Maternal and Child Health Services Title V Block Grant

Alabama

FY 2026 Application/ FY 2024 Annual Report

Created on 8/5/2025 at 9:18 AM

Table of Contents

I. General Requirements

I.A. Letter of Transmittal

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

July 22, 2025

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 2024 Annual Report and FY 2026 Application. The document is being submitted electronically using the web-based application format. 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,

Amanda C. Martin, MSPH
Director, Bureau of Family Health Services
Interim Title V Director

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

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix 2 of the 2026 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms",* OMB NO: 0915-0172; Expires: December 31, 2026.

II. MCH Block Grant Workflow

Please refer to figure 3 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms", OMB NO: 0915-0172; Expires: December 31, 2026.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

The Alabama Department of Public Health (ADPH) is the primary health agency for the state, operating with the mission to promote, protect, and improve Alabama's health. Public health functions are shared by state and local offices. Statewide programs are coordinated through the Central Office; the 8 public health districts have the responsibility for delivering public health services and programs in their designated areas. In the communities, 67 county health departments (CHD) work to preserve, protect, and enhance community health and environments.

The ADPH Bureau of Family health Services (BFHS), located in the Central Office, administers the Alabama Maternal and Child Health Services (MCH)Title V Block Grant Program. The bureau houses most of the department's MCH programs. Core services include managing clinical services protocol, providing case management, conducting outreach, and educating the public about services. Alabama Title V epidemiology staff support implementing, monitoring, and evaluating Title V strategies.

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

CRS continues to operate 7 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 7 programs are Clinical Medical, Clinical Evaluation, Hemophilia, Care Coordination, Information and Referral, Parent Connection, and Youth Connection. Coordinated health services are delivered via 14 community-based offices across 7 districts. Through statewide partnerships with various entities and agreements with the state's two tertiary-level pediatric hospitals, CRS continues to bridge gaps in the system of care for CYSHCN and their families. These partnerships increase the state's capacity to address the health, social, and educational needs of CYSHCN.

Furthermore, Alabama Title V staff collaborate with other ADPH and ADRS staff and with a variety of local, state, and federal stakeholders to assess the magnitude of factors impacting the state of health of Alabama's MCH population. Program staff rely on these partnerships to prioritize population health needs and create methods of addressing current and emerging needs.

See section III.C.2.b.ii.a. Organizational Structure for additional information on the divisions and programs administered by BFHS and ADRS

MCH Needs

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

The following information is a summary of the selected 2021-2025 NPMs, ESMs, SPMs, and accomplishments. See section III.E.3. State Action Plan Narrative by Domain for additional information.

ADPH Highlights

NPM – Well-Woman Visit

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

NPM – Risk-Appropriate Perinatal Care

ESM RAC.3 - Number of steps of the CDC's LoMC process completed in order to design and align the Alabama Maternal Regionalization System Guidelines with the national criteria for the maternal levels of care

NPM – Safe Sleep

ESM SS.3 - The proportion of mothers enrolled in the Cribs for Kids Program who self-reported that their infants are using the cribs for all periods of sleep at the home setting

NPM – Developmental Screening

ESM DS.3 - Proportion of children aged 12 and 24 months that have a reported blood lead screening in the past year

ESM DS.4 - Proportion of children birth to age 19 that received a well-child appointment in the past year

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

NPM – Adolescent Well-Visit

ESM AWV.2 - Proportion of adolescents, aged 12 to 19, that received an adolescent well visit in the past year

NPM – Preventive Dental Visit

ESM PDV-Pregnancy.3 - The number of providers including hygienists, nurses, social workers, physicians, pediatricians, nutritionists, and dentists who were provided oral health education and training tailored specifically to the MCH pregnant population

ESM PDV-Child.3 - The number of providers including hygienists, nurses, social workers, physicians, pediatricians, nutritionists, and dentists who were provided oral health education and training tailored specifically to the MCH child population

Women's Health

- Well Woman (WW): The WW Program provides preconception, inter-conception, and post-conception health care to women as a foundation for wellness. In FY 2024, Alabama WW Program was available in 9 counties and enrolled 532 participants.

Perinatal and Infant Health

- Safe Sleep: In 2023, sudden unexplained infant deaths were the third leading cause of infant deaths. Alabama is a Cribs for Kids Partner. Through this partnership, the Fetal Infant Mortality Review (FIMR) Program distributed 1,389 cribs with safe sleep information to families throughout the state.
- Count the Kicks: Count the Kicks is an evidence-based stillbirth prevention program that provides educational resources to health care providers and expectant parents. In CY 2024, 136 health care professionals and community workers received free Count the Kicks educational resources. A total of 45,401 educational materials were mailed.
- From Day One (FDO): FDO is a comprehensive patient-centered program designed to educate and support expectant mothers from the first trimester of pregnancy through their child's first year of life. Administered by the Jefferson County Department of Health (JCDH), FDO participants receive a baby safety shower to increase client knowledge on infant safety with a goal of reducing infant mortality and childhood injury. In 2024, there were a total of 3 showers and 29 maternity clients participated along with 42 guests.

- Promoting Healthy Birth Outcomes: The Mobile County Health Department (MCHD) provides education to increase awareness of factors that adversely affect the health of mothers and babies; promote and increase available education and resources; and provide services to decrease the rates of infant and maternal mortality. In FY 2024, 134 mothers and over 500 community members received education.

Child and Adolescent Health

- Childhood Lead Poisoning Prevention: In 2024, the number of children less than 6 years of age in Alabama receiving at least one BLL screen was 46,895; 1,288 individuals were referred for case management services which include family education, home visits to assess for lead sources, and referral to the Alabama Early Intervention System for evaluation and additional developmental services.
- Oral Health Screenings: The OHO collaborated with Alabama Pre- K Early Childhood education, Head Start, and Early Head Start to fulfill dental screening enrollment requirements. A total of 3,334 children were screened in FY 2024.
- Access to Oral Health at ADPH: There are two dental clinics operated by the Department. Between the Tuscaloosa CHD and the Greene CHD dental clinics, there were 2,031 (Medicaid and ALL Kids) patients seen in the dental clinics.
- WIC Oral Health Referrals: The Northeastern Public Health District screened 6,557 children in the WIC Program for oral health; 3,432 children were referred to a local dentist for an oral exam; 3,396 follow-up contacts were completed; and 1,142 children received oral exams.
- Schools of Dental Hygiene Partnerships: The Northern Public Health District improved access to dental care for children ages 0-17 and expectant mothers. Alabama Title V purchased dental supplies for 145 children to receive dental cleanings and exams.
- EPSDT Screenings: The Southwestern Public Health District completed 133 EPSDT screenings, resulting in 27 children receiving resources for dental care, 16 children receiving mental/behavioral health referrals, 2 EI referrals, 22 vision referrals, 2 hearing referrals, 6 elevated lead referrals, and 20 referrals for follow-up appointments with the primary medical provider.
- Pre-K Oral Health Screenings: The West Central Public Health District staff completed dental screenings and distributed oral health supplies for 198 Pre-K students at several elementary schools in the Tuscaloosa County School System.
- Suicide awareness: The West Central Public Health District implemented QPR Gatekeeper and Response Training to better identify and refer those who are at risk for suicide. Trainings were facilitated at eight high schools and facilities within 6 counties. In FY 2024, 208 youth and adults participated in the QPR Gatekeeper trainings; 13 youth participated in the Response trainings.
- Oral Health Presentations: In FY 2024, the OHO educated 1,179 health provides on the importance of oral health, community water fluoridation, human papilloma virus (HPV), preventive dental visits for children and expectant moms, and access to dental care.

CRS Highlights

NPM – Transition to Adult Health Care

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

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

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

CRS is committed to creating a culture of continuous quality improvement (QI) to improve service delivery for CYSHCN and their families and has incorporated QI throughout the activities and approaches in the State Action Plan. At the end of FY 2024, the CRS Care Coordination Program Specialist and Maternal and Child Coordinator conducted training on the brand-new Transition Program and Protocol Policy for all CRS staff. The new protocol is the result of the CRS Transition Task Force that was formed in FY 2022 to review the current CRS transition process and determine ways to strengthen service delivery to youth with special health care needs (YSHCN). Training included the newly designed Readiness Assessment. Modeled on the Got Transition® Six Core Elements of Health Care Transition™ tools the new assessment is now applicable for both youth and caregivers of youth with medical complexity. Using the new assessment care coordinators can collect vital information from enrolled youth or their caregiver to individualize the plan of care (PoC) and address the specific needs of YSHCN.

ADRS and CRS continue their long-standing commitment to family and youth engagement and the principles of family-centered care. For over 30 years, this commitment has been an integral part of CRS from direct services to infrastructure building and population health work. CRS' commitment to family engagement and family-centered care is evident through the Parent Connection Program. CRS makes a significant investment in family partnerships by employing parents and caregivers of CYSHCN that serve as Parent Consultants (PCs). The PCs carry out the activities of the Parent Connection Program while supporting families and sharing life experiences. CRS has been utilizing the National Family Voices Family Engagement in Systems Assessment Tool (FESAT) in assessing how well CRS is supporting family engagement in systems-level initiatives. Participants in the FY 2024 consensus scoring discussions all agreed that there are Family Engagement champions present at every level of CRS. It was noted that parent leadership and partnerships are a piece of CRS culture.

The CRS Care Coordination Program continues to ensure CYSHCN and their families connect to wrap-around services they require for optimal behavioral, developmental, health, and wellness outcomes using an interdisciplinary approach to care coordination. CRS care coordinators advocate for CYSHCN and their families within and outside CRS to improve the system of care. Using a holistic approach, families are supported in working collaboratively with their doctors and other service providers to best meet their needs.

CRS Leadership has used survey data from the annual Care Coordination Family Survey administered by the University of Alabama at Birmingham (UAB) Applied Evaluation and Assessment Collaborative (AEAC) to strengthen the Care Coordination Program. Survey respondents indicate an overall satisfaction with CRS Care Coordination services and a high percentage indicate that they received help finding hard to access services. The component with the lowest percentage met within the composite measure pertained to individuals having a PoC. Educating families regarding understanding of the PoC is key to improving survey results. Knowledge regarding the PoC and the purpose of a PoC is part of an ongoing improvement initiative. Staff are also continuing to utilize the Care Coordination Program booklet created as part of the 2021 – 2025 State Action Plan to provide families, community partners, and providers with something tangible they can refer to should they have questions about CRS Care Coordination services. Collaboration and partnerships among CYSHCN, their families, care coordination staff, and community partners ensures a system of community-based services are provided to CYSHCN.

BFHS and CRS in collaboration with the UAB School of Public Health (SOPH), Department of Health Care Organization and Policy, AEAC, have completed the Alabama 2025 Title V Comprehensive Needs Assessment. See section III.C. Needs Assessment for additional information on the process, findings, and state priority needs selected for all MCH population domains for 2026-2030.

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

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

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

Alabama Title V funds are used to fill gaps in health care, providing services not otherwise sustained through non-federal MCH dollars, particularly in CHDs. The Alabama Title V MCH Program works to respond to emerging MCH needs, supporting families and adapting programming as needed. BFHS administration ensures that a continual and comprehensive review of finances and programming is in place so that utilization of Title V funds fully supports state priority needs in alignment with federal guidelines. From the FY 2024 Title V funds, $6,258,745 were expended on preventive and primary care for children and $4,473,156 were expended on CSHCN. Additionally, there were $49,696,932 in state match funds expended on the MCH population.

The Alabama MCH Block Grant funds provide critical infrastructure, training, support, and resources to the state's overall MCH efforts. Alabama Title V is continually exploring options to shift reimbursable direct service expenditures to the appropriate payors and leverage Title V funds to address existing gaps in Alabama's public health investments, partnerships, systems, and services.

III.A.3. MCH Success Story

Perinatal/Infant Health

After a FIMR 2022 case abstract review, per protocol, a mother that suffered an infant death was contacted to offer a note of sympathy along with resources to identify and address her grief. The mom was also asked if she was willing to share her story, confidentially to educate more moms in an effort to prevent similar future deaths. Upon contact, the FIMR coordinator discovered that the mom was pregnant again and in need of a safe place for her baby to sleep. Her previous infant's death was due to unsafe sleeping conditions. The mom loved having the opportunity to tell other mothers about what happened to her and to not let it happen to them. She wants to tell other moms to get a safe place for their baby to sleep, like a crib or pack n play, put them in it, and on their back. She said she was more at ease knowing this baby was safe, unlike her baby that she lost. As she did not have money at the time to buy a safe place for her baby to sleep, she was very appreciative and thanked the FIMR coordinator numerous times.

Children with Special Health Care Needs

Every Friday night in the Fall, Adryan Gaines takes the field with the Oneonta High School marching band. Using an adaptive drum kit, which is placed on a platform, he plays bass, snare, suspended cymbal, bells, and maracas with his feet. The freshman honor student was born with arthrogryposis which causes both arms to be contracted, always finds a way to participate in school activities and takes care of himself independently. It is easy to see his determination.

Adryan began practicing with the band in 2023 and played in his first game during the 2024 season. He said it was the culmination of many hours of hard work and hopes it inspires others to do the same. He said, "Sometimes when I'm playing, I think, 'What if someone is seeing this and they want to do it?'" "It makes me feel happy that somebody might be inspired by me playing the foot drum."

Adryan, who was first enrolled in the Early Intervention Program, reconnected with ADRS through CRS when he started middle school and wanted to increase his independence. His mother, Jessica McCurry, said her son was very involved in establishing his own plan of care with Social Work Administrator Holly Edwards. She said, "He just kind of took charge." "He told us what he needed and what worked best for him - and what he thought might not work as well."

After a seating clinic and evaluation, CRS Occupational Therapist Dana Grady and Cliff McClinton from Physician's Home Health Superstore in Gadsden obtained for him several pieces of long-handled adaptive equipment to assist with dressing, and EazyHold tools to hold small items like toothbrushes, curved utensils for eating, a bath chair, non-slip mats around the shower, and suction brushes for him to bath himself in the shower. They also recommended motion-detected shampoo and body wash dispensers. Adryan said he is excited to continue challenging himself by trying more activities as he progresses through high school.

III.B. Overview of the State

III.B.1. State Description

Background

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

The Alabama State Legislature consists of 35 Senators and 105 members of the House of Representatives. It is one of the few state legislatures in which members of both chambers serve 4-year terms and in which all are elected in the same cycle. The Republican party holds the majority in both the Senate and the House. During both the 2024 and 2025 legislative sessions, many bills have been introduced that impact Alabama's MCH population. Although state employees cannot lobby, many MCH experts are called upon to provide education about programs that benefit this population.

Alabama has over 300 state agencies and departments. These entities carry out the day-to-day operations of state government and implement laws passed by the legislature. They cover a wide range of functions, from public health and education to environmental management and transportation.

ADPH is the state's primary health agency. In 2025, the Alabama Department of Public Health celebrates 150 years of promoting, protecting, and improving the health of the state's residents. A timeline of success with the department can be found by following the included link: https://storymaps.arcgis.com/stories/058ebdb6dc144d0bb04d545ab1280e29.

Alabama law designates the State Committee of Public Health as an advisory board to the state in all medical, sanitation, and public health matters. The State Committee of Public Health meets monthly, therefore; when not in session, the State Health Officer, head of ADPH, is empowered to act on behalf of the committee.

ADPH operates on a mission to promote, protect, and improve Alabama's health with a focus on healthy people and healthy communities. In 2019, ADPH leadership released a 5-year strategic plan. The plan focuses on five main areas: health outcome improvement; financial sustainability; workforce development; organizational adaptability; and data-driven decision making. ADPH's strategic plan was revised with specific efforts to pursue in 2023, allowing additional time for programs to continue working toward achievement of milestones outlined in the plan. ADPH successfully completed the review process to maintain national accreditation status through the Public Health Accreditation Board; the strategic plan will be updated as the agency moves forward in the next reaccreditation cycle.

ADPH is divided into eight public health districts that are overseen by a district health officer or district administrator. District offices manage CHDs in all 67 counties. CHD staff work to preserve, protect, and enhance the general health and environment of the community by:

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

regulations

The 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, family-centered, comprehensive, coordinated system of services. CRS is divided into 7 districts, encompassing 14 community-based offices covering all 67 counties. The districts are overseen by a district supervisor responsible for ensuring the delivery of quality services that meet the community's needs. CRS staff within the community-based offices provide medical, rehabilitative, care coordination, and support services for CYSHCN and their families.

The Alabama MCH Services Title V Block Grant Program funds programs and services offered at all 67 ADPH CHDs and 14 CRS community-based offices. Both agencies complement each other to promote the work of MCH. ADPH often refers newborn hearing and/or screening cases to CRS. Together both agencies represent the MCH population on various councils and at stakeholder meetings. Both the Assistant ADRS Commissioner and CSHCN Director, Cathy Caldwell, and the CRS MCH Coordinator, Stacey Neumann, are former ADPH employees with many years of service with the MCH population, thus enhancing efforts between the two agencies.

Alabama is 1 of 10 states that have not expanded Medicaid. However, the state legislature has continued to appropriate General Funds money to maintain services, especially those geared towards moms and children. For many years., AMA has relied on ADPH to meet state match requirements for various services that support the MCH population. Both ADPH and CRS have agreements in place to provide services for Medicaid enrollees.

Selected Changes in Alabama's Population /Economic Environment and Poverty Levels/Trends in Numbers of Alabama Title V-Served Persons

Total Population
According to the 2023 ACS 5-Year Survey, Alabama's estimated population is just over 5 million (n=5,054,253), which is a slight increase compared to 2022 (n=5,028,092). When stratifying by race, 65.4 percent (n=3,303,370/5,054,253) of Alabamians were white, followed by 34.6 percent (n=1,750,883/5,054,253) being either black or other. Compared to 2022, the 2023 racial distribution remained essentially unchanged. Assessing ethnicity, only 5.4 percent (n=271,640/5,054,253) of Alabamians were of Hispanic origin in 2023, representing a slight increase compared to 4.6 percent (n=232,407/5,028,092) in 2022.

The 2023 statewide death rate declined from 12.3 per 1,000 population to 11.6 per 1,000 population. For both 2022

and 2023, the leading cause of death among Alabama residents was heart disease. Compared to 2022, the 2023 heart disease mortality rate decreased from 2.94 per 1,000 population to 2.85 per 1,000 population. Despite the decrease in Alabama's overall mortality rate, CHS observed an increase in IMRs and FMRs. Compared to 2022, the 2023 statewide IMR increased from 6.7 per 1,000 live births to 7.8 per 1,000 live births. When stratifying by race, CHS observed an increase in the IMRs for both black and white infants. The black IMR increased from 12.4 per 1,000 live births to 13.2 per 1,000 live births, followed by the white IMRs increasing from 4.3 per 1,000 live births to 5.7 per 1,000 live births. Like the statewide IMR, the statewide FMR has also risen from 7.3 per 1,000 live births to 7.5 per 1,000 live births. The black FMR increased from 12.4 per 1,000 live births in 2022 to 12.9 per 1,000 live births in 2023, while the white FMRs remained the same.

0-24 Year-Old Residents

The 2023 ACS 5-Year Survey estimated that 31.8 percent (n=1,605,951/5,054,253) of the Alabama population was less than 24 years old. Among those less than 24, over 40 percent (42.1 percent; n=675,999/1,605,951) were 15 years or older. According to CDC Wonder, the leading cause of death in 2023 was accidents (unintentional injuries) which was also the leading cause of death in 2022.

Live Births

According to CHS, the 2023 statewide total number of live births was 57,835. CHS observed a minimal decrease in Alabama's birth rate, from 11.5 per 1,000 population in 2022 to 11.3 per 1,000 population in 2023. Compared to other states, CDC Wonder projected Alabama to have the 18th highest birth rate in the country. Almost 70 percent (69.9 percent; n=40,448/57,385) of Alabama births during 2023 were white, with the remaining 30.1 percent (n=17,387/57,835) being black or other. Compared to 2022, racial percentages remained consistent.

The following charts highlight additional Vital Statistics data.

Vital Statistics, 2022-2023

	Number	Rate/Percent	
Births	58,162	11.5	(Per 1,000 population)
Births to Teenagers	3,494	10.9	(Per 1,000 females aged 10-19 years)
Low Weight Births	6,068	10.4	(Percent of all live births)
Birth to Unmarried Women	26,335	45.3	(Percent of all live births)
Deaths	62,241	12.3	(Per 1,000 population)
Marriages	36,869	7.3	(Per 1,000 population)
Divorces	16,069	3.2	(Per 1,000 population)
Induced Terminations of Pregnancy	6,154	6.2	(Per 1,000 females aged 15-44 years)
Infant Deaths (Neonatal + Postneonatal)	391	6.7	(Per 1,000 live births)
Neonatal Deaths (0-27 days of life)	208	3.6	(Per 1,000 live births)
Postneonatal Deaths (28-364 days of life)	183	3.1	(Per 1,000 live births)

Total estimated state population is 5,074,296.

Source ADPH 2023 Annual Report

	Number	Rate/Percent	
Births	57,835	11.3	(Per 1,000 population)
Births to Teenagers	3,467	10.6	(Per 1,000 females aged 10-19 years)
Low Weight Births	6,051	10.5	(Percent of all live births)
Births to Unmarried Women	26,576	46.0	(Percent of all live births)
Deaths	59,211	11.6	(Per 1,000 population)
Marriages	35,218	6.9	(Per 1,000 population)
Divorces	15,384	3.0	(Per 1,000 population)
Induced Terminations of Pregnancy	3,307	3.3	(Per 1,000 females aged 15-44 years))
Infant Deaths (Neonatal + Postneonatal)	449	7.8	(Per 1,000 live births)
Neonatal Deaths (0-27 days of life)	283	4.9	(Per 1,000 live births)
Postneonatal Deaths (28-364 days of life)	166	2.9	(Per 1,000 live births)

Total estimated state population is 5,108,468.

Source ADPH 2024 Annual Report

Alabama's Leading Causes of Death, 2022-2023

Cause of Death	Rank	Number	Rate[1]	Population
Total Deaths		**62,241**		**5,074,296**
Heart Diseases	1	14,929	294.2	
Malignant Neoplasms	2	10,297	202.9	
COVID-19	3	3,557	70.1	
Accidents	4	3,492	68.8	
Cerebrovascular Diseases	5	3,285	64.7	
Chronic Lower Respiratory Diseases	6	3,149	62.1	
Alzheimer's Disease	7	2,651	52.2	
Diabetes Mellitus	8	1,638	32.3	
Nephritis, Nephrotic Syndrome, and Nephrosis	9	1,323	26.1	
Septicemia	10	1,176	23.2	
Chronic Liver Disease and Cirrhosis	11	966	19.0	
Influenza and Pneumonia	12	954	18.8	
Essential (Primary) Hypertension and Hypertensive Renal Disease	13	844	16.6	
Suicide	14	837	16.5	
Homicide	15	704	13.9	
All Other Causes, Residual		12,439		

[1]Rate is per 100,000 population.

Source ADPH 2023 Annual Report

Cause of Death	Rank	Number	Rate[1]	Population
Total Deaths		59,211		5,108,468
Heart Diseases	1	14,573	285.3	
Malignant Neoplasms	2	10,559	206.7	
Accidents	3	3,556	69.6	
Cerebrovascular Diseases	4	3,197	62.6	
Chronic Lower Respiratory Diseases	5	3,115	61.0	
Alzheimer's Disease	6	2,338	45.8	
Diabetes Mellitus	7	1,438	28.1	
Nephritis, Nephrotic Syndrome, and Nephrosis	8	1,305	25.5	
Septicemia	9	1,105	21.6	
Influenza and Pneumonia	10	962	18.8	
Chronic Liver Disease and Cirrhosis	11	948	18.6	
COVID-19	12	923	18.1	
Essential (Primary) Hypertension and Hypertensive Renal Disease	13	869	17.0	
Suicide	14	864	16.9	
Homicide	15	715	14.0	
All Other Causes, Residual		12,744		

[1]Rate is per 100,000 population.

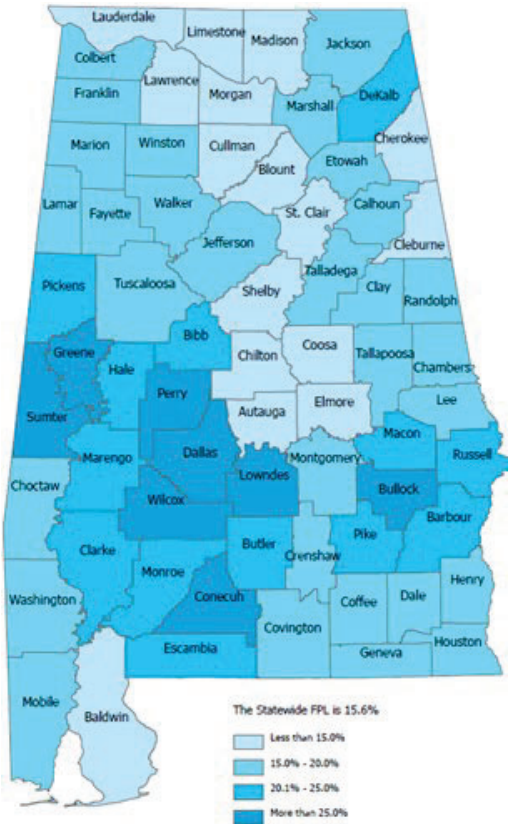
Source ADPH 2024 Annual Report

Economic Environment and Poverty Levels

Every year, the U.S. Census Bureau utilizes the CPI-U tool to adjust its poverty thresholds for inflation. If the individual or a household's income was under their poverty threshold, the ACS Survey estimates will mark them below the FPL. The poverty threshold is based on the family size and the family members' age. The poverty threshold is lower among individuals 65 years or older compared to those under 65 years old. In 2023, the poverty threshold for a household with two children was set to $24,549, while a household with three children was set to $31,008. Compared to 2022, the thresholds had a slight increase.

In 2023, an average of 15.6 percent (n=768,185/4,913,932) of Alabama families lived under the national FPL. The 2023 ACS 5-Year statewide FPL estimate remained relatively stable, with only a 0.1 percent decrease, with the 2022 ACS 5-Year estimate being 15.7 percent (n=768,897/4,890,427). While 11.4 percent (n= 369,687/3,254,319) of white households were under the FPL, black households were over two times more likely to be under the FPL at 25.3 percent (n= 322,862/1,273,760). The FPL map shows the county distribution of FPL within Alabama. Only 16 of Alabama's 67 counties had less than 15.0 percent of families living below the FPL, and 8 counties had more than 25.0 percent of families under the FPL.

2023 County Distribution of Households below FPL



Source: 2023 American Community Survey 5-Year Population Estimates, Table S1701

Trends In Numbers of Alabama Title V-Served Persons
For the FY 2023 Annual Report, FY 2023 was the time frame used to assess the total number of Title V MCH populations (pregnant women, infants CY 2024 increased slightly to 39,584.

The following figures represent trends in CYSHCN, which received services directly from CRS. In FY 2024, CRS served 15,901 CYSHCN, an increase of 4.4 percent over FY 2023. Of the 15,901 served, 86 percent were under age 16. In FY 2023, CRS served 15,234 CYSHCN, an increase of 10.6 percent over FY 2022. CRS clinics continue to expand in terms of the number of clients served and the availability of clinic options. The expansion of clinic options is a result of newly formed partnerships with physicians and allied health professionals throughout the state to meet the specific needs of each district.

CRS staff reached approximately 169,760 CYSHCN and their families in FY 2024 via incoming toll-free calls, information and referrals, Parent and Youth Connection and ADRS Facebook pages, ADRS/CRS website, local hearing screenings, and outreach activities. The FY 2024 number reached is significantly higher than the FY 2023 number reached of 93,625. The increase in the number reached is a result of maximizing the use of social media and raising awareness of CRS services through participating in community and statewide outreach events.

Health Care Environment

MCH Specific Statutes and Regulations

Per ADPH Administrative Code 420-4-1, blood lead results are a notifiable condition in Alabama; therefore, physicians, dentists, nurses, medical examiners, hospital administrators, nursing home administrators, lab directors, school principals, and day care directors are responsible for reporting them to the ADPH. The recommended method of reporting is through direct electronic submission or by using the Blood Lead REPORT Card which may be found at alabamapublichealth.gov

The SPAC was established in 1980 by the passage of the Alabama Perinatal Act (22-12A-4). Its purpose is to advise Alabama's State Health Officer in the planning, organization, and evaluation of the state's perinatal program.

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

ADPH Care Coordination Programs

Early and Periodic Screening, Diagnostic and Treatment Care Coordination Program
ADPH in partnership with AMA provides EPSDT care coordination services to Medicaid-eligible infants and children with lead poisoning, infants with failed hearing screenings, infants with questionable or unsatisfactory newborn screenings in the hospital, infants and children with birth defects, and infants diagnosed with congenital syphilis. Care coordination services are comprehensive services that assist eligible individuals in gaining access to needed medical, social, educational, and other services. Non-Medicaid recipients receive care coordination services from ADPH Central Office staff in BFHS.

Family Planning Care Coordination Program
ADPH in partnership with AMA offers FP care coordination services to Medicaid-eligible women who are at high risk for unintended pregnancies and receive direct clinical FP services. This program aims to create a partnership with each patient to address any barriers to successful FP, thereby reducing the number of unintended pregnancies. This is achieved through a bio-psychosocial approach to care coordination. Care coordinators provide FP risk assessments and assist women in reducing the rate of unplanned pregnancies, sexually transmitted infections, and HIV/AIDS.

Title X Care Coordination Program
Care coordination services are provided through a Title X Supplemental Grant for women seeking FP services in underserved communities. Care coordinators provide FP support and related health services that will improve the overall health of individuals in underserved counties. The counties served are Butler, Chilton, Dallas, Hale, Lowndes, Marengo, and Wilcox. Care coordinators provide FP risk assessments and assist women in reducing the rate of unplanned pregnancies, sexually transmitted infections, and cervical cancer.

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

Screening, Brief Intervention, and Referral to Treatment
The SBIRT Program aims to prevent the unhealthy consequences of alcohol and drug use among those who may not have reached the diagnostic level of a substance use disorder, and to help those with the disease of addiction enter and stay with treatment. ADPH provides SBIRT screening to adults receiving services at health departments in several districts throughout the state, but not currently statewide.

Screening - A quick, simple method of identifying patients who use substances at at-risk or hazardous levels and who may already have substance use-related disorders. The screening instrument provides specific information and feedback to the patient related to his/her substance use. The typical screening process involves the use of a brief 1-3

question screen. If a person screens positive on one of these instruments, he/she is then given a longer alcohol or drug use evaluation, using a standardized risk assessment tool.

Brief Intervention - A time-limited, patient-centered strategy that focuses on changing a patient's behavior by increasing insight and awareness regarding substance use. Depending on severity of use and risk for adverse consequences, a 5–10-minute discussion or a longer 20–30-minute discussion provides the patient with personalized feedback showing concern over drug and/or alcohol use.

Referral to Treatment – A more advanced treatment option referring the patient to a higher level of care. This care is often provided at specialized addiction treatment programs. The referral to treatment process consists of helping patients access specialized treatment, selecting treatment facilities, and facilitating the navigation of any barriers such as cost of treatment or lack of transportation that would hinder them from receiving treatment in a specialty setting.

Well Woman
The goal of the WW Program is to provide preconception, inter-conception, and post-conception health care to women of childbearing ages as a foundation for wellness and to reduce CVD risk factors in Alabama. Social workers provide care coordination and health coaching to help increase the number of women of child-bearing ages receiving a preventative wellness screening and participating in behavioral changes to reduce CVD risk factors in Alabama. Care coordination services include but are not limited to appointment scheduling and reminders, referrals to community resources, healthy behavior support sessions, referrals to nutrition classes with a registered dietitian, disease and medication management education, coordination of access to physical activity, and additional care coordination services as needed.

In addition to ADPH's robust case management system, it is worth noting that the department is the lead agency for the administration of FP and WIC services. Both services are provided at every CHD with some locations having multiple sites in both our urban and rural counties. Additionally, WIC is provided at an FQHC, three delivering hospitals, and at the Poarch Band of Creek Indians reservation.

ADPH Collaborations with AMA

In 2024 and at the request of AMA, the quarterly meetings between BFHS and AMA Health Systems were expanded to include all staff that collaborate on programs between the two agencies. As an extension of these meetings, staff from each agency participate in collaborative meetings on infant and maternal mortality, case management, and maternity care. While the request to expand the meeting audience was understood, it has necessitated additional calls and meetings to address BFHS specific needs.

BFHS continues to partner with AMA to administer the 1115(a) FP Waiver known as Plan First. Plan First recipients can receive FP services in every CHD. This program has improved contraception access throughout the state, to include providing a wide variety of contraceptives. FP participants are often referred to both the WW and ABCCED programs as appropriate.

Also, as Alabama continues to identify maternity care deserts, both agencies are continuing joint work to address access to care and to reduce chronic diseases. The long-term goal is to improve birth outcomes for moms and their babies. Thanks to the postpartum extension implemented by AMA in 2023, ADPH is able promote access to health and dental care with this population.

The Bureau of Children's Health Insurance administers ALL Kids, Alabama's separate CHIP. ALL Kids provides comprehensive health coverage to eligible children and uses the Blue Cross Blue Shield of Alabama provider network. In addition to the ALL Kids Program, and as a result of provisions in the Affordable Care Act, CHIP also funds a group of Medicaid-eligible children, which is administered by AMA.

At the end of FY 2024, total CHIP enrollment was 180,952 (ALL Kids 93,901; MCHIP 87,051) The total unduplicated number of children ever enrolled in Alabama CHIP during FY 2024 was 239,271 (117,774 ALL Kids; 121,497 MCHIP). In FY 2024, the ALL Kids program paid over $312 million in claims primarily to Alabama providers.

CRS Collaborations with AMA
To ensure consistent quality, statewide standards of care and access to community-based clinical services, AMA and CRS have negotiated a list of approved interdisciplinary clinics. CRS operates these clinics within AMA's Children's Specialty Clinic Services requirements as outlined in Chapter 61 of the AMA Administrative Code.

CRS serves in an advisory role to AMA for program and policy decisions likely to affect CYSHCN and its subgroup, CMC, and serves as a voice for this population. The AMA Commissioner has assigned specific AMA staff members to work with CRS. Meetings between AMA and CRS are held quarterly to discuss issues or concerns regarding services provided to AMA recipients with special health care needs. See section III.B.3.c. Relationship with Medicaid for more detailed information.

CRS Services to Certain Medicare Enrollees
CRS administers the statewide Hemophilia Program for children and adults pursuant to Alabama Administrative Code. In FY 2024, CRS served 60 adults with Medicare as part of the program. CRS assisted clients with Medicare coverage in selecting the health plan option that best addressed their needs and helped them locate Medicare pharmacies for factor treatment of bleeding disorders. In FY 2024, CRS paid insurance premiums for 10 clients with bleeding disorders.

Health Care Coverage and Healthcare Provider Access

Maternity Care

Access to maternal health services continues to decline in Alabama. Alabama currently has 43 hospitals with labor and delivery services. Of the 54 counties designated as rural, only 15 counties are providing obstetrical services. At least 25 Alabama counties lack obstetricians, gynecologists, family-practice physicians, or nurse practitioners to deliver babies in those counties. Stakeholders from the Alabama Perinatal Quality Care Initiative, major insurance providers, state agencies and universities, healthcare providers, and the legislature are working to address these barriers.

Oral Health

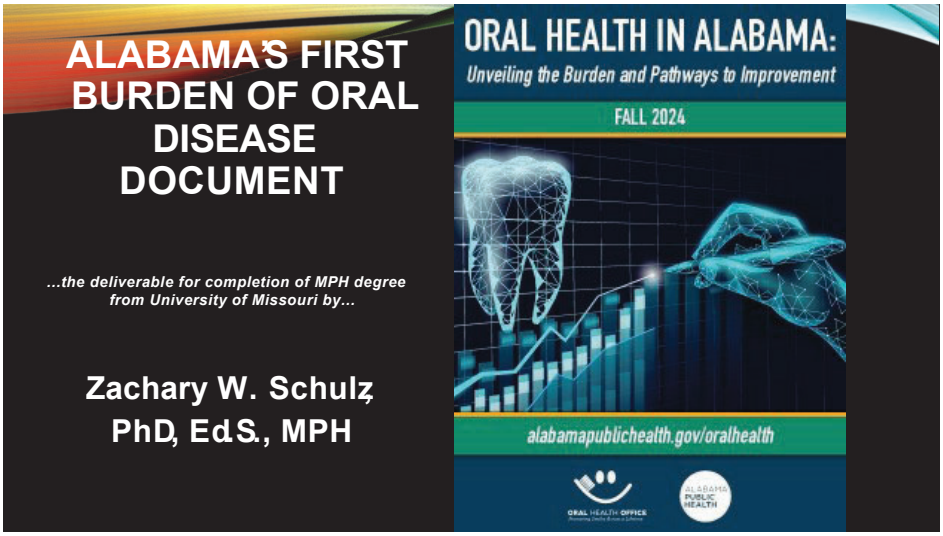
Understanding and addressing the oral health disease burden in Alabama is of paramount importance for the well-being of its residents. Oral health is intricately linked to overall health, impacting individuals' quality of life, employability, and systemic health outcomes. With a growth rate slightly below the national average, Alabama's population of over 5 million residents is marked by a significant rural presence, encompassing 54 out of 67 counties. The state's racial composition reflects disparities compared to national averages. Also, rural areas face notable challenges, including limited access to dental care and higher rates of disability, poverty, and lower educational attainment.

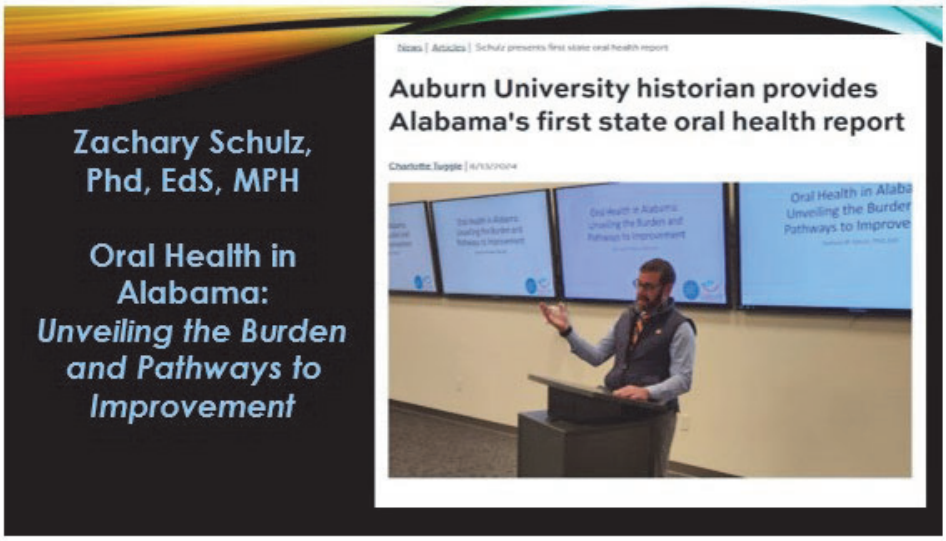
As adults age, the intricate link between oral health and overall well-being becomes critical in Alabama as resources to aid oral health diminish for interested parties. Despite advancements, issues like tooth decay and gum disease persist, impacting not only oral health but also contributing to broader health concerns. Special populations, including older adults, children in poverty, and minority groups, face unique challenges that necessitate individualized approaches. Disparities based on factors like poverty, race, and ethnicity underscore the need for targeted interventions.

Protective factors that include dental sealants, regular dental visits, and water fluoridation play a crucial role in preventing and addressing oral health risks. However, the oral health workforce in Alabama exhibits differences compared to the national landscape, with a lower density of dentists per capita. Dental education, exemplified by institutions like the UAB School of Dentistry, serves as a cornerstone in preparing professionals to address the diverse oral health challenges faced by Alabama communities.

One of the greatest achievements of the OHO in 2024 was the development and release of Alabama's first

published burden of oral disease document. The document was one of the deliverables in the culmination of efforts initiated by a University of Missouri MPH candidate who was assisted and overseen by the OHO under the purview of ADPH Administration. The candidate, Dr. Zachary Schulz, a highly accomplished dual degreed educator and interdisciplinary researcher in the History Department at Auburn University, holding a PhD in History from Purdue University and an Education Specialist Degree in Adult Education from Auburn University, captured in compelling and laymen fashion the state's first comprehensive report on oral disparities. The document, **Oral Health in Alabama: *Unveiling the Burden and Pathways to Improvement***, illuminates the relationship between oral and overall heath, heightening awareness of the historical medical-dental schism created by cordoning off the mouth from the rest of the body. The document has garnered the attention of internal, local, state, and national stakeholders, creating an impetus to translate the data into actionable results. It is also to be considered as the segue into the creation of Alabama's next State Oral Health Plan, providing baseline data for developing the next 5-year plan.





Visit the OHO website to view the Fall 2024 Oral Health Report on the burden of oral disease in Alabama. Learn more about the collaboration between OHO and Dr. Schulz from the article published by Auburn University.

The OHO continues to be notified of water systems that plan to discontinue community water fluoridation. ADPH promotes water fluoridation and released the following statement to raise public awareness on the benefits of

fluoridation.

ADPH Statement on Community Water Fluoridation

Fluoride exists naturally in the earth's crust. Community water fluoridation is the act of adjusting the fluoride concentration in a community's water supply to the optimal level safe for consumption, set forth by the U.S. Public Health Service. Years of research and evidence since the 1940s show fluoridation reduces tooth decay and benefits the oral health of people of all ages and income groups. Because of its contribution to the dramatic decline in tooth decay in the United States since the 1960s, the CDC named community water fluoridation one of 10 great public health achievements of the 20th century. ADPH continues to support community water fluoridation because it is one of the most effective strategies for communities to improve the oral health of all their residents.

CYSHCN

Addressing the service delivery needs of Alabama's CYSHCN presents special challenges because CYSHCN often needs 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, which can result in difficulty understanding needed care. These barriers are especially challenging for families trying to navigate a complex system of care.

CRS faces continued challenges serving families in rural areas. The state is largely rural, with greater population concentrations surrounding three larger metropolitan areas (Mobile, Birmingham, and Huntsville). In rural areas, more risk factors exist that could potentially increase the percentage of CYSHCN in the general child population, such as higher poverty levels and lower education levels. According to the U.S. Department of Agriculture Economic Research Service, based on 2023 data, the poverty rate in rural Alabama is 19.1 percent, compared with 14.8 percent in urban areas of the state, and 16.3 percent of the rural population has not completed high school. According to the U.S. Census Bureau 2023 ACS, 21.1 percent of Alabama's children under 18 years live below the poverty threshold.

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 metropolitan areas, necessitating travel to access them. In general, the state has a poor public transportation system. Although private programs exist in some areas and reimbursement for transportation is provided through various sources (including AMA and CRS), the state lacks the infrastructure to meet transportation needs in all locations.

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 medical, rehabilitative, and evaluation services delivered by an interdisciplinary team, along with care coordination and family support services 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.

III.B.2. State Title V Program

III.B.2.a. Purpose and Design

The Alabama Title V MCH Block Grant Program is administered by ADPH through BFHS. Funds provided by the 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 PHD, OHO, OWH, CAHD, 67 CHDs in 8 public health districts, and other sub-grantees and partner projects.

Like many Title V-funded states, Alabama supports the life course approach to MCH and further operates by

providing the 10 essential services under the 3 tiers of the MCH Pyramid of Services.

BFHS maintains partnerships with local and state agencies including, but not limited to, AMA, DHR, DMH, and local agencies participating in the Healthy Start Initiative. Staff participate in and lead state committees and initiatives, such as SPAC, OHCA, and SAIMRP, to ensure consistent collaboration with stakeholders that can help strategically align MCH goals and activities. ADPH convenes partners and funds projects to enact public health policies, plans, and laws, and implement QI projects. These efforts are exemplified through the establishment of the MMRP and the continued involvement with the ALPQC. In addition to state and community relationships, ADPH maintains partnerships with federal agencies and receives technical assistance in the MCH transformation from agencies such as AMCHP, CDC, the NICHD. These national partnerships provide ADPH with evidence-based resources, opportunities for creative thinking and constructive critique, as well as training that supports staff's work to improve the health status of the MCH population. BFHS continues to identify new stakeholders and works toward a collective impact that supports the goals of Title V.
Staff supported by the MCH Block Grant include public health professionals, data analysts, nurses, social workers, medical and dental providers, and financial and administrative personnel. The BFHS director and supporting program directors continually assess and monitor the MCH population health status and the implementation of evidence-based strategies to ensure BFHS staffing is at an adequate level to meet those needs. Staff are also encouraged to pursue workforce development opportunities. While not funded by Title V funds, the WIC Division, the Cancer Prevention and Control Division, the FP Division, and the APPB are located within the same bureau as the Alabama Title V MCH Program. Outside of BFHS, Title V staff collaborate with other ADPH bureaus and programs such as BCL, Office of HIV Prevention and Care, CHIP, BPPS, Bureau of Health Statistics, and others.

BFHS collaborates with stakeholders to leverage program capacity to identify the priority needs of mothers, children, and families across the state and to develop strategies to meet those needs. The UAB AEAC and BFHS Title V Program staff meet monthly to coordinate ongoing needs assessments support and assistance with data collection and reporting. Title V MCH programs develop and implement activities and initiatives that address the core functions of assessment, assurance, and policy development. Program strategies are designed to increase awareness of health status, provide services, and promote behavior change to improve health outcomes among the MCH population. Coordinating strategies are developed for providers working with women, children, including CYSHCN, and families.
ADPH ensures local access to care and investigates emerging health problems by providing direct services through the CHDs. The six public health districts under the umbrella of ADPH receive Title V funding for core staff and infrastructure, which allows them to serve the immediate needs of the MCH population within Alabama's 67 counties. MCHD and JCDH are independent; however, both departments receive sub-awards to support MCH activities.

Through the MCH Transformation and the emphasis on performance and accountability, work continues within the public health districts to address local health needs, NPMs, NOMs, and the ESMs. The district MCH services and programs are coordinated by District MCH Coordinators and monitored and assessed by the ADPH MCH coordinator. BFHS district staff mobilize community leaders and facilitate partnerships between those leaders, policymakers, health care providers, and community members.

CRS

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

The Title V CSHCN Director serves as the Assistant Commissioner of ADRS and the Director of CRS. This position reports directly to the ADRS Commissioner. CRS is organized into three levels – state, district, and local. At the state level, administrative staff provide program direction through policy and staff development, program planning and evaluation, data analysis, quality assurance, technical assistance, and fiscal management. The Assistant Commissioner and State Office staff continually discuss ways to build upon the strategies outlined in the State Action

Plan to improve access to care and deliver high quality services. In addition, CRS contracts with a pediatrician that serves as the CRS medical director. The medical director provides guidance on medical concerns, participates in policy development and QI initiatives, assists with recruiting specialty physicians, and serves as the pediatrician for the TTC as needed. State Office staff and the medical director are supported by Title V funds.

As the State CSHCN Program, CRS routinely convenes and collaborates with local and state entities to design policies and promote service delivery that results in family-centered, community-based, well-coordinated care for CYSHCN. Some key partnerships are AMA, FVA, UAB SOPH, DECE, Alabama EI Program, and VRS. In addition, CRS staff lead and participate in state committees and initiatives, such as ACHIA, OHCA, Alabama Interagency Autism Coordinating Council, CPC, SHAA, EHDI Program, Alabama NBS, and NBHS Advisory Committees. Serving on these committees and initiatives promotes collaboration among key stakeholders to ensure all Alabama CYSHCN and their families receive quality care.

A statewide partnership for CRS is the Alabama CPC system which originated from the Alabama Juvenile Justice Coordinating Councils and is under the coordination of DECE. Each local CPC is chaired by the county's juvenile judge and has members from a diverse cross-section of public and private individuals interested in the general needs of all children and families in the state. Local CPCs are designed to support providers of children's services as they work collaboratively in developing community service plans to address the needs of children ages 0-19 and their families. Creating a CPC in each county ensures that the unique needs of each community can be addressed. At the state level, these local needs become the driving force for children's policies.

The ADRS Commissioner serves as a member of the State CPC, and CRS Care Coordinators participate in local meetings in all 67 counties within the state. Participation in the CPC allows CRS staff to share insight into the unique needs of CYSHCN and raise awareness of the impact these needs have on resources within their local community. CRS Care Coordinators from across the state report that participating in local CPC meetings helps raise awareness of CRS services, particularly in rural areas where services are limited. A CRS Care Coordinator, serving on the Montgomery County CPC, successfully connected a council member with CRS services to assist a child in obtaining the necessary wheelchair modifications to be able to ride the school bus. In addition, connecting with representatives from other agencies leads to invitations to participate in task forces/groups with similar missions. CRS staff also obtain information regarding resources for CYSHCN in their communities that they were previously unaware of. For instance, in a rural community, a CRS Care Coordinator discovered a valuable resource offered through the Alabama Community College System to support YSHCN transition from high school to college.

To further improve care for mothers, infants, and children, Alabama has an MCH Partnership meeting that occurs three times a year and consists of representatives from all of Alabama's Title V-funded programs as well as other MCH-related programs. As one of the lead agencies, CRS coordinates an annual meeting. CRS State Office specialists represent CRS at all partnership meetings and share updates on services for CYSHCN and their families. Other participating MCH stakeholders include ADPH, DMH, FVA, MOD, DHR, AMA, DECE, Alabama EI, and LEND Programs. The partnership meetings provide an opportunity for individuals to assess the changing needs of the states MCH population, discuss necessary policy changes, leverage resources, and form collaborations to better serve the MCH community.

CRS entered into an agreement with UAB SOPH, Department of Health Care Organization and Policy, AEAC to consult and assist with administering the activities outlined in the State Action Plan. This includes the design, administration, and analysis of surveys. CRS and AEAC hold monthly evaluation meetings to work collaboratively on the evaluation components and outcomes. During the monthly meetings AEAC and CRS staff discuss access to services and evaluate service delivery effectiveness to ensure quality care to CYSHCN and their families. AEAC supports evaluation efforts for multiple state agencies which allows them to assist CRS from a holistic and systems-level perspective.

CRS is an active member of ACHIA which is a statewide collaboration of public and private partners that uses measurement-based efforts and a systems approach to improve the quality of children's health. The vision of ACHIA is ensuring Alabama's children achieve optimal health outcomes. The mission of ACHIA is to improve health outcomes by fostering a culture of continuous QI through partnerships with practitioners, payers, families, and organizations that deliver care to Alabama children. ACHIA is administratively housed in the UAB Department of

Pediatrics. The ADRS Assistant Commissioner is a member of the ACHIA Steering Committee along with members from AMA, CHIP, ADPH, DECE, DMH, and COA.

In addition, the ADRS Assistant Commissioner serves as a member of the National Academy for State Health Policy (NASHP) Executive Committee. In this role, she co-chairs the Child and Family Health Committee. This committee's focus is on positively impacting health policy on a national and state level. Serving as a member allows input into topics for the NASHP Annual Conference. Topics currently being considered include children's mental health, perinatal health, systems of care of CMC, and prevention services in child welfare.

All these efforts and partnerships contribute to CRS' ability to serve CYSHCN in Alabama and implement the strategies outlined in the State Action Plan. Coordination, collaboration, and partnerships are key to ensuring CYSHCN and their families have access to care that improves their overall quality of life. CRS staff at all levels continue to collaborate with our existing partners while actively seeking new partnerships.

III.B.2.b. Organizational Structure

ADPH

The Governor, Alabama Legislature, and the 17-member State Committee of Public Health have oversight and authority over ADPH. Medical leaders in Alabama advocated constitutional authority to oversee matters of public health 150 years ago in 1875. The purpose of the authority was to develop a system of hygiene to preserve and prolong life, plan an educational program for all people on the rules of healthful existence, and determine a way to enforce health laws for the welfare of all people.

The ADPH Central Office is comprised of 23 core offices, bureaus, and centers, along with divisions dedicated to legal matters and district health operations. ADPH BFHS, located in the Central Office, administers the Title V MCH Services Block Grant Program. The ADPH Chief Medical Officer provides oversight of BFHS. Also, under the purview of the chief medical officer are the district medical officers, Bureau of Clinical Laboratories, HIV Prevention & Care, Informatics & Data Analytics, Disease Control and Prevention, and Home and Community Services.

BFHS is comprised of 7 core divisions and 2 offices. Alabama Title V MCH Program funds strategically support personnel and the implementation, monitoring, and evaluation of MCH-focused activities, data collection, and program evaluation throughout these divisions and offices. Staff establish local, state, and federal partnerships to develop, identify, and recommend quality and impartial, preventive, educational; and early treatment strategies to prevent illness, injury, disease, and death; and to eliminate differences. Title V funds support breastfeeding; well visits; community water fluoridation; developmental screenings; transition; fetal, infant, and maternal mortality review committees; PRAMS Program activities; and advocacy to increase impartiality 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.

The full list of Alabama Title V-funded programs and activities is as follows:

- State Perinatal Program
- Fetal and Infant Mortality Review
- Office of Women's Health
- Administrative Division
- Well Woman
- Office of Women's Health
- MCH Operations
- MCH Epidemiology
- EPSDT
- Lead Education
- Healthy Child Care Alabama
- Social Work Case Management
- Family Planning

- Oral Health Screening
- Community Water Fluoridation
- Community Prevention Programs, Mobile County Health Department
- Maternal and Child Health, Jefferson County Department of Health

CRS

Created by the Alabama Legislature in 1994, ADRS is the state agency that serves Alabamians with disabilities from birth throughout their lives. ADRS uses the “continuum of care” approach which ensures that there is help at every stage of a person’s life. Services are provided through four main programs (EI, CRS, VRS, SAIL) that reach residents in all (67) counties.

The Alabama Board of Rehabilitation Services, whose members are appointed by the Governor, oversees ADRS. 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.

See organizational charts for additional information on programs, services, and staffing.

III.B.3. Health Care Delivery System

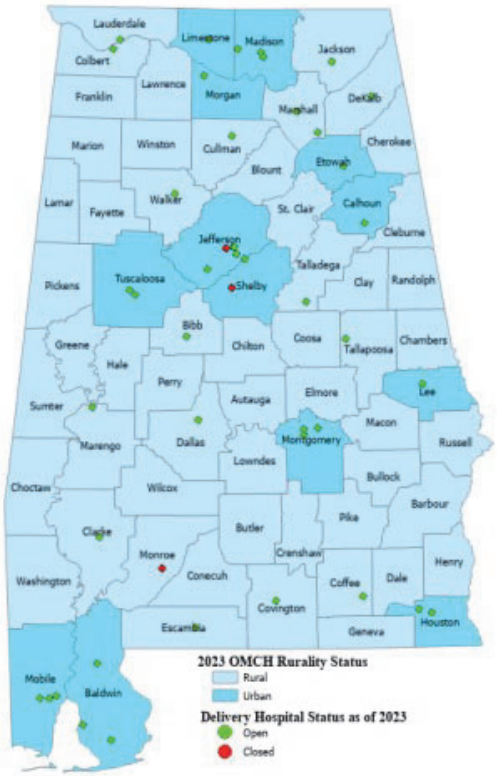
III.B.3.a. System of Care for Mothers, Children, and Families

According to the 2023 ACS 5-Year Survey, Alabama had an estimated population of just over 5 million people. For 2023, the leading cause of death among Alabama residents was heart disease. The 2023 statewide death rate was 11.6 per 1,000 population, a decrease from 12.3 per 1,000 population in 2022. Despite the decrease in Alabama’s overall mortality rate, CHS observed an increase in IMRs and FMRs. Also, there was a minimum decrease in Alabama’s birth rate, from 11.5 per 1,000 population in 2022 to 11.3 per 1,000 population in 2023.

According to the AOHW, Alabama has one PCP for every 2,410 residents. While this number seems adequate, the distribution of PCPs make access difficult for some residents. Additionally, per the 2020 State Health Assessment, Alabama had a higher percentage of uninsured population than the U.S. (17.5 percent compared to 13.6 percent) in 2019. Males had a higher uninsured prevalence compared to females (18.9 percent and 16.3 percent, respectively). Black adults had a higher uninsured prevalence of healthcare coverage than White adults (18.7 percent and 15.1 percent, respectively). Alabamians between 18-24 years old have the highest population percentage of uninsured at 24.3 percent.

Access to maternal health services continues to decline in Alabama. Alabama currently has 43 hospitals with labor and delivery services. Based on population ranges set by OMCH, county population estimates from the 2023 ACS 5-Year Survey can be classified as either rural (<100,000) or urban (≥100,000). Of the 54 counties designated as rural, only 15 counties are providing obstetrical services. At least 25 Alabama counties do not have obstetricians, gynecologists, family-practice physicians, or nurse practitioners who deliver babies in those counties.

Distribution of 2023 Delivering Hospitals by Residential Status



Source: 2023 American Community Survey 5-Year Population Estimates, Table DP05
Note: Rural counties defined as <100,000 population and urban counties defined as ≥100,000 population.

Understanding gaps in the delivery of health care is critical to addressing many of the community health factors impacting MCH and the focus areas of the Title V MCH Block Grant. ADPH and other state and local agencies work through strategic systems approach to align resources and statewide efforts to improve population health.

Alabama' Public Health, Medicaid, mental health, developmental disability, and early childhood programs are all housed in independent agencies; therefore, Alabama Title V staff intentionally engage in interagency collaborations to facilitate partnerships with those programs.

The ADECE has the primary responsibility of providing children from birth to age 8 high-quality early care and education. ADECE utilizes federal and state funds for the establishment, operation, and administration of a variety of services and programs. Per its 2023 Annual Report, ADECE operated on a total budget of $218,172,945, distributed between programs such as Strong Start Strong Finish, Office of School Readiness, Summer and After School Programs, and the First Teacher Home Visiting Program.

ADMH serves more than 200,000 Alabama citizens with mental illnesses, developmental disabilities, and substance use disorders. The ADMH Program includes, but is not limited to, the Alabama Crisis System of Care, Certified Community Behavioral Health Clinics, Autism Program, Child/Adolescent Mental Illness Treatment, Infant/Early Childhood Special Programs, School Based Mental Health Collaboration, and Substance Use Treatment Services. ADPH continued an ongoing collaboration with ADMH to expand SBIRT training to providers statewide during FY 2025.

In addition to its partnerships with AMA, DHR, ECE, and ADRS, the Alabama Title V Program collaborates internally with ADPH bureaus and offices focused on rural health, immunization, injury prevention, nutrition and physical activity, and other programs that impact MCH.

Below is a high-level overview of ADPH programs and services that impact MCH health care delivery as reported in the ADPH 2024 Annual Report.

The ADPH EHR System was implemented in 2017 and is the system of record for all clinical encounters and includes interfaces with the state lab, vaccine registry, the AMA One Health Record, and the newborn screening surveillance system for disease reporting. All patients have access to a patient portal, where they can see detailed information about previous visits and have access to all prescriptions as well as all laboratory orders and results which they have had. ADPH has approximately 950 active users of the EHR, which include nurses, providers, social workers, disease intervention specialists, and other non-clinical roles. EHR staff provide on-site training monthly for all users on a first-come, first-served basis.

The Infection Control and Employee Health Program provides educational support for the district IPC teams. Each district team provides testing, vaccination, and education for emerging diseases. These teams have the capability to respond quickly and efficiently to furnish crucial services to Alabamians in community settings statewide. District IPC teams provide support and education regarding infection control principles, Respiratory Protection Program, CPR, and nurse competency training for departmental staff. IPC teams mobilize statewide as needed to assist within county health departments with testing and vaccination as well as community agencies. With the loss of federal funding in March 2025, the teams were dissolved and workers were moved to other clinical programs.

The mission of Public Health Nursing is to ensure conditions in which individuals, families, and communities can be healthy, utilizing the unique expertise of ADPH nurses to assess, plan, and implement programs that promote health and prevent disease. ADPH employs approximately 750 nurses. Approximately 300 of those nurses provide FP, child health, preventive and treatment services for disease control, and immunizations. ADPH nurses are active in the community through involvement in health fairs and other educational opportunities. ADPH is an approved provider of continuing nursing education and offers numerous opportunities for CE hours via satellite and on-site classes.

ADPH's skilled social workers use social work values, knowledge, and community resources to promote positive health outcomes while respecting personal choice and promoting the health and well-being of individuals, groups, and communities. ADPH social workers act as liaisons within their respective communities, educating and advocating for changes to improve disproportionate outcomes. ADPH is an approved provider of social work CE and during 2024 provided social work CE credit for more than 25 programs, both onsite and via satellite. The department employs approximately 125 social workers who provide care in CHD clinics, patient homes, and the local community. They are responsible for programmatic oversight in the county, district, and Central Office. Social workers provide direct services to a multitude of Alabamians in a variety of settings and programs within the department including ASRAE, APREP, ALL Babies, CHIP, Child Car Seat Inspection Stations, COVID-19 Response and Education, Diabetes Self-Education, Elevated Lead, Emergency Preparedness, FP Care Coordination, HIV Care Coordination, Home Health, Licensure and Certification, Newborn Screening Care Coordination, Newborn Hearing Screening, Maternity Mortality Review, STD, Suicide Prevention, Telehealth, Tobacco Prevention, TB, Well Woman, and WISEWOMAN, and serve on several committees at the local level.

The goal of the IMM Division is to reduce vaccine-preventable disease and increase immunization rates. The division has four branches: Surveillance, Registry (ImmPRINT), VFC and IQIP, and Administration. The Surveillance Branch conducts the Alabama School Entry Survey in conjunction with the Alabama Department of Education and private schools. This survey evaluates the immunization status of all children to ensure they have a COI or a valid exemption on file in compliance with the 2009 School Immunization and Rules. In the 2023-2024 Annual School Entry Survey, all medical and religious exemptions combined have risen to 2.19 percent, an increase of 0.91 percent, for students in public and private schools. The percentage of students with expired and no COI was 4.02 percent, a decrease from the previous year by 0.92 percent. In addition, the branch oversees vaccine-preventable disease investigations statewide. IMM field staff investigate vaccine-preventable disease reports submitted by notifiable disease reporters and laboratories. In 2024, the IMM field staff investigated and confirmed 1,308 cases of diseases. The VFC Branch manages Alabama's VFC Program, a federal entitlement program that provides vaccines at no cost to providers who see children under 19 years of age who are uninsured, Medicaid-eligible, underinsured, American Indian, or Alaskan Native. As of December 2024, 541 enrolled public and private providers received approximately $90 million worth of vaccines. As part of the vaccines distributed, the VFC Program provided 131,300 doses of seasonal influenza vaccine to providers in all 67 counties. IMM field staff perform regulatory VFC site visits and IQIP assessment visits on 50 percent of enrolled providers to promote proper vaccine storage and handling, accurate and safe administration of vaccines, and vaccine coverage improvement. The branch also manages the

federal Section 317 vaccine funding for uninsured/underinsured adults.

The Alabama Trauma System comprises 59 trauma centers, including out-of-state trauma centers. The efforts and dedication of trauma centers, EMS, the Alabama Trauma Communication Center, regional EMS offices, and state and regional councils working together to facilitate the timely routing of trauma patients to the appropriate hospitals. From January 1, 2024 – December 31, 2024, 12,850 patients were entered into the trauma system. The most common mechanism of injury was motor vehicle-related.

The mission of the Alabama EMSC Program is to prevent and reduce child, youth, and adolescent disabilities and deaths that are the result of severe illness and injury. Several services are available through the program, including education for prehospital professionals; continual permanent installation of the EMSC Program into Alabama's EMS system; and assurance that pediatric equipment, according to the American Academy of Pediatrics/American College of Emergency Physicians guidelines, is available on prehospital emergency vehicles that transport children.

For more than 25 years, the ABCCED Program has provided free breast and cervical cancer screening and diagnostic services for women in Alabama who have no insurance and are at or below 250 percent of the poverty level. Breast cancer screening includes free clinical breast exams and biennial mammograms. Cervical cancer screening includes a free pelvic exam, a Pap smear, and an HPV test. Diagnostic services such as mammograms, ultrasounds, surgical consultations, biopsies, and colposcopies are provided if needed. If a patient is diagnosed with breast cancer or cervical pre-invasive or invasive cancer, she is eligible to receive treatment through AMA. Since 2014, a total of 1,021 breast cancers and 3,288 cervical pre-invasive and invasive cancers have been diagnosed through ABCCEDP.

The Alabama Comprehensive Cancer Program facilitates the statewide Alabama Comprehensive Cancer Control Coalition. The coalition is a statewide group of cancer-related organizations and advocates that are responsible for assessing the burden of cancer, determining priorities for cancer prevention and control, and implementing the 2022-2027 Alabama Cancer Control Plan. The plan serves as a blueprint for every person in the state to have an equally effective chance of receiving appropriate healthcare of equal quality. The goals and objectives of this cancer plan are aligned with state partners' programs and plans to include the State Vaccination Plan, the Tobacco Prevention and Control Plan, and the Nutrition and Physical Activity Plan.

The mission of the OHPC is to improve the quality of life for all Alabamians by ending intersecting epidemics impacting HIV and Hepatitis C through accessible, and stigma-free prevention and treatment services. OHPC's role continues to rely on meaningful collaboration with community partners to reduce the incidence of HIV infections, increase life expectancy for those infected, and improve the quality of life for persons living with or affected by HIV. Reducing new HIV infections by 75 percent in 5 years and by 90 percent by 2030 are the goals of Ending the HIV Epidemic (EHE): A Plan for America, with multiyear funding appropriations directed to highly impacted communities nationwide.

As of December 31, 2023, 16,276 individuals infected with HIV were known to be living in Alabama. Per data collected by the HIV Surveillance Branch, Data Management Division, there were 769 new cases of HIV diagnosed in 2023. The 2023 HIV statewide incidence rate was 15.2 cases per 100,000 individuals. As of December 31, 2024, the office served 4,142 clients through ADAP. Of that number, 1,337 uninsured individuals received ADAP-funded medications, 2,754 individuals were provided ADAP-funded health insurance, and 51 individuals were provided ADAP-funded Medicare Part D prescription insurance. Presently, 16 providers receive funding through the department to provide core medical and support services to HIV clients.

The NPA Division provides state leadership and represents the department on issues related to nutrition, physical activity, food access, chronic disease, and wellness. Alabama consistently ranks high among other states for problems related to poor health, such as physical inactivity, low fruit and vegetable consumption, obesity, chronic disease, and food insecurity. The vision is for Alabamians of all ages to have access to and embrace a culture of healthy choices as their normal way of life. NPA coordinates the following initiatives to support healthy behaviors and improve food access in adults and youth:

- The AWA is a volunteer membership organization that strives to create a healthier Alabama by leading unified

efforts to implement strategies that improve health outcomes through accessing healthier nutrition choices and regular physical activity. In 2024, AWA released the “For Every Body Campaign,” designed to support the ALPAN by encouraging healthy lifestyle behaviors and access to resources for all Alabamians. The campaign includes positive, inclusive messaging with graphics that are applicable to a range of sectors, including business and industry; education; fitness and sports; healthcare; nonprofit, volunteer, and faith-based organizations; public health; public lands, parks, and recreation; and transportation, community planning, and access. The campaign messages are available in English and Spanish and can also be used to promote state and local events and encourage the use of community resources.

- As a subcontractor for the SNAP Education Program, the NPA Division provides nutrition education to individuals who are eligible for SNAP benefits. Education activities took place in schools, local health departments, and senior nutrition centers, where approximately 1,300 individuals received direct education on nutrition and health topics. Evaluations of school children participating in nutrition education classes demonstrated improvements in eating habits and increased minutes of physical activity per day.

- In celebration of National Nutrition Month in March, the theme “Beyond the Table” was promoted by assisting CHDs to create nutrition displays in the lobbies utilizing a bulletin board kit. Forty-four counties received the kits and participated to help celebrate the month-long campaign emphasizing the importance of making informed food choices and developing sound eating habits. A photo contest was also held for employees to promote National Nutrition Month. To enter the contest, participants submitted a photo that they had personally taken, highlighting how they engage in and enjoy good nutrition and physical activity in Alabama. Winning photos were selected and included in a 2025 calendar highlighting and encouraging healthy habits year-round.

- During National Fruits and Veggies Month in September, the division highlighted the health benefits of consuming America’s original and favorite plants – fruits and vegetables. A checklist was created to share 30 ways (one for each day of the month) to enjoy fruits and veggies. Checklists were distributed to every CHD, as well as shared with the public via social media. A coloring sheet featuring fruits and veggies was included on the back of each checklist for children.

- The Healthy Alabama Communities Designation Program was developed in partnership with AlaHA, Blue Cross and Blue Shield of Alabama, and Alabama Communities of Excellence to empower small communities to prioritize the health of their residents. Through environmental, policy, and system changes that support better nutrition and physical activity, the program recognizes communities making progress toward creating a healthy community.

The OPCRH administers programs to improve healthcare access and quality in rural and medically underserved communities. Currently, 55 of Alabama’s 67 counties have areas designated as being medically underserved. These underserved areas have a high prevalence of healthcare issues, including chronic diseases such as diabetes, hypertension, heart disease, and other challenges, such as a high rate of substance abuse. OPCRH employs several programs and works closely with partners such as the Alabama Rural Health Association, AlaHA, Alabama Primary Health Care Association, and departmental bureaus to address these health issues. Some major initiatives in OPCRH are recruiting and retaining healthcare professionals and technical assistance to assist 40 small, rural hospitals and healthcare providers in transitioning to a new, value-based healthcare system.

OPCRH utilizes a national, web-based recruitment system called the National Rural Recruitment and Retention Network to recruit physicians to medically underserved areas. During FY 2024, approximately 3,180 primary care practitioners were referred to rural hospitals and clinics in Alabama. OPCRH also assists communities in establishing CMS-certified rural health clinics. Another recruitment program is the National Health Service Corps (NHSC), which has both scholarship and loan repayment components. The NHSC Program aims to recruit various health professionals, from physicians, dentists, and nurses to behavioral health professionals. Currently, 105 Alabama participants are in the NHSC Program. These programs are supplemented by a J-1 Visa Waiver Program, which enables placement of foreign-trained physicians in return for 3 years of service in medically underserved

areas. Seventy-nine healthcare providers currently deliver medical care to rural and medically underserved Alabamians under the J-1 Visa Waiver Program.

Over the past year, OPCRH provided technical assistance to 156 rural health clinics. OPCRH collaborates with various entities to address workforce issues essential to improving the health of Alabama residents. One such initiative is the partnership with the UAB Heersink School of Medicine at the Huntsville Regional Medical Campus to assist in the administration of the Alabama Rural Medical Service Awards. This state-funded program incentivizes primary care physicians, obstetricians, and family practice nurse practitioners to practice full-time in rural Alabama. In 2024, 14 primary care physicians and 3 nurse practitioners were awarded in this program.

In 2024, OPCRH continued to work to update the Health Professional Shortage Area designations. These areas determine eligibility for the NHSC Program, specific federal grants, and the J-1 Visa Waiver Program. Alabama's 40 small, rural hospitals were also assisted under federal grants administered by OCPRH, which target improvement of operational efficiency, quality, and hospital sustainability. The division continues to work closely with the Alabama Hospital Association to provide relief and support to Alabama's small rural hospitals through these federal grant programs.

Public Health services in Alabama are primarily delivered through CHDs, making those departments the largest system of care for Alabama Title V to meet the needs of mothers, children, including adolescents, and families. Larger counties and counties with specific needs have more than one CHD location. A wide variety of valuable information and services are provided at CHDs. Typical services and information include the following:

- ABCCED Program
- Birth, Death, Marriage, and Divorce Certificates
- Child Health
- CHIP
- COVID-19 Testing and Vaccinations
- Dental Services/Health Education and Community Fluoridation Programs
- Diabetes
- Disease Surveillance and Outbreak Investigations
- FP
- Food and Lodging Protection
- HIV Prevention and Care
- Home Care Services
- Immunization
- Laboratory Services
- Nursing Services
- Nutrition Services
- Sexually Transmitted Diseases Education and Treatment
- Solid Waste
- Telehealth
- WIC

In September 2023, ADPH began the review process to maintain national accreditation status through the PHAB. After a PHAB site visit and submission of an updated SHIP, in November 2024, the department received official notification of reaccreditation from PHAB, valid through 2030.

Alabama's SHIP is a strategic 5-year plan developed based upon data provided by Alabama communities and implemented through a collaborative partnership with stakeholders. In 2021 ADPH's OPM established the initial SHIP Steering Committee to inform the development of the plan. OPM surveyed staff and existing partners to solicit stakeholder participation. Stakeholders were organizations or individuals who were trying to affect change or someone who would be impacted by the change. There were 17 state and local agencies, businesses and advocacy organizations and local agencies that contributed to SHIP. The data used to build SHIP was obtained by ADPH through the administration of the State Health Assessment, which is conducted every 5 years and updated annually. This data provides the top health indicators for Alabama. The 2020 State Health Assessment resulted in the following indicators:

- Mental Health and Substance Abuse
- Access to Care
- Pregnancy Outcomes
- Nutrition and Physical Activity
- Social Determinants of Health
- Sexually Transmitted Infections
- Geriatrics
- Cardiovascular Diseases
- Child Abuse and Neglect
- Environmental Health
- Violence
- Cancer
- Diabetes
- Tobacco Usage and Vaping

After conducting an analysis of the health indicators, available resources, and participant capacity, the SHIP Steering Committee decided to group indicators and focus on the three priority areas: (1) networks to provide better access to care; (2) supporting partnerships to empower community resilience and mental wellness; (3) improving the quality of life. For each priority area, potential partners and policy approaches were outlined and goals and strategies were identified to support implementation of the plan. Alabama SHIP is designed to be a living document and will evolve as needs of the communities change.

III.B.3.b. System of Services for CSHCN

CRS

Serving as the State CSHCN Program, CRS ensures access to quality healthcare and services for CYSHCN. CRS fills a valuable role, providing medical and rehabilitative services to children with a qualifying medical diagnosis. Referrals are received from hospitals, healthcare providers, specialists, ADPH NBHS, community organizations, and self-referrals. At enrollment, individuals presenting with no insurance receive assistance in submitting a joint application for AMA, CHIP, and the Federally Facilitated Marketplace. The joint eligibility system determines which of the programs the child is eligible to receive coverage. CRS also works with private insurers to ensure coverage for services for CYSHCN. 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 may authorize and pay for the purchase of items such as equipment, medication, allied health services, including approved therapies, and other products as identified in a participant’s PoC and prescribed out of CRS clinics. CRS is the payor of last resort.

CRS has a Care Coordination Program that provides an interdisciplinary approach to care coordination to ensure CYSHCN and their families connect to wrap-around services they require for optimal behavioral, developmental, health, and wellness outcomes. Care Coordination services are provided by licensed social workers and registered nurses located in 14 community-based offices across the state. These individuals provide support to help families navigate the complex system of care for CYSHCN. CRS care coordinators coordinate with community partners to ensure a statewide system of services that reflects the components of comprehensive, community-based, and family-centered care.

CRS also collaborates with local school systems and families to address the complex issues associated with each student’s disabilities and special health care needs, helping children to be as independent as possible at school. Through services such as counseling, specialized therapy, and assistive technology for children and families, and disability training for teachers and school staff, CRS offers the support vital to classroom success. In addition, CRS offers individuals, families, and youth peer-to-peer support through the Parent and Youth Connection Programs.

Alabama, like many other states, has too few pediatric specialty providers, and the problem is much worse in rural areas. To address this issue, CRS works with multiple partners through a variety of routes to ensure CYSHCN have access to quality care. For example, CRS has a partnership with the Department of Orthopedics at USA to provide

orthopedic services for CRS orthopedic clinics. The continued partnership with USA has allowed for the expansion of clinics in rural areas. CRS also has an agreement with the Division of Pediatric Rehabilitation Medicine at COA that allows CRS to provide neurology services across the state. These ongoing partnerships allow CRS to expand needed medical clinics across the state to improve access and ensure a more comprehensive system of care for CYSHCN and their families. The goal is to improve systems of care and build bridges to connect specialty providers with the families who need these services.

Leadership in each CRS office strives to identify gaps in service specific to their area. Montgomery office staff noticed that young children presenting in the neurology clinic had previously been in the NICU and were lost to follow-up. This led staff to initiate discussions with local birthing hospitals about the benefits of CRS offering a pediatric evaluation/NICU follow-up clinic. In FY 2024, CRS began offering a NICU clinic in partnership with a pediatric neurologist. NICU clinic is an evidence-based interdisciplinary, family-centered evaluation/assessment clinic that identifies services for clients with multiple medical complaints, developmental delays, and/or complex needs. The clinic serves as a “hub,” directing families to the most appropriate resources, and families are assigned a care coordinator who helps them navigate the complex system of care. Families receive a comprehensive developmental assessment from a team of professionals in a one-on-one environment, allowing time for questions and concerns to be addressed. Local pediatricians have expressed appreciation for offering this much-needed service and improving access to care. Since the clinic’s inception, referrals continue to increase. The clinic is also benefiting families that reside outside the Montgomery district but do not have a NICU clinic available in their area.

CRS serves as the second-tier screener for NBHS, and at times, CRS serves as the initial screener. CRS employs pediatric audiologists who conduct diagnostic evaluations and provide direct services in hearing clinics throughout the state. CRS audiologists have a strong partnership with the ADPH EHDI Program. CRS and EHDI continue to work closely together to develop timely and appropriate guidelines to meet the overall EHDI goal of 1-3-6 (hearing screen by 1 month, diagnostic hearing evaluation by 3 months, and early intervention referral by 6 months.) CRS has a direct reporting system in place with the ADPH EHDI Program. As a result, CRS audiology clinics have seen a significant increase in referrals. CRS audiologists screened 1,188 newborn babies for second-tier universal NBHS in FY 2024, which accounted for 40 percent of all babies who failed their inpatient newborn hearing screenings.

Coupled with the growing number of referrals and CRS audiologists reaching their maximum capacity to provide services, CRS continues its partnership with the Woolley Institute for Spoken-Language Education (WISE) to improve access to services. WISE is a statewide, family-focused program working in collaboration with Alabama’s EI System, local school systems, and private and public entities that advance the education of deaf children. Utilizing WISE as a vendor to access their mobile audiology unit improves access to services, reduces wait times, and provides a timely diagnosis.

CRS, in partnership with EI and the UAB Civitan-Sparks Clinic, developed a pilot Pediatric Evaluation – Autism Diagnostic Clinic for children currently enrolled in EI. Children are identified for evaluation by trained EI screening sites based on their modified checklist for autism in toddlers score, and referrals are made to CRS or other community evaluation partnering sites. Once a referral is received at CRS, the client is enrolled in CRS and subsequently scheduled for two diagnostic dates: one for hearing evaluation and ADOS-2 testing, and the final date for the interdisciplinary diagnostic clinic. Pilot data is being collected regarding clinic outcomes and will be used to impact and address the growing need for early autism diagnosis. Within CRS, the pilot is currently being conducted at the Tuscaloosa, Homewood, and Mobile CRS offices. EI was able to provide funding for all CRS SLPs to receive intensive training in the administration of the ADOS-2.

Dr. Justin Schwartz and Dr. Sarah O’Kelly from the UAB Civitan-Sparks Clinic have been vital partners in providing staff training, consultation, and mentorship through case reviews. During monthly meetings with CRS and EI staff, they continue to provide resources and expertise to further develop the clinic and create standards for best practice in autism diagnostics. All CRS staff participate in a monthly Zoom meeting based on the ECHO Model and led by Drs. Schwartz and O’Kelly. The sessions are recorded and made available for those who could not attend or want a refresher.

CRS Huntsville continues to partner with The Smith Family Clinic for Genomic Medicine, LLC, a wholly owned subsidiary of Hudson Alpha Institute for Biotechnology, to host a genetics clinic for CYSHCN. The clinic's mission is

to diagnose patients who have been undiagnosed or misdiagnosed. The clinic geneticist has the unique opportunity to offer whole genome sequencing, provided by Hudson Alpha, which reads a patient's entire deoxyribonucleic acid (DNA). The data is analyzed to find genetic changes that may indicate the cause of a patient's disease. In some cases, these results yield information critical to directing the efficacy of a patient's treatment.

CRS administers the statewide Hemophilia Program for children and adults pursuant to Alabama Administrative Code. Through the Hemophilia Program, CRS provides access to clotting factor as well as interdisciplinary, comprehensive care to ensure optimal outcomes for Alabamians with hemophilia and related bleeding disorders. CRS staff meet with clients/families during enrollment to obtain medical and social history information, develop a PoC, obtain written consent, determine the family's financial resources, and the need for referral to other agencies. Community-based services include care coordination, family support, home visits, nutritional assessment, and client education.

CRS nurse care coordinators assist school-age clients with hemophilia in providing IEP/504 medical input regarding emergency treatment for hemophilia. They also coordinate with the school nurse to assist with school medication forms and developing individualized and emergency health plans specific to the child's bleeding disorder. Coordination with specialty pharmacies is a key component to ensuring accessible and quality skilled nursing is provided with medication administration in the home when needed. To ensure children and adults with hemophilia receive care in a well-functioning system, care coordinators arrange referrals to other specialists and work to educate individuals and families on how to handle emergency bleeds.

Through these collaborative efforts, CRS continues to utilize partners in innovative ways to ensure a well-functioning system of services for CYSHCN.

III.B.3.c. Relationship with Medicaid

ADPH

Within the state of Alabama, the Title V MCH Program and Title XIX Medicaid Program share a common goal in working to improve the overall health of the MCH population. Agreements are in place to provide care coordination, FP, and dental consulting services.

BFHS has a longstanding agreement in place with AMA for care coordination related to EBLL in children, NBS, NBHS, and ensuring access to childhood immunizations. The care coordination agreement was updated in FY 2024 to allow for case management with congenital syphilis cases.

Another longstanding agreement allows all CHDs to provide FP counseling and contraceptives to recipients of Plan First. CHDs continue to be the largest providers seeing Plan First patients statewide. BFHS has a new agreement in place with AMA for care coordination related to FP.

In FY 2023, the OHO Dental Director agreed to be a contract dentist for AMA due to the agency's dental director retiring in December 2022. The retirement soon led to a backlog of PAs for dental treatment of Alabama children enrolled in AMA. An MOU was agreed upon between ADPH and AMA whereas the OHO Dental Director would review PAs, allowing for uninterrupted approval for dental treatment. This MOU provides for uninterrupted dental services for Alabama's vulnerable children thus improving access to care. The MOU included financial reimbursement to ADPH for the time expended for the PA review. The agreement continued into FY 2024 as the most recent MOU was executed for a period of 5 years.

CRS

To ensure consistent quality, statewide standards of care, and access to community-based clinical services, AMA and CRS have negotiated a list of approved interdisciplinary clinics. CRS operates these clinics within AMA's Children's Specialty Clinic Services requirements as outlined in Chapter 61 of the AMA Administrative Code. CRS works with AMA to add new specialty clinics or modify existing clinics as needed. Some clinics are provided via telemedicine in accordance with the AMA Telemedicine Policy. CRS and AMA have negotiated a clinic encounter rate that AMA pays per specialty medical clinic visit for an AMA enrolled child. In addition to covering the cost of the

clinic visit it helps fund wraparound services to the client.

CRS serves in an advisory role to AMA for program and policy decisions likely to affect CYSHCN and its sub-group, CMC, and serves as a voice for this population. The AMA's Commissioner has assigned specific AMA staff to work with CRS. Meetings between AMA and CRS are held quarterly to discuss issues or concerns regarding services provided to AMA recipients with special health care needs. If issues arise outside the quarterly meetings, the CRS AMA liaison will contact AMA to discuss.

CRS serves as the reviewer of all statewide requests for AMA funding for ACD and houses all AMA PA requests for ACDs. CRS is the only provider of medically necessary orthodontia for AMA recipients. CRS works closely with AMA's Dental Director regarding coverage for orthodontia services. CRS is a direct provider with AMA for audiological services, hearing aids, and related supplies, thereby providing better coordination of these services for AMA-eligible CRS clients. In addition, CRS staff participate on advisory committees and work groups associated with various AMA initiatives. The CRS Speech-Language Pathologist Program Specialist was appointed to the ASHA Committee on Medicaid for 2025-2027. ASHA is a national association so serving on this committee will not only impact AMA but nationwide as well.

During FY24 quarterly meetings, CRS State Office staff advocated for specific coverage changes to improve service delivery. The CRS Audiology Program Specialist worked with AMA to increase the allowable number of and reimbursement rate for earmolds. Through her expertise as a licensed and certified doctor of audiology she recognized these changes would improve the quality of care. Due to the overall growth of infants and children increasing the number of allowable earmolds will ensure children are provided properly fitted hearing aids. Increasing the reimbursement rate allows the purchase of a higher quality earmold. Children with hearing loss that have unique ear anomalies or require a special coating to prevent external or middle ear infections will benefit greatly by a higher quality earmold. The CRS Clinical Program Specialist worked with AMA to address an ongoing formula shortage issue for Enteral formula. As the Clinical Program Specialist and a registered dietitian, she was able to recommend Nutren 2.0 formula be added to the Cerebral Palsy diagnosis to assist with the shortage. This addition not only addressed the shortage issue for CRS but for all providers in the state. It is through this unique relationship with AMA that CRS can leverage federal and state resources to ensure quality care for CYSHCN in Alabama.

CRS also coordinates with AMA to ensure staff are aware of AMA eligibility requirements, covered services, and waiver options. CRS has an ongoing collaboration with AMA to meet HIPAA standards for privacy and billing. CRS staff have access to AMA eligibility data for confirming coverage as outlined in the provider agreement between AMA and ADRS. If a CRS client is found to be uninsured, CRS care coordinators will assist the parent/guardian in submitting a joint application for AMA, CHIP, and the Federally Facilitated Marketplace. The joint eligibility system determines which of the programs the child is eligible to receive coverage. Alabama has a low incidence of uninsured children, which is due to a focus on education and outreach regarding insurance coverage for children. CRS also works with private insurers to ensure coverage for services for CYSHCN.

AMA 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 process. AMA implemented a consolidated care coordination system through a Section 1915 (b) Waiver effective October 1, 2019. This consolidated system resulted in the formation of ACHNs. CRS care coordinators have developed a close partnership and collaborated with the care coordination staff at the ACHN regional offices to better serve CYSHCN. Although EPSDT services are the responsibility of the primary healthcare provider for all children under AMA managed care arrangements, CRS coordinates services with the medical home to ensure access to specialty care and related services through AMA.

III.B.4. MCH Emergency Planning and Preparedness

There is a State of Alabama EOP and an ADPH-developed EOP. The ADPH EOP is reviewed every 2 years or as needed by the CEP, the State Health Officer, and all ADPH bureau staff with emergency assignments within the EOP. ADPH EOP does not specifically include language to address the needs of the MCH population. However, it does provide the opportunity for special assistance requests from the CEP Social Work Coordinator to access resources for people who are considered vulnerable, underserved, disabled, or have special needs. CEP does

recognize pregnant women and children as fitting into one of these groups.

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

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

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

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

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

- Identify how essential job duties can continue outside of ADPH offices
- Define processes to maintain a system of care for the MCH population

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

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

III.C. Needs Assessment

III.C.1. Five-Year Needs Assessment Summary and Annual Updates

III.C.1.a. Process Description

Every 5 years, each MCH Title V Block Grant Program is required to conduct and submit a formal assessment of their state's MCH needs. The 2025 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 the needs of infants, children and youth, women of childbearing age, and their families. CRS' activities focused on assessing the needs of CYSHCN and their families. Both ADRS and ADPH entered into a contractual agreement with the UAB School of Public Health AEAC to facilitate implementation of the Needs Assessment process. UAB entered into agreements with community-based organizations to assist with community engagement during the Needs Assessment. These groups included the Alabama Network of Family Resource Centers, FVA, UA, and UCP-H.

GOALS, FRAMEWORK AND METHODOLOGY

Goals - The primary goal of the Comprehensive 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 2024-2025 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 2025 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) administer an online survey (survey of healthcare providers, families, and adolescents available in English and Spanish), review the FAD to identify trends and unequal outcomes, convene community focus groups, and complete key informant interviews; 2) synthesize data to identify potential priority need topics; 3) present data and needs to the MCH Needs Assessment Advisory Group and facilitate preliminary selection of priority needs; 3) present preliminary need rankings to MCH leaders in FHS and facilitate final selection of the state's priority MCH needs; and 4) develop 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' process were as follows: 1) enter into an agreement with the UAB School of Public Health's AEAC Department of Health Policy and Organization to design and implement a process for data collection, analysis, and reporting on data collected from Alabama families, practitioners, and other stakeholders; 2) convene the CRS Needs Assessment Advisory Committee to assist with the process; 3) administer an online survey, conduct eight focus groups, hold two listening sessions, and conduct nine key informant interviews; 4) hold a Needs Assessment Prioritization meeting; and 5) convene the CRS State Office Leadership Team to select priority needs for CSHCN and the development of a State Action Plan that will guide Alabama's Title V CSHCN Program efforts for the next five-year 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 2024-2025 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 all locations with the printed marketing materials in English and Spanish; 4) identifying non-medical organizations to participate in key informant interviews; 5) partnering with ANFRC through UAB to facilitate community engagement through focus groups; 6) 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; and 7) convening MCH leaders in FHS, which consists of FHS Division and Program 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.

ADPH step 6 "convening the MCH Needs Assessment Advisory Group" occurred following analysis and synthesis of all data. Findings were presented at 2 full-day meetings organized around MCH population domains (Woman/Maternal and Perinatal/Infant on day one and Child and Adolescents on day two). More than 50 individuals representing a wide array of stakeholders from state and community organizations, ADPH staff, and regional MCH coordinators reviewed data and potential priority needs. Meeting participants rated each need based on key criteria (importance based on data; alignment with other priorities and efforts in the state; and potential for effective approaches or solutions) and provided feedback on the identified needs to guide the final prioritization and selection.

CRS - The primary ways in which CRS involved stakeholders consisted of 1) forming and convening the CRS Needs Assessment Advisory Committee to offer insight and guidance on areas of focus and methods for the needs assessment 2) utilizing CRS staff and social media to promote and encourage Alabama families to participate in the online survey 3) utilizing CRS local staff to identify community partners and stakeholders for key informant interviews and potential sites for conducting focus groups 4) ensuring the Needs Assessment Prioritization Meeting included a broad range of CRS partners and MCH stakeholders 5) convening the CRS State Office Leadership Team to select the priority needs and develop the State Action Plan.

Following analysis and synthesis of all data, findings were presented at a full-day meeting that included over sixty individuals with an interest in CSHCN. These individuals represented a wide array of stakeholders from state and community organizations, family-led organizations, members of the needs assessment advisory committee, and key members of CRS staff, including parent consultants. Following the presentation and discussion of data, meeting participants were able to rate the needs based on key criteria and provide feedback on the identified needs. The meeting included large group and small group discussions to engage participants, which stimulated conversations beyond the immediate prioritization and provided useful strategy ideas and potential partnership opportunities that could be leveraged during the next five-year block grant cycle.

QUANTITATIVE AND QUALITITATIVE METHODS AND DATA SOURCES USED

ADPH - Quantitative data from FAD were analyzed, along with data from a web-based survey. This survey also included open-ended questions for qualitative analysis. Additional qualitative data came from newly convened focus groups, key informant interviews, transcripts from related projects (Maternal Health Taskforce listening sessions; ALL Babies evaluation focus groups).

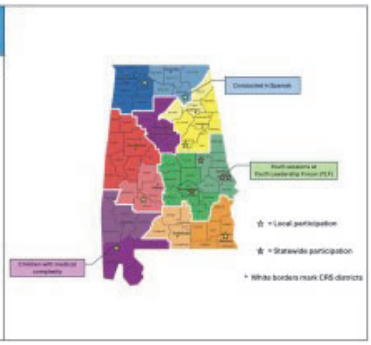
Federally Available Data (FAD)	Community Survey	Key Informant Interviews	Focus Groups & Listening Sessions
Key MCH indicators provided to states.	936 Responses (Online, English & Spanish) Families & Individuals = 634 Health Care/Health-Related Care Providers = 262 Organizational Partners = 399 ADPH employees = 298	8 Participants Representatives from multiple partner organizations	12 Focus Groups (1 in Spanish) Data Access: 9 Maternal Task Force Listening Sessions 2 ALL-Babies Evaluation Project Focus Groups (1 in Spanish)

CRS - Quantitative data used included FAD. Three other quantitative data sources were incorporated into the process. These sources included three years of data from two surveys of CRS clients and their caregivers focusing on services related to transition to adulthood, including adult health care, and on care coordination services. The third source was the consensus scoring documents from three years of the Family Engagement in Systems Assessment Tool (FESAT).

UAB AEAC collected qualitative data by administering an online survey, conducting eight focus groups, two listening sessions, and nine key informant interviews. CRS staff and parent consultants worked with the community partner organizations to recruit families for focus groups. Listening sessions occurred during existing events or convenings.

Nine key informant interviews were conducted with representatives of local, state, public, and private groups that work with CYSHCN and their families.

Federally Available Data (FAD)	Survey	Focus Groups & Listening Sessions	Key Informants	Other Existing Information
Key MCH indicators provided to states (specific to CYSHCN) These are National Performance Measures	427 Responses (Online, English & Spanish) • Parent/Caregiver of CYSHCN = 225 • YSHCN = 58 • Health Care/Health-Related Care Provider = 86 • Teacher/Childcare Provider = 59 • Advocacy or Community Support Organization = 36 • State Agency Employee = 35	8 Focus Groups & 2 Listening Sessions Focus Groups: • Parents/ Caregivers of CYSHCN – English = 5 • Parents/ Caregivers of CYSHCN – Spanish = 1 • Youth/ Young Adult with SHCN = 2 Listening Sessions: • Alabama Hands and Voices (40+ families of children 18 months - teens) • CRS State Parent Advisory Committee (20+ Local Parent Consultants and Local Parent Advisory Committee Members)	9 Participants • Health and Health-Related Care Providers (rural pediatrician, nurse practitioner, school therapists • Rural Teacher, Secondary Grades • Health Care Equipment Vendors • Advocacy & Community Organization Staff	• CRS Transition Survey • CRS Care Coordination Survey • CRS FESAT Consensus Scoring



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

UAB worked closely with ADPH and CRS to develop data collection methods and tools, analyze and synthesize data, and identify needs. UAB co-facilitated a two-phase process with both ADPH and CRS, including advisory committee members, partners, and staff to finalize the selection of priority needs. These priority needs were then aligned with measures to drive improvement and served as the foundation for the development of a State Action Plan.

ADPH - FHS' MCH Epi staff are a common element in all aspects of the Needs Assessment process: 1) MCH Epi staff members participated in the Needs Assessment Advisory Group Meeting during which the state's MCH priority needs were identified and ranked, 2) 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. MCH Epi staff assist in the preparation the MCH annual applications/reports and support program staff in monitoring ongoing Needs Assessment activities, ensuring integration of the staff in all phases of the Needs Assessment process.

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 12 need topics for CSHCN. CRS used a two-phased process to prioritize the needs. The first phase occurred during the previously mentioned Needs Assessment Prioritization Meeting held in April 2025. The second phase occurred when the UAB AEAC and CRS State Office Leadership Team met to select the final priority needs. CRS leadership utilized knowledge of agency capacity and feasibility considerations, along with input obtained from stakeholders, to reach a consensus on the state's priority needs for CSHCN.

III.C.1.b. Findings

III.C.1.b.i. MCH Population Health and Wellbeing

MCH POPULATION HEALTH STATUS

Based on the quantitative and qualitative analyses conducted as part of the FY 2024-2025 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.

MCH Strengths/Successes: The following strengths and successes were identified across all MCH population domains.

Availability of Certain Services and Providers	• Services such as therapies, equipment, and supplies have improved ove time and are now more accessible. • Availability of OB/GYNs, pediatricians, and maternal-fetal medicine specialists in urban areas. • UAB and other hospitals recognized for high-quality care, especially for NICU and high-risk pregnancies. • County health departments praised for offering family planning, contraceptives, vaccinations, STD screening, and cancer screenings.
Community Support	• Community programs and other parents provide strong support. • Community member willingness to help and support each other is a strength.
Mental Health and Social Support Awareness	• There is reduced stigma and growing awareness of postpartum depressi trauma-informed care, and mental health needs. • School-based mental health providers are a strength.
Policy Improvements	• An example is recent legislation for paid parental leave for state employees.
Positive Experiences with Specific Services and Providers	• Examples include comprehensive CRS Clinics, providers (pediatricians, specialty care), therapists, care coordinators, and interpreters.
Supportive Organizations and Programs; Community and Educational Programs	• Strengths include organizations and programs: CRS, WIC, Medicaid, ALL Kids/ALL Babies, community programs, parent leadership programs, earl Intervention programs; Title X, Well Woman Programs, Head Start, Early Head Start, First Class Pre-K, Cribs for Kids, breastfeeding support and education, and early hearing detection and intervention.

Cross-Cutting Systems Issues: The following issues were identified as system needs that impact all MCH population domains. These were not included in prioritization but rather will underpin State Action Plan development as important factors to consider in selecting strategies and action steps.

Need Topic	Key Findings
Food Sufficiency	• Concerning and unequal levels of food sufficiency for children. • Increased concern about food security for all MCH populations. • Increased concern about lack of or unequal access to healthy and fresh foods, fruits, and vegetables.
MCH Workforce	• Inadequate and unequal distribution of critical MCH providers to support access to health/medical, mental health, and dental services.
Adequate Insurance for All	• Increased concerns about access to affordable health insurance that meets needs for all MCH populations.
Community Health Factors	• Increased concerns related to community health factors, including cost of living, jobs, wages, and transportation.
Housing Instability	• Concerning and unequal levels of housing insufficiency for children. • Increased concerns about lack of or unequal access to safe and affordable housing.
Systems of Support and Resources for Families	• Lack of, lack of awareness of, or unequal access to systems of support for families, including resources and education. • Lack of father-inclusive programs and resources
Culturally and Linguistically Appropriate and Respectful Providers and Care	• Increased concerns related to insufficient or unequal language access for some groups. • Increased concerns related to lack of respectful, non-judgmental providers and care, especially for those with Medicaid and people from minority races or ethnicities.
Recreational Opportunities and Safe, Affordable Options for Physical Activity	• Lack of or unequal access to safe, affordable recreational opportunities and options for physical activity for people of all ages.

FAD Analyses for All MCH Population Domains:
National priority areas represented by important MCH health outcome and systems indicators are provided to states by MCHB through data and trend analyses contained in the FAD resource document. Most recently available data were reviewed and synthesized for each population domain, comparing Alabama performance to U.S. averages and Alabama trends over time. These trends are indicated in color-coded charts below, with red (statistically worse), green (statistically better), and yellow (concerning trend – not statistically worse, but trending in a negative direction). When available, disaggregated indicator data were reviewed to identify any unequal outcomes based on sociodemographic characteristics.

***Women/Maternal Health* - Overview of Health Status**
Challenges and Gaps Related to Major Morbidity, Mortality, Health Risks or Wellness

Alabama mothers are at a higher risk for preterm delivery or any pregnancy complications due to being either overweight (BMI 25.0-29.9) or obese (BMI ≥ 30.0) at delivery. As BMI increases, the likelihood of pregnancy complications increases. According to CHS, 62.7 percent (n=36,237/57,835) of the 2023 deliveries occurred among mothers being either overweight or obese.

Developing hypertension during pregnancy can also increase the risk of eclampsia, where maternal complications, including kidney failure, liver damage, stroke, or even death, can occur. While 5.3 percent (n=3,085/57,835) of 2023

delivering mothers had hypertension prior to their pregnancy, 13.2 percent (n=7,631/57,835) developed gestational hypertension during their pregnancy.

The risk of eclampsia is also elevated among mothers with a history of tobacco use. Prior to becoming pregnant, less than 5 percent (4.3 percent; n=2,498/57,835) of mothers delivering during 2023 had a history of smoking at least one cigarette 3 months prior to pregnancy. Among those with any prior smoking history, close to 90 percent (89.2 percent; n=2,227/2,498) reported continued tobacco use during pregnancy.

As the trend for maternal mortality worsens, the MMRC reviews all potential maternal deaths where a death certifier (coroner, medical examiner, or physician) can identify whether pregnancy occurred within one year of death on a death certificate. As confirmation of deaths resulting from pregnancy, the AL-MMRC compiles and reviews medical records, autopsy reports, and obituaries. According to CHS, the 2023 statewide total number of potential maternal deaths was 47. When stratifying by race, over half (53.2 percent; n=25/47) were white, while 46.8 percent (n=22/47) were black and other. Over 60 percent (61.7 percent; n=29/47) occurred after 6 weeks postpartum (within 43-365 days of delivery). Over 80 percent (83.0 percent; n=39/47) completed at least a high school education. When stratifying by age, potential maternal deaths were highest among mothers in the 25 to 29 age group (25.5 percent; n=12/47).

In consideration of the national priority areas related to the Women/Maternal Health Domain, Alabama is performing either about the same or worse than the nation but has been stable or trending better over time for most. Concerning trends are noted for postpartum contraception use and maternal mortality. Unequal outcomes are noted for many indicators, primarily based on race/ethnicity, income, education level, age, and insurance type.

Indicator	Value	Comparison to U.S.	State Trend
National Performance Measures			
Postpartum Visit – Attendance	92.3%	Comparable	Stable
Postpartum Visit - Recommended Components	74.4%	Worse (lower)	Stable
Postpartum Mental Health Screening	76.2%	Worse (lower)	Not available
Postpartum Contraception Use	56.3%	Better (higher)	Decreasing (worsening)
Preventive Dental Visit – Pregnancy	41.1%	Worse (lower)	Stable
Standardized Measures			
Well-Woman Visit	74.5%	Comparable	Stable
Low-Risk Cesarean Delivery	28.3%	Worse (higher)	Decreasing (improving)
Smoking – Pregnancy	3.9%	Worse (higher)	Decreasing (improving)
National Outcome Measures			
Maternal Mortality	35.2 per 100,000	Worse (higher)	Increasing (worsening)
Postpartum Depression	15.8%	Worse (higher)	Stable

Color Key: = statistically worse = statistically better = concerning trend

Based on all data from the mixed methods Needs Assessment, the following need topics and key findings were identified for the Women/Maternal Health Domain.

Need Topics	Key Findings
Access to Health and Dental Care Services	• Lack of or unequal access to comprehensive, respectful health care services, including primary care, preventive screenings, family planning/contraception, care for chronic conditions, and dental care, especially in rural areas and for those with Medicaid insurance. • Lack of or unequal access to preventive dental visits during pregnanc especially in rural areas and for those with Medicaid insurance.
Access to Prenatal Care and Labor and Delivery Hospitals	• Lack of or unequal access to respectful prenatal care and labor and delivery hospitals, especially in rural areas. • Lack of or unequal access to supports for women receiving care for high-risk pregnancies or emergency transport for high-risk deliveries.
Birthing Choices and Access to Alternative Providers	• Lack of or unequal access to alternative birth attendants and supports, including certified nurse midwives and doulas.
Comprehensive Mental Health and Wellness Treatment and Supports	• Lack of, lack of awareness of, or unequal access to comprehensive mental health treatment and wellness supports, including postpartu depression screening and care.
Comprehensive Postpartum Care and Education	• Lack of or unequal access to comprehensive, respectful postpartum care that includes all recommended components of care. • Lack of, lack of awareness of, or unequal access to postpartum education, assistance programs, and community supports.

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 Health Domain, "**Comprehensive Postpartum Care and Education**" was selected as the state priority need.

***Perinatal/Infant Health* - Overview of Health Status**

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

A LBW or preterm delivery can elevate the risk of death or increase the development of long-term health conditions, including developmental disabilities, chronic health conditions, or respiratory issues. In 2023, 10.5 percent (n=6,051/57,835) of infants had a birth weight under 2,500 grams. Approximately 15.1 percent (n=8,708/57,835) of births were considered preterm due to the delivery taking place between 20 and 36 weeks of gestation. NICU services were provided to half (50.1 percent; n=3,034/6,051) of LBW deliveries and 37.3 percent (n=3,249/8,708) of preterm deliveries.

According to CHS, 449 infant deaths were reported during 2023. The 2023 Alabama IMR was 7.8 deaths per 1,000 live births, which was above the U.S. provisional IMR of 5.6 deaths per 1,000 live births. The 2023 three leading causes of infant death were congenital malformations, deformations, and abnormalities; disorders related to short gestation and LBW, not elsewhere classified; and SIDS. Compared to 2022, SIDS dropped from being tied for second with disorders related to short gestation and LBW, not elsewhere classified, to the third leading cause of death.

In consideration of the national priority areas related to the Perinatal/Infant Health Domain, Alabama is performing worse than the nation for most, although trends have been stable or improving over time for most values. Statistically worse trends are noted for early prenatal care and infant mortality. Unequal outcomes are noted for many indicators, primarily based on race/ethnicity, income, education level, age, and insurance type.

Indicator	Value	Comparison to U.S.	State Trend
National Performance Measures			
Breastfeeding – Initiation	75.0%	Worse (lower)	Increasing (improving)
Breastfeeding - Exclusive to 6 Months	26.8%	Comparable	Increasing (improving)
Safe Sleep - Back Sleep Position	74.5%	Worse (lower)	Increasing (improving)
Safe Sleep - Separate Approved Sleep Surface	28.1%	Worse (lower)	Increasing (improving)
Safe Sleep - No Soft Bedding	65.9%	Worse (lower)	Increasing (improving)
Risk-Appropriate Perinatal Care	87.5%	Not available	Stable
Standardized Measures			
Early Prenatal Care	71.3%	Worse (lower)	Decreasing (worsening)
National Outcome Measures			
Low Birth Weight	10.4%	Worse (higher)	Stable
Preterm Birth	12.9%	Worse (higher)	Stable
Infant Mortality	7.8 per 1,000	Worse (higher)	Increasing (worsening)
SUID Mortality	175.4 per 100,000	Worse (higher)	Stable

Color Key: = statistically worse = statistically better = concerning trend

Based on all data from the mixed methods Needs Assessment, the following need topics and key findings were identified for the Perinatal/Infant Health Domain.

Need Topic	Key Findings
Access to Comprehensive Health Care	• Lack of or unequal access to comprehensive, respectful healthcare, including well visits, developmental screening, and specialty care.
Access to Labor and Delivery Hospitals	• Lack of or unequal access to labor and delivery hospitals.
Affordable, Quality Childcare	• Lack of or unequal access to affordable, quality childcare.
Breastfeeding Education and Supports	• Lack of, lack of awareness of, or unequal access to breastfeeding education and supports. • Inconsistent breastfeeding supports immediately following delivery.
Infant Mortality	• Concerning levels, trends, and unequal outcomes related to infant mortality, including associated conditions (pre-term birth, low birth weight).
Safe Sleep Environment	• Undesirably low levels of infants being placed in a safe sleep environment, with unequal observance among groups. • Increased difficulty in meeting some measures of safe sleep environment, including separate sleep surface without soft objects/loose bedding, with unequal observance among groups. • Concerning levels and unequal outcomes related to SUID 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 an improved outcome for the Perinatal/Infant Population Health Domain, "**Infant Mortality**" was selected as the state priority need.

Child Health **- Overview of Health Status**

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

According to CDC Wonder, Alabama's 2023 population estimate for children ages 1 to 14 exceeded 850,000 (n=867,648), representing 17.1 percent of the 2023 ACS 5-year statewide population estimate (n=867,648/5,054,253). Approximately 64.1 percent (n=556,528/867,648) were white, followed by 35.9 percent (n=311,120/867,648) for black and other.

With the worsening trend in child mortality, CHS preliminary findings identified 213 deaths occurring in 2023 among the 1 to 14-year age group. Similar to 2022, accidents (unintentional injuries) were the 2023 leading cause of death for both the 1 to 4-year age group and the 5 to 14-year age group. For this cause of death among the 1 to 4 age

group, 60.0 percent (n=21/35) were white and 40.0 percent (n=14/35) were black and other. Among the 5 to 14-year age group, 56.8 percent (n=21/37) were white and 43.2 percent (n=16/37) were black and other. This trend is consistent on a national scale, with accidents ranked as the leading cause of death. According to the CDC Wonder, 2,873 children within these age groups died due to accidents in 2023.

In consideration of the national priority areas related to the Child Population Health Domain, Alabama has mixed performance compared to the nation but has been stable over time for many. Concerning trends are noted for several indicators, though statistically better trends are seen for exposure to smoking in the household. Unequal outcomes are noted for many indicators, primarily based on race/ethnicity, income, caregiver education level, age, CSHCN status, and insurance type.

Indicator	Value	Comparison to U.S.	State Trend
National Performance Measures			
Food Sufficiency – 0-11 years	61.8%	Worse (lower)	Decreasing (worsening)
Housing Instability – 0-11 years	20.5%	Worse (higher)	Increasing (worsening)
Developmental Screening (9-35 months)	29.1%	Comparable	Increasing (improving)
Childhood Vaccination (combined 7 series)	63.7%	Worse (lower)	Decreasing (worsening)
Preventive Dental Visit – Child	80.5%	Comparable	Stable
Physical Activity – Child	30.6%	Better (higher)	Decreasing (worsening)
Medical Home – All Children	50.9%	Better (higher)	Stable
Medical Home – All Children Care coordination	71.9%	Better (higher)	Stable
Medical Home – All Children Personal doctor or nurse	73.6%	Comparable	Stable
Medical Home – All Children Usual source of sick care	79.2%	Better (higher)	Stable
Medical Home – All Children Family-centered care	84.7%	Comparable	Stable
Medical Home – All Children Referrals	78.6%	Comparable	Stable
Standardized Measures			
Smoking – Household	13.9%	Worse (higher)	Decreasing (improving)
Adequate Insurance – 0-17 years	74.6%	Better (higher)	Stable
MMR Vaccination	93.8%	Comparable	Stable
National Outcome Measures			
Child Mortality	24.8 per 100,000	Worse (higher)	Increasing (worsening)
Obesity – 6-17 years	22.8%	Worse (higher)	Stable

Color Key: = statistically worse = statistically better = concerning trend

Based on all data from the mixed methods Needs Assessment, the following need topics and key findings were identified for the Child Health Domain.

Need Topic	Key Findings
Access to Comprehensive Health Care	• Lack of or unequal access to comprehensive health care, including well visits and developmental screening.
Access to Preventive Dental Visits for Children and Adolescents	• Lack of or unequal access to preventive dental visits for children and adolescents, especially in rural areas and for those with Medicaid insurance.
Affordable, Quality Childcare	• Lack of or unequal access to affordable, quality childcare.
Bullying and School Safety	• Increased concerns about experiences of bullying, including in school settings.
Cell Phone/Social Media Usage	• Excessive use of cell phones and social media.
Child Mortality	• Concerning levels, trends, and unequal outcomes related to child mortality.
Childhood Vaccinations	• Decreasing (worsening) and unequal levels of childhood vaccinations.
Exposure to Smoking in Household	• Concerning levels and unequal outcomes related to exposure to smoking in the household for children and adolescents.
Food Sufficiency	• Concerning and unequal levels of food sufficiency for children.
Housing Instability	• Concerning and unequal levels of housing insufficiency for children.
Mental Health and Behavioral Treatment and Supports	• Lack of, lack of awareness of, or unequal access to comprehensive mental health and behavioral health treatment and supports for children.
Obesity	• Concerning levels and unequal outcomes related to child and adolescent 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 Health Domain, "**Access to Comprehensive Health Care**" was selected as the state priority need.

***Adolescent Health* - Overview of Health Status**

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

According to CDC Wonder, Alabama's 2023 population estimate for children ages 15 to 24 exceeded 650,000 (n=685,602), representing 13.6 percent of the 2023 ACS 5-year statewide population estimate (n=658,602/5,054,253). Approximately 64.7 percent (n=443,914/685,602) were white, followed by 35.3 percent (n=241,688/685,602) for black and other.

Based on CHS 2023 preliminary findings, 724 deaths occurred within the 15 to 24-year age group. As the leading cause of death, accidents (unintentional injuries) contributed close to 40 percent (36.7 percent; n=266/724) of the total deaths occurring within this age group. When stratifying by race for the overall leading cause of death, 65.0 percent (n=173/266) were white, and 35.0 percent (n=93/266) were black and other. Although accidents (unintentional injuries) were the leading cause of death for both overall and white, assault (homicide) was identified as the leading cause of death among black and other, representing over half (52.9 percent; n=176/333) of the deaths within this racial group.

Reviewing teen pregnancy, the percentage of births delivered among females aged 10 to 19 years was 6.0 percent (n=3,467/57,835). Compared to 2022, teen births did not fluctuate. CHS states that the 2023 birth rate was 10.6 per 1,000 female teenagers. Close to 90 percent (89.6 percent; n=3,107/3,467) of teenage mothers were unmarried at the time of delivery. Approximately 10.6 percent (n=48/449) of infant deaths occurred among teenage mothers.

In consideration of the national priority areas related to the Adolescent Health Domain, Alabama is performing either about the same or worse than the nation for most. Performance over time has been mixed, with statistically better improvement noted in HPV vaccination, adolescent motor vehicle death, and teen births. Concerning trends are noted for many indicators, including the adolescent well-visit, mental health treatment, physical activity, flu vaccination, adolescent suicide, and adolescent depression/anxiety. Unequal outcomes are noted for many indicators, primarily based on race/ethnicity, income, caregiver education level, age, CSHCN status, and insurance type.

Indicator	Value	Comparison to U.S.	State Trend
National Performance Measures			
Adolescent Well-Visit	70.0%	Comparable	Decreasing (worsening)
Adult Mentor	90.0%	Comparable	Stable
Mental Health Treatment, if needed	81.6%	Comparable	Decreasing (worsening)
Bullying – Victimization	33.5%	Comparable	Stable
Transition to Adult Healthcare	17.2%	Comparable	Increasing (improving)
Standardized Measures			
Physical Activity – Adolescent	11.1%	Comparable	Decreasing (worsening)
HPV Vaccination	79.0%	Comparable	Increasing (improving)
Flu Vaccination	43.0%	Worse (lower)	Decreasing (worsening)
National Outcome Measures			
Adolescent Mortality	53.7 per 100,000	Worse (higher)	Mixed
Adolescent Motor Vehicle Death	19.8 per 100,000	Worse (higher)	Decreasing (improving)
Adolescent Suicide	7.3 per 100,000	Comparable	Increasing (worsening)
Teen Births	24.8 per 1,000	Worse (higher)	Decreasing (improving)
Adolescent Depression/Anxiety	15.8%	Better (lower)	Increasing (worsening)

Color Key: = statistically worse = statistically better = concerning trend

Based on all data from the mixed methods Needs Assessment, the following need topics and key findings were identified for the Adolescent Health Domain.

Need Topic	Key Findings
Adolescent Mortality	• Concerning levels and unequal outcomes related to adolescent mortality, including motor vehicle death.
Adolescent Well-Visit	• Worsening trend and unequal outcomes related to receipt of adolescent well-visit.
Adult Mentor	• Unequal outcomes for youth having adult mentors and positive role models.
Bullying	• Increased concerns about experiences of bullying, including in school settings and for specific groups of youth.
Cell Phone/Social Media Usage	• Excessive use of cell phones and social media.
Comprehensive Sexual Health Education and Risk Reduction	• Lack of, lack of awareness of, or unequal access to comprehensive sexual health education, including birth control options and family planning services. • Concerning levels and unequal outcomes related to teen births. • Increased concerns about risky sexual behaviors among youth.
Exposure to Smoking in Household	• Concerning levels and unequal outcomes related to exposure to smoking in the household for children and adolescents.
Flu Vaccination	• Concerning levels and worsening trends for receipt of flu vaccination.
Mental Health and Behavioral Treatment and Supports	• Lack of, lack of awareness of, or unequal access to comprehensive mental health and behavioral health treatment and supports for adolescents.
Obesity	• Concerning levels and unequal outcomes related to child and adolescent obesity.
Physical Activity and Safe Social and Recreational Opportunities	• Lack of or unequal access to safe social and recreational opportunities, including options for physical activity.
Substance Use	• Increased concerns about youth substance use, including alcohol, drugs, and vapes.
Transition to Adulthood	• Lack of education and support for adolescents transitioning from pediatric care to adult health care. • Lack of education and support for adolescents to prepare for transitioning to adulthood and independence in general.

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 Health Domain, "**Adolescent Safety and Wellness**" was selected as the state priority need.

CSHCN - Overview of Health Status

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

In consideration of the national priority areas related to the CSHCN Health Domain, Alabama is performing either about the same or worse than the nation for most, though statistically better outcomes are noted for medical home and the care coordination subcomponent of medical home. Trends over time have been stable or improving for many indicators. Concerning trends are noted for several indicators, including food sufficiency and the personal doctor or nurse subcomponent of medical home. Statistically worse trends are seen for the usual source of sick care subcomponent of medical home. Due to data source and sample size limitations, it is difficult to identify unequal outcomes within the sub-population of CSHCN, but unequal outcomes are noted for all children, primarily based on race/ethnicity, income, caregiver education level, age, CSHCN status, and insurance type.

Indicator		Value	Comparison to U.S.	State Trend
National Performance Measures				
Food Sufficiency (0-11 years)	All	61.8%	Worse (lower)	Decreasing (worsening)
	CYSHCN	54.8%	Worse (lower)	Decreasing (worsening)
Housing Instability (0-11 years)	All	20.5%	Worse (higher)	Unavailable
	CYSHCN	29.9%	Worse (higher)	Unavailable
Bullying – Victimization	All	32.5%	Comparable	Stable
	CYSHCN	47.4%	Comparable	Decreasing (improving)
Transition to Adult Healthcare	All	15.5%	Comparable	Stable
	CYSHCN	23.2%	Comparable	Increasing (improving)
Medical Home	All	50.9%	Better (higher)	Stable
	CYSHCN	46.5%	Better (higher)	Increasing (improving)
Medical Home – CYSHCN Personal doctor or nurse		78.0%	Comparable	Decreasing (worsening)
Medical Home – CYSHCN Usual source of sick care		78.3%	Worse (lower)	Decreasing (worsening)
Medical Home – CYSHCN Family-centered care		78.7%	Worse (lower)	Increasing (improving)
Medical Home – CYSHCN Referrals		75.1%	Better (higher)	Increasing (improving)
Medical Home – CYSHCN Care coordination		66.0%	Better (higher)	Increasing (improving)

Color Key: = statistically worse = statistically better = concerning trend

Based on all data from the mixed methods Needs Assessment, the following need topics and key findings were identified for the CSHCN Domain.

Need Topic	Key Findings
Access to Community Services and Supports	• Inadequate and unequal access to and availability of community services and supports, especially in rural areas. These are services and supports that foster quality of life and engagement in daily activities outside of addressing medical or health care needs, including respite care, recreational opportunities, and childcare programs that are trained to support CYSHCN and willing to accept them.
Access to Health and Health-Related Services and Equipment	• Inadequate and unequal access to and availability of health and health-related services, in-home supports, medical equipment, and supplies, especially in rural areas and for people whose first language is not English.
Adequate Insurance and Financial Supports	• Inadequate insurance, including financial strain from out-of-pocket costs, benefit limits, non-covered items, and complicated processes for approvals and waivers.
Community Factors that Influence Health Outcomes	• Unequal experiences of community factors that influence health outcomes, overall and specifically for families of CYSHCN. These are system and community issues that influence health and well-being, including high cost of living, unsuitable housing, lack of housing modifications and accessible homes, financial strain and difficulty maintaining employment, and food insecurity.
Comprehensive Care Coordination and Supports for System Navigation	• Insufficient or unequal assistance to help families navigate the system of care, including identifying providers, programs, family supports, and community resources. • Inconsistent comprehensive care coordination that includes topics beyond health medical needs, including services/supports that address quality of life, engagement in daily activities, and the non-medical drivers of health.
Family and Youth Engagement	• Inconsistent opportunities for families and youth to engage in policymaking and the design, delivery, and evaluation of programs and policies.
Family and Youth Peer Supports	• Lack of opportunities to create "community" for families, caregivers, and youth. • Lack of peer support – including coping, mental health, and emotional support – and opportunities to learn from each other and share resources.
Health Teaching and Information Needs	• Lack of (accurate) information about specific conditions and disabilities. Lack of awareness of policies, rights, and processes. • Lack of preparation for families to engage in partnerships with professionals who work with their children/youth and to participate in shared-decision-making about their care.
Medical Home	• Lack of or inadequate access to comprehensive medical homes, including comprehensive care coordination, streamlined referrals, and communication across systems/between providers. • Inconsistent medical provider knowledge about CYSHCN and specific conditions. Inconsistent provision of health care that focuses on overall well-being and quality of life versus clinical care only. • Lack of preparation of the medical provider workforce to provide family-centered care, engage in partnerships with families, and participate in shared-decision-making with them about the care of their children.
Special Education Services and Integration into School Systems	• Insufficient special education services and integration into school systems, including before and after school programs, teacher and para-teacher training, unequal accommodations, and truancy/absenteeism policies.

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 CSHCN Domain, "**Transition to Adulthood**," "**Comprehensive Care Coordination and Supports for System Navigation**" and "**Family and Youth Peer Support**" were selected as the state priority needs.

Cross-Cutting/Systems Building

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, "**Access to Comprehensive Oral Health Education and Services for all MCH Populations**" was selected as the state priority need.

III.C.1.b.ii. Title V Program Capacity

III.C.1.b.ii.a. Impact of Organizational Structure

ADPH

ADPH and 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 CRS and BFHS Directors. Staff members from CRS and BFHS meet throughout the 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 BFHS, located in the Central Office, administers the Maternal and Child Health Services Title V Block Grant. ADPH contracts with CRS to administer services to 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 Office, the Women's and Children's Health Division, Consultants-Pediatric Division, the Office of Women's Health, and multi-county public health districts. Other programs administered by BFHS include the Title X FP Grant, WIC, Cancer Prevention and Control Program, and PRAMS. The colocation of these programs and offices provides BFHS the opportunity to partner with programs impacting the health of the MCH population with funds from federal grants outside of HRSA.

Each CHD in the public health districts, as well as MCHD and JCDH receive an annual allotment of Alabama Tile V Funds to support their governance of public health services delivered by each CHD. The CHDs have a longstanding commitment to the provision of child health services, FP services, sexual health education, immunization, and WIC services for women and children. The CHDs are also the home base for the District MCH Coordinators that are instrumental in providing leadership for the development and expansion of evidence-based programs county wide, focused in the areas of infant mortality, women's health, oral health care, child health, and suicide prevention. BFHS leadership meet with district MCH staff, both monthly and quarterly to discuss issues related to service delivery, staffing concerns, and program challenges and successes.

CRS

ADRS serves as the state agency responsible for providing services to individuals with disabilities from birth throughout their lives. For over 30 years ADRS has been the agency dedicated to serving individuals across the lifespan. CRS is a division of ADRS and builds on the ADRS mission of enabling Alabama's children and adults with disabilities to achieve their maximum potential.

Services are provided through four main programs that reach residents in all 67 counties. The programs are EI, CRS, VRS, and SAIL. CRS, a division of ADRS, has administrative responsibility for the State Title V CSHCN Program and the Alabama Hemophilia Program. As a division of ADRS, CRS builds on the "continuum of care" approach in providing services to CYSHCN from birth to 21. Being housed in ADRS provides a unique opportunity for CRS to partner closely with the other divisions especially EI and VRS. In many counties, CRS offices are co-located with EI and VRS.

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. As the state agency serving individuals with disabilities the Commissioner and Assistant Commissioner work directly with other agency Commissioners regarding responding to the needs of CSHCN and their families. The needs of CSHCN are complex and require collaboration with state and community agencies such as AMA, Department of Education, and Mental Health among others. These collective efforts further ensure CSHCN achieve their maximum potential and contribute to their overall quality of life.

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. 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. The ADRS Commissioner meets quarterly with the ADRS Assistant Commissioner and state office specialists to discuss issues

surrounding service delivery, staffing challenges, and workforce development. During these meetings the Commissioner offers insight and potential solutions to access to services and staffing issues.

The seven 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 14 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. Staff at the local level collaborate with the ADPH MCH coordinator in their area to partner on initiatives and address MCH needs.

CRS state office leadership and district supervisors gather quarterly to discuss issues related to service delivery, staffing concerns, program challenges and successes. The goal of the quarterly meetings is to ensure quality services are being provided to CYSHCN. These same staff participate in a quarterly field leadership team meeting where the ADRS Commissioner and division directors provide updates that impact individual divisions as well as the agency as a whole. Having strong and knowledgeable leaders contributes to the overall success of the organization in meeting the needs of the individuals served.

III.C.1.b.ii.b. Impact of 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 BFHS and the programs administered by BFHS, the Alabama 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 that directly impact the Women/Maternal Domain are FP, WIC, and ABCCED. Subsequently, the programs and activities of the Child and Adolescent Health Division directly impact the Adolescent and Child Domains. The Perinatal/Infant Domain is impacted by the programs and activities of the BFHS Perinatal Health Division.

To maintain capacity, ADPH, including BFHS, 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 Alabama Title V Program through difficult times. The Alabama Legislature approved a 2026 General Fund budget of $3.7 billion which increased spending over the current year by $347 million. The FY 2026 General Fund budget will allocate funds for non-education state programs, such as AMA, prisons, courts, law enforcement, mental health, public health, and others. The General Fund budget is 6 percent higher than FY 2025. Alabama’s record-setting General Fund is generational money which makes possible greater investments in vital public services. AMA will receive $1.18 billion, a $223.8 million increase over FY 2025. ADPH receives $159 million, a $28 million increase over FY 2025, with most of the money allocated being for the CHIP state match.

The Title V Program, as well as other programs administered by BFHS, serves all of the state's 67 counties. BFHS 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.

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. BFHS continues its aim to partner with AMA and AlaHA at every available opportunity. BFHS routinely attends meetings with both agencies, sits on committees with common goals, and invites them to participate in all statewide MCH programs. BFHS has several programs that collaborate closely with AMA. The Title X Program works to ensure that contraception and other family planning needs are met.

CRS Agency Capacity

The Title V CSHCN Program, administered by CRS, ensures the capacity to promote and protect the health of CSHCN in our state. CRS' mission embodies the principles of comprehensive, community-based, and family-centered care. The mission of CRS is to enable children and youth with special health care needs and adults with hemophilia to achieve their maximum potential within a community-based, family-centered, comprehensive, coordinated system of services. Coordinated health services are delivered via 14 community-based offices across 7 service districts serving all 67 counties. 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 services. CRS offices are co-located with EI and VRS in most locations, which facilitates service coordination.

As described in the Health Care Delivery System section, CRS collaborates with providers in the public and private sectors to provide community-based care and improve access to care. Providers work in the CRS medical clinics related to their specialty area. Medical clinics include discipline specialists, neurologists, orthopedists, pediatric rehabilitative medicine, hematologists, orthodontists, ENTs, developmental pediatricians, and other physician specialists. CRS also enrolls vendors to address any gaps in service for medical and evaluation clinics. Vendors include physicians, CRNPs, audiologists, registered dietitians, speech language pathologists, occupational therapists, physical therapists, and durable medical equipment specialists. Having a broad network of providers and vendors available increases CRS' capacity to meet the needs of the specific district office. These individuals often travel to CRS clinic sites in rural areas where specialty services are not otherwise available. CRS leadership continually works to recruit providers and vendors to provide quality services and fill gaps.

CRS has a Care Coordination Program that provides an interdisciplinary approach to care coordination to ensure CYSHCN and their families connect to wrap-around services they require for optimal behavioral, developmental, health, and wellness outcomes. Care Coordination services are provided by licensed social workers and registered nurses located in the 14 community-based offices across the state. These individuals provide support to help families navigate the complex system of care for CYSHCN. CRS care coordinators coordinate with community partners to ensure a statewide system of services that reflects the components of comprehensive, community-based, and family-centered care for CYSHCN.

Alabama's Disability Determination Services (DDS) field office staff submit referrals for children evaluated for SSI to the CRS State Office. These referrals are disseminated to the appropriate CRS local office for follow-up. Families referred by DDS are contacted regarding CRS services, including care coordination. CRS provides rehabilitative services to eligible individuals under the age of 16 receiving benefits under Title XVI. Although CRS does not provide services to the blind, CRS staff refer families to AIDB. Founded in 1858, AIDB provides comprehensive education, rehabilitation, and services for individuals of all ages who are deaf, blind, and deafblind, and their families.

As a division of an agency dedicated to serving individuals with special health care needs, CRS is committed to continuing to strengthen the system of care for CYSHCN. This commitment involves addressing the findings of the Comprehensive Needs Assessment either directly or through relationships with state and community partners.

III.C.1.b.ii.c. Title V Workforce Capacity and Workforce Development

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

ADPH employs various positions that are instrumental in implementing various MCH positions. The department utilizes the State Merit Classification System to fill position vacancies. Qualifying applicants are placed on registers.

The ADPH MCH workforce includes a medical officer, a bureau administrator, a dental director, health service administrator, an epidemiology manager, research analysts and statisticians, as well as numerous administrative support assistants, social workers, and nurses. Form 7 provides more details regarding the department's workforce capacity and current vacancies.

BFHS has vacancies with three MCH-related positions. These include two health services administrators needed for the Perinatal Health Division and the OMCH director positions. The third vacancy is the epidemiologist for the PRAMS Program.

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

Gary Pugh, DO, joined BFHS in January 2022 as the BFHS medical officer. Before joining BFHS, Dr. Pugh worked as a private practitioner for over 20 years. Academic credentials include an undergraduate degree in Biology and a medical degree specialized in Obstetrics and Gynecology.

Amanda Martin, MSPH, started with ADPH in 2001 as a health educator. In 2008, she joined BFHS' WIC Division and was later appointed as the state WIC director in September 2013. Ms. Martin now serves as director of BFHS. Ms. Martin is also serving as the interim director for the Alabama Title V Program and PHD. 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 BFHS 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.

Tommy Johnson, DMD, joined BFHS in October 2017 as the ADPH state dental director. Before joining BFHS, Dr. Johnson worked as a private practitioner for over 28 years. Academic credentials include a medical degree specialized in Dentistry.

Samille Jackson, MSPH, began her career with ADPH in 2007 and transferred to BFHS in September 2017, as the first 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.

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 BFHS in July 2000. In April 2005, he assumed directorship of BFHS' Administrative Division. Academic credentials include an undergraduate degree in Accounting and a graduate degree in Business Administration.

Tim Feuser, MPH, joined BFHS in 2015 and serves as the director of the MCH Epi Branch. Prior to joining the branch, Mr. Feuser served as an epidemiologist in the Cancer Prevention and Control Division for the WISE WOMAN Program. Mr. Feuser is also the SSDI project director. Mr. Feuser earned his Master of Public Health degree at Georgia State University.

ADPH's workforce development activities are coordinated by the ER Division within the Office of Human Resources. ER is committed to ensuring a supportive and efficient workplace while promoting public health careers throughout the state. As such, ER serves as the liaison between the department and its workforce, providing guidance, training, and oversight in all aspects of human resource management. ER is responsible for the department's recruitment efforts and for reaching universities and colleges throughout the state. The communications and public relations specialist position was created with the goal of having a recruiter in each of the six public health districts. The recruiters' responsibilities are to ensure that universities and communities are aware of the various jobs that the department has to offer and to inform them of the department's current needs. They also serve as the face for career fairs and job fairs in the surrounding counties of their districts, bringing awareness to positions that the department has to offer. On September 26, 2024, the Office of Human Resources and ER hosted a Public Health 101 Career

Day. It was an invaluable opportunity for Public Health students from UAB, Auburn University at Montgomery, South University of Montgomery, and Samford University to engage with each department bureau and the various jobs within those bureaus. BFHS staff participated in the career day, giving students the opportunity to speak with public health professionals, providing a unique insight into various public health career paths.

Outside of departmental-sponsored development, employees seek opportunities available through national partnerships. Regarding recruitment and retention, ADPH partners with various colleges and universities within the state to host current students in nursing, public health epidemiology, and other disciplines. These partnerships provide ADPH with the opportunity to recruit and retain a highly skilled workforce. Through the internship program, individuals are offered an opportunity to make a positive contribution and to develop professional skills and experience.

Alabama Tile V leadership continues to seek guidance and assistance from the National MCH Workforce Development Center and apply for training opportunities presented by the Center, AMCHP, *HRSA*, and other state and federal partners to ensure our workforce has the knowledge and tools necessary for effective program planning and implementation

CRS: MCH Workforce Capacity

Given the nature of the services provided, CRS employs a workforce that consists of nurses, social workers, speech language pathologists, audiologists, physical and occupational therapists, and registered dietitians. A specialized staff allows for an interdisciplinary team to provide quality medical, rehabilitative, care coordination and support services for CSHCN and their families.

Current vacancies within the CRS District Offices include administrative support assistants, social workers, nurses, and audiologists. There are also three vacant LPC positions through the contract with Easter Seals of Central Alabama. See section III.C.1.b.iv. Family and Community Partnerships for additional information on the parent consultant positions. Recruitment efforts are underway to fill all vacant positions and include coordinating with ADRS Personnel and Human Resources Division to expand online job postings.

CRS experienced some staff changes at the ADRS State Office. These positions serve in leadership roles and contribute to all activities described in the State Action Plan.

Effective July 1, 2024, Ms. Kim McLaughlin who served as the CRS assistant director retired. Ms. McLaughlin had 25 years' experience at CRS. Given her extensive experience and knowledge Ms. McLaughlin participated on the interview panel for the new assistant director.

Effective August 1, 2024, Connie Martin, LICSW-S, began serving as the assistant director. Her academic credentials include an undergraduate and graduate degree in social work. Ms. Martin has over 17 years with CRS. She served as a care coordinator, social work administrator and most recently as the district supervisor for the Mobile District. However, her most important role has been as a mother of a CSHCN. Her daughter Taylor received CRS services for over 13 years before she passed away. Ms. Martin is an advocate for families of CSHCN and uses her experience to ensure services are delivered using a family centered approach to care.

Effective April 2, 2024, Carlene Robinson resigned from the epidemiologist, senior position. Dr. Robinson left CRS to pursue a career in academia.

Additional biographies of selected key Title V personnel in CRS:

Jane Elizabeth Burdeshaw, is the ADRS Commissioner. She has 27 years with the agency and has an MS degree.

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.

Stacey Neumann, LGSW, serves as the Maternal and Child Coordinator. Before joining CRS, she worked for ADPH serving in various roles throughout her 17-year public health career. Her academic credentials include an undergraduate degree in human development and family studies and a graduate degree in social work.

Kristin Moore, MSW, LICSW, serves as the Care Coordination Program Specialist. She has over 9 years' experience as a CRS staff member. Her academic credentials include an undergraduate degree in Psychology and graduate degree in Social Work.

Amy Ingram, Au.D., CCC-A, serves as the Audiology Program Specialist with CRS. She has over 12 years' experience as a pediatric audiologist with 5 of those years as a CRS staff member. Her academic credentials include an undergraduate degree in communication disorders and a doctoral degree in audiology.

Recognizing the importance of recruitment and retention in an everchanging workforce, the ADRS Commissioner and ELT work to identify ways to impact recruitment and retention across the agency. In Spring 2023, a Flexible Work Schedule Policy was implemented so that employees can choose an option that best fits their life and promotes a healthy work life balance. This year a new policy was implemented to reimburse for the renewal of professional licenses. These policy changes are a means to demonstrate the value of ADRS employees.

In addition, ELT implemented an ongoing email address specifically for obtaining recruitment and retention ideas from staff. These ideas are shared with the ADRS Recruitment and Retention Committee, which consists of supervisory staff from all divisions. The committee meets quarterly to discuss recruitment and retention strategies including staff suggestions and to determine which strategies to present to ADRS leadership.

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

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

To ensure the ongoing delivery of quality services, CRS has developed strong partnerships with colleges and universities across the state to recruit prospective employees. Staff either exhibit or present at the following annual events: the JSU Social Work Conference, UA Health Sciences Job Fair, the UA Career Fair, Tuskegee University Career Fair, Troy University Rehabilitation Counselor Program, Samford SLP School, and Auburn University Audiology Doctoral Students. CRS SLPs present to university speech programs statewide and teach SLP courses. To broaden the reach for potential recruitment opportunities, the ADRS Human Resources Development Division implemented LEaP. This program can be accessed by individuals searching for internships across the U.S. and provides an electronic and streamlined approach to those individuals interested in interning at CRS. The broader reach in turn, expands recruitment opportunities for CRS.

III.C.1.b.ii.d. State Systems Development Initiative (SSDI)

The purpose of the SSDI Grant is to develop, enhance, and expand Alabama Title V MCH data capacity. The 2025 Needs Assessment identified priority areas where FHS staff worked closely with the MCH Epi Branch to develop ESMs.

ADPH's capacity to provide MCH-related data enables programs such as lead, HCCA, FP, oral health, fetal infant mortality, and maternal mortality to make informed decisions on policy changes. SSDI staff's collaborative relationships with other ADPH programs strengthen FHS' data capacity in general and that of the Title V MCH Program. With access to the preceding data sources, the MCH Program works with individual FHS divisions and offices to effectively highlight the impact on the MCH population.

FHS partners with many and varied organizations, such as AMA, to ensure the achievement of the overall purpose of the federal SSDI and the MCH Block Grant. FHS and CRS staff collaborate to coordinate the MCH Block Grant application/annual report. SSDI staff work closely with the State MCH Coordinator to ensure that all items for the MCH Block Grant application/annual report are uploaded in a timely manner.

The following summary pertains to actual or anticipated accomplishments, barriers, and steps to overcome during the reporting period of December 1, 2024 through November 30, 2025. Effective November 1, 2024, the position of SSDI Project Director was transitioned from the MCH Epi Branch Director to the MCH Division/Title V Director. Effective May 16, 2025, the SSDI Project Director position was reinstated to the MCH Epi Branch Director upon the resignation of the MCH Division Director.

Goal 1: *Strengthen capacity to collect, analyze, and use reliable data for the Title V MCH Block Grant to ensure data-driven programming.*

Funded by OIDA, DataCamp licenses were provided to epidemiologists across ADPH to increase knowledge of Power BI, SAS, Python, and other programming languages. The priority area for the MCH Epi Branch is to complete Power BI training so that MCH dashboards can be implemented. The MCH Epi Branch strengthened its capacity to collect data for the Title V MCH Block Grant through REDCap. The MCH Epi Branch created online surveys for oral health, WW, and postpartum screening using REDCAP training videos. The OHO plans to use a QR code survey to evaluate the usefulness of oral health educational materials tailored for pregnant women and children. Oral health advocates will be given the opportunity to provide their location so OHO can better identify which areas of the state are being reached. Through a collaboration with PRAMS, a QR code to a survey was included on the fact sheet to increase the statewide distribution of dental health kits, also known as oral health kits in past MCH Block Grant submissions. To capture information about the new universal PPV NPM, the MCH Epi Branch developed a survey where mothers can answer questions on the barriers to postpartum care access. If the mother did attend a PPV, questions focused on the health topics, including mental health and birth control methods. A similar REDCap survey was developed to increase enrollment within active WW Program locations and capture knowledge of chronic diseases.

Goal 2: *Strengthen access to, and linkage of, key MCH datasets to inform MCH Block Grant programming and policy development and ensure and strengthen information exchange and data interoperability.*

As mentioned in Goal 1, REDCap surveys for select MCH population domains were developed to provide additional MCH datasets. The MCH Epi Branch staff attended meetings to build an Alabama Title V MCH HPV educational tutorial to educate oral health providers on how best to discuss the HPV vaccine with patients. With the implementation of these modules, AAP PROS can track those who completed the modules by profession. These modules are tailored towards dentists, dental hygienists, licensed practical nurses, nurse practitioners, registered nurses, and social workers. The MCH Epi director is in the final stages of identifying children with missing or unknown race by linking ACLPPP data to birth certificate data. With the hospital discharge data rollout, the MCH Epi Branch can now contact OIDA for data requests. MCH Epi staff are working to obtain severe maternal morbidity data using associated ICD-10 codes as referenced by the CDC. For the new additions to the MCH Block Grant, the MCH Epi staff connected with NCEMCH at Georgetown University, CAHD, and PHD staff to brainstorm data sources that can be used for the two new universal NPMs (MH and PPV). During this meeting, the NCEMCH team provided OMCH with a spreadsheet of strategies applicable to these NPMs. After internal discussion, staff reached out to AMA, OIDA, and ALL Kids as potential data sources to be used for the MH and PPV NPMs. If data can be obtained, linking educational efforts to these data sources will be the approach to assess improvement.

Goal 3: *Enhance the development, integration, and tracking of community health factors to inform Title V*

programming.

In November 2024, the OHEMH established the Health Equity Cross Collaboration Initiative Meeting. The goal of this meeting was to allow discussion of community health factors. The meeting serves as a platform to enable the ADPH programs to present any implemented initiatives to better serve Alabamians and promote collaboration across ADPH programs. One highlighted initiative was the Nutrition and Physical Activity Division's Pinterest recipe board. The recipe board provides nutritious recipes that are low-cost and easy to prepare. The OHO staff plans to attend future meetings.

Goal 4: *Develop and enhance capacity for timely MCH data collection, analysis, reporting, and visualization to inform rapid state program and policy action related to emergencies and emerging issues/threats, such as COVID-19.*

The MCH Epi Branch implemented the CDC's Link Plus record linkage tool during the FY 2024 reporting period to enhance data capacity for timely MCH data collection and analysis. For the Form 5 Pregnant population, this software calculates a likelihood score to determine if a pregnant mother received services for both a crib from the Cribs for Kids Program and a positive pregnancy test from FP to deduplicate program recipients effectively. To advance data capacity in SAS coding, the SSDI project coordinator completed the UAB School of Public Health Introduction to SAS course. As mentioned in Goal 1, the MCH Epi Branch has access to DataCamp, where new systems and data visualization methods can be practiced through Power BI.

Effective February 1, 2025, the MCH Epi Branch had two vacant epidemiologist positions for PRAMS and FIMR. Accounting for these vacancies, the SSDI project coordinator began providing technical assistance to the FIMR Program, and another MCH Epi Branch staff member was assigned to support the PRAMS Program. Due to uncertainty with future funding, the department is currently filling vacancies based upon approved funding. Staff will be transitioned to funded positions to the extent possible.

SSDI Goals and Objectives

A discussion of progress on SSDI goals and objectives is organized around the goals and the objectives within each goal. The discussion primarily focuses on objectives being addressed during the reporting period of December 1, 2024, through November 30, 2025. The remaining objectives for the four goals for the upcoming budget years are scheduled to be implemented accordingly.

Goal 1: Strengthen capacity to collect, analyze, and use reliable data

Goal 1 pertains to *strengthening the capacity to collect, analyze, and use reliable data for the Title V MCH Block Grant to ensure data-driven programming.*

The objectives listed for Goal 1 are straightforward activities requiring the building and expansion of MCH data capacity to support Title V efforts. The general approach to needs assessment involves collaborations, data analyses, compilations of findings, identifying priorities and associated ESMs, and report preparations.

Objective 1.1: *Provide details concerning involvement in assisting the state's Title V MCH Block Grant Program with the Title V MCH Block Grant 5-year Needs Assessment process.*

- Before meeting with UAB AEAC, SSDI met with MCH Program staff to identify the health issues respondents can select from across domains.
- A list of 35 potential key informant interviewees was provided to the UAB AEAC.
- A survey announcement was released for broad dissemination.
- The final survey for the MCH Needs Assessment was sent to UAB AEAC.
- The ADPH website was updated to encourage participation in the Title V MCH Needs Assessment. Survey announcement fliers were distributed to internal and external partners, including CHDs and other entities serving the MCH population, and posted on the ADPH Facebook page, LinkedIn account, and website.
- The Maternal and Child Health Needs Assessment Survey was open for the public through April 30, 2025.
- SSDI participated in the Prioritization Meeting, identifying Alabama's 7 - 10 priorities from the 2025 Needs

Assessment conducted by UAB AEAC.

Objective 1.2*: Provide details concerning involvement in assisting the state's Title V MCH Block Grant with development, selection, refinement, and tracking of data and performance measures that are associated with the Title V MCH Block Grant performance measure framework, NOMs, NPMs, SPMs, and ESMs.*

- SSDI had initial meetings with staff from the Child and Health and the Perinatal Health Divisions, as well as the OHO to discuss the measures reported in the previous 5-year report period. Upon receiving the Title V MCH Needs Assessment findings from UAB AEAC, SSDI met with program staff to review what respondents selected regarding health priorities and linking a measure for the priority area.
- When applicable, the impact of residential status was explored in the data sources used for the measures. Potential data sources for the universal NPMs (MH and PPV) were identified.

Objective 1.3*: By the annual deadline, submit the MCH Block Grant application/annual report.*

- For the Title V MCH Needs Assessment year, SSDI Program staff met to review data capacity on the health priorities identified from the 2025 Needs Assessment. SSDI requested a meeting with HRSA so that program staff could discuss the challenges with finding a data source for the universal MH NPM. SSDI continued efforts on the data components for the remaining forms.

SSDI requested data from AMA, JCDH, MCHD, and NBSP for external partners. SSDI reported the most current performance measures data from these sources.

Goal 2: Strengthen access to, and linkage of, key MCH datasets

Goal 2 pertains to *strengthening access to, and linkage of, key MCH datasets to inform MCH Block Grant programming and policy development, and ensuring and strengthening information exchange and data interoperability.*

Objective 2.1: *Provide details concerning involvement in developing and implementing a plan for overcoming barriers to data needs across the funding cycle for state Title V MCH Block Grant Programs.*

- SSDI connected with MCH District Coordinators during monthly meetings to offer any data support needs, specifically REDCap.
- Technical support for CAHD and PHD for the universal NPMs (MH and PPV) will continue.
- The indicators captured in the hospital discharge data will be explored to strengthen the narrative portion and measures.
- With the findings from the prioritization meeting, future meetings with program staff will be focused on the implementation of measures.

Goal 3: Enhance the development, integration, and tracking of community health factors

Goal 3 pertains to *enhancing the development, integration, and tracking of community health factors to inform Title V programming.*

Objective 3.1: *Work to provide more analysis of health factors.*

- MCH Epi staff provided data analysis, interpretation, and presentation for the 2019 - 2023 FIMR Annual Report, which is projected to be released in Summer 2025.
- MCH Epi staff provided data analysis, interpretation, and presentation for the 2022 Lead Annual Report, which is projected to be released in Summer 2025.
- MCH Epi staff provided data analysis, interpretation, and presentation for the 2020 – 2021 MMR Annual Report, which is projected to be released in Summer 2025.
- MCH Epi staff provided data analysis, interpretation, and presentation for the Oral Health brochure, fact sheet, and associated REDCap survey, which is projected to be released in Summer 2025.

- MCH Epi staff provided data analysis, interpretation, and presentation for the 2016 – 2022 PRAMS Annual Report, which is projected to be completed in Fall 2025.
- MCH Epi staff provided data analysis, interpretation, and presentation for the WW brochure, fact sheet, and associated REDCap survey, which is projected to be released in Summer 2025.

Goal 4: Develop and enhance capacity for timely MCH data collection, analysis, reporting, and visualization

Goal 4 pertains to *developing and enhancing the capacity for timely MCH data collection, analysis, reporting, and visualization to inform rapid state program and policy action related to emergencies and emerging issues/threats.*

Objective 4.1: *Develop better support for ongoing MCH needs.*

- MCH Epi Branch aims to create an MCH dashboard using Power BI.
- Continued use of the general MCH email address monitored by multiple staff to better support MCH's ongoing needs.
- Continued monitoring of the OMCH website to ensure the web page is current.

Plans for Upcoming Budget Year

For the upcoming budget year, the SSDI Program director will collaborate with program leadership to publish annual reports for ACLPPP, FIMR, MMR, and PRAMS. Addressing data barriers specifically with the universal NPMs (MH and PPV) for the MCH Block Grant will be the priority for the next budget year. SSDI continues to work with program staff to address any data-related concerns the reviewers might have for the next submission. With the resources available, SSDI continues to focus on increasing data capacity in ArcGIS Pro, Link Plus, Microsoft Access, Power BI, REDCap, and SAS.
A review of Alabama's current SSDI budget with the FHS Administrative Division prompts no action to revise the budget. For the next budget year, SSDI staff do not anticipate any future shift of grant funds totaling more than 25 percent. Based on current projections, no funds will be available for carry forward.

III.C.1.b.ii.e. Other Data Capacity

ADPH

FHS MCH Epidemiology Branch staff support several programs that receive Title V funding. Those programs include ACLPPP, WW, OHO, SPP, and FIMR. Staff create data reports, complete data requests submitted by individuals within and outside ADPH and participate in evaluation projects. The MCH Epidemiology Branch has access to the following data sources: ADPH EHR system, HHLPSS, PRAMS, Swaddle, CDC MMRIA, and Vital Stats. The MCH Epidemiology Branch provides technical assistance to program managers in developing local, state, and federal reports. The branch's support is necessary to implement effective and evidence-based MCH strategies in an effort to prevent or reduce disease, injury, disability, and mortality. Staff also supported activities of the Comprehensive Needs Assessment.

CRS

The ADRS Computer Services Division, in partnership with CRS, maintains and enhances the CRS CHARMS and its Business Information System platform to ensure accurate data collection and reports. Within these systems, data are collected regarding demographics, diagnostic criteria, enrollment, clinic visits, community wrap-around services, care coordination case numbers, plan of care status, and expenditures on client services. Informational reports can be generated in these areas at the district or office level and by individual employees. The system is also used to monitor and report on MCH Block Grant performance measures and required data points.

CRS State Office staff and computer services programmers have a CHARMS task force that holds regularly scheduled meetings to identify and prioritize needed system enhancements to ensure efficient and accurate data collection. Priority in FY 2024 was given to the continued development and testing of a charting template for the

registered dietitian nutritionists, which was released in May 2024. In addition, CRS and computer services staff continued working to implement electronic prescribing services through NewCrop, rolled out the ability to search for clients by date of birth, removed as much PHI from reports as possible, and continued enhancing the plan of care and improving reporting capabilities.

CRS leadership continues to utilize the efficiency measures that were identified through working with the National MCH Workforce Development Center. These measures include data elements from CHARMS that allow CRS to conduct quarterly reviews of overall clinic attendance, clinic attendance rates, clinic revenue, and expenses, utilizing enhanced system reporting. The trackable data is compiled in a dashboard, and trends are analyzed and discussed at leadership meetings. The information is utilized in policy development, determining budgets, and identifying staffing ratios.

III.C.1.b.iii. Title V Program Partnerships, Collaboration, and Coordination

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

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

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

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

ADPH leads, facilitates, and supports various task forces, steering committees, coalitions, and work groups to provide education, outreach, training, and resources during legislative meetings, annual summits, health fairs, and other exhibiting opportunities. In addition to being educational, these occasions provide the opportunity for Title V staff and partners to make recommendations ~~r~~egarding MCH strategies to improve health, prevent injuries, and reduce mortality for women, infants, children, and their families.

CRS
Throughout the application, CRS has highlighted various ongoing partnerships, collaborations, and coordination with entities across the state to ensure quality health care and services for CYSHCN and their families. Below are additional collaborative efforts to enhance the capacity to meet the needs of CYSHCN within ADRS and with other state and local entities.

ADRS is the state's lead agency for coordinating services for Alabamians with TBI. In partnership with the ADRS TBI Program, CRS provides care coordination to children with TBI and other acquired brain injuries. CRS TBI care coordinators attend regular core competency in TBI training sponsored by the TBI Program. Along with other ADRS staff, the CRS Care Coordination Program Specialist serves on the AHITF, which is the statewide advisory board for TBI in Alabama.

APTAT is one of 56 Assistive Technology Act Programs federally funded by HRSA and is administered through

ADRS. APTAT recently conducted a series of Rural Roadshows to increase awareness of and access to assistive technology in rural areas. CRS partnered with APTAT to identify host sites and recruit individuals to participate in the events. CRS also promotes the APTAT AT4ALL database of devices available for demonstration and loan to Alabama residents.

CRS partners with the UAB Center of Excellence on Developmental Disabilities to administer the PIPA Leadership Training Program for individuals with developmental disabilities and their family members. PIPA provides training for participants to develop the knowledge and skills needed to advocate for opportunities and supports that promote self-determination, independence, and integration in all aspects of community life for themselves and others. The partnership allows CRS PCs to participate in the program to enhance their understanding of advocacy and policymaking.

CRS partners with several entities to provide training to staff and families. A recent example is a series of trainings on supporting families in the school system, specifically regarding IEPs and 504s. The training was provided by the Alabama Parent Education Center, a non-profit organization that supports and assists underserved families, including those with disabilities.

CRS partners with Alabama Lifespan Respite to assist families in obtaining respite services. Alabama Lifespan Respite is a statewide program provided by United Cerebral Palsy of Huntsville. CRS care coordinators connect families with Alabama Lifespan Respite, where the family can receive financial assistance for respite services. Receiving respite services is a benefit that improves the family's overall quality of life.

CRS continues its partnership with the USA PCCC, which started when the USA PCCC served as the project site for the CMC CoIIN Project. CRS maintains an on-site care coordinator at the PCCC, which improves coordination between the clinic and CRS. The partnership has increased referrals to CRS and enables the care coordinator to assist in scheduling and case follow-up.

Alabama Hands & Voices is a parent-led, parent-driven non-profit organization supporting all families with children who are deaf or hard of hearing, regardless of communication choice. The organization embraces parent and professional collaboration to enable deaf and hard-of-hearing children to reach their full potential. They provide families with resources, networks, and information needed to improve their children's communication access and educational outcomes. CRS has an ongoing partnership with Alabama Hands & Voices and recently partnered to form a support group for teens who are deaf/hard of hearing. In addition to these initiatives, CRS staff work with an extensive group of partners such as the ARC of Alabama, Children's Harbor, United Ability, Auburn University Regional Autism Network, Full Life Ahead, Alabama Partnership for Children, ADPH OHO, and the WIC Program.

CRS staff in the local offices are skilled at community engagement and building relationships with healthcare and community-based providers, non-profit organizations, schools, and families. The staff are dedicated to strengthening the local system of care for CYSHCN through maintaining community partnerships. To build relationships with families, the local offices hold special events for CYSHCN throughout the year, including Wheelchair Washes, Back to School Events, Fall Festivals, Pictures with Santa, and Easter Egg Hunts. The events are held with support from local businesses, schools, non-profits, and community organizations. During these events, CRS staff and community partners provide information, build relationships, and most of all, provide a fun experience for CYSHCN and their families. Local audiology staff partner with Head Start and school systems during the Fall to conduct hearing screenings. Early detection of hearing problems can lead to improved school success. Staff also participate in community events such as local Special Olympics, resource fairs, and school events.

III.C.1.b.iv. Family and Community Partnerships

ADPH

BFHS continues exploring opportunities to involve families, youth, and fathers in more MCH Program planning and implementation activities. As plans for the next comprehensive needs assessment were developed, MCH leadership strategically identified community partners, to include local agencies, families, fathers, youth, and individuals self-identifying as specific ethnicities. Also, considering the success of the key connection that we

established during the 2020 Needs Assessment process, we continued our partnership with the Alabama Network of Family Resource Centers during the 2025 Comprehensive Needs Assessment. In collaboration with UAB AEAC, BFHS plans to facilitate connections between the Alabama Network of Family Resource Centers program consumers and MCH Program staff in an effort to involve these individuals and families in program design and policymaking to improve health and healthcare. BFHS continues to seek guidance from state and national partners on strategies to collaborate with community leaders and groups as well as families of every background in every step of program implementation, including needs and assets assessments, program planning, service delivery, program monitoring, and QI activities.

CRS

ADRS and CRS continue to have a commitment to family engagement and the principles of family-centered care. For over 30 years, this commitment has been an integral part of CRS, from direct services to infrastructure building and population health work. CRS's commitment to family engagement and family-centered care is evident through the Parent Connection Program. CRS makes a significant investment in family partnerships by employing parents and caregivers of CYSHCN who serve as PCs. The PCs carry out the activities of the Parent Connection Program while supporting families and sharing their individual experiences.

The current PC structure includes a full-time SPC, 2 part-time RPCs, and 10 LPCs located in CRS community-based offices. These positions are filled by parents who are full-time caregivers of CYSHCN. The SPC coordinates the CRS Parent Connection Program, serves on the CRS Management Team, advises in collaborative interagency efforts, recruits suitable candidates to fill LPC vacancies, facilitates the SPAC, and publishes the Parent Connection email newsletter. As a CRS staff member, the SPC is involved in all aspects of program planning and policy development. The SPC ensures the family perspective is included at the beginning stages of all CRS activities.

The RPCs supervise the LPCs and serve as a PC in their local office. The RPCs and LPCs provide the family perspective in policy development, serve on various community groups, collaborate with other parent organizations, and provide training opportunities for CYSHCN parents and caregivers. The RPCs and LPCs are included in discussions about clinic operations at their respective offices and provide insight on improving service delivery. The PC's' input is so valuable as they routinely meet with families and learn of issues, concerns, or ideas that might not be shared with other staff. New staff in local CRS offices spend time in orientation with the LPCs to learn more about their role and the principles of family-centered care. Most importantly, the LPCs provide ongoing peer-to-peer support to families receiving services through CRS.

The following stories from CRS LPCs illustrate the impact of the CRS Parent Connection Program:

"I met a family at the CF clinic whose child had just been diagnosed with autism earlier that day. I could tell that Mom felt defeated. Although they were there for their regular CF visit, I decided to talk to Mom about early intervention. I gave her resources close to her home that provided EI services, and also called the location to introduce her and to let them know she would be coming. I wanted to make it easy for her. Through early intervention services, her child is now receiving therapy and support to help with communication and social skills. Now, at the age of 3, her child is thriving in a mainstream daycare and continues to make progress with the help of ongoing support from early intervention services. I believe this story showcases exactly what CRS parent connection is about: recognizing needs and ensuring that resources are provided to our parents."

"As a Parent Consultant, I have been able to connect families to resources that they were not aware of, such as Medicaid Waivers, AlHipp, and respite (the BIG 3!). It is so rewarding when you see a family again after they have started utilizing these things. They come back with some financial relief, are more relaxed, and well... just happier! Having the opportunity to really connect with families, to really get to know them, to share our stories, and to hopefully help make their journeys a little easier just by listening, engaging, and sharing is so impactful."

To ensure that YSHCN have a voice, CRS has a Youth Connection Program to facilitate youth involvement in policy development and decision-making. As part of the Youth Connection Program, CRS employs two part-time YCs. The

individuals in these positions utilize their experiences to provide recommendations on policies that impact YSHCN and coordinate outreach efforts to engage with YSHCN across the state. YCs utilize social media to increase connections with YSHCN in Alabama through the Youth Connection Facebook page. The YCs also interact and share their experience transitioning from pediatric to adult health care. YCs present at the Annual Alabama Governor's Youth Leadership Forum (YLF). YLF is an innovative, intensive, 5-day career leadership training program sponsored by ADRS. The forum helps empower high school students with disabilities through sessions on self-esteem, self-advocacy, career choice, independent living, and leadership.

SPCs, RPCs, LPCs, and YCs are an integral part of ongoing needs assessment activities, including serving as members of the CRS Needs Assessment Advisory Committee. The SPC, LPC, and YCs are part of the Block Grant State Action Plan Team that meets monthly to discuss progress on the strategies and measures outlined in the plan. These individuals contribute greatly to the discussion as they are looking at the action plan through their individual experience.

Establishing advisory committees is an important component of the Parent and Youth Connection Programs. The SPC coordinates SPAC, which brings together LPAC members to meet with ADRS leadership, CRS State Office staff, and other agency partners. During the SPAC, individuals inform leadership of the current challenges and barriers in accessing care for CYSHCN, as well as successes in the system of care. In turn, CRS leadership utilizes this time to collaborate with families on policy development to improve service delivery within CRS. The family and leadership collaboration allows CRS to develop programs and services that are responsive to the needs using a family-centered approach.

The LPCs coordinate an LPAC in their district to identify and address issues related to navigating the system of care in their geographic location. The LPACs offer families the opportunity to provide input regarding CRS policy and program changes at the local level and to interact with local staff members. LPACs are opportunities for community partners to share information and for families to find mutual support by coming together with other families in their area. Some recent topics addressed in LPAC meetings include guardianship, supported decision making, sibling support, individualized education plans, dental health, first aid, and CPR training.

YCs coordinate a statewide YAC. The YCs hold YAC meetings to provide YSHCN a platform to inform CRS and its partners about concerns faced by YSHCN and to assist in developing programs to meet these needs. The YAC also provides a platform for youth to share and mutually support each other. In FY 2024, the frequency of YAC meetings was impacted due to vacancies in the YC positions.

In addition to coordinating advisory committees, the PCs at all levels work to address the needs of Alabama’s CYSHCN and their families. LPCs continue to coordinate and host the Family Connection Series, which was established during the pandemic. The sessions occur bimonthly. In FY 2024, topics included guardianship and conservatorship, pediatric feeding disorders, the Regional Autism Network, Respite, and supported decision-making.

SPCs, RPCs, and LPCs serve on many state and local committees and task forces, such as the FAN State Team, UCEDD, EI Interagency Coordinating Council, Alabama Newborn Hearing Screening Advisory Committee, APTAT Advisory Council, and Alabama Special Education Advisory Panel. The LPCs also represent CRS at many community events across the state, such as health fairs and expos. The LPCs coordinate the submission of nominees from each office for the “Hero of the Month” Award presented by the Kids Wish Network. Serving on these various committees and participating in outreach activities allow the LPCs to strengthen partnerships and identify opportunities for new partnerships with entities that serve CYSHCN. The SPC and LPCs also provide training to groups, including UAB SOPH students and the UAB Pediatric Pulmonary Center trainees.

Family Voices Partnership

CRS maintains a strong partnership with FVA, home of Alabama’s F2F HIC. A significant collaboration between CRS and FVA is the annual Partners in Care Summit, a project of the F2F HIC. This annual gathering is a great opportunity for learning, networking, and interacting with others who care about CYSHCN and their families. Participants develop strategies to strengthen partnerships between families and professionals, ultimately leading to

improved outcomes for CYSHCN. CRS' continued support has helped the conference to grow and allowed for national speakers to present on topics related to medical homes, transition to adulthood, and family/professional partnerships. The summit is attended by families, CRS staff from across the state, and other community partners. The theme of the 2024 Partners in Care Summit was "Partnerships that Assure a Good Life – For Everyone." There were over 160 people in attendance. Topics discussed included information regarding Medicaid waivers, navigating the system of care for YSHCN, and learning how to develop and use a Care Map. On the second day, providers and families met together, focusing on current challenges to developing quality systems of care for CYSHCN and their families in Alabama, as well as developing strategies to strengthen partnerships between families and professionals. The goal of all the discussions was to improve outcomes for CYSHCN and their families.

During the pandemic, the Family Resource Specialists from the F2F HIC and LPCs created a private Facebook group entitled, "AL Special Needs Parent Support Group." The group continued post-pandemic and is still active today. It has over 1,700 members and is a wonderful community for families of CSHCN to share information, supplies, equipment, and support.

CRS also assists FVA in collecting data about the needs expressed by families in the state and the types of information shared. Through a data-sharing agreement, CRS collects and shares data with FVA related to the six core outcomes. Historically, the highest number of requests are regarding accessing community services, followed by accessing a medical home, and partnering/decision-making with providers. Additionally, the data sharing agreement allows CRS to connect clients interested in participating in the Parent-to-Parent Program with FVA.

III.C.1.c. Identifying Priority Needs and Linking to Performance Measures

Final selection of priority needs was done in a two-phase process. As discussed above, both ADPH and CRS convened meetings with advisory committee members, partners, and stakeholders (including families and family-led organizations) to review synthesized data and provide input regarding potential priority needs through rating each need according to three criteria (importance based on data; alignment with other priorities and efforts in the state; and potential for effective approaches or solutions). Using a QR code, attendees entered criteria ratings into a form hosted on the Qualtrics Survey Platform that calculated average ratings for each need on each criterion, as well as the sum of all three. The average of the summed criteria ratings was used to establish the rank order of the priority needs. Following these meetings, synthesized data and preliminary rankings of needs were reviewed by ADPH's and CRS' respective leadership teams to select the final state priority needs. These meetings were facilitated by UAB and involved reaching consensus via discussions guided with the following criteria:

- Importance based on data
- Effective interventions or potential solutions
- Feasibility
- Alignment with other priorities and initiatives in the agency
- Opportunities to collaborate with national, state, and/or community partners
- Data/Method to assess availability

The following table presents the state priority needs aligned with selected measures driving improvement.

Priority Need	Measure	Domain
Comprehensive Postpartum Care and Education	NPM: Postpartum Visit	Women/Maternal
Infant Mortality	NPM: Safe Sleep	Perinatal/Infant
Access to Comprehensive Health Care	NPM: Medical Home	Child
Adolescent Safety and Wellness	NPM: Bullying	Adolescent
Comprehensive Care Coordination and Supports for System Navigation	NPM: Medical Home	CYSHCN
Transition to Adulthood	NPM: Transition	CYSHCN
Family and Youth Peer Supports	SPM: Family and Youth Supports	CYSHCN
Access to Comprehensive Oral Health Education and Services for all MCH Populations	SPM: Preventive Dental Visit	Cross-cutting

Though the additional identified needs for each domain were not included in the final list, ADPH and CRS leadership felt that through addressing the selected priority needs, many of these other needs could be addressed directly or indirectly through comprehensive strategies aligned under the selected NPMs and newly developed SPMs. Further, synthesized data summaries and all identified needs will be shared with partner organizations and publicly so that other groups can use the information to guide their work. The broader systems needs that cross-cut all domains were not included in prioritization and will be used as foundational considerations in the development of strategies that will support outcome improvements for all of Alabama's MCH populations.

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 nine identified needs are not included in the final list, the CRS State Office Leadership Team recognized that many of the other needs could be addressed directly or indirectly through comprehensive strategies aligned under the selected NPM (Medical Home). Inadequate supports for transition to all aspects of adulthood was the only CSHCN priority retained from the 2021-2025 needs assessment cycle. Through the addition of a new ESM and revised objectives and strategies, CRS will continue to enhance transition to adulthood services for YSHCN. Based on the overall findings CRS State Office Leadership Team made the decision to create a new SPM around the Family and Youth Peer Supports need topic versus the 2021-2025 SPM related to Family Engagement.

III.D. Financial Narrative

	2022		2023	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$11,482,727	$11,684,723	$11,523,951	$12,060,270
State Funds	$31,724,878	$38,348,573	$28,435,542	$46,069,628
Local Funds	$0	$0	$0	$0
Other Funds	$1,566,690	$892,986	$1,566,177	$1,779,852
Program Funds	$26,066,122	$29,024,019	$34,032,841	$38,674,960
SubTotal	$70,840,417	$79,950,301	$75,558,511	$98,584,710
Other Federal Funds	$123,892,360	$116,939,135	$113,526,397	$135,250,058
Total	$194,732,777	$196,889,436	$189,084,908	$233,834,768

	2024		2025	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$11,684,723	$12,021,137	$12,077,186	
State Funds	$37,841,184	$49,696,932	$45,484,837	
Local Funds	$0	$0	$0	
Other Funds	$1,577,948	$964,596	$1,536,572	
Program Funds	$33,881,586	$40,089,867	$36,646,585	
SubTotal	$84,985,441	$102,772,532	$95,745,180	
Other Federal Funds	$116,251,504	$147,128,740	$135,252,873	
Total	$201,236,945	$249,901,272	$230,998,053	

	2026	
	Budgeted	Expended
Federal Allocation	$12,021,137	
State Funds	$49,195,177	
Local Funds	$0	
Other Funds	$1,536,572	
Program Funds	$38,279,659	
SubTotal	$101,032,545	
Other Federal Funds	$147,137,014	
Total	$248,169,559	

III.D.1. Expenditures

ADPH

As per Block Grant requirements, the budget for each reporting year was set 2 years prior in the application (i.e., FY 2024 budget was set in the FY 2022 Annual Report). Over time, actual expenditures appear to give a more accurate reflection of costs expected instead of making estimates for a future budget environment 2 years out.
/2026/ ADPH continues to provide care coordination services to children identified with an abnormal NBS, NBHS, or an elevated lead level. Beginning in FY 2025, ADPH began providing FP Case Management services.

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 FY 2024 Annual Report Expended, all MCH cost centers spending on Preventive and Primary Care for Children was 52.06 percent, transferred 37.21 percent of the Block Grant to Children’s Rehabilitation Services which exceeded the federally required minimum of 30 percent and the administrative cost capped at 10 percent.

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

ADPH is currently attempting to provide a more complete report of persons served by Title V entities to better capture the full “reach” of the MCH Population. As an example, ADPH has sought to include estimates 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 an MOA. Medicaid agrees to reimburse ADPH for their proportionate share of FIMR Program services. Medicaid is billed on a quarterly basis for FIMR services based upon an agreed cost-basis capitated rate.

For a description of the FIMR Project, refer to the Perinatal/Infant Health Domain annual narrative.

Form 2: MCH Budget/Expenditures Details

Line 1A. (Preventive and Primary Care for Children) – FY 2024 Annual Report expended amount of $6.25 million increased from the FY 2022-2024 Application Budgeted amount of $5.35 million, a difference of $902 thousand or 16.86 percent. In FY 2022, when the budget was developed for 2024 the children served made up 45.8 percent of the total program cost compared to the actual expended in FY 2024 of 52.06 percent. The higher percentage in services to children results in an expected increase in the cost to the programs.

Line 1 (B). (Children with Special Health Care Needs) - FY 2024 Annual Report Expended amount of $4.47 million increased from the FY 2022-2024 Application Budgeted amount of $3.51 million, a difference of $967 thousand or 27.61percent. As specified in Section 505 (3) (B) of the Social Security Act “at least 30 percent of the MCH Block Grant award must be allocated for services provided to children with special health care needs”. When the FY 2024 budget was developed in FY 2022, 30 percent of the MCH Block Grant award of $11,684,723 was $3.505 million. The actual MCH Block Grant award for FY 2024 was $12,021,137, instead of the minimum 30 percent, CRS received 37.2 percent or $4.47 million. In 2024, ADPH was able to assist CRS by providing an additional funding of

$866 thousand above the required minimum to cover unfunded services to CSHCN. For the FY 2026 Application Budget, the CRS percentage is set at 35 percent. Based on the current NOA of $12,021,137, the CRS Federal Allocation would be $4,207,398.

Line 3. (State MCH Funds) - FY 2024 Annual Report Expended amount of $49.6 million increased from the FY 2022-2024 Application Budgeted amount of $37.8 million, a difference of $11.8 million or 31.33 percent. The State Match increase resulted from a combination of factors: (1) other support income rising FY 2024 to $43.6 million compared to $40.6 million budgeted for FY 2022-2024, a $3.0 million difference; and (2) increase in actual expenditures for FY 2024 to $80.0 million compared to the budget for FY 2022-2024 of $65.9 million, a difference of $14.1 million. The net differences of these two factors indicate that expenditures increased at a higher rate than income which requires a higher match contribution by ADPH of approximately $11.1 million. CRS' share of the change in State Match is $688 thousand or 5.49 percent.

Line 5. (Other Funds) – CRS FY 2024 Annual Report Expended amount was $965 thousand which is a decrease from the FY 2022-2024 Application Budgeted reported at $1.577 million, a decrease of $613 thousand or -38.8 percent. See CRS section for Form 2 explanation.

Line 6. (Program Income) – FY 2024 Annual Report Expended amount of $40.1 million increased from the FY 2022-2024 Application Budget amount of $33.9 million, a net difference of $6.2 million or 18.32 percent. The net $6.2 million increase is composed of the following factors. In FY 2024, the ADPH program that showed substantial increase when compared to the projected FY 2022-2024 budget was FP Medicaid ($4.4 million). The FY 2024 ADPH budget was built during a period of changing operations and anticipated loss in revenue from Medicaid networks providing case management services. ADPH program income increased more than the expected projection. CRS program income increased by $2.1 million, a 12.14 percent change during this reporting period. See CRS section for Form 2 explanation.

Form 2 (+/- 10% Variance)				
MCH	Budget	Expended		+/-10%
Bud/Expenditure Details	FY 2024	FY 2024	Difference	Variance
Preventive/Primary Care for Children	$5,355,859	$6,258,745	$902,886	16.86%
Children with Special Health Care Needs	3,505,417	4,473,156	967,739	27.61%
State MCH Funds	37,841,184	49,696,932	11,855,748	31.33%
Other Funds (CRS)	1,577,948	964,596	(613,352)	-38.87%
Program Income	33,881,586	40,089,867	6,208,281	18.32%
Totals	$82,161,994	$101,483,296	$19,321,302	23.52%

Line 9. (**Other Federal Funds**) – *These funds are under the control of the FHS Bureau/Title V MCH Director*. Reported are programs with +/- 10 percent cost variance when comparing FY 2022-2024 Application Budget versus FY 2024 actual expended.

Early Head Start Program - FY 2024 Annual Report Expended amount of $1.27 million increased from the FY 2022-2024 Application Budgeted amount of $878 thousand, a difference of $390 thousand or 44.4 percent. Most of the increase is related to personnel costs of $240 thousand and allocated costs to the program of $122 thousand, totaling $362 thousand.

Alabama Pregnancy Risk Assessment Monitoring System (PRAMS) – FY 2024 Annual Report Expended amount of $185 thousand increased from the FY 2022-2024 Application Budgeted amount of $158 thousand, a difference of $27 thousand or 17.58 percent. For FY 2024, the personnel cost increased approximately $28 thousand with 2.75 FTE's compared to 2.0 in FY 2022-2024.

State Systems Development Initiative (SSDI) – FY 2024 Annual Report Expended amount of $138 thousand decreased from the FY 2022-2024 Application Budgeted amount of $169 thousand, a difference of $31thousand or -18.27 percent. The program in FY 2024 included one EPI position compared to FY 2022 with a director and EPI position.

Well Women Program – FY 2024 Annual Report Expended amount of $1.625 million decreased from the FY 2022-2024 Application Budgeted amount of $1.773 million, a difference of $148 thousand or -8.35 percent. In the FY 2022-2024 application, the FY 2024 budgeted amount was incorrectly reported at $1.1 million. The correct amount should have been reported was $1.77 million. When comparing the actual FY 2024 expended of $1.63 million to the correct $1.77 million, a decrease $148 thousand which is less than the 10 percent variance at 8.35 percent. This explanation was added for clarity for the difference in the FY 2022-2024 application. During FY 2024, Well Woman was available in nine counties (Barbour, Butler, Dallas, Henry, Macon, Marengo, Montgomery, Russell, and Wilcox) with plans to expand into three additional counties (Bullock, Covington, and Lowndes) starting October 2024. Between implementation and FY 2024, program support and staffing increased to cover the Central Office and program needs in the current and expansion counties.

Women, Infants and Children (WIC) – FY 2024 Annual Report Expended amount of $142million increased from the FY 2022-2024 Application Budgeted amount of $112million, a difference of $30 million or 26.8 percent. Most of the increase is related to rise in Food Costs $26million, also added is $4 million associated with the cost centers that support increases in caseload. Average caseload increased from 108,660 in FY 2022 to 111,702 in FY 2024 difference of 3,042 or 3 percent.

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

Line 2. (infants less than 1 year) – FY 2024 Annual Report Expended amount of $6.71 million increased from the FY 2022-2024 Application Budgeted amount of $4.46 million, a difference of $2.25 million or 50.32 percent. From FY 2022 to FY 2024, net total infant activity increased by 1,453 or 26.4 percent. The increased activity results in an anticipated rise in costs of providing these services. During this period most of the change was in Jefferson County with activity increasing by 1,631 with Mobile County offsetting the total activity by -183.

Line 3. (children 1-22 years) – FY 2024 Annual Report Expended of amount $52.6 million increased from the FY 2022-2024 Application Budgeted amount of $40.7 million, a difference of $11.9 million or 29.2 percent. Total cost increased 28 percent from FY 2022 ($80 million) to FY 2024 ($102 million). During FY 2022, children 1-22 years of age made up 90 percent of total child health visits. In FY 2022, total budgeted cost for FY 2024 was reported at $85 million. After excluding from the calculation (PW, Infants, CRS, Adm.) net total budgeted cost for 1-22 years is $40.7 million. In FY 2024, children 1-22 years of age made up 89 percent of total child health visits. Total expended cost was reported at $102 million. Excluding from the calculation (PW, Infants, CRS, Adm.) net total expended cost for 1-22 years would be $52.6 million. The result children 1-22 activity increased (50,154 to 54,504) 8.67 percent and cost was up $11.9 million during the referenced time.

Line 5. (All Others - Adm) -- FY 2024 Annual Report Expended amount of $4.42 million increased from the FY 2022-2024 Application Budgeted amount of $3.98 million, a difference of $444 thousand or 11.17 percent. The factors affecting the change in cost is seen in personnel cost: 2 cost-of-living raises, annual merit raises, and healthcare benefits increasing over the 2-year span.

Form 3a (+/- 10% Variance)

Individuals Served	Budget FY 2024	Expended FY 2024	Difference	+/-10% Variance
Pregnant Women	$393,942	$398,727	$4,785	1.21%
Infants< 1 Year	4,461,628	6,706,671	2,245,042	50.32%
Children 1-22 Years	40,692,583	52,580,607	11,888,024	29.21%
CSHCN	35,461,862	38,666,882	3,205,020	9.04%
All Others	3,975,425	4,419,645	444,220	11.17%
Totals	**$84,985,441**	**$102,772,532**	**$17,787,091**	**20.93%**

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 2024 Annual Report Expended amount of $54.4 million increased from the FY 2022-2024 Application Budgeted amount of $41.9 million, a difference of $12.4 million or 29.7 percent. From FY 2022 to

FY 2024, FP visits increased 3 percent and Child Health visits were up 10.4 percent. As expected with the changes in activity, Direct Services net cost increased $10.2 million. Increases were seen in cost centers related to Family Planning Exam (463) $5.7 million and Child Health Primary Care (027) and Assessment (025) $4.4 million. CRS cost for Direct Services increased $2.2 million during the reporting period. See CRS section for Form 3b explanation.

Line 2. (Enabling Services) - FY 2024 Annual Report Expended amount of $16.0 million increased from the FY 2022-2024 Application Budgeted amount of $13.9 million, a difference of $2.1 million or 14.71 percent. ADPH share of the net increase in cost was $878 thousand. ADPH programs with most of the changes were FP Referrals ($1.34 million) offset by a decrease in FP Community Health Advisor (-$518 thousand). CRS share of the cost was $1.2 million. See CRS section for Form 3b explanation.

Line 3. (Public Health Services) - FY 2024 Annual Report Expended amount of $32.4 million increased from the FY 2022-2024 Application Budgeted amount of $29.1 million, a difference of $3.3 million or 11.30 percent. Prior to FY 2024, FP clerical services were rolled up with FP Exams into Direct Care, however after discussion with the FP director, 50 percent of the cost should be considered Public Health Services based, with this change resulting in a net increase of $4.4 million. This was offset by CRS share of Public Health Services cost which decreased by -$1.2 million. See CRS section for Form 3b explanation. //2026//

Form 3b (+/- 10% Variance)

Individuals Served	Budget FY 2024	Expended FY 2024	Difference	+/-10% Variance
Direct Services	$41,923,093	$54,368,196	$12,445,103	29.69%
Enabling Services	13,982,089	16,038,513	2,056,424	14.71%
Public Health Services	29,080,258	32,365,823	3,285,565	11.30%
Totals	**$84,985,440**	**$102,772,532**	**$17,787,092**	**20.93%**

CRS

/2026/ Per Block Grant requirements, the budget for each reporting year is set 2 years prior in the application (i.e., FY 2024 budget was set in the FY 2022 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.

Each year CRS expends funds to promote and support family engagement through our Parent Connection Program. Specifically related to the employment and support of parents/caregivers of CYSHCN as PCs. The actual expenditures related to the program can fluctuate based on the number of filled positions each FY. The budget includes 1 SPC, 12 LPCs, and 2 YC positions however the expenditures vary due to turnover and vacant positions. CRS also expends funds to support specific activities of Alabama's F2F HIC. See section III.C.1.b. iv. Family and Community Partnerships for more detailed information related to the Parent Connection Program and F2F support.

Form 2: MCH Budget/Expenditures Details

Line 5. (Other Funds) – CRS FY 2024 Annual Report Expended amount of $964 thousand decreased from the FY 2024 Application Budgeted amount of $1.5 million, a difference of $613 thousand or 39 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.

Line 6. (Program Income) – CRS FY 2024 Annual Report Expended amount of $19.9 million increased from the FY 2024 Application Budgeted amount of $17.8 million, a difference of $2 million or 12 percent. The increase is a result of the budgeted amount being based on a lower Medicaid cost-based reimbursement rate. FY 2024 yielded a higher Medicaid clinic encounter rate and visits which impacted the actual program income received in FY 2024.

Form 2 (+/- 10% Variance)				
MCH	Budget	Expended		+/-10%
Budget/Expenditure Details	FY 2024	FY 2024	Difference	Variance
State MCH Funds	$12,532,758	$13,221,266	$688,508	5.49%
Other Funds	1,577,948	964,596	(613,352)	-38.87%
Program Income	17,815,829	19,978,838	2,163,009	12.14%
Totals	$31,926,535	$34,164,700	($2,238,165)	7.01%

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

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

Using new methodology and a greater understanding of the three levels of service it was determined that non-federal funds previously reported in Public Health Services and Systems on Form 3b Non-Federal MCH Block Grant should be allotted to the Direct Services level. CRS, as the Alabama CSHCN Program, provides clinical medical and evaluation services to children and youth with special health care needs in the state and as such allots funds to provide these services. It was also determined that CRS care coordination activities should be reported in Enabling Services. CRS employs 34 nurses and 56 SWs that provide care coordination services for CSHCN and their families. These activities had previously been reported between Direct and Public Health Services and Systems. The current variance in service level expenditures is primarily due to the budget being set 2 years prior. //2026//

Form 3b (+/- 10% Variance)				
	Budget	Expended		+/-10%
Individuals Served	FY 2024	FY 2024	Difference	Variance
Direct Services	19,333,649	$21,550,398	$2,216,749	11.47%
Enabling Services	6,071,725	$7,249,967	1,178,242	19.41%
Public Health Services	6,551,071	$5,393,361	-1,157,710	-17.67%
Totals	$31,956,445	$34,193,726	$2,237,281	7.00%

III.D.2. Budget

ADPH

/2026/ Alabama remains one of the nation's only states that separates general government and education funding into two separate budgets: the general fund budget and the ETF budget. The $3.7 billion State General Fund passed is a $347 million increase over FY 2025. The FY 2026 General Fund budget will allocate funds for non-education state programs, such as Medicaid, prisons, courts, law enforcement, mental health, public health, and others. The budget is 6 percent higher than FY 2025. Alabama's record-setting General Fund is generational money which makes possible greater investments in vital public services. AMA will receive $1.18 billion, a $223.8 million increase over FY 2025. Public Health receives $159 million, a $28 million increase over FY 2025.

At the end of FY 2024, Alabama Title V MCH Program received total funding of $12,021,137. The most recent final funding level received was for FY 2024 which was used in FY 2025 and will be used for this current MCH application. The FY 2026 president's budget request for the MCH Block Grant program is $767 million. The request includes $593 million for formula awards to states to promote and improve the health and wellbeing of the nation's mothers, children (including CYSHCN), and their families. This level for the states is consistent with FY 2024 final and the FY 2025 enacted funding.

The Title X FP Program in FY 2025 was level funded at $5,549,663 and will be budgeted at this level for the FY 2026 application. In summary, there is a possibility that Title X funding will be eliminated in FY 2026 based on the president's budget proposal. This has caused concern among healthcare providers and FP advocates. However, the situation is dynamic, with an ongoing lawsuit filed by NFPRHA. The future of Title X funding depends on developments related to the FY 2026 budget proposal and legal challenges.

FHS has faced both budget challenges and successes during the current FY. This includes both federal and state funding sources. This has allowed FHS the opportunity to explore new ways to implement programs.

Alabama WIC spent much of the year operating under a continuing resolution while also experiencing increases in food costs. Alabama WIC was able to sustain its caseload and support increases in food redemption. The program has benefited from reallocations during the year.

The Cancer Prevention and Control Division received full funding for the Alabama Breast and Cervical Cancer Early Detection Program. Enrollment criteria are maximized and approximately 11,000 women are expected to be screened.

Alabama's Title X Program continues to provide a comprehensive contraceptive menu, including IUDs and implants to any woman of childbearing age in any of the 81 sites across the state, which includes a health department in every county.

The program purchased and promoted HPV vaccination throughout the state again this year, ensuring the most vulnerable access to the vaccine. The FP/Title X Program continues to provide cancer detection exams for our patients. The program has a robust breast exam and follow-up system that includes referrals for genetic testing, if indicated. We continue to advance the colposcopy services, improving access to care by having a trained NP in each of our six districts. In 2024, the trained NPs completed 894 colposcopies for our ADPH patients, preventing the undue burden of traveling for the procedure. We are currently working on certifying five additional NPs for colposcopy, ensuring easier access for our patients.

The Newborn Screening Program requires all infants born in Alabama to have a blood spot test completed and sent to the ADPH Bureau of Clinical Laboratories to determine if there is a genetic disorder. FHS continues to provide case management for infants screening positive for a disorder and those with failed hearing screenings. The program cover personnel costs for FHS SWs to track and refer infants.

The MCH Block Grant continues to provide funding to SSDI and PRAMS to ensure that quality work continues with both programs. The Lead Title V epidemiologist provides in kind support and supervision. This has allowed for

increased collaborations and data sharing across all MCH programs.

APPB continues to receive grants from the Department of Health and Human Services, Administration for Children and Families. Alabama receives awards from the Title V SRAE Program and PREP. SRAE provides education to youth on the optimal health behavior of avoiding non-marital sexual activity and other risky behaviors. Evidence-based and/or evidence-informed programming is provided in community-based settings as requested. PREP provides education to young people on both abstinence and contraception to prevent pregnancy and STIs, including HIV/AIDS. During FY 2025, APPB is working to restructure their model of program delivery, allowing the program to offer services in additional counties. APPB plans to continue reviewing curricula options and intends to offer additional program models during FY 2026 to increase program reach.

The continued support of community water fluoridation by the OHO remains intact. Funding opportunities for updating fluoridation equipment, purchasing new fluoridation equipment, and providing funds for community water fluoridation initiation in previously non-adjusted systems are carried out by submission of a competitive RFP process. In 2025, grant funding was awarded to four systems, enabling uninterrupted fluoridation to the communities they serve. It is the intent of the OHO to issue funding opportunities on an annual basis, pending any local or statewide mandates which would dictate otherwise.

Access to maternity care continues to be an issue in Alabama. In 2024, Alabama lost another delivering hospital, taking the number to 43 hospitals remaining in our state's
67 counties. Funding was received from the Governor's office and extensive work is ongoing to develop a pilot program that will provide access to prenatal care in rural areas through various delivery methods. By providing prenatal care to individuals in areas with high infant mortality rates, ADPH hopes to see a decline in infant mortality and premature delivery rates over time.

ADPH is preparing to provide FP case management to all Medicaid enrollees beginning in FY 2025. ADPH began providing FP Case Management in FY 2025 and plans to continue this service for FY 2026. From 2019 to 2024, case management has been provided via Medicaid’s ACHN. //2026//

CRS

/2026/ The Alabama CSHCN Program is administered by CRS, a division of ADRS. ADPH contracts with CRS, to provide services for CSHCN and allocates the required 30 percent of Title V MCH Block Grant funds to CRS for this effort. MCH Block Grant funds are a critical financial piece of support, along with state support for ADRS. As per block grant requirements, the budget for each reporting year is set 2 years prior in the application. CRS bases the budget on expenditures for the preceding FY and the CRS legislative budget request at that time.

Each FY supervisors and directors within CRS and ADRS offices submit their budget requests via the ADRS electronic BEACH. The individual district budgets and State Office budget are reviewed with the ADRS Office of Accounting and the ADRS Commissioner. The ADRS Commissioner, Chief Financial Officer, accounting staff and CRS program staff discuss the budget requests and make any necessary updates prior to final submission. Anticipated changes to CRS programs, staffing needs, and levels of support are discussed during the budget reviews. The overall goal is to ensure CRS serves CSHCN in an effective and fiscally responsible manner. Funds are allocated based on the final and approved budgets.

CRS provides services to CYSHCN and their families through the following programs: Clinical Medical, Clinical Evaluation, Hemophilia, Care Coordination, Information and Referral, Parent Connection, and Youth Connection. The budget supports these programs by providing direct services to CYSHCN and their families, enabling services through the Care Coordination Program, and infrastructure and program planning through public health systems and services.

The budget includes funding for the Parent Connection Program that employs individuals who serve as PCs and to support specific activities of Alabama’s F2F HIC. See Section III.C.1.b. iv. Family and Community Partnerships for more detailed information related to the Parent Connection Program and F2F support.

In FY 2026, CRS anticipates receiving 4.2 million in MCH funds, a state allocation of approximately $12.7 million, a state allocation for the Alabama Hemophilia Program of $1.2 million and anticipates 17.9 million from program income. CRS anticipates receiving $37,300 from the Maternal and Child Health Bureau as a sub-grantee to Hemophilia of Georgia to provide comprehensive care to persons with hemophilia. These funds will be used to continue providing quality services to CSHCN.

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.3., State Action Plan Narrative by Domain. //2026//

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

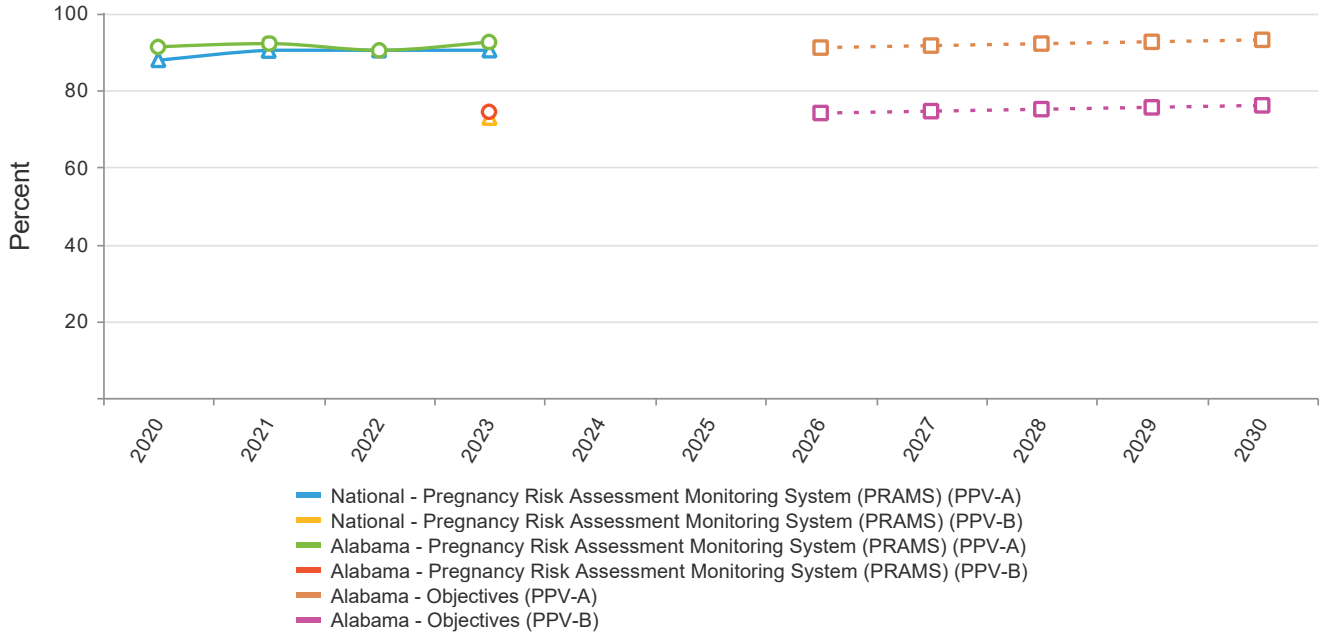
III.E.3 State Action Plan Narrative by Domain

If a Priority Population is selected for an NPM, then this section will display only the data associated with the Priority Population in the charts, data tables, and field notes. Additional NPM data are available in the Form 10 appendix.

Women/Maternal Health

National Performance Measures

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components - PPV
Indicators and Annual Objectives



NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth - PPV

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2023	**2024**
Annual Objective		
Annual Indicator	90.1	92.3
Numerator	47,402	48,210
Denominator	52,623	52,236
Data Source	PRAMS	PRAMS
Data Source Year	2022	2023

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	91.0	91.5	92.0	92.5	93.0

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components - PPV

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2023	**2024**
Annual Objective		
Annual Indicator	77.6	74.4
Numerator	36,618	35,476
Denominator	47,206	47,663
Data Source	PRAMS	PRAMS
Data Source Year	2022	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	74.0	74.5	75.0	75.5	76.0

Evidence-Based or –Informed Strategy Measures

ESM PPV.1 - Percent of postpartum survey respondents who attend their postpartum visit appointment.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	50.0	52.0	54.0	56.0	58.0

State Performance Measures

SPM 1 - Percent of survey respondents ages 15 to 55 eligible to enroll into WW who report having a trusted birth control method and are not planning for a pregnancy within the next 12 months.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	50.0	51.0	52.0	53.0	54.0

Evidence-Based or –Informed Strategy Measures

None

State Action Plan Table

State Action Plan Table (Alabama) - Women/Maternal Health - Entry 1	
Priority Need	
Comprehensive Postpartum Care and Education	
NPM	
NPM - Postpartum Visit	
Five-Year Objectives	
By 2030, at least 54 percent of REDCap survey respondents reported attending at least one postpartum visit within 12 weeks of delivery.	
By 2030, attend 200 community outreach events statewide to distribute the postpartum bookmarks among the MCH pregnant population.	
Strategies	
Coordinate ACHN maternity care case workers to provide postpartum educational materials statewide.	
Coordinate with FIMR nurses to distribute postpartum educational materials within their perinatal regions.	
Coordinate with various providers and hospitals to distribute postpartum educational materials statewide and emphasize the importance of postpartum care.	
ESMs	**Status**
ESM PPV.1 - Percent of postpartum survey respondents who attend their postpartum visit appointment.	Active
NOMs	
Maternal Mortality	
Neonatal Abstinence Syndrome	
Women's Health Status	
Postpartum Depression	
Postpartum Anxiety	

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

Priority Need

Comprehensive Postpartum Care and Education

SPM

SPM 1 - Percent of survey respondents ages 15 to 55 eligible to enroll into WW who report having a trusted birth control method and are not planning for a pregnancy within the next 12 months.

Five-Year Objectives

By 2030, at least 54 percent of all survey respondents reported not planning for pregnancy due to access of a trusted birth control method

By 2030, an additional 5 percent of all WW enrollment resulted from participation from the REDCap survey.

By 2030, attend at least 30 community outreach events and health fairs to promote WW and encourage completion of the REDCap survey

Strategies

Share the QR link to REDCap survey on social media websites including the WW Facebook page.

Coordinate WW outreach events with the MCH District coordinators to expand area of reach for the QR code.

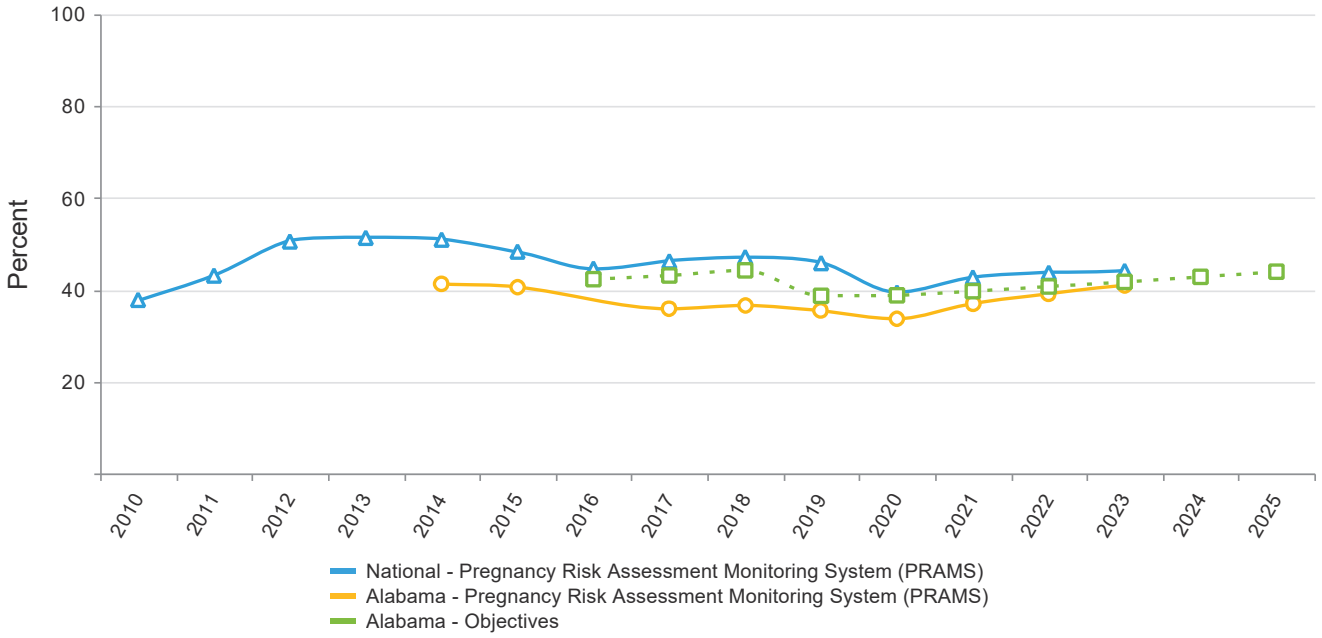
Aim to achieve at least a 10 percent REDCap survey response rate annually among eligible WW participants being seen at active WW CHDs to answer questions concerning their access to a trusted birth control method.

ESMs	Status

No ESMs were created by the State. ESMs are optional for this measure.

2021-2025: National Performance Measures

2021-2025: NPM - Percent of women who had a dental visit during pregnancy - PDV-Pregnancy Indicators



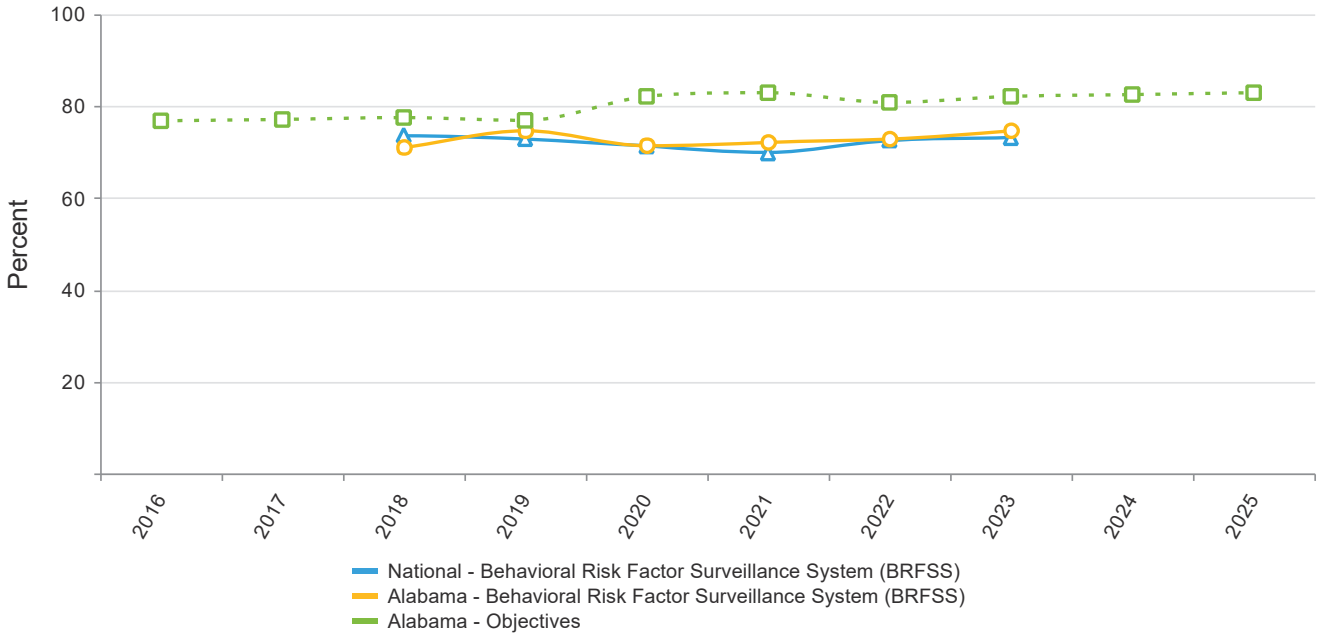
Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	38.8	39.7	40.7	41.7	42.8
Annual Indicator	35.4	33.6	37.1	39.1	41.1
Numerator	19,451	15,240	19,911	21,200	22,238
Denominator	54,884	45,331	53,737	54,271	54,050
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2022	2023

2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM PDV-Pregnancy.3 - The number of providers including hygienists, nurses, social workers, physicians, pediatricians, nutritionists, and dentists who were provided oral health education and training tailored specifically to the MCH pregnant population

Measure Status:	**Active**	
State Provided Data		
	2023	**2024**
Annual Objective		
Annual Indicator	19	106
Numerator		
Denominator		
Data Source	OHO	OHO
Data Source Year	FY 2023	FY 2024
Provisional or Final ?	Final	Final

2021-2025: NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV Indicators



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	82	82.8	80.7	82	82.4
Annual Indicator	74.4	71.4	72.0	72.7	74.5
Numerator	629,176	607,073	622,981	631,221	667,996
Denominator	846,056	850,307	865,327	868,542	897,120
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2019	2020	2021	2022	2023

2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM WWV.2 - Increase the percentage of women receiving both FP services and WW services by two percent within active WW counties.

Measure Status:	Active		
State Provided Data			
	2022	**2023**	**2024**
Annual Objective			7.1
Annual Indicator	5.1	6.2	6.1
Numerator	200	305	319
Denominator	3,885	4,891	5,188
Data Source	Cure MD	Cure MD	Cure MD
Data Source Year	FY 2022	FY 2023	FY 2024
Provisional or Final ?	Final	Final	Final

Well Woman Program

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

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

The goal of the ADPH WW Program is to provide preconception, inter-conception, and post-conception health care to women of childbearing age as a foundation for wellness and to reduce cardiovascular disease (CVD) risk factors in Alabama. The program activities that support the prevention and maintenance of chronic disease and a healthy lifestyle are preconception, inter-conception, and post-conception health planning; CVD risk factor screening; risk reduction counseling to help women understand their risks and discuss the participant's readiness to embrace healthier behaviors; health coaching and support to set goals and help women discover healthy lifestyle behaviors to prevent, minimize, or delay the onset of chronic disease; vision screening; oral screening; and continued education to county health department staff on the benefits of a referral from FP to WW for health screening, goal setting, and healthy lifestyle education.

The potential impact on maternal health inequities through the WW Program is a decrease in hypertension and BMI; an increase in understanding the impact of chronic disease on maternal morbidity and mortality through preconception, inter-conception, and post-conception education; CVD risk factor screening through risk reduction counseling with the NP; an increase in knowledge of healthy behavior through quarterly health coaching with the WW social worker(s), education with a registered dietician; and continuity in preventative health care through the availability of services offered by the WW and FP programs in the CHDs in active WW counties.

A WW visit consists of enrollment with the WW social worker, a CVD risk factor screening by the registered nurse or NP; an annual or initial FP visit as necessary, or other visit type within the scope of the ADPH services; preconception, inter-conception, and post-conception planning needs; risk reduction counseling with the NP; health coaching and case management with the social worker; and identification of any alert lab values to be assessed by the NP or a PCP with education provided to the participant. Cardiovascular health, diabetes, nutrition, and physical activity pamphlets and educational materials are provided to the participant as needed in English and Spanish. Participants also receive nutrition counseling and education with a registered dietitian.

Enrollment with the WW social worker includes a psychosocial assessment screening using the SBIRT universal mental health and substance use screening tool, and discussion of the participant's current habits related to healthy behaviors through the WW Baseline 1 Questionnaire. This questionnaire addresses the Transtheoretical Model (TTM), also known as the Stages of Change Model. The stages are precontemplation, contemplation, preparation, action, maintenance, and relapse. This information gives the staff and participants insight into where each participant is in their journey to sustain a healthier lifestyle and how they can better work toward making changes and maintaining goals that are set. Case management involves three health coaching sessions, a 7-month follow-up, and case management as needed. Through the health coaching sessions, the social worker helps establish goals to address identified risk factors or other psychosocial needs impacting health and provide interventions through case management to help participants reach their goals. In the 7-month follow-up, the social worker reviews progress made by the participant toward the goals set and measures the Baseline 1 Questionnaire responses to determine changes and/or improvement in knowledge and healthy habits. The WW social work staff continued to work within the social work protocol and documentation guidance that was completed in FY 2023. This protocol implementation and documentation update created guidance for the social workers and allowed for more continuity in WW counties.

These updates and streamlining in documentation also allowed the program to create a report to track health coaching sessions that are completed, thus improving 2024 data reported.

The WW Program was available in nine counties in Alabama for FY 2024. The counties included Barbour, Butler, Dallas, Henry, Macon, Marengo, Montgomery, Russell, and Wilcox. Future expansion is a goal of the program to continue to educate women on the importance of preconception, inter-conception, and post-conception health planning to improve the health of women of childbearing age and to decrease the rates of maternal and infant mortality. The map below illustrates the WW counties operating in FY 2024 and the counties added in FY 2025.

The WW Program utilizes the “A New Leaf: Choices for Healthy Living” curriculum. This curriculum is a nationally recognized, science-based intervention tool that emphasizes practical strategies for making changes in dietary intake and physical behaviors. The New Leaf manual and cookbook are available in English and Spanish. As a part of the program, a registered dietician also offers classes to provide education and nutrition counseling so participants can make informed choices about their eating habits. Increased physical activity is also an important component of ensuring optimal health and is encouraged through goal setting with the WW social worker and NP. Physical activity resources are provided through the dissemination of educational material and barrier reduction tools to sustain a healthy lifestyle. Partnerships with local community businesses and programs also allow participants to engage in physical activity either virtually or in person. The program accepts referrals from a variety of sources, including, but not limited to, self-referrals, referrals from community partners, local physicians, and other

programs within ADPH, such as FP. Throughout FY 2024, referrals were also received from 211KNOW, a health and wellness messaging service.

OWH and WW continue to partner with the Alabama Women's Commission and exploreMedia for 211KNOW to compile researched nutritional and physical activity information sent through weekly text messages to program participants to promote health and well-being. Participants received these encouraging, educational messages at the same time twice weekly, which allowed them to have access to recipes, self-improvement, physical activity tips, and other tools to empower women in their journey to adopt a healthier lifestyle. The geographical areas targeted within Alabama were Autauga, Barbour, Bibb, Bullock, Butler, Sumter, Chambers, Chilton, Choctaw, Clay, Coosa, Crenshaw, Dallas, Elmore, Greene, Hale, Lowndes, Macon, Marengo, Montgomery, Lee, Perry, Pike, Randolph, Russell, Tallapoosa, and Wilcox Counties. The campaign sent a total of 104 messages to the targeted audience, and there was a total of 17,959 links accessed from 8,282 subscribers in the same targeted geographical area throughout the year. The 211KNOW successes for FY 2024 were an 83 percent increase in enrollment, a 300 percent increase in social media subscriber recruitment, and an increase in awareness of 211KNOW with over 10.7 million views on social media. The 18 outreach events generated more subscribers, which increased the number of women getting health and wellness education on a consistent basis. The goal moving forward into 2025 is to continue to partner with the Alabama Women's Commission and the OWH Steering Committee to provide these educational messages to reach women throughout the state.

Telehealth is incorporated into the program protocol as an option for follow-up with the NP in completing the risk reduction counseling session. The risk reduction counseling session is typically completed in person on the same day as the enrollment screening and includes a review of medical history, a healthy lifestyle assessment to include preconception, inter-conception and post-conception health planning to increase knowledge of the impact of chronic disease related to maternal morbidity and mortality;, a review of lab and clinical results from the enrollment screening;, a review and/or conduction of a CVD 10-year risk calculation (if not done) and discussion;, a review of the baseline/risk reduction data information in the EHR;, determination of a target blood pressure reading for participants with hypertension;, a review of the participant's priority areas and determination of readiness for change;, a discussion of diet and physical activity;, and a determination of the participant's ability to participate in physical activity. A home BP monitor with BP log is given to each participant on initial enrollment, and education is provided by the RN/NP. The program also offers nutrition classes, support groups, and physical activity resources virtually. Program implementation of virtual means created flexibility and the opportunity to reach program participants in a capacity that has the potential to impact their lifestyle and behaviors regarding the goals made to improve their health.

In FY 2024, the WW Program enrolled a total of 532 participants. Of these 532 participants, 319 were referred from FP, 15 percent enrolled with a BMI greater than 25 (overweight), 80 percent enrolled with a BMI greater than 30 (obese), and a total of 44 percent showed a decrease in BMI from enrollment to their next annual appointment. The program recognizes hypertension as a systolic reading greater than or equal to 130 and a diastolic reading greater than or equal to 80. On the initial WW visit, 57 percent of participants had a blood pressure reading greater than 130/80. Three hundred and forty-two or 64 percent of the total number of women enrolled have been involved in the program and were returning for annual enrollment. Of the 342 participants who returned for an annual screening, 42 percent had a decreased BP. The average age of participants enrolled in FY 2024 was 39 years, with 3 percent of participants enrolled identifying as Hispanic, 10 percent of participants enrolled identifying as white, and 87 percent of participants enrolled identifying as black.

In FY 2022, an average of 20 percent of WW participants returned for an annual screening. In FY 2023, WW saw an increase where 43 percent of participants returned to the program for annual enrollment. FY 2024 also experienced an increase with an average of 64 percent of participants returned for annual enrollment appointments to continue in

the program. There are several factors that contributed to this increase in participant returns for annual screenings. The addition of the social work protocol provided organization, guidance, and continuity in enrollment, case management, and follow-up. The WW social work staff also received protocol training and documentation guidance in 2023 and have continued to follow this guidance. Streamlined social work documentation continued to provide efficiency in data collection, case management, and follow-up. Consistency in staffing and increased clinic schedule availability in the county health departments were also contributing factors to increased return rates. Regular communication and encouragement in maintaining healthy habits are key components used to motivate participants to engage in the program and to return annually for screening giving them the opportunity to decrease BP and BMI, increase knowledge of healthy eating habits and nutrition, increase knowledge of healthy lifestyle education, encouragement to increase physical activity, increase knowledge of the importance of hypertension medication adherence, and follow up as needed for medical evaluations.

The WW Program updated and organized the clinic protocol manual in July 2024 to provide increased continuity to each component of the program. The program also received a mini-grant from the Reproductive Health National Training Center (RHNTC) to assist in the preparation of program expansion into three additional counties. Barrier reduction items, home BP monitors, and lab supplies were purchased for dissemination in Bullock, Lowndes, and Covington Counties starting in October 2024. A multi-district staff training was also held to educate all WW staff on maternal morbidity and mortality, the components and the impact of WW, reporting requirements, documentation requirements, an audit tool review, nutrition, oral health, and understanding and prevention of chronic disease.

Program Success Story:

The WW Program sees successes in participants each year. These successes can be habits that are changed to sustain a healthier lifestyle, decrease BP and/or BMI, increase physical activity, increase knowledge of healthy foods and water intake, and so much more. The WW SW staff often have the unique opportunity to hear from participants about positive impacts the program has had on their lives as they have worked to attain goals throughout the year(s). During FY2024, one participant shared with the WW SW that “this program has changed her life” at her annual enrollment visit. The WW SW stated this participant “has lost weight, is now only on one medication and no longer needed other diabetic or cholesterol medication. She reads her New Leaf book and refers to it often. She is very active in the program and tries to engage in physical activity 4-6 days per week”. The WW SW shared that overall, this participant has been very engaged in all components of the program, and she has seen great progress in all of the goals that she has set for herself.

Oral Health Office

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

ESM PDV-Pregnancy.3 - The number of providers, including hygienists, nurses, social workers, physicians, pediatricians, nutritionists, and dentists, who were provided oral health education and training tailored specifically to the MCH pregnant population

Community Health Workers
The OHO was invited to present, alongside the Senior Manager of Community Outreach, USA Health Mitchell Cancer Institute, a morning-long session to a group of CHWs in Mobile, Alabama. The presentation was the first one regarding oral health provided by the Senior Manager, and support from the OHO was crucial to provide a successful outcome. A pre- and post-test were administered to the approximately 50 attendees. The average pretest score between all participants was 63 percent, and after the training, the post-test average score increased 13 percentage points to 76 percent.

Board of Dental Examiners of Alabama
By virtue of the established relationship between the OHO and the Board of Dental Examiners of Alabama, a symbiotic relationship has emerged. Being made aware of decreased availability of financial resources and other difficulties surrounding the Second District Dental Society impacting its ability to provide CEs for members, the OHO offered the district's members three free CE hours for attending a quarterly OHCA meeting. Strategically, the meeting not only featured education on HPV-related oral cancers and their prevention, but it also touted a presentation on Alabama's first Burden of Oral Disease Document presented by OHO intern author, Dr. Zachary Schulz. Providing 18 dentists, 16 hygienists, and 2 dental assistants 3 hours of CE, the platform piqued the interest of private practitioners heretofore oblivious to the state of oral health in Alabama, including the severe lack of dental providers. The engagement with the private sector also bolstered requests for presentations from the OHO to other meetings, as well as an increased interest in how the clinicians might offer assistance in screenings and other activities of public health.

OHO also presented a session, Public Health OHO 101, for Second District Dental Hygienists. Covered topics included the Alabama Comprehensive Needs Assessment, BSS, HPV Vaccination, CWF, and Community Dental Hygienist Certification.

Gulf Coast Dental Conference
Each year, the ALDA' Annual State Conference continues to grow, so does its appeal to a broader audience beyond Alabama dental providers. Reflected in its name, the GCDC, the annual event now attracts beach goers seeking dental CE credits from across the U.S. In 2023, the conference was uprooted from its venue of many years at the Perdido Beach Resort in Orange Beach, Alabama, due to the decision of the resort to discontinue hosting conferences during its peak season. A new venue was identified in San Destin, Florida, providing a much larger and accessible location for the event. Over the past few years, ALDA has come to realize the support and significance of the OHO across a broad spectrum. The educational materials available to providers have become highly anticipated at recent state conferences. In 2024, requests for informational packets distributed to attendees at the meeting have increased significantly. Pamphlets, brochures, and incentive items related to preventive dental visits for children and expectant mothers, periodontal implications on pregnancy, medical-dental HPV education and HPV vaccines (dental vs systemic implications), how dental providers can be effective in preventing stillbirth by introduction of the Count the Kicks campaign to expectant patients, CWF, etc., initiate robust conversations between attendees and OHO staff. The newly forged relationship has encouraged a new segue to bridge the disconnect between the public and private dental sectors. In 2024, these educational encounters reached approximately 1,000 providers, breaching statewide boundaries, as the GCDC had representation from 28 states at the conference.

Alabama Academy of General Dentistry
The OHO's participation as a vendor in the Alabama Academy of General Dentistry Annual Conference provided the opportunity to discuss with current third- and fourth-year dental students (D3 and D4) Alabama's need for dentists in rural areas. Participation also provided a venue to share the importance of CWF for the State.

Well Woman
The OHO staff presented on the oral health connection to your overall health during the Well Woman Annual Training. Attendees included Well Woman district and state staff.

Ongoing activities in Alabama to improve oral health:

Water Fluoridation
The OHO provides funding opportunities for community water systems to apply for grants up to $25,000 each ($100,000 total) for the purpose of updating old fluoridation equipment, purchasing/upgrading fluoridation

equipment, or initiating CWF. The OHO Fluoridation Coordinator sends RFPs statewide to all systems, both adjusting and non-adjusting. Preference is given to any system desiring to initiate fluoridation. OHO received RFPs totaling $94,207 from five water systems. The cities of Anniston (awarded $25,000 with approximately 65,000 residents), Brewton (awarded $17,316 with approximately 11,430 residents), Evergreen (awarded $18,555 with 1,658 residents), Foley (awarded $19,716 with approximately 16,500 residents), and Troy (awarded $13,620 with approximately 20,000 residents), were all awarded the entire amount requested in each of their RFPs, positively impacting approximately 114,618 residents' oral health. Those receiving grant funds are obligated to CWF for 5 years from the award year. As good stewards of grant funds, the residual funds of approximately $5,793 were allocated to Tuscaloosa CHD for the purchase of equipment to assist in outfitting a satellite operatory in the Perry CHD. The site will be run by the Tuscaloosa dental staff to increase access to dental care in a county devoid of providers.

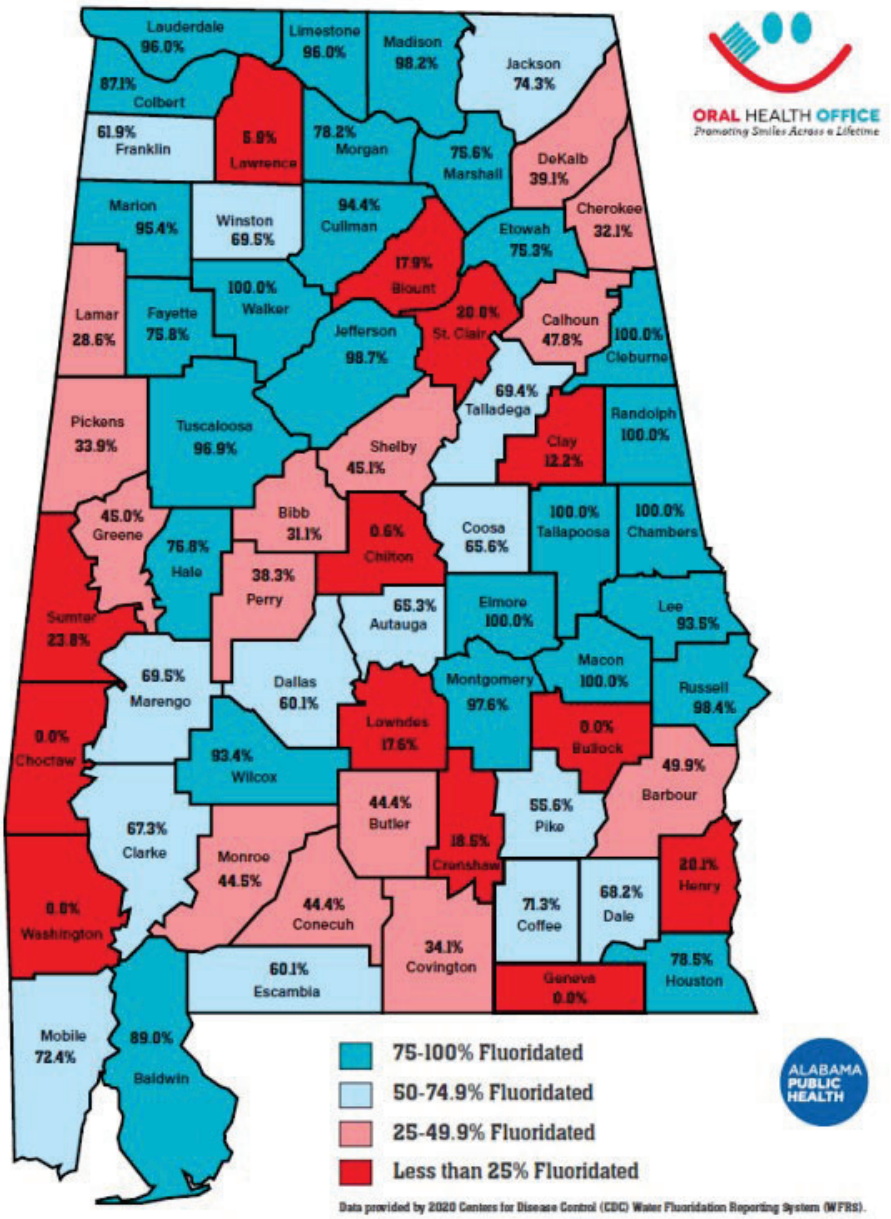
Conversely, OHO was notified of several water systems that planned to discontinue Community Water Fluoridation, citing numerous reasons ranging from safety concerns to financial insufficiencies. A problem with the wording of the fluoridation law requiring systems to notify the State Health Officer no less than 90 days prior to changes in fluoridation level adjustment should be worded to require a 90-day notice prior to a meeting to vote on the continuation of community water fluoridation. Plans to submit verbiage to amend the law accordingly will be crafted before the next legislative season. Efforts to intervene were successful in a separate instance, causing uninterrupted levels of optimally adjusted fluoridation. The following is a list of systems that have or plan to discontinue community water fluoridation.

	A	B	C	D	E	F
1	De-fluoridating	Date of De-Defluor	Populatio	Address	City	County
2						
3						
4	Madison Utilities	6/16/2025	62,038	420 Dunlop Blv	Madsion	Madison
5	Grand Bay Water	5/25/25	11,100	12455 AL-188	Grand Bay	Mobile
6	Orange Beach Water	3/25/25	17,196	22000 COTTON	Gulf Shores	Baldwin
7	Sylacauga Water	9/17/24	22,000	1414 Edwards S	Sylacauga	Talladega
8	Childersburg Water	4/30/24	9,603	117 6TH AVENU	Childersbu	Talladega
9	Abbeville water	3/1/24	2,960	101 EAST WASH	Abbeville	Henry
10						
11						
12						
13	Population total affected		124,897			

For the first time in several years, the OHO was invited to attend, as well as offer a presentation to attendees of the 46th Annual Alabama Rural Water Association Conference. The Fluoridation Coordinator, along with the Oral Health Coordinator and Dental Director, provided an hour-long update on the most recent (2020) CDC Alabama-specific fluoridation data. Prior to the conference, the OHO created statewide maps illustrating the levels of fluoridation in each of the 67 counties. In 2020, approximately 72.7 percent of the U.S. population on community water systems (CWS) received fluoridated water, with Alabama touting a level of approximately 77.7 percent. Quality fluoridation awards were presented onsite to the water systems achieving optimal fluoridation levels for the prior year. A question-and-answer session followed the presentation, providing the opportunity to answer pertinent questions as well as offer gratitude to the systems for their efforts in providing fluoridated water to residents. The OHO staff also served as vendors, having a table to address specific questions from water system workers and one-on-one discussions on how to apply for the annual fluoridation grants offered by the OHO. Relationships heretofore non-existent were initiated with members of organizations such as the Alabama Department of Environmental Management (ADEM), leading to a commitment for further engagement to provide the best quality of water service to

Alabama. This commitment became evidenced by the assembly of key personnel at a “Drinking Water Week” Proclamation signing by Governor Kay Ivey on April 11, 2024.

Fluoride in Public Drinking Water Supplies of Alabama in 2020



ORAL HEALTH OFFICE
Promoting Smiles Across a Lifetime

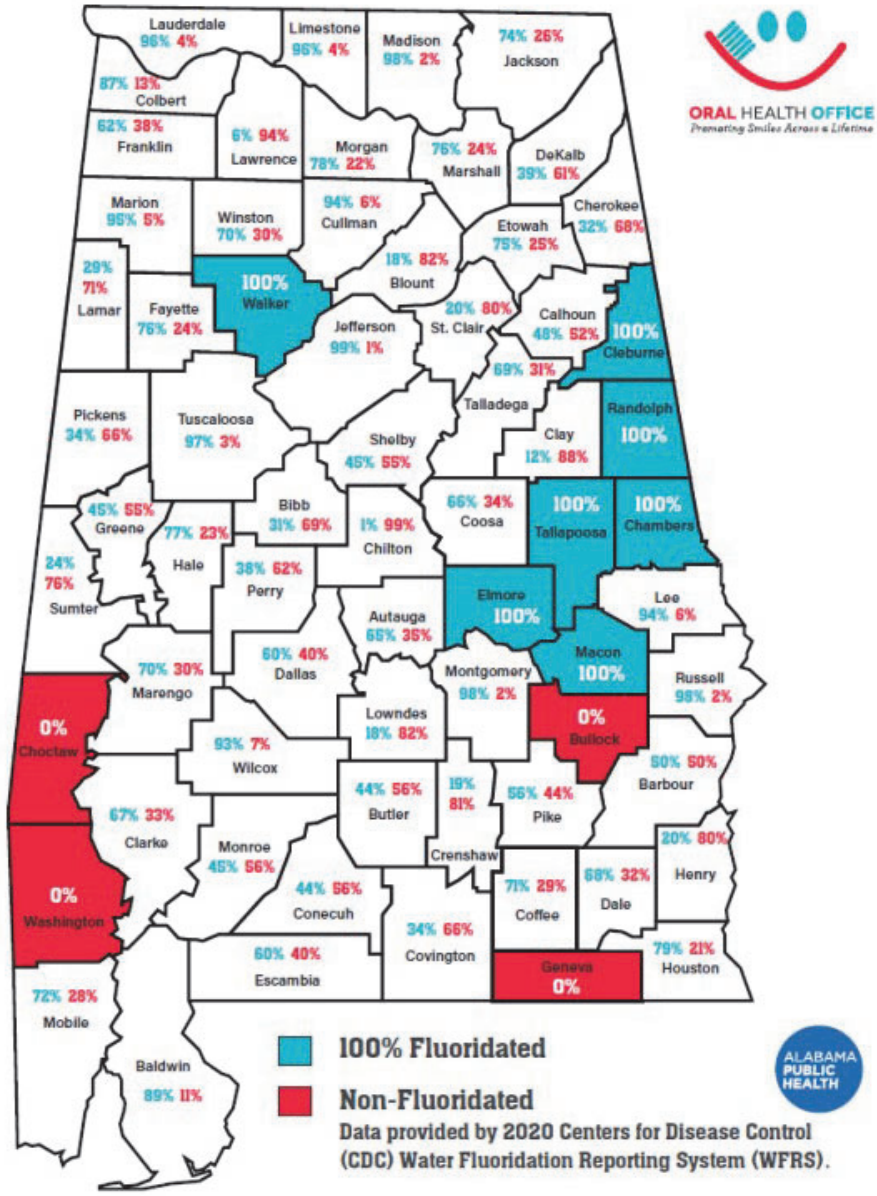
ALABAMA PUBLIC HEALTH

Data provided by 2020 Centers for Disease Control (CDC) Water Fluoridation Reporting System (WFRS).

Populations on public water systems may exceed the county census population. Many water systems span multiple counties. WFRS collects population data for primary and secondary counties for each water system. However, due to difficulty in assigning population values to multiple counties, the primary county information can be over-estimated.

September 2023

Fluoridated & Non-Fluoridated Public Water Systems in AL by Counties



Populations on public water systems may exceed the county census population. Many water systems span multiple counties. WFRS collects population data for primary and secondary counties for each water system. However, due to difficulty in assigning population values to multiple counties, the primary county information can be over-estimated.

September 2023

Oral Health Education

Medical Minutes

For the second consecutive year, the OHO joined a host of other ADPH programs to promote its own messaging via the UAB Medical Minute series on the importance of oral health and its inextricable correlation to overall health including decreased incidence of dental caries, increased positive birth outcomes, and elevated self-esteem. Through a well-established partnership between UAB doctors and ADPH, one-minute messages are provided throughout UAB football and basketball games on the jumbotrons at their respective venues. Reaching an extremely diverse demographic, the messages had impressions of 400,588 (up from 258,518 in 2023) at the football games

and 306,672 (up from 26,591 in 2023) basketball games in 2024. The oral health messaging was one component of eight subjects, including STDs, influenza, nutrition, opioids, COVID-19, diabetes, and cancer. A similar educational campaign was undertaken by USA, but those impressions are unavailable at this time.

Oral Cancer Awareness

In its sixth year since launch, the #WATCHYOURMOUTH oral cancer awareness campaign continued to achieve momentum and support from unexpected sources. In 2023, Dr. David Bronner, CEO of Retirement Systems of Alabama provided resources to bolster attention to oral cancer in Alabama. The campaign, originally the culmination of efforts between the OHO and the USA Mitchell Cancer Institute, is a diverse and multi-faceted awareness effort which draws on social media, printed educational materials, professional and public figure and sports endorsement, community engagement, and visuals (Light-up Alabama Red) among others to highlight the symptoms, treatment, and prevention of oral cancers. Dr. Bronner's involvement is a personal one, having been diagnosed with oral cancer 3 years prior. Through his resources, he has afforded the OHO unique avenues to promote awareness surrounding the disease. In 2023, Dr. Bronner provided a recorded 10-minute candid interview, chronicling his journey from diagnosis, treatment, and the resulting aftermath, which is available on the OHO website. He also offered to produce a public service announcement (PSA) in 2023, which he voluntarily re-aired on 10 television stations statewide in April 2024 to raise awareness. Additionally, he requested that an article be written for the RSA statewide newsletter, the *Advisor*, which is distributed to all current and previous state employees, as well as nationwide to a variety of recipients, to highlight the success story of the campaign for bringing attention to this worthwhile cause. He also carved time from his schedule to participate in the Oral Cancer Awareness Month Proclamation signing by Governor Kay Ivey. View Dr. Bronner's PSA and interview.

VAX2STOPCANCER

The OHO has a unique tether to VAX2STOPCANCER, a nonprofit working to prevent cancer by expanding the use of the HPV vaccine through education, public awareness, and advocacy. The professional relationship between the OHO and the Board of Dental Examiners of Alabama allows 1 hour of CE credit to be issued to Alabama dental providers upon completion of the online course offered by VAX2STOPCANCER. Learn more about VAX 2 STOP CANCER.

Montgomery Area Coalition for the Homeless
The OHO staff attend the MACH event annually to distribute dental health kits to those affected by homelessness. Staff also assists in locating dental services when needed and enrollment in available insurance plans for those who qualify.

Of paramount importance to the mission of the OHO is its provision of dental health kits, including high-quality toothbrushes, toothpaste, floss (if age-appropriate), and educational material to children and expectant mothers. The stories of children stating they have never had a toothbrush, or that there is one toothbrush shared amongst all the members of their family, seem impossible to fathom, but in rural Alabama, it is not rare. Educational material is designed or acquired so that is pertinent and written on a very basic level for maximum comprehension by children and provided to them. In 2024, the OHO provided approximately 20,952 dental health kits to mothers and children at events, in addition to those that were distributed at oral health screenings for Pre-K, Headstart, and K-6 grades. These screenings are provided by OHO due to local dentists' inability or unwillingness to provide screenings.

Oral Health Care

Pay It Forward

The partnership between the OHO and HandsOn River Region/Pay It Forward is in its sixth year, whereas the OHO provides a grant in the amount of $25,000 annually to help low-income citizens who lack dental insurance receive needed dental treatment and give back to the community at the same time. HandsOn River Region provides staffing for Pay It Forward to orchestrate a value-based program allowing clients to log volunteer hours (choosing from over

200 nonprofit agencies in the River Region) in exchange for dental treatment. Initially, the target population was expectant mothers vetted through Gift of Life. Since its inception, the program has expanded to include expectant fathers enrolled in Gift of Life programs, as well as chronically unemployed individuals. The partnership was recognized as a Best Practice by the Association of State and Territorial Dental Directors in 2020. The program has experienced its share of lingering challenges due to the closing of dental offices during COVID-19, with many of the volunteer dentists taking a hiatus from volunteer services altogether, concentrating on the continued stabilization of their patient population. Read more about Pay It Forward

Calhoun Community College and Wallace State Community College

Two and a half years since the implementation of the partnership forged between the ADPH Northern District and two community college-based dental hygiene programs at Calhoun Community College and Wallace State Community College, enthusiastic participation and continued excitement abounds. Wallace State, with an established program of 20-plus years, and Calhoun State, now in its third year, both continue agreements to accept ADPH referrals, providing in-kind services in exchange for dental hygiene supplies. The programs provide a range of services from diagnostic radiographs, blood pressure screenings, diabetes screenings, cleanings, oral cancer exams, oral health education regarding HPV and HPV vaccination promotion, and appropriate referrals for treatment. The services are provided to uninsured children through age 18 and expectant mothers. Patient satisfaction surveys are completed upon each visit.

Calhoun Community College
72 children and 29 mothers FY 2024
296 children and 33 mothers (since February 2022)

Wallace State Community College
69 children and 8 mothers FY 2024
218 children and 34 mothers (since February 2022)

Singing River Dentistry

In another pilot program, the Northern District successfully engaged with a private entity, Singing River Dentistry, through a MOU to provide the same services as the community college hygiene program partners. Totaling 10 different locations in the northern tier of the state, the office in Russellville, Alabama, was chosen as the initial location for the partnership due to its rural setting and lack of access to dental providers. Patient satisfaction and educational surveys comprise the final aspects of patient encounters, similar to the model set forth with the community colleges.

Singing River Dentistry
5 children FY 2024
14 children (since January 2024)

Free and Charitable Clinic List

The OHO is often contacted by residents in need of dental consult/treatment. With only one CHD dental facility located in West Alabama, it is imperative that resources be made available to those in need within the parameters of their socioeconomic means. Throughout the state, numerous FQHCs can be found. Some of the FQHCs have varying degrees of dental provision, but the procedures offered change on an unpredictable and irregular basis. For this reason, the OHO revises a list of free and sliding-scale clinics throughout the state and updated on the ADPH website.

ADPH Public Health District Initiative
ADPH, JCDH, and MCHD coordinators submitted MCH FY 2024 project proposals to address needs within the Women/Maternal Health Domain. The following is a summary of those county projects.

East Central Public Health District

The WW Program continued to be implemented in the district in Russell, Macon, and Montgomery Counties to enhance access to healthcare for women ages 15 to 55, provide preconception and inter-connection care counseling, provide risk assessment and behavior modification, prevent and/or manage a chronic disease, and reduce maternal and infant morbidity and mortality. The District MCH Coordinator and clinic staff partnered with

local primary care physicians and community programs, including the GOL Foundation, Inc. (a Healthy Start Program grantee), the Wellness Coalition, and the Alabama Cooperative Extension System, in order to continue implementing the district's WW Program. The program is continuing to see increased participation in all three targeted counties. As part of a QI project to increase participation rates, the District MCH Coordinator implemented new marketing tools and health-related incentives for WW participants.

The women enrolled in the program have experienced a 2 percent decrease in BMI.

Success Stories:

A participant joined the Russell County WW program in April 2024 to live a healthier lifestyle. She has changed her eating habits to eat more plant-based foods, started meal prepping, and gone to the gym several times a week. She lost 28 pounds by December 2024.

A participant joined the Russell County WW program in 2019, became pregnant, and rejoined after pregnancy in December 2021. Her goals were to reduce the number of sweets she ate and increase physical activity. She weighed 232 pounds in 2021. During her last annual visit in February 2024, she weighed 175 pounds.

In addition to expanding the WW Program, the District MCH Coordinator has collaborated with local churches, universities, and other community partners to host monthly community resource fairs, health expos, conferences, and more. Hundreds have benefited from presentations and demonstrations covering topics such as healthy nutrition, mental health and wellness, and physical activity. Throughout FY 2024, the East Central District MCH Coordinator participated in 50 events and reached more than 3,000 people.

Southeastern Public Health District

Per the 2024 Robert Wood Johnson County Health Rankings report, 14 percent of adults in Barbour County were uninsured. In Henry County, 12 percent of adults were uninsured. Additionally, Barbour County's ratio of primary care physicians to patients was reported as 2,070:1, while Henry had a ratio of 3,440:1.

The WW Program continued to be implemented in Barbour and Henry Counties in an effort to enhance healthcare access for women, thereby reducing maternal morbidity and mortality. During FY 2024, Barbour County enrolled 118 participants in the Well Woman Program, and Henry County enrolled 48 participants. Since the WW nutrition education classes are offered virtually, participation increased by an average of 2 attendees monthly. There was an average of 5 -10 participants regularly utilizing the Eufaula Recreation Center facility.

During FY 2024, the District MCH Coordinator and WW staff partnered with eight local agencies to support the WW Program. Those agencies were Eufaula Recreation Center, Wallace Community College, Eufaula Housing Authority, SpectraCare (local mental health services), The Eufaula Pregnancy Resource Center, the Barbour Chamber of Commerce, the UAB Cancer Center, and the Barbour and Henry County Cooperative Extension Service Offices. The WW Program and SpectraCare collaborated to conduct four successful drug takeback events in Barbour and Henry Counties. Additionally, district WW staff collaborated with the aforementioned local service agencies in promoting several health observances and hosting community awareness events. The events highlighted cardiovascular health, diabetes treatment and prevention, drug abuse prevention, and breast cancer awareness. In an effort to expand participation and promote services, in April 2024, the Cooperative Extension Service hosted an educational awareness day specifically for the Hispanic population. WW was presented during this event.

Northern Public Health District

Oral health was the chosen area of focus for the Northern Public Health District in order to address deficiencies in the lack of access and availability of dental care. The district maintained past partnerships and recruited new resource options for access to dental care for children ages 0-17 and expectant mothers. The partnership continued with Calhoun Community College and Wallace State Community College. Singing River Dentistry was added to the project in January 2024 to expand the provision of free oral health services for uninsured or underinsured expectant mothers and children. ADPH provides in-kind reimbursement through the provision of dental supplies for all partners per 100 patients served in FY 2024. A total of 19 expectant mothers received dental cleanings and exams through the college's dental hygiene programs.

Over 4,800 oral health information cards and 600 incentive items were distributed within the Northern District to all 12 CHDs, community organizations, public schools, provider offices, and during community health/resource fair events.

Southwestern Public Health District

Alabama's infant mortality rate of 6.7 deaths per 1,000 live births in 2022 increased to 7.8 in 2023, which is the latest year reported. However, the infant mortality rate for Marengo County in 2022 was 9.2 and decreased to 5.3 in 2023. Alabama's low birthweight also decreased from 10.4 percent in 2022 to 10 percent in 2023. Marengo County's 2023 profile indicates LBW improved from 14.8 percent in 2021 to 8.7 percent in 2022. However, there has been a significant increase in the low birth weight in 2023 to 14.5 percent. A total of 449 infants born in Alabama died before reaching 1 year of age in 2023, which was also a significant increase from 391 infant deaths in 2022. According to Alabama's 2020 State Health Assessment, lack of adequate nutrition and physical activity ranked as one of the top health concerns in the Southwestern District. Furthermore, per the 2025 Robert Wood Johnson County Health Report, Marengo County's Health Profile reported 21 female deaths in 2022 were due to heart disease, and 1 death was due to diabetes. Unfortunately, these numbers increased to 27 deaths due to heart disease and 6 deaths due to diabetes in 2023.

In an effort to support women in Marengo County, ages 15-55, in achieving more positive pregnancy outcomes and in better self-management of chronic health conditions, the district decided to continue the implementation of the WW Program. Nineteen women benefited from program services during FY 2024. In addition to promoting WW throughout the county, the Southwestern District MCH Coordinator facilitates the district's Maternal and Child Health Advisory Committee. The MCH District Coordinator is also a member of the Southern Region II Community Action Team, Wilcox Empowerment, and the Community Action Network.

Other ADPH Women/Maternal Health Programs

Office of Women's Health

OWH provides statewide leadership and coordination to promote the health of women and girls through policy, advocacy, education, and partnership. The office achieves its mission and vision by educating healthcare professionals and motivating behavior change in consumers through the dissemination of health information. Education programs that have been provided to incarcerated women at Julia Tutwiler Prison are currently on hold due to staff changes at the prison. However, OWH hopes to resume the education programs sometime in 2025.

Family Planning

The FP Program promotes the well-being of families, responsible behavior, and healthy mothers and babies. The program's goal is to prevent unintended pregnancies through education and contraceptive services, allowing for the planning and timing of pregnancies. The program is funded in part by federal Title X FP services grants. For more than 50 years, Title X clinics have played a critical role in ensuring millions of low-income or uninsured individuals have access to a broad range of FP and related preventive health services. Title X is the only federal grant program solely dedicated to providing individuals with comprehensive FP and related preventive health services.

Title X FP services are available in all 67 CHDs and sub-recipient sites, resulting in 81 sites across Alabama. The program provides a wide range of confidential and professional FP services to females and males of all ages, regardless of income, and many clients may be eligible for free or reduced-cost services. Program services include testing for pregnancy and sexually transmitted diseases, breast and cervical cancer screening, reproductive and contraceptive counseling, and access to a broad range of contraceptive methods, including oral and injectable contraception, intrauterine devices (IUD), contraceptive implants, emergency contraception, and referrals for male and female sterilization.

Program initiatives continue to provide inclusive, comprehensive FP services. In FY2024, department providers served 40,132 clients, completing nearly 81,889 in-person visits; Title X sub-recipients, Jefferson County Department of Health and Mobile County Health Department, provided services to an additional 9,186 clients.

During FY2024, the program continued advancing colposcopy services, improving access-to-care and increasing patient compliance with abnormal cervical screening follow-up. Six NP seniors service the state's health districts providing this critical diagnostic service. Plans are underway to expand the colposcopy program by partnering with CDC and the Public Health Infrastructure Grant (PHIG) to train two additional NPs per each district, enabling the department to provide colposcopy diagnostic services to even more Alabama women in the most rural areas. The colposcopy program has made a substantial impact in the lives of some by finding 12 cervical cancers and precancers that may have gone undetected due to the client's inability to access the diagnostic care needed.

Alabama's FP Program is able to boast a comprehensive contraceptive menu, giving clients a vast choice of birth control methods. The program can offer not only oral and injectable contraception but also IUDs and implants provided by CNPs in the local clinics, improving access to these long-acting contraception products.

Through community-based outreach, education, and collaborative relationships with community organizations, FP emphasizes the goals of reducing cervical cancer morbidity and mortality through regular cervical cancer screening and preventing cervical cancer with the HPV vaccine. The HPV vaccine, Gardisil®9, prevents most cervical cancers, as well as six HPV-related oropharyngeal cancers, and is available to all CHD clinics. The program promotes community awareness of the broad range of FP services and contraceptive methods available in local department clinics. In 2024, the Title X SW provided individualized, risk-based care coordination services, such as education and follow-up, to facilitate clients' completion of provider referrals for higher-level medical care and/or completion of the HPV vaccination series in seven focused-risk counties.

Special Supplemental Nutrition Program for Women, Infants, and Children

WIC provides federal grants managed by the USDA, FNS to states for supplemental foods, health care referrals, nutrition education, and breastfeeding support for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age 5 who are found to be at nutritional risk. Each state receives an annual food and NSA allocation. In addition to the food and NSA allocation, each state is entitled to an annual BFPC grant award to further support breastfeeding among WIC participants. Alabama's WIC Program is administered by FHS. There is no state match requirement to receive WIC funding, and no state or other federal

program funds are provided to support Alabama's WIC Program. The FY for WIC begins October 1st and runs through the following September 30th. Alabama's WIC Program has a broad reach with an average monthly participation of 111,702 during FY 2024. It is important to note that Alabama's WIC Program serves approximately half of the infants born in Alabama each year, providing a unique opportunity to positively impact future generations. WIC is one of the most successful nutrition programs available in the United States, providing nutritious foods and breastfeeding support for 50 years as of WIC's 2024 anniversary. WIC services and benefits have a positive impact on reducing childhood obesity and infant mortality. WIC also has a positive impact on infant and childhood immunizations, which benefits both the individual and the community.

Breastfeeding promotion and support continue to be a major benefit to WIC participants. Breastfeeding promotion and support are available for all women and infants enrolled in WIC. Breastfeeding support includes information on techniques to improve supply, infant latch, and other components of successful lactation. Women wanting to breastfeed are paired with a breastfeeding peer counselor to obtain additional support and may be eligible to receive breast pumps. Breastfeeding peer counselors are funded through the BFPC grant, while breast pumps are purchased with WIC food funds. During FY 2024, Alabama WIC continued to promote and utilize Pacify, a mobile app providing 24/7 video calls with IBCLCs and connecting participants with their local WIC clinic through a one-click phone connection feature. Alabama's WIC program is excited to provide real-time access to IBCLCs whenever WIC breastfeeding moms need it (even in the middle of the night). Making Pacify available to WIC participants has the potential to enhance and improve the breastfeeding experience and result in an increase in initial breastfeeding rates, as well as the duration of time WIC infants are breastfed. Alabama's WIC Program remains open to data-driven innovations, methodologies, and new technologies to further enhance breastfeeding promotion and support efforts.

Nationally, WIC is focusing on outreach, innovation, modernization, and new technologies to remove barriers and increase participation. Alabama's WIC Program utilizes a portion of NSA funds on outreach activities, such as recruitment and retention efforts aimed at increasing WIC participation, and augments outreach efforts with recent WIC modernization and WIC technology grants awarded by USDA FNS to WIC state agencies. The WIC Program utilizes EBT, known as eWIC in Alabama. Issuing food benefits through eWIC significantly improves the shopping experience and allows WIC participants to redeem benefits at different stores based on their current needs. WIC families can purchase some or all of their WIC benefits during a single shopping trip. For authorized vendors offering self-checkout, WIC shoppers can also utilize self-checkout with eWIC.

Another innovative outreach method utilized is the Alabama WIC app, which serves as a one-stop shop for several resources including eligibility requirements, a map to find the nearest WIC clinic, the WIC approved foods brochure, a bar code scanner that can be used while shopping to determine if a food is included in the WIC approved product list, a custom-built appointment reminder, healthy recipes, breastfeeding resources, a convenient link to online nutrition education classes, and social media posts to stay up-to-date with any current WIC news. Alabama transitioned to the WICShopper app at the end of FY 2024, which offers all existing functionality as the Alabama WIC app with the added benefit of real-time EBT data. WICShopper is currently utilized by 35 different WIC state agencies and Indian Tribal Organizations. The WICShopper app enables WIC participants to see if a food item is WIC-approved, if the item is issued to them, and if they have an adequate remaining monthly balance to purchase the food item. WICShopper will also enhance Alabama's WIC communication methods by enabling targeted push notifications to specific participants (e.g., alerting participants of expiring benefits to increase redemption, encouraging breastfeeding and Pacifier awareness among moms approaching their delivery dates, or even notifying individual families issued an affected formula that a recall has been issued).

In addition to providing a WIC mobile app, online nutrition education is available to all WIC participants through

WICHealth, augmenting in-person nutrition education efforts and available to WIC participants 24/7 from any location with an internet connection. WICHealth provides easily accessible nutrition education with age-appropriate feeding topics to support healthy nutrition at all stages from pregnancy through birth, infancy, toddler years, and early childhood.

In addition to new technologies, WIC continues to utilize partnerships with other organizations to reach potentially eligible families. For example, WIC partners with Head Start programs to provide outreach and additional sites for WIC enrollment. As many families served by Head Start may be eligible to receive WIC, this is an ideal partnership for both programs. Another alternate site for WIC enrollment includes select birthing hospitals in Alabama. Pregnant WIC participants are also eligible to enroll in TodaysBaby, an educational program designed by health care experts to provide baby care information in the form of short videos, text messages, and social media posts from pregnancy until the baby is 6 months old. More information is available on the ADPH website at www.alabamapublichealth.gov/wic.

Maternal Mortality Review Program

In August 2024, the CDC awarded $2.975 million to the ADPH MMRP over 5 years through the ERASE MM Grant to expand support to Alabama's MMRC. The MMRC is comprised of a diverse group of individuals from all over the state. There are a total of 55 members with a variety of disciplines/specialties that include: obstetricians/gynecologists, maternal fetal medicine, pathologists, psychiatrists, substance use disorder specialists, cardiologists, emergency physicians, registered nurses/nurse practitioners, social workers, family physicians, certified nurse midwife, PharmD, anesthesiology, public health, private insurance and Medicaid representatives, hematology/oncology, CHW, MOD, ALPQC, DHR, GOL, Coroner, and My Care Alabama.

State funds through the general fund budget will continue for the MMRP as well. These funds were secured through the efforts of MOD and MASA. Funding from the Alabama Legislature has been allocated to the ADPH MMRP to perform maternal autopsies at no charge to families. The Maternal Autopsy Program was established in December 2023 as a pilot in five counties and expanded statewide in October 2024.

Cancer Prevention

The ABCCEDP, which provides free breast and cervical cancer screenings and diagnostic services for women with incomes at or below 250 percent of the poverty level and no insurance. If they are legal residents, women diagnosed with breast and cervical cancer are eligible for Medicaid treatment. Annually, approximately 11,000 women are served.

Due to the high rate of cervical cancer incidence and mortality in Alabama, the Division collaborated with UAB to implement OPERATION WIPE OUT, a statewide effort to eliminate cervical cancer by 2033 in Alabama. The effort focuses on 3 steps to eliminate cervical cancer: increasing HPV vaccination in girls and women aged 9-45, increasing cervical cancer screening with the HPV/Pap test, and improving appropriate follow-up for women who have abnormal findings. Alabama remains the first and only state in the nation to announce an action plan to eliminate cancer. Since its implementation in May 2023, OPERATION WIPE OUT efforts have garnered national and international attention. As co-lead in the effort, ADPH has supported multiple states and partners in developing their own plans. In addition, ADPH has made significant contributions to the HPV Southeast Roundtable's plan to eliminate cervical cancer. Partnering with the Rotary Club of Birmingham has led to opportunities to share OPERATION WIPE OUT at their national convention in 2024 and international convention in 2025. ADPH and WIPE OUT leaders have developed multiple resources, a website, a Google group to facilitate communication among partners, and social media handles.

Women/Maternal Health - Application Year

In the upcoming reporting year, BFHS will address one priority need identified for Women/Maternal Health Domain for the 2026 - 2030 State Action Plan. The need is: Comprehensive postpartum care and education. See section III.E. Five-Year State Action Plan for additional information.

Described below are the supporting activities for the implementation of the NPM in FY2026.

NPM PPV – A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components

ESM PPV.1 – Percent of postpartum survey respondents who keep their postpartum visit appointment

PHD has transitioned from NPM RAC to focus its strategies on the new postpartum NPM

- *(ESM 3.1) goal met - Percent of delivering hospitals convened at a meeting to share data and discuss the Alabama Perinatal Regionalization System*
- *(ESM 3.2) goal met - 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*

The FIMR Program created a bookmark educating on the importance of postpartum visits that will be distributed in FY 2026. The back side of the bookmark will feature a survey link for recently delivered mothers to answer questions regarding different aspects of their postpartum care. The survey question topics include attending a postpartum appointment within 12 weeks of delivery, continuity of care from delivering provider, insurance type, discussion of physical and mental health during their postpartum appointment(s), and which source is most frequently used to seek further information about their care. It will also feature links to various postpartum education resources.

Increasing participation in the postpartum QR code survey will help highlight the successes and potential barriers postpartum mothers are facing regarding their overall health and wellbeing following their delivery. FIMR Program staff will assist in disseminating the postpartum bookmark at outreach events. The significance of establishing the new ESM is to increase the awareness of the importance of attending postpartum follow-up appointments while learning about the barriers as to why patients are not able to attend them. Missing a postpartum follow-up appointment can lead to undetected health issues and hinder a smooth transition to motherhood.

The plan is to engage family and community partnerships to increase the awareness of postpartum follow-up appointment compliance with hopes of improving the health and well-being of postpartum mothers. The QR code link to the REDCap survey will be shared on social media, outreach events within each perinatal region, and within the CHDs. The FIMR Program also plans to focus its efforts in postpartum educational outreach among the 25 Alabama counties designated as maternity care deserts in the March of Dimes Maternity Care Deserts Across the US 2024 Report. The March of Dimes identified maternity care deserts based on the availability of birthing centers, hospitals providing obstetric care, and obstetric clinicians.

5-Year Objectives

- By 2030, at least 54 percent of REDCap survey respondents reported attending at least one postpartum follow-up appointment within 12 weeks of delivery
- By 2030, attend 200 community outreach events statewide to distribute the postpartum bookmarks among the MCH recently delivered population

SPM 1 – Percent of survey respondents ages 15 to 55 eligible to enroll into WW who report having a trusted birth control method and are not planning for a pregnancy within the next 12 months

The WW Program created a brochure for distribution among the 12 active WW CHDs and the broader community. The brochure features a QR code which links to a survey for eligible WW participants to answer questions concerning birth control access, CVD risk factors, and interest in enrolling in the WW Program. In the brochure, the WW Program highlights the significance of heart disease, morbidity, mortality, and the cardiovascular challenges faced by PRAMS respondents during their pregnancies. Additionally, the brochure offers links to educational resources focusing on the following: how to enroll in FP, mental health, nutrition, physical activity, and smoking cessation.

Increasing enrollment in WW will help to reduce the CVD risk of women within reproductive age, resulting in healthier maternal and infant outcomes. The WW Program will also be able to capture data focused on the importance of cardiovascular health when planning for pregnancy and access to trusted birth control methods through dissemination of the WW survey. The significance of establishing the new SPM is to increase enrollment in WW, to educate women on the importance of maintaining healthy lifestyle goals, and to reduce the CVD risk factors of women within reproductive age, resulting in healthier maternal and infant outcomes. The goal of the new WW SPM is to increase enrollment within the WW Program and to capture data concerning the importance of cardiovascular health when planning for pregnancy and access to birth control methods. Although the ESM (WWV.2) will not be reported during the 2026 - 2030 reporting period, the WW Program will continue to work towards its goal of achieving a two percent increase in FP enrollment. During FY 2025, CHDs will review and modify its case management protocol as needed to potentially increase FP enrollment. Effective FY 2025, the WW Program expanded its services to three new CHDs located in Bullock, Covington, and Lowndes Counties. For the 2026 – 2030 reporting period, WW developed a SPM to monitor the impact of having a trusted birth control method on pregnancy among WW participants ages 15 to 55.

The plan to engage family and community partnerships to improve health and well-being is to share the survey throughout the community and on social media, coordinate WW outreach events with MCH district coordinators and WW social workers, and promote program enrollment in the 12 active WW CHDs. WW Program staff will coordinate outreach events with the MCH district coordinators to expand the area of reach for survey distribution.

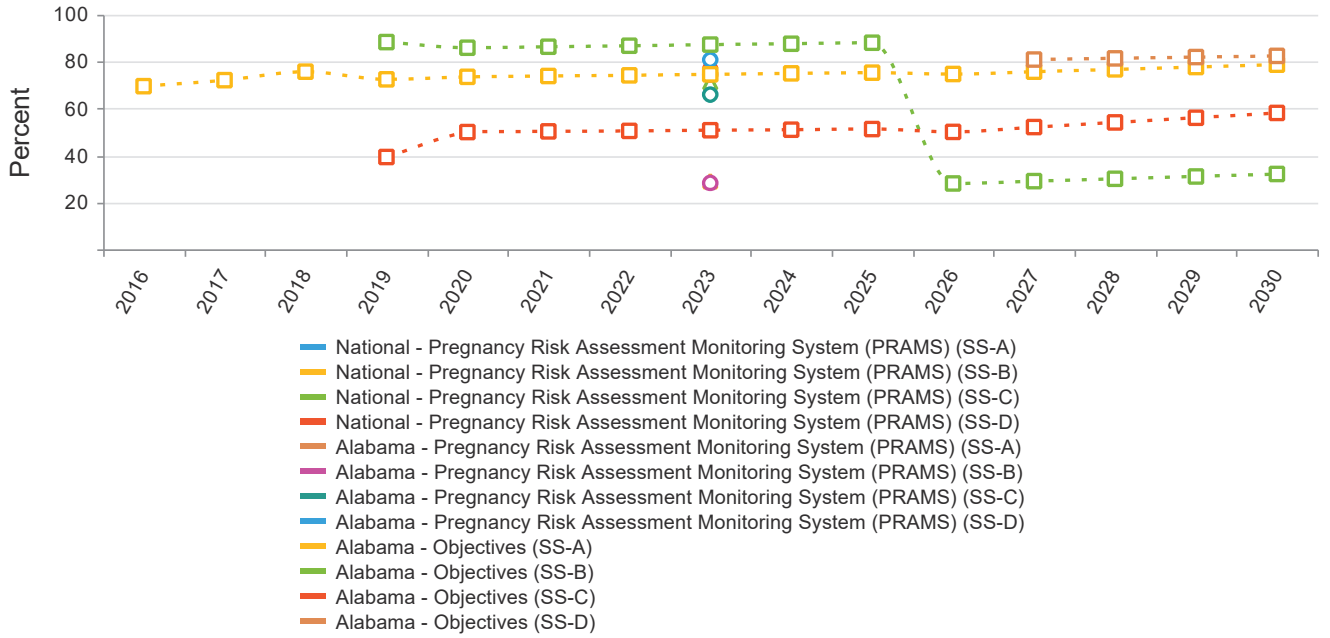
5-Year Objectives

- By 2030, at least 10 percent of all eligible WW participants receiving services at the active WW CHDs will complete the survey
- By 2030, at least 54 percent of all survey respondents will report not planning for pregnancy due to access of a trusted birth control method
- By 2030, an additional 5 percent increase in WW enrollment
- By 2030, attend at least 30 community outreach events and health fairs to promote WW and encourage completion of the survey

National Performance Measures

NPM - 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 D) Percent of infants room-sharing with an adult during sleep - SS

Indicators and Annual Objectives



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

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	73.3	73.7	74.4	74.4	74.8
Annual Indicator	72.0	73.3	76.8	77.2	74.5
Numerator	37,266	31,945	39,817	40,037	37,648
Denominator	51,781	43,605	51,868	51,871	50,503
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2022	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	74.5	75.5	76.5	77.5	78.5

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

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	85.7	86.1	87	87	87.4
Annual Indicator	33.3	34.6	35.7	33.1	28.1
Numerator	16,967	15,074	18,338	16,787	14,168
Denominator	50,878	43,622	51,403	50,730	50,438
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2022	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	28.1	29.1	30.1	31.1	32.1

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

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	49.9	50.2	50.7	50.7	50.9
Annual Indicator	44.4	42.3	48.3	46.8	65.9
Numerator	22,734	18,238	24,583	23,964	33,724
Denominator	51,234	43,152	50,900	51,162	51,189
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2022	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	50.0	52.0	54.0	56.0	58.0

NPM - D) Percent of infants room-sharing with an adult during sleep - SS

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	80.7
Numerator	41,352
Denominator	51,222
Data Source	PRAMS
Data Source Year	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	80.7	81.2	81.7	82.2	82.7

Evidence-Based or –Informed Strategy Measures

ESM SS.1 - The proportion of mothers enrolled in the Alabama Cribs for Kids® Program who self-reported that their infants are using the cribs (Pack-n-Play) for all periods of sleep at the home setting

Measure Status:	Active

State Provided Data		
	2023	2024
Annual Objective		
Annual Indicator		72.7
Numerator		133
Denominator		183
Data Source		PHD
Data Source Year		FY 2024
Provisional or Final ?		Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	72.0	74.0	76.0	78.0	80.0

State Action Plan Table

State Action Plan Table (Alabama) - Perinatal/Infant Health - Entry 1

Priority Need

Infant Mortality

NPM

NPM - Safe Sleep

Five-Year Objectives

By 2030, the Alabama Cribs for Kids® Program aims to provide a crib (Pack-n-Play) to at least 4000 new mothers.

By 2030, maintain SIDS as the third leading cause of death or lower for infants as presented in the 2023 CHS Infant Mortality Report. Prior CHS annual infant mortality reports listed SIDS as the second leading cause of death.

By 2030, the out-based FIMR staff will attend 200 community outreach events to promote the Cribs for Kids® Program.

Strategies

Coordinate efforts with the ACHN maternity care workers to expand area of reach for the Alabama Cribs for Kids® Program.

Coordinate efforts with the FIMR nurse coordinator to expand area of reach for the Alabama Cribs for Kids® Program.

Coordinate efforts with FIMR nurse coordinators to implement bill boards on the importance of safe sleep within their regions.

Coordinate efforts to promote the Alabama Cribs for Kids® program at community outreach events including Babypalooza.

Coordinate efforts to encourage community participation with Clear the Crib Challenge statewide.

Aim for at least a 10 percent survey response rate annually for Alabama Cribs for Kids® participants to answer questions concerning Pack-n-Play use for their infant at 2 to 3 weeks of age after it is delivered

ESMs	Status
ESM SS.1 - The proportion of mothers enrolled in the Alabama Cribs for Kids® Program who self-reported that their infants are using the cribs (Pack-n-Play) for all periods of sleep at the home setting	Active

NOMs
Infant Mortality
Postneonatal Mortality
SUID Mortality

2021-2025: National Performance Measures

2021-2025: NPM - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III + Neonatal Intensive Care Unit (NICU) - RAC
Indicators and Annual Objectives

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

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		83.8	84.8	77.9	80
Annual Indicator	83.5	88.2	87	87.5	86.7
Numerator	963	963	841	969	883
Denominator	1,153	1,092	967	1,108	1,019
Data Source	CHS	CHS	CHS	CHS	CHS
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Provisional	Provisional

2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM RAC.3 - Number of steps of the CDC's LoMC process completed in order to design and align the Alabama Maternal Regionalization System Guidelines with the national criteria for the maternal levels of care

Measure Status:	**Active**	
State Provided Data		
	2023	**2024**
Annual Objective		
Annual Indicator		97.7
Numerator		42
Denominator		43
Data Source		AL SPP
Data Source Year		2024
Provisional or Final ?		Final

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 RAC.3 - Number of steps of the CDC's LoMC process completed in order to design and align the Alabama Maternal Regionalization System Guidelines with the national criteria for the maternal levels of care

After ADPH completed its collaboration with AlaHA focused on infants delivering at the appropriate level of care, a new collaboration began with AlaHA to focus on LoMC. A workgroup was formed with staff representing the delivering hospitals and AlaHA to explore how the team would strategize the implementation of regionalized risk-appropriate maternal care. AlaHA encouraged hospitals to complete the LoMc tool. With LoMC defined, facilities identified and addressed gaps in capabilities and personnel to align with national standards. Regions and health systems were then able to examine the capabilities of their facilities and define criteria for care locally allowing for designated transfer of care based on risk.

The SPP held a meeting in Montgomery in June 2024 at AlaHA where results were given to each hospital and levels were discussed. Very few hospitals were at the level they considered themselves- largely affecting Level 2 and Level 3 hospitals. UAB and USA Women's and Children were the only hospitals that were truly the level they considered themselves to be with UAB at Level 4 and USA at Level 3. There were discussions on maternal transfers and obstacles that were causing them not to be at the level according to LoMC. It was reiterated that the appropriate care level for patients should be driven by the medical needs and not limited to or governed by financial constraints (hospitals agreed financial constraints were an issue). Each hospital representative present was charged with going back to their hospital and doing a deep dive into what it would take to obtain those levels. The hospitals have had a year to look at what they would have to do to obtain their considered level. The next meeting is in June 2025 for hospitals to discuss any progress that has been made, what obstacles they are still facing, and a general look at the health of their maternal landscape.

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

ESM SS.3 - The proportion of mothers enrolled in the Cribs for Kids Program who self-reported that their infants are using the cribs for all periods of sleep at the home setting

During FY 2024, 1,389 pregnant women were enrolled in the Cribs for Kids Program. Surveys asked participants about crib usage when the baby is 2-3 weeks of age and again at 6-8 weeks. The ESM measure assessed crib usage among infants at 2-3 weeks of age. Approximately 13.2 percent (n=183/1,389) completed a survey regarding crib use when the baby was 2 to 3 weeks old. In terms of crib use, 72.7 percent (n=133/183) selected either always or almost always for their baby. Of those who completed the survey, the primary racial groups are as follows: 53.0 percent (n=97/183) were black, on-Hispanic, 31.1 percent (n=57/183) were white, non-Hispanic, and 12.6 percent (n=23/183) were Hispanic. Looking at the survey respondents' valid address information, 68.9 percent (n=126/183) of the survey respondents resided in an urban county, while 31.1 percent (n=57/183) resided in a rural county.

During the last 2 months of FY 2024, the Cribs for Kids Program implemented a better tracking system for completing follow-up with participants concerning the completion of the first and second surveys. To increase the survey response rate, the Perinatal Health Division planned to incorporate diapers as an incentive for survey completion starting FY 2025.

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

Fetal/Infant Mortality Review

Regional FIMR nurses continue to present de-identified case summaries to our RPAC case review teams for discussion. These teams are made up of professionals from law enforcement, medical providers, social workers,

coroners, DHR, and AMA. The teams discuss the cases, the contributing factors, and make recommendations to prevent similar tragedies in the future. The region-specific recommendations are brought to the cross-sector CATs for implementation. The FIMR team has transitioned from a state created reporting system to the national FIMR data base.

State Perinatal Advisory Committee

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

Breastfeeding

WIC breastfeeding staff and PHD staff work closely with community partners to identify resources that support breastfeeding families and to find new ways for connecting families with those resources. FIMR partnered with PRAMS to identify issues related to breastfeeding. The Wellness Coalition and FIMR partnered together to create a resource guide that provides information to families about the benefits of breastfeeding. The guide has a QR code that can be scanned to launch the PHD website where they will be able to find more information and resources that are available to them.

Collaborating Partners and Initiatives for the MCH Populations

Count the Kicks

Count the Kicks, developed by the non-profit organization Healthy Birth Day, Inc is on a mission to improve birth outcomes through programming, advocacy, and support while reducing racial disparities that persist. Count the Kicks helps save babies from preventable stillbirths, prevents preterm births, and improves outcomes for moms. CDC lists a change in a baby's movement as 1 of its 15 urgent maternal warning signs. Count the Kicks is an evidence-based stillbirth prevention program that provides educational resources to health care providers and expectant parents. In conjunction with the parental education, Count the Kicks offers a free kick-counting app to monitor the quantity and strength of a fetus' kicks beginning in the third trimester. This hallmark tool is available in 16 languages.
In CY 2024, 136 health care professional and community workers placed orders for Count the Kicks educational resources. Through these orders, there were 45,401 Count the Kicks materials such as brochures, app reminder cards, and posters mailed out in Alabama. In May 2024, 98 health care professionals and community workers attended a Count the Kicks webinar. During CY 2024, there were a total of 1,890 website visits from pregnant moms. In Fall 2022, Alabama became the first state (aside from Iowa) to promote Count the Kicks in dental offices. Since the initial year of launch, the OHO has continued to promote the campaign, sometimes initially with skepticism, but always ultimately being embraced by the providers. The momentum of the OHO efforts has continued to generate nationwide interest and implementation. In a recent email from Healthy Birth Day, the OHO was informed, "We are adding 11 states in the next month, making a total of 17!!! Mainly, thanks to you!", bolstering the fact that medical-dental integration is a testament to put the mouth back in the body.

Success Story

Due to ADPH sharing the word about Count the Kicks, he ACHNs are promoting it through maternity care social workers. In January 2024, a network social worker shared the app with a first-time mom and noted that the app has been known to help prevent infant deaths. Together they downloaded the app and walked through how to use it. The following week the new mom reached out to the social worker and noted that fetal movements had dropped causing concern. With social worker assistance, the mom was seen by her doctor within an hour and was scheduled for an emergency C-section as soon as she got there. The umbilical cord was wrapped around the neck and if she had not noticed the decreased kicks, neonatal demise would be evident. Thanks to an attentive mother and the Count the Kicks app, the baby's life was saved.

Babypalooza

In 2024, Alabama held Babypalooza events in three of the largest cities: Birmingham, Mobile, and Huntsville. For the second year in a row, FHS was a sponsor for Babypalooza. There were over 7,500 in attendance. The OHO educated attendees on the importance of oral health during pregnancy, having potential implications in terms of preterm births and low birth-weight babies, both of which can contribute to infant mortality. The attendees were informed and educated on Count the Kicks in an effort to promote awareness of consistent movements of an unborn child during pregnancy as it relates to possible distress of the child and stillbirth potential.

Staff from the PHD presented education on safe sleep, the benefits of breastfeeding, the importance of prenatal care, birth spacing, and information about eligibility for a free crib through our Cribs for Kids Program. Attendees were also awarded incentives for participating in an educational game whereas large dice-shaped cubes were rolled, revealing questions for parents about the different topics for which they received education.

Alabama Perinatal Quality Collaborative

The ALPQC has continued their work with hospitals and providers to implement AIM Patient Safety Bundles on hypertension, postpartum hemorrhage, and hypothermia in neonatal infants. The ALPQC was able to build on the AIM Patient Safety Bundles by piloting the Postpartum Bracelet Project in eight delivering facilities. The purpose of this project is to help doctors, nurses, and other first responders recognize the potential for post-pregnancy related health conditions preventing maternal deaths through education, recognition, and intervention. The PHD staff serve on the steering committee of the ALPQC. Staff from the ALPQC serve on various workgroups and committees lead by ADPH.

March of Dimes

The PHD staff are participants in the MOD workgroups on policy, services, and support related to substance abuse disorders for pregnant women and new mothers.

Increasing Access to Prenatal Services

Labor and Delivery services were temporarily paused at a delivering facility in rural Marengo County in May 2024. Those services were expected to resume September 1, 2024, but they have yet to do so. Forty-three delivering hospitals remain in our state's 67 counties. According to the OPCRH, only 15 of the 54 counties currently considered rural have hospitals providing obstetrical services. At least 25 Alabama counties do not have obstetricians, gynecologists, family-practice physicians, or nurse practitioners who deliver babies who work in those counties.

ADPH Public Health District Initiative

ADPH, JCDH, and MCHD MCH coordinators submitted MCH FY 2024 project proposals to address needs within the Perinatal/Infant Health Domain. These projects focused on infant mortality and injury prevention. Below is a summary of those efforts.

East Central Public Health District
Most often, there is no single factor that causes the death of an infant, and it is often the result of several contributing and associated factors. Leading causes of infant death that contribute to infant mortality in Alabama include birth

defects, low birthweight and preterm births, and SIDS. Associated factors include race, where one lives, environmental influences, and available resources known as community health factors. The rate of preterm birth in Alabama is highest for black infants (16.9 percent), followed by Native American infants (14.4 percent), Hispanic infants (10.3 percent), white infants (11.6 percent), and Asian infants (10.2 percent). Alabama tied with Texas for the eleventh worst state for having a baby. With a higher-than-average mortality rate of both maternal and infants, an astounding 41.40 deaths per 100,000 live births, and 7.08 deaths per 1,000 in infants, which is the fourth worst in the nation for both.
The East Central District continued its Infant Safe Sleep Outreach and Education Project. The district MCH coordinator spoke at conferences, community events, Children's Policy Council meetings, and agencies to promote safe sleep and Count the Kicks. The district MCH coordinator also continued to partner with the Wellness Coalition to maintain lactation rooms and baby depots in Lowndes, Macon, and Montgomery Counties. The depots are a one-stop place where parents and caregivers receive information on healthy babies and healthy moms.

Jefferson County Department of Health

JCDH operates the FDO Program with the goal of improving pregnancy and birth outcomes for women and infants in Jefferson County. FDO is a comprehensive patient-centered program designed to educate and support expectant mothers from the first trimester of pregnancy through their child's first year of life. FDO promotes early access to prenatal care and connects families to beneficial community resources. The patients served by FDO consist of high-risk pregnant women, their infants, and maternal partners. Emphasis is placed on low-resourced, low income, under-insured, uninsured, and minority patient populations. FDO works with Connection Health to provide CHWs to achieve the program goals. CHWs provide the day-to-day monitoring of each participant in the program. In previous studies, it was shown that the western area of Jefferson County accounted for 66 percent of burn injuries, 55 percent of bicycle injuries, and 57 percent of poisonings admitted to COA. With the use of Zip Code mapping, it was determined that the majority of FDO participants live in western Jefferson County.

FDO Program participants receive a baby safety shower in their third trimester of pregnancy. The goal of the Baby Safety Shower is to increase client knowledge on infant safety, thereby reducing the number of childhood injuries and improving infant mortality. Each shower is planned as a special event for the program participant, one supportive person, and all children under the age of 5 in the household. Baby Safety Showers are held quarterly at JCDH and last approximately 2.5 hours. During the Baby Safety Shower, JCDH staff, community partners, and first responders deliver presentations covering a variety of infant health, injury prevention, and safety topics. Participants receive education on safe sleep, breastfeeding, fire safety, gun safety, personal safety, car seat safety, stress reduction, and oral health. Also, at the conclusion of the shower, participants take home safety-related items.

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

Depending on the number of participants, as well as attempting to maintain cost effectiveness, some showers were held in person whereas others were held via Zoom in 2024. Break-out rooms were utilized when the FDO Baby Safety Showers were held via Zoom. This allowed the LEP participants to participate at the same time with an interpreter present. Preparation for the in-person and virtual Baby Safety Showers included helping participants with creating email addresses to receive information about the Baby Safety Shower. This assistance was provided to 90 percent of the Hispanic clients.

In 2024, there were a total of 3 showers and 29 maternity clients participated along with 42 guests. Since July 2018, when the first Baby Safety Shower was held, there have been a total of 22 Baby Safety Showers with a total of 268 maternity clients and 203 family members participating.

Touchless distribution drive-up was held at the local health department in order for the participants to receive the "in-kind" gifts. The safety items distributed in 2023 were Dreambaby® Household Safety Kits, diapers, safety tubs, and Graco® Pack 'n Play playards. The Graco® playards were donated by the IMPACT Family Counseling Cribs for

Kids Program. IMPACT also provided safe sleep information and demonstration during the shower. Diapers were provided by the local diaper bank and feminine products were provided by the Junior League of Birmingham.

One month after the Baby Safety Shower each participant completes a post-test to evaluate knowledge and retention of safety education provided at the shower. In 2024, the pre-test score range for each question was 48 - 100 percent, and after the shower, the post-test score range was 94 - 100 percent.

Finally, when a participant has completed the full 18-month FDO Program, a face-to-face evaluation is done by the CHW in the home. This evaluation includes questions about the of use of safety related items and safety knowledge received at the baby safety shower. A 6-month post-graduation phone interview and evaluation is done by the program administrator or designee to ensure sustained safety adherence. This evaluation assesses safety knowledge and collects data on any preventable injuries sustained at home since safety shower participation.

Mobile County Health Department

From 2020 to present, the state of Alabama has had the third highest MMR in the U.S. According to rankings provided by CDC, between 2022 and 2023 that rate was 64.63 per 100,000 live births, which is significantly higher than the national average of 34.09 per 100,000 live births. Women in Alabama succumbed from pregnancy and pregnancy-related complications at twice the national rate. For black women that rate is exceedingly higher at 100 per 100,000 live births. The fetal and infant mortality rates also rank high in Alabama with over 400 infants dying before they reach their first birthday. Data provided by *2023 March of Dimes Report Card* indicates an infant mortality rate of 7.8 per 1,000 live births in Alabama. This number is higher than the national rate of 5.6 reported by CDC. In Mobile County, the infant mortality rate is 6.7. Contributing to the high rates include LBW, preterm births, birth defects, and SUID such as SIDS. The maternal, fetal, and infant mortality rates are disparagingly higher for black mothers and babies who live in poverty, lack education, and lack quality prenatal and maternal care.

MCHD has a primary care division, FH, with a mobile medical unit and eight clinic sites located throughout the county. FH clinics are designated as FQHC and Primary Medical Homes. FH serves uninsured, underinsured, Medicaid recipients, and those with other forms of health insurance. MCHD has patient care coordinators to help navigate community members to various services provided at the agency. MCHD's Prevention and Wellness Division promotes education, health and wellness, and preventive services to the communities of Mobile County. The MCHD MCH Program helps to encourage and promote healthy women during pregnancy, childbirth, and postpartum as well as the healthy development of infants and children. The program provides education, information, resources, access, and referrals to recommended prenatal and postpartum services including doula services, oral health, well-childcare, infant and maternal mortality prevention education services, behavioral health services to address postpartum depression and other mental health concerns, newborn screenings, child immunizations as well as maternal, and infant and child nutrition through WIC.

The MCHD MCH Program coordinator also works with the FIMR coordinator to provide information to mothers in recognizing key factors that may contribute to SIDS and maternal mortality. The MCH Program helps with Group Connect activities within MCHD Family Support/Home Visitation which services young pregnant and parenting youth, teens, and young adults aged 10 - 19. The MCH Program also provides assistance and services to pregnant and parenting families ages 19 - 44 in Mobile County through community partnerships and collaborations.

The MCHD MCH Program promotes doula and prenatal services, the importance of breastfeeding and lactation services, provides education on safe sleep practices, promotes car seat safety, and encourages positive parenting in collaboration with the Fatherhood Initiative. The goals of the MCH Program are to increase awareness of factors that adversely affect the health of mothers and babies; promote and increase education and resources available to mothers living in Mobile County; and provide services to decrease the rates of infant and maternal mortality in the county. Community collaborations include over 10 community-based, faith-based, and health services organizations. Through its collaborative efforts, the MCH Program assisted over 134 mothers and children and reached over 500 community members in FY 2024.

Safe sleep classes are offered to Home Visitation/Family Support participants starting at 6 months prenatal up to 12 months postpartum. There were eleven safe sleep classes held during FY 2024. Each class participant received a portable Pack 'n

Play playard for their baby and a certificate of completion as incentives participating in the 1-hour class. MCH Program staff participated in seven group connect activities and numerous community outreach events where information, education, and resources on mental health, healthy eating, breastfeeding, car seat safety, and safe sleep, along with information on local resources, education and services, and other MCH topics were provided. In addition to the community events and group connect activities, the partnership between the MCH and Lead Poisoning Prevention Programs progressed in the first quarter as the need to educate parents on lead exposure and poisoning for children remained relevant. During National Lead Poisoning Prevention Week, October 22-28, 2023, program information and resources were shared with the Family Support/Home Visitation Program participants.

In November 2023, a significant staffing change occurred within the MCH program. The MCHD MCH coordinator offboarded from the agency. Due to the coordinator vacancy, proposed activities such as outreach participation, virtual MCH webinars and trainings, and other initiatives were continued by the MCHD MCH Program administrator. Additionally, to fill the gap, Safe Sleep Ambassador trainings were completed by the collaborating Family Support/Home Visitation parent educators. The newly trained ambassadors continued the safe sleep classes and referrals to existing and new participants without interruption. Participation in outreach and community events and MCH trainings also remained, along with referrals for other services such as child passenger safety, doula services, and behavior health.

In FY 2024, the MCHD MCH Program welcomed two new collaborations and partnerships. The first was with a local doula company, Mama Bloom Doula Company, LLC, which was established to provide quality prenatal and postpartum doula services to pregnant and parenting families. This collaboration is essential in promoting healthy pregnancies, healthy outcomes, and a reduction of maternal and infant health disparities. In addition to doula services, the MCH Program continued to provide referral services to lactation consultants to encourage breastfeeding. The second was with the Greater Mobile Chapter of the Links, Incorporated. The Mobile Chapter requested to host a car seat donation drive in March where over 30 child passenger safety seats were donated to the MCH Program.

In the month of February, National Children's Dental Health Month was observed through billboard messaging and during the virtual Group Connect meeting. A local dentist presented on the importance of dental health for both mom and baby, with an emphasis on those pregnant and breastfeeding. The young ladies in attendance were not only asking questions and showing interest in referrals for dental services, but dental professions as well. Through the Alabama Career Center, some young ladies were later provided with information on programs to further careers as dental hygienists and dental assistants. Medicaid has discontinued dental services for young adults aged 19 and up, therefore; participants were encouraged to find local providers, including those at FQHCs that offer sliding and nominal fee scales.

In March 2024, the MCH program administrator attended a Medical Town Hall in the City of Prichard with a focus on maternal health. Local physicians including obstetricians and other health care providers were present. A special guest, Mr. Anthony Wallace, whose wife Dr. Chaniece Wallace tragically passed away due to complications from her first pregnancy, spoke about the tragic and preventable loss.
In 2024, the MCH program administrator participated in the Inaugural Period Party presented by a local service organization whose purpose is to encourage, educate, and empower young girls in grades 9 - 12. The importance of healthy relationships, hygiene, mental and physical health, and responsible choices were shared. The mothers attending the event along with their daughters asked for information on perimenopause, menopause, and changing hormones. Several of the mothers wanted information to share with their daughters on reproductive health.

In May 2024, MCH information and resources were shared with the East Coast Migrant population. Over 30 families received folders on MCH resources in both English and Spanish including safe sleep books.

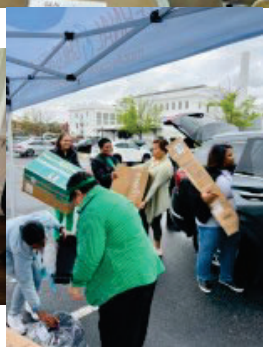
In June 2024, a billboard campaign was launched in collaboration with the MCHD FIMR coordinator to encourage education on gestational diabetes and promote healthy nutrition during pregnancy. Billboards were created and placed in locations throughout Mobile County that read: *"Do You Know How Your Weight Affects Your Pregnancy?"* The campaign was designed to address the areas in Mobile County having the most fetal/infant deaths, along with obesity as a factor. This campaign received positive community feedback and resulted in several families receiving education, referrals, and nutrition resources encouraging a healthy

pregnancy.

Throughout FY 2024, the MCH Program administrator attended outreach and health events as well as garnered new partnerships for the MCH Program. A summary of events follows:

- Mobile Babypalooza Expo - over 150 families and vendors participated in the event.
- Juneteenth Health Event - shared MCH information, including oral health and Count the Kicks.
- City of Prichard Housing Authority, Back-to-School Event - over 100 families in attendance.
- Southwest Mobile County Chamber of Commerce Annual Kid's Day Event - Over 250 families received information, education, and resources on lead, Count the Kicks, child health immunizations, developmental milestones, doulas, safe sleep, and breastfeeding.
- MCHD WIC 50th Anniversary and Breastfeeding Celebration - over 40 women and families in attendance.

In summary, FY 2024 continued the momentum of the previous grant year in providing additional education, resources, and information to pregnant, parenting mothers and families in Mobile County with an emphasis on the Family Support/Home Visitation and Fatherhood Initiative participants and their children. With an increase in new participants for Family Support/Home Visitation, safe sleep classes were referred to the Cribs for Kids® - Alabama Program. The search to fill the MCHD MCH coordinator position continued. The MCH coordinator vacancy reduced some activities early in the first quarter including safe sleep classes, car seat safety referrals, and daycare and provider visits. However, the MCH Program continued to thrive in its goals to decrease the maternal and infant mortality rates in Mobile County through its program objectives and a host of services, education, resources, and community partnerships. In FY 2024 and beyond, the MCH Program looks forward to expanding information on doula services, breastfeeding campaigns, addressing issues directly affecting black maternal health, and providing maternal and infant health resources to communities in Mobile County. The program's future goals will be continuing campaigning for safe sleep and car seat safety, being instrumental in helping to address maternal mental health, and utilizing all forms of social and print media to reach more mothers to help combat the high rates of fetal, infant, and maternal mortality in Mobile County and the state of Alabama.



Southeastern Public Health District

CHS reported that the Southeastern Public Health District had an infant mortality rate of 6.7 for all 10 counties in 2022. Nine of the ten counties within the district experienced at least 1 infant death in 2020, with a total loss of 27 infants. In January 2023, the district introduced the *Safe Bama Baby Project* in three counties. In 2024 the Southeastern District expanded SBB to include four new counties, bringing the total to seven. The participating counties are Barbour, Butler, Coffee, Crenshaw, Dale, Houston, and Pike. SBB is a grassroots safe sleep survey and education project designed to increase local safe sleep practices. There are now 4 district staff certified as Cribs for Kids® Safe Sleep Ambassadors. These ambassadors identified and met with WIC recipients and gifted them tote bags containing oral health, car safety, and safe sleep educational materials and related items. SBB surveyed women in their third trimester of pregnancy and parents/caregivers of infants up to 4 months of age and provided individualized education. If the ambassadors determined that a safe sleep space was needed, they submitted a referral to SPP for the pregnant mom to receive a Cribs for Kids® Cribette®. The incentive item for completing the survey included a Snoozzzette™ Cotton SleepSack from Cribs for Kids®. The zip-able blanket reinforces safe sleep practices.

Unfortunately, in June 2024 the Butler County Health Department was destroyed in a fire. The fire consumed SBB supplies as well as the June surveys for both Crenshaw and Butler Counties. Survey and incentive distribution data will be estimated in this report. Total survey loss is estimated to be between 21-25 surveys for Crenshaw and Butler Counties. An estimated 536 tote bags were distributed in participating counties. Data was collected from 476 surveys. Notable survey responses for the year include: 56 percent deny receiving prior safe sleep education for baby; 67 percent believe that baby should be propped up, placed on their side, or stomach for sleep if baby has GERD or often spits-up; 52 percent of infant sleep spaces contained dangerous items; 5 percent smoke or vape in the home; and 5 percent do not plan to vaccinate. Eleven families were referred for a Cribette®. A total of eight

percent of the mothers that completed the SBB required the assistance of an interpreter. Due to differences in dialects, a picture flip book was utilized to provide visual reference in the event the interpreter was unfamiliar with the object of discussion. In 2025, the district MCH coordinator plans to complete a video in collaboration with the Office of Minority Health in an effort to provide education and assist with taking the SBB survey.

Other ADPH Perinatal/Infant Health Programs

Pregnancy Risk Assessment Monitoring System

PRAMS is a joint surveillance project between the CDC Division of Reproductive Health and state health departments, developed in 1987 to reduce infant morbidity and mortality. ADPH began participating in PRAMS in 1993. The purpose of PRAMS is to find out why some infants are born healthy, and others are not and to positively influence maternal behaviors before, during, and immediately after birth. Mothers are randomly selected from the state's birth registry using Alabama's defined stratum of Medicaid versus non-Medicaid insurance. Developed by the CDC, sample sizes ranging from approximately 1,000 - 3,000 women represent all new mothers who either delivered a live-born infant or had an infant death during the time frame of interest. The PRAMS survey captures information on maternal experiences and behaviors before, during, and after pregnancy by asking mothers questions about their pregnancy and their new infant. To encourage survey completion, sampled mothers can receive rewards such as diapers, insulated coolers, manicure sets, and thermometers if they complete the survey.

There were 1,493 mothers selected to receive a PRAMS survey in 2024. Of these, nearly half of the mothers (47.8 percent; n=714/1,493) completed the survey. To continue building new and existing partnerships, PRAMS staff worked with FIMR and the OHO staff during FY 2024. With the PRAMS data selected by FIMR, PRAMS began designing a breastfeeding factsheet. PRAMS met with the OHO to start designing an oral health fact sheet highlighting 2016 – 2021 PRAMS survey data on dental cleanings, nicotine use, and alcohol use. To continue its existing partnership with the MMRP, PRAMS data was provided to strengthen recommendations highlighted in the 2020 – 2021 MMR Annual Report. Moving forward into FY 2025, the FIMR Breastfeeding Fact Sheet was completed and posted to the Alabama PRAMS website. In addition, PRAMS partnered with eight healthcare providers who agreed to place the fact sheet in their waiting rooms. Providers were selected from counties with the lowest breastfeeding initiation percentages as reported by CHS. With the continued partnership with the OHO, a fact sheet and brochure are being developed to highlight what PRAMS respondents selected concerning their oral health. The OHO will work with OCHA to distribute the produced materials to their target population. Similar to the OHO, a brochure and fact sheet are also being developed for the WW Program highlighting the following topics for 2021 - 2022: chronic disease health conditions before pregnancy, alcohol use, physical activity, and plans for birth control use. The goal is to distribute the fact sheet and brochure within the 12 active WW locations.

Alabama Newborn Screening Program

The ANSFD is part of the BCL. ANSFD ensures that state laws, rules, and regulations mandating newborn screening are followed. Newborn screening includes the bloodspot, hearing, and pulse oximetry screening to detect critical congenital heart defects. In 2024, there were 7.0 FTE to support newborn screening follow-up activities for all disorders tested.

ANSFD establishes protocols to ensure early identification and follow-up of infants affected with certain genetic or metabolic conditions. Early diagnosis reduces morbidity, premature death, intellectual disability, and other developmental disabilities. The program partners with pediatric specialists throughout the state to ensure all babies identified with abnormal results receive timely diagnosis and treatment.

BCL is the sole provider of blood analysis for newborn screening in Alabama. BCL screens approximately 58,000 babies annually, and approximately 150,000 specimens are sent yearly to the lab for testing. The testing panel allows screening for approximately 59 core and secondary disorders. BCL also provides filter paper for screening to medical providers. The current disorder panel includes 35 core conditions of the 38 nationally RUSP.

In 2024, the Administrative Code, Chapter 420-10-1: Care and treatment of infants identified through the Newborn Screening Program, was amended to add Pompe disease and Mucopolysaccharidosis type I. Testing was

implemented for both conditions on July 29, 2024. ADPH partners with the UAB Department of Genetics to evaluate and confirm the diagnosis for these two genetic disorders.

In February 2001, the EHDI Program was established as a new initiative to ensure that every baby born in Alabama is screened for hearing loss. The program aims to provide early and appropriate hearing screening and follow-up when indicated so that infants who are deaf or hard-of-hearing are identified as early as possible and receive timely diagnosis and intervention. In 2008, newborn hearing screening became mandated by public health law. The Alabama EHDI Program collaborates with the ACCP and FHS to provide care coordination services to any baby who does not pass the newborn hearing screening at birth. The ACCP provides case management services, including coordinating appointments, assisting with insurance, and providing transportation and resources as needed to families. Currently, BCL funds social work staff with the BFHS at 2.45 FTE to provide care coordination services to newborn screening referrals. Additionally, the Alabama EHDI contracts with Auburn University, Department of Speech, Language, and Hearing Sciences, to fund four audiology graduate student interns to support hearing activities. The Alabama EHDI Program is supported by two federal grants provided by CDC and HRSA.

In 2024, ANSFD received 2,951 lab, hearing, and heart defect referrals requiring follow-up. Of the babies requiring follow-up, 173 were identified with a disorder (see the table below).

NBS Screening Disorders based on DOB for calendar year 2024	Number of Referrals for Follow-up	Number of Infants Identified	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	1	0	0
Biotinidase deficiency	0	0	0
Carnitine uptake defect (CUD)	72	0	1
Citrullinemia type 1	11	0	0
Classic Galactosemia	20	0	3
Classical Phenylketonuria (PKU)	12	3	3
Congenital Adrenal Hyperplasia	26	2	2
Congenital Hypothyroidism	88	55	55
Critical Congenital Heart Disease	5	1	1
Cystic Fibrosis	273	12	12
Glutaric acidemia type 1	4	1	1
Hearing Loss	1,950	42	42
Holocarboxylase Synthase Deficiency	0	0	0
Homocystinuria	74	0	1
Isovaleric acidemia	9	0	0
LCHAD (Long-chain)	3	0	0
Maple Syrup Urine Disease	33	0	0
MCADD (Medium-chain)	11	3	3
*Methylmalonic acidemia (Cbl A, B)	26	0	0
*Methylmalonic acidemia mutase		0	0
*Propionic acidemia		0	0
Multiple Carboxylase Deficiency	0	0	0
SCID	130	1	1
S Beta thalassemia	6	6	6
SC disease	17	17	17
SS Disease	23	23	23
Trifunctional protein deficiency	1	0	0
Tyrosinemia Type I	93	0	1
VLCAD (very long chain)	5	0	0
SMA (February 14, 2022)	26	3	3
X-ALD (March 13, 2023)	0	0	0
MPS-1 (July 29, 2024) [+1-pilot]	5	0	5
Pompe (July 29, 2024) [+2-pilot]	19	3	19
TOTALS	2951	173	200

*Same analyte is used

ANSFD mandates initial newborn blood screening at 24 - 48 hours of age, with a second screen highly recommended as best practice at 2 - 6 weeks of age to detect delayed thyroid evaluations. Many pediatric providers collect a second newborn screen between 2 and 6 weeks of age. In addition, ANSFD notifies providers if an infant had an initial unsatisfactory newborn screen.

ANSFD seeks to expand relationships with other health professionals in the state, including hospitals and

pediatricians, to enhance existing services and ensure objectives are met. Additionally, 6 Community-Based Sickle Cell Associations provide counseling services for children identified with sickle cell disease and sickle cell trait. The Alabama EHDI Program collaborates with the NCHAM to ensure that all infants with hearing loss are identified as early as possible and provided with timely and appropriate audiological, educational, and medical intervention. In addition, the program collaborates with ADRS, including Alabama EI Services and CRS, to ensure all infants with hearing loss are identified by 3 months of age and enrolled in EI services before 6 months of age.

ANSFD partners with the UAB Sparks Clinic to provide a grant to supplement metabolic foods and formula for infants identified with an inborn error of metabolism. In addition, the program contracts with seven medical consultants connected with diagnostic centers throughout the state who provide comprehensive diagnostic services and medical treatment. One diagnostic center provides confirmatory testing and treatment to newborns who are identified with a newborn screening condition. Children diagnosed with sickle cell disease receive consultation with a board-certified pediatric hematologist at one of three regional pediatric hematology treatment centers. Children diagnosed with cystic fibrosis are referred to an accredited Cystic Fibrosis Care Center, which provides comprehensive care and treatment.

ANSFD has an active advisory committee that consists of professionals and citizens knowledgeable in the area of newborn screening. The Alabama Newborn Screening Advisory Committee provides advice to the ADPH on issues relative to newborn screening and meets twice a year.

ANSFD maintains a website to provide parents and healthcare professionals with access to information. The website includes information on news and events, frequently asked questions, parent information and resources, hearing information and resources, practitioner information and resources, disorder descriptions, rules and laws, brochures and education material, and newborn screening education resources. The website is found at the following link: https://www.alabamapublichealth.gov/newbornscreening/index.html.

Perinatal/Infant Health - Application Year

In the upcoming reporting year, BFHS will address one priority need identified for Perinatal/Infant Health Domain for the 2026 - 2030 State Action Plan. The need is: Infant Mortality. See section III.E. Five-Year State Action Plan for additional information.

Described below are the supporting activities for the implementation of the NPM in
FY 2026.

NPM SS - 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 D) Percent of infants room-sharing with an adult during sleep

ESM SS.3 - The proportion of mothers enrolled in the Cribs for Kids Program who self-reported that their infants are using the cribs for all periods of sleep at the home setting

The FIMR Program will continue to prioritize the need of reducing the number of sleep-related infant deaths by attending and promoting various educational opportunities across the five designated perinatal regions and continuing the Alabama Cribs for Kids® Program. The Alabama Cribs for Kids® Program receives funding annually to help provide a Pack-n-Play to infants 1 year of age and younger that are truly in need of a safe sleeping space. The FIMR Program works with various community partners to promote this program and assists in the completion of the required referrals when needed.

The FIMR Program has created multiple resources that help heighten the awareness of safe sleep practices for all infants ensuring that all Alabamians are following the ABCs of safe sleep. Every October, the FIMR Program promotes Safe Sleep and Sudden Infant Death Syndrome Awareness Month by partnering with various community partners, hospitals, schools, and universities to have them partake in the Clear the Crib Challenge. These clips are then shared across multiple platforms to help educate the public on what a safe sleeping space should look like. The FIMR Program also presents and attends multiple conferences and community baby showers annually to discuss the importance of safe sleep in order to reduce the number of sleep-related infant deaths.

The FIMR program will be able to use the data collected from the Alabama Cribs for Kids® Program follow-up surveys to focus outreach areas where respondents answer less than “always” for questions regarding how their baby sleeps in their home. The plan to engage family and community partnerships to decrease the number of SIDS while raising the awareness of the importance of safe sleep practices is ongoing. FIMR Program staff will coordinate outreach events statewide to continue to promote the Alabama Cribs for Kids® Program and the importance of safe sleep practices. The use of social media platforms and billboards across the state are two additional ways the importance of following safe sleep practices will be shared.

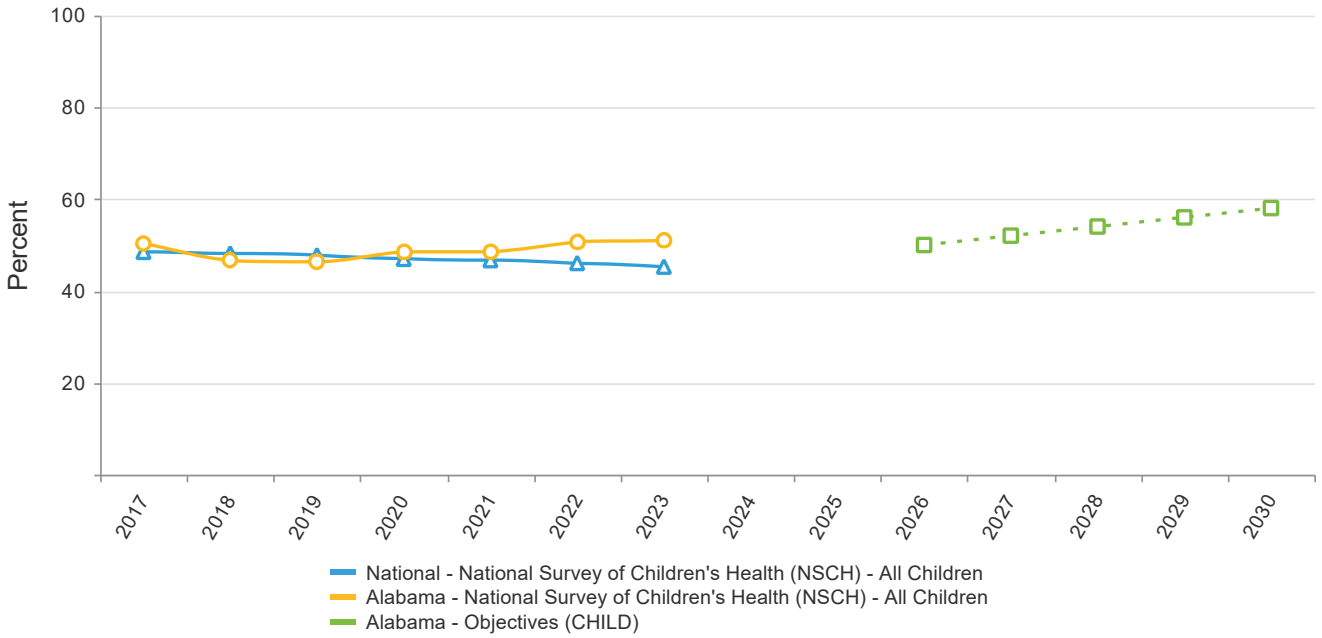
5-Year Objectives

- By 2030, the Alabama Cribs for Kids® Program aims to provide a Pack-n-Play to at least 4,000 individuals.
- By 2030, maintain SIDS as the third leading cause of death or lower for infants as presented in the 2023 CHS Infant Mortality Report. Prior CHS annual infant mortality reports listed SIDS are the second leading cause of infant death.
- By 2030, the out-based FIMR staff will attend 200 community outreach events to promote the Cribs for Kids® Program.

Child Health

National Performance Measures

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



NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Child Health - All Children

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - All Children		
	2023	**2024**
Annual Objective		
Annual Indicator	50.5	50.9
Numerator	555,448	566,035
Denominator	1,099,447	1,112,681
Data Source	NSCH-All Children	NSCH-All Children
Data Source Year	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	50.0	52.0	54.0	56.0	58.0

Evidence-Based or –Informed Strategy Measures

ESM MH.1 - Percent of medical home bookmark survey respondents who find the educational material useful for finding a medical home for their child

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	50.0	52.0	54.0	56.0	58.0

ESM MH.2 - Percent of CSHCN that have a comprehensive Plan of Care.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	50.0	55.0	61.0	67.0	74.0

State Action Plan Table

State Action Plan Table (Alabama) - Child Health - Entry 1	
Priority Need	
Access to Comprehensive Health Care for Children	
NPM	
NPM - Medical Home	
Five-Year Objectives	
By 2030, at least 58 percent of survey respondents found the information concerning the medical homes useful.	
By 2030, at least 125 medical providers offering lead screenings have collaborated with ADPH to distribute the medical home bookmarks, with the initial focus serving those living in rural counties.	
By 2030, ACLPPP will attend at least 25 outreach events targeting medical doctors and families statewide for distribution of medical home bookmarks.	
Strategies	
Coordinate efforts with MCH District Coordinators to expand the area of reach for distribution of the medical home bookmarks.	
Coordinate efforts with the ACLPPP to expand the area of reach for distribution of the medical home bookmarks among medical providers offering lead screenings.	
Coordinate efforts with CHDs to expand the area of reach for distribution of the medical home bookmarks.	
ESMs	**Status**
ESM MH.1 - Percent of medical home bookmark survey respondents who find the educational material useful for finding a medical home for their child	Active
ESM MH.2 - Percent of CSHCN that have a comprehensive Plan of Care.	Active

NOMs

Children's Health Status

CSHCN Systems of Care

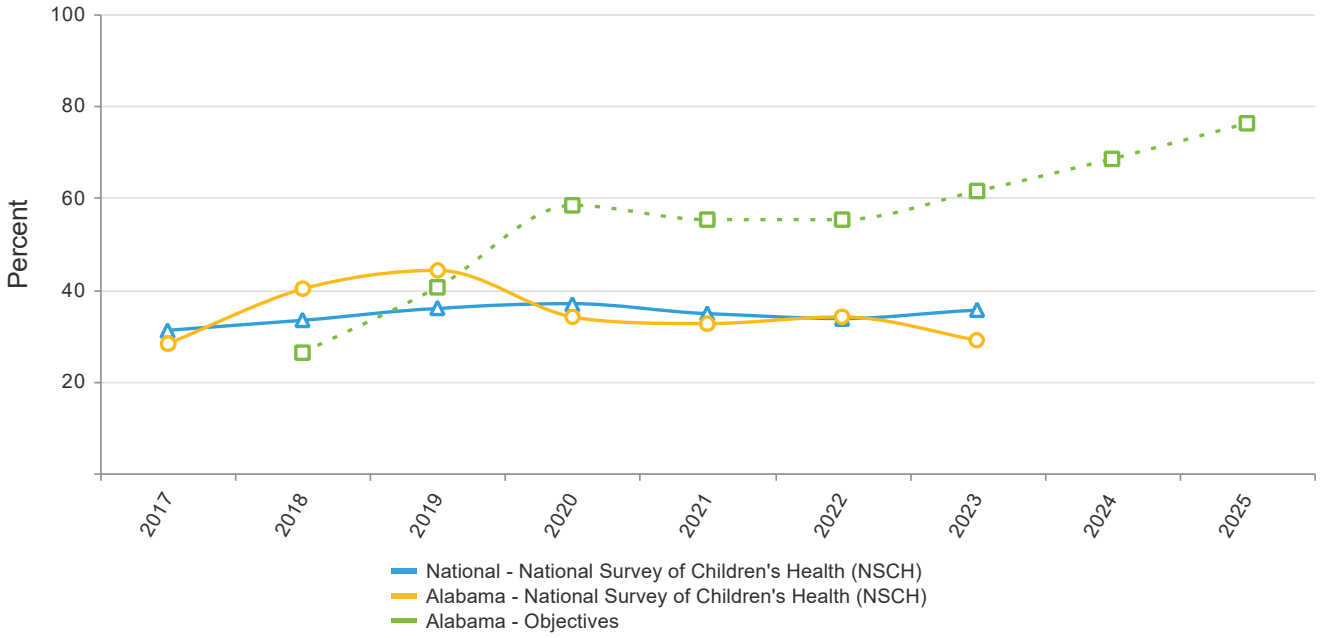
Flourishing - Young Child

Flourishing - Child Adolescent - CSHCN

Flourishing - Child Adolescent - All

2021-2025: National Performance Measures

2021-2025: NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year - DS Indicators



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	58.3	55.2	55.2	61.4	68.4
Annual Indicator	44.6	33.3	32.2	34.2	29.1
Numerator	54,906	40,489	40,979	47,079	41,149
Denominator	122,972	121,453	127,325	137,459	141,567
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM DS.3 - Proportion of children aged 12 & 24 months that have a reported blood lead screening in the past year

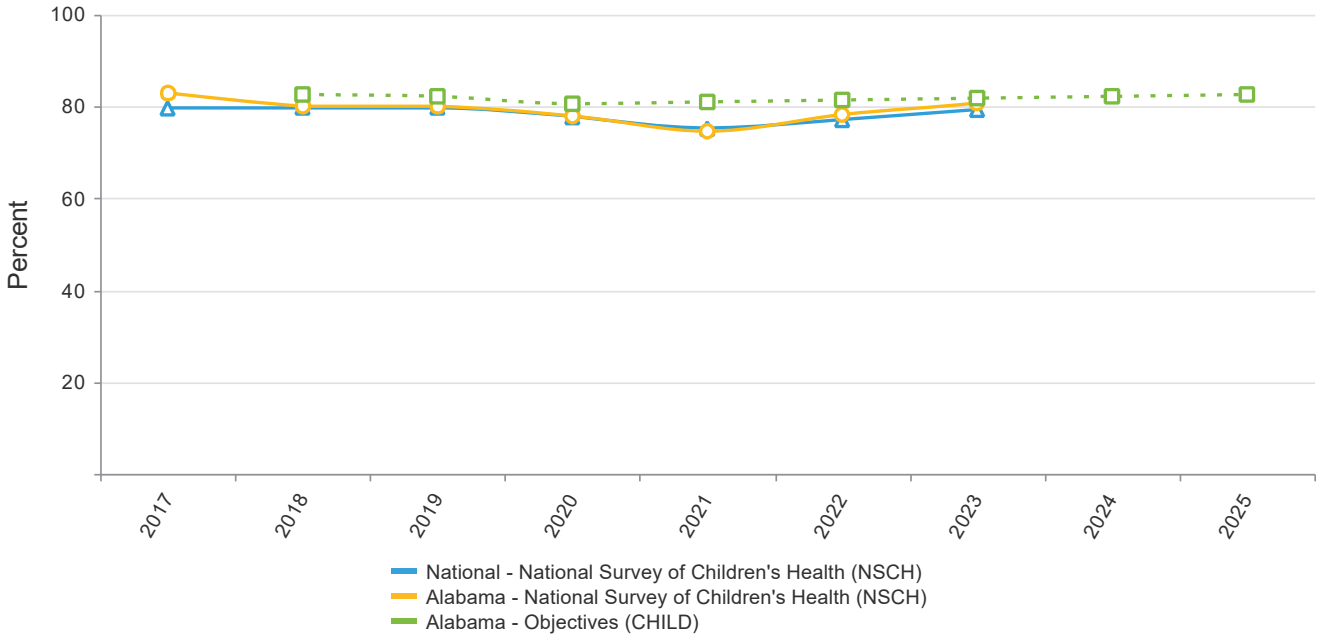
Measure Status:	Active				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		56.8	59.9	60.5	60.3
Annual Indicator	56.2	59.3	56.4	59.7	59.8
Numerator	32,982	36,814	34,885	36,528	35,074
Denominator	58,688	62,081	61,904	61,186	58,607
Data Source	AMA	AMA	AMA	AMA	AMA
Data Source Year	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Provisional or Final ?	Final	Final	Final	Final	Final

2021-2025: ESM DS.4 - Proportion of children birth to age 19 that received a well-child appointment in the past year

Measure Status:	Active		
State Provided Data			
	2022	**2023**	**2024**
Annual Objective			25
Annual Indicator	25.3	30.8	22
Numerator	489	658	458
Denominator	1,935	2,134	2,082
Data Source	CAHD	CAHD	CAHD
Data Source Year	FY 2022	FY 2023	FY 2024
Provisional or Final ?	Final	Final	Final

2021-2025: NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - PDV-Child

Indicators



2021-2025: 2021-2025: NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - PDV-Child - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	80.5	80.9	81.3	81.7	82.1
Annual Indicator	80.8	78.2	74.3	78.2	80.5
Numerator	838,606	800,897	741,934	796,856	839,808
Denominator	1,037,949	1,024,513	998,660	1,019,192	1,043,538
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM PDV-Child.3 - The number of providers including hygienists, nurses, social workers, physicians, pediatricians, nutritionists, and dentists who were provided oral health education and training tailored specifically to the MCH child population

Measure Status:	**Active**	
State Provided Data		
	2023	**2024**
Annual Objective		
Annual Indicator	53	143
Numerator		
Denominator		
Data Source	OHO	OHO
Data Source Year	FY 2023	FY 2024
Provisional or Final ?	Final	Final

2021-2025: State Performance Measures

2021-2025: SPM 9 - Percent of 2 year old children who have received two blood lead tests at 12 and 24 months as recommended by the ACLPP Program

Measure Status:	**Active**		
State Provided Data			
	2022	**2023**	**2024**
Annual Objective			25.7
Annual Indicator	21.4	23.7	24.3
Numerator	3,429	3,916	4,084
Denominator	16,024	16,540	16,831
Data Source	HHLPSS	HHLPSS	HHLPSS
Data Source Year	2021-2022	2022-2023	2023-2024
Provisional or Final ?	Final	Final	Final

Child & Adolescent Health Division

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

ESM DS.3 - Proportion of children aged 12 and 24 months that have a reported blood lead screening in the past year

According to the FY 2024 AMA EPSDT report, 58,607 children from ages 1 to 2 years old received at least one initial or periodic screening. Of those screened, 59.8 percent (n=35,074/58,607) completed a blood lead test. Lead testing in FY 2024 remained relatively stable compared to FY 2023, increasing from 59.7 percent (n=36,528/61,186) to 59.8 percent (n=35,074/58,607).

The ACLPPP receives funding through a memorandum of agreement with AMA, a cooperative agreement with the CDC, and through the Alabama MCH Title V Block Grant. The combined goals of these funding sources are to maintain a childhood lead poisoning prevention program which ensures blood lead testing and reporting, enhances blood lead surveillance, improves linkages of lead-exposed children to recommended services, and develops targeted population-based interventions which prevent lead poisoning, with a focus on Medicaid-enrolled children less than 6 years of age.

In October 2021, the CDC adopted a new BLRV of 3.5 µg/dL based on current NHANES data. The ACLPPP aligned with the new BLRV in January 2022 with intentions of serving even more children going forward. This BLRV change doubled case management referrals and prompted program expansion. A second nurse was hired, increasing the capacity for close medical management as well as education and outreach. With a renewed focus on education and outreach, the ACLPPP anticipates surpassing all previous annual blood lead testing rates with a goal of decreasing the overall rate of children with BLL results at or above the current BLRV of 3.5 µg/dL.

In 2024, the preliminary number of children less than 6 years of age in Alabama receiving at least one BLL screening was 46,895, which is relatively unchanged from 2023. Of those reported, 1,664 children were reported to have at least one BLL result greater than or equal to the BLRV of 3.5 µg/dL. Following program protocols, 1,288 individuals were referred for case management services, which include family education, and may also include home visits to assess for lead sources as well as a referral to the Alabama Early Intervention System for evaluation and additional developmental services, as needed.

In order to achieve program goals, education and outreach remains a program priority. An invaluable part of program outreach is the contract and partnership with subgrantee, MCBH. The MCBH provides targeted education and outreach for lead poisoning prevention in the high-risk city of Mobile within Mobile County. In FY 2024, the MCBH participated in approximately 17 events, including professional conferences, community events, face-to-face meetings, and webinars. The ACLPPP also exhibited at 15 professional conferences and visited 37 medical clinics providing medical practitioners with current program recommendations and available program resources for patients, as well as participating in 26 community events. Program outreach efforts have increased the accessibility of lead poisoning prevention information, including recommendations for testing and reporting, for medical providers, daycares, and the community.

ESM DS.4 - Proportion of children birth to age 19 that received a well-child appointment in the past year

In FY 2024, seven CHDs offered well child appointments. Locations included Butler, Clay, Geneva, Marengo, Randolph, Talladega, and Wilcox. In 2024, a fire led to the potential suspension of Well Child services offered at Butler CHD. The 2023 ACS 5-year population estimates determined which counties have met the OMCH case definition for rural (< 100,000 population) and urban (≥ 100,000 population). According to OMCH breakdown, Alabama is considered largely rural with 54 of the state's 67 counties meeting the rural population criteria. According to the OMCH case definition, all well child sites are located in rural counties. The numerator represented the total number of EPSDT screenings completed and billed by the CHDs. The denominator represented those who were eligible to receive an EPSDT screening at those CHDs. Of those seen within the CHDs, 21.4 percent (n=445/2,082) received a well child appointment. Compared to the previous reporting period, the enrollment percentage decreased from 30.8 percent (n=658/2,134) to 22.0 percent (n=458/2,082). Well child services were evenly distributed between Black, non-Hispanic (42.8 percent; n=892/2,082) and White, Non-Hispanic (41.8 percent; n=870/2,082), with both races comparable with only a 1 percent difference. Hispanics represented a much smaller proportion at only 11.0 percent (n=228/2,082) of eligible children.

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

In 2024, there were 16,831 children who were at least 2 years old residing in Alabama. CDC recommends all children should complete a lead screening at 12 and 24 months. Among children receiving a lead screening, 24.3 percent (n=4,084/16,831) were screened at the recommended 12- and 24-month intervals compared to 23.7 percent (n=3,916/16,540) in the previous reporting period, representing a slight increase. Alabama is a largely rural state and residential status may have an impact on children receiving the recommended number of lead screenings. With the Alabama's 2023 ACS 5-year county population estimates, OMCH identified which counties are either rural (< 100,000 population) or urban (≥ 100,000 population). Close to 45 percent (44.8 percent; n=7,534/16,831) of 2 year old children lived in an urban county, while 36.4 percent (n=6,129/16,831) lived in a rural county.

The ACLPPP continued efforts to improve the number of children receiving both recommended screenings through education, outreach, prevention, and other activities with a special focus in rural areas.

Oral Health Office

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

ESM PDV-Child.3 - The number of providers including hygienists, nurses, social workers, physicians, pediatricians, nutritionists, and dentists who were provided oral health education and training tailored specifically to the MCH child population

The OHO presented to HCCA Nurse Coordinators, the importance of healthy oral health in children being the foundation of good overall health in the future. Plans are underway to coordinate with HCCA to develop a lesson plan for HCCA nurses to provide oral health trainings to daycare workers and families.

The OHO collaborated with CRS and Dr. Janice Jackson a Chair and Professor in the UAB School of Dentistry during Children's Dental Health Month to provide oral health information in the feeding clinic for Jefferson County.

Oral Health Care

Alabama Department of Early Childhood Education

The OHO continues to collaborate with Alabama Pre- K Early Childhood Education, Head Start, and Early Head Start to fulfill dental screening enrollment requirements. Oral health is part of the comprehensive health assessment for enrolled children. The OHO willingness to screen ensures program compliance. The OHO conducted screenings for a total of 3,334 children in Head Start and Pre-K programs

Singing River Dentistry

In another pilot program, the Northern District successfully engaged with a private entity, Singing River Dentistry, through an MOU to provide the same services as the community college hygiene program partners. Totaling 10 different locations in the northern tier of the state. The office in Russellville, Alabama, was chosen as the initial location for the partnership due to its rural setting and lack of access to dental providers. Patient satisfaction and educational surveys comprise the final aspects of patient encounters, similar to the model set forth in the community colleges.

Singing River Dentistry
5 children in FY 2024
14 children since January 2024

Tuscaloosa County Health Department Dental Clinic

The Tuscaloosa CHD is the only ADPH dental clinic. It provides preventive and restorative services for children mainly covered by Medicaid and All Kids. The facility consists of three operatories with a clinical staff of a dentist, a hygienist, and an assistant. The clinic hosts fourth year (D4) dental students for pediatric rotations from the UAB School of Dentistry. The facility is plagued with a high broken appointment rate which will hopefully be lessened by the implementation of appointment text reminders, pending approval by finance and IT. Tuscaloosa County is adjacent to Greene County, one of several Alabama counties with no dentist. To provide some modicum of dental services to children in in this county, the dental staff from the Tuscaloosa CHD outfitted two exam rooms with portable dental equipment in the Greene CHD. With such limited staff, resources for the Greene CHD are minimal, but the services are a valuable asset to the draw of the health department, and much appreciated by those utilizing its services. In 2024 there were 2,031 patients seen in the dental clinics. In 2024 discussions began to establish a single operatory in the Perry County Health Department for similar access to care reasons.

D4 Students During Tuscaloosa CHD Rotation

Ongoing Activities in Alabama to Improve Oral Health:

TeamSmile

The data collected by the OHO 2020-2022 BSS continued to be the impetus of ongoing efforts to increase access to care for Alabama children. As a result of identifying a particular area of the state in Blount County with exceptionally high decay rates, the UAB School of Dentistry expanded the screening population beyond the kindergarten and third grade population. Alabama currently has the lowest number of dentists to population in the U.S., with Blount County being 1 of 11 counties that only have 1 dentist under 40 years of age. Additionally, only 18 percent of the county has fluoridated water. The alarming results culminated in the school partnering with TeamSmile to bring the first ever event to Alabama. TeamSmile partners with oral health professionals and professional sport organizations to provide free dental care and education to underserved children. TeamSmile and UAB organized an event at the school's Bartow Arena bringing together 170 UAB and community volunteers, including the OHO Dental Director and Oral Health Coordinator, and served a total of 237 children. Dental services included exams, X-rays, hygiene, fillings, sealants and silver diamine fluoride application, and extractions. The children were also able to enjoy face painting, mascots, UAB sports team representatives, and other fun activities. The event was so successful and impactful that a second event is scheduled for Fall 2025.

Father Purcell Memorial Center for Exceptional Children

The Father Purcell Memorial Exceptional Children's Center is a skilled pediatric nursing home for 58 developmentally disabled children. It serves children throughout the U.S. of all races and creeds, providing custodial care, medical treatment, and rehabilitation programs. The mission of the Father Purcell Memorial Exceptional Children's Center is to provide a residential care program to developmentally disabled children, their families, and the larger community without regard to race, color, religion, nationality or socioeconomic status.

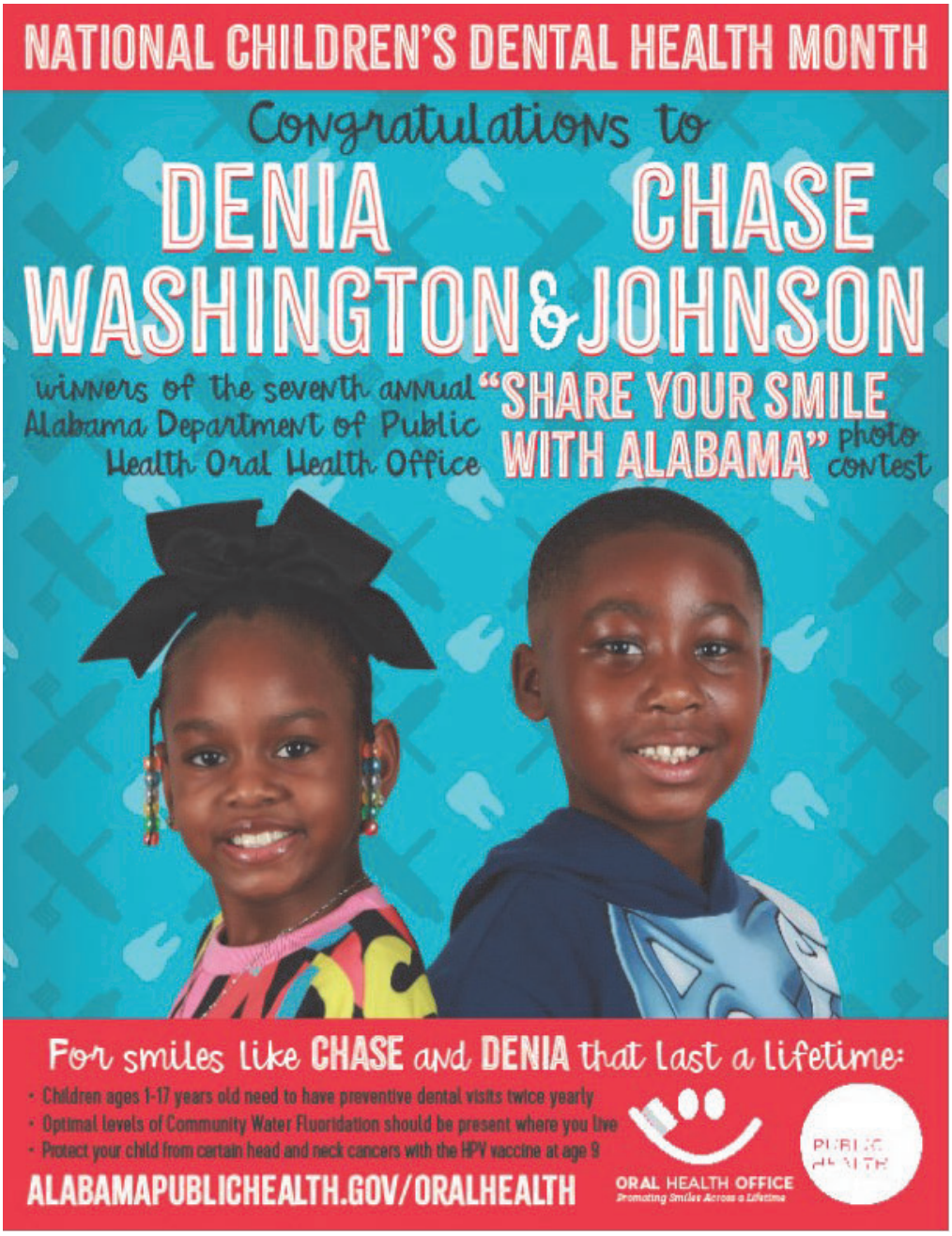
As one of only two residences of its type in Montgomery, the offer by the OHO to supply dental health kits to the children was eagerly and graciously accepted some years ago. On a 3-month schedule, new dental health kits are sent to the nursing staff with the understanding that additional shipments can be requested at any time as needs emanate from outbreaks and increased contagious illness. In 2024, as a result of the established rapport by the OHO, the BFHS chose to provide Christmas gifts which were distributed during a visit from Santa Claus and Mrs. Claus, (BFHS Medical Officer and his wife). Each child was outfitted with knitted scarves, mittens, and hats during

the visit, providing useful clothing items and cheer for residents and staff alike.

Oral Health Education

Share Your Smile with Alabama

The seventh annual *Share Your Smile with Alabama* smile contest successfully concluded in February 2024, coinciding with NCDHM. The contest features a boy and girl third grade winner selected from non-professional photo submissions by parents/guardians throughout the state. The winners are invited to the ADPH TV studio for a live news conference to announce the winners. The children are featured on billboards near their school and on posters and flyers which highlight NCDHM, the importance of preventive dental visits, promotion of the HPV vaccine for boys and girls, and the importance of community water fluoridation. The staff at the American Dental Association has made a point to promote the contest on an annual basis to other state programs in search of innovative methods to promote NCDHM. At each of the eight news conferences to date when winners were announced, Alabama's State Health Officer made it a point to say, "This is my favorite thing we do at ADPH."



Strolling Thunder

Strolling Thunder is a national advocacy event hosted by ZERO TO THREE. Strolling Thunder focuses on policy solutions that ensure all babies and families in Alabama have what they need to thrive including good health, strong families, and positive early learning experiences. This fun, family-friendly event is a day when babies, toddlers, their families, and advocates for young children can gather in one location, at the Alabama State Capitol. The event brings attention to what families need to thrive, provides the opportunity to meet with state and local elected officials, and gather information on how to raise strong babies on topics such as literacy, infant and early childhood mental health, breastfeeding, development, nutrition and much more.

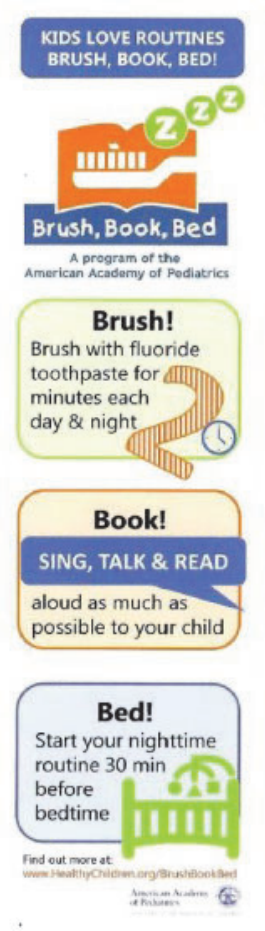
Numerous divisions and programs from ADPH attended as vendors providing information on their initiatives and educational materials. Participating for the third year in 2024, the OHO provided answers (printed and verbal) to

questions related to the importance of oral health during pregnancy, the care of children's teeth, and the importance of CWF. Dental health kits consisting of age-appropriate toothbrushes, toothpaste, floss, and toothbrush timers were provided to attendees ranging in age from toddlers to adults.

Brush, Book, Bed

In a previous year, engagement with the Alabama Chapter of AAP led to a partnership with the OHO utilizing the Brush, Book, Bed Campaign. The premise of the campaign was to establish the importance of a regular and repeatable nighttime routine for children to establish guidelines to promote healthy bedtime habits. The importance is stressed to encourage children to brush their teeth, read a book, and go to bed at the same time each night. Since the initial campaign, and even in the absence of a structured collaboration with AAP, the OHO has continued to promote the well-received initiative with enthusiastic engagement from parents as well as organizations.
Learn more about the campaign in *YOUR MOUTH YOUR HEALTH*

Brush, Book, Bed Bookmark



ADPH Public Health District Initiative

District MCH Coordinators submitted FY 2024 project proposals to address needs within the Child Health Domain. These county-specific projects targeted access to oral health care, increased EPSDT visits, and suicide prevention. Below is a summary of those efforts.

Northeastern Public Health District

Good oral health is important to a child's physical, social, and mental development. Even though tooth decay can be prevented, most children in Alabama still develop cavities. Tooth decay is known as the most common chronic disease among children. It unequally affects minority and low–socioeconomic status children and is associated with many poor outcomes. Loss of teeth, impaired growth, decreased weight gain, poor school performance, and poor quality of life are among the poor outcomes. The most recent data on children in Alabama showed 30-50 percent have early childhood caries. Potential risks for children, often identified during WIC visits, include infrequent daily dental hygiene and yearly dental exams. For the above reasons, the Northeastern Public Health District chose to focus on oral health. The goal of the project is to improve oral health in children ages 6 months to 5 years that are currently receiving WIC, to increase routine dental exams, and to identify dental caries.

Partnerships were developed with the WIC Nutritionists to complete a dental questionnaire to determine if a yearly exam has been completed and to screen for dental problems. At the conclusion of the screening, parents were given a list of dentists to choose from for their child's oral exam. Six months following the original WIC clinic screening, two

office assistants and the District MCH Coordinator follow up on each patient to determine if they have completed the oral exam with a dentist. Dental exams were verified through AMA, and if the child did not have Medicaid, then the parents received a phone call to determine if the child completed their dental appointment. If these methods are unsuccessful an email is sent through the WIC EHR system, to attempt one last effort to contact parents. Each child referred for dental care received a toothbrush, toothpaste, and floss. Each child screened received educational materials to promote good oral health.

In FY 2024, 6,557 children in the WIC Program were screened; 3,432 children were referred to a local dentist for an oral exam; 3,396 follow-up contacts were completed; and 1,142 children received oral exams. There was a 43.3 percent increase in completed exams from FY 2023.

The District MCH Coordinator participated in 20 health fairs and events in the district and distributed dental education materials and incentive items to promote good oral health.

Northern Public Health District

The district maintained past partnerships and recruited new resource options for access to dental care for children ages 0-17 and expectant mothers. The partnership continued with Calhoun Community College and Wallace State Community College. Singing River Dentistry was added to the project in January 2024 to expand the provision of free oral health services for uninsured or underinsured expectant mothers and children. ADPH provides in-kind reimbursement through the provision of dental supplies for all partners per 100 patients served in FY 2024. A total of 145 children received dental cleanings and exams through the partnerships.

Southwestern Public Health District

The 2025 Robert Wood Johnson County Health Report indicated a continued decline in the overall health outcome rank for Marengo and Wilcox Counties. Marengo declined from rank 54 in 2021 to rank 57 in 2022. The report shows that Marengo County has again declined, to rank 58 in the state in 2023. In 2021, 2022, and 2023, Wilcox County remained the lowest rank for the state at 67 among Alabama’s 67 counties. Marengo and Wilcox Counties both show that 3 percent of children were uninsured in 2022. This number has increased to 4 percent in 2023 and remained at 4 percent in 2024 for both counties.

The rate of children in poverty in Marengo County has increased from 33 percent in 2023 to 34 percent in 2024. The rate of children in poverty in Wilcox County was 29 percent in 2022 and increased to 49 percent during 2023. The rate decreased slightly in 2024 to 46 percent. The average rate of children in poverty in Alabama was 22 percent in 2024. However, Alabama continued to have a higher percentage of children in poverty compared to the national average at 16 percent in 2024.

The EPSDT Program is designed to identify children under the age of 21 that are enrolled in Medicaid with actual or potential health problems and to screen, diagnose, and treat the problems before they become permanent, lifelong disabilities. Prevention can help ensure the early identification, diagnosis, and treatment of conditions before they become more complex and costly to treat. EPSDT visits will ensure children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services. A past due EPSDT list of Medicaid eligible patients has been provided to aid clerical staff in contacting potential patients in Marengo and Wilcox Counties to schedule EPSDT screenings. However, due to lack of accurate contact information for eligible participants, scheduling appointments has proven to be difficult. The District MCH Coordinator provides outreach and education to local medical clinics and community groups to provide education regarding the importance of the EPSDT screenings. In addition, radio and newspaper announcements have been disseminated to each community

regarding availability and contact information for scheduling appointments. Parents can schedule EPSDT visits, or children can be referred by their primary medical provider.

Alabama children will be healthier by receiving preventative services and management of developmental issues and diseases. Identified children will receive referrals for dental care, mental health care, and CRS resources as needed. Marengo and Wilcox Counties have seen a decrease in the number of children seen in each clinic for EPSDT visits in FY 2024. Marengo County completed 93 screenings in FY 2024 compared to 123 completed in FY 2023. The screenings completed in Marengo County resulted in 27 children receiving referrals or resources for dental care, 7 children receiving mental/behavioral health referrals, 1 Early Intervention referral, 8 vision referrals, 2 hearing referrals, 5 elevated lead referrals, and 17 referrals for follow-up appointments with the primary medical provider.

Wilcox County completed 40 screenings for FY 2024 compared to 103 screenings completed in FY 2023. The screenings completed in Wilcox County resulted in 8 children receiving referrals or resources for dental care, 1 referral for Early Intervention, 1 Mental/Behavioral Health referral, 14 vision referrals, 1 elevated lead referral, and 3 referrals for follow-up appointments with the primary medical provider.

West Central Public Health District

The West Central Public Health District is located in a more rural area of the state and dental services are severely lacking in certain counties. There is no private dental provider in Greene County, and this is a barrier to care for the residents in the county. The 2018 OHO State Oral Health Plan indicates that children in Greene County have a high risk for dental caries and lack a dental home. Data also shows that poor dental hygiene and oral health can affect physical health. For the previously mentioned reasons, the district decided to focus on improving oral health care for pregnant women and children ages 21 and younger.

CHD WIC staff used a dental screening tool to help identify children and pregnant women who needed dental care. A total of 4,083 WIC participants were screened for oral health needs and of those screened, 374 were referred for dental services. The District MCH Coordinator partnered with the Tuscaloosa CHD dental clinic to provide services for those who were identified as needing dental care if they did not already have a dental home. Dental services were provided by the Tuscaloosa CHD dental staff twice a month at the Greene CHD. A total of 82 exams were completed in the Greene CHD dental clinic. In FY 2024, there were 135 children who received fluoride varnish and 29 children who received silver diamine fluoride application. This was an increase by 56 children who received fluoride varnish compared to the previous year. There was a total of 33 children who received sealants compared to 13 children who received sealants in 2023. All children seen received dietary counseling along with oral hygiene instructions.

In addition to providing dental services in Greene County, the TCHD dental staff completed 112 dental screenings at Eutaw Primary School in Greene County and 66 dental screenings at Robert C. Hatch in Perry County. The staff also completed dental screenings for 198 Pre-K students at several elementary schools in the Tuscaloosa County School System. Each child screened received a dental kit that included a toothbrush, toothpaste, dental floss, and educational materials to bring about awareness of the importance of good oral health. The goal to increase access to oral health care in Greene County was met for FY 2024.

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

Other ADPH Child Health Programs

Healthy Child Care Alabama Program

HCCA is designed to address the integration of health concepts and child care health and safety issues in out-of-home child care by using the Nurse Health Consultant and Child Care Models. It is a collaborative effort between ADPH and DHR. HCCA provides services statewide through 15 nurse consultants. HCCA nurse supervisors, based in Montgomery, provide oversight and management of the program and if required, interim services in the absence of a HCCA nurse consultant. During FY 2024 HCCA nurse consultants provided 8,963 health and safety classes to 49,313 provider staff.

The HCCA website has a page for parents with resources such as information on the flu; oral health; hand, foot and mouth disease; RSV; immunizations; and head lice. The website includes a page with related links that provide referral sources, such as DECE, ALL Kids, Help Me Grow Alabama, and DHR.

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

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

HCCA nurse consultants are available to providers by phone throughout the day. In addition, HCCA nurse consultants provide flu information to providers for parents prior to September 1, each year.

Child Passenger Safety

The Child Passenger Safety Training Program, housed within BPPS, conducted 5 technician trainings, adding 28 technicians, 1 fitting station, and 4 car seat distribution sites in the state. Two staff members received endorsements as hybrid and lead instructors, and another participated in the instructor candidacy mentoring program and became an instructor. The program hosts a monthly car seat clinic, available by appointment only, to educate caregivers, check car seats, and provide car seats to individuals who otherwise would not be able to obtain one. Throughout the year, information was distributed to 177 families who attended car seat clinics. Child Passenger Safety Program staff also hosted car seat events in two rural and underrepresented communities, serving 31 families and providing 41 car seats.

Child Death Review

The ACDRS, housed within BPPS, reviews and identifies unexplained or unexpected child deaths in Alabama to develop strategies to prevent such deaths from occurring. Forty-two local child death review teams throughout the state review child death cases each year. For the 2023 reporting year, there were 302 reviewable cases; that number decreased from 309 reviewable cases in 2022. Motor vehicle incidents, sleep-related deaths, and bodily force and weapon-related deaths remain the three leading causes of death for children in Alabama. In June, ACDRS sponsored a 2-day training for law enforcement, coroners, child advocates, nurses, social workers, and EMS personnel. The Sudden Unexpected Infant Death Investigation training included death scene re-enactment and scene reconstruction. The 26 attendees received training on how to document and investigate infant and child deaths and child abuse cases more effectively. Investigation kits were provided to law enforcement to use in their jurisdictions when investigating cases. The program continues to partner with UAB and USA on prevention efforts in the state. Through awareness, education, and prevention efforts, ACDRS continues to work to make strides that reduce child deaths in Alabama.

Child Health - Application Year

In the upcoming reporting year, BFHS will address one priority need identified for the Child Health Domain for the 2026 - 2030 State Action Plan. The need is access to comprehensive healthcare for children. See section III.E. Five-Year State Action Plan for additional information.

Described below are the supporting activities for the implementation of the NPM in FY 2026.

NPM MH – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH

ESM MH.1 - Percent of medical home bookmark survey respondents who find the educational material useful for finding a medical home for their child

The established priority needs for 2021 – 2025 focused on impacting the developmental screening NPM (the percent of children ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year), with the ESMs and SPMs reporting on performance of the five EHS programs participating in the EHSCCP grant program, well-child screenings among active CHDs, and lead testing statewide. Efforts will be transitioned to develop an effective ESM to positively impact the medical home NPM.

For the Child Health Domain, access to comprehensive health care for children as the priority area for the 2026 – 2030 reporting period based on the findings from the Title V MCH Needs Assessment was selected. Planned activities include the distribution of newly developed medical home bookmarks through outreach efforts made by the ACLPPP and the MCH District Coordinators at community events, CHDs, and medical providers offering lead screenings. The medical home bookmark features six aspects of a medical home. These include accessible, family centered, continuous, comprehensive, coordinated, and compassionate.

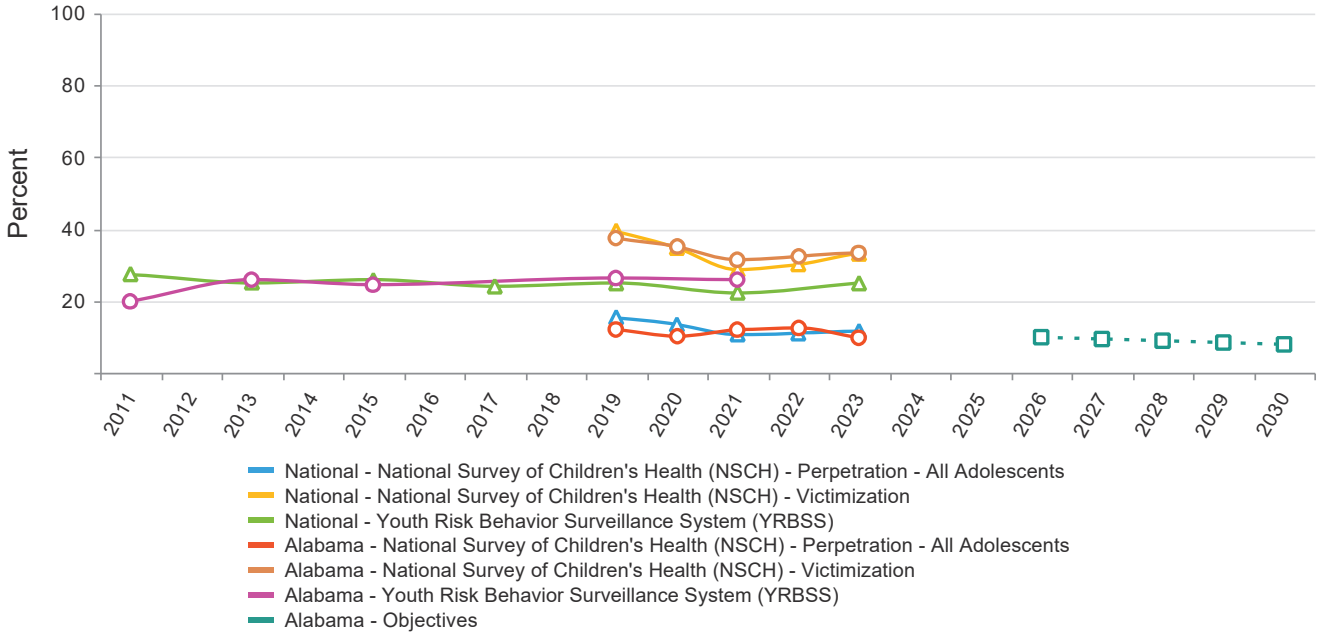
The aim is to provide education and increase awareness on the importance of children having access to a medical home among families. Within the medical home bookmark, a QR code will give recipients an opportunity to answer questions concerning their child's access to a medical home. The survey questions were developed in collaboration with the MCH Evidence Center at the National Center for Education in Maternal and Child Health.

As shown in the State Action Plan, the 5-year objective goals are set to achieve statewide distribution of the medical home bookmarks by 2030. Through the partnerships and community events mentioned above, surveys completed through REDCap will be analyzed to make adjustments as needed to the educational outreach model.

Adolescent Health

National Performance Measures

NPM - Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others - BLY
Indicators and Annual Objectives



NPM - Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others - BLY - Adolescent Health

Federally Available Data	
Data Source: Youth Risk Behavior Surveillance System (YRBSS)	
	2024
Annual Objective	
Annual Indicator	25.9
Numerator	55,850
Denominator	215,916
Data Source	YRBSS
Data Source Year	2021

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - Perpetration - All Adolescents	
	2024
Annual Objective	
Annual Indicator	10.0
Numerator	38,479
Denominator	384,155
Data Source	NSCHP-All Adolescents
Data Source Year	2022_2023

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - Victimization	
	2024
Annual Objective	
Annual Indicator	33.5
Numerator	128,534
Denominator	383,399
Data Source	NSCHV-All Adolescents
Data Source Year	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	10.0	9.5	9.0	8.5	8.0

Evidence-Based or –Informed Strategy Measures

ESM BLY.1 - The percent of youth, ages 10-19 who report an increase in knowledge, intention to change behavior, and/or confidence in abilities after receiving positive youth development education that addresses bullying prevention.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	50.0	52.0	54.0	56.0	58.0

State Action Plan Table

State Action Plan Table (Alabama) - Adolescent Health - Entry 1

Priority Need

Adolescent Safety and Wellness

NPM

NPM - Bullying

Five-Year Objectives

By 2030, 58 percent of survey respondents ages 10 to 19 report an increase in knowledge after receiving positive youth development education that addresses bullying prevention.

By 2030, 58 percent of survey respondents ages 10 to 19 report an increase in intention to change behavior, after receiving positive youth development education that addresses bullying prevention.

By 2030, 58 percent of survey respondents ages 10 to 19 report an increase in confidence in abilities after receiving positive youth development education that addresses bullying prevention.

By 2030, reach at least 7,500 youth through positive youth development education that addresses bullying prevention.

Strategies

Determine bullying prevention topics to address through positive youth development education.

Establish curriculum and/or program models that address selected bullying prevention topics.

Incorporate bullying prevention topics, curriculum and/or program models into current positive youth development education.

Coordinate with the evaluation team to develop survey questions that measure an increase in knowledge, intention to change behavior, and/or confidence in abilities related to bullying prevention.

Provide training to staff delivering positive youth development education that addresses bullying prevention.

Aim for at least a 10 percent annual survey response rate among youth ages 10 to 19 who initiated positive youth development education that addresses bullying prevention.

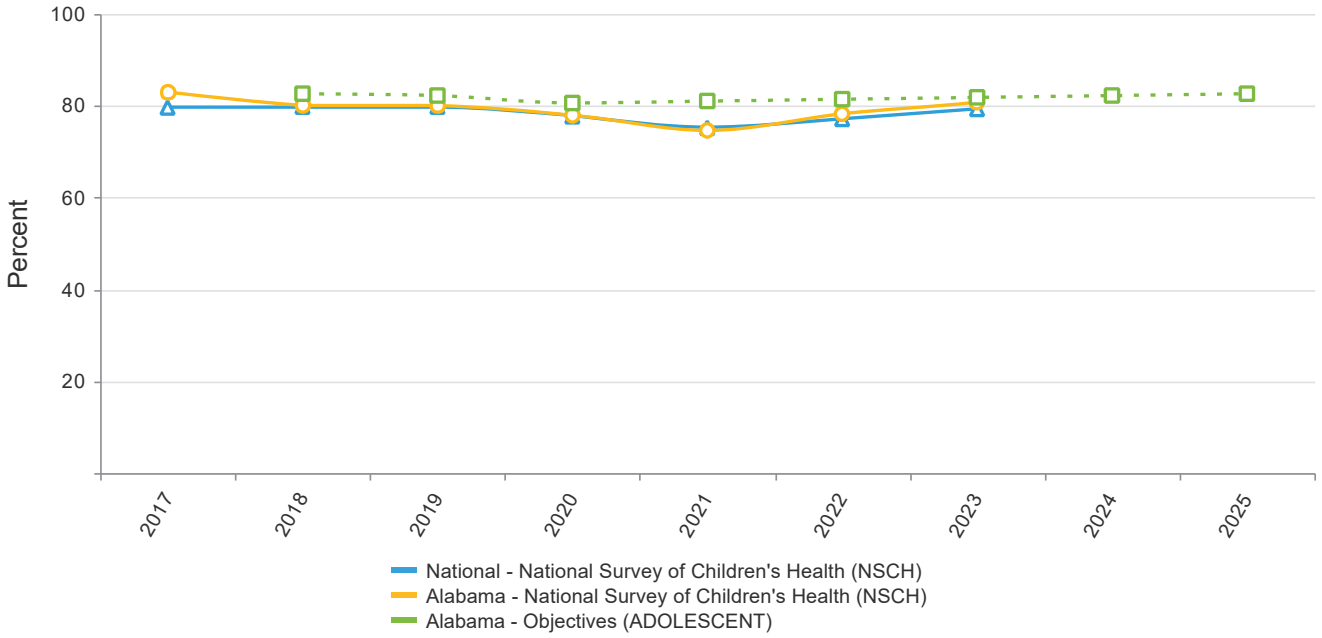
ESMs	Status
ESM BLY.1 - The percent of youth, ages 10-19 who report an increase in knowledge, intention to change behavior, and/or confidence in abilities after receiving positive youth development education that addresses bullying prevention.	Active

NOMs

- Adolescent Mortality
- Adolescent Suicide
- Adolescent Firearm Death
- Adolescent Injury Hospitalization
- Adolescent Depression/Anxiety
- Adverse Childhood Experiences

2021-2025: National Performance Measures

2021-2025: NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - PDV-Child
Indicators



2021-2025: NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - PDV-Child - Adolescent Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	80.5	80.9	81.3	81.7	82.1
Annual Indicator	80.8	78.2	74.3	78.2	80.5
Numerator	838,606	800,897	741,934	796,856	839,808
Denominator	1,037,949	1,024,513	998,660	1,019,192	1,043,538
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

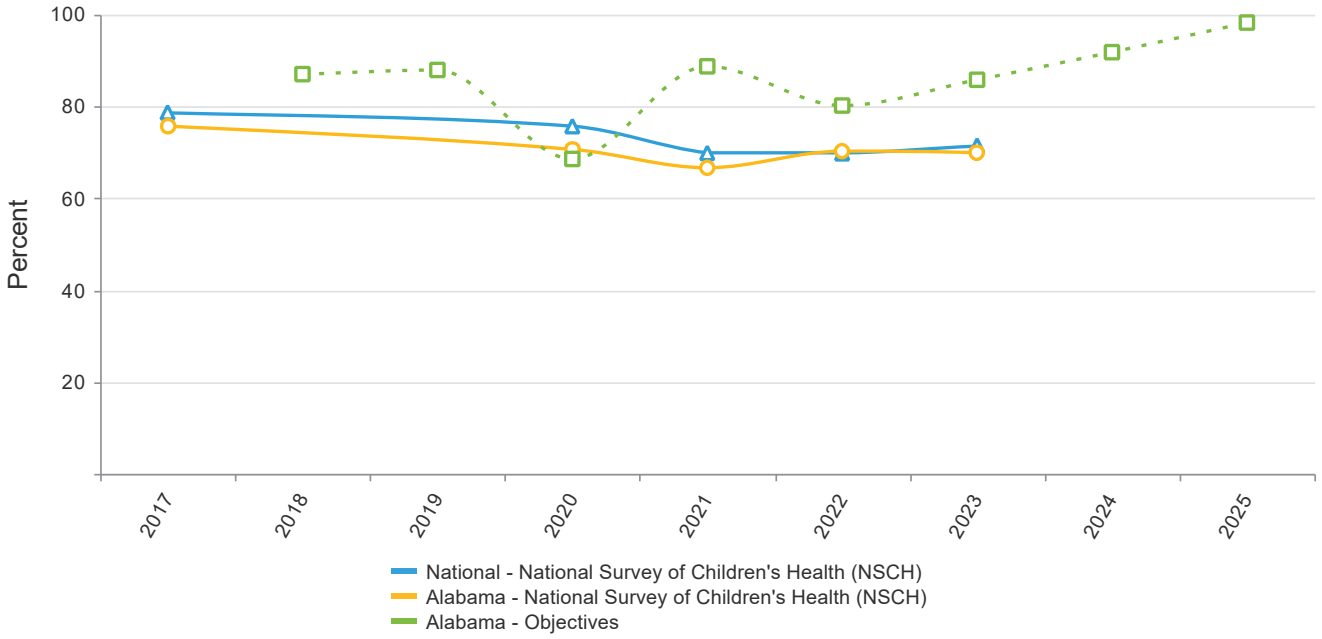
2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM PDV-Child.3 - The number of providers including hygienists, nurses, social workers, physicians, pediatricians, nutritionists, and dentists who were provided oral health education and training tailored specifically to the MCH child population

Measure Status:	**Active**	
State Provided Data		
	2023	**2024**
Annual Objective		
Annual Indicator	53	143
Numerator		
Denominator		
Data Source	OHO	OHO
Data Source Year	FY 2023	FY 2024
Provisional or Final ?	Final	Final

2021-2025: NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV

Indicators



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	68.5	88.6	80.1	85.7	91.7
Annual Indicator	77.4	70.0	65.6	70.1	70.0
Numerator	253,566	244,204	242,660	268,610	272,175
Denominator	327,459	348,830	369,817	383,218	389,070
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2019	2019_2020	2020_2021	2021_2022	2022_2023

2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM AWV.2 - Proportion of adolescents, aged 12 to 19, that received an adolescent well-visit in the past year

Measure Status:	Active		
State Provided Data			
	2022	**2023**	**2024**
Annual Objective			35
Annual Indicator	34.5	38.4	36.2
Numerator	93,115	109,732	102,838
Denominator	270,078	285,578	284,470
Data Source	AMA	AMA	AMA
Data Source Year	FY 2022	FY 2023	FY 2024
Provisional or Final ?	Final	Final	Final

Child & Adolescent Health Division

ESM AWV.2 - Proportion of adolescents, aged 12 to 19, that received an adolescent well visit in the past year

The OMCH utilized AMA data to capture how many adolescent well visits were provided among individuals ages 12 to 19. Adolescent well visits in FY 2024 remained relatively stable compared to FY 2023, decreasing from 38.4 percent (n=109,732/285,578) to 36.0 percent (n=102,838/284,470).

Oral Health Office

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

ESM PDV-Child.3 - The number of providers including hygienists, nurses, social workers, physicians, pediatricians, nutritionists, and dentists who were provided oral health education and training tailored specifically to the MCH child population

The OHO has a unique tether to VAX2STOPCANCER, a nonprofit working to prevent cancer by expanding the utilization of the HPV vaccine through education, public awareness, and advocacy. The professional relationship between the OHO and the Board of Dental Examiners of Alabama allows 1 hour of CE credit to be issued to Alabama dental providers upon completion of the online course offered by VAX2STOPCANCER.

ADPH Public Health District Initiative

West Central Public Health District

In 2022, CHS reported suicide as the thirteenth leading cause of death in Alabama with 837 citizens dying by suicide. The 2022 suicide rate in Alabama was 16.5 per 100,000 population, which is higher than the U.S rate of 14.3 per 100,000. The district set two goals related to suicide: 1) increase suicide awareness in pregnant women and adolescents by increasing the number of those trained in QPR Gatekeeper Training Curriculum and 2) increase suicide awareness in adolescents by increasing the number of adolescents trained in RESPONSE.

The QPR Gatekeeper Training, designed for those who are of high school age and older, helps those trained to better identify and refer those who are at risk for suicide. In-person gatekeeper trainings were facilitated at eight high schools and facilities within Bibb, Hale, Perry, Sumter, Tuscaloosa, and Walker Counties. In FY 2024, 208 youth and adults participated in the QPR Gatekeeper Trainings. This was an increase compared to 143 youth and adults in FY 2023; the goal to increase suicide awareness during this FY was met. The participants are now able to recognize and respond to suicide warning signs, have an increased knowledge of depression and suicide, and know where to refer someone for help.

Evidence of the increase in suicide awareness was reinforced through the responses provided by participants on their post training surveys. Some notable statements are as follows:

- “Suicidal people don’t want to die. They want to be heard, or all their problems go away,”
- “Persuade someone to stay alive. Listen to the problem and give them full attention. Do not judge them.”
- “The strongest predictor of suicide is hopelessness,”
- “I learned that depending on the situation at hand, you can either ask direct or indirect questions about someone’s stance on suicide and if they’re considering it.”
- “Most people who are thinking of killing themselves want someone to listen to them. They want to know people care about them,”
- “I learned that asking a question can help save a life”
- “Different signs and symptoms to look for when someone might be suicidal like behavioral clues and indirect verbal clues.”
- “Suicide is more serious than I thought, and I learned how to approach and help someone who is thinking of

suicide."

The evidence-based Response curriculum is designed for middle school age children and teens. Response increases a student's awareness about what they can do to provide support and hope if a student or friend is thinking about suicide. This awareness is vital to any suicide prevention effort, as it is often peers who first notice or are told about a person's thoughts or intent to end their life. The participants are then able to provide support and hope to students or friends who may be thinking about suicide and direct them on where to seek help. In-person training was facilitated in Perry County at RISE UP Summer Camp. A total of 13 youth participated in the Response Trainings and they are now able to provide support and hope to students or friends who may be thinking about suicide. The increase in awareness and impact made on participants is evidenced by their responses on the Post-Training Surveys. Some notable statements are as follows:

- "Social media can cause depression."
- "I learned if your friend is giving stuff away you should check up on them."
- "One thing that I learned is suicide is very bad for young people and that a true friend would check up on you and not let nothing bad happen to you like hurting yourself, and that life might get hard but you still got to keep going."
- "I've learned that others can be in denial about others feelings and that can be a barrier to finding how people with suicidal thoughts feel and from that you can't save them from those thoughts."

The District MCH Coordinator participated in numerous community events across Bibb, Greene, Hale, Perry, and Tuscaloosa Counties where suicide information and promotional items were provided at each of the community events. All who participated in either the QPR Gatekeeper and Response Trainings received incentive items including a drawstring backpack, t-shirt, ink pens, lanyards, silicon wrist bands, highlighters, and lip balm with the "Just Talk About It" suicide prevention logo and hotline number, along with educational material.

The district MCH coordinator serves as head of the West Central MCH Advisory Committee that meets quarterly to promote MCH programs and policies along with serving on the Region II Perinatal Advisory Committee; Smoke Free Tuscaloosa Coalition; Back 2 Basics – breastfeeding support services; and Children's Policy Council for Greene, Hale, Lamar, and Tuscaloosa Counties. The coordinator also serves on the Doing What Matters for Alabama's Children Conference Planning Committee. This conference is held each year in Tuscaloosa, Alabama, with a wide range of topics that focus on improving and supporting the well-being of Alabama's children with approximately 300-400 attendees each year. For the 2024 conference, the MCH Coordinator co-facilitated a QPR Training for one of the breakout sessions. Due to the structure of the conference, it was not feasible for the District MCH Coordinator to obtain pre- and post- training surveys for this training.

Other ADPH Adolescent Health Programs

Adolescent Pregnancy Prevention Branch

The APPB works to reduce the incidence of unplanned pregnancies and STIs among teens in Alabama. APPB's work is made possible through federal grants from the Department of Health and Human Services, Administration for Children and Families. Alabama receives awards from the Title V SRAE Program, and the State Personal Responsibility Education Program. 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 ASRAE provides evidence-based and evidence-informed abstinence education to middle school aged youth in school and community settings as requested including in youth-serving organizations. This programming equips youth with the tools needed to resist risky sexual behaviors and to make healthy relationship choices. APREP provides education regarding abstinence and contraception to youth in community settings as requested including in youth-serving organizations and high schools. Youth received evidence-based, medically accurate programs including lessons on adulthood preparation, designed to promote successful transition to young adulthood. During FY 24, APPB provided programming to approximately 986 youth participating in APREP and 356 youth participating

in ASRAE.

Youth Tobacco Prevention

The Youth Tobacco Prevention Program, housed within BPPS, was awarded approximately $949,131 to effect social norm change around tobacco use, address the marketing of emerging products to youth, promote policies that protect youth from nicotine initiation and exposure to secondhand smoke, and promote tobacco cessation. Youth Tobacco Prevention Program grantees delivered 537 presentations based on the Stanford Medicine Tobacco Prevention Curriculum; of those 537 presentations, 323 were youth-led. In conjunction with the presentations, 8,378 pre- and post- tests were completed by youth in grades 6-12. Youth Tobacco Prevention Program grantees organized or participated in 199 community awareness activities such as local coalition meetings, health fairs, and the Great American Smokeout. Social media continued to play an important role in educating the public. Approximately 83,000 individuals were reached through the Alabama You Choose as well as ADPH Facebook pages and tobacco-related websites.

In partnership with a local media company, the youth program's mass media campaign launched in July 2024. The message addressed the youth vaping epidemic. This successful campaign yielded approximately 10.1 million impressions through television, social media, and streaming services. Digital display ads on websites generated 765,000 impressions, social media yielded 4.3 million impressions, and over-the-top video advertising generated 5 million impressions.

Tobacco use continues to be the leading cause of preventable death in Alabama, killing more than 8,600 smokers and costing the state more than $2.19 billion in annual healthcare costs directly caused by smoking. The Tobacco Prevention and Control Program works to help tobacco users to quit, prevent youth and young adults from starting tobacco use, and protect people from exposure to secondhand smoke. The program leveraged resources to help Alabamians quit by obtaining Medicaid reimbursement for Quitline services, utilizing a $309,020 grant from CDC to build Quitline capacity, and $567,762 in state funds to provide up to 8 weeks of nicotine replacement therapy patches, as well as conduct targeted outreach efforts to support the Alabama Tobacco Quitline. For 2024, the Quitline had 2,337 calls, 24,506 website hits, 978 counseling enrollments, 8,978 online chats, and 88 text enrollments. The program also utilized $473,539 from CDC grant funds to implement evidence-based, mass-reach media efforts to advertise for the Quitline and bring public awareness to the dangers of secondhand smoke exposure and menthol use.

Adolescent Health - Application Year

In the upcoming reporting year, BFHS will address one priority need identified for Adolescent Health Domain for the 2026 - 2030 State Action Plan. The need is: Adolescent Safety and Wellness. See section III.E. Five-Year State Action Plan for additional information.

Described below are the supporting activities for the implementation of the NPM in FY2026.

NPM BLY – Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others - BLY

ESM BLY.1 - The percent of youth, ages 10-19 who report an increase in knowledge, intention to change behavior, and/or confidence in abilities after receiving positive youth development education that addresses bullying prevention.

Bullying is a complex topic. Youth that bully, are bullied, and/or observe bullying are all impacted. Because of this, there are multiple risk factors and protective factors that should be addressed. Prevention activities should work to change social climates, help students feel connected, and should be integrated with related efforts.

The 2025 Needs Assessment identified several priority topics that fall under the identified need of, Adolescent Safety and Wellness. Bullying is one specific topic identified as a priority. Other risk factors and protective factors related to bullying were also identified as priority topics within this need. For this application year, these recently identified priorities will take precedence of the previous priority needs for the Adolescent Health Domain. The Bullying NPM aligns with adolescent safety and wellness, and a new ESM was created for this domain.

The APPB provides education to help youth build connection, positive interpersonal skills, social competence, resilience, and to empower youth. At the conclusion of each programming cohort, participants complete a retrospective survey. APPB staff will work with the MCH Epidemiology Branch to develop survey questions that measure an increase in knowledge, intention to change behavior, and/or confidence in abilities related to bullying prevention. The survey questions specific to bullying prevention will be added to the current survey tool. This provides a more realistic assessment of perceived change in knowledge and skills and carries more limited socially desirable answers as compared to the use of a true baseline survey. Program staff plan to add additional sessions to target and educate parents of youth and encourage parent-child communication.

Survey questions will address topics covered during programming that relate to bullying prevention. Participants will be asked to indicate in terms of specific objectives where they stand now that they have been exposed to the program concurrently and indicate where they stood with respect to the same items and on the same scales, before they participated in the program. This provides a more realistic assessment of perceived change in knowledge and skills and carries more limited socially desirable answers as compared to the use of a true baseline survey.

In FY 2026, APPB will (1) determine bullying prevention topics to address through positive youth development education; (2) establish curriculum and/or program models that address selected bullying prevention topics; (3) incorporate bullying prevention topics, curriculum, and/or program models into current positive youth development education; and (4) provide training to staff delivering positive youth development education that addresses bullying prevention. APPB will (1) coordinate with public health districts to increase the reach of positive youth development education for ages 10 - 19; and (2) coordinate with ADPH programs already providing positive youth development education to add bullying prevention content.

5-Year Objectives:

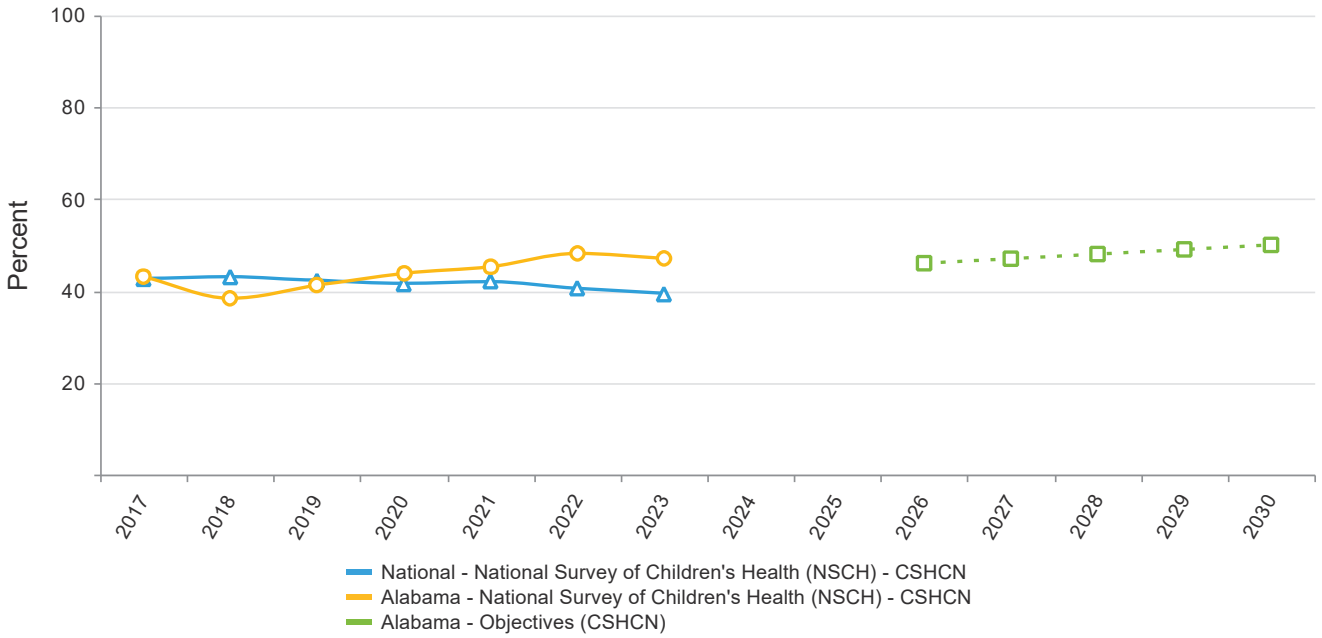
- By 2030, 58 percent of survey respondents ages 10 to 19 report an increase in knowledge after receiving positive youth development education that addresses bullying prevention.
- By 2030, 58 percent of survey respondents ages 10 to 19 report an increase in intention to change behavior, after receiving positive youth development education that addresses bullying prevention.
- By 2030, 58 percent of survey respondents ages 10 to 19 report an increase in confidence in abilities after receiving positive youth development education that addresses bullying prevention.

- By 2030, reach at least 7,500 youth through positive youth development education that addresses bullying prevention.

Children with Special Health Care Needs

National Performance Measures

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



NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2023	**2024**
Annual Objective		
Annual Indicator	46.5	47.1
Numerator	114,586	149,752
Denominator	246,328	318,263
Data Source	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	46.0	47.0	48.0	49.0	50.0

Evidence-Based or –Informed Strategy Measures

ESM MH.1 - Percent of medical home bookmark survey respondents who find the educational material useful for finding a medical home for their child

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	50.0	52.0	54.0	56.0	58.0

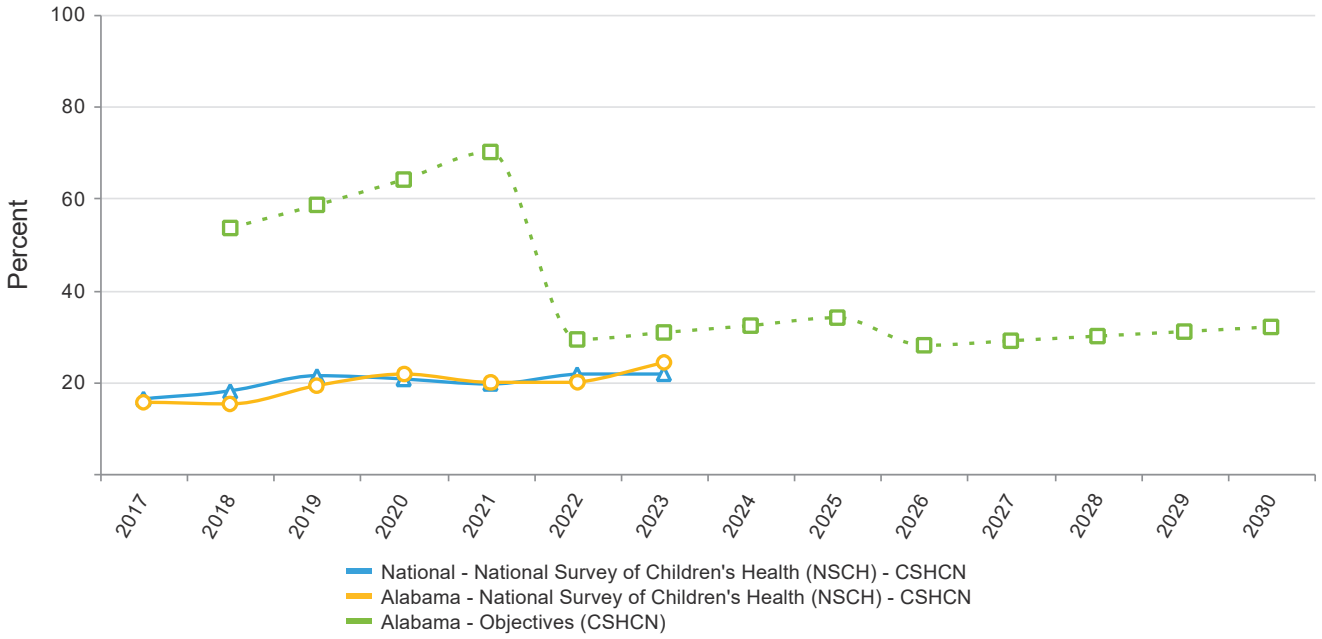
ESM MH.2 - Percent of CSHCN that have a comprehensive Plan of Care.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	50.0	55.0	61.0	67.0	74.0

NPM - 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 - TAHC
Indicators and Annual Objectives



NPM - 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 - TAHC - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	64	70	29.3	30.8	32.3
Annual Indicator	23.8	27.9	22.5	23.2	24.3
Numerator	21,076	25,741	22,337	26,372	32,343
Denominator	88,591	92,115	99,074	113,766	133,124
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	28.0	29.0	30.0	31.0	32.0

Evidence-Based or –Informed Strategy Measures

ESM TAHC.1 - Percent of YSHCN enrolled in state CSHCN program who report satisfaction with their transition experience to adulthood.

Measure Status:	Inactive - Replaced

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		50	58	67	77
Annual Indicator		72.2	78	78.3	83.3
Numerator		39	39	54	30
Denominator		54	50	69	36
Data Source		CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Provisional

ESM TAHC.2 - Percent of YSHCN enrolled in state CSHCN program who report increased preparedness to transition to adulthood.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	60.0	66.0	73.0	80.0	88.0

State Performance Measures

SPM 2 - Percent of children with special health care needs, ages 0-17, whose parent receives emotional support with parenting.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	82.0	84.0	86.0	88.0	90.0

Evidence-Based or –Informed Strategy Measures

SPM ESM 2.1 - Percent of progress made in achieving strategies to increase peer support for parents and caregivers of CSHCN and YSHCN.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	35.0	46.0	60.0	78.0	100.0

State Action Plan Table

State Action Plan Table (Alabama) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Insufficient or unequal assistance to help families navigate the system of care.	
NPM	
NPM - Medical Home	
Five-Year Objectives	
Increase the number of enrolled CSHCN who have a comprehensive Plan of Care by 10% annually.	
Strategies	
MH 2.1. Train CRS staff on Medical Home and developing a comprehensive Plan of Care with a family and person-centered approach to increase quality service provision.	
MH 2.2. Continue to provide comprehensive care coordination to CSHCN through system navigation, education, resource identification, referral and follow up.	
MH 2.3. Partner with families to develop a plan of care that incorporates a psychosocial assessment of patient and family needs, therapy evaluations, and physician recommendations to meet the specific needs of the child and family.	
MH 2.4. Promote effective and efficient use of health care resources to increase connections, family and provider partnerships and provide information about Medical Home.	
MH 2.5 Foster communication among CRS staff, families, community and health care providers to strengthen relationships for improved system navigation.	
ESMs	**Status**
ESM MH.1 - Percent of medical home bookmark survey respondents who find the educational material useful for finding a medical home for their child	Active
ESM MH.2 - Percent of CSHCN that have a comprehensive Plan of Care.	Active

NOMs

- Children's Health Status
- CSHCN Systems of Care
- Flourishing - Young Child
- Flourishing - Child Adolescent - CSHCN
- Flourishing - Child Adolescent - All

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

Priority Need

Inadequate supports for transition to all aspects of adulthood.

NPM

NPM - Transition To Adult Health Care

Five-Year Objectives

Increase the percent of YSHCN enrolled in State CSHCN program who report increased preparedness to transition to adulthood by 10% annually.

Strategies

TAHC 2.1. Continue to administer the CRS Transition Program and conduct outreach to promote the program to YSHCN across the state.

TAHC 2.2. Provide families with individualized skills and tools to prepare for transition to adulthood and lifelong care.

TAHC 2.3. Develop and implement a health care transition quality improvement and evaluation plan to assess the effectiveness of the CRS Transition Program.

TAHC 2.4. Utilize CRS staff including the Parent and Youth Consultants to provide support and increase awareness of the importance of preparing for transition to adulthood.

TAHC 2.5. Provide technical assistance and guidance on planning for transitioning to an adult health care provider for CRS staff.

ESMs	Status
ESM TAHC.1 - Percent of YSHCN enrolled in state CSHCN program who report satisfaction with their transition experience to adulthood.	Inactive
ESM TAHC.2 - Percent of YSHCN enrolled in state CSHCN program who report increased preparedness to transition to adulthood.	Active

NOMs

CSHCN Systems of Care

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

Priority Need

Lack of peer support and opportunities to create community for families, caregivers, and youth.

SPM

SPM 2 - Percent of children with special health care needs, ages 0-17, whose parent receives emotional support with parenting.

Five-Year Objectives

Increase family and youth peer support for CYSHCN using the Family and Youth Support Measurement tool as a measurement. Increase yearly score by 30% to achieve a maximum allowable score of 28 (100%) points by the end of the 5-year needs assessment cycle.

Strategies

SPM 2.1 Enhance the CRS Parent and Youth Connection programs to build community for individuals to share their experiences.

SPM 2.2 Utilize OCI to create marketing materials and a social media campaign to promote and encourage utilization of the Parent and Youth Connection programs.

SPM 2.3 Engage with community stakeholders and families to identify existing community support groups and other peer support opportunities for families of CSHCN and YSHCN.

SPM 2.4 Create peer support resource list for parents and caregivers of CSHCN and YSHCN and share via social media and Parent Connection e-newsletter.

SPM 2.5 Facilitate access to the identified peer support resources through CRS clinics.

SPM 2.6 Create an ongoing Family and Youth Peer Support Column for the Parent Connection e-newsletter that highlights coping techniques, mental health topics, and emotional support information.

SPM 2.7 Collaborate with FVA to promote Parent-to-Parent mentoring to assist parents with navigating complex medical systems.

ESMs	Status
SPM ESM 2.1 - Percent of progress made in achieving strategies to increase peer support for parents and caregivers of CSHCN and YSHCN.	Active

NOMs

CSHCN Systems of Care

2021-2025: State Performance Measures

2021-2025: SPM 2 - Strengthen and enhance family/youth partnerships, involvement and engagement in advisory groups, program development, policymaking, and system-building activities to support shared decision making between families and health-related professionals.

Measure Status:	**Active**				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		33	50	67	88
Annual Indicator		45.8	58.3	62.5	95.2
Numerator		11	14	15	20
Denominator		24	24	24	21
Data Source		CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

2021-2025: SPM 3 - Increase the capacity of families to connect CYSHCN to the health and human services they require for optimal behavioral, developmental, health, and wellness outcomes through our Care Coordination Program.

Measure Status:	**Active**				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		50	58	67	77
Annual Indicator		33.1	38.6	40.8	45.6
Numerator		138	276	225	212
Denominator		417	715	552	465
Data Source		CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Provisional

The Alabama CSHCN Program is administered by CRS, a division of ADRS. 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, family-centered, comprehensive, coordinated system of services. CRS' mission embodies the principles of comprehensive, community-based, and family-centered care. Coordinated health services are delivered via 14 community-based offices across 7 districts. In Alabama, 21.9 percent of children and youth ages 0-17 have a special health care need, higher than the national percentage (20.8 percent). Based on these estimates, 243,751 children and youth in Alabama have a special health care need (www.childhealthdata.org/browse/survey).

In FY 2024, the Block Grant State Action Plan Team continued to meet to discuss activities surrounding the outlined strategies and work through any challenges encountered while attempting to carry out the activities. The team includes members of the CRS Needs Assessment Leadership Team, an LPC, and a social work transition specialist.

In addition, ADRS CRS renewed the agreement with the UAB SOPH, Department of Health Care Organization and Policy, AEAC to consult and assist with administering the activities outlined in the Block Grant State Action Plan. These activities include survey design, administration, and analysis. AEAC and CRS held monthly meetings throughout FY 2024 to work collaboratively on evaluation components.

Priority Need – Lack of or inadequate access to services necessary for CSHCN to transition to all aspects of adult life

NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

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

Ensuring YSHCN are equipped with the skills and tools necessary to transition to adult health care has always been a priority for CRS. At age 14, youth are transferred to their district's transition social worker. During FY 2024, these specialists continued to provide targeted, comprehensive services to help CRS-enrolled youth and their families plan for adulthood. Services include providing care coordination, transportation assistance, referral to community resources, and translation services when needed. Transition social workers use the Six Core Elements of Health Care Transition™ Transition Readiness Assessment for Youth and the Transition Readiness Assessment for Parents/Caregivers to assess transition to adulthood readiness. CRS staff also participate in transition to adulthood team meetings with local school districts to assist YSHCN plan for adulthood.

In FY 2024, there were 19 CRS transition social workers serving 3,423 YSHCN ages 14-21. These social workers ensure that YSHCN have a comprehensive PoC in place. The plan covers health/medical issues, educational needs, developmental and independent living skills, and transitioning to adult health care. The plan is updated as needs change and annually with the youth and their family.

CRS offers YSHCN ages 12 to 21 the opportunity to participate in the TTC. In FY 2024, CRS had 52 YSHCN participate in TTC. The TTC is offered at five locations throughout the state and is a specialized clinic designed to assist YSHCN as they make the transition to adult life. YSHCN attending TTC participate in a vocational evaluation. The results of the evaluation are used to assist in identifying additional services, supports, and accommodations for high school, college, and/or career to maximize the individual's potential. During the clinic, the attendee and their family work together with a team to explore options in planning for the future. Topics include education, independent living, employment, assistive technology, and recreation. Based on the specific needs of the youth that attends TTC, the team may consist of the following: adolescent medicine physician; rehabilitation medicine physician; pediatrician; rehabilitation technology specialist; vocational assessment specialist; vocational rehabilitation counselor; community support specialists; physical therapist; nutritionist; audiologist; SLP; care coordinator; parents, other relatives, and friends; and school staff among others. After completing the clinic, the attendee and their family are provided a copy of the vocational evaluation and a written summary from the clinic visit, along with team

members' suggestions and resources for further planning. Recommendations from the Vocational Evaluation Reports can be shared with the school system for IEP planning and to support college accommodation requests.

The VRS Program is also located within ADRS. A continuum of services between CRS and VRS is encouraged through regular meetings and consistent communication between CRS transition social workers and VRS counselors to ensure appropriate accommodations are in place for educational and employment success. CRS and VRS staff continued to collaborate to address issues and challenges in the transition to adulthood process. Throughout FY 2024, CRS and VRS staff met to assure that YSHCN received timely and appropriate services to assist them with health, education, and employment-related challenges.

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 providers and community services. Building these networks occurs at the local level and is completed through in-person presentations to physicians providing adult healthcare and participation in outreach activities focused on transitioning to adult providers.

Throughout FY 2024, CRS continued to partner with the UAB Medicine STEP Medical Clinic. The STEP Program started in September 2020 to assist with the transition to adult care and was the first formal program of its kind in Alabama and the surrounding region. STEP is designed to facilitate the transition of care for patients with chronic/complex diseases of childhood as they are preparing to exit the COA system for the adult model of care at UAB. In FY 2024, the CRS transition and TBI social work specialists from the Homewood office continued to provide social work support in the STEP Clinic. In partnership with the UAB staff social worker, CRS social workers facilitate patient referrals between programs, assist with access to needed resources, and provide community-based follow-up. CRS staff also provide a link between UAB physicians and ADRS programs across the state, supporting a continuation of care for young adults with complex medical needs previously unavailable for this population. CRS staff also served on the planning committee for a conference related to the needs of young adults with medical complexity in conjunction with UAB STEP and United Ability.

Another strong collaboration to enhance transition to adulthood for YSHCN needs in Alabama is with the local school systems. Representatives from CRS continued working 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, becoming a self-advocate, transitioning from high school to college, Medicaid waivers, and employment.

All the previously described activities have been further strengthened by data collected through the Transition Survey as part of the Block Grant State Action Plan. In FY 2024, the AEAC readministered the jointly designed Transition Survey to assess the effectiveness and individual satisfaction of CRS transition services. The survey captured the perception and experiences of transition-age youth receiving services in FY 2023. The overall goal of the survey is to collect vital information from enrolled youth to improve services for YSHCN as they transition to adulthood. CRS leadership utilize data from the full survey reports provided by the UAB AEAC to identify strategies for improving services.

During FY 2024, the Block Grant State Action Plan Team was able to analyze the survey data to identify improvements in survey design and question phrasing. It was determined that allowing a "Don't Know" option on several questions throughout the survey had the potential to skew data. This option was not necessary as the individual would know whether they received the service or whether something occurred. It was also determined that there were several questions that could be removed because the data provided was not actionable by CRS. CRS and the AEAC worked together on the changes and the AEAC made the applicable changes in Qualtrics. Prior to readministering the survey both entities conducted in-depth testing to ensure any changes to the survey design and logic were correctly implemented.

The survey data proved most valuable in strengthening the efforts of the CRS Transition Task Force to develop a procedural framework that promotes quality and consistency within the CRS Transition to Adulthood Program. The task force that was formed in FY 2022 reviewed the current CRS transition process and determined ways to strengthen service delivery to YSHCN. Examining areas of lower performance in the survey data contributed to improving task force outcomes.

At the end of FY 2024 the CRS care coordination program specialist and MCH coordinator conducted training on the brand-new Transition Program and Protocol Policy for all CRS staff. Training included the newly designed Readiness Assessment. Modeled on the Got Transition® Six Core Elements of Health Care Transition™ tools the new assessment is now applicable for both youth and caregivers of youth with medical complexity. Using the new assessment, care coordinators can collect vital information from enrolled youth or their caregiver to individualize the PoC and address the specific needs of YSHCN. During the training, the new Transition Program Policy and Protocol document was reviewed, and staff were educated on the importance of creating an environment of transition where all team members contribute to the process. Ultimately, the task force created tools and developed protocol that focuses on identifying the best ways to individually equip youth and their families with the skills and information needed to achieve their maximum potential.

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

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

ADRS and CRS have a long-standing commitment to family and youth engagement and the principles of family-centered care. For over 30 years, this commitment has been an integral part of CRS from direct services to infrastructure building and population health work. CRS makes a significant investment in family partnerships by employing parents and caregivers of CSHCN through the CRS Parent Connection Program and Youth Connection Program. See section III.C.1.b.iv. Family and Community Partnerships for additional information on the Parent and Youth Connection Programs.

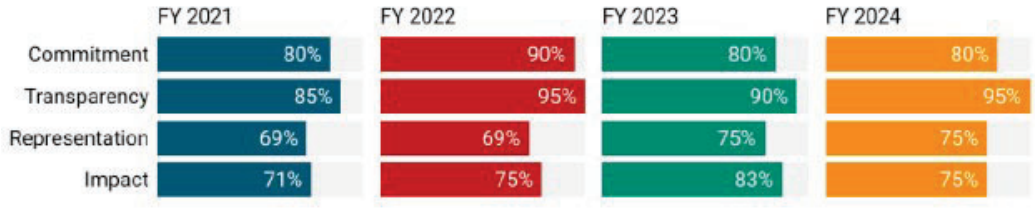
Recognizing the value of the National Family Voices FESAT in assessing how well an organization supports family engagement in systems-level initiatives, CRS identified using the FESAT and its four domains of family engagement as part of the 2021-2025 Block Grant State Action Plan.

In the summer of FY 2024, CRS readministered the FESAT and held consensus scoring meetings. Individuals participating in the consensus scoring discussions included CRS State Office staff, district supervisors, and LPCs. In FY 2024, one new LPC and State Office staff participated in the process. These individuals were able to view the previously recorded National Family Voices training to ensure knowledge of the FESAT and the scoring process. Each participant was asked to review the FESAT materials and consider their initial scores for each statement, representing assessment of the level of family engagement within the organization based on their personal knowledge and experiences. These scores would then be discussed during the consensus scoring meetings.

UAB AEAC faculty and staff facilitated two consensus scoring sessions live via Zoom. The choice to continue holding the meetings via Zoom was to maximize participation across geographic locations. Participants shared their initial scores for each question using the Zoom poll feature. The facilitator noted the variation in scores and encouraged discussion. Following the discussion, polls were re-launched, and participants again submitted a score that reflected his or her opinion after hearing the discussion. Consensus was reached on the score for each question based on the majority score of the final (second) poll. The consensus discussion served as an opportunity for participants to understand each other's points of view. It also raised awareness about the discrepancies in the knowledge of CRS policies and specific activities surrounding family engagement that exist between those participating and created an awareness about the need to share information more broadly.

A comparison of the FY 2021 FESAT baseline scores to subsequent years was conducted to identify areas of improvement. The overall Family Engagement Score remained at 83 percent in FY 2023 compared to the FY 2021 baseline score of 76 percent. Though the FY 2024 overall score represents a slight decline from FY 2022 and FY2023 performances, this most recent score of 81 percent is a 5-percentage point increase over the FY 2021 baseline. This overall 5- percentage point difference represents a 6.6 percent increase for the FY 2024 overall score compared to the FY 2021 baseline [calculation: ((81 - 76) / 76) * 100].

CRS FESAT Score by Domain, FY 2021-2024



Across all four years, the Commitment and Transparency domains have had scores above 80 percent. Despite some variability, these domains have consistently represented areas of better performance/strongest family engagement. Representation has been the lowest-scoring domain across all four years, though FY 2023 and FY 2024 scores improved compared to the FY 2021 baseline.

Participants in the FY 2024 consensus scoring discussions all agreed that there are family engagement champions present at every level of CRS, including among the State Office, district supervisors, and LPCs. It was noted that parent leadership and partnerships are a piece of the CRS culture.

The discussions indicated challenges and barriers in the Representation domain continue to exist specifically around language barriers when providing services to families that do not speak English as their primary language. Alabama is a diverse state with a multitude of languages spoken in the home. In addition to the list of languages, there are several dialects included among these languages. These dialects create additional barriers to including family leaders in meetings where they are encouraged to let their voices and experiences be heard. Without interpreters with specific knowledge of each language and dialect, those voices are not captured. Resources are not available to bring in an interpreter for each language, and the only option is to use phone applications to translate.

Utilizing the information gained through the UAB AEAC FESAT Report, ongoing efforts were made during FY 2024 to continue the Family Engagement QI Initiatives. Districts continued existing QI projects or identified a new project for the rest of the 5-year cycle. Projects include incorporating the LPC in the enrollment process, assessing transition to adulthood needs, and improving clinic flow based on family input. In addition, the Family Engagement QI Initiative site on SharePoint was continually updated. The SharePoint site provided each district supervisor the opportunity to review other initiatives and quarterly reports.

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

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

The CRS Care Coordination Program provides an interdisciplinary approach to care coordination to ensure CYSHCN and their families connect to wrap-around services they require for optimal behavioral, developmental, health, and wellness outcomes. CRS delivers services using an interdisciplinary team approach and care coordinators are essential team members. Working together, the team provides coordinated services to improve the quality of life for CYSHCN and their families. Care coordination is provided by licensed social workers and registered nurses located in the 14 community-based offices across the state. In addition, there are social work specialists trained in transition to adulthood and TBI. These social workers manage caseloads related to their assigned specialty.

All CRS care coordinators provide support to help families navigate the complex system of care for CYSHCN. This support includes ongoing need assessments, providing options for CRS medical and evaluation clinics, providing education regarding health care needs, participating in school meetings and advocating for school-based services, exploring transportation options, locating community resources, making referrals for services, and helping families prepare YSHCN for transition to adulthood. CRS care coordinators advocate for CYSHCN and their families within and outside CRS to improve the system of care. Through these advocacy efforts, they develop a long-term relationship with families built on trust and established individual goals.

Support also includes ensuring CYSHCN and their families have a medical home and that the CRS care coordinator is communicating regularly with the medical home for continuity of care. Using a holistic approach, families are supported in working collaboratively with their doctors and other service providers to best meet the client's needs. This support includes keeping the family informed of appointments, following up on recommendations by the medical home, and assisting with insurance needs. CRS care coordinators and LPCs assist families without medical homes to locate appropriate community PCPs.

Alabama, like many other states, has too few PCPs who serve CYSHCN and too few pediatric specialty providers, especially in rural areas. CRS care coordinators continue efforts to identify community PCPs willing to accept CYSHCN as patients. Local care coordinators work to build relationships with PCPs that serve CYSHCN to establish referral services through outreach activities and participating in community events. These outreach efforts include sharing information regarding CRS services and the CRS referral process through regular office visits and phone calls. Building relationships at the local level ensures that care coordinators have the connections to facilitate referrals to those providers with experience in providing services to CYSHCN.

Expanding outreach activities and promoting awareness of the CRS Care Coordination Program within the medical community and among families of CYSHCN is a top priority. Staff continued to promote the program using The Care Coordination Program booklet created as part of the Block Grant State Action Plan. Utilization of the booklet is providing families, community partners, and providers with something tangible they can refer to should they have questions about CRS care coordination services.

An additional component of comprehensive care coordination includes a jointly developed PoC. During FY 2024, the Care Coordination Program Specialist continued to educate care coordinators regarding the newly designed PoC implemented in 2023. The CRS PoC is jointly developed with the family to ensure it includes goals selected by the family and has value for the family. The PoC is a living document that care coordinators update throughout the year. Care coordinators print a goal sheet that is provided to the family and includes the agreed upon goals, action steps, and responsible party. Another key feature is the ability of the interdisciplinary team members to recommend goals for the PoC.

The following stories from CRS care coordinators illustrate the impact of CRS care coordination:

"An additional benefit of CRS Care Coordination is someone to hold space for a family member having a bad day. Sometimes our families call us needing support, feeling exhausted and uncertain. Even if there isn't a solution, we can stay on the phone or in the room with them, and know they are not alone and that CRS can support them through care coordination, parent support, and clinical evaluations. Care coordination is about more than connecting services, it is allowing families the space to feel heard and supported."

"As Care Coordinators it is our job to identify barriers to families on enrollments, at clinic visits or when doing annual plans of care. By educating our families on resources in our area, we utilize a community approach to improve the family's quality of life. CRS care coordination is a free program for children and youth with special health care needs, so for a parent who does not know where to turn for help, our care coordinators can help point them in the right direction and offer support that is unavailable elsewhere. Our program is very unique and special!"

In FY 2024, the AEAC readministered the jointly designed Care Coordination Family Survey to assess the effectiveness of the CRS Care Coordination Program and determine those who report receiving comprehensive care coordination. The survey captured the perceptions and experiences of those receiving care coordination services in FY 2023.

Analyzing the AEAC CRS Care Coordination Survey Report the Block Grant State Action Plan team identified some areas for improvement. Survey respondents indicated an overall satisfaction with CRS Care Coordination services and a high percentage indicated that they received help finding hard to access services. The component with the lowest percentage met within the composite measure pertained to individuals having a PoC. Educating families

regarding understanding of the PoC is key to improving survey results. The newly designed PoC had only been implemented for a short time during the period being surveyed. Knowledge regarding the PoC and the purpose of a PoC is part of an ongoing improvement initiative. The CRS Care Coordination Program Specialist at the State Office is hopeful that the impacts of the newly designed PoC will be seen in the FY 2025 survey data. There are also ongoing efforts to train staff regarding the importance of the family's involvement in the development of the PoC.

Data indicated a need to improve families understanding on the role of the CRS care coordinator in some areas of the state. Utilizing the previously mentioned Care Coordination Program brochure at enrollment to review the care coordinator role and program benefits should ultimately improve understanding.

Children with Special Health Care Needs - Application Year

In the upcoming reporting year, CRS will address the three priority needs identified for CSHCN for the 2026 - 2030 State Action Plan. These are: insufficient or unequal assistance to help families navigate the system of care; inadequate supports for transition to all aspects of adulthood; and lack of peer support and opportunities to create community for families, caregivers, and youth. See section III.E. Five-Year State Action Plan for additional information.

In the upcoming year, the CRS Block Grant State Action Plan team will reconvene with new members to include an LPC and the SPC. During the monthly meetings the team will discuss implementation efforts for the 2026 – 2030 State Action Plan. Ongoing discussions in FY 2026 will include progress on the action plan as well as identifying needed changes. CRS will continue to consult and receive assistance from the UAB AEAC in administering the activities outlined in the plan. AEAC and CRS will continue to convene monthly to collaborate on ways to improve services for CYSHCN and their families.

Outlined below are the activities the Block Grant State Action Plan team identified to focus on in FY 2026.

NPM TAHC – 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 TAHC.2 – Percent of YSHCN enrolled in State CSHCN Program who report increased preparedness to transition to adulthood

In FY 2026, CRS will collaborate with the UAB AEAC to revise the Transition Survey developed in the previous 5-year cycle. Revisions will focus on ensuring the survey addresses components related to preparedness to transition to adulthood. Data from the 2025 Transition Survey will be considered when making the revisions.

In FY 2026, UAB AEAC will administer the revised Transition Survey. During the previous 5-year cycle Transition Survey response rates were low. Recognizing this as an existing challenge, CRS State Office staff will work to strengthen previously identified strategies to increase the response rate. These strategies include working with CRS clerical staff to ensure they are collecting and validating emails, providing transition social work specialists with an advance list of the survey sample so that they can ensure emails are valid, and promoting the survey release among staff to increase awareness.

In FY 2026, the CRS Care Coordination Program specialist and supervisory staff will continue auditing care coordination records to ensure that staff are following the revised Transition Policy and Procedures implemented in FY 2024. This includes working to ensure care coordinators are incorporating transition planning into the child's existing PoC and partnering with youth and families to develop transition goals. Care coordinators will also focus on sharing information and identifying referral services for YSHCN. CRS staff will continue to collaborate with VRS staff to ensure applicable YSCHN benefit from the services available through VRS.

To further ensure a continuation of care for transitioning young adults with complex medical needs, CRS will continue its partnership with the UAB STEP Medical Clinic. The STEP clinic serves as a referral source for CRS clients transitioning to adult care. CRS will continue involvement in the annual statewide STEP and United Ability Transition Conference as well as the annual Transition Hot Topics Conference. These annual conferences bring together providers and families from across the state to learn about important topics and resources for a successful transition experience. See section III.E.3. CSHCN Annual Report for additional information on the STEP clinic partnership.

In addition, CRS will implement the following new measures:

As part of the 2026 - 2030 Comprehensive Needs Assessment cycle CRS developed two new measures. Although these measures are each tied to one specific priority need the objectives and strategies will ultimately have a positive impact on other needs identified during the needs assessment process.

SPM 2 – Percent of progress made in achieving strategies to increase peer support for parents and caregivers of CSHCN and YSHCN

For 2026, CRS will utilize the LPCs and YCs to assess existing community support groups and other peer support opportunities for CSHCN and YSHCN. Evaluating current resources will allow the Block Grant State Action Plan team to identify areas lacking adequate supports. The team and CRS leadership will engage in conversations to identify and pursue partnerships to address the gaps.

NPM MH – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

ESM MH.2 – Percent of enrolled CSHCN that have a comprehensive plan of care

In FY 2026, CRS will receive a detailed survey report that includes comparison data from the baseline and subsequent years of the CRS Care Coordination Survey from UAB AEAC. The Block Grant State Action Plan Team will include the survey data as part of ongoing discussions to identify and implement strategies to strengthen the CRS Care Coordination Program. The data will allow the Care Coordination Program Specialist to identify areas of comprehensive care coordination that need additional training. Staff will receive ongoing training related to the PoC and ensuring plans are developed using a family and person-centered approach. The team will begin discussions on ways to educate staff regarding the medical home concept and ensuring all staff work to promote the concept within the clinic setting.

In FY 2026, the Care Coordination Program Specialist will continue holding quarterly supervisory Zooms to share information, identify additional training needs, and modifications or enhancements to the electronic PoC in CHARMS. During the Zooms, supervisory staff will be reminded to ensure all CRS care coordinators discuss the importance of a medical home and use a person-centered approach to care plan development.

Cross-Cutting/Systems Building

State Performance Measures

SPM 3 - Percent of dental health kit survey respondents who plans to use the dental health kit, which includes age-appropriate toothbrush, educational materials, dental floss, timer, and toothpaste

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	50.0	52.0	54.0	56.0	58.0

Evidence-Based or –Informed Strategy Measures

None

State Action Plan Table

State Action Plan Table (Alabama) - Cross-Cutting/Systems Building - Entry 1

Priority Need

Access to Comprehensive Oral Health Education and Services for all MCH Populations

SPM

SPM 3 - Percent of dental health kit survey respondents who plans to use the dental health kit, which includes age-appropriate toothbrush, educational materials, dental floss, timer, and toothpaste

Five-Year Objectives

By 2030, at least 58 percent of all dental health kit recipients who completed the REDCap survey plans to use the dental health kit.

OHO and its partners attend at least 50 community outreach events annually to increase distribution of dental health kits.

By 2030, at least 75 percent of schools visited for oral health screenings and receiving dental health kits had more than 50 percent of the students eligible to receive food assistance.

Strategies

Expand the area of reach for the distribution of the dental health kits distributed throughout the MCH populations at outreach events.

Coordinate with CRS for dental health kits to be distributed at clinics and any outreach events.

Coordinate with the Alabama Cribs for Kids® Program for distribution of dental health kits and the educational materials tailored specifically for infants

Coordinate with the Healthy Childcare of Alabama for distribution of dental health kits and the educational materials tailored specifically for children ages 3 to 5.

Aim for at least an annual 10 percent REDCap survey response rate for dental health kit recipients to answer questions concerning plans to use the contents of the dental health kit and what their current oral health practices are in preventing tooth decay.

ESMs	Status

No ESMs were created by the State. ESMs are optional for this measure.

2021-2025: State Performance Measures

2021-2025: SPM 5 - Increase the proportion of EHS programs participating in the EHSCCP grant program that maintain ten percent of their population with children with special needs.

Measure Status:	**Active**				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		0.6	0.6	0.8	1
Annual Indicator	40	40	80	80	80
Numerator	2	2	4	4	4
Denominator	5	5	5	5	5
Data Source	Program Data	Program Data	Program Data	Program Data	Program Data
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

In March 2020, FHS convened stakeholders to hear a presentation of the data collected by AEAC, followed by sessions to rate and rank the identified needs. The need, “Inequitable access to health resources based on race/ethnicity, socioeconomic status, geographic location, and education” was ranked in the top three in all domains. Needs statements related to mental health were ranked in the top three in the Women’s/Maternal Health Domain and the Adolescent Health Domain. Needs related to mental health ranked fourth in the Child Health Domain. The Alabama Title V Leadership Team identified an inclusive priority need statement for the 2021-2025 State Action Plan, “Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they live, learn, work, and play.” From 2021-2024 training opportunities were developed with state and federal partners to equip FHS staff with the necessary tools and resources to address community health factors impacting the health of Alabama’s MCH population. The remaining domain specific objectives and strategies continued to be implemented throughout FY 2024. They are highlighted below and incorporated throughout the population domain annual reports.

Child Health

SPM 5 - Increase the proportion of EHS programs participating in the EHSCCP Grant Program that maintain 10 percent of their population with children with special needs.

- Increase the number of EHS programs that accept children with disabilities.

All of the EHS programs reached 10 percent of their population with children with special needs and they continue to maintain that threshold. This measure is being retired due to reaching the goal.

Women’s Health

Strategies

- Increase the proportion of WW preventative visits in all program-specific counties for women ages 15-55 and educate the public in all program-specific counties of available WW services
- Recruit women ages 15-55 to the WW Program for CVD risk factor screenings, healthy life/reproductive health planning (inter-conception and preconception care), health coaching, and nutritional counseling
- Provide risk-reduction counseling to help clients understand their risks, health coaching to set goals for behavioral change, and nutritional counseling and support to WW participants to help discover healthy lifestyle behaviors
- Recruit all women ages15-55 residing in counties participating in the WW Program via marketing materials and social media
- Continue to use Spanish-speaking marketing materials to recruit the population and offer Spanish literature for education and healthy lifestyle behaviors
- Target underinsured and/or uninsured women ages 15-55 to enroll in the WW Program

Completed Activities

- WW staff participated in community outreach by promoting WW to diverse groups of women at community health fairs, local businesses, community partners, social media, and through the 211KNOW text messaging service
    - Staff shared English and Spanish WW flyers at all health fairs, local businesses, and community partners in each county
    - WW social workers, MCH coordinators, and ADPH public health educators shared information about the program to English and
      Spanish speaking communities in the counties where WW is available.
        - Access to preventative health care
        - CVD risk factor screening
        - Nutrition counseling and education
        - Pre/inter/post-conception counseling
- Promoted the program and educated patients in CHDs on the importance of access to preventative health care and the availability of preventative screenings, education, and case management through enrollment in WW in available counties

    - WW flyers (English and Spanish) displayed in the CHDs for all people to see who participate in services provided
    - Staff promoted the program with FP patients
        - Discussed screening/management of HTN; screening for increased BMI, increased cholesterol, and diabetes; oral and vision screenings; and education for healthy life planning
- Worked with enrollees to determine their stage of change to set achievable goals for a healthier lifestyle and decrease CVD risk factors through risk reduction counseling with the NP
    - Addressed any alert lab values with appropriate education and follow-up
- Reviewed and discussed the goals set with the NP to create an achievable plan through health coaching and case management with the WW SW
- Educated women on healthy nutritional choices in classes and mini sessions offered with a RD
    - General nutrition information was provided, but the RD also shared specific guidance based on the needs of the participants

The objectives, strategies, and activities related to inequitable access to health resources in women's health are active components of the WW Program. The WW related objectives and strategies for the cross-cutting performance measure will now become inactive due to the incorporation of all the strategies and activities as regular practice in the program.

Cross-Cutting/Systems Building - Application Year

In the upcoming reporting year, BFHS will address one cross-cutting priority need identified for the 2026 - 2030 State Action Plan. The need is: Access to Comprehensive Oral Health Education and Services for all MCH Populations. See Section III.E. Five-Year State Action Plan for additional information.

Described below are the supporting activities for the implementation of the NPM in FY2026.

NPM PDV – (A) Percent of women who had a preventive dental visit during pregnancy
(B) Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

SPM 3 - Percent of dental health kit survey respondents who plans to use the dental health kit, which includes age-appropriate toothbrush, educational materials, dental floss, timer, and toothpaste

Across all MCH populations, the OHO shared close to 25,000 dental health kits for CY 2024, with the number staying relatively stable in prior calendar years. Depending on the recipients' age, OHO includes age-appropriate educational materials, highlighting the importance of oral health during pregnancy, infant's wellness, and the wellness of children and adolescents. The OHO plans to develop and disseminate an oral health survey allowing respondents to provide feedback on any barriers to using the contents of the dental health kits, their oral health practices, and the effectiveness of the educational resources included in the dental health kits. The OHO can share these findings with its partners for determination of a more effective approach in educating the MCH populations on the importance of using what was provided in the dental health kits.

In FY 2026, the OHO will collaborate with CRS, HCCA, and PHD to expand the area of reach for the dental health kits distributed to the MCH population through clinics and outreach events. OHO will work to create new messaging and educational materials tailored specifically for the MCH population domains.

III.F. Public Input

ADPH

BFHS maintains a Title V MCH webpage (a part of ADPH's main website) and it may be accessed at www.alabamapublichealth.gov/mch. The MCH webpage informs the public about the Federal-State Title V partnership. The SSDI coordinator will continue to update the state Title V MCH website to link to the latest MCH Block Grant Annual Report/Application and to post any associated attachments. Also, the “contact us” page on this site provides a mechanism for the public to email comments directly to the MCH Title V Program. The public can email comments directly to other BFHS programs using their individual web pages on the ADPH site as well. Additionally, ADPH utilizes several sources of social media which are open to public comment. WW takes advantage of the benefits of social media by hosting a Facebook page and permitting its SWs to post county program information. The WW Facebook page facilitates open and public communication directly between the district WW staff, partners, and program participants.

As a part of the 2025 MCH Needs Assessment, BFHS sought public input via the following initiatives: one web-based survey (survey of families, adolescents, and healthcare providers), 11 focus groups, 7 key informant interviews, and two state advisory group meetings convened to select priority needs for the MCH Needs Assessment. Requests for copies of the 2025 Title V MCH Block Grant Comprehensive Needs Assessment will be accepted through the Title V MCH webpage.

BFHS also seeks input by convening or participating in state advisory groups that has consumer representation for persons affected by particular health issues. The Alabama NSP has an active advisory committee that consists of professionals and citizens knowledgeable in the area of newborn screening. The purpose of the ANSAC is to engage stakeholders, address newborn screening needs, share updates, and advise on newborn screening services in Alabama. The ANSAC advises its stakeholders on both screening for hematological and biochemical disorders and on screening for hearing impairment. BFHS SW staff continue to remain involved with NBS panel updates and birth defects reporting requirements. BFHS SW staff provide case management for all failed or not completed hearing tests.

FPAC meets quarterly in conjunction with the OWH meetings. FPAC members broadly represent their various communities across the state and are knowledgeable of the FP service needs in their area. A consumer of the program is also a member. The purpose of the committee is to provide feedback regarding the development, implementation, and evaluation of the FP Program, as well as to review and approve any educational or informational material used in the program. This committee ensures that the FP 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.

The BFHS Cancer Prevention and Control Division obtains public input through the Alabama Comprehensive Cancer Control Coalition. The Coalition meets quarterly to share resources and ideas and develop interventions that will reduce the burden of cancer in Alabama. The Coalition’s goal is to implement the goals and objectives in the 5-Year Alabama Cancer Control Plan. The newest 5-year plan (2022-2026) was released in June 2022. The Coalition includes representatives from stakeholders including community organizations, advocates, cancer survivors, universities, hospitals, cancer centers, public health professionals, and private companies.

The Alabama WIC Program is federally funded by the USDA. Per federal regulations, all WIC agencies must post for public comment its annual State Plan and Procedure Manual. Receipt of federal funds is contingent upon completing this process.

CRS

The ADRS Office of Communications and Information maintains the Department’s website, which includes the CRS webpage (www.rehab.alabama.gov/services/crs). The ADRS website allows CRS to seek public comments through

the “contact us” feature on the webpage. The public can email comments directly to CRS or call a 1-800 number for direct contact. CRS utilizes several social media sources, which are always open to public comment. The SPC and YC use social media to foster communication among the public, CRS staff, partners, and program participants through the Parent Connection and Youth Connection Facebook pages.

CRS values public input from families of CSHCN and YSHCN and seeks feedback from families and youth on an ongoing basis through the SPAC, LPACs, and YAC. These advisory groups allow individuals to provide input regarding policy development, program activities, and the Block Grant State Action Plan. Families are compensated for participation in advisory committees and childcare is provided to reduce barriers to participation.

CRS 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 stakeholders from hospitals, volunteer agencies, medical specialists, adults with hemophilia, parents of children with hemophilia, and the general public.

As part of the FY 2025 Needs Assessment process, CRS sought public input via an online survey, eight focus groups, two listening sessions, nine key informant interviews, and convening the CRS Needs Assessment Advisory Committee. The advisory committee consists of members from a broad range of state and community-based agencies and organizations serving CYSHCN in Alabama. The committee was instrumental in ensuring the needs assessment activities were reflective of voices in underserved communities throughout rural and urban areas of the state. The UAB AEAC contracted with family-led organizations throughout the process to assist in recruiting family participation from their area. Insights gained during the needs assessment process were key in developing the Block Grant State Action Plan for CSHCN.

Staff provide another vital avenue for collecting ongoing feedback. CRS State Office staff seek input throughout the year from district supervisors and local CRS staff at all levels, which in turn includes the families that they serve. To better understand the challenges CSHCN faces, state office specialists often spend time at the 14 community-based offices observing clinics and interacting with staff and families. The CRS MCH coordinator also presents to staff throughout the year regarding the history of the Title V Block Grant, overview of the Needs Assessment Process, and updates related to the Block Grant State Action Plan activities.

III.G. Technical Assistance

ADPH

OMCH anticipates the need for technical assistance with our partners at either AMCHP, HRSA, the MCH Evidence Center at the National Center for Education in Maternal and Child Health, or the UAB School of Public Health regarding the following elements for the 2026 – 2030 State Action Plan:

- Creating effective new measures and revising existing measures as needed for the 2026 – 2030 reporting period.
- Incorporating the use of the hospital discharge data source for the 2026 – 2030 reporting period.
- Developing effective 5-year objectives and strategies for new and continued ESMs and SPMs highlighted in the 2026 – 2030 State Action Plan.
- Accurately utilizing the Healthcare Effectiveness Data and Information Set codes designated for postpartum care.

CRS

CRS anticipates the need for technical assistance regarding the following elements of the 2026 – 2030 State Action Plan:

Training staff on Medical Home and the subcomponents of Medical Home. Specifically, around the Family Centered Care subcomponent.

Care Coordination Standards for CSHCN

Peer to Peer Supports for Parents of CSHCN and YSHCN

CRS will continue participating in technical assistance opportunities provided through AMCHP.

CRS leadership staff have been discussing ideas for a 2026 National MCH Workforce Development Center Learning Journey application. CRS previously worked with the Center and continues to utilize tools and skills from our Learning Journey experience.

CRS will utilize technical assistance as needed from the MCH Evidence Center at the National Center for Education in Maternal and Child Health. Technical assistance received from the Center related to establishing measures for the previous 5-year cycle was extremely beneficial in ensuring CRS created impactful measures.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Alabama MCH Title V-Alabama Medicaid MOUs_072225b.pdf

V. Supporting Documents

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

Supporting Document #01 - CSHCN Checklist for SPM 2 FY24.pdf

Supporting Document #02 - CRS Comprehensive Care Coordination Measure.pdf

Supporting Document #03 - AL MCH Acronyms_2025.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - Alabama MCH Title V Organizational Charts_071025.pdf

VII. Appendix

+

This page is intentionally left blank.

Form 2
MCH Budget/Expenditure Details

State: Alabama

	FY 26 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 12,021,137	
A. Preventive and Primary Care for Children	$ 6,258,745	(52%)
B. Children with Special Health Care Needs	$ 4,207,398	(35%)
C. Title V Administrative Costs	$ 1,202,112	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 11,668,255	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 49,195,177	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 1,536,572	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 38,279,659	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 89,011,408	
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)	$ 101,032,545	
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)	$ 147,137,014	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 248,169,559	

OTHER FEDERAL FUNDS	FY 26 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > National Hemophilia Program	$ 37,300
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 141,894,507
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 138,572
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program	$ 648,064
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 185,569
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 547,797
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 791,170
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Early Head Start - Child Care Partnerships (EHS-CC) Grant	$ 1,268,705
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Well Woman	$ 1,625,330

	FY 24 Annual Report Budgeted		FY 24 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 11,684,723 (FY 24 Federal Award: $ 12,021,137)		$ 12,021,137	
A. Preventive and Primary Care for Children	$ 5,355,859	(45.8%)	$ 6,258,745	(52%)
B. Children with Special Health Care Needs	$ 3,505,417	(30%)	$ 4,473,156	(37.2%)
C. Title V Administrative Costs	$ 1,168,471	(10%)	$ 1,202,112	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 10,029,747		$ 11,934,013	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 37,841,184		$ 49,696,932	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 1,577,948		$ 964,596	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 33,881,586		$ 40,089,867	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 73,300,718		$ 90,751,395	
A. Your State's FY 1989 Maintenance of Effort Amount $ 15,408,615				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 84,985,441		$ 102,772,532	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 116,251,504		$ 147,128,740	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 201,236,945		$ 249,901,272	

OTHER FEDERAL FUNDS	FY 24 Annual Report Budgeted	FY 24 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Early Head Start - Child Care Partnerships (EHS-CC) Grant	$ 878,516	$ 1,268,705
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 784,136	$ 791,170
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 527,550	$ 547,797
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 157,824	$ 185,569
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program	$ 668,733	$ 648,064
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 169,547	$ 138,572
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 111,935,298	$ 141,894,507
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > National Hemophilia Program	$ 29,900	$ 29,026
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Well Woman	$ 1,100,000	$ 1,625,330
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > CMC-COIIN Boston University	$ 0	$ 0

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs**
	Fiscal Year:	**2026**
	Column Name:	**Application Budgeted**
	Field Note: Line 1 (B). (Children with Special Health Care Needs) - For the FY 2026 Application Budget CRS percentage is set at 35% based on the current NOA of $12,021,137 the CRS Federal Allocation would be $4,207,398.	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Line 1A. (Preventive and Primary Care for Children) – FY 2024 Annual Report expended amount of $6.25m increased from the FY 2022-2024 Application Budgeted amount of $5.35m, a difference of $902k or 16.86%. In FY 2022, when the budget was developed for 2024 the children served made up 45.8% of the total program cost compared to the 52.06% based on actual cost in FY 2024. The higher percentage in services to children results in an expected increase in the cost to the programs	
3.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Line 1 (B). (Children with Special Health Care Needs) - FY 2024 Annual Report Expended amount of $4.47m increased from the FY 2022-2024 Application Budgeted amount of $3.51m, a difference of $967k or 27.61%. As specified in Section 505 (3) (B) of the Social Security Act “at least 30% of the MCH grant award must be allocated for services provided to children with special health care needs”. When the FY 2024 budget was developed in FY 2022, 30% of the MCH grant award of $11,684,723 was $3.505m. The actual MCH grant award for FY 2024 was $12,021,137, instead of the minimum 30%, CRS received 37.2% or $4.47m. In 2024 Public Health was able to assist CRS by providing an additional funding of $866k above the required minimum to cover unfunded services to children with special needs. For the FY 2026 Application Budget CRS percentage is set at 35% based on the current NOA of $12,021,137 the CRS Federal Allocation would be $4,207,398.	
4.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**

	Field Note: Line 3. (State MCH Funds) - FY 2024 Annual Report Expended amount of $49.6m increased from the FY 2022-2024 Application Budgeted amount of $37.8m, a difference of $11.8m or 31.33%. The State Match increase resulted from a combination of factors: (1) Other support income rising FY 2024 to $43.6m compared to $40.6m budgeted for FY 2022-2024, a $3.0m difference; and (2) increase in actual expenditures for FY 2024 to $80.0m compared to the budget for FY 2022-2024 of $65.9m, a difference of $14.1m. The net differences of these two factors indicate that expenditures increased at a higher rate than income which requires a higher match contribution by ADPH of approximately $11.1m. CRS share of the change in State Match is $688k or 5.49%.	
5.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Line 5. (Other Funds) – CRS FY 2024 Annual Report Expended amount was $965k which is a decrease from the FY 2022-2024 Application Budgeted reported at $1.577m, a decrease of $613k or -38.8%. 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.	
6.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Line 6. (Program Income) – FY 2024 Annual Report Expended amount of $40.1m increased from the FY 2022-2024 Application Budget amount of $33.9m, a net difference of $6.2m or 18.32%. The net $6.2m increase is composed of the following factors. In FY 2024, the ADPH program that showed substantial increase when compared to the projected FY 2022-2024 budget was Family Planning Medicaid ($4.4m). The FY 2024 ADPH budget was built during a period of changing operations and anticipated loss in revenue from Medicaid's networks providing case management services. ADPH's program income increased more than the expected projection. CRS program income increased by $2.1m, a 12.14% change during this reporting period. The increase in CRS program income is a result of the budgeted amount being based on a lower Medicaid cost-based reimbursement rate. FY 2024 yielded a higher Medicaid clinic encounter rate and visits which impacted the actual program income received in FY 2024.	
7.	**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:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Early Head Start Program - FY 2024 Annual Report Expended amount of $1.27m increased from the FY 2022-2024 Application Budgeted amount of $878k, a difference of $390k or 44.4%. Most of the increase is related to personnel costs $240k and allocated costs $122k, totaling $362k.	

8.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Alabama Pregnancy Risk Assessment Monitoring System (PRAMS) – FY 2024 Annual Report Expended amount of $185k increased from the FY 2022-2024 Application Budgeted amount of $158k, a difference of $27k or 17.58%. FY 2024 the personnel cost increased approximately $28k with 2.75 FTE's compared to 2.0 in FY 2022-2024.	
9.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: State Systems Development Initiative (SSDI) – FY 2024 Annual Report Expended amount of $138k decreased from the FY 2022-2024 Application Budgeted amount of $169k, a difference of $31k or -18.27%. The program in FY 2024 included one EPI position compared to FY 2022 with a Director and EPI position.	
10.	**Field Name:**	**Other Federal Funds, US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Women, Infants and Children (WIC) – FY 2024 Annual Report Expended amount of $142m increased from the FY 2022-2024 Application Budgeted amount of $112m, a difference of $30m or 26.8%. Most of the increase is related to Food Costs up $26m and $4m is associated with the cost centers that support increases in caseload. Average Caseload increased from 108,660 in FY 2022 to 111,702 in FY 2024 difference of 3,042 or 3%.	
11.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Well Woman**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**

Field Note:
Well Women Program – FY 2024 Annual Report Expended amount of $1.625m decreased from the FY 2022-2024 Application Budgeted amount of $1.773m, a difference of $148k or -8.35%. In the FY 2022-2024 application the FY 2024 budgeted amount was incorrectly reported at $1.1m the correct amount that should have been reported was $1.773m. When comparing the actual FY 2024 expended of $1.63m to the correct $1.77m, a decrease $148k which is less than the 10% variance at 8.35%. During FY2024, Well Woman was available in nine counties (Barbour, Butler, Dallas, Henry, Macon, Marengo, Montgomery, Russell, and Wilcox) with plans to expand into three additional counties (Bullock, Covington, and Lowndes) starting October 2024. Between implementation and fiscal year 2024, program support and staffing increased to cover the state office and program needs in the current and expansion counties.

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Alabama

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 26 Application Budgeted	FY 24 Annual Report Expended
1. Pregnant Women	$ 19,804	$ 4,889
2. Infants < 1 year	$ 333,078	$ 82,235
3. Children 1 through 21 Years	$ 6,258,745	$ 6,258,745
4. CSHCN	$ 4,207,398	$ 4,473,156
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 10,819,025	$ 10,819,025

IB. Non-Federal MCH Block Grant	FY 26 Application Budgeted	FY 24 Annual Report Expended
1. Pregnant Women	$ 378,925	$ 393,837
2. Infants < 1 year	$ 6,430,903	$ 6,624,437
3. Children 1 through 21 Years	$ 46,771,179	$ 46,321,862
4. CSHCN	$ 32,287,696	$ 34,193,726
5. All Others	$ 4,344,818	$ 4,419,645
Non-Federal Total of Individuals Served	$ 90,213,521	$ 91,953,507
Federal State MCH Block Grant Partnership Total	$ 101,032,546	$ 102,772,532

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Line 2. (Infants<1 year) – FY 2024 Annual Report Expended amount of $6.71m increased from the FY 2022-2024 Application Budgeted amount of $4.46m, a difference of $2.25m or 50.32%. From FY 2022 to FY 2024, net total infant activity increased by 1,453 or 26.4%. The increased activity results in an anticipated rise in costs of providing these services. During this period most of the change was in Jefferson County with activity increasing by 1,631 with Mobile County offsetting the total activity by -183.	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Line 3. (Children 1-22 Years) – FY 2024 Annual Report Expended of amount $52.6m increased from the FY 2022-2024 Application Budgeted amount of $40.7m, a difference of $11.9m or 29.2%. Total cost increased 28% from FY 2022 ($80m) to FY 2024 ($102m). During FY 2022, children 1-22 years of age made up 90% of total child health visits. In FY 2022, total budgeted cost for FY 2024 was reported at $85m. After excluding from the calculation (PW, Infants, CRS, Adm.) net total budgeted cost for 1-22 years is $40.7m. In FY 2024, children 1-22 years of age made up 89% of total child health visits. Total expended cost was reported at $102m. Excluding from the calculation (PW, Infants, CRS, Adm.) net total expended cost for 1-22 years would be $52.6m. The result children 1-22 activity increased (50,154 to 54,504) 8.67% and cost was up $11.9m during the referenced time.	
3.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Line 5. (All Others - Adm) -- FY 2024 Annual Report Expended amount of $4.42m increased from the FY 2022-2024 Application Budgeted amount of $3.98m, a difference of $444k or 11.17%. The factors affecting the change in cost is seen in personnel: 2 cost-of-living, annual merit raises and healthcare benefits increasing over the 2-year span.	

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 26 Application Budgeted	FY 24 Annual Report Expended
1. Direct Services	$ 5,225,040	$ 4,992,369
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 1,919,766	$ 1,780,075
B. Preventive and Primary Care Services for Children	$ 2,085,129	$ 1,933,405
C. Services for CSHCN	$ 1,220,145	$ 1,278,889
2. Enabling Services	$ 1,283,419	$ 1,328,712
3. Public Health Services and Systems	$ 5,512,678	$ 5,700,056
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		$ 543,278
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Other		
CRS: Purchased Services, Health Insurance		$ 1,168,364
ADPH: CH Assess & Primary Care Program support		$ 3,280,727
Direct Services Line 4 Expended Total		$ 4,992,369
Federal Total	$ 12,021,137	$ 12,021,137

IIB. Non-Federal MCH Block Grant	FY 26 Application Budgeted	FY 24 Annual Report Expended
1. Direct Services	$ 53,473,095	$ 49,375,826
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 13,405,553	$ 13,338,258
B. Preventive and Primary Care Services for Children	$ 14,560,262	$ 14,487,170
C. Services for CSHCN	$ 25,507,280	$ 21,550,398
2. Enabling Services	$ 9,080,881	$ 14,709,802
3. Public Health Services and Systems	$ 26,457,431	$ 26,665,767
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 1,882,253
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 2,674,170
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Other		
ADPH: Non-Federal cost for MCH activities		$ 44,819,403
Direct Services Line 4 Expended Total		$ 49,375,826
Non-Federal Total	$ 89,011,407	$ 90,751,395

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:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Line 1. (Direct Services) - FY 2024 Annual Report Expended amount of $54.4m increased from the FY 2022-2024 Application Budgeted amount of $41.9m, a difference of $12.4m or 29.7%. From FY 2022 to FY 2024, Family Planning visits increased 3% and Child Health visits were up 10.4%. As expected with the changes in activity, Direct Services net cost increased $10.2m. Increases were seen in cost centers related to Family Planning Exam (463 cc) $5.7m and Child Health Primary Care (027 cc) and Assessment (025 cc) $4.4m. CRS cost for Direct Services increased $2.2m during the reporting period. See section III.D.1. Expenditures for Form 3b for CRS explanation.	
2.	**Field Name:**	**IIA. Federal MCH Block Grant, 2. Enabling Services**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Line 2. (Enabling Services) - FY 2024 Annual Report Expended amount of $16.0m increased from the FY 2022-2024 Application Budgeted amount of $13.9m, a difference of $2.1m or 14.71%. ADPH share of the net increase in cost was $878k. ADPH programs with most of the changes were FP Referrals ($1.34m) offset by a decrease in FP Community Health Advisor (-$518k). CRS share of the cost was $1.2m. See section III.D.1. Expenditures for Form 3b for CRS explanation.	
3.	**Field Name:**	**IIA. Federal MCH Block Grant, 3. Public Health Services and Systems**
	Fiscal Year:	**2024**
	Column Name:	**Annual Report Expended**
	Field Note: Line 3. (Public Health Services) - FY 2024 Annual Report Expended amount of $32.4m increased from the FY 2022-2024 Application Budgeted amount of $29.1m, a difference of $3.3m or 11.30%. Prior to FY 2024, Family Planning clerical services were rolled up with FP Exams into Direct Care, however after discussion with the FP Director 50% of the cost should be considered Public Health Services based, this change resulted in a PHS net increase of $4.4m. This was offset by CRS share of Public Health Services cost which decreased by -$1.2m. See section III.D.1. Expenditures for Form 3b for CRS explanation.	

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

State: Alabama

Total Births by Occurrence: 56,546 **Data Source Year: 2024**

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	56,546 (100.0%)	3,915	225	225 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	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)	Mucopolysaccharidosis Type I (MPS I)	Primary Congenital Hypothyroidism	Propionic Acidemia
S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1
ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Newborn Hearing	56,546 (100.0%)	1,950	94	94 (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
ACLPPP	47,571	1,142	886	886
ABCCED - Breast Cancer Screening	8,312	73	56	56
ABCCED - Cervical Cancer Screening	3,899	285	150	150

4. Long-Term Follow-Up

The Alabama Newborn Screening Follow-Up Program (ANSFD) designed its protocol to ensure early identification and follow-up of infants affected with certain genetic or metabolic conditions. Early diagnosis reduces intellectual disability, morbidity, premature death, and other developmental disabilities. The ANSFD collaborated with pediatric specialists throughout the state to ensure timely diagnosis and treatments for all infants with abnormal lab results. The ANSFD does not provide long-term follow-up beyond referring an infant for treatment. Once a condition is confirmed, either a primary care provider or a specialty care center monitors the long-term follow-up.

Effective April 2024, the NBSP collaborated with FHS care coordinators to provide ongoing long-term care coordination services for infants born with reportable birth defects lasting until either the case plan goals are met or if family no longer wishes to receive assistance.

Form Notes for Form 4:

Form 4 included the efforts made to complete testing and provide treatment as needed to those served by the Alabama Breast and Cervical Cancer Early Detection Program (ABCCED), the Alabama Childhood Lead Poisoning Prevention Program (ACLPPP), and the Newborn Screening Program (NBSP). All data sections presented in Form 4 reflected the testing and treatment efforts completed during CY 2024.

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2024**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: According to CHS, the number of live births that occurred in Alabama in CY 2024 was 56,546. Alabama utilized the CY 2024 CHS birth file to determine if the recorded registration state was marked Alabama. The CHS number of live births occurring in Alabama remained stable with 56,546 reported in CY 2024 and 56,448 reported in CY 2023	
2.	**Field Name:**	**Core RUSP Conditions - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2024**
	Column Name:	**Core RUSP Conditions**
	Field Note: The CHS reported 56,546 births during CY 2024. Among these births, the NBSP completed 56,929 initial screenings. An infant can receive an additional initial screening when admitted into NICU. The difference between data sources remained stable with 276 in CY 2023 and 383 in CY 2024.	
3.	**Field Name:**	**Core RUSP Conditions - Total Number of Out-of-Range Results**
	Fiscal Year:	**2024**
	Column Name:	**Core RUSP Conditions**
	Field Note: As of CY 2024, the NBSP tested for 36 disorders, including 35 disorders from the Core Recommended Uniform Screening Panel (RUSP) and 1 state specific disorder (Multiple Carboxylase Deficiency). Beginning July 2024, the NBSP implemented testing for lysosomal storage disorders, specifically MPS-I and Pompe disease.	
4.	**Field Name:**	**Core RUSP Conditions - Total Number Confirmed Cases**
	Fiscal Year:	**2024**
	Column Name:	**Core RUSP Conditions**
	Field Note: The number in this section excluded Alabama newborns whose parents either moved out of state or were not Alabama residents at time of delivery.	

5.	**Field Name:**	**Core RUSP Conditions - Total Number Referred For Treatment**
	Fiscal Year:	**2024**
	Column Name:	**Core RUSP Conditions**
	Field Note: In CY 2024, 252 newborns received a referral for treatment, while 225 referrals were confirmed with a NBSP health disorder. Since follow up for early intervention is not possible, the referral number excluded Alabama newborns whose parents either moved out of state or were not Alabama residents at time of delivery. For reporting purposes, the number of newborns referred for treatment will equal the number of confirmed cases. Otherwise, the area of reach for treatment referrals exceeded 100.0 percent.	
6.	**Field Name:**	**Newborn Hearing - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2024**
	Column Name:	**Other Newborn**
	Field Note: The NBSP completed 56,929 initial screenings. Initial screenings included the newborn hearing component. An infant can receive an additional initial screening when admitted into NICU. Accounting for additional initial screenings, the number represented the total number of births (n=56,546) reported during CY 2024.	
7.	**Field Name:**	**Newborn Hearing - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2024**
	Column Name:	**Other Newborn**
	Field Note: During CY 2024, 1,950 Alabama newborns was within the presumptive positive cutoff values set by the NBSP medical consultants.	
8.	**Field Name:**	**Newborn Hearing - Total Number Confirmed Cases**
	Fiscal Year:	**2024**
	Column Name:	**Other Newborn**
	Field Note: Since follow up for out of state early intervention is not possible, the confirmed number of cases for CY 2024 excluded Alabama newborns whose parents either moved out of state or were not Alabama residents at time of delivery.	
9.	**Field Name:**	**Newborn Hearing - Total Number Referred For Treatment**
	Fiscal Year:	**2024**
	Column Name:	**Other Newborn**

	Field Note: For reporting purposes on newborn hearing, the number referred for treatment will equal the number of confirmed cases during CY 2024. Otherwise, the area of reach for treatment referrals for newborn hearing exceeded 100.0 percent. The total number referred for treatment for CY 2024 also excluded Alabama newborns whose parents either moved out of state or were not Alabama residents at time of delivery.	
10.	**Field Name:**	**ACLPPP - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2024**
	Column Name:	**Older Children & Women**
	Field Note: During CY 2024, 47,571 unique children under 18 years old were tested for lead. The ACLPPP utilized either capillary or venous as the primary testing methods for lead detection. The number remained relatively stable from 48,420 in CY 2023 to 47,571 in CY 2024.	
11.	**Field Name:**	**ACLPPP - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2024**
	Column Name:	**Other Newborn**
	Field Note: Presumptive positive screenings include children under 18 years old who had at least one capillary blood lead level at or above the BLRV of 3.5 mcg/dL. If a child is positive during a presumptive lead screening, then additional testing will be completed to confirm if the child is positive. With this protocol, there will be overlap between the presumptive positive screens and total number of confirmed cases. The number of presumptive positive screens slightly decreased from 1,341 in CY 2023 to 1,142 in CY 2024.	
12.	**Field Name:**	**ACLPPP - Total Number Confirmed Cases**
	Fiscal Year:	**2024**
	Column Name:	**Other Newborn**
	Field Note: In 2022, the CDC changed the presumptive positive screening range from ≥5 mcg/dL to ≥3.5 mcg/dL. The number represented the number of unique children under 18 years old with a venous test result either meeting or exceeding the BLRV of 3.5 mcg/dL. The number of confirmed cases remained relatively stable from 893 in CY 2023 to 886 in CY 2024.	
13.	**Field Name:**	**ACLPPP - Total Number Referred For Treatment**
	Fiscal Year:	**2024**
	Column Name:	**Other Newborn**

	Field Note: In 2022, the CDC changed the presumptive positive screening range from ≥5 mcg/dL to ≥3.5 mcg/dL. The number represented the number of unique children under 18 years old with a venous test result either meeting or exceeding the BLRV of 3.5 mcg/dL. For reporting purposes on lead testing, the number referred for treatment will equal the number of confirmed cases. Otherwise, the area of reach for treatment referrals for lead screening exceeded 100.0 percent. The number of confirmed cases remained relatively stable from 893 in CY 2023 to 886 in CY 2024.	
14.	**Field Name:**	**ABCCED - Breast Cancer Screening - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2024**
	Column Name:	**Older Children & Women**
	Field Note: The ABCCED counted patients who had either a biopsy, clinical breast exam, mammogram, MRI, or ultrasound for the total number of breast cancer screenings completed during CY 2024.	
15.	**Field Name:**	**ABCCED - Breast Cancer Screening - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2024**
	Column Name:	**Other Newborn**
	Field Note: ABCCEDP counted patients who had a mammogram with an abnormal result during CY 2024.	
16.	**Field Name:**	**ABCCED - Breast Cancer Screening - Total Number Confirmed Cases**
	Fiscal Year:	**2024**
	Column Name:	**Other Newborn**
	Field Note: ABCCEDP counted patients who had a biopsy confirming breast cancer during CY 2024.	
17.	**Field Name:**	**ABCCED - Breast Cancer Screening - Total Number Referred For Treatment**
	Fiscal Year:	**2024**
	Column Name:	**Other Newborn**
	Field Note: All confirmed breast cancer cases diagnosed during CY 2024 received a referral for treatment.	
18.	**Field Name:**	**ABCCED - Cervical Cancer Screening - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2024**

	Column Name:	**Older Children & Women**
	Field Note: The ABCCED counted patients who had either a clinical office visit, HPV test, Pap test, or colposcopy for the total number of cervical cancer screenings completed during CY 2024.	
19.	**Field Name:**	**ABCCED - Cervical Cancer Screening - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2024**
	Column Name:	**Other Newborn**
	Field Note: ABCCEDP counted patients who had an abnormal pap test and a positive HPV positive test during CY 2024.	
20.	**Field Name:**	**ABCCED - Cervical Cancer Screening - Total Number Confirmed Cases**
	Fiscal Year:	**2024**
	Column Name:	**Other Newborn**
	Field Note: ABCCEDP counted CY 2024 cancer and pre-cancer cases being confirmed through a colposcopy. Cancer and pre-cancer cases are defined based on the grading of the cervical intraepithelial neoplasia being either two or higher.	
21.	**Field Name:**	**ABCCED - Cervical Cancer Screening - Total Number Referred For Treatment**
	Fiscal Year:	**2024**
	Column Name:	**Other Newborn**
	Field Note: All confirmed cervical cancer and cervical pre-cancer cases diagnosed during CY 2024 received a referral for treatment.	

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 2024

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	7,551	42.7	0.0	10.7	21.6	25.0
2. Infants < 1 Year of Age	2,796	63.0	0.0	0.0	0.0	37.0
3. Children 1 through 21 Years of Age	25,219	73.9	1.5	9.8	14.8	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	15,901	77.1	3.3	17.4	2.2	0.0
4. Others	4,018	53.0	0.0	26.8	2.6	17.6
Total	39,584					

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

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	57,858	Yes	57,858	69.2	40,038	7,551
2. Infants < 1 Year of Age	56,448	Yes	56,448	99.7	56,279	2,796
3. Children 1 through 21 Years of Age	1,349,246	Yes	1,349,246	76.6	1,033,522	25,219
3a. Children with Special Health Care Needs 0 through 21 years of age^	402,439	Yes	402,439	42.2	169,829	15,901
4. Others	3,701,337	Yes	3,701,337	76.6	2,835,224	4,018

^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:	**2024**

Field Note:
The number represented the following services provided in CY 2024: positive pregnancies among Family Planning participants and the number of cribs provided by the Cribs for Kids Program. Statewide, 7,551 received either service. The number of unique positive pregnancy tests completed in CY 2024 was higher compared to FY 2023, increasing from 4,698 to 6,529. The increase resulted from the inclusion of unique positive pregnancy tests being completed at Mobile County Health Department and Jefferson County Department of Health. Since ADPH does not have access to Family Planning patient level data for these providers, cribs provided to either Jefferson or Mobile residents were excluded. After exclusion, the number of cribs distributed in CY 2024 almost doubled compared to FY 2023, increasing from 565 to 1,022. This upward trend can be linked to promotion of the Cribs for Kids Program through the regional nurse coordinators and community outreach events such as Babypalooza. The CDC's Link Plus record linkage tool was utilized to identify and remove duplicates between data sources.

Looking at county specific level initiatives, the Jefferson County Department of Health developed the From Day One program, which was implemented within obstetrical offices in Jefferson County. Since its inception in February 2018, the From Day One is a comprehensive patient centered program designed to educate and support expectant mothers starting at their first trimester until the child's first year of life. Core strategies include the following: 1. Identify barriers to care; 2. Improving access to care; 3. Provide continuous education; 4. Enhancing support networks and empowering women to set and meet preventative health goals. From Day One has been implemented within obstetrical offices active in Jefferson County. In CY 2024, From Day One enrolled 52 expectant mothers with over 90 percent (90.4 percent; n=47/52) having Medicaid insurance.

2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2024**

Field Note:
The number represented the case management services provided for newborn hearing in CY 2024. During CY 2024, 2,796 were referred to the case management team. Case management services in CY 2024 remained relatively stable compared to FY 2023, increasing from 2,500 to 2,796. Alabama served mostly a Medicaid population, with over 60 percent (63.1 percent; n=1,764/2,796) having Medicaid insurance. In CY 2024, more referrals were completed due to an issue within the NATUS system where passing results for some cases were not being pulled correctly. This issue was prevalent for the last three months of 2024. The issue was not resolved until March 2025.

As a component of the From Day One Program, the Jefferson County Department of Health partnered with Connection Health to complete home and infant safety assessments. During CY 2024, Connection Health completed 179 home environmental and wellbeing assessments. The Community Health Workers used a checklist to assess home safety for the infant; including the inspection of cabinet locks, first aid kits, functional smoke detectors, infant bathtub thermometer, outlet covers, proper storage of chemicals, safe changing area, and secured window cords. During these visits, families also received guidance on safe sleep practices and car seat safety.

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

	Fiscal Year:	**2024**

Field Note:
The number represented the child and adolescent health visits completed statewide for CY 2024. Child and adolescent visits in CY 2024 remained relatively stable compared to FY 2023, decreasing from 26,172 to 25,219. From all children receiving child health services from either ADPH affiliates, Jefferson County Department of Health, or Mobile County Health Department (CHD), care coordination services for hearing were provided for 105 non-Medicaid insured children ages 1 to 3.

On a smaller scope, the Oral Health Office continued its initiatives to provide direct and enabling services for this MCH population. Effective January 2024, the Oral Health Office expanded its scope of preventive dental services provided by starting a new partnership with Singing River Dentistry and continuing its existing partnerships with Calhoun Community College and Wallace Community College. Preventive dental visits included dental sealants and silver diamine fluoride treatment. Within these locations, 183 received a preventive dental visit during CY 2024. During CY 2024, the dental screenings provided by Tuscaloosa CHD for school aged children living in Greene and Perry Counties increased compared to FY 2023, rising from 358 to 375 individuals. At Tuscaloosa CHD, dental services were provided for 1,940 individuals ages 1 to 21. During CY 2024, dental health kits containing age-appropriate toothbrushes, toothpastes, floss, and toothbrushes was provided to 17,424 individuals at community events and health fairs statewide.

In the West Central District, two suicide prevention trainings (Response and QPR) are offered, with curricula tailored for middle school students and individuals aged 14 years and older. With these trainings, participants are better equipped to identify the warning signs for suicide and notify the appropriate representatives to ensure timely support. In 2024, 183 participants ages 1 to 21 completed either training.

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2024**

Field Note:
The "Title V Total Served" number represents individuals that received services through attending a CRS medical or evaluation clinic during FY24. It is an unduplicated count. See section III.B.3.b. Health Care Delivery System - System of Services for CSHCN for additional information. The "Primary Source of Coverage" percentages for CSHCN are obtained from the CRS report titled, "MCH Grant Clients by Insurance Status and County." The percentages for each source of coverage remain similar to the previous FY. CRS information is reported by FY as that is how the data is collected and reported.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2024**

Field Note:
The number represented Family Planning participants aged 22 to 55 eligible to receive Well Woman services during CY 2024. The selected locations for Well Woman services are based on lack of access to primary care, lack of resources, barriers to care, rurality status, and the capacity of public health staff to provide services. The number of women eligible for Well Woman that are also enrolled in Family Planning was higher in CY 2024 compared to FY 2023, increasing from 3,748 to 4,018. As of CY 2024, 12 County Health Departments provided Well Woman services, with 3 new County Health Departments becoming active in October 2024. Close to 80 percent (77.8 percent; n=3,120/4,018) were Black, non-Hispanic. Almost half (49.7 percent; n=1,995/4,018) were between the ages of 25 and 34. These locations are primarily active within rural counties, with over 90 percent (91.7 percent; n=11/12) of the 2023 American Community Survey 5-year county estimates being below 100,000. Approximately 71.6 percent (n=2,875/4,018) were seen within a rural county as defined by the Office of Maternal and Child Health.

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2024**

Field Note:
Statewide, 43 delivering hospitals remained active, while two delivery hospitals closed its labor and delivery services during CY 2024.

The Perinatal Health Division (PHD) utilized Baby books to increase awareness among the pregnant population on safe sleep practices. As of CY 2024, the PHD distributed 18,672 Baby books statewide. Distribution of Baby books was achieved through community outreach, delivering hospital partnerships, and regional nurse managers. During CY 2024, 86.0 percent (n=37/43) of the delivering hospitals provided this resource among their deliveries. The CHS number of deliveries occurring at the partnered delivering hospitals remained relatively stable with 39,760 in FY 2023 and 40,019 in CY 2024.

2.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2024**

Field Note:
In CY 2024, the Alabama Newborn Screening Program (NBSP) completed 56,929 initial screenings. The CHS number of NICU transfers remained stable with 675 reported in FY 2023 and 678 reported in CY 2024. If a NICU transfer occurs, an additional initial screening will be completed for the infant (< 1 years old). After accounting for NICU transfers, 56,251 unique infants (< 1 years old) received at least one initial screening, representing 99.7 percent (n=56,251/56,448) of the total HRSA reported infant population (< 1 year old).

3.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2024**

	Field Note: According to CDC, roughly 4,511,000 Alabamians had access to a community water system (CWS) in 2022. The number of Alabamians having access to fluoridated waters through their CWS remained relatively stable with 76.6 percent (n=3,454,238/4,511,00) in 2022 and 77.7 percent (n=3,469,133/4,467,001) in 2020. Compared to other states, Alabama was ranked 24nd in both 2020 and 2022 in the percent of the population receiving fluoridation through their CWS. Approximately 1,033,522 children ages 1 to 21 had access to water fluoridation through their CWS, with the estimate utilizing the 2022 CDC statewide fluoridation rate of 76.6 percent on the total HRSA reported children population ages 1 to 21 years old (n=1,349,246). In CY 2024, OHO completed its goal of 30 CWS site visits to encourage continuation of maintaining the optimal fluoridation levels recommended by CDC. Strengthening partnerships with CWS remains a top priority for the OHO. With the goal of initiating Community Water Fluoridation statewide, the OHO utilized Title V funding to give opportunities for CWS to apply for funding to purchase and update fluoridation equipment as needed.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2024**
	Field Note: The numerator is the number of CYSHCN reached by CRS for FY 2024 (169,760). The numerator includes the following counts for CRS: toll free calls, SS contacts, information and referrals, Facebook (ADRS, Parent Connection, and Youth Connection) reaches, ADRS/CRS website hits, local hearing screenings, outreach activities, and number served. The FY 2024 number reached is significantly higher than the FY 2023 number reached of 93,625. The increase in the number reached is a result of maximizing the use of social media and raising awareness of CRS services through participating in community and statewide outreach events. CRS information is reported by FY as that is how the data is collected and reported.	
5.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2024**
	Field Note: Access to water fluoridation through a CWS remained the largest area of reach for this MCH population. Approximately 2,835,224 individuals older than 21 had access to water fluoridation through their CWS, with the estimate utilizing the 2022 CDC statewide fluoridation rate of 76.6 percent on the total HRSA reported population older than 21 years old (n=3,701,337). As mentioned in the 5B field note for children ages 1 to 21 years old, the OHO utilized Title V funding to either initiate or sustain Community Water Fluoridation statewide through partnerships with CWS, thus impacting the MCH population older than 21 years old.	

Data Alerts:

1.	Reported percentage for Others on Form 5b is greater than or equal to 50%. The Others denominator includes both women and men ages 22 and over. Please double check and justify with a field note.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Alabama

Annual Report Year 2024

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	57,909	33,215	14,687	7,650	126	948	69	1,176	38
Title V Served	57,909	33,215	14,687	7,650	126	948	69	1,176	38
Eligible for Title XIX	24,316	9,599	9,017	4,856	47	156	41	583	17
2. Total Infants in State	56,546	32,490	14,257	7,525	122	934	67	1,123	28
Title V Served	56,546	32,490	14,257	7,525	122	934	67	1,123	28
Eligible for Title XIX	23,726	9,382	8,730	4,802	45	153	41	561	12

Form Notes for Form 6:

Following the protocol set by CHS, SAS was used to determine whether a mother should be categorized in the multiple race Non-Hispanic category or the single Non-Hispanic race categories listed in Form 6. For this report, Alabama is reporting the total number of births that occurred during CY 2024. For this analysis, Alabama will look at the 15 racial categories listed in the birth files to see if the mother selected multiple options for race.

For the single race category, there were minority groups that fell under the umbrella of the Non-Hispanic Asian group and the Non-Hispanic Native Hawaiian or Other Pacific Islander group. The next step to this analysis was to look at Hispanic status. To determine Hispanic status, the CHS code for Hispanic Status must be between 200 and 299. The Others and unknown category would include the following: unknown race, other race, or unknown Hispanic origin.

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2024**
	Column Name:	**Total**
	Field Note: Based on the CHS data source, Total Deliveries in State represented the total number of Alabama resident live births that happened during CY 2024.	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2024**
	Column Name:	**Total**
	Field Note: During CY 2024, perinatal regionalization identified and referred high risk mothers to hospitals with the appropriate level of care. With perinatal regionalization being active, Title V Served will be the same as the number for the total deliveries in State.	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2024**
	Column Name:	**Total**
	Field Note: Based on CHS data, the number represented the number of Alabama residents whose payment source at delivery was Title XIX (Medicaid) during CY 2024.	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2024**
	Column Name:	**Total**
	Field Note: Based on CHS data, Total Infants in State represented the total number of occurrent births that happened with CY 2024. Occurrent births included mothers who delivered in Alabama regardless of residency status.	

5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2024**
	Column Name:	**Total**
	Field Note: During CY 2024, perinatal regionalization remained active. Title V Served will be the same as the number for the Total Infants in State.	
6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2024**
	Column Name:	**Total**
	Field Note: Using CHS data, the total number represented births that occurred within Alabama whose payment source at birth was identified as Title XIX (Medicaid).	

Form 7
Title V Program Workforce

State: Alabama

Form 7 Entry Page

A. Title V Program Workforce FTEs	
Title V Funded Positions	
1. Total Number of FTEs	267
1a. Total Number of FTEs (State Level)	42
1b. Total Number of FTEs (Local Level)	225
2. Total Number of MCH Epidemiology FTEs (subset of A. 1)	1
3. Total Number of FTEs eliminated in the past 12 months	0
4. Total Number of Current Vacant FTEs	33
4a. Total Number of Vacant MCH Epidemiology FTEs	3
5. Total Number of FTEs onboarded in the past 12 months	28

B. Training Needs (Optional)	
1	DataCamp
2	REDCap
3	
4	

Form Notes for Form 7:

ADPH cost center data provided by the Bureau of Financial Services estimated the Title V Program Workforce FTEs. ADPH had a total of 31 FTEs representative of district level staff and 10 FTEs representative of state level staff. ADPH had two MCH Epi vacancies and onboarded six new Title V workforce staff.

Data provided by ADRS Personnel and Human Resources Division estimated the number of CRS FTEs devoted to serving CYSHCN. FTEs reported here are not limited to those paid by Title V due to other fund sources being used for CYSHCN services. As of March 2025, 215 FTEs are in the field and 11 FTEs are at the state office.

Field Level Notes for Form 7:

Form 7 Field Level Notes Table

1.	**Field Name:**	**Total Number of FTEs**
	Field Note: Data provided by the ADRS Personnel and Human Resources Division was used to provide the number of CRS FTEs devoted to serving CYSHCN. FTEs reported here are not limited to those paid for by Title V, because other funds support staff providing services to CYSHCN. As of March 31, 2025, 215 FTEs are in the field and 11 FTEs are at the state office.	
2.	**Field Name:**	**Total Number of FTEs (State Level)**
	Field Note: CRS Total Number of FTEs (State Level) = 11 as of March 31, 2025. These positions include the Assistant Commissioner, Administrators, State Office Specialists, and Administrative Support Assistants.	
3.	**Field Name:**	**Total Number of FTEs (Local Level)**
	Field Note: CRS Total Number of FTEs (Local Level) = 215 as of March 31, 2025. These positions include District Supervisors, Social Workers, Nurses, Specialists, and Administrative Support Assistants.	
4.	**Field Name:**	**Total Number of Current Vacant FTEs**
	Field Note: CRS Total Number of Current Vacant FTEs = 23 as of March 31, 2025. Vacant positions are within the CRS Districts and include administrative support assistants, social workers, nurses, and audiologists. There are also three vacant local parent consultant positions through the contract with Easter Seals of Central Alabama.	
5.	**Field Name:**	**Total Number of Vacant MCH Epidemiology FTEs**
	Field Note: CRS has one vacant Epidemiologist position at the state level.	
6.	**Field Name:**	**Total Number of FTEs onboarded in the past 12 months**
	Field Note: CRS Total Number of FTEs onboarded in the past 12 months = 22 Date range used = 4/1/24 - 3/31/25. Positions filled include Administrative Support Assistants, Social Workers, and Specialists.	

Form 7 Field Level Notes Table

7.	**Field Name:**	**Training Needs Line 1**
	Field Note: Funded by OIDA,the MCH Epi Branch received licenses for DataCamp. DataCamp has interactive courses and exercises pertaining to Power BI, SQL, and other programming tools. To expand data capacity, the MCH Epi Branch completed the Power BI training to learn how to create interactive dashboards. These dashboards will disseminate MCH data to the public.	
8.	**Field Name:**	**Training Needs Line 2**
	Field Note: The MCH Epi Branch received access to REDCap in 2025. REDCap is a secure web application for building and managing online surveys and databases. Using REDCap training videos, the MCH Epi Branch created several interactive surveys streamlining data collection for the OHO and Well Woman.	

Form 8
State MCH and CSHCN Directors Contact Information

State: Alabama

1. Title V Maternal and Child Health (MCH) Director	
Name	Amanda C. Martin
Title	Director, Bureau of Family Services
Address 1	201 Monroe Street
Address 2	
City/State/Zip	Montgomery / AL / 36104
Telephone	(334) 206-9420
Extension	
Email	amanda.martin@adph.state.al.us

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Cathy Caldwell
Title	Assistant Commissioner
Address 1	602 South Lawrence Street
Address 2	
City/State/Zip	Montgomery / AL / 36104
Telephone	(334) 293-7049
Extension	
Email	cathy.caldwell@rehab.alabama.gov

3. State Family Leader (Optional)	
Name	Sylvia Bowen
Title	CRS State Parent Consultant
Address 1	602 South Lawrence Street
Address 2	
City/State/Zip	Montgomery / AL / 36104
Telephone	(334) 293-7215
Extension	
Email	sylvia.bowen@rehab.alabama.gov

4. State Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

5. SSDI Project Director	
Name	Tim Feuser
Title	MCH Epidemiology Director and SSDI Project Director
Address 1	PO Box 303017
Address 2	
City/State/Zip	Montgomery / AL / 36130
Telephone	(334) 206-5398
Extension	
Email	tim.feuser@adph.state.al.us

6. State MCH Toll-Free Telephone Line	
State MCH Toll-Free “Hotline” Telephone Number	(800) 654-1385

Form Notes for Form 8:

None

Form 9
List of Priority Needs – Needs Assessment Year

State: Alabama

Application Year 2026

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Insufficient or unequal assistance to help families navigate the system of care.	New
2.	Inadequate supports for transition to all aspects of adulthood.	Revised
3.	Lack of peer support and opportunities to create community for families, caregivers, and youth.	New
4.	Comprehensive Postpartum Care and Education	New
5.	Infant Mortality	Continued
6.	Access to Comprehensive Health Care for Children	New
7.	Adolescent Safety and Wellness	New
8.	Access to Comprehensive Oral Health Education and Services for all MCH Populations	New

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10
National Outcome Measures (NOMs)

State: Alabama

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

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

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

State Provided Data	
	2024
Annual Indicator	0.0
Numerator	
Denominator	
Data Source	FHS PHD
Data Source Year	2024

NOM SMM - Notes:

With the hospital data source now available, the MCH Epi Branch will work with OIDA to determine if data for this NOM can be provided.

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2023	35.1	3.5	102	290,323
2018_2022	38.6	3.7	112	290,226
2017_2021	41.9	3.8	122	291,018
2016_2020	38.7	3.6	113	292,115
2015_2019	34.3	3.4	101	294,125
2014_2018	28.5	3.1	84	294,932

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM MM - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	20.1	0.3	3,417	170,024
2022	20.9	0.4	3,445	164,579
2021	22.9	0.4	3,641	159,313
2020	24.8	0.4	3,788	152,853
2019	25.6	0.4	3,955	154,529
2018	25.2	0.4	3,924	155,697
2017	27.0	0.4	4,241	157,072
2016	28.4	0.4	4,480	158,008
2015	30.1	0.4	4,739	157,380
2014	32.0	0.5	5,009	156,495
2013	34.3	0.5	5,392	157,394
2012	39.2	0.5	6,195	158,036
2011	41.0	0.5	6,609	161,135
2010	44.0	0.5	7,343	166,863
2009	48.3	0.5	8,205	169,867

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM TB - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	10.4 %	0.1 %	6,032	57,828
2022	10.4 %	0.1 %	6,047	58,125
2021	10.4 %	0.1 %	6,053	58,030
2020	10.8 %	0.1 %	6,219	57,630
2019	10.5 %	0.1 %	6,136	58,590
2018	10.7 %	0.1 %	6,184	57,735
2017	10.3 %	0.1 %	6,038	58,902
2016	10.3 %	0.1 %	6,096	59,127
2015	10.4 %	0.1 %	6,218	59,641
2014	10.1 %	0.1 %	5,989	59,388
2013	10.0 %	0.1 %	5,805	58,134
2012	10.0 %	0.1 %	5,853	58,419
2011	9.9 %	0.1 %	5,896	59,331
2010	10.3 %	0.1 %	6,165	60,023
2009	10.3 %	0.1 %	6,454	62,443

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM LBW - Notes:

None

Data Alerts: None

NOM - Percent of preterm births (<37 weeks gestation) - PTB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	12.9 %	0.1 %	7,469	57,836
2022	12.8 %	0.1 %	7,461	58,118
2021	13.1 %	0.1 %	7,609	58,033
2020	12.9 %	0.1 %	7,442	57,621
2019	12.5 %	0.1 %	7,311	58,586
2018	12.5 %	0.1 %	7,204	57,727
2017	12.0 %	0.1 %	7,090	58,909
2016	12.0 %	0.1 %	7,083	59,120
2015	11.7 %	0.1 %	6,999	59,640
2014	11.7 %	0.1 %	6,926	59,397
2013	11.8 %	0.1 %	6,842	58,140
2012	11.9 %	0.1 %	6,976	58,413
2011	11.9 %	0.1 %	7,032	59,327
2010	12.5 %	0.1 %	7,484	59,990
2009	12.5 %	0.1 %	7,801	62,420

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM PTB - Notes:

None

Data Alerts: None

NOM - Stillbirth rate per 1,000 live births plus fetal deaths - SB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	7.3	0.4	426	58,575
2021	8.7	0.4	510	58,564
2020	8.4	0.4	489	58,136
2019	8.9	0.4	526	59,141
2018	8.5	0.4	497	58,258
2017	9.2	0.4	545	59,486
2016	9.3	0.4	558	59,709
2015	9.0	0.4	544	60,201
2014	8.8	0.4	528	59,950
2013	8.9	0.4	521	58,688
2012	8.9	0.4	527	58,975
2011	8.8	0.4	529	59,883
2010	9.1	0.4	550	60,600
2009	8.6	0.4	544	63,019

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM SB - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	5.5	0.3	320	58,342
2021	7.5	0.4	436	58,314
2020	7.2	0.4	418	57,892
2019	7.2	0.4	426	58,861
2018	6.9	0.4	401	57,970
2017	7.2	0.4	427	59,178
2016	8.3	0.4	494	59,405
2015	8.0	0.4	478	59,921
2014	7.3	0.4	438	59,650
2013	8.5	0.4	499	58,433
2012	8.8	0.4	517	58,721
2011	8.0	0.4	475	59,619
2010	8.6	0.4	516	60,330
2009	7.7	0.4	484	62,733

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM PNM - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	6.7	0.3	389	58,149
2021	7.6	0.4	439	58,054
2020	7.0	0.4	403	57,647
2019	7.7	0.4	452	58,615
2018	6.9	0.4	401	57,761
2017	7.4	0.4	435	58,941
2016	9.0	0.4	534	59,151
2015	8.3	0.4	496	59,657
2014	8.7	0.4	515	59,422
2013	8.6	0.4	500	58,167
2012	8.9	0.4	519	58,448
2011	8.2	0.4	488	59,354
2010	8.7	0.4	524	60,050
2009	8.3	0.4	517	62,475

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM IM - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	3.6	0.3	208	58,149
2021	4.0	0.3	231	58,054
2020	3.9	0.3	226	57,647
2019	4.1	0.3	243	58,615
2018	4.4	0.3	252	57,761
2017	4.3	0.3	254	58,941
2016	5.4	0.3	321	59,151
2015	5.0	0.3	301	59,657
2014	5.1	0.3	305	59,422
2013	5.6	0.3	323	58,167
2012	5.8	0.3	340	58,448
2011	5.2	0.3	309	59,354
2010	5.4	0.3	323	60,050
2009	5.1	0.3	316	62,475

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM IM-Neonatal - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	3.1	0.2	181	58,149
2021	3.6	0.3	208	58,054
2020	3.1	0.2	177	57,647
2019	3.6	0.3	209	58,615
2018	2.6	0.2	149	57,761
2017	3.1	0.2	181	58,941
2016	3.6	0.3	213	59,151
2015	3.3	0.2	195	59,657
2014	3.5	0.2	210	59,422
2013	3.0	0.2	177	58,167
2012	3.1	0.2	179	58,448
2011	3.0	0.2	179	59,354
2010	3.3	0.2	201	60,050
2009	3.2	0.2	201	62,475

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM IM-Postneonatal - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	166.8	17.0	97	58,149
2021	218.8	19.4	127	58,054
2020	225.5	19.8	130	57,647
2019	209.8	18.9	123	58,615
2018	249.3	20.8	144	57,761
2017	232.4	19.9	137	58,941
2016	309.4	22.9	183	59,151
2015	283.3	21.8	169	59,657
2014	301.2	22.6	179	59,422
2013	326.6	23.7	190	58,167
2012	296.0	22.5	173	58,448
2011	283.0	21.9	168	59,354
2010	299.8	22.4	180	60,050
2009	312.1	22.4	195	62,475

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM IM-Preterm Related - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	175.4	17.4	102	58,149
2021	170.5	17.2	99	58,054
2020	176.9	17.5	102	57,647
2019	170.6	17.1	100	58,615
2018	117.7	14.3	68	57,761
2017	191.7	18.1	113	58,941
2016	216.4	19.2	128	59,151
2015	184.4	17.6	110	59,657
2014	181.8	17.5	108	59,422
2013	171.9	17.2	100	58,167
2012	152.3	16.2	89	58,448
2011	143.2	15.5	85	59,354
2010	136.6	15.1	82	60,050
2009	155.3	15.8	97	62,475

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM IM-SUID - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2024
Annual Indicator	0.0
Numerator	
Denominator	
Data Source	FHS PHD
Data Source Year	2024

NOM NAS - Notes:

With the hospital data source now available, the MCH Epi Branch will work with OIDA to determine if data for this NOM can be provided.

Data Alerts: None

NOM - Percent of children meeting the criteria developed for school readiness - SR

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	66.6 %	3.4 %	111,515	167,370

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 SR - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	10.7 %	1.1 %	111,932	1,044,296
2021_2022	12.1 %	1.2 %	123,961	1,021,249
2020_2021	12.7 %	1.2 %	127,316	1,001,999
2019_2020	13.1 %	1.4 %	133,960	1,021,639
2018_2019	12.8 %	1.5 %	132,155	1,031,677
2017_2018	12.5 %	1.6 %	127,104	1,020,389
2016_2017	12.4 %	1.6 %	127,090	1,020,850

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 TDC - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	24.8	2.1	136	547,814
2022	30.5	2.4	164	537,690
2021	26.9	2.2	146	543,455
2020	26.7	2.2	143	535,078
2019	32.3	2.5	173	535,424
2018	26.9	2.3	144	534,364
2017	24.6	2.1	132	536,937
2016	22.9	2.1	123	537,913
2015	23.6	2.1	128	541,244
2014	25.0	2.1	136	543,901
2013	25.3	2.2	138	546,207
2012	26.3	2.2	145	551,124
2011	28.4	2.3	156	549,586
2010	26.0	2.2	144	553,130
2009	26.7	2.2	147	551,483

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM CM - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	53.7	2.8	357	664,713
2022	45.2	2.6	295	652,561
2021	58.4	3.0	380	650,347
2020	47.9	2.8	297	620,337
2019	48.2	2.8	301	624,113
2018	46.2	2.7	289	626,175
2017	46.9	2.7	294	627,266
2016	50.4	2.8	316	626,927
2015	44.3	2.7	279	629,274
2014	43.3	2.6	274	632,306
2013	39.4	2.5	251	637,220
2012	45.1	2.7	291	644,819
2011	45.8	2.6	300	655,606
2010	45.4	2.6	301	663,126
2009	45.1	2.6	300	665,683

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM AM - Notes:

None

Data Alerts: None

NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 - AM-Motor Vehicle

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021-2023	19.8	1.4	199	1,002,577
2020_2022	19.5 ϟ	1.4 ϟ	189 ϟ	967,825 ϟ
2019_2021	22.6	1.5	214	947,326
2018_2020	22.0	1.5	207	939,422
2017_2019	22.9	1.6	217	948,102
2016_2018	25.0	1.6	239	955,033
2015_2017	25.0	1.6	240	958,914
2014_2016	24.6	1.6	236	957,959
2013_2015	20.8	1.5	199	958,263
2012_2014	21.5	1.5	207	962,433
2011_2013	22.4	1.5	219	978,412
2010_2012	24.2	1.6	242	1,001,033
2009_2011	24.2	1.5	248	1,023,913
2008_2010	26.2	1.6	271	1,035,662
2007_2009	29.6	1.7	306	1,033,470

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM AM-Motor Vehicle - Notes:

None

Data Alerts: None

NOM - Adolescent suicide rate, ages 10 through 19 per 100,000 - AM-Suicide

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2023	7.3	0.6	144	1,967,621
2020_2022	6.0	0.6	116	1,923,245
2019_2021	6.9	0.6	130	1,894,797
2018_2020	6.9	0.6	129	1,870,625
2017_2019	7.1	0.6	134	1,877,554
2016_2018	6.8	0.6	127	1,880,368
2015_2017	6.1	0.6	114	1,883,467
2014_2016	5.7	0.6	108	1,888,507
2013_2015	5.2	0.5	99	1,898,800
2012_2014	5.2	0.5	99	1,914,345
2011_2013	5.2	0.5	100	1,937,645
2010_2012	5.4	0.5	106	1,963,551
2009_2011	5.0	0.5	99	1,984,415

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM AM-Suicide - Notes:

None

Data Alerts: None

NOM - Adolescent firearm mortality rate, ages 10 through 19 per 100,000 - AM-Firearm

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2023	19.4	1.0	381	1,967,621
2020_2022	17.8	1.0	343	1,923,245
2019_2021	16.2	0.9	307	1,894,797
2018_2020	14.3	0.9	267	1,870,625
2017_2019	13.6	0.9	256	1,877,554
2016_2018	13.6	0.9	256	1,880,368
2015_2017	12.1	0.8	228	1,883,467
2014_2016	10.3	0.7	195	1,888,507
2013_2015	8.4	0.7	160	1,898,800
2012_2014	8.0	0.7	153	1,914,345
2011_2013	8.6	0.7	167	1,937,645
2010_2012	9.1	0.7	179	1,963,551
2009_2011	8.3	0.7	165	1,984,415
2008_2010	8.5	0.7	169	1,993,892
2007_2009	8.6	0.7	172	1,992,452

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM AM-Firearm - Notes:

None

Data Alerts: None

NOM - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9 - IH-Child

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

State Provided Data	
	2024
Annual Indicator	0.0
Numerator	
Denominator	
Data Source	FHS CAHD
Data Source Year	2024

NOM IH-Child - Notes:

With the hospital data source now available, the MCH Epi Branch will work with OIDA to determine if data for this NOM can be provided.

Data Alerts: None

NOM - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19 - IH-Adolescent

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

State Provided Data	
	2024
Annual Indicator	0.0
Numerator	
Denominator	
Data Source	FHS CAHD
Data Source Year	2024

NOM IH-Adolescent - Notes:

With the hospital data source now available, the MCH Epi Branch will work with OIDA to determine if data for this NOM can be provided.

Data Alerts: None

NOM - Percent of women, ages 18 through 44, in excellent or very good health - WHS

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	49.6 %	2.4 %	447,032	901,305
2022	50.0 %	2.6 %	438,758	878,238
2021	55.8 %	2.3 %	489,377	877,325
2020	54.8 %	2.0 %	469,164	855,934
2019	51.6 %	1.9 %	441,111	854,275
2018	47.8 %	2.0 %	408,587	855,056
2017	54.0 %	2.0 %	464,409	859,530
2017	54.0 %	2.0 %	464,409	859,530
2016	53.3 %	1.8 %	459,002	860,852
2015	54.9 %	1.8 %	470,780	857,569
2014	54.2 %	1.8 %	465,383	858,595
2013	54.9 %	2.1 %	471,684	859,508
2012	53.1 %	1.8 %	455,904	858,764

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM WHS - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	89.6 %	1.2 %	995,131	1,110,429
2021_2022	90.7 %	1.1 %	996,628	1,099,059
2020_2021	90.8 %	1.0 %	982,326	1,081,428
2019_2020	89.0 %	1.3 %	963,022	1,082,033
2018_2019	87.9 %	1.5 %	954,053	1,085,487
2017_2018	88.3 %	1.6 %	959,734	1,087,120
2016_2017	87.5 %	1.6 %	956,048	1,092,782

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 CHS - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 2 through 4, and adolescents, ages 6 through 17, who are obese (BMI at or above the 95th percentile) - OBS

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	15.6 %	0.2 %	4,564	29,284
2018	16.2 %	0.2 %	6,225	38,400
2016	16.3 %	0.2 %	6,937	42,671
2014	16.3 %	0.2 %	7,077	43,509
2012	15.6 %	0.2 %	7,160	45,769
2010	15.8 %	0.2 %	7,246	45,743
2008	14.9 %	0.2 %	6,439	43,267

Legends:

Indicator has a denominator <20 and is not reportable

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	22.8 %	2.0 %	161,677	710,166
2021_2022	23.3 %	2.0 %	159,576	686,038
2020_2021	23.4 %	1.9 %	158,684	676,792
2019_2020	23.1 %	2.1 %	157,921	684,922
2018_2019	20.0 %	2.2 %	134,435	672,553
2017_2018	20.2 %	2.3 %	134,564	665,927
2016_2017	22.1 %	2.4 %	146,632	664,213

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 OBS - Notes:

None

Data Alerts: None

NOM - Percent of women who experience postpartum depressive symptoms - PPD

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	15.8 %	1.4 %	8,191	51,952
2022	16.2 %	1.4 %	8,525	52,533
2021	18.7 %	1.6 %	9,785	52,283
2020	20.8 %	1.7 %	9,048	43,590
2019	23.5 %	1.6 %	12,454	53,091
2018	17.3 %	1.4 %	9,112	52,710
2017	19.9 %	1.5 %	10,710	53,919
2015	16.3 %	1.3 %	8,898	54,491
2014	17.6 %	1.3 %	9,621	54,657

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM PPD - Notes:

None

Data Alerts: None

NOM - Percent of women who experience postpartum anxiety symptoms - PPA

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	26.9 %	1.7 %	14,057	52,184

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 PPA - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 6 through 11, who have a behavioral or conduct disRecordOrder - BCD

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	12.0 %	2.1 %	44,188	368,905
2021_2022	14.3 %	2.3 %	51,719	361,667
2020_2021	12.1 %	2.0 %	43,358	359,512
2019_2020	7.8 %	1.7 %	28,247	361,914
2018_2019	10.3 %	2.4 %	38,072	368,355
2017_2018	14.4 %	3.3 %	53,604	371,385
2016_2017	14.4 %	3.2 %	53,723	371,877

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 BCD - Notes:

None

Data Alerts: None

NOM - Percent of adolescents, ages 12 through 17, who have depression or anxiety - ADA

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	15.8 %	1.9 %	62,454	395,851
2021_2022	13.5 %	1.7 %	52,309	388,410
2020_2021	11.6 %	1.7 %	43,295	372,312
2019_2020	9.5 %	1.5 %	35,538	372,671
2018_2019	7.2 %	1.2 %	26,765	374,082
2017_2018	8.5 %	1.5 %	31,751	375,465
2016_2017	10.0 %	1.8 %	37,744	378,839

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 ADA - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	19.7 %	2.5 %	62,607	318,263
2021_2022	19.0 %	2.6 %	60,320	317,351
2020_2021	15.8 %	2.3 %	47,469	300,026
2019_2020	13.8 %	2.2 %	39,996	288,819
2018_2019	12.7 %	1.9 %	39,493	310,536
2017_2018	12.7 %	2.1 %	42,863	336,797
2016_2017	18.2 %	2.8 %	64,730	354,960

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 SOC - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 6 months through 5, who are flourishing - FL-YC

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	79.3 %	2.4 %	249,413	314,555
2021_2022	80.4 %	2.6 %	248,159	308,554
2020_2021	83.3 %	2.4 %	248,581	298,470
2019_2020	85.1 %	2.8 %	261,618	307,440
2018_2019	86.3 %	2.7 %	270,572	313,376

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 FL-YC - Notes:

None

Data Alerts: None

NOM - Percent of children with and without special health care needs, ages 6 through 17, who are flourishing - FL-CA

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	35.5 %	3.3 %	92,640	260,753
2021_2022	38.2 %	3.5 %	102,137	267,357
2020_2021	43.7 %	3.5 %	103,595	237,157
2019_2020	49.7 %	4.0 %	109,287	220,069
2018_2019	50.8 %	4.2 %	120,947	238,252

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 FL-CA - Notes:

None

Data Alerts: None

NOM - Percent of children with and without special health care needs, ages 6 through 17, who are flourishing - FL-Child Adolescent

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	58.0 %	2.1 %	439,376	758,054
2021_2022	57.8 %	2.1 %	427,964	741,061
2020_2021	63.1 %	1.9 %	453,537	718,377
2019_2020	68.3 %	2.1 %	497,123	727,637
2018_2019	66.9 %	2.3 %	497,048	742,752

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 FL-Child Adolescent - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, who have experienced 2 or more Adverse Childhood Experiences - ACE

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	20.1 %	1.4 %	218,059	1,084,288
2021_2022	22.0 %	1.5 %	232,340	1,058,372
2020_2021	22.1 %	1.5 %	229,743	1,037,312
2019_2020	20.3 %	1.6 %	212,569	1,044,630
2018_2019	20.4 %	1.8 %	216,262	1,062,473
2017_2018	23.1 %	2.0 %	246,717	1,068,865
2016_2017	26.6 %	2.0 %	285,572	1,071,813

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 ACE - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Alabama

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth - PPV

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2023	**2024**
Annual Objective		
Annual Indicator	90.1	92.3
Numerator	47,402	48,210
Denominator	52,623	52,236
Data Source	PRAMS	PRAMS
Data Source Year	2022	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	91.0	91.5	92.0	92.5	93.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**

Field Note:
Using federally available data, the PRAMS estimates remained relatively stable with the PRAMS survey respondents self-reporting attending a postpartum visit within 12 weeks after giving birth at 90.1 percent (n=47,402/52,623) in 2022 and 92.3 percent (n=48.210/52,236) in 2023. Since the estimates are above 90 percent, Alabama has initially set the annual goals to incrementally increase by 0.5 percent, with the 2030 annual objective goal being 93.0 percent.

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components - PPV

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2023	**2024**
Annual Objective		
Annual Indicator	77.6	74.4
Numerator	36,618	35,476
Denominator	47,206	47,663
Data Source	PRAMS	PRAMS
Data Source Year	2022	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	74.0	74.5	75.0	75.5	76.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**

Field Note:
Using federally available data, the PRAMS estimates showed a slight decrease with the PRAMS survey respondents self-reporting attending a postpartum visit and receiving the recommended care components at 77.6 percent (n=36,618/47,206) in 2022 and 74.4 percent (n=35,476/47,663) in 2023. Accounting for the downward trend and postpartum educational outreach taking place for the 2026 - 2030 reporting period, Alabama has initially set the annual incremental goals to 0.5 percent, with the 2030 annual objective goal being 76.0 percent.

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

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	73.3	73.7	74.4	74.4	74.8
Annual Indicator	72.0	73.3	76.8	77.2	74.5
Numerator	37,266	31,945	39,817	40,037	37,648
Denominator	51,781	43,605	51,868	51,871	50,503
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2022	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	74.5	75.5	76.5	77.5	78.5

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**

Field Note:
Using federally available data, the PRAMS annual estimates were fluctuating between 2019 and 2023 for the percent of PRAMS respondents placing their infants to sleep on their back. Since the 2023 PRAMS estimate was 74.5 percent (n=37,648/50,503), the Alabama FIMR will set its annual objectives to increase incrementally by 1.0 percent, with the 2030 annual objective goal being 78.5 percent. The Alabama Cribs for Kids® Program provided families with a Pack-n-Play, with an educational component emphasizing the importance of placing the infant on their back. The Alabama Cribs for Kids® Program has seen an increase in enrollment from 723 enrolled in FY 2023 to 1,389 enrolled in FY 2024. Coordinated efforts made by the Cribs for Kids® Program, ACHNs, and the FIMR coordinators on safe sleep should result in an annual incremental increase.

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

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	85.7	86.1	87	87	87.4
Annual Indicator	33.3	34.6	35.7	33.1	28.1
Numerator	16,967	15,074	18,338	16,787	14,168
Denominator	50,878	43,622	51,403	50,730	50,438
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2022	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	28.1	29.1	30.1	31.1	32.1

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**

Field Note:
Using federally available data, the PRAMS estimates were fluctuating between 2019 and 2023 for the percent of PRAMS respondents placing their infants to sleep on a separate approved sleep surface. Since the 2023 PRAMS estimate was 28.1 percent (n=14,168/50,438), the Alabama FIMR will also set its annual objectives to increase incrementally by 1.0 percent, with the 2030 annual objective goal being 32.1 percent. The Alabama Cribs for Kids® Program provided families in need with a Pack-n-Play, where enrollment has increased within the past two years. The efforts made by ADPH should result in an annual incremental increase for placing infants to sleep on a separate approved sleep surface.

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

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	49.9	50.2	50.7	50.7	50.9
Annual Indicator	44.4	42.3	48.3	46.8	65.9
Numerator	22,734	18,238	24,583	23,964	33,724
Denominator	51,234	43,152	50,900	51,162	51,189
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2022	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	50.0	52.0	54.0	56.0	58.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**

Field Note:
Using federally available data, the PRAMS estimates were fluctuating between 2019 and 2023 for the percent of infants being placed to sleep without soft objects or loose bedding. Since the 2023 PRAMS estimate may be an outlier year, the Alabama FIMR will also set the baseline objective to 50.0 percent, with the annual objectives to increase incrementally by 2.0 percent, with the 2030 annual objective goal being 58.0 percent. The Alabama Cribs for Kids® Program provided families with a Pack-n-Play with the core education component focusing on infants being placed to sleep without soft objects or loose bedding. The Alabama Cribs for Kids® Program has continued to increase its enrollment over the past years. Every October, the Alabama FIMR Program promotes the importance of infants being placed to sleep without soft objects with the Clear the Crib Challenge. Statewide collaboration includes various community partners, hospitals, schools, and universities. The efforts made by ADPH should result in an annual incremental increase for placing infants to sleep without soft objects or loose bedding.

NPM - D) Percent of infants room-sharing with an adult during sleep - SS

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	80.7
Numerator	41,352
Denominator	51,222
Data Source	PRAMS
Data Source Year	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	80.7	81.2	81.7	82.2	82.7

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**

Field Note:
The American Academy of Pediatrics recommends that infants sleep in the parent's room, close to the parent's bed, but on a separate surface designed for infants. Studies have shown that room sharing can lower the risk of infant mortality by 50 percent. Using federally available data, the 2023 PRAMS estimated that 80.7 percent (n=41,352/51,222) of PRAMS respondents did put their infant in the same room during periods of sleep. Another core educational component for the Cribs for Kids® Program included emphasizing the importance of room sharing for their infant. Based on the reference data, the Alabama FIMR will set the baseline 2026 objective to 80.7 percent, anticipating the annual objectives to increase incrementally by 0.5 percent, with the 2030 annual objective goal being 82.7 percent.

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2023	**2024**
Annual Objective		
Annual Indicator	46.5	47.1
Numerator	114,586	149,752
Denominator	246,328	318,263
Data Source	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	46.0	47.0	48.0	49.0	50.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**

Field Note:
Baseline objective set based on the NSCH-CSHCN 2022-2023 NPM MH data for Alabama.
Based on the 2022-2023 data 45.3 percent of CSHCN have a medical home in Alabama.
CRS will set the annual objective based on the 2022-2023 data. Baseline set at 46 percent with an incremental increase of 1.0 percent.

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Child Health - All Children

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - All Children		
	2023	**2024**
Annual Objective		
Annual Indicator	50.5	50.9
Numerator	555,448	566,035
Denominator	1,099,447	1,112,681
Data Source	NSCH-All Children	NSCH-All Children
Data Source Year	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	50.0	52.0	54.0	56.0	58.0

Field Level Notes for Form 10 NPMs:

1. **Field Name:** **2026**

Column Name: **Annual Objective**

Field Note:
Using federally available data, the NSCH estimates for parents self-reporting not having any problem in getting a needed referral remained relatively stable with 50.5 percent (n=555,448/1,099,447) in the 2021 - 2022 reporting period and 50.9 percent (n=566,035/1,112,681) for the 2022 - 2023 reporting period. Similar to the developed medical home ESM, the CAHD will set its 2026 baseline objective value to 50.0 percent. The CAHD will set its annual objectives to increase incrementally by 2.0 percent, with the 2030 annual objective goal being 58.0 percent. Depending on the 2023 - 2024 NSCH findings, the CAHD will make adjustments as needed for the 2027 - 2030 annual objective goals.

NPM - 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 - TAHC - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	64	70	29.3	30.8	32.3
Annual Indicator	23.8	27.9	22.5	23.2	24.3
Numerator	21,076	25,741	22,337	26,372	32,343
Denominator	88,591	92,115	99,074	113,766	133,124
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	28.0	29.0	30.0	31.0	32.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**

Field Note:
Baseline objective set based on the NSCH-CSHCN 2022-2023 NPM TAHC data for Alabama.
Based on the 2022-2023 data 26.6 percent of CSHCN received services to prepare for transition in Alabama.
Annual objectives set to increase incrementally at 2.0 percent.

NPM - Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others - BLY - Adolescent Health

Federally Available Data	
Data Source: Youth Risk Behavior Surveillance System (YRBSS)	
	2024
Annual Objective	
Annual Indicator	25.9
Numerator	55,850
Denominator	215,916
Data Source	YRBSS
Data Source Year	2021

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - Perpetration - All Adolescents	
	2024
Annual Objective	
Annual Indicator	10.0
Numerator	38,479
Denominator	384,155
Data Source	NSCHP-All Adolescents
Data Source Year	2022_2023

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - Victimization	
	2024
Annual Objective	
Annual Indicator	33.5
Numerator	128,534
Denominator	383,399
Data Source	NSCHV-All Adolescents
Data Source Year	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	10.0	9.5	9.0	8.5	8.0

Field Level Notes for Form 10 NPMs:

1. **Field Name:** **2026**

   Column Name: **Annual Objective**

   Field Note:
   Of the three federally available data sources, Alabama selected the NSCH-Perpetration data source for the bullying NPM. For 2018 and moving forward, NSCH survey respondents answered the following question in terms of bullying: In the past 12 months, how often did this child bully others, pick on them, or exclude them? The 2022 - 2023 NSCH estimate was 10.0 percent (n=38,479/384,155). With this new priority area, Alabama has initially set the annual decremental goals to 0.5 percent, with the 2030 annual objective goal being 8.0 percent.

Form 10
National Performance Measures (NPMs) (2021-2025 Needs Assessment Cycle)

State: Alabama

2021-2025: NPM - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III + Neonatal Intensive Care Unit (NICU) - RAC

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

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		83.8	84.8	77.9	80
Annual Indicator	83.5	88.2	87	87.5	86.7
Numerator	963	963	841	969	883
Denominator	1,153	1,092	967	1,108	1,019
Data Source	CHS	CHS	CHS	CHS	CHS
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Provisional	Provisional

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The 2020 number was updated to include all VLBW deliveries that were delivered at a hospital with a classification of level III or higher. Originally, the reported numerator only looked at VBLW who were transferred to the Level III+ or higher NICUs.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: After review of the 2021 Block Grant Annual Report, the numerator and denominator reported for 2020 and 2021 reported LBW cases (Less than 2500 grams). Based on the measure, the number should only include cases where the birth weight was less than 1500 grams. The numerator is defined as the number of all VLBW infants being born in a hospital with a Level III+ NICU. The denominator is defined as the number of VLBW infants born within Alabama.	

3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
In 2022, Alabama has 14 NICU's with a Level III or more classification. During this year, 87.0 percent (841/967) of the infants with very low birth weight were delivered at these hospitals. Among these delivered, 54.2 percent (456/841) of these infants were Black and 43.8 percent (368/841) were White. Looking at the mother's age breakdown, 54.5 percent (458/841) of the mothers who delivered at these hospitals were between the ages of 20 and 29. Looking at education level, 87.6 percent (737/841) has at least completed high school education or higher.

4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
In 2023, the number of delivering hospitals with a Level III or higher NICU decreased from 14 to 12. These two hospitals discontinued its NICU services on October 25, 2023, The VLBW babies who were delivered at these two hospitals before this date were included in the numerator. Looking at 2022, these two hospitals provided NICU services to 16 VLBW infants. Due to the data validation process performed by CHS, the number will not be marked final until 2025.

During this year, 88.6 percent (969/1,108) of the infants with VLBW were delivered to these hospitals with level III or higher NICU classification. Of those delivered, 48.3 percent (468/969) of these infants were Black and 49.7 percent (482/969) were White. Looking at the mother's age breakdown, 50.4 percent (489/969) of the mothers delivered at these hospitals occurred between the ages of 20 and 29. Looking at education level, 86.0 percent (834/969) has at least completed high school education or higher.

5.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**

Field Note:
In 2024, 12 delivering hospitals had either a Level III or IV NICU, with 86.7 percent (n=883/1,019) of the total number of VLBW (<1,500 grams) births being admitted into their NICU. Of those delivered, 49.3 percent (n=435/883) of these infants were Black and 48.6 percent (n=429/883) were White. Looking at the mother's age breakdown, 54.4 percent (n=480/883) of the mothers delivered at these hospitals occurred between the ages of 25 and 34. Concerning the mother's education level, 88.2 percent (n=779/883) has at least completed high school education or higher.

2021-2025: NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year - DS

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	58.3	55.2	55.2	61.4	68.4
Annual Indicator	44.6	33.3	32.2	34.2	29.1
Numerator	54,906	40,489	40,979	47,079	41,149
Denominator	122,972	121,453	127,325	137,459	141,567
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Field Level Notes for Form 10 NPMs:

None

2021-2025: NPM - Percent of women who had a dental visit during pregnancy - PDV-Pregnancy

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	38.8	39.7	40.7	41.7	42.8
Annual Indicator	35.4	33.6	37.1	39.1	41.1
Numerator	19,451	15,240	19,911	21,200	22,238
Denominator	54,884	45,331	53,737	54,271	54,050
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2022	2023

Field Level Notes for Form 10 NPMs:

None

2021-2025: NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - PDV-Child - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	80.5	80.9	81.3	81.7	82.1
Annual Indicator	80.8	78.2	74.3	78.2	80.5
Numerator	838,606	800,897	741,934	796,856	839,808
Denominator	1,037,949	1,024,513	998,660	1,019,192	1,043,538
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Field Level Notes for Form 10 NPMs:

None

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

Field Level Notes for Form 10 NPMs:

None

2021-2025: NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	68.5	88.6	80.1	85.7	91.7
Annual Indicator	77.4	70.0	65.6	70.1	70.0
Numerator	253,566	244,204	242,660	268,610	272,175
Denominator	327,459	348,830	369,817	383,218	389,070
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2019	2019_2020	2020_2021	2021_2022	2022_2023

Field Level Notes for Form 10 NPMs:

None

2021-2025: NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	82	82.8	80.7	82	82.4
Annual Indicator	74.4	71.4	72.0	72.7	74.5
Numerator	629,176	607,073	622,981	631,221	667,996
Denominator	846,056	850,307	865,327	868,542	897,120
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2019	2020	2021	2022	2023

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Alabama

SPM 1 - Percent of survey respondents ages 15 to 55 eligible to enroll into WW who report having a trusted birth control method and are not planning for a pregnancy within the next 12 months.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	50.0	51.0	52.0	53.0	54.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**

Field Note:
The WW program set the baseline objective goal to 50 percent for participants self-reporting not planning for pregnancy due to having access to a trusted birth control method. Based on the trend observed for the inactivated WW ESM, the WW program will set its annual objectives to increase incrementally by 1.0 percent, with the 2030 annual objective goal being 54.0 percent.

SPM 2 - Percent of children with special health care needs, ages 0-17, whose parent receives emotional support with parenting.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	82.0	84.0	86.0	88.0	90.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**

Field Note:
Baseline objective set based on the NSCH-CSHCN 2022-2023 Indicator 6.15 data for Alabama.
Based on the 2022-2023 data 80.1 percent of those parenting or raising a CSHCN had someone to turn to for day-to-day emotional support with parenting or raising children.
Annual objectives set to increase incrementally at 2.0 percent.

SPM 3 - Percent of dental health kit survey respondents who plans to use the dental health kit, which includes age-appropriate toothbrush, educational materials, dental floss, timer, and toothpaste

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	50.0	52.0	54.0	56.0	58.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**

Field Note:
The OHO program set its baseline 2026 objective goal to 50 percent for survey respondents self-reporting using the contents of the dental health kits. The OHO program will set its annual objectives to increase incrementally by 2.0 percent, with the 2030 annual objective goal being 58.0 percent. Depending on the survey results, adjustments will be made as needed to the annual objective goals.

Form 10
State Performance Measures (SPMs) (2021-2025 Needs Assessment Cycle)

2021-2025: SPM 2 - Strengthen and enhance family/youth partnerships, involvement and engagement in advisory groups, program development, policymaking, and system-building activities to support shared decision making between families and health-related professionals.

Measure Status:	**Active**				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		33	50	67	88
Annual Indicator		45.8	58.3	62.5	95.2
Numerator		11	14	15	20
Denominator		24	24	24	21
Data Source		CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: New SPM for the 2021-2025 5 Year Needs Assessment Cycle Annual progress for SPM 2 is tracked utilizing a Checklist Criteria Scoring Tool. The tool allows the CSHCN program to monitor progress on meeting the objectives outlined in the action plan. Scoring is based on a total score (maximum =24) and will be measured to monitor progress. Scoring: 0=not started/no progress; 1=initial activity/minimal progress; 2=some activity/moderate progress; 3=completed or sustaining level progress. See the FY 2021 scored checklist titled CSHCN Checklist Criteria Scoring Tool for SPM 2 in section V. Supporting Documents.	
2.	**Field Name:**	**2022**

	Column Name:	**State Provided Data**

Field Note:
Annual progress for SPM 2 is tracked utilizing a Checklist Criteria Scoring Tool. The tool allows the CSHCN program to monitor progress on meeting the objectives outlined in the action plan.

Scoring is based on a total score (maximum =24) and will be measured to monitor progress. Scoring: 0=not started/no progress; 1=initial activity/minimal progress; 2=some activity/moderate progress; 3=completed or sustaining level progress.

See the FY22 scored checklist titled CSHCN Checklist Criteria Scoring Tool for SPM 2 in section V. Supporting Documents.

3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
Annual progress for SPM 2 is tracked utilizing a Checklist Criteria Scoring Tool. The tool allows the CSHCN program to monitor progress on meeting the objectives outlined in the action plan.

Scoring is based on a total score (maximum =24) and will be measured to monitor progress. Scoring: 0=not started/no progress; 1=initial activity/minimal progress; 2=some activity/moderate progress; 3=completed or sustaining level progress.

See the FY23 scored checklist titled CSHCN Checklist Criteria Scoring Tool for SPM 2 in section V. Supporting Documents.

4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**

Field Note:
Annual progress for SPM 2 is tracked utilizing a Checklist Criteria Scoring Tool. The tool allows the CSHCN program to monitor progress on meeting the objectives outlined in the action plan.

Scoring is based on a total score (maximum =21) and will be measured to monitor progress. Scoring: 0=not started/no progress; 1=initial activity/minimal progress; 2=some activity/moderate progress; 3=completed or sustaining level progress.

See the FY24 scored checklist titled CSHCN Checklist Criteria Scoring Tool for SPM 2 in section V. Supporting Documents. Note: Denominator changed in FY24 due to the removal of item #6. Item #6 was removed due to CRS collaborating in an existing family leadership training program. Collaborating in an existing program removed the need for CRS to create and implement a family leadership institute.

2021-2025: SPM 3 - Increase the capacity of families to connect CYSHCN to the health and human services they require for optimal behavioral, developmental, health, and wellness outcomes through our Care Coordination Program.

Measure Status:	**Active**				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		50	58	67	77
Annual Indicator		33.1	38.6	40.8	45.6
Numerator		138	276	225	212
Denominator		417	715	552	465
Data Source		CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Provisional

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
New SPM for the 2021-2025 5 Year Needs Assessment Cycle

Data Source = CRS Care Coordination Family Survey
The CRS Care Coordination Family Survey was under development during FY21. See section III.E.2.c. CSHCN Annual Report for additional information on survey development and design.

Data = FY21 data is reflective of the Care Coordination Family Survey conducted in FY22 on individuals receiving care coordination services in FY20 and FY21. The survey was open March 10, 2022 through April 10, 2022.

Numerator = 138, Denominator = 417
Composite Measure: In order to be counted as receiving comprehensive care coordination, the respondent had to meet pre-determined criteria assessed by six specific questions focused on whether their care coordination was 1) assessment-driven, 2) patient and family centered, and 3) team-based. See section V. supporting documents for a detailed overview of the composite measure.

2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Data Source = CRS Care Coordination Family Survey
See section III.E.2.c. CSHCN Annual Report for
additional information on survey administration.

Data = FY22 data is reflective of the Care Coordination Family Survey conducted in FY23 on individuals receiving care coordination services in FY22.
The survey was open March 20, 2023 through May 3, 2023.

Numerator = 276, Denominator = 715
Composite Measure: In order to be counted as receiving comprehensive care coordination, the respondent had to meet pre-determined criteria assessed by six specific questions focused on whether their care coordination was 1) assessment-driven, 2) patient and family centered, and 3) Team-Based. See section V. supporting documents for a detailed overview of the composite measure.

3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
Data Source = CRS Care Coordination Family Survey
See section III.E.2.c. CSHCN Annual Report for
additional information on survey administration.

Data = FY23 data is reflective of the Care Coordination Family Survey conducted in FY24 on individuals receiving care coordination services in FY23.
The survey was open March 25, 2024 through April 15, 2024.

Numerator = 225, Denominator = 552
Composite Measure: In order to be counted as receiving comprehensive care coordination, the respondent had to meet pre-determined criteria assessed by six specific questions focused on whether their care coordination was 1) assessment-driven, 2) patient and family centered, and 3) Team-Based. See section V. supporting documents for a detailed overview of the composite measure.

4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**

Field Note:
Data Source = CRS Care Coordination Family Survey
See section III.E.3. CSHCN Annual Report for
additional information on survey administration.

Data = FY24 data is reflective of the Care Coordination Family Survey conducted in FY25 on individuals receiving care coordination services in FY24.
The survey was open April 3, 2025 through April 27, 2025.

Numerator = 212, Denominator = 465
Composite Measure: In order to be counted as receiving comprehensive care coordination, the respondent had to meet pre-determined criteria assessed by six specific questions focused on whether their care coordination was 1) assessment-driven, 2) patient and family centered, and 3) Team-Based. See section V. supporting documents for a detailed overview of the composite measure.

2021-2025: SPM 5 - Increase the proportion of EHS programs participating in the EHSCCP grant program that maintain ten percent of their population with children with special needs.

Measure Status:	Active				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		0.6	0.6	0.8	1
Annual Indicator	40	40	80	80	80
Numerator	2	2	4	4	4
Denominator	5	5	5	5	5
Data Source	Program Data	Program Data	Program Data	Program Data	Program Data
Data Source Year	2020	2021	2022	2023	2024
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
This measure is new with the goal of tracking the number of EHS that maintain a specified level of CSHCN.

Objectives were set to increase by one program out of the six (e.g. 1/6=0.17) annually.

This measure was based upon the total number of program partners participating in the EHSCCP Grant. Program partners are allotted a total number of slots(children) per year. The number of actual center sites vary by geographic region, based upon size and need.

The total number of partners does not include the AU Hub.

Annual Indicator data is automatically generated.

Annual Objective data, in this section, is pre-populated by HRSA and can not be changed.

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. The JCCEO ended its agreement with the DHR and the slots were transferred to other centers.

In 2020, two of the five centers met their goal of ten percent or higher. In 2021, it was discovered that special needs children were under reported to DHR. Therefore, the ADPH added policies to the Care Coordination Protocol to include working with centers to identify children with special needs, assisting in obtaining the IFSP, verifying the number of special needs children monthly at each center, and reporting to DHR children not listed on their monthly report. The desire is that these efforts will help to improve the percentage of children identified with special needs at each center.

Objectives beyond the year 2020 were set to increase by one additional program out of the five (e.g. 3/5=0.60) annually.

Annual Indicator data is automatically generated.

Annual Objective data, in this section, is pre-populated by HRSA and can not be changed.

3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
In 2021, two of the five program partners met their goal of ten percent or higher. Before the end of 2020, there were only five program partners instead of six originally mentioned in this measure. JCCEO ended its agreement with the DHR and the slots were transferred to other centers. Due to this, not all slots were assigned during the first months of the program term that ran from August 2020-July 2021. While enrolled in the EHSCCP program, children receive screenings, ongoing assessment, and referrals for evaluation of disabilities or special needs.

During year 2021, it was discovered that Special Needs Children were under reported to DHR. Therefore, the ADPH added policies to the Care Coordination Protocol to include working with centers to identify children with special needs, assisting in obtaining the IFSP, verifying the number of special needs children monthly at each center, and reporting to DHR children not listed on their monthly report.

Annual Indicator data is automatically generated.

Annual Objective data, in this section, is pre-populated by HRSA and can not be changed.

4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
In 2022, four of the five program partners met their goal of maintaining at least ten percent of their population as children with special needs. The ADPH continues to provide Care Coordination services that include working with centers to identify children with special needs, assisting in obtaining the IFSP, verifying the number of special needs children monthly at each center, and reporting to DHR children not listed on their monthly report.

The ADPH also provides outreach to increase awareness and access for children with disabilities and special needs to a comprehensive child development program that provides early education and support services to children and families. Staff continue to work to increase the enrollment of children who are identified as having special needs and help to retain this population in the EHSCCP Program until the child ages out or is no longer eligible for enrollment.

Additionally, a child is counted if they are enrolled in the EHSCCP program during the reported calendar year and were eligible for services under the IDEA during the same calendar year. Data is obtained from the DHR through EHSCCP documentation provided by the Program Partners.

Annual Indicator data is automatically generated.

Annual Objective data, in this section, is pre-populated by HRSA and can not be changed.

5.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
Each program partner is allocated a specific number of slots from the EHS-CCP Program total population. In 2023, four of the five program partners met their goal of maintaining at least ten percent of their population as children with special needs. Reporting is for a calendar year which includes two program terms, 2022-2023 and 2023-2024. ADPH continues to provide Care Coordination services that include working with centers to identify children with special needs, assisting in obtaining the IFSP, verifying the number of special needs children monthly at each center, and reporting to DHR children not listed on their monthly report.

EHS programs are required to provide services to children with disabilities. By determining the proportion of EHS program partners with ten percent of their population as children with special needs, we can work to improve access to early childhood education and reduce barriers for this population. With five program partners located throughout the state, measuring the proportion of partners with ten percent of their population having special needs, we can focus outreach efforts in underrepresented locations. The desire is that these efforts will help improve the percentage of children identified with special needs at each center.

6.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**

Field Note:
Each program partner is allocated a specific number of slots from the EHS-CCP Program total population. In 2024, four of the five program partners met their goal of maintaining at least ten percent of their population as children with special needs.

Although this SPM will not be reported during the 2026 - 2030 reporting period, the BFHS Social Work team plans to continue to work toward efforts and partnerships to continue to provide care coordination services. EHS Care Coordination will continue working with EHS centers with the following activities: identify children with special needs each month, assist in obtaining the IFSP, monitor monthly reporting at each center, and report to DHR the children not listed on monthly reports. Care Coordination efforts will continue to assist centers with meeting and/or maintaining the goal to serve at least ten percent of their population as children with special needs.

2021-2025: SPM 9 - Percent of 2 year old children who have received two blood lead tests at 12 and 24 months as recommended by the ACLPP Program

Measure Status:	Active		
State Provided Data			
	2022	**2023**	**2024**
Annual Objective			25.7
Annual Indicator	21.4	23.7	24.3
Numerator	3,429	3,916	4,084
Denominator	16,024	16,540	16,831
Data Source	HHLPSS	HHLPSS	HHLPSS
Data Source Year	2021-2022	2022-2023	2023-2024
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

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

In 2022, there were 16,024 children who were 2 years old that received at least 1 reported lead test. Alabama linked the 2021 reported lead tests to these children to see if the provider practice completed the first 12 month follow-up. After analysis, Alabama was able to identify 3,429 children who received both screenings at 12 and 24 months.

2.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
In 2023, there were 16,540 children who were at least 2 years old. Of these children, Alabama looked to see whether these children completed a lead screening at 12 months and 24 months as recommended by the ACLPPP. Among those being served, 3,916 were screened for lead at 12 and 24 months. Compared to the previous reporting period, the percentage of two-year-old children receiving both screenings increased from 21.4 percent to 23.7 percent. This percentage increase is most likely due to the outreach activities performed by the nurse coordinator. Moving forward, the ACLPPP is working closely with CHS to see if a linkage is possible to update the child's race and ethnicity information based on their birth certificate. If successful, the ACLPPP will be able to report racial breakdown of lead screening.

3.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**

Field Note:
In 2024, there were 16,831 children who were at least 2 years old residing in Alabama. CDC recommends all children should complete a lead screening at 12 month and 24 months. Among children receiving a lead screening, 24.3 percent (n=4,084/16,831) were screened at the recommended 12 and 24 month intervals compared to 23.7 percent (n=3,916/16,540) in the previous reporting period, representing a slight increase. Alabama is a largely rural state and residential status may have an impact on children receiving the recommended number of lead screenings. With the Alabama's 2023 ACS 5-year county population estimates, OMCH identified which counties are either rural (< 100,000 population) or urban (≥ 100,000 population). Close to 45 percent (44.8 percent; n=7,534/16,831) of 2 year old children lived in an urban county, while 36.4 percent (n=6,129/16,831) lived in a rural county.

Although the SPM will not be reported during the 2026 - 2030 reporting period, the ACLPPP continued efforts to improve the number of children receiving both recommended screenings through education, outreach, prevention, and other activities with special focus in rural areas.

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Alabama

ESM PPV.1 - Percent of postpartum survey respondents who attend their postpartum visit appointment.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	50.0	52.0	54.0	56.0	58.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**

Field Note:
The PHD will set its baseline 2026 objective goal to 50 percent of the survey respondents self-reporting attending their postpartum visit appointment. The PHD will set its annual objectives to increase incrementally by 2.0 percent, with the 2030 annual objective goal being 58.0 percent. Depending on the survey results, adjustments will be made as needed to the annual objective goals.

ESM SS.1 - The proportion of mothers enrolled in the Alabama Cribs for Kids® Program who self-reported that their infants are using the cribs (Pack-n-Play) for all periods of sleep at the home setting

Measure Status:	Active

State Provided Data		
	2023	2024
Annual Objective		
Annual Indicator		72.7
Numerator		133
Denominator		183
Data Source		PHD
Data Source Year		FY 2024
Provisional or Final ?		Final

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	72.0	74.0	76.0	78.0	80.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
The goal of this measure is to learn if mothers are using the cribs provided by Cribs for Kids® Program as recommended by the PHD. In FY 2023, the number of cribs provided by the Cribs for Kids® Program was 723. To increase program enrollment, the Cribs for Kids® Program has worked with the following partners: FIMR regional coordinators, ACHNs, provider offices, and pregnancy resource centers. These partners have played a key role in encouraging mothers to complete surveys concerning crib use. In addition to our partners, the Cribs for Kids® Program will be implementing the diaper initiative in June 2024 to increase the survey response rate. Moving forward, the Cribs for Kids® Program will be working towards the implementation of safe sleep billboards throughout Alabama.

2.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**

Field Note:
During FY 2024, 1,389 pregnant women were enrolled in the Cribs for Kids® Program. Surveys asked participants about crib usage when the baby is two to three weeks of age and again at six to eight weeks. The ESM measure assessed crib usage among infants at two to three weeks of age. Approximately 13.2 percent (n=183/1,389) completed a survey regarding crib use when the baby was 2 to 3 weeks old. In terms of crib use, 72.7 percent (n=133/183) selected either always or almost always for their baby. Of those who completed the survey, the primary racial groups are as follows: 53.0 percent (n=97/183) were Black, non-Hispanic, 31.1 percent (n=57/183) were White, non-Hispanic, and 12.6 percent (n=23/183) were Hispanic.

The 2023 ACS 5-year population estimates determined which counties have met the OMCH case definition for rural (< 100,000 population) and urban (≥ 100,000 population). According to OMCH breakdown, Alabama is considered largely rural with 54 of the state's 67 counties meeting the rural population criteria. Looking at the survey respondents' valid address information, 68.9 percent (n=126/183) of the survey respondents resided in an urban county, while 31.1 percent (n=57/183) resided in a rural county.

During the last two months of FY 2024, the Cribs for Kids® Program implemented a better tracking system for completing follow up with participants concerning the completion of the first and second survey. To increase the survey response rate, the Perinatal Health Division will incorporate diapers as an incentive for survey completion starting FY 2025. Effective FY 2025, billboards in Regions I, II, III, and V continue to educate on safe sleep education as well as the importance of treating infections associated with prematurity.

3.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**

Field Note:
Based on the baseline FY 2024 findings, the 2026 baseline annual objective goal was set for 72 percent rate for the Cribs for Kids® survey respondents selecting either always or almost always on crib use. The PHD will aim for a two percent annual incremental increase for the 2027 - 2030 annual objective goals. The PHD will make adjustments as needed for these goals.

ESM MH.1 - Percent of medical home bookmark survey respondents who find the educational material useful for finding a medical home for their child

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	50.0	52.0	54.0	56.0	58.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**

Field Note:
The CAHD will set its baseline 2026 objective goal to 50 percent of the survey respondents self-reporting finding the educational materials useful when finding a medical home for the child. The CAHD will set its annual objectives to increase incrementally by 2.0 percent, with the 2030 annual objective goal being 58.0 percent. Depending on the survey results, adjustments will be made as needed to the annual objective goals.

ESM MH.2 - Percent of CSHCN that have a comprehensive Plan of Care.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	50.0	55.0	61.0	67.0	74.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**

Field Note:
Baseline Objective Set at 50% - Estimating a 10% increase annually.

CRS will set the baseline 2026 objective goal to 50 percent of the individuals enrolled will have a comprehensive Plan of Care. CRS anticipates the annual objectives to increase incrementally by 10 percent. Depending on the initial audit findings, adjustments will be made as needed to the annual objective goals.

ESM TAHC.1 - Percent of YSHCN enrolled in state CSHCN program who report satisfaction with their transition experience to adulthood.

Measure Status:	Inactive - Replaced

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		50	58	67	77
Annual Indicator		72.2	78	78.3	83.3
Numerator		39	39	54	30
Denominator		54	50	69	36
Data Source		CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Provisional

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2021**

Column Name: **State Provided Data**

Field Note:
New ESM for the 2021-2025 5 Year Needs Assessment Cycle

Data Source = CRS Transition Survey
The CRS Transition survey was under development during FY 2021.
See section III.E.2.c. CSHCN Annual Report for additional information on survey development and design.

Data = FY 2021 data is reflective of the Transition survey conducted in FY 2022 on individuals ages 19 – 21 receiving transition services in FY 2020 and FY 2021.
The survey was open December 13, 2021 through February 28, 2022.

Numerator = 39, Denominator = 54
The numerator includes all respondents who answered, “Very Satisfied” or “Somewhat Satisfied” on the questions “Thinking about all of the questions you just answered, how satisfied are you OVERALL with your CRS transition services?” OR “Thinking about all of the questions you just answered, how satisfied is your youth OVERALL with their CRS transition services?”

2. **Field Name:** **2022**

	Column Name:	**State Provided Data**
	Field Note: Data Source = CRS Transition Survey See section III.E.2.c. CSHCN Annual Report for additional information on survey administration. Data = FY 2022 data is reflective of the Transition survey conducted in FY 2023 on individuals between the ages of 19 – 21 receiving transition services in FY 2022. The survey was open February 13, 2023 through April 4, 2023. Numerator = 39, Denominator = 50 The numerator includes all respondents who answered, “Very Satisfied” or “Somewhat Satisfied” on the questions “Thinking about all of the questions you just answered, how satisfied are you OVERALL with your CRS transition services?” OR “Thinking about all of the questions you just answered, how satisfied is your youth OVERALL with their CRS transition services?”	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Data Source = CRS Transition Survey See section III.E.2.c. CSHCN Annual Report for additional information on survey administration. Data = FY 2023 data is reflective of the Transition survey conducted in FY 2024 on individuals between the ages of 19 – 21 receiving transition services in FY 2023. The survey was open February 20, 2024 through March 15, 2024. Numerator = 54, Denominator = 69 The numerator includes all respondents who answered, “Very Satisfied” or “Somewhat Satisfied” on the questions “Thinking about all of the questions you just answered, how satisfied are you OVERALL with your CRS transition services?” OR “Thinking about all of the questions you just answered, how satisfied is your youth OVERALL with their CRS transition services?”	
4.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**

Field Note:
Data Source = CRS Transition Survey
See section III.E.3 CSHCN Annual Report for additional information on survey administration.

Data = FY 2024 data is reflective of the Transition survey conducted in FY 2025 on individuals between the ages of 19 – 21 receiving transition services in FY 2024.
The survey was open May 5, 2025 through May 25, 2025.

Numerator = 30, Denominator = 36
The numerator includes all respondents who answered, “Very Satisfied” or “Somewhat Satisfied” on the questions “Thinking about all of the questions you just answered, how satisfied are you OVERALL with your CRS transition services?” OR “Thinking about all of the questions you just answered, how satisfied is your youth OVERALL with their CRS transition services?”

ESM TAHC.2 - Percent of YSHCN enrolled in state CSHCN program who report increased preparedness to transition to adulthood.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	60.0	66.0	73.0	80.0	88.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**

Field Note:
Baseline Objective Set at 60% - Estimating a 10% increase annually.

CRS will set the baseline 2026 objective goal to 60 percent of the survey respondents will report increased preparedness to transition to adulthood. CRS anticipates the annual objectives to increase by 10 percent annually. Adjustments will be made to the annual objectives if needed based on the initial survey results.

ESM BLY.1 - The percent of youth, ages 10-19 who report an increase in knowledge, intention to change behavior, and/or confidence in abilities after receiving positive youth development education that addresses bullying prevention.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	50.0	52.0	54.0	56.0	58.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**

Field Note:
The baseline objective is set to 50 percent for youth survey respondents ages 10 to 19 reporting an increase in knowledge, intention to change behavior, and/or confidence in abilities after receiving positive youth development education that addresses bullying prevention. A two percent incremental increase for each reporting year is anticipated, with the 2030 annual objective set for 58 percent. Adjustments will be made as needed for the 2027 - 2030 annual objective goals based on the 2026 baseline results.

SPM ESM 2.1 - Percent of progress made in achieving strategies to increase peer support for parents and caregivers of CSHCN and YSHCN.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	35.0	46.0	60.0	78.0	100.0

Field Level Notes for Form 10 ESMs:

None

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2021-2025 Needs Assessment Cycle)

2021-2025: ESM RAC.3 - Number of steps of the CDC's LoMC process completed in order to design and align the Alabama Maternal Regionalization System Guidelines with the national criteria for the maternal levels of care

Measure Status:	**Active**	
State Provided Data		
	2023	**2024**
Annual Objective		
Annual Indicator		97.7
Numerator		42
Denominator		43
Data Source		AL SPP
Data Source Year		2024
Provisional or Final ?		Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: The participating delivering hospitals will complete the surveys by the summer of 2024. With this information, CDC will grade the survey results for each delivering hospital and assess the hospitals' level of care.	
2.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: In CY 2024, Region II lost a labor and delivery service facility. Accounting for this closure, 43 delivering hospitals remained active statewide. In June 2024, the Alabama Hospital Association coordinated efforts to encourage survey completion concerning the maternal levels of care for the active delivering hospitals. Approximately 97.7 percent (n=42/43) completed the LoMC tool. Moving forward into FY 2025, the Alabama Hospital Association will be hosting a meeting in which attendees will include the Perinatal Health Division and all remaining delivering hospitals. This meeting is a follow up to discuss the continued efforts to reach the delivering hospitals' declared maternal levels of care.	

2021-2025: ESM DS.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					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		56.8	59.9	60.5	60.3
Annual Indicator	56.2	59.3	56.4	59.7	59.8
Numerator	32,982	36,814	34,885	36,528	35,074
Denominator	58,688	62,081	61,904	61,186	58,607
Data Source	AMA	AMA	AMA	AMA	AMA
Data Source Year	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Provisional or Final ?	Final	Final	Final	Final	Final

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 AMA EPSDT report. In FY 2019, of the 61,836 total eligible receiving at least one initial or periodic screening for ages 1 to 2 years, 33,751 persons in this age group blood lead levels were screened/tested. For FY 2018, this figure represented 54.6 percent of children ages 1 to 2 years receiving a blood lead screening. Objectives for subsequent years have been set to require an annual increase of one percent from this baseline. Annual Indicator data is automatically generated. Annual Objective data, in this section, is pre-populated by HRSA and can not be changed.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Data guiding annual objectives for this SPM comes from the FY 2020 AMA EPSDT report. In FY 2020, of the 58,688 total eligible receiving at least one initial or periodic screening for ages 1 to 2 years, 32,928 persons in this age group blood lead levels were screened/tested. For FY 2020 this figure represented 56.2 percent of children ages 1 to 2 years receiving a blood lead screening. Objectives for subsequent years have been set to require an annual increase of one percent from this baseline.

Annual Indicator data is automatically generated.

Annual Objective data, in this section, is pre-populated by HRSA and can not be changed.

3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Data guiding annual objectives for this SPM comes from the FY 2021 AMA EPSDT report. In FY 2021, of the 62,081 total eligible receiving at least one initial or periodic screening for ages 1 to 2 years, 36,841 persons in this age group blood lead levels were screened/tested. For FY 2021 this figure represented 59.3 percent of children ages 1 to 2 years receiving a blood lead screening. Objectives for subsequent years have been set to require an annual increase of one percent from this baseline.

Annual Indicator data is automatically generated.

Annual Objective data, in this section, is pre-populated by HRSA and can not be changed.

4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Data guiding annual objectives for this state performance measure comes from the FY 2022 AMA EPSDT report. In FY 2022, of the 61,904 total eligible receiving at least one initial or periodic screening for ages 1-2 years, 34,885 blood leads were screened/tested for persons in this age group. This data for FY 2022 represented 56.4 percent of children ages 1-2 years receiving a blood lead screening. Objectives for subsequent years have been set to require an annual increase of one percent from this baseline.

5.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
According to the FY 2023 AMA EPSDT report, 61,186 children within the 1–2-year-old age group received at least one initial or periodic screening. Of those screened, 59.7 percent (36,528/61,186) completed a blood lead test. Compared to the previous reporting period, the percentage for blood lead testing increased from 56.4 percent to 59.7 percent. In FY 2023, the Medicaid EPSDT requirement was re-implemented.

6.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**

Field Note:
According to the FY 2024 AMA EPSDT report, 58,607 children from ages 1 to 2 years old received at least one initial or periodic screening. Of those screened, 59.8 percent (n=35,074/58,607) completed a blood lead test. Lead testing in FY 2024 remained relatively stable compared to FY 2023, slightly increasing from 59.7 percent (n=36,528/61,186) to 59.8 percent (n=35,074/58,607).

2021-2025: ESM DS.4 - Proportion of children birth to age 19 that received a well-child appointment in the past year

Measure Status:	Active		
State Provided Data			
	2022	**2023**	**2024**
Annual Objective			25
Annual Indicator	25.3	30.8	22
Numerator	489	658	458
Denominator	1,935	2,134	2,082
Data Source	CAHD	CAHD	CAHD
Data Source Year	FY 2022	FY 2023	FY 2024
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
In FY 2022 (October 2021- September 2022), seven CHDs offered well child appointments. The numerator represents the total number of EPSDT screenings completed and billed by the CHDs. After internal discussion, the denominator was changed to only look at those between birth to age 19 within the seven counties. Of those seen within the CHDs, 25.3 percent (489/1,935) received a well child appointment.

2.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
In FY 2023 (October 2022- September 2023), seven CHDs offered well child appointments. These CHDs were located within Butler, Clay, Geneva, Marengo, Randolph, Talladega, and Wilcox. The numerator represented the total number of EPSDT screenings completed and billed by the CHDs. The denominator represented those who were eligible to receive a EPSDT screening at those CHDs. Of those seen within the CHDs, 30.8 percent (658/2,134) received a well child appointment. Compared to the previous reporting period, the percentage of enrollment increased from 25.3 percent to 30.8 percent. The eligible EPSDT breakdown included 45.7 percent (975/2,134) non-Hispanic Black, 41.5 percent (885/2,134) non-Hispanic White, and 8.2 percent (174/2,134) Hispanic.

3.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**

Field Note:
In FY 2024, seven CHDs offered well child appointments. Locations included Butler, Clay, Geneva, Marengo, Randolph, Talladega, and Wilcox. In 2024, a fire led to the potential suspension of Well Child services being offered at Butler CHD.

The 2023 ACS 5-year population estimates determined which counties have met the OMCH case definition for rural (< 100,000 population) and urban (≥ 100,000 population). According to the OMCH breakdown, Alabama is considered largely rural with 54 of the state's 67 counties meeting the rural population criteria. All well child provider sites are located in rural counties as defined by OMCH.

The numerator represented the total number of EPSDT screenings completed and billed by the CHDs. The denominator represented those who were eligible to receive an EPSDT screening at those CHDs. Of those seen within the CHDs, 21.4 percent (n=445/2,082) received a well child appointment. Compared to the previous reporting period, the enrollment percentage decreased from 30.8 percent (n=658/2,134) to 22.0 percent (n=458/2,082). Well child services were evenly distributed between Black, non-Hispanic (42.8 percent; n=892/2,082) and White, non-Hispanic (41.8 percent; n=870/2,082), with both races comparable with only a 1 percent difference. Hispanics represented a much smaller proportion at only 11.0 percent (n=228/2,082) of eligible children.

2021-2025: ESM PDV-Pregnancy.3 - The number of providers including hygienists, nurses, social workers, physicians, pediatricians, nutritionists, and dentists who were provided oral health education and training tailored specifically to the MCH pregnant population

Measure Status:	**Active**	
State Provided Data		
	2023	**2024**
Annual Objective		
Annual Indicator	19	106
Numerator		
Denominator		
Data Source	OHO	OHO
Data Source Year	FY 2023	FY 2024
Provisional or Final ?	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
This new measure was written to more accurately reflect the OHO efforts to help reach the MCH pregnant population. In FY 2023, there were 19 OHO advocates who received oral health educational packets and trainings tailored specifically to the MCH pregnant population. Among these OHO advocates, the OHO provided 4,068 educational packets.

The OHO takes a proactive approach to address potential negative effects of periodontal disease among pregnancy outcomes. Merely promoting and increasing dental visits during pregnancy does not negate the effects of a history of periodontal maintenance neglect. Thus, the OHO aims to educate any persons of childbearing age about how periodontal disease can increase the risk for preterm births and LBW.

2.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**

Field Note:
During FY 2024, 106 oral health advocates received educational packets and trainings tailored specifically for the MCH pregnant population. These oral health advocates assisted OHO with the overall distribution of 9,504 educational packets being shared among the MCH pregnant population. The number of educational packets increased over two fold during FY 2024 with 9,504 compared to FY 2024 with 4,068.

Although the ESM will not be reported during the 2026 - 2030 reporting period, the OHO developed a bookmark for oral health advocates to scan a QR code to complete a REDCap survey. The REDCap survey captured information on the following: dental practice location, the importance of HPV vaccination, and the usefulness of the information provided. The OHO will utilize the survey finding to identify where to focus educational efforts among the MCH pregnant population within Alabama.

2021-2025: ESM PDV-Child.3 - The number of providers including hygienists, nurses, social workers, physicians, pediatricians, nutritionists, and dentists who were provided oral health education and training tailored specifically to the MCH child population

Measure Status:	**Active**	
State Provided Data		
	2023	**2024**
Annual Objective		
Annual Indicator	53	143
Numerator		
Denominator		
Data Source	OHO	OHO
Data Source Year	FY 2023	FY 2024
Provisional or Final ?	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
This new measure was written to more accurately reflect the OHO efforts to help reach the MCH child population. In FY 2023, there were 53 OHO advocates who received oral health education and training tailored specifically to the MCH child population. Among these OHO advocates, OHO provided 20,900 educational packets.

2.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**

Field Note:
During FY 2024, 143 oral health advocates received educational packets and trainings tailored specifically for the MCH child population. The OHO worked closely with the Healthy Childcare of Alabama and Well Woman for their staff to receive educational packets to be distributed among the MCH child population. The area of educational reach increased almost three-fold during FY 2024 (n=143) compared to FY 2023 (n=53). These oral health advocates assisted OHO with the overall distribution of 24,336 educational packets being shared among the MCH child population. The distributed number of educational packets increased during FY 2024 with 24,366 compared to FY 2023 with 20,900.

Although the ESM will not be reported during the 2026 - 2030 reporting period, the OHO developed a bookmark for oral health advocates to scan the QR code to complete a REDCap survey. The REDCap survey captured information on the following: dental practice location, the importance of HPV vaccination, and the usefulness of the information provided. The OHO will utilize the survey finding to identify where to focus educational efforts among the MCH child population within Alabama.

2021-2025: ESM AWV.2 - Proportion of adolescents, aged 12 to 19, that received an adolescent well-visit in the past year

Measure Status:	Active		
State Provided Data			
	2022	**2023**	**2024**
Annual Objective			35
Annual Indicator	34.5	38.4	36.2
Numerator	93,115	109,732	102,838
Denominator	270,078	285,578	284,470
Data Source	AMA	AMA	AMA
Data Source Year	FY 2022	FY 2023	FY 2024
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Alabama originally used the NSCH to determine the total number of adolescents aged 12 to 19 who completed an adolescent well visit that occurred with the CHDs. One limitation to this data source is that the survey data does not include those between the ages of 18 and 19. After internal review, AMA data will be used as the new data source to determine how many adolescents between the ages of 12 and 19 received a well visit. Utilization of this data source will help better link the efforts made by WW, FP, and the APP programs to encourage this population to complete a well visit.

2.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
Like the previous reporting period, AMA data was utilized to capture how many adolescent well visits were provided to adolescents between the ages of 12 and 19. Compared to the previous reporting period, the completion percentage of adolescent well visits increased from 34.5 percent to 38.4 percent. In FY 2023, the AMA adolescent well visit requirement was re-implemented.

3.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**

Field Note:
The OMCH utilized AMA data to capture how many adolescent well visits were provided among individuals ages 12 to 19. Adolescent well visits in FY 2024 remained relatively stable compared to FY 2023, decreasing from 38.4 percent (n=109,732/285,578) to 36.2 percent (n=102,838/284,470).

2021-2025: ESM WWV.2 - Increase the percentage of women receiving both FP services and WW services by two percent within active WW counties.

Measure Status:	Active		
State Provided Data			
	2022	**2023**	**2024**
Annual Objective			7.1
Annual Indicator	5.1	6.2	6.1
Numerator	200	305	319
Denominator	3,885	4,891	5,188
Data Source	Cure MD	Cure MD	Cure MD
Data Source Year	FY 2022	FY 2023	FY 2024
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: During FY 2022 (October 2021-September 2022), 5.1 percent (200/3,885) of the total FP participants seen within the active WW nine active counties were enrolled into WW. To increase awareness of the WW program and other important health topics, FP participants have the opportunity to receive text messaging services provided by 211KNOW. Text messages were sent with messages about self-improvement, recipes, exercise, and various resources that empower women to create a healthier lifestyle. 211KNOW flyers are disseminated by exploreMedia staff at various community events and by WW social workers in the CHDs and throughout the community through outreach events.	
2.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
During FY 2023, 6.2 percent (305/4,891) of the total FP participants seen within the nine active WW counties were enrolled into WW. The nine active counties included the following: Butler, Barbour, Dallas, Henry, Macon, Marengo, Montgomery, Russell, and Wilcox. A notable change that could have an impact on reported numbers was the inactivation of three CHDs located in Perry, Greene, and Hale counties due to staffing changes and vacancies. Compared to the previous reporting period, the enrollment percentage increased from 5.1 percent to 6.2 percent. This increase in enrollment is due to outreach activities, the 211KNOW text message service, the implementation of the social work protocol, WW clinic protocol manual updates, and the activation of WW in CHDs that were inactive in the previous reporting year. The protocols provided additional guidance to the CHDs concerning enrollment, case management, documentation, and follow-up.

In an effort to meet the two percent increase in enrollment moving forward, the program staff plan to increase program promotion and education on the benefits of WW in decreasing CVD risk factors; increase case management and available resources; and support to sustain a healthier lifestyle within the FP population. CHDs have also hired more staff to increase schedule availability for WW appointments. The program has continued its partnership with exploreMedia, the Alabama Women's Commission, and the DMH to provide the 211KNOW text message service. FP and WW participants can receive text messages focused on various health topics to improve physical and mental health and reduce CVD. 211KNOW flyers were disseminated by exploreMedia staff, MCH Coordinators, and WW social workers at various community events. The FP breakdown included 78 percent (3,818/4,891) non-Hispanic Black, 9 percent (433/4,891) Hispanic, and 42.2 percent (2,160/4,891) between the ages of 20 and 29.

3.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**

Field Note:
During FY 2024, WW was active in nine CHDs: Butler, Barbour, Dallas, Henry, Macon, Marengo, Montgomery, Russell, and Wilcox. Close to 60 percent (n=319/532) of WW participants were already enrolled in FP and 6.1 percent (n=319/5,188) of FP participants seen in the 9 active WW CHDs were newly enrolled WW participants.

Alabama is a largely rural state, potentially impacting those served by WW. Utilizing Alabama's 2023 ACS 5-year county population estimates, the OMCH defined counties as either rural (< 100,000 population) or urban (≥ 100,000 population). Excluding Montgomery CHD, all active WW sites are located in rural counties. Over 71 percent (71.3 percent; n=3,697/5,188) of eligible FP participants lived in an Alabama county defined as urban, with the remaining 28.7 percent (28.7 percent; n=1,491/5,188) living in a rural county (< 100,000 population).

The percentage of FP participants enrolled in WW remained relatively stable with 6.2 percent (n=305/4,891) in FY 2023 and 6.1 percent (n=319/5,188) in FY 2024. The majority of FP participants identify as Black, non-Hispanic (78.4 percent; n=4,065/5,188) with White, non-Hispanic individuals representing 10.9 percent (n=565/5,188) and Hispanics representing 9.6 percent (n=497/5,188). Over 40 percent of FP participants were between the ages of 20 and 29 (42.1 percent; n=2,187/5,188).

Although the ESM will not be reported during the 2026 - 2030 reporting period, the WW will continue to work towards its goal of achieving a two percent increase in FP enrollment. During FY 2025, CHDs will review and modify its case management protocol as needed to potentially increase FP enrollment. Effective FY 2025, the WW has expanded its services to three new CHDs located in Bullock, Covington, and Lowndes. For the 2026 - 2030 reporting period, WW developed a SPM to monitor the impact of having a trusted birth control method on pregnancy among Well Woman participants ages 15 to 55.

Form 10
State Performance Measure (SPM) Detail Sheets

State: Alabama

SPM 1 - Percent of survey respondents ages 15 to 55 eligible to enroll into WW who report having a trusted birth control method and are not planning for a pregnancy within the next 12 months.
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	The goal is to increase enrollment within the WW program and to capture data concerning the importance of cardiovascular health when planning for pregnancy and access to birth control methods.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of survey respondents who had a reported birth control method and are not planning for a pregnancy within the next 12 months. **Denominator:** The number of survey respondents
Data Sources and Data Issues:	The WW Program created a brochure for distribution among the 12 active WW CHDs and the broader community. The brochure features a QR code linking to a REDCap survey data source for eligible participants to answer questions concerning birth control access, CVD risk factors, and interest in enrolling in the WW program. On the brochure, the WW Program highlights the significance of heart disease mortality and the cardiovascular challenges faced by PRAMS respondents during their pregnancies. Additionally, the brochure offers links to educational resources focusing on the following: how to enroll in family planning, mental health, nutrition, physical activity, and smoking cessation.
Significance:	Increasing the enrollment in WW will help to reduce the CVD risk of women within reproductive age, resulting in healthier maternal and infant outcomes.

SPM 2 - Percent of children with special health care needs, ages 0-17, whose parent receives emotional support with parenting.
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	Ensure parents and caregivers of CSHCN and YSHCN have opportunities for needed peer support.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children with special health care needs, ages 0 through 17, whose parent reports that they have someone they can turn to for day-to-day emotional support with parenting or raising children. **Denominator:** Number of children with special health care needs, ages 0 through 17.
Healthy People 2030 Objective:	Reduce anxiety and depression in family caregivers of people with disabilities — DH D01
Data Sources and Data Issues:	Data Source = NSCH Data Issues = Small sample size could impact data outcome.
Significance:	Caregivers of CSHCN experience substantial strain caring for their child's special needs, due to high needs for health and other support services. Caregiver stress can affect an individual's overall well-being and quality of life. Ensuring parents and caregivers of CSHCN and YSHCN have opportunities for needed peer support is critical to well-being and quality of life. Citations: Studies have shown that families of CSHCN have benefited from social, emotional, and informational support from other families with similarly affected children. Schor EL, Klima T, Henry HKM, Gray A, Okumura MJ. Pediatric Subspecialist Referrals to Peer Support for Families. Matern Child Health J. 2025 Jan;29(1):57-66. doi: 10.1007/s10995-024-04033-y. Epub 2024 Dec 12.

SPM 3 - Percent of dental health kit survey respondents who plans to use the dental health kit, which includes age-appropriate toothbrush, educational materials, dental floss, timer, and toothpaste
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	To increase the percent of those who plans to use the dental health kit, which includes age-appropriate toothbrush, dental floss, and age-specific educational materials.
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>The number of REDCap survey respondents reported using an dental health kit, which includes age-specific toothbrush, educational materials, dental floss, timer, and toothpaste</td></tr><tr><td>**Denominator:**</td><td>The total number of REDCap survey respondents who received an dental health kit.</td></tr></table>
Data Sources and Data Issues:	Dental health kits include an age-appropriate toothbrush, educational materials, dental floss, timer, and toothpaste. Across all MCH populations, the OHO shared close to 25,000 dental health kits for CY 2024, with the number staying relative stable in prior calendar years. Depending on the recipients' age, OHO includes age-appropriate educational materials, highlighting the importance of oral health during pregnancy, infant's wellness, and the wellness of children and adolescents. The OHO plans to incorporate a QR code for recipients to a REDCap survey. With this data source, survey respondents will complete questions concerning any barriers to using the contents of the dental health kits, their oral health practices, and the effectiveness of the age-appropriate educational packets included in the dental health kits. The OHO can share these findings to its partners for determination of a more effective approach in educating the MCH populations on the importance of using what was provided in the dental health kits.
Significance:	Understanding recipients' behavioral intention to maintain the recommended oral health practices is key to modify the educational efforts OHO and its partners take to improve oral health statewide.

Form 10
State Performance Measure (SPM) Detail Sheets (2021-2025 Needs Assessment Cycle)

2021-2025: SPM 2 - Strengthen and enhance family/youth partnerships, involvement and engagement in advisory groups, program development, policymaking, and system-building activities to support shared decision making between families and health-related professionals.
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	Strengthen and enhance partnerships between families, youth, healthcare providers, and related health professionals.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Annual Score on the Checklist Criteria Scoring Tool **Denominator:** Total Possible Points on the Checklist Criteria Scoring Tool
Healthy People 2030 Objective:	MICH-31: Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, and coordinated systems.
Data Sources and Data Issues:	Annual progress will be tracked utilizing a Checklist Criteria Scoring Tool which was created to monitor progress towards meeting the objectives outlined in the action plan. Scoring will be based on a total score (maximum=24) and will be measured yearly for increase or decrease from prior year. Scoring: 0=not started/no progress; 1=initial activity/minimal progress; 2=some activity/moderate progress; 3=completed or sustaining level progress. Data Issues: Failure to accurately document action on the criteria could lead to inaccurate annual scoring and inaccurate monitoring of progress on meeting the goals and objectives of the measure.
Significance:	Partnerships with individuals/families/family-led organizations are one of the guiding principles in developing the MCH Block Grant. The Title V MCH Block Grant Guidance to states defines family partnership as “the intentional practice of working with families for the ultimate goal of positive outcomes in all areas through the life course.” Our vision in creating this SPM is to recognize the value and importance of family/youth partnerships in our CSHCN program. Strengthening these partnerships and recognizing them as leaders who are continually engaged in the decision-making process will ensure that the programs and services we provide are family centered.

2021-2025: 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:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of respondents who report receiving comprehensive care coordination services. **Denominator:** Number of survey respondents.
Healthy People 2030 Objective:	MICH-31: Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, coordinated systems.
Data Sources and Data Issues:	Data Source: CRS Care Coordination Family Survey will be developed to measure that comprehensive care coordination services are being provided to families. Comprehensive Care Coordination is a patient-and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the caregiving capabilities of families. Care coordination addresses interrelated medical, social, developmental, behavioral, educational, and financial needs in order to achieve optimal health and wellness outcomes. Baseline to be determined by 2021. Data Issues: A potential issue when collecting data using a survey format is a limited number of respondents which could impact the outcome.
Significance:	The Standards for Systems of Care for CYSHCN Version 2.0 defines pediatric care coordination as a patient-and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the care giving capabilities of families. Care coordination addresses interrelated medical, social, developmental, behavioral, educational, and financial needs to achieve optimal health and wellness outcomes. The Standards Cite care coordination as part the Medical Home domain.

2021-2025: SPM 5 - Increase the proportion of EHS programs participating in the EHSCCP grant program that maintain ten percent of their population with children with special needs.
Population Domain(s) – Cross-Cutting/Systems Building

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the proportion of EHS programs participating in the EHSCCP grant program that maintain ten percent of their population with children with special needs.</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 EHS programs participating in the EHSCCP grant program that maintain ten percent of their population with children with special needs</td></tr>
<tr><td>Denominator:</td><td>Number of EHS programs participating in the EHSCCP grant program</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>DHR EHS Program Information</td></tr>
<tr><td>Significance:</td><td>Head Start is a federally funded, locally administered comprehensive child development program that provides early education and support services to children and families with household incomes up to 130 percent of poverty by federal standards (about $33,000 for a family of four). Head Start serves children ages 3 to 5, while EHS serves infants and toddlers. Many Head Start programs collaborate with child care and public preschool programs to serve eligible children, including children of migrant and tribal families. Head Start has expanded and innovated over its 50-year history, pioneering home visiting services, infant-toddler care, and raising the standard for teacher training. For example, the percent of Head Start teachers with a bachelor’s degree or higher increased nationwide from 44 percent in 2007 to 73 percent in 2015, a direct result of requirements included in the 2007 Head Start reauthorization.

The State(s) of Head Start report was supported with funding provided by the Bill and Melinda Gates Foundation. The findings, interpretations, and conclusions in this report are solely those of the authors. The State(s) of Head Start digest provides a printed narrative and summary information with charts. For more information on the State(s) of Head Start and detailed state-by-state profiles on quality access, and funding, please visit www.nieer.org.</td></tr>
</table>

2021-2025: SPM 9 - Percent of 2 year old children who have received two blood lead tests at 12 and 24 months as recommended by the ACLPP Program
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Based on CDC recommendations, 2 year old children should complete a lead test screening at both their 12 and 24 month follow-up visits.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of 2 year old children who were tested for lead poisoning at their 12 month and 24 follow-up visit **Denominator:** Number of 2 year old children who were enrolled into the HHLPSS
Data Sources and Data Issues:	Healthy Homes and Lead Poisoning Surveillance System (HHLPSS)
Significance:	Lead is a potent and pervasive neurotoxicant. EBLL can result in decreased IQ, academic failure, and behavioral problems in children. There are approximately half a million U.S. children, ages 1-5, with BLL above 3.5 micrograms per deciliter, the reference level at which CDC recommends public health actions be initiated. No safe BLL in children has been identified. Because lead exposure often occurs with no obvious symptoms, it frequently goes unrecognized. By school age, children with a history of lead exposure can exhibit poor attention and impulse control, with lower intelligence and academic performance. A blood lead test is the only reliable way to identify a lead-poisoned child. This percentage represents the efforts taken by the lead program to increase testing and improve reporting. For outreach, the nurse educator has completed site visits primarily at pediatric and family practice clinics. Brochures, posters, and testing recommendations are given to these clinics so that provider and their clients can receive lead poisoning prevention information.

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 PPV.1 - Percent of postpartum survey respondents who attend their postpartum visit appointment. NPM – A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components - PPV

Measure Status:	Active
Goal:	The goal is to collect data regarding the quality of their postpartum care and understand the barriers in receiving postpartum care.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of Postpartum survey respondents who had at least one postpartum visit within 12 weeks of delivery. **Denominator:** The total number of Postpartum survey respondents
Data Sources and Data Issues:	The Perinatal Health Division plans to develop a bookmark for distribution statewide. The bookmark includes a QR link to a REDCap survey for new mothers to answer questions about attending a postpartum visit within 12 weeks of delivery. The Perinatal Health Division designed additional survey questions focusing on the care components for postpartum (counseling, screening, and management of health issues).
Evidence-based/informed strategy:	The bookmark highlights the importance for new mothers to keep a postpartum visit within 12 weeks of delivery. The postpartum bookmark features five topics of postpartum care focused on accessibility, patient-centered, comprehensive, coordinated, and compassionate. The bookmark will be shared statewide for distribution among ACHN maternity care case workers, CHDs, FIMR nurses, pediatric offices, and hospitals. Through these partnerships, assisting new mothers through educational resources should elevate the national percent of new mothers attending a postpartum visit within 12 weeks of delivery.
Significance:	Postpartum care should be considered an ongoing process to better serve the women's needs during this new transition in their lives. The REDCap survey serves as a baseline to better understand the issues new mothers face during their postpartum visit and assessing the satisfaction of services provided at their postpartum visit. The Perinatal Health Division will share these findings to its partners to increase awareness on the importance of postpartum care.

ESM SS.1 - The proportion of mothers enrolled in the Alabama Cribs for Kids® Program who self-reported that their infants are using the cribs (Pack-n-Play) for all periods of sleep at the home setting
NPM – 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 D) Percent of infants room-sharing with an adult during sleep - SS

Measure Status:	Active
Goal:	The goal is to increase the proportion of Cribs for Kids participants to use the cribs (Pack-n-Play) provided for their infants for every sleep.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of mothers who self-reported crib use for all periods of sleep at the home setting among infants at two to three weeks of age **Denominator:** Number of mothers enrolled in the Cribs for Kids Program.
Data Sources and Data Issues:	The PHD uses Microsoft Access to capture the total number of enrolled participants for the Cribs for Kids program. The Cribs for Kids program has designed surveys to capture crib usage when the baby is two to three weeks of age and again at six to eight weeks. For this measure, the PHD will be looking specifically at the surveys when the infant is at two to three weeks of age. To evaluate crib use, mothers will be asked whether they used the cribs for all periods of sleep at their home setting.
Evidence-based/informed strategy:	With collaboration of the Cribs for Kids program, the PHD can educate and provide cribs to expectant mothers so they can incorporate the recommended safe sleep practices for their infants. Before receiving a crib, mothers must first review how to incorporate the recommended safe sleep practices for their infant. The main safe sleep topics discussed include the following: placing the infants on their back, a firm mattress with no debris, and a smoke-free environment.
Significance:	By increasing the utilization of crib enrollment in the Cribs for Kids program, the goal is to reduce the number of SIDS.

ESM MH.1 - Percent of medical home bookmark survey respondents who find the educational material useful for finding a medical home for their child
NPM – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH

Measure Status:	Active
Goal:	To provide education and increase awareness on the importance of children having access to medical home among families.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of survey respondents who found the information useful in finding a medical home **Denominator:** The number of survey respondents
Data Sources and Data Issues:	The CAHD developed a medical home bookmark for distribution to families statewide. A QR code will be added to the bookmark and will take potential survey respondents to a REDCap survey. With this data source, survey respondents will be given the opportunity answer questions related to child's access to care to a primary medical provider and the usefulness of the educational information provided about medical homes.
Evidence-based/informed strategy:	The bookmark featured six aspects of a medical home. These include accessible, family centered, continuous, comprehensive, coordinated, and compassionate. Through the efforts made by the MCH coordinators and the collaborations with the Medicaid and AllKids, assisting families through educational outreach should elevate the national percent of children ages 0 to 17 having access to a medical home .
Significance:	The REDCap survey captures information on whether families are using either the emergency room or urgent care as their primary access to care. Better understanding the barriers concerning access to care with a primary care provider will ensure a more effective approach in educational outreach of the importance of having a medical home for their child.

ESM MH.2 - Percent of CSHCN that have a comprehensive Plan of Care.
NPM – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH

Measure Status:	Active
Goal:	Increase the percentage of CSHCN receiving care coordination services through the CSHCN program who have a comprehensive Plan of Care.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of plans that meet the definition of comprehensive Plan of Care. **Denominator:** Total number of audited Plan of Care documents.
Data Sources and Data Issues:	Data Source = CRS Care Coordination Audit Tool – A sample of Plan of Care documents will be audited for each CRS district. A random sampling will be conducted to identify records for auditing. A comprehensive Plan of Care includes goals developed through conversation with the client and family, ongoing assessment, annual reevaluation, and follow-up. Data Issues = A potential issue when utilizing audit findings as a data source is small sample size.
Evidence-based/informed strategy:	The CRS Care Coordination Program provides an interdisciplinary approach to care coordination to ensure CYSHCN and their families connect to wrap-around services they require for optimal behavioral, developmental, health, and wellness outcomes. The strategy of continuing to provide comprehensive care coordination to CSHCN through system navigation, education, resource identification, referral and a comprehensive Plan of Care will positively impact all five components of the Medical Home NPM. A key component of the program is utilizing a comprehensive Plan of Care which is an established standard for the Systems of Care for CSHCN that is individualized and family centered. A comprehensive plan offers clients and families a roadmap for accessing services, creates a comprehensive picture of client/family goals, needs, preferences, and services, and supports accountability among the members of the care team. A comprehensive Plan of Care aims to enhance communication, care coordination, and overall quality. It is the central location from where all care coordination activities flow. CRS serves CSHCN with complex medical needs who are less likely to have access to a medical home due to community health factors, making the need for a comprehensive plan even more critical. The CRS Care Coordination Program embodies all five aspects of the Medical Home NPM and when done successfully should have a positive impact on the NPM. Citation: Parents and HCPs perceive a care plan to be a useful tool in the care of CSHCN with medical complexity. By strengthening relationships and enhancing information sharing, care plans are perceived to improve quality of care in multiple domains. Exploring the usefulness of comprehensive care plans for children with medical complexity (CMC): a qualitative study. BMC Pediatric. 2013 Jan 19;13:10.
Significance:	Ensuring families have a comprehensive Plan of Care will have an overall positive impact on the CRS Care Coordination Program and the families served. This impact includes families understanding the importance of all five components of a medical home. Auditing for comprehensive Plan of Care documents will allow for CRS leadership to identify needed areas of training, areas for improvement and highlight care coordination strengths. The audits will ensure CRS staff are building partnerships with families, providers, and community resources to establish true medical homes. Analyzing the audit findings over time will enable CRS leadership to identify progress related to all five components of medical home.

ESM TAHC.1 - Percent of YSHCN enrolled in state CSHCN program who report satisfaction with their transition experience to adulthood.
NPM – 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 - TAHC

Measure Status:	Inactive - Replaced
Goal:	To improve transition services and the overall transition experience.
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 youth or that indicate satisfaction regarding their transition experience.</td></tr><tr><td>**Denominator:**</td><td>Total number of youth surveyed.</td></tr></table>
Data Sources and Data Issues:	Survey based on the Six Core Elements of Health Care Transition 2.0 Health Care Transition Feedback Survey for Youth and the State and Local Area Integrated Telephone Survey (SLAITS) 2007 Survey of Adult Transition and Health (SATH). A potential issue when collecting data using a survey format is a limited number of respondents which could impact the outcome.
Evidence-based/informed strategy:	Inactive Measure
Significance:	The Standards for Systems of Care for CYSHCN Version 2.0 System Domain Transition to Adulthood indicates the system should contact the young adult/caregiver confirming transfer of care and eliciting feedback on experience with the transition process. Ensuring the successful transition of youth and young adults with special health care needs is essential to individual self-determination and self-management. Young adult/caregiver perception of satisfaction with their transition to adult health care will help determine QI measures to drive program development that supports the achievement of successful outcomes.

ESM TAHC.2 - Percent of YSHCN enrolled in state CSHCN program who report increased preparedness to transition to adulthood.
NPM – 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 - TAHC

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To improve transition to adulthood readiness 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 ages 14-21 or their caregiver that indicate increased preparedness to transition to adulthood.</td></tr>
<tr><td>Denominator:</td><td>Total number of youth ages 14-21 or their caregiver surveyed.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Date Source = Survey developed during the previous five-year cycle will be modified to capture level of preparedness. The 2021-2025 transition survey was designed in collaboration with UAB AEAC and was 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). The survey was designed around elements of transition that are offered through CRS and required of CRS staff. Cognitive interviewing was used with youth and parents to allow them the opportunity to provide input on survey questions, flow, and comprehension.
Data Issues = A potential issue when collecting data using a survey format is a limited number of respondents which could impact the results.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>Serving as the state CSHCN program CRS ensures access to quality health care and services for CYSHCN. Ensuring YSHCN are equipped with the skills and tools necessary to transition to adulthood is a priority for CRS. Services provided include care coordination, transportation assistance, referral to community resources, and translation services when needed. CRS provides YSHCN transition to adulthood planning targeted to the individuals needs that they might otherwise not receive. The strategy of continuing to administer the CRS Transition Program will allow CRS to focus on improving YSHCN preparedness to transition to adulthood including an adult health care provider. Ensuring YSHCN are prepared for transitioning to adulthood includes youth recognizing the importance of having a health care professional; speaking with their doctor or health care provider privately; gaining skills to manage their care; and understanding changes that happen at age 18 in regard to privacy, consent, and decision making. All these components are included in the CRS Transition Program Policy and Procedures. If CRS staff implement the Transition program as designed, it should in turn improve the NPM.
Citations:
YSHCN and their families need educational, psychosocial, and medical support from their health care teams during the transition from pediatric to adult health care. Transition to Adulthood for Youth With Chronic Conditions and Special Health Care Needs Journal of Adolescent Health, Volume 66, Issue 5, 631 – 634, May 2020.
Transition is a dynamic process that is preceded by transition readiness, and improvement in readiness is dependent on good transition assessment and planning. Youth with Special Health Care Needs: Transition to Adult Health Care Services. Maternal Child Health J 17, 1744–1752 (2013).</td></tr>
</table>

Significance:	The ESM measures if individuals receiving CRS transition services feel better prepared to transition to adulthood including adult health care. Survey data will be utilized by CRS to identify what is working in the Transition program and what is not working. If survey respondents indicate increased preparedness, then the CRS Transition Program is having a positive impact. Analyzing the overall survey data will allow CRS leadership to identify areas for improvement and enhance areas of the program that are working.

ESM BLY.1 - The percent of youth, ages 10-19 who report an increase in knowledge, intention to change behavior, and/or confidence in abilities after receiving positive youth development education that addresses bullying prevention.
NPM – Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others - BLY

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Provide education to help youth build connection, positive interpersonal skills, social competence, resilience and to empower youth to prevent bullying.</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 youths that complete the retrospective survey and report an increase in at least one of the measured categories (knowledge, intention, and confidence).</td></tr>
<tr><td>Denominator:</td><td>Number of youths that complete the retrospective survey.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>The data source is the APPB programming retrospective survey. The voluntary survey is completed at the conclusion of programming. All youth that receive education may not be present for the retrospective survey. Survey questions specific to bullying prevention will need to be developed and added to the survey tool.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>Bullying is a complex topic. Youth that bully, are bullied, and/or observe bullying are all impacted. Because of this, there are multiple risk factors and protective factors that that should be addressed. Prevention activities should work to change social climates, help students feel connected, and should be integrated with related efforts.

Sources: [Stopbullying.gov: Bullying Prevention Training Module https://www.stopbullying.gov/resources/training-center]
Positive Youth Development “strategies focus on enhancing the positive qualities adolescents already possess.” [https://opa.hhs.gov/adolescent-health/positive-youth-development]</td></tr>
<tr><td>Significance:</td><td>Survey questions will address topics covered during programming that relate to bullying prevention. Participants will be asked to indicate in terms of specific objectives where they stand now that they have been exposed to the program and, concurrently, they indicate where they stood with respect to the same items and on the same scales, before they participated in the program. This provides a more realistic assessment of perceived change in knowledge and skills and carries more limited socially desirable answers as compared to the use of a true baseline survey.</td></tr>
</table>

ESM 2.1 - Percent of progress made in achieving strategies to increase peer support for parents and caregivers of CSHCN and YSHCN.
SPM 2 – Percent of children with special health care needs, ages 0-17, whose parent receives emotional support with parenting.

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Ensure parents and caregivers of CSHCN and YSHCN have opportunities for needed peer support.</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>Annual Score on the Family and Youth Peer Support Measurement Tool</td></tr>
<tr><td>Denominator:</td><td>Total Possible Points on the Family and Youth Peer Support Measurement Tool</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source = Annual Progress will be tracked utilizing a Family and Youth Peer Support Measurement Tool which was created to monitor progress towards achieving the strategies and objectives outlined in the action plan. Scoring will be based on a total score and will be measured annually for increase from the prior year. Scoring: 0=not started/no progress; 1=initial activity/minimal progress; 2=some activity/moderate progress; 3=ongoing activity/sustaining level progress 4=completed. 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>Evidence-based/informed strategy:</td><td>Increasing the percentage on the Family and Youth Peer Support Measurement Tool indicates that progress is being made towards achieving the strategies outlined in the action plan. CRS will conduct an environmental scan to identify existing peer support opportunities. The findings will be used to map existing peer support opportunities and identify gaps and needs within the community. CRS will utilize the Parent and Youth Connection program to connect families with peer support and partner with community organizations to establish new opportunities. An increase in the measurement tool score is evidence of progress which is in turn indicative of increased awareness of peer support opportunities for parents and caregivers of CSHCN and YSHCN.
One study found that receipt of emotional support services or informal sources of emotional support was associated with increased reports of positive coping for caregivers for all CSHCN. Family Support Services and Reported Parent Coping Among Caregivers of Children with Emotional, Behavioral, or Developmental Disorders. J Dev Behav Pediatr. 2024 Jan 1;45(1):e54-e62.</td></tr>
<tr><td>Significance:</td><td>Utilizing the Family and Youth Peer Support Measurement Tool will measure progress towards achieving the strategies and objectives outlined in the action plan. The Block Grant State Action Plan team will be monitoring progress throughout the year and scoring the tool annually. Through ongoing assessment, the Block Grant State Action Plan team will be able to monitor where we are in the process, identify barriers to achieving the outlined strategies and areas of needed improvement. If the score is low that would be indicative of minimal forward progress which would lead to an assessment of the action plan for needed strategy adjustments or changes.</td></tr>
</table>

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2021-2025 Needs Assessment Cycle)

2021-2025: ESM RAC.3 - Number of steps of the CDC's LoMC process completed in order to design and align the Alabama Maternal Regionalization System Guidelines with the national criteria for the maternal levels of care
2021-2025: NPM – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III + Neonatal Intensive Care Unit (NICU) - RAC

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the number of delivering hospitals who have completed the CDCs LoMC tool to ensure that the pregnant population delivers at the appropriate level of care hospital.</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 delivering hospitals that have completed the CDC's LoMC tool.</td></tr>
<tr><td>Denominator:</td><td>The total number of delivering hospitals.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Alabama Maternal Regionalization System Data.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The goal of this measure is to ensure that the pregnant population receives care at the appropriate level hospital. When referred to the appropriate level of care hospitals the pregnant population can be seen at the level three or higher hospitals which provide medical service tailored to the VLBW infants and high risk pregnancies.</td></tr>
<tr><td>Significance:</td><td>Creation of a system that aligns the maternal levels of care with Alabama Maternal Regionalization System Guidelines utilizing CDC LoMC ensures that there is a regionalized system for the pregnant population in Alabama. The CDC LoMC tool is designed to help states and other jurisdictions monitor the health of the pregnant population and refer maternal risk appropriate care, as needed. CDC LoMC uses the minimum information necessary to identify a facility’s maternal level of care, based on criteria by ACOG. In 2019, ACOG updated its LoMC tool to access the hospitals' maternity facility capabilities and offers a framework for integrated systems that address maternal health needs.

According to the CDC, the steps of the LoMC tool Process are as follows: Step 1: BUILD SUPPORT FOR PARTICIPATION - An agency or organization serving as a state champion for CDC LoMC identifies stakeholders to help encourage birth facilities to use the CDC LoMC 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 LoMC 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>

2021-2025: ESM DS.3 - Proportion of children aged 12 & 24 months that have a reported blood lead screening in the past year
2021-2025: NPM – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year - DS

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the proportion of children aged 12 & 24 months that have a reported blood lead screening in the past year</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 children aged 12 & 24 months that have a reported blood lead screening in the past year</td></tr>
<tr><td>Denominator:</td><td>Number of children aged 12 & 24 months</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>AMA Data</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>Lead testing is a AMA mandate to be performed as part of the EPSDT checkup at the 12 month and 24 month visit. In addition, the testing is important to identify children who are exposed to lead and to provide corrective interventions.</td></tr>
<tr><td>Significance:</td><td>Early identification of developmental disorders or conditions that are contributors to development disorders.</td></tr>
</table>

2021-2025: ESM DS.4 - Proportion of children birth to age 19 that received a well-child appointment in the past year
2021-2025: NPM – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year - DS

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the proportion of children birth to age 19 that received a well-child appointment in the past year within the seven CHDs. The active CHDs include Butler, Clay, Geneva, Marengo, Randolph, Talladega, and Wilcox.</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 EPSDT screenings performed in the CHDs in the past year</td></tr>
<tr><td>Denominator:</td><td>Number of children birth to age 19 who received services in the CHDs in the past year</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Ensemble was the data source to get the total number of EPSDT screenings. Ensemble is a budget tool to show how many visits were completed, billed, and paid for within the CHDs. CureMD is the EHR system utilized by CHDs to record EPSDT visits and was used to determine the total number for children seen in the seven active counties.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>With this informed strategy, MCH is able to provide EPSDT screenings within seven CHDs. The creation of this measure would be used to see how Alabama can promote the importance of the EPSDT screenings among children within this age group. Alabama has a District MCH Coordinator stationed in two of the active counties to highlight the importance of EPSDT screenings.</td></tr>
<tr><td>Significance:</td><td>Early identification of developmental disorders is critical to the well-being of children and their families.</td></tr>
</table>

2021-2025: ESM PDV-Pregnancy.3 - The number of providers including hygienists, nurses, social workers, physicians, pediatricians, nutritionists, and dentists who were provided oral health education and training tailored specifically to the MCH pregnant population
2021-2025: NPM – Percent of women who had a dental visit during pregnancy - PDV-Pregnancy

Measure Status:	Active
Goal:	To increase the distribution of educational materials regarding the importance of preventive dental visits to improve pregnancy outcomes.
Definition:	**Unit Type:** Count **Unit Number:** 100,000 **Numerator:** The number of persons receiving educational materials related to preventive dental visits for pregnant mothers. **Denominator:**
Data Sources and Data Issues:	Oral health advocates will request educational materials at community outreach, schools, dental providers, faith based organizations, etc. Based on the need for educational materials, the reported numbers can vary from year to year. Another limitation to this measure is that the women either could or could not be pregnant at the time they received the educational materials.
Evidence-based/informed strategy:	This is an emerging topic of discussion and consequently there is no known evidence-based strategy. When we become aware of additional data this section will be updated.
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 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.

2021-2025: ESM PDV-Child.3 - The number of providers including hygienists, nurses, social workers, physicians, pediatricians, nutritionists, and dentists who were provided oral health education and training tailored specifically to the MCH child population
2021-2025: NPM – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - PDV-Child

Measure Status:	Active
Goal:	To increase the distribution of educational materials regarding the importance of preventive dental visits to improve oral health outcomes among children and adolescents.
Definition:	**Unit Type:** Count **Unit Number:** 100,000 **Numerator:** The number of persons receiving educational materials related to preventive dental visits for children ages 1 through 17. **Denominator:**
Data Sources and Data Issues:	OHO advocates will request educational materials at community outreach, schools, dental providers, faith based organizations, etc. Based on the need for educational materials, the reported numbers can vary from year to year.
Evidence-based/informed strategy:	This is an emerging topic of discussion and consequently there is no known evidence-based strategy. When we become aware of additional data this section will be updated.
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 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.

2021-2025: ESM AWV.2 - Proportion of adolescents, aged 12 to 19, that received an adolescent well-visit in the past year
2021-2025: NPM – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the proportion of adolescents, age 12 to 19, with Medicaid Insurance that received an adolescent well-visit within Alabama</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>The number of adolescents, aged 12 to 19, with Medicaid insurance that received an adolescent well-visit within Alabama</td></tr>
<tr><td>Denominator:</td><td>The total number of adolescents, aged 12 to 19, with Medicaid insurance.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Instead of using the NSCH, AMA will be able to provide more accurate data on the total number of adolescents aged 12 to 19 who completed an adolescent visit. One limitation with this data source is that the number would not include adolescents who have either private/other insurance or no insurance.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>Alabama created this informed strategy to see how many adolescents between the ages of 12 and up to 19 completed a medical visit. According to AMA, adolescent Well Visits include the following: a physical exam, immunizations follow-up, developmental assessment, oral health risk assessment, and any needed referrals. With access to Medicaid data. Alabama will be able to determine how many individuals within this age group received a medical visit.</td></tr>
<tr><td>Significance:</td><td>Early identification of developmental disorders is critical to the well-being of adolescents and their families</td></tr>
</table>

2021-2025: ESM WWV.2 - Increase the percentage of women receiving both FP services and WW services by two percent within active WW counties.
2021-2025: NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV

Measure Status:	Active
Goal:	The goal is to increase WW enrollment among FP participants by two percent.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of FP participants enrolled in the WW Program **Denominator:** The total number of FP Participants within the active WW Counties.
Data Sources and Data Issues:	ADPH uses the EHR system known as Cure MD to store data for the WW Program and FP.
Evidence-based/informed strategy:	The WW program addresses chronic health conditions through evidence-based strategies including the New Leaf curriculum and the CVD risk assessment.
Significance:	Increasing the enrollment in WW will help to reduce the CVD risk of women within reproductive age, resulting in healthier maternal and infant outcomes.

Form 11
Other State Data

State: Alabama

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
Part 1 – MCH Data Access and Linkages

State: Alabama

Annual Report Year 2024

	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	No	
3) Medicaid	Yes	No	Annually	12	No	
4) WIC	Yes	No	Daily	0	No	
5) Newborn Bloodspot Screening	Yes	No	Annually	12	No	
6) Newborn Hearing Screening	Yes	No	Quarterly	3	No	
7) Hospital Discharge	No	No	Never	NA	No	
8) PRAMS or PRAMS-like	Yes	Yes	More often than monthly	12	No	

Other Data Source(s) (Optional)

	Access				Linkages	
Data Sources	**(A) State Title V Program has Consistent Annual Access to Data Source**	**(B) State Title V Program has Access to an Electronic Data Source**	**(C) Describe Periodicity**	**(D) Indicate Lag Length for Most Timely Data Available in Number of Months**	**(E) Data Source is Linked to Vital Records Birth**	**(F) Data Source is Linked to Another Data Source**
9) Vital Records Fetal	Yes	Yes	Daily	0	No	
10) EHR (CureMD)	Yes	Yes	Daily	0	No	
11) NFIMR	Yes	No	Annually	12	No	
12) Lead (HHLPSS)	Yes	Yes	Daily	0	No	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None

Form 12
Part 2 – Products and Publications (Optional)

State: Alabama

Annual Report Year 2024

Form 12 Products And Publications

State of Alabama
Maternal and Child Health Services Block Grant
2024 Annual Report/2026 Application

List of Attachments

Where Cited in Report/Application	***Description or Title***
Section I.A.	Letter of Transmittal
Section I.B.	Fact Sheet: Form SF424
Section I.C.	Submit Certify Page
Supporting Document #01	Organizational Charts
Supporting Document #02	Acronyms and Abbreviated Names
Supporting Document #03	State Action Plan Table

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

July 22, 2025

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 2024 Annual Report and FY 2026 Application. The document is being submitted electronically using the web-based application format. 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,

Amanda C. Martin, MSPH
Director, Bureau of Family Health Services
Interim Title V Director

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

To enhance security and meet federal compliance standards, HRSA will soon require identity verification to access the EHBs for all Applicants/Grant Recipients, Service Providers, Technical Analysts, and Consultants – through Login.gov or ID.me. Please stay tuned for further communications with specific instructions and timelines.

SF-424 - Part 1

240821: ALABAMA DEPARTMENT OF HEALTH

Due Date: 7/28/2025 11:59:00 PM (Due in: 3 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	
Legal Name	ALABAMA DEPARTMENT OF HEALTH
CRS Entity Identification Number (e.g. 1-53-2079819-A-2)	1-63-6000619-B-6
Employer Identification Number (e.g. 53-2079819)	63-6000619
Organizational UEI	**WDVJK7FUB8A6**

Mailing Address (Required)

Address Type ◉ Domestic Address ○ International Address Refresh

Specify Domestic Address (Street Address or PO Box Only or Rural Route)

◉ **Address**	Street Number Street Name P O BOX 303017 Bureau of Financial S Select One Number
○ **PO Box Only**	Number
○ **Rural Route**	Type Select Route Number Box
City	MONTGOMERY (Required if Zip is not specified)
Urbanization	(Used only for Puerto Rico(PR))
State	AL (Required if City is specified)
Zip Code (Lookup)	36130 - 3017 (Required if City is not specified)

Organizational Unit

Department Name	
Division Name	

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:	

Title of Position	Name	Phone	Email	Options
Bureau of Family Health Services Director	Ms. Amanda Martin	(334) 206-9420	amanda.martin@adph.state.al.us	Change

Go to Previous Page Save Save and Continue

To enhance security and meet federal compliance standards, HRSA will soon require identity verification to access the EHBs for all Applicants/Grant Recipients, Service Providers, Technical Analysts, and Consultants – through Login.gov or ID.me. Please stay tuned for further communications with specific instructions and timelines.

SF-424 - Part 2

240821: ALABAMA DEPARTMENT OF HEALTH

Due Date: 7/28/2025 11:59:00 PM (Due in: 3 days) | Section Status: Complete

Resources

View

Application | Action History | Funding Opportunity Announcement | FOA Guidance | Application User Guide

✔ SF-424 - Part 1 ✔ **SF-424 - Part 2**

Fields with are required

Areas Affected by Project (Cities, Counties, States, etc.) (Maximum 1) Attach File

No documents attached

Descriptive Title of Applicant's Project	Maternal and Child Health Services

Project Description (Maximum 1) Attach File

No documents attached

Project Abstract

Project Abstract	Approximately 2 pages (Max 4000 Characters with spaces).

Congressional Districts

Applicant	AL-02
Program/Project	AL-All Districts

Additional Congressional District (Maximum 1) Attach File

No documents attached

Proposed Project Period

Start Date	10/1/2025
End Date	9/30/2027

Estimated Funding

Federal (This amount is populated from Budget Section A - Total Federal New or Revised Budget.)	$12,021,137.00
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.)	$49,195,177.00
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.)	$1,536,572.00
Program Income (This amount is populated from Budget Section C - Non Federal Resources.)	$38,279,659.00
Total	$101,032,545.00

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
State Dental Director	Dr. Tommy Johnson	(334) 206-5398	tommy.johnson@adph.state.al.us	Change

Go to Previous Page Save Save and Continue

I certify assurances and certifications, as specified in Appendix 2 of the 2026 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

Certified by samille.jackson@adph.state.al.us on 7/25/2025 3:41:02 PM

Cancel

ALABAMA PUBLIC HEALTH

Organizational Chart

State Government

State Committee of Public Health

State Health Officer
Scott Harris, MD, MPH

Public Health Administrative Officer
Catherine M. Donald, MBA

- **Children's Health Insurance**
  Wanda Davis
  Administrative Services, ALL Kids Customer Service, Customer Services/Community Education, Program Operations and Professional Services, Program 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**
  Leslie Hay
  Administration, Business and Information Architecture, Database Administration, Logistics, Project Management Support, Technical Support

Chief Legal Officer
Brian Hale, JD

- **General Counsel**
  Sancha Howard, JD
- **Compliance**
  Pam Kendrick
- **Facilities Management and Technical Services**
  Kristi Rollins
  Technical Services
- **Health Provider Standards**
  Denise Milledge
  Assisted Living, Acute and Continuing Care, Nursing Home, CLIA, Licensure, Certification
- **Program Integrity**
  Debra Thrash, CPA, CIA

Chief Medical Officer
Karen Landers, MD, FAAP

- **District Medical Officers**
  East Central/West Central, Northern/Northeastern, Southeastern/Southwestern
- **Clinical Laboratories**
  Sharon P. Massingale, PhD, HCLD
  Administrative Support Services, Clerical, Clinical Chemistry, Microbiology, Newborn Screening, Quality Management, Sanitary Bacteriology/Media, STD/Serology, Mobile
- **HIV Prevention and Care**
  Vontrese McGhee
- **Informatics and Data Analytics**
  Sherri Davidson, PhD, MPH
- **Medical Officer, Disease Control and Prevention**
  Burnestine Taylor, MD
- **Medical Officer, Family Health Services**
  Gary Pugh, DO, FACOG
- **Medical Director, Health Provider Standards/Home and Community Services**
  Amber Clark-Brown, MD

Governmental Affairs and Community Relations
Carolyn Bern, MPA

- **Health Equity and Minority Health**
  Latisha Kennebrew
- **Environmental Toxicologist**
  John Guarisco, PhD
- **State Public Health Veterinarian**
  Dee W. Jones, DVM
- **Communicable Disease**
  Harrison Wallace, MPH
  Immunization, Infectious Diseases and Outbreaks, STD Control, Tuberculosis Control
- **Family Health Services**
  Amanda Martin, MSPH
  Administration, Child and Adolescent Health, Cancer Prevention and Control, Family Planning, Office of Women's Health, Oral Health, Perinatal Health, WIC
- **Home and Community Services**
  Choona Lang, BSN, MHA, DHEd
  Accounts Payable, Accounts Receivable, Budget and Personnel, Home Care Services

District Operations
Ricky Elliott, MPH

- **Local Health Services**
  Public Health Districts
  County Health Departments
- **Digital Health**
  April Golson
- **Billing Compliance and Integrity**
  April Golson

Chief of Staff
Michele Jones, MS

- **Deputy Chief of Staff**
  Brent Hatcher
- **Clinical Management and Practice**
  Kaye Melnick, MSN, RN
  Nursing, Social Work, Clerical, Electronic Health Record, Infection Control & Employee Health
- **Environmental Services**
  Ron Dawsey, MPH
  Community Environmental Protection, Food/Milk Lodging
- **Prevention, Promotion, and Support**
  Jamey Durham, MBA
  Behavioral Health, Health Media and Communications, Management Support, Nutrition and Physical Activity, Pharmacy, Primary Care and Rural Health, Wellness

Human Resources
Lisa Jones

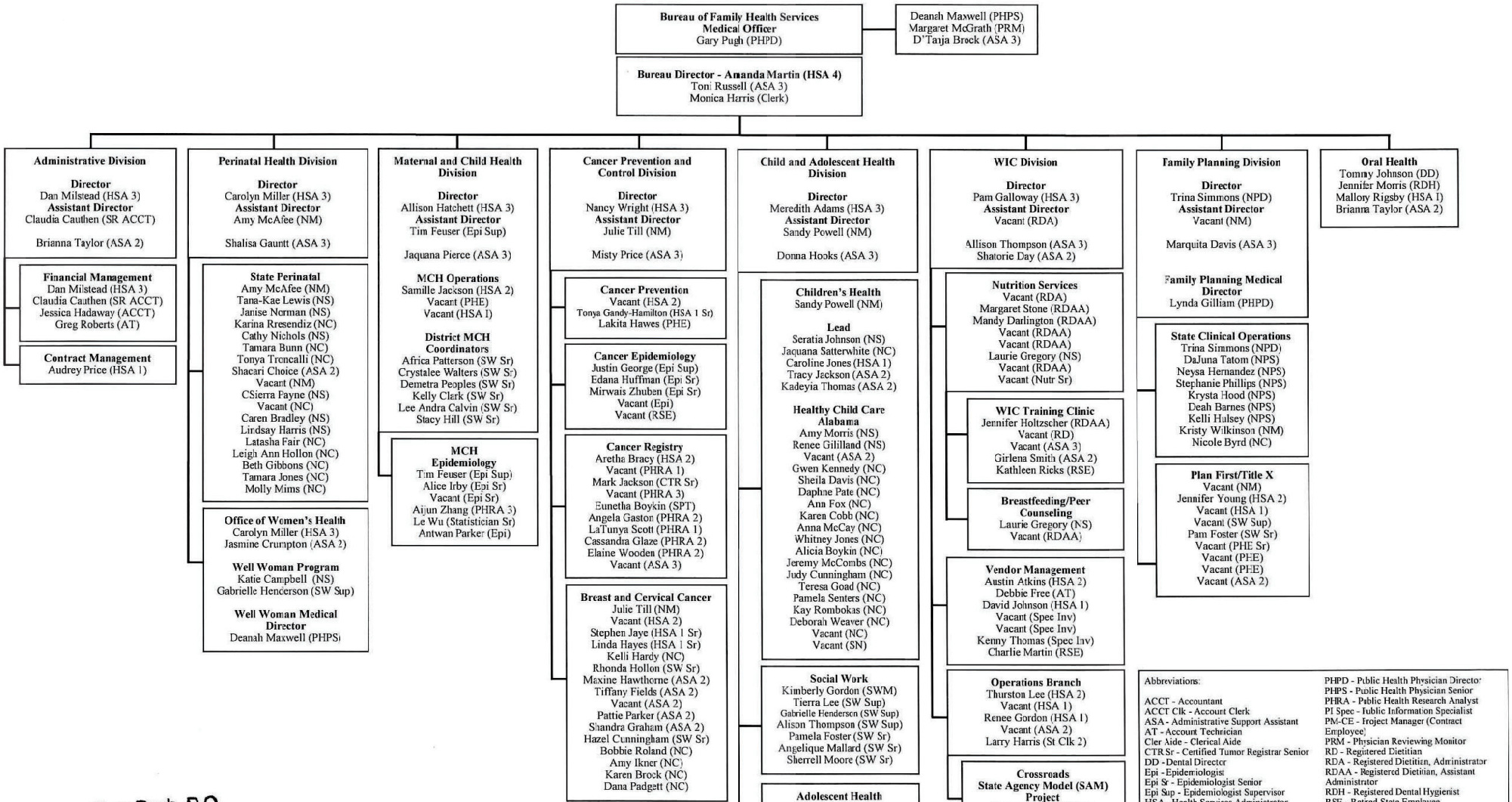
- **Emergency Medical Services**
  Jamie Gray, BS, AAS, NRP
- **Emergency Preparedness**
- **Employee Relations**
  Danita Rose
  Civil Rights, ADA
- **Radiation Control**
  Cason Coan
  Licensing and Registration, Environmental Radiation, Emergency Planning and Response, X-Ray Inspection, Radioactive Materials Inspection
- **Workforce Development**
  Ken Harrison

Legislative and External Affairs

April 1, 2025

Scott Harris

State Health Officer



Gary Pugh, D.O.

10/23/2024

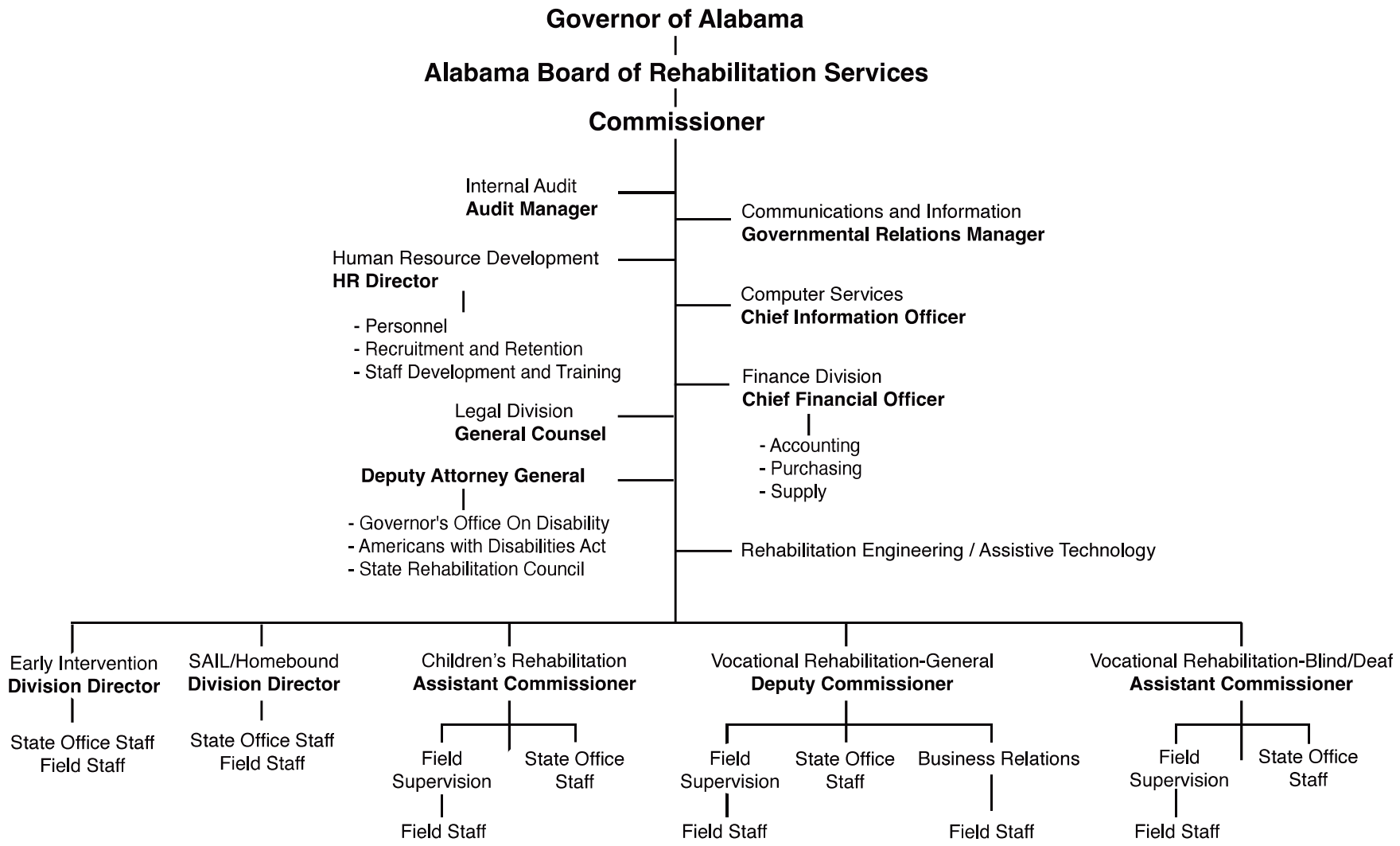
Gary D. Pugh, D.O., F.A.C.O.G — Date

Amanda C. Martin

10/22/2024

Amanda C. Martin, MSPH — Date

Alabama Department of Rehabilitation Services Organizational Chart

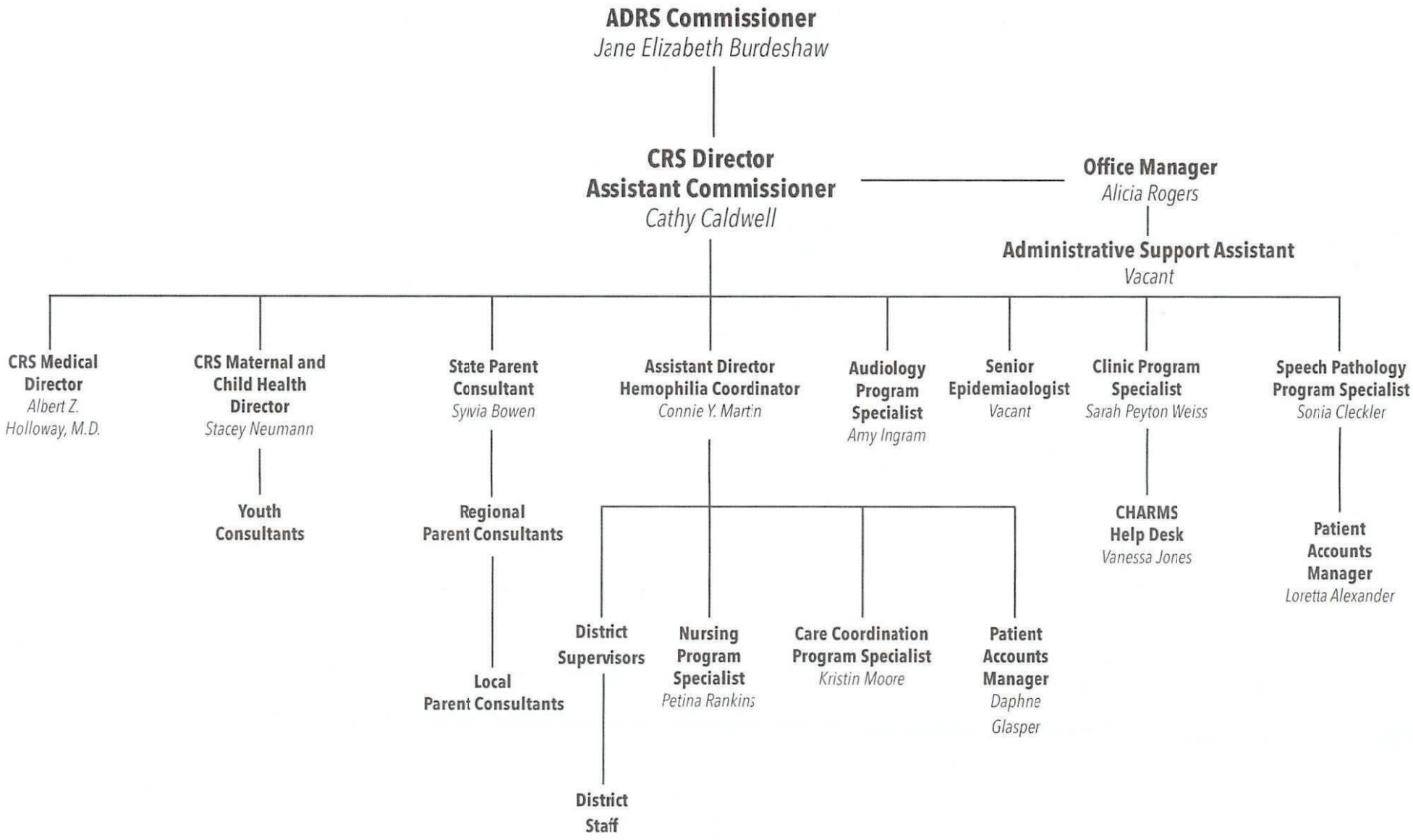


July 2, 2024
Commissioner, Alabama Department of Rehabilitation Services

ADRS

Alabama's children and adults with disabilities

Children's Rehabilitation Service Organizational Chart



April 14, 2025
Assistant Commissioner, Alabama Department of Rehabilitation Services
Cathy Caldwell

CHILDREN'S Rehabilitation Service
A program of the Alabama Department of Rehabilitation Services

Supporting Document

Acronyms and Abbreviated Names

Acronym/Name	***Explanation***
AAP	American Academy of Pediatrics
AAPD	Alabama Chapter of the Academy of Pediatric Dentistry
ABBCCED	Alabama Breast and Cervical Cancer Early Detection Program
ABC	Alabama Breastfeeding Committee
ABR	Auditory Brainstem Response, Auditory Brain Response
ACA	Affordable Care Act
ACCF	Alabama Child Caring Foundation
ACCP	Alabama Care Coordination 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
ACLPPP	Alabama Childhood Lead Poisoning Prevention Program
ACMG	American College of Medical Genetics
ACOG	American College of Obstetricians and Gynecologists
ACS	American Community Survey
ADAP	Alabama Disabilities Advocacy Program
ADAP	Alabama Drug Assistance Program
ADECE	Alabama Department of Early Childhood Education
ADMH	Alabama Department of Mental Health
ADOS-2	Autism Diagnostic Observation Assessment
ADPH	Alabama Department of Public Health
ADRS	Alabama Department of Rehabilitation Services
AEAC	Applied Evaluation and Assessment Collaborative
AEMA	Alabama Emergency Management Agency
AFF	American Fact Finder
AHITF	Alabama Head Injury Task Force
AHP	Adolescent Health Program
AIDB	Alabama Institute for the Deaf and Blind
AIDS	Acquired Immune Deficiency Syndrome
AMA	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
ALPAN	Alabama State Physical Activity and Nutrition Plan
ALPQC	Alabama Perinatal Quality Collaborative
ALSDE	Alabama State Department of Education
AMCHP	Association of Maternal and Child Health Programs
ANFRC	Alabama Network of Family Resource Centers
ANSFD	Alabama Newborn Screening Follow-up Division
AOHW	Office of Healthcare Workforce
APEC	Alabama Parent Education Center
APPB	Adolescent Pregnancy Prevention Branch
APREP	Alabama Personal Responsibility Education Program
APTAT	Accessing Potential Through Assistive Technology
ARMS	Alabama Resource Management System
ARRA	American Recovery and Reinvestment Act
ASA	Administrative Support Assistant
ASCCA	Alabama's Special Camp for Children and Adults
ASHA	American Speech Language Hearing Association
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
AWA	Alabama Wellness Alliance
BAHA	Bone anchored hearing aid
BEACH	Budget Estimation and Computation Helper
BCBS	Blue Cross and Blue Shield of Alabama, Blue Cross Blue Shield of Alabama
BCL	Bureau of Clinical Laboratories
BFHS	Bureau of Family Health Services
BFPC	Breastfeeding Peer Counseling
BLL	Blood Lead Level
Block Grant	MCH Title V Block Grant to States Program
BLRV	Blood Lead Reference Value
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
CAHMI	Child and Adolescent Health Measurement Initiative
CAHPS	Consumer Assessment of Healthcare Providers and Systems (r)
CAST-5	Capacity Assessment for State Title V
CAT	Community Action Team
CCHD	Critical Congenital Heart Disease
CCRS	Centralized Care Coordination Referral System, Care Coordination Referral System
CDC	U.S. Centers for Disease Control and Prevention
CDH	Child Death Review
Census	U.S. Census, U. S. Census Bureau
CEP	Center for Emergency Preparedness
CER	Comparative Effectiveness Research
CHARMS	Children's Health and Resource Management System
CHD	County Health Department
CHIP	Alabama's State Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act
CHS	Center for Health Statistics
CHW	Community Health Workers
CI	Confidence Interval
CJIC	Criminal Justice Information Center
CMC	Children with Medical Complexity
CMS	Centers for Medicare and Medicaid Services
CNP	Certified Nurse Practitioner
CPoC	Comprehensive Plan of Care
COA	Children's Hospital of Alabama
COBRA	Consolidated Omnibus Budget Reconciliation Act
COI	Certificate of Immunization
COIIN	Collaborative Improvement and Innovation Network
COOP	Continuity of Operations Plan
COVID-19	Coronavirus Disease 2019
CPC	Children's Policy Council
CPR	Cardiopulmonary Resuscitation
CRS	Children's Rehabilitation Service
CRT	Case Review Team
CSHCN	Children with Special Health Care Needs
CVB	Cash Value Benefit
CVD	Cardiovascular Disease
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
DDS	Disability Determination Services

DDU	Disability Determination Unit
DECA	Department of Economic and Community Affairs
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
DOSE	Direct On Scene Education
EBLL	Elevated Blood Lead Level
EBT	Electronic Benefit Transfer
ECCS	Early Childhood Comprehensive Systems
ECD	East Central Public Health District
e.g.	For Example
EHB	Electronic Handbooks
EHDI	Early Hearing Detection and Intervention
EHR	Electronic Health Record
EHS	Early Head Start
EHSCCP	Early Head Start Child Care Partnership
EI	Early Intervention Program
EIS	Alabama Early Intervention System
ELT	Executive Leadership Team
EMSC	Emergency Medical Services for Children
EMST	Emergency Medical Services and Trauma
EOP	Emergency Operations Plan
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment; Early Periodic Screening, Diagnosis, and Treatment
ESMs	Evidence-Based or –Informed Strategy Measures
ESF	Emergency Support Functions
ETF	Education Trust Fund
F2F HIC	Family to Family Health Information Center
FAD	Federally Available Data
FAN	Family Advisory Network
FAND	Functional and Access Needs in Disasters
FDO	From Day One
FES	Family Engagement in Systems
FESAT	Family Engagement in Systems Assessment Tool
FH	Family Health
FIMR	Fetal/Infant Mortality Review, Fetal and Infant Mortality Review Program
FIT	Fecal Immunochemical Test
FMAP	Federal Medical Assistance Percentages
FNS	Food and Nutrition Service
Form SF424	The Face Sheet
FP	ADPH Family Planning Program
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FTE	Full Time Equivalent
FTP	File Transfer Protocol
FVA	Family Voices of Alabama
FY	Fiscal Year
FY 2025 Needs Assessment	FY 2025 5-Year Statewide MCH Needs Assessment
Governor	Governor of the State of Alabama
GCDC	Gulf Coast Dental Conference
HCCA	Healthy Child Care Alabama
HCFA	Health Care Financing Administration
HEDIS	Health Plan Employer Data and Information Set
HIE	Health Information Exchange
HIV	Human Immunodeficiency Virus
HIPAA	Health Insurance Portability and Accountability Act
HHLPSS	Healthy Housing and Lead Poisoning Surveillance System
HOH	Hard of Hearing

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
IBCLC	International Board Certified Lactation Consultants
i.e.	That Is
IEP	Individualized Education Plan
IFSP	Individualized Family Service Plan
IMM	Immunization
ImmPrint	Immunization Provider Registry with Internet Technology, Immunization on Provider Registry with Internet Technology
IMR	Infant Mortality Rate
IPC	Infection Prevention and Control
IQIP	Immunization Quality Improvement Program
IT	Information Technology
IUD	Intrauterine Device
JCDH	Jefferson County Department of Health
JCIH	Joint Committee on Infant Hearing
JSU	Jacksonville State University
LARCs	Long-Acting Reversible Contraceptives
LBW	Low Birth Weight
LEAH	Leadership and Education in Adolescent Health
LEaP	Learning Experience and Placement Program
LEND	Leadership Education in Neurodevelopmental and Other Related Disabilities
LEP	Limited English proficiency
LGBTQ	Lesbian, Gay, Bisexual, Transgender, or Questioning
LOCATe	Level of Care Assessment Tool
LoMC	Levels of Maternal Care
LPACs	Local Parent Advisory Committees, CRS Local Parent Advisory Committees
LPC	Local Parent Consultant
MACH	Montgomery Area Coalition for the Homeless
MAR	Medically at Risk
MCADD	Medium-chain Acyl-CoA Dehydrogenase Deficiency
MCBH	Mobile County Board of Health
MCH	Maternal and Child Health
MCHB	Maternal and Child Health Bureau
MCHD	Mobile County Health Department
MCH Epi	MCH Epidemiology Branch
MCH Epi Branch	Maternal and Child Health Epidemiology Branch
MCHIP	Medicaid-eligible children
MCH Leadership Team	MCH Needs Assessment Leadership Team
MCH Needs Assessment Report	Statewide 5-Year Maternal and Child Health Needs Assessment Report, Alabama
MCTF	Mass Care Task Force
Pyramid	Pyramid developed by MCHB, depicting 4 levels of service
MCH Reports/Application	Maternal and Child Health Block Grant Services Reports/Applications
MCH Title V funds	Maternal and Child Health Services Block Grant funds
MH	Medical Home
MMA	Methylmalonic Acidemia
MMRC	Maternal Mortality Review Committee
MMRP	Maternal Mortality Review Program
MMRIA	Maternal Mortality Review Information Application
MOD	March of Dimes
MOU	Memorandum of Understanding
NASHP	National Academy for State Health Policy
NCHAM	National Center for Hearing Assessment and Management
NCQA	National Committee for Quality Assurance
NBHS	Newborn Hearing Screening
NBS	Newborn Screening

NBSP	Newborn Screening Program
NCDHM	National Children's Dental Health Month
NCEMCH	National Center for Education in Maternal and Child Health
NED	Northeastern Public Health District
Needs Assessment Report	Statewide 5-Year Maternal and Child Health Needs Assessment Report, Alabama
NFP	Nurse Family Partnership
NFPRHA	National Family Planning and Reproductive Health Association
NHANES	National Health and Nutrition Examination Survey
NHSC	National Health Service Corps
NICHD	Eunice Kennedy Shriver National Institute of Child Health and Human Development
NICU	Neonatal Intensive Care Unit
NIEER	National Institute for Early Education Research
NOM	National Outcome Measure
NP	Nurse Practitioner
NPA	Nutrition and Physical Activity
NPM	National Performance Measure
NSA	Nutrition Services Administration
NSCH	National Survey of Children's Health
NSCH-CSHCN	National Survey of Children with Special Health Care Needs
OHCA	Oral Health Coalition of Alabama
OHEMH	Office of Health Equity and Minority Health
OHO	Oral Health Office
OHPC	Office of HIV Prevention and Care
OIDA	Office of Informatics and Data Analytics
OMCH	Office of Maternal and Child Health
OPCRH	Office of Primary Care and Rural Health
OPM	Office of Performance Management
OT	Occupational Therapist
OWH	Office of Women's Health
PAT	Parents as Teachers
PC	Parent Consultants
PCCM	Primary Care Case Management
PCP	Primary Care Physician
PCRH	The Office of Primary Care and Rural Health
PDV	Preventive Dental Visit – Pregnancy
PHAB	Public Health Accreditation Board
PHD	Perinatal Health Division
PHE	Public Health Emergency
PIPA	Partners in Policymaking Alabama
PKU	Phenylketonuria
Plan First	Family Planning Medicaid Waiver
PMH	Primary Medical Homes
PoC	Plan of Care
PPV	Postpartum Visit
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
RAC	Risk-Appropriate Perinatal Care
RDH	Registered Dental Hygienist
RPACs	Regional Perinatal Advisory Committees
RUSP	Recommended Uniform Screening panel
RWJ	Robert Wood Johnson
SS	Safe Sleep
SAIL	State of Alabama Independent Living Program
SAIMRP	State of Alabama Infant Mortality Reduction Plan
SAMHSA	Substance Abuse and Mental Health Services Administration
SBB	Safe Bama Baby Survey
SBIRT	Screening, Brief Intervention, and Referral to Treatment
School of Dentistry	University of Alabama School of Dentistry in Birmingham

SCID	Severe Combined Immunodeficiency
SED	Southeastern Public Health District
SHAA	Speech Language Hearing Association of Alabama
SHARP	Sexual Health and Adolescent Risk Prevention
SHIP	State Health Improvement Plan
SHPDA	State Health Planning and Development Agency
SIDS	Sudden Infant Death Syndrome
SLPs	Speech Language Pathologists
SLP	Samford Speech Language Pathology
SNAP	Supplemental Nutrition Assistance Program
SOPH	School of Public Health
SPAC	State Perinatal Advisory Committee
SPAC	State Parent Advisory Committee
SPC	State Parent Consultant
SPM	State Performance Measure
SPoC	Shared Plan of Care
SPP	State Perinatal Program
SRAE	Sexual Risk Avoidance Education
SSA	Social Security Administration
SSDI	State Systems Development Initiative
SSI	Supplemental Security Income
STAR	Alabama's Assistive Technology Resource Program
STEP	Staging Transition for Every Patient
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
SUID	Sudden Unexpected Infant Death
SUDI	Sudden Unexpected Death in Infancy
SWD	Southwestern Public Health District
TANF	Temporary Assistance to Needy Families
TB	Tuberculosis
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
UA	United Ability
UA	University of Alabama
UAB	University of Alabama at Birmingham
UCP-H	United Cerebral Palsy of Huntsville
UNHS	Universal Newborn Hearing Screening
U.S.	United States of America
USA	University of South Alabama
USA PCCC	University of South Alabama Pediatric Complex Care Clinic
USDA	United States Department of Agriculture
VFC	Vaccines for Children
VLBW	Very Low Birth Weight
VLCAD	Very Long–chain Acyl-CoA Dehydrogenase Deficiency
VRS	Vocational Rehabilitation Service
WCD	West Central Public Health District
WIC	Special Supplemental Nutrition Program for Women, Infants and Children
WW	Well Woman
YAC	Youth Advisory Council
YC	Youth Consultants
YLF	Youth Leadership Forum
YRBSS	Youth Risk Behavior Survey System
YSHCN	Youth with Special Health Care Needs

Alabama State Action Plan Table 2026 Application/2024 Annual Report

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Women/Maternal Health					
Comprehensive Postpartum Care and Education	By 2030, at least 54 percent of all survey respondents reported not planning for pregnancy due to access of a trusted birth control method By 2030, an additional 5 percent of all WW enrollment resulted from participation from the REDCap survey. By 2030, attend at least 30 community outreach events and health fairs to promote WW and encourage completion of the REDCap survey	Share the QR link to REDCap survey on social media websites including the WW Facebook page. Coordinate WW outreach events with the MCH District coordinators to expand area of reach for the QR code. Aim to achieve at least a 10 percent REDCap survey response rate annually among eligible WW participants being seen at active WW CHDs to answer questions concerning their access to a trusted birth control method.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 1: Percent of survey respondents ages 15 to 55 eligible to enroll into WW who report having a trusted birth control method and are not planning for a pregnancy within the next 12 months.	
Comprehensive Postpartum Care and Education	By 2030, at least 54 percent of REDCap survey respondents reported attending at least one postpartum visit within 12 weeks of delivery. By 2030, attend 200 community outreach events statewide to distribute the postpartum bookmarks among the MCH pregnant population.	Coordinate ACHN maternity care case workers to provide postpartum educational materials statewide. Coordinate with FIMR nurses to distribute postpartum educational materials within their perinatal regions. Coordinate with various providers and hospitals to distribute postpartum educational materials statewide and emphasize the importance of postpartum care.	ESM PPV.1 - Percent of postpartum survey respondents who attend their postpartum visit appointment.	NPM - Postpartum Visit	**Linked NOMs:** Maternal Mortality Neonatal Abstinence Syndrome Women's Health Status Postpartum Depression Postpartum Anxiety
Perinatal/Infant Health					
Infant Mortality	By 2030, the Alabama Cribs for	Coordinate efforts with the ACHN maternity care workers to expand area of	ESM SS.1 - The	NPM - Safe Sleep	**Linked NOMs:**

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
	Kids® Program aims to provide a crib (Pack-n-Play) to at least 4000 new mothers. By 2030, maintain SIDS as the third leading cause of death or lower for infants as presented in the 2023 CHS Infant Mortality Report. Prior CHS annual infant mortality reports listed SIDS as the second leading cause of death. By 2030, the out-based FIMR staff will attend 200 community outreach events to promote the Cribs for Kids® Program.	reach for the Alabama Cribs for Kids® Program. Coordinate efforts with the FIMR nurse coordinator to expand area of reach for the Alabama Cribs for Kids® Program. Coordinate efforts with FIMR nurse coordinators to implement bill boards on the importance of safe sleep within their regions. Coordinate efforts to promote the Alabama Cribs for Kids® program at community outreach events including Babypalooza. Coordinate efforts to encourage community participation with Clear the Crib Challenge statewide. Aim for at least a 10 percent survey response rate annually for Alabama Cribs for Kids® participants to answer questions concerning Pack-n-Play use for their infant at 2 to 3 weeks of age after it is delivered	proportion of mothers enrolled in the Alabama Cribs for Kids® Program who self-reported that their infants are using the cribs (Pack-n-Play) for all periods of sleep at the home setting		Infant Mortality Postneonatal Mortality SUID Mortality
Child Health					
Access to Comprehensive Health Care for Children	By 2030, at least 58 percent of survey respondents found the information concerning the medical homes useful. By 2030, at least 125 medical providers offering lead screenings have collaborated with ADPH to distribute the medical home bookmarks, with the initial focus serving those living in rural counties. By 2030, ACLPPP will attend at least 25 outreach events targeting medical doctors and families statewide for distribution of medical home bookmarks.	Coordinate efforts with MCH District Coordinators to expand the area of reach for distribution of the medical home bookmarks. Coordinate efforts with the ACLPPP to expand the area of reach for distribution of the medical home bookmarks among medical providers offering lead screenings. Coordinate efforts with CHDs to expand the area of reach for distribution of the medical home bookmarks.	ESM MH.1 - Percent of medical home bookmark survey respondents who find the educational material useful for finding a medical home for their child ESM MH.2 - Percent of CSHCN that have a comprehensive Plan of Care.	NPM - Medical Home	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Adolescent Health					
Adolescent Safety and Wellness	By 2030, 58 percent of survey respondents ages 10 to 19 report an increase in knowledge after receiving positive youth development education that addresses bullying prevention. By 2030, 58 percent of survey respondents ages 10 to 19 report an increase in intention to change behavior, after receiving positive youth development education that addresses bullying prevention. By 2030, 58 percent of survey respondents ages 10 to 19 report an increase in confidence in abilities after receiving positive youth development education that addresses bullying prevention. By 2030, reach at least 7,500 youth through positive youth development education that addresses bullying prevention.	Determine bullying prevention topics to address through positive youth development education. Establish curriculum and/or program models that address selected bullying prevention topics. Incorporate bullying prevention topics, curriculum and/or program models into current positive youth development education. Coordinate with the evaluation team to develop survey questions that measure an increase in knowledge, intention to change behavior, and/or confidence in abilities related to bullying prevention. Provide training to staff delivering positive youth development education that addresses bullying prevention. Aim for at least a 10 percent annual survey response rate among youth ages 10 to 19 who initiated positive youth development education that addresses bullying prevention.	ESM BLY.1 - The percent of youth, ages 10-19 who report an increase in knowledge, intention to change behavior, and/or confidence in abilities after receiving positive youth development education that addresses bullying prevention.	NPM - Bullying	**Linked NOMs:** Adolescent Mortality Adolescent Suicide Adolescent Firearm Death Adolescent Injury Hospitalization Adolescent Depression/Anxiety Adverse Childhood Experiences
Children with Special Health Care Needs					
Insufficient or unequal assistance to help families navigate the system of care.	Increase the number of enrolled CSHCN who have a comprehensive Plan of Care by 10% annually.	MH 2.1. Train CRS staff on Medical Home and developing a comprehensive Plan of Care with a family and person-centered approach to increase quality service provision. MH 2.2. Continue to provide comprehensive care coordination to CSHCN through system navigation, education, resource identification, referral and follow up.	ESM MH.1 - Percent of medical home bookmark survey respondents who find the educational material useful for finding a medical home for their child	NPM - Medical Home	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
		MH 2.3. Partner with families to develop a plan of care that incorporates a psychosocial assessment of patient and family needs, therapy evaluations, and physician recommendations to meet the specific needs of the child and family. MH 2.4. Promote effective and efficient use of health care resources to increase connections, family and provider partnerships and provide information about Medical Home. MH 2.5 Foster communication among CRS staff, families, community and health care providers to strengthen relationships for improved system navigation.	ESM MH.2 - Percent of CSHCN that have a comprehensive Plan of Care.		
Inadequate supports for transition to all aspects of adulthood.	Increase the percent of YSHCN enrolled in State CSHCN program who report increased preparedness to transition to adulthood by 10% annually.	TAHC 2.1. Continue to administer the CRS Transition Program and conduct outreach to promote the program to YSHCN across the state. TAHC 2.2. Provide families with individualized skills and tools to prepare for transition to adulthood and lifelong care. TAHC 2.3. Develop and implement a health care transition quality improvement and evaluation plan to assess the effectiveness of the CRS Transition Program. TAHC 2.4. Utilize CRS staff including the Parent and Youth Consultants to provide support and increase awareness of the importance of preparing for transition to adulthood. TAHC 2.5. Provide technical assistance and guidance on planning for transitioning to an adult health care provider for CRS staff.	***Inactive -*** *ESM TAHC.1 - Percent of YSHCN enrolled in state CSHCN program who report satisfaction with their transition experience to adulthood.* ESM TAHC.2 - Percent of YSHCN enrolled in state CSHCN program who report increased preparedness to transition to adulthood.	NPM - Transition To Adult Health Care	**Linked NOMs:** CSHCN Systems of Care
Lack of peer support and opportunities to create community for families, caregivers, and youth.	Increase family and youth peer support for CYSHCN using the Family and Youth Support Measurement tool as a measurement. Increase yearly score by 30% to achieve a maximum allowable score of 28 (100%) points by the end of the 5-year needs assessment cycle.	SPM 2.1 Enhance the CRS Parent and Youth Connection programs to build community for individuals to share their experiences. SPM 2.2 Utilize OCI to create marketing materials and a social media campaign to promote and encourage utilization of the Parent and Youth Connection programs. SPM 2.3 Engage with community stakeholders and families to identify existing community support groups and other peer support opportunities for families of CSHCN and YSHCN.	SPM ESM 2.1 - Percent of progress made in achieving strategies to increase peer support for parents and caregivers of CSHCN and YSHCN.	SPM 2: Percent of children with special health care needs, ages 0-17, whose parent receives emotional support with parenting.	**Linked NOMs:** CSHCN Systems of Care

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
		SPM 2.4 Create peer support resource list for parents and caregivers of CSHCN and YSHCN and share via social media and Parent Connection e-newsletter. SPM 2.5 Facilitate access to the identified peer support resources through CRS clinics. SPM 2.6 Create an ongoing Family and Youth Peer Support Column for the Parent Connection e-newsletter that highlights coping techniques, mental health topics, and emotional support information. SPM 2.7 Collaborate with FVA to promote Parent-to-Parent mentoring to assist parents with navigating complex medical systems.			
Cross-Cutting/Systems Building					
Access to Comprehensive Oral Health Education and Services for all MCH Populations	By 2030, at least 58 percent of all dental health kit recipients who completed the REDCap survey plans to use the dental health kit. OHO and its partners attend at least 50 community outreach events annually to increase distribution of dental health kits. By 2030, at least 75 percent of schools visited for oral health screenings and receiving dental health kits had more than 50 percent of the students eligible to receive food assistance.	Expand the area of reach for the distribution of the dental health kits distributed throughout the MCH populations at outreach events. Coordinate with CRS for dental health kits to be distributed at clinics and any outreach events. Coordinate with the Alabama Cribs for Kids® Program for distribution of dental health kits and the educational materials tailored specifically for infants Coordinate with the Healthy Childcare of Alabama for distribution of dental health kits and the educational materials tailored specifically for children ages 3 to 5. Aim for at least an annual 10 percent REDCap survey response rate for dental health kit recipients to answer questions concerning plans to use the contents of the dental health kit and what their current oral health practices are in preventing tooth decay.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 3: Percent of dental health kit survey respondents who plans to use the dental health kit, which includes age-appropriate toothbrush, educational materials, dental floss, timer, and toothpaste	