adverse pregnancy outcomes may result from lack of proper preventive dental care. It is incumbent upon the dental community to stay abreast of the most up to date information in order to promote and provide these services to better attain positive pregnancy outcomes. Dental providers are also charged with the diagnosis and prevention of certain oral and oropharyngeal cancers through physical exams and referrals for the FDA approved HPV vaccine, necessitating the need for continual education. This is extremely important in Alabama, as the state consistently ranks high in both incidence and mortality resulting from these oral cancers.

ESM 13.1.2 - Percentage of dental providers that received information/education regarding their perinatal patients about the FDA approved HPV vaccine in order to reduce the risk of oropharyngeal, cervical, and other HPV-related cancers
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Active
Goal:	Increase the number of pregnant women vaccinated against HPV through the education of dental providers.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** 0 **Denominator:** 500
Data Sources and Data Issues:	Oral Health Program
Evidence-based/informed strategy:	This is an emerging topic of discussion and consequently there is no known evidence-based strategy.
Significance:	Oral health is inextricably linked to overall general health and well-being. People with limited access to preventive oral health services are at greater risk for oral diseases that lead to sometimes devastating outcomes. There are profound and consequential oral health disparities within Alabama and the American population, as well as barriers hampering segments of the population from attaining optimal oral health. There are safe and effective measures to prevent the most common dental diseases such as dental caries, as well as more complex oral cavity disease processes. An increase in professionals educated on the need for oral health care and equity for certain populations and the need for collaboration between state and local agencies as well as regulatory bodies will contribute to diverse policies and advocacy for those in need. It is important for providers to receive education on oral health for pregnant women as that is a great unmet need for this population. Potentially profound adverse pregnancy outcomes may result from lack of proper preventive dental care. It is incumbent upon the dental community to stay abreast of the most up to date information in order to promote and provide these services to better attain positive pregnancy outcomes. Dental providers are also charged with the diagnosis and prevention of certain oral and oropharyngeal cancers through physical exams and referrals for the FDA approved HPV vaccine, necessitating the need for continual education. This is extremely important in Alabama, as the state consistently ranks high in both incidence and mortality resulting from these oral cancers.

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

Measure Status:	Active
Goal:	Increase the number of preventive dental visits for children ages 1-17 through the education of dental providers.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** 0 **Denominator:** 500
Data Sources and Data Issues:	Oral Health Program
Evidence-based/informed strategy:	There is currently no known evidence-based information available on this subject at this time.
Significance:	Oral health is inextricably linked to overall general health and well-being. People with limited access to preventive oral health services are at greater risk for oral diseases that lead to sometimes devastating outcomes. There are profound and consequential oral health disparities within Alabama and the American population, as well as barriers hampering segments of the population from attaining optimal oral health. There are safe and effective measures to prevent the most common dental diseases such as dental caries, as well as more complex oral cavity disease processes. An increase in professionals educated on the need for oral health care and equity for certain populations and the need for collaboration between state and local agencies as well as regulatory bodies will contribute to diverse policies and advocacy for those in need. Dental providers are also charged with the diagnosis and prevention of certain oral and oropharyngeal cancers through physical exams and referrals for the FDA approved HPV vaccine, necessitating the need for continual education. This is extremely important in Alabama, as the state consistently ranks high in both incidence and mortality resulting from these oral cancers.

ESM 13.2.2 - Percentage of dental providers that received information/education regarding informing their families of patients at 9 years of age about the FDA approved HPV vaccine in order to prevent future oropharyngeal, cervical and other HPV-related cancer
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Increase the number of children 9-17 vaccinated against HPV through the education of dental providers.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** 0 **Denominator:** 500
Data Sources and Data Issues:	Oral Health Program
Evidence-based/informed strategy:	There is currently no known evidence-based information available on this subject at this time.
Significance:	Oral health is inextricably linked to overall general health and well-being. People with limited access to preventive oral health services are at greater risk for oral diseases that lead to sometimes devastating outcomes. There are profound and consequential oral health disparities within Alabama and the American population, as well as barriers hampering segments of the population from attaining optimal oral health. There are safe and effective measures to prevent the most common dental diseases such as dental caries, as well as more complex oral cavity disease processes. An increase in professionals educated on the need for oral health care and equity for certain populations and the need for collaboration between state and local agencies as well as regulatory bodies will contribute to diverse policies and advocacy for those in need. Dental providers are also charged with the diagnosis and prevention of certain oral and oropharyngeal cancers through physical exams and referrals for the FDA approved HPV vaccine, necessitating the need for continual education. This is extremely important in Alabama, as the state consistently ranks high in both incidence and mortality resulting from these oral cancers.

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)

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>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.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>VLBW deliveries in Level 3 and Level A hospitals</td></tr>
<tr><td>Denominator:</td><td>Number of VLBW births statewide</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Alabama Department of Public Health's Center for Health Statistics</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>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.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>The number of licensed Emergency Medical Responders and Emergency Medical Technicians who have received DOSE training.</td></tr>
<tr><td>Denominator:</td><td>The total number of Emergency Medical Responders and Emergency Medical Technicians licensed by the Office of Emergency Medical Services and Trauma in Alabama.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>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.</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>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.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>The 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.</td></tr>
<tr><td>Denominator:</td><td>The total number of parents, who bring their children to Well-Child Clinics at county health departments.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>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.</td></tr>
<tr><td>Significance:</td><td>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</td></tr>
</table>

	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>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<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>
</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:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** 100 **Denominator:** 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:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** 100 **Denominator:** 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.

2016-2020: 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 to prepare for the transition to adult health care

Measure Status:	Active
Goal:	Improve the percentage of CYSHCN ages 14-21 who receives transition services.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **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.
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.

2016-2020: 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:	**Unit Type:** Percentage **Unit Number:** 100 **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.
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.

2016-2020: 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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>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.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>The total number of currently established Maternity Care Districts in which ADPH staff have provided care coordination. Goal: Two of the 14 Maternity Care Districts.</td></tr>
<tr><td>Denominator:</td><td>The total number of currently established Maternity Care Districts that provide maternity care services throughout the state. There are 14 established Maternity Care Districts.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Alabama Medicaid, ADPH Programs providing services to Medicaid insured maternity patients.</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

2016-2020: 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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>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.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of infants/children ages 1-17 years who received a preventive dental visit in the past 12 months.</td></tr>
<tr><td>Denominator:</td><td>Number of infants/children ages 1-17 years in Alabama.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>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.</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

Form 11
Other State Data

State: Alabama

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: Alabama

Annual Report Year 2020

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Daily	0		
2) Vital Records Death	Yes	Yes	Daily	0	Yes	
3) Medicaid	Yes	No	Annually	12	No	
4) WIC	Yes	No	Daily	0	No	
5) Newborn Bloodspot Screening	Yes	No	Annually	12	No	
6) Newborn Hearing Screening	Yes	No	Quarterly	3	No	
7) Hospital Discharge	No	No	Never	NA	No	
8) PRAMS or PRAMS-like	Yes	Yes	More often than monthly	12	No	

Form Notes for Form 12:

None

State of Alabama
Maternal and Child Health Services Block Grant
2020 Annual Report/2022 Application

List of Attachments

Where Cited in Report/Application	***Description or Title***
Section I.A.	Letter of Transmittal
Section I.B.	Fact Sheet: Form SF424
Section I.C.	Submit Certify Page
Supporting Document #01	Organizational Charts
Supporting Document #02	Acronyms and Abbreviated Names

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

August 27, 2021

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 2020 Annual Report and FY 2022 Application. The document is being submitted electronically using the Web-based application format for the document. Per our understanding of the federal guidance, the document is now submitted entirely via the Web, and no paper copies of this letter or any part of the application are required.

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

Sincerely,

Jessica Hardy

Jessica Hardy, M.P.H., D.N.P
Director, Office of Women's Health
Director, Maternal and Child Health

JH/JP

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

alabamapublichealth.gov

PHAB
Advancing public health performance
Accredited Health Department

SF-424 - Part 1

189400: PUBLIC HEALTH, ALABAMA DEPARTMENT OF

Due Date: 9/1/2021 11:59:00 PM (Due in: 5 days) | Section Status: Complete

Resources

View

Application | Action History | Funding Opportunity Announcement | FOA Guidance | Application User Guide

SF-424 - Part 1 SF-424 - Part 2

Fields with are required

Applicant Information

Applicant Identifier	189400
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 Numb 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
	Samille J Jackson	(334) 206-9339	samille.jackson@adph.state.al.us	Change

Go to Previous Page Save Save and Continue

SF-424 - Part 2

Success:
Information entered on the 'Part 2' page was saved successfully. The Section status is **Complete**.

189400: PUBLIC HEALTH, ALABAMA DEPARTMENT OF

Due Date: 9/1/2021 11:59:00 PM (Due in: 1 days) | Section Status: Complete

Announcement Number: HRSA-22-001
Announcement Name: Maternal and Child Health Services
Created by: Tammie,Yeldell on 03/31/2021 11:54:00 AM
Application Type: New
Grant Number: N/A
Last Updated By: Tammie,Yeldell on 08/31/2021 6:40:00 PM
Application Package: SF424 Short Form
Application FY: 2022
Program Type: Non-Construction

Resources

View

Application | Action History | Funding Opportunity Announcement | FOA Guidance | Application User Guide

SF-424 - Part 1 **SF-424 - Part 2**

Fields with are required

Areas Affected by Project (Cities, Counties, States, etc.) (Maximum 1) Attach File

No documents attached

Descriptive Title of Applicant's Project Maternal and Child Health Services

Project Description (Maximum 1) Attach File

No documents attached

Project Abstract

Approximately 2 pages (Max 4000 Characters with spaces).

Project Abstract

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 10/1/2021

End Date 9/30/2023

Estimated Funding

Federal (This amount is populated from Budget Section A - Total Federal New or Revised Budget.)	$11,482,727.00
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.)	$31,724,878.00
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.)	$1,566,690.00
Program Income (This amount is populated from Budget Section C - Non Federal Resources.)	$26,066,122.00
Total	$70,840,417.00

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 ▼

Go to Previous Page | Save | Save and Continue

Application - Submit Certify

Confirmation:

Note: This is a confirmation page! You must click the appropriate button to complete your action.

189400: PUBLIC HEALTH, ALABAMA DEPARTMENT OF

Due Date: 9/1/2021 11:59:00 PM (Due in: 1 days) | Application Status: In Progress

Resources

View

Application | Action History | Funding Opportunity Announcement | FOA Guidance | 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)

☐ Please check the box to electronically sign the Application.

Cancel | Submit to HRSA

Supporting Document

ALABAMA PUBLIC HEALTH

State Government

State Board of Health

State Committee of Public Health

State Health Officer
Scott Harris, MD, MPH

Public Health Administrative Officer
Catherine M. Donald, MBA

Children's Health Insurance
Teela Sanders, JD
Administrative Services, ADPH Health Policy, ALL Kids Customer Service, Customer Services/Community Education, Program Operations and Professional Services, Program Services

Facilities Management and Technical Services
Kristi Rollins (Acting)
Technical Services

Financial Services
Shaundra B. Morris, MAcc, CPM

Health Statistics
Nicole Rushing, MPH
Administrative Services, Quality Assurance and Registration, Record Services, Special Services, Statistical Analysis

Information Technology
Regina Patterson
Administration, Business and Information Architecture, 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
Denise Milledge (Acting)
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

Informatics and Data Analytics
Sherri Davidson, PhD, MPH, State Epidemiologist

General Counsel
Brian Hale, JD

Compliance

Chief of Staff
Michele Jones, MS

Emergency Medical Services
Jamie Gray, BS, AAS, NRP

Environmental Services
Sherry Bradley, MPA
Community Environmental Protection, Food/Milk Lodging

Prevention, Promotion, and Support
Jamey Durham, MBA
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

Telehealth
April Golson

Governmental Affairs and Community Relations
Carolyn Bern, MPA

Health Equity and Minority Health

June 9, 2021

Scott Harris

State Health Officer

Bureau of Family Health Services
Director - Grace Thomas (PHPD)

Assistant to Bureau Deputy Director
Tarina Moores (ASA 3)
Ruthie Spencer (RSE)

Deputy Director - Amanda Martin (HSA 4)

Assistant to Bureau Director
D'Tanja Brock (ASA 3)

Medical Director
Vacant (PHPS)

Deanah Maxwell (PHPS)
Lynda Gilliam (PHPS)

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 Wyatt (ACCT)
Greg Roberts (AT)

Contract Management
Audrey Price (HSA 1)

Pediatric Consultant
Karen Landers (PHPD)

Oral Health
Tommy Johnson (DD)
Jennifer Morris (RDH)
Summer Macias (PI Spec)
Jessica Durham (ASA 2)

MCH Coordinator
Samille Jackson (HSA 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)
Vacant (HSA 1)
Lakita Hawes (PHE)

Cancer Epidemiology
Justin George (Epi Sup)
Tim Feuser (Epi)
Edana Huffman (Epi)
Mirwais Zhuben (Epi)
Vacant (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)
Katelynn Thompson (PHRA 1)
Cassandra Glaze (PHRA 2)
Elaine Wooden (PHRA 1)
Vacant (ASA 3)

Breast and Cervical Cancer
Amy Stratton (NM)
Kay Mathews (HSA 2)
Stephen Jaye (HSA 1)
Vacant (HSA 1)
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)
Karen Brock (NC)
Cindy Brewer (NC)

Perinatal Health Division

Director
Janice Smiley (HSA 3)
Assistant Director
Tammie Yeldell (Epi Sup)

Daphne Buskey (ASA 3)

State Perinatal
Catina Swindle(NM)
Vacant (NS)
Pamela Farris (NC)
Trendle Samuel (NS)
Janise Norman (NC)
Cathy Nichols (NS)
Toni Beasley (NC)
Tonya Troncalli (NC)
CSierra Payne (NS)
Shirley Daniel (NS)
Lindsay Harris (NS)
Jessica Bowman (NC)
Eleanor Freeman (NC)
Beth Shoemaker (NC)
Vacant (NC)
Vacant (NC)
Anderia Morris (ASA 2)
Kierra Montgomery (ASA 2)

MCH Epidemiology
Tammie Yeldell (Epi Sup)
Alice Irby (Epi Sr)
Julie Nightengale (PHRA 3)
William Duncan (PHRA 2)
Vacant (PHRA 3)
Vacant (Epi)
Taishayla McKitt (Epi)
Tara Harriel (ASA 3)

Newborn Screening
Rachael Montgomery (NM)
Mary Ellen Whigham (NS)
Vacant (NC)
Vacant (NS)
Nancy Strong (NC)
Stephanie Rhodes (NS)
Vacant (ASA 2)

Infant Mortality Prevention
Vacant (SW Sr)

Child and Adolescent Health Division

Director
Meredith Adams (HSA 3)
Assistant Director
Sandy Powell (NM)

Vacant (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
Pashley McClain (NS)
Julie Till (NS)
Nona Smith (ASA 2)
Katie Brent (ASA 2)
Gwen Kennedy (NC)
Sheila Davis (NC)
Daphne Pate (NC)
Renea Gilliland (NC)
Ann Fox (NC)
Karen Cobb (NC)
Ginger Letson (NC)
Vacant (NC)
Alicia Boykin (NC)
Marsha Galloway (NC)
Judy Cunningham (NC)
Teresa Goad (NC)
Deborah Weaver (NC)
Pamela Senters (NC)
Angelia Rombokas (NC)
Ashley King (NC)

Social Work
Carolyn Miller (SWM)
Vacant (SW Sup)
Vacant (SW Sup)
Vacant (SW Sup)
Pamela Foster (SW Sr)
Rebekah Smay (SW Sr)
Angela Daniel (SW Sr)
Vacant (SW Sr)
Charlena Freeman (RSE)

Adolescent Health

Adolescent Pregnancy Prevention
Valerie Lockett (HSA 2)
Jasmine Abner (PHES)
Chelsei Martin (PHE)
LeKenya Croom (SW Sr)
Vacant (ASA 2)

WIC Division

Director
Allison Hatchett (HSA 3)
Assistant Director
Pam Galloway (Nutr A)

LaDeidra Lee (ASA 3)
Yolanda Johnson (ASA 2)

Nutrition Services
Pam Galloway (Nutr A)
Vacant (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)
Pamala Pace (HSA 1)
Vacant (Spec Inv)
Vacant (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
Beth Allen (NPD)
DaJuna Tatom (NPS)
Neysa Hernandez (NPS)
Stephanie Phillips (NPS)
Krysta Hood (NPS)
Vacant (NM)
Thelma McDade (NC)
Toni Russell (ASA 3)

Office of Women's Health Well Woman
Jessica Hardy (NA)
Sabrina Horn (NC)
Jessa Powell (ASA 3)
Vacant (Stu Aide)

Financial/Contract Management
Chelsea McLaurine (HSA 2)

Family Planning Plan First/Title X
Laurie Gregory (NM)

Nikki Kiefer (HSA 1)

Vacant (SW Sup)
Pam Foster (SW Sr)
Rebekah Smay (SW Sr)
Vacant (PHE Sr)
Chansica Lanier (PHE)
Laquesha Hawkins (PHE)
Vacant (PHE)
Vacant (PHE)
Vacant (PHE)
Vacant (PHE)
Vacant (ASA 2)

Abbreviations:

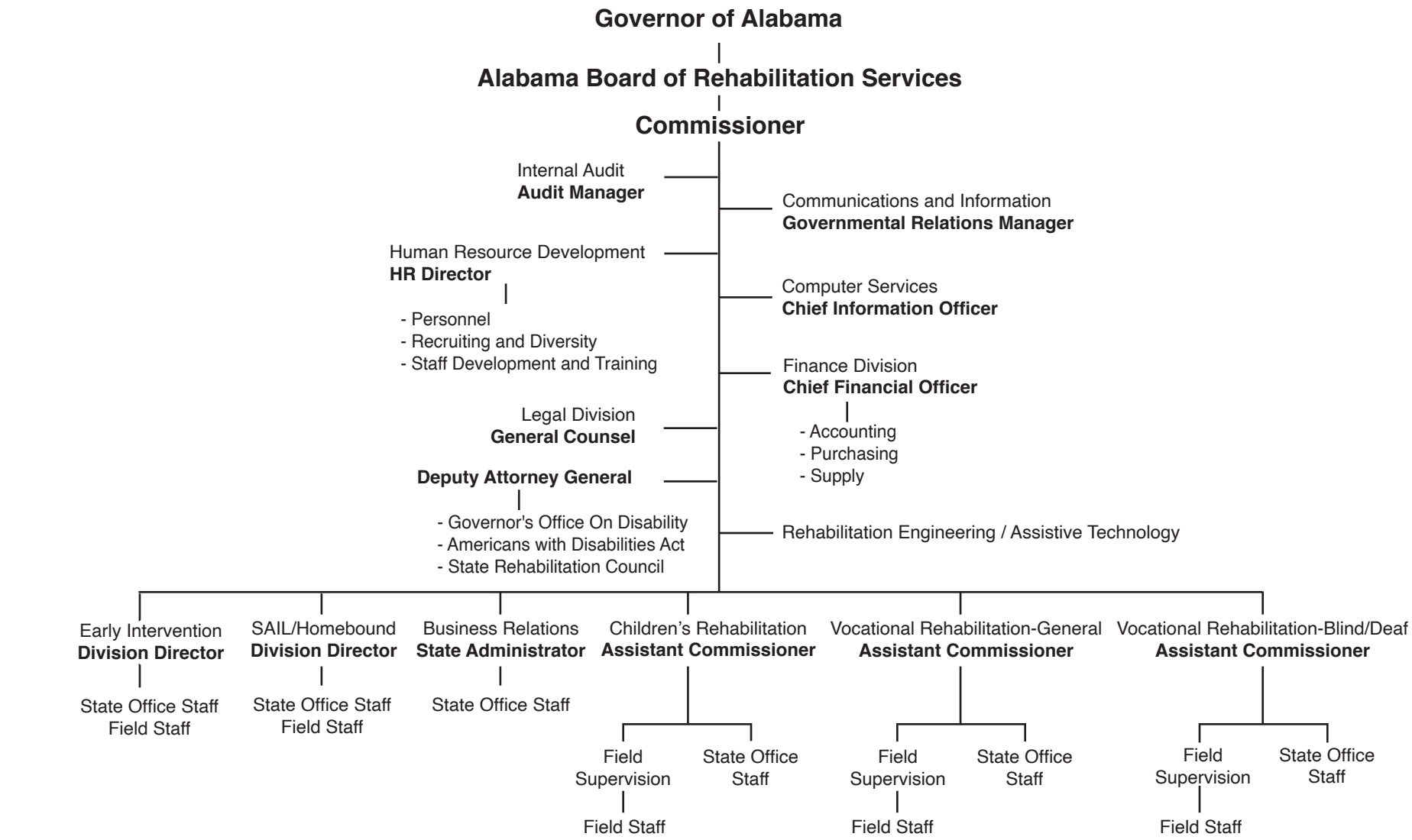
ACCT - Accountant
ACCT Clk - Account Clerk
ASA - Administrative Support Assistant
AT - Account Technician
Cler Aide - Clerical Aide
CTR Sr - Certified Tumor Registrar Senior
DD - Dental Director
Epi - Epidemiologist
Epi Sr - Epidemiologist Senior
Epi Sup - Epidemiologist Supervisor
HSA - Health Services 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 H MD

March 1, 2021

Grace Thomas — Date

Alabama Department of Rehabilitation Services Organizational Chart



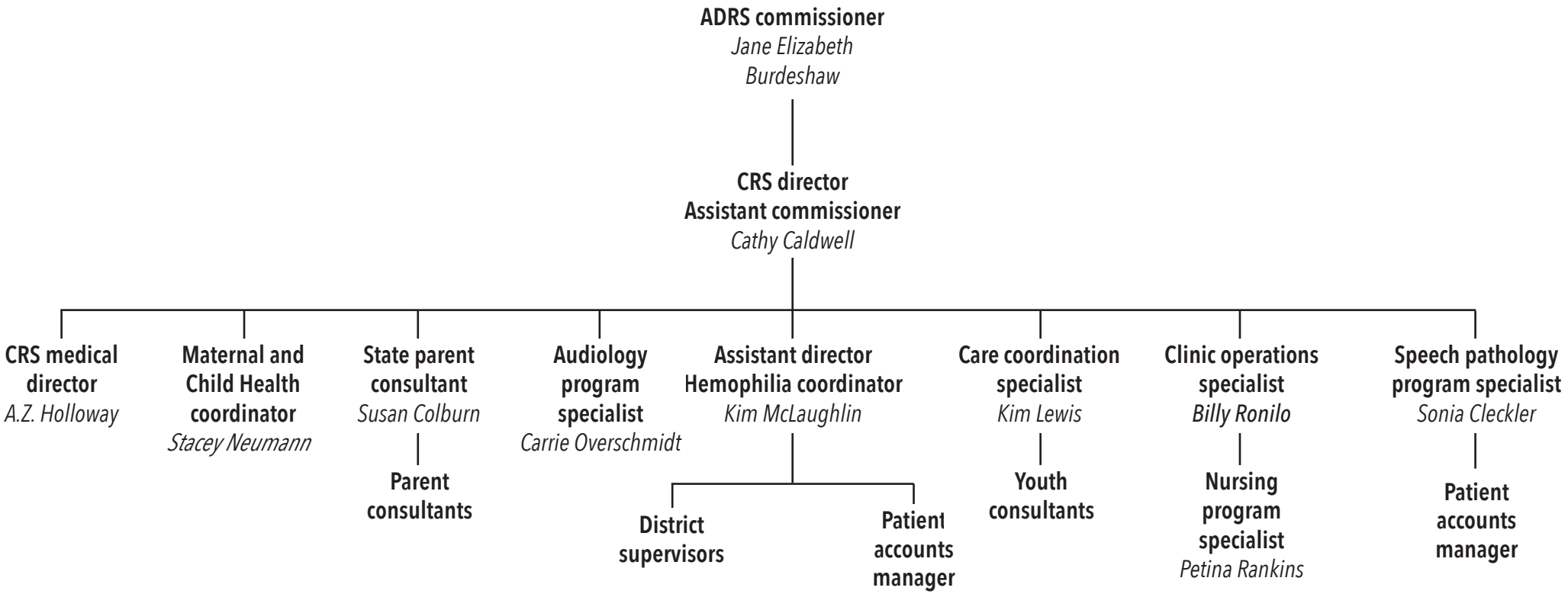
March 2, 2021
Commissioner, Alabama Department of Rehabilitation Services

ADRS

Alabama's children and adults with disabilities

Children's Rehabilitation Service

Organizational Chart



06/19

Supporting Document

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 Fact Finder
AHP	Adolescent Health Program
AIDS	Acquired Immune Deficiency Syndrome
Alabama Medicaid	Alabama Medicaid Agency
Alabama River Region	Montgomery, Lowndes, Autauga, Elmore, and Macon counties; central Alabama
AlaHA	Alabama Hospital Association
ALDA	Alabama Dental Association
ALL Kids	Alabama's State Children's Health Insurance Program
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 Collaborative Improvement and Innovation Network
CMS	Centers for Medicare and Medicaid Services (located in the U.S. Dept. of Health and Human Services)
CPoC	Comprehensive Plan of Care
COA	Children's Hospital of Alabama
COBRA	Consolidated Omnibus Budget Reconciliation Act
COIIN	Collaborative Improvement and Innovation Network to Reduce Infant Mortality
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
DME	Durable Medical Equipment
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
F2F HIC	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
HIE	Health Information Exchange
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
MCHD	Mobile County Health Department
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
PPE	Personal Protective Equipment
PRAMS	Pregnancy Risk Assessment Monitoring System
PREP	Personal Responsibility Education Program
Project HOPE	Project Harnessing, Opportunity for Positive, Equitable early childhood development
PT	Physical Therapist
QPR	Question -Persuade-Refer
RCO	Regional Care Organization, Medicaid Reform
RDH	Registered Dental Hygienist
RNPC	Regional Nurse Perinatal Coordinator
ROSE	Reaching Our Sisters Everywhere
ROV	Record of Visit
RPACs	Regional Perinatal Advisory 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
SPoC	Shared Plan of Care
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
TTC	Teen Transition Clinic
TVIS	Title V Information System
UAB	University of Alabama at Birmingham
UCP	United Cerebral Palsy
UNHS	Universal Newborn Hearing Screening
U.S.	United States of America
USA	University of South Alabama
USA PCCC	University of South Alabama Pediatric Complex Care Clinic
USDA	United States Department of Agriculture
VFC	Vaccines for Children
VLBW	Very Low Birth Weight
VLCAD	Very Long–chain Acyl-CoA Dehydrogenase Deficiency
VRS	Vocational Rehabilitation Service
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