Maternal and Child Health Services Title V Block Grant

Alaska

FY 2018 Application/ FY 2016 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

THE STATE of ALASKA

GOVERNOR BILL WALKER

Department of Health and Social Services

DIVISION OF PUBLIC HEALTH
Section of Women's, Children's, and Family Health

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July 3, 2017

Maternal Child Health Bureau
Health Services Resource Administration
5600 Fishers Lane RM 18-31
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To Whom It May Concern:

Please accept this submittal for the Title V Maternal Child Health FY18 application from the State of Alaska, Division of Public Health, Section of Women's, Children's, and Family Health. We have met the requirements of 33% for preventative and primary care for children, and 33% for CYSHCN. We look forward to our application review scheduled in Seattle on August 18, 2016.

If you have any questions, please contact Stephanie Birch, Section Chief at 907-334-2424.

Thank you for this opportunity to apply.

Sincerely,

Stephanie Birch

Stephanie Birch, RN, MPH, MSN, FNP
MCH Title V Director
Section Chief

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 C of the 2015 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 "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

Alaska Maternal and Child Health Title V Block Grant Executive Summary

Alaska's maternal child health priorities for 2015-2020 are divided by population domain and described below, including the population-based national performance measures (NPMs) chosen to track and demonstrate impact. State performance measures (SPMs) were developed to address population needs that were identified through the 2015 Five Year Needs Assessment process but were not adequately addressed by the NPMs.

Women/Maternal Health

WOMEN'S NATIONAL PERFORMANCE MEASURE (NPM 1): PERCENT OF WOMEN WITH A PAST YEAR PREVENTATIVE MEDICAL VISIT

- Objectives: By 2021, increase to 70.5% the percent of Alaska women with a past year preventative medical visit

MAJOR ACCOMPLISHMENTS

- The Breast and Cervical Health Check (BCHC) Program utilized ArcGIS mapping technology to identify communities in the state with the highest proportion of low income women who are rarely (> 5 years since last screening) or never screened for cervical cancer, and the project provided health information to hundreds of women in the Kenai Peninsula area.

SIGNIFICANT CHALLENGES

- Staff turnover in key roles in both the Adult Health Services Unit and within collaborating partner agencies in 2017 has presented delays and shifts in critical work planned for the Women's domain.

Perinatal/Infant Health

PRIORITY NEED: REDUCE SUBSTANCE ABUSE AMONG FAMILIES, INCLUDING ALCOHOL, TOBACCO AND DRUGS.

NFANT NATIONAL PERFORMANCE MEASURE (NPM 5): PERCENT OF INFANTS PLACED TO SLEEP ON THEIR BACKS.
NFANTS STATE PERFORMANCE MEASURE (SPM 1): PERCENT OF WOMEN (WHO DELIVERED A LIVE BIRTH AND WERE TRYING TO GET PREGNANT) WHO HAD ONE OR MORE ALCOHOLIC DRINKS IN AN AVERAGE WEEK DURING THE 3 MONTHS BEFORE PREGNANCY

Objectives:

- Increase the percent of Alaska infants placed to sleep on their backs to 86% by 2021.
- Among Alaska women who delivered a live birth and reported that they were trying to get pregnant, decrease the percent who indicated that they had one or more alcoholic drinks in an average week during the 3 months before pregnancy to 22% by 2021.

MAJOR ACCOMPLISHMENTS

- The Alaska Infant Safe Sleep Program strengthened partnerships with Healthy Native Babies (HNB) and Alaska Tribal Health to promote the use of HNB and develop additional resources for families to promote safe sleep practices.
    - Increased emphasis that materials are culturally appropriate by conducting focus groups and developing culturally and regionally applicable webinar-based HNB workshops.

- The Alaska Infant Safe Sleep Program contracted with Helvey Communications to develop a 90-minute workshop on infant safe sleep for hospital staff based on HNB curriculum with verbal commitment from Joint Base Elmendorf/Richardson and Mat-Su Regional hospitals to participate.

- The Maternal Child Death Review (MCDR) program increased the diversity of experts participating in monthly reviews and attending the annual review and recommendations meeting, resulting in more representative and applicable prevention recommendations for populations across the state.

- The MCDR program improved the utilization of the Sudden Unexplained Infant Death Investigation (SUIDI) form by law enforcement, allowing for more comprehensive review by the MCDR, identification of risk factors, and increased ability to make correct death classifications.
    - Recommendations made at the MCDR 2016 annual meeting included developing targeted prevention efforts that address unsafe sleep settings including: bed sharing, intoxicated care givers, and unique challenges faced by families in rural Alaska (e.g. house hold crowding).

SIGNIFICANT CHALLENGES

- Clinical Lactation Consultants from around the state report growing concerns about care providers' recommendations around the use of marijuana and breastfeeding, particularly with recommendation that mothers not breastfeed their babies if they are known marijuana users. During 2012-2014, PRAMS data described entrenched rates of tobacco, alcohol and marijuana use that remained relatively unchanged over the past five years. Prenatal use of cigarettes was 13.2%, marijuana 5.5%, and alcohol 6.9%.

- MCDR continues to review all SUID deaths in Alaska and is trying to improve the timeliness and consistency with SUID classifications. Challenges with data sharing and obtaining records from law enforcement continue to contribute to delayed reviews.

Child Health

PRIORITY NEED: INCREASE ACCESS AND PREVENTATIVE HEALTH CARE SERVICES TO ALASKANS AND THEIR FAMILIES.

CHILD NATIONAL PERFORMANCE MEASURE (NPM 6): PERCENT OF CHILDREN, AGES 10 THROUGH 71 MONTHS, RECEIVING A DEVELOPMENTAL SCREENING USING A PARENT-COMPLETED SCREENING TOOL
CHILD NATIONAL PERFORMANCE MEASURE (NPM 7): RATE OF HOSPITALIZATION FOR NON-FATAL INJURY PER 100,000 CHILDREN AGES 0 THROUGH 9 AND ADOLESCENTS 10 THROUGH 19
CHILD STATE PERFORMANCE MEAUSURE (SPM 5): (NEW) PERCENT OF DEATHS AMONG CHILDREN AGES 0-17 YEARS CLASSIFIED AS MALTREATMENT-RELATED BY THE MCDR COMMITTEE

Objectives

- Increase the percentage of children ages 9-71 months who receive a developmental screening using a parent-completed screening tool to 37% by 2021.
- By 2021, decrease the rate of injury related hospital admissions among children 0-9 years to 164 per 100,000.

- Reduce the percentage of child maltreatment related deaths (as specified by the MCDR program) occurring in Alaska among children ages 0-17 to 15% by 2021.

MAJOR ACCOMPLISHMENTS

- The Alaska Longitudinal Child Abuse and Neglect Linkage (ALCANLink) project was fully implemented. ALCANLink integrates the 2009-2011 PRAMS cohorts with multiple administrative data sources over time including child welfare.
  - ALCANLink calculated that among children born in Alaska during 2009-2011, 1 in every 3.3 will experience a report of harm to child welfare before age 7 years.
  - Increased linkages of additional data into ALCANLink (e.g. Medicaid, and Behavioral Health data)
  - Exponential interest in these data from partners and directly influence of policy of these data related to Medicaid Reform and prevention targeting
- The Alaska Statewide Violence and Injury Prevention Partnership (ASVIPP) was developed with Title V staff serving as co-chair.
- The MCDR program improved the process of developing prevention recommendations related to child injury/maltreatment .
  - Participation in the National CDR steering committee meeting by invitation
- The Surveillance of Child Abuse and Neglect (SCAN) program expanded partnerships, resulting in a reinvigoration for developing a centralized repository website describing child wellbeing in Alaska (including data from ACES, child welfare, ALCANLink, and MCDR).
  - Included in the ASVIPP plan (see bullet above)

SIGNIFICANT CHALLENGES

- Continued lack of resources for comprehensive injury prevention activities and competing priorities by DHSS leadership (e.g. emphasis on opioids from a primarily adult user perspective).
- Need for resources to further develop the ALCANLink project and establish a “transferable” platform for other PRAMS jurisdictions to adopt and allow for state-by-state comparisons, and improve accessibility of these data to researchers and policy makers.

Adolescent Health

PRIORITY NEED: INCREASE HEALTHY RELATIONSHIPS.

ADOLESCENT NATIONAL PERFORMANCE MEASURE (NPM 9): PERCENT OF ADOLESCENTS, AGES 12 THROUGH 17, WHO ARE BULLIED OR WHO BULLY OTHERS

ADOLESCENT NATIONAL PERFORMANCE MEASURE (NPM 7): RATE OF INJURY RELATED HOSPITAL ADMISSIONS PER POPULATION 0 THRU 19 YEARS.

ADOLESCENT STATE PERFORMANCE MEASURE (SPM 2): PERCENT OF STUDENTS WHO REPORT THAT THEY WOULD FEEL COMFORTABLE SEEKING HELP FROM AT LEAST ONE ADULT BESIDES THEIR PARENTS IF THEY HAD AN IMPORTANT QUESTION AFFECTING THEIR LIFE

Objectives

- Decrease the percentage of Alaska students in grades 9-12 who report that they were bullied on school property during the past 12 months to 21% by 2021 (YRBS).
- Decrease the percentage of Alaska adolescents ages 12-17 who are reported by a parent/guardian to bully others in the past month to 12% by 2021 (NSCH).
- Decrease the rate of injury-related hospital admissions among adolescents’ ages 10-19 years to 164 per 100,000 by 2021.

MAJOR ACCOMPLISHMENTS

- Alaska’s teen birth rates continue to decline, dropping from 42.6 per 1,000 teens in 2008 to 25.5 per 1,000 teens in

2016.

- The MCDR program began implementing reviews and developing recommendations related to adolescent deaths up to age 18.
- The Adolescent Health Program increased the number of participating students in an evidence based healthy relationship program by more than 25% (or 1000 students more than originally anticipated).

SIGNIFICANT CHALLENGES

- Unknown and limited funding from CDC and HRSA on future adolescent health related grants.

Children with Special Health Care Needs

PRIORITY NEED: IMPROVE SYSTEMS OF CARE FOR FAMILIES WITH CHILDREN YOUTH WITH SPECIAL HEALTH CARE NEEDS

CYSHCN NATIONAL PERFORMANCE MEASURE (NPM 11): PERCENT OF CHILDREN WITH AND WITHOUT SPECIAL HEALTH CARE NEEDS HAVING A MEDICAL HOME.

Objectives

- By 2021, increase the proportion of CYSHCN who receive integrated care through a patient/family centered medical/health home approach by 20% over Alaska's reported 2009/10 levels of 42.8%.

MAJOR ACCOMPLISHMENTS

- Help Me Grow Alaska initial planning was completed with broad support and newly identified funding sources and champions. This benchmark represents the culmination of Title V planning efforts and will be critical to the successful launch and expansion of the Help Me Grow model in Alaska, beginning with three place-based communities: Norton Sound, Mat-Su, and Kodiak (Early Childhood Comprehensive Systems project communities).

SIGNIFICANT CHALLENGES

- Technology issues have prevented the timely development of the cloud-based “Shared Plan of Care” (SPoC) for the School Nurse Care Coordination Project. The development of the electronic (SPoC) has presented significant challenges in Alaska, as also reported by other states engaged in this work. In the meantime, alternative electronic solutions continue to be explored and clinical SPoC development and processes have been further refined to improve coordination of care for CYSHCN between medical home and school settings.

Cross-Cutting/Life Course

PRIORITY NEED: INCREASE ACCESS AND PREVENTATIVE HEALTH CARE SERVICES TO ALASKANS AND THEIR FAMILIES. INCREASE EVIDENCE BASED SCREENING FOR ALL MCH POPULATIONS FOR BEHAVIORAL AND MENTAL HEALTH PROBLEMS

LIFE COURSE PERFORMANCE MEASURE (NPM 13): A.) PERCENT OF WOMEN WHO HAD A PREVENTATIVE DENTAL VISIT DURING PREGNANCY AND B.) PERCENT OF CHILDREN, AGES 1 TO 17 YEARS, WHO HAD A PREVENTATIVE DENTAL VISIT IN THE LAST YEAR.

LIFE COURSE PERFORMANCE MEASURE (NPM 14): PERCENT OF WOMEN WHO SMOKE DURING PREGNANCY AND PERCENT OF CHILDREN WHO LIVE IN HOUSEHOLDS WHERE SOMEONE SMOKES

LIFE COURSE STATE PERFORMANCE MEASURE (SPM 4): PERCENT OF WOMEN WHO REPORT BEING SCREENED FOR DEPRESSION DURING PRENATAL CARE

Objectives

- Increase the percentage of Alaska women who had a dental visit during pregnancy to 60% by 2021.

- Increase the percent of Alaska children ages 1-17 years who had a preventative dental visit in the past year to 77% by 2021.
- Decrease the percent of Alaska women who use tobacco during pregnancy to 10.5% by 2021.
- Decrease the percent of Alaska children ages 1-17 years who live in households where someone smokes to 22.5% by 2021.
- By 2021, increase the proportion of Alaska women who report being screened for depression during prenatal care to 81.5%

MAJOR ACCOMPLISHMENTS

- The Oral Health Program staff successfully educated staff in the Division of Health Care Services (Medicaid Program) on the need for coverage of the new code for a caries arresting medicament application (CDT code D1354) in the Medicaid/CHIP program. The Division of Health Care Services provided coverage of the procedure with the release of the revised dental fee schedule release in June 2016. Early reports in Alaska indicate the coverage is assisting in treatment of early childhood caries in young children in the dental clinic setting - in some cases reducing the need to take children in for general anesthesia in the hospital or ambulatory surgery setting.

SIGNIFICANT CHALLENGES

- Alaska provides adult dental services for emergent and enhanced dental procedures – this includes dental coverage for adult pregnant women. With the state budget deficits over the past two years there are concerns on maintaining the adult dental coverage – an optional service under the state's Medicaid program. The state legislature directed the department to reduce expenditures in the adult dental Medicaid services coming out of the 2015 legislative session – those reductions primarily resulted in changes in services related to dentures. The ongoing budget climate continues to threaten future coverage of adult dental services.

II. Components of the Application/Annual Report

II.A. Overview of the State

State Overview

Alaska is a large, sparsely populated state. The land mass of the state encompasses 570,641 square miles, averaging a population density of just 1.3 persons per square mile. This is the lowest population density of any state. The July 2016 Alaska resident population was estimated at 739,828 by the Alaska Department of Labor and Workforce Development. This represented an increase of 2,645 people compared to 2015. There were 11,250 births in 2016. Alaska had 158,935 children less than 15 years of age (21.5% of the total population) and 146,430 women of childbearing age (15-44 years) in 2016 (19.8% of the total population). Alaska's population is younger than the national average but the gap is narrowing, as Alaska has the fastest growing senior population in the U.S. The U.S. median age in 2016 was 38.1 years, and the median age for Alaska was 34.7.

In 2016, approximately 80% of people in Alaska lived in cities or places with populations of 2,500 or more. Cities with more than 10,000 people included the Municipality of Anchorage (299,037), the City and Borough of Juneau (32,739), and the City of Fairbanks (31,957). These three areas were home to 49% of Alaska's population. Alaska has a trend of migration from rural to urban areas that has remained fairly stable over the past 20 years. Over five-year periods, an average of 11% of the rural adult population moves to an urban area. In the same amount of time, an average of 2% of the urban adult population moves to a rural area. Of those who dwell in rural areas, the majority are Alaska Native people.

Alaska was home to 20,838 active duty military personnel in 2015, representing nearly 3% of the state's population. The state also had 29,252 military dependents. Anchorage, Fairbanks, and Kodiak Island all have large active duty military and dependent populations.

According the Department of Labor statewide projections, Alaska's statewide population is projected to increase from 737,625 in 2015 to 899,825 in 2045. As Alaska's population ages in the coming years, annual growth is expected to slow. Alaska's population aged 65+ is expected to grow at the fastest rate over the projection period, followed by the population aged 0-17. The population aged 18-64 is projected to increase at the slowest rate.

About 59% of people living in Alaska are migrants to the state. Based on American Community Survey data, 7% of Alaskans were foreign-born between 2010 and 2014.

In 2015, 68% of Alaska's population was reported to be White, 18% Alaska Native/American Indian, 9% Asian or Pacific Islander, and 5% African American. Alaskans of Hispanic origin made up 7%.

The largest differences in health trend status are between the Alaska Native and non-Native populations and between rural/frontier and urban populations. The health status of Alaska Native people is poorer than that of non-Native people in several domains. Living in remote communities with high unemployment rates, low income and significantly higher costs for food, fuel, and supplies as well as barriers to accessing health care services are contributing factors.

Significant improvements in health of Alaska Native people have been made since the 1970s. Large investments in infrastructure including housing, safe water and sanitation facilities, village community health aide staffed tribal village clinics, and regional hospitals contributed to significant improvements in life expectancy, infant mortality and infectious disease. However, research documents that continuing and significant disparities remain, including in key

MCH outcomes such as postneonatal mortality; child, adolescent, teen (especially teen suicide), and female mortality; and oral health. The causes of these disparities are multifactorial and include a long history of discrimination and the loss of traditional lifestyles. As the Alaska Native population becomes increasingly urban or adopts western lifestyles and diet, whether by choice or not, chronic diseases such as diabetes and heart disease are of increasing concern.

Cultural diversity among the non-Native population is increasing. More than half of the students in the Anchorage School District are ethnic minorities, speaking 107 different languages. A culturally diverse workforce that reflects the culture, language and respects the traditions of the populations is a crucial strategy for reducing health disparities. In the 2013-2014 school year, 27 of the top 30 highest diversity public schools in the United States were in Anchorage (Alaska Public Media 2017).

Factors Affecting Health Status

Uninsured populations are less likely to access routine, preventive care and more likely to seek care when health problems are severe and require treatment. In 2015, 59% of Alaskan adults aged 19-64 years were covered by employer or other private health insurance; 21% were covered by Medicaid or other public insurance (Kaiser Foundation). With the expansion in Medicaid approved in the previous fiscal year, the number of children ever enrolled in Title XXI-CHIP increased from 10,182 in FFY 15 to 15,662 in FFY16 and in Title XIX from 87,537 in FFY15 to 90,644 in FFY16.

Poverty affects health both through decreased access to material resources, like health care and nutritional food, and through increased exposure to negative social and environmental factors, like violence, lead, and air pollution. It is associated with poor maternal health and birth outcomes such as infant mortality, low birth weight, and child maltreatment. Relative to the general US population in 2015, proportionately fewer Alaskans lived in poverty (10.3 % compared to 13.5 %); 14.7% of Alaskan children under 18 years lived in poverty. In 2015, 24.2% of the Alaska Native population in Alaska lived in poverty, compared to 6.6% of the White population.

Survivors of violent crimes are at risk for posttraumatic stress disorder, major depressive episodes, and drug abuse/dependence. Youth exposed to community violence have increased rates of anxiety, aggression, and future violent behavior. In 2015, Alaska's homicide rate per 100,000 individuals was 8.0, compared to 4.9 for the US. Overall, in 2011-2012, 10.5% of Alaska parents of children aged 0-17 years reported that their child was ever a victim or a witness of neighborhood violence. Adverse Childhood Experiences (ACEs) are major risk factors for leading causes of illness and death as well as poor quality of life. The higher the number of ACEs a person has, the more likely they experience poor health. The 2013-2015 Alaska BRFSS found that 22.2% of Alaskans had at least one ACE, while 19.5% reported four or more (http://ibis.dhss.alaska.gov/indicator/view/xace4cnt.HA.html).

Community policies also affect maternal and child health status, including baby-friendly hospitals and water fluoridation. In 2015, 29.5% of Alaska births occurred in hospitals that were designated Baby-Friendly (Providence Alaska Medical Center-Anchorage & Bartlett Regional Medical Center-Juneau). During 2008-2014, the Alaska population served by community water systems with fluoridated water dropped from 62.8% to 49.3% due to the discontinuation by some of the larger communities through local rule.

Factors Impacting Health Services Delivery

Approximately 75% of Alaskan communities, including the capital city of Juneau, are not connected to a road system. Accessing "nearby health services" or specialized health care means travel by commercial jet, small plane, the marine ferry system, all-terrain vehicles, small boats or snow machines. Some residents may travel distances

equivalent to Washington, D.C. to New Orleans for even routine medical care. Severe weather can render travel impossible, creating especially critical situations in medical emergencies.

Geographic isolation means significant challenges in assuring all MCH populations have access to routine preventive care, acute medical and specialty care. Specialty care, even in urban areas of the state, is limited. For example, the only Level III neonatal intensive care facility is located in Anchorage. Many communities have no facilities equipped for childbirth so pregnant women must leave their homes four weeks before their due date and travel to a larger community with a hospital that performs births. Even well-child check-ups, prenatal exams and regular dental exams are difficult to provide. Recruiting and retaining physicians and primary health care providers for non-urban practices is also a barrier to providing health care services.

Title V in the Context of Alaska's Health Care Delivery System

The Alaska Department of Health and Social Services (DHSS) was originally established in 1919 as the Alaska Territorial Health Department. With the proclamation of statehood on January 3, 1959, the department's responsibilities were expanded to include the protection and promotion of public health and welfare. These core duties are reflected in the mission of the department – to promote and protect the health and well-being of Alaskans – and are outlined in Article 7, Sections 4 and 5 of the Constitution of the State of Alaska.

Programs for the MCH and CYSCHN populations in Alaska are primarily managed within Sections of the Division of Public Health (DPH) located in DHSS. The Section of Women's, Children's and Family Health (WCFH) is the designated Title V and CYSCHN agency and is located in DPH. WCFH programs are described in the WCFH Program Descriptions supporting document #4) The Section of Chronic Disease Prevention and Health Promotion (CDPHP) manages the following MCH programs: Family Violence and Prevention; Injury Prevention: Child Passenger Safety, Bike-n-Walk Safely Alaska!, Kids Don't Float, Helmet Safety; Obesity Prevention and Control; Youth Risk Behavior Survey (YRBS); Tobacco Prevention and Control. The Section of Epidemiology (SOE) manages the Alaska Immunization Program.

Other MCH programs are managed in other Divisions of DHSS: EPSDT Outreach – Division of Health Care Services (Medicaid agency); Infant Learning/Early Intervention Program – transferred to the Division of Senior and Disability Services in SFY17; Early Childhood Comprehensive Systems (ECCS) – Office of Children's Services (OCS), the child protection agency; Strengthening Families – OCS; WIC/Nutrition Programs – Division of Public Assistance.

Over the past few years, DHSS has faced significant budget cuts in their share of state general fund dollars and has eliminated or significantly reduced programs while trying to live within a budget that entirely depends on the price of oil and federal funding. The DPH is not well understood by the Legislature and thus is frequently the target of across-the-board cuts.

Three local governments, the Municipality of Anchorage, North Slope Borough, and Maniilaq Association, operate local health departments with limited services and no strong MCH presence. The Alaska DHSS offers a wide range of health assessment and disease prevention services through 17 Public Health Centers (PHC) and itinerant nursing services. However, since 2015, 41 public health nursing positions have been cut in addition to closure of six community PHC's across the state. Specific services that are no longer provided due to recent budget cuts include well child exams for children over 7 years of age and immunizations, reproductive health services, and sexually transmitted infection screening and treatment for adults over 30.

Health care delivery in Alaska consists of three separate systems; tribal, military and private. The Alaska Native Tribal Health Consortium (ANTHC) is a consortium of tribal entities that provides several levels of medical care: primary care at village clinics, primary and secondary care at regional hospitals, and tertiary care at the Alaska Native Medical Center in Anchorage. ANTHC receives some funding by Indian Health Service but is supported to a greater extent by the various regional corporations. On the private side, there are private non-profit and for profit secondary and tertiary care hospitals as well as employed and private practice health care providers. The military system is fairly expansive with clinics and hospitals in some of the larger population areas of the state as well as a relationship with the Veteran's Administration supporting the active duty and retired armed forces.

A number of innovative systems have been created to overcome barriers to health care delivery related to high transportation costs and lack of skilled resources in the small communities. The Community Health Aide Program is a network of about 500 tribal Community Health Aides/Practitioners (CHAPs) who work in village clinics to provide basic health care services and referrals. The CHAP program is a vital link in the Alaska Tribal Health System. The Alaska Dental Health Aide Therapist Initiative, another ANTHC program, is conducted in collaboration with the University of Alaska-Barrow and various established sites in Bethel and Anchorage to train Alaska Native dental health aides for community-level dental disease prevention in underserved Alaska Native populations. The Behavioral Health Aide Project aims to develop village-based behavioral health service capacity, focusing on prevention, early intervention and case management.

State priorities

The mission of the Alaska DHSS is to promote and protect the health and well-being of Alaskans. The Department's 2016 priorities span the breadth of the department and encompass the unique service-areas represented within.

DHSS, in partnership with ANTHC, developed Healthy Alaskans 2020 (HA2020) health priorities during a series of expert workgroup meetings and public input surveys during 2012 and 2013. HA2020 is a science-based framework designed to guide efforts in Alaska over the next decade to improve health and ensure health equity for all Alaskans. The 25 health priorities include reducing the rates of cancer, suicide, child maltreatment and interpersonal violence and sexual assault. Alaskans also wanted to see alcohol, tobacco and drug use curtailed, and an increase in disease prevention through vaccines, improved access to in-home water and wastewater services, and lowering Alaska's obesity rate. As well, there were three priorities around reducing the proportion of Alaskans without access to high quality and affordable healthcare, including increasing the percent of women who received prenatal care in the first trimester. Target goals for each of the 25 indicators have been established and strategies, actions, and key partners to reach the goals have been identified.

The Alaska DPH mission is to protect and promote the health of Alaskans; with a vision of healthy Alaskans today and tomorrow.

The Strategic Plan also identified 13 "Winnable Battles." Seven of these related to MCH priorities, including:

- Increase appropriate cervical cancer screening
- Increase the proportion of children who are at a healthy weight
- Reduce the proportion of children who die before their first birthday
- Increase the percent of children with on-time immunizations
- Reduce the rate of teen pregnancy
- Increase proportion of Alaskans with an appropriate medical home
- Decrease use of smoking, chewing, and vaping tobacco products

In SFY2017, the Section of Women's, Children's and Family Health established their own strategic plan reflective of the priorities outlined in the MCH Title V needs assessment as well as state priorities. The infographic that was developed is attached.

Impact of health care reform and ACA implementation on health status and delivery of services:

In July 2015 Alaska's Governor announced a decision to expand Medicaid under Executive authority. Medicaid expansion began September 1st, 2015 in Alaska. By April 30, 2017, 32,958 Alaskans were covered by Medicaid under expansion, according to DHSS figures. Expanding Medicaid will eventually give over 40,000 Alaskans access to affordable health care and help reduce over-utilization of emergency services

The 2016 legislative session saw several bills aimed at Medicaid reform. The provisions of these bills were ultimately consolidated into Senate Bill (SB) 74 which was signed by Governor Walker in June 2016. As a review, the legislation, SB 74 included the following provisions to:

- 1115 demonstration waivers to receive federal authority to fund models of primary care case management and/or managed care/coordinated care organization delivery models;
- 1115 waiver to receive federal authority to fund a redesign of the Medicaid behavioral health system to provide specialized services to targeted populations that will achieve improved health outcomes for identified disparity groups that are currently underserved.
- 1945 options under the Social Security Act for waivers to provide coordinated care for health homes and increase available federal match rates for the programs collaborative hospital project(s) for emergency room diversion and primary care coordination to address emergency-room super-utilizers;
- 1915(i) and 1915(k) waivers for the home and community based services program which provide additional federal match for support of these programs. As of SFY 2017, the 1915 (i) waiver is on hold
- Develop a collaborative project with the department and state hospital association to reduce emergency department usage with a focus on those that frequently utilize services;
- Direction to the department for demonstration projects on payment reforms case management models, workforce development and innovative service delivery models;
- Direction to the department to provide reimbursement and increase capability for telehealth including expanding use for primary care, behavioral health services and urgent care; and
- Develop coordinated care demonstration projects with one or more third parties with respect to improving efficacy of the health care delivery model, improving access to services and/or improving the quality of care for Medicaid recipients

The legislature in SFY17 is currently in a special session as of this writing completing an extension of 120 days from their 90-day session. An operating budget was just signed heading off the potential government shut down. The legislature has been called back into session for a fourth time to work on a long term fiscal plan, but legislators are currently packing up their offices and have not met on this topic. The state is facing a 4-billion-dollar deficit for SFY18 that begins July 1, 2017 as a result of the state's dependence on oil as its primary source of income. The Division of Public Health's reliance on federal dollars has become even more critical over the last couple of years.

The 2017 legislative session which started in January 2017 had a few bills affecting Alaska's MCH population. These included:

- **SB053/HB025**: This bill requires healthcare insurers, including Medicaid services, to cover 12 months of prescriptive oral contraceptives at a time. HB025 was referred to the Rules Committee and SB053 was referred to the Health and Social Services and Labor and Commerce Committees. This bill did not pass.

- **HB250** redefines an unborn child as a “preborn” child and states that “a person commits the crime of murder of a preborn child if the person … knowingly removes, or causes or permits the removal of, a preborn child from the state for the purpose of killing the preborn child.” HB 250, in addition to criminalizing abortion, legally forbids a woman from traveling outside the state to obtain an abortion, removes the right to privacy for women seeking an abortion, and limits legal challenges to the measure. The amendments to AS 18.05.032 take out references to abortion procedures and substitute “preborn” for “unborn” in the text. WCFH would have to amend the resources section of the website to remove abortion providers, as well as taking out the description of the abortion procedures on the site if this bill passed. HB250 was referred to the Health & Social Services, State Affairs Judiciary, and Finance Committees and did not move forward.

- **HB026** relates to breaks for employees who are nursing mothers, specifically the time and space that must be provided. This bill was referred to the House Labor & Commerce Committee and did not move forward.

The Process to Determine Alaska's Title V MCH Priorities:

The Section of WCFH is guided by the maternal and child health pyramid of health services. Its programs stress improving health status, assuring health service access, and eliminating health disparities in present and future generations of Alaskans. The Title V Five Year Needs Assessment enables WCFH to reconfirm or realign its priorities for the next five years. The ultimate goals of the Needs Assessment are: 1) improved outcomes for maternal and child health populations; and 2) strengthened partnerships. The federal Maternal and Child Health Bureau identified ten steps as part of the State Title V MCH Needs Assessment Framework. These steps are:

1. Engage stakeholders
2. Assess needs, desired outcomes and identify mandates
3. Examine strengths and capacity
4. Select priorities
5. Seek resources
6. Set performance objectives
7. Develop an action plan
8. Allocate resources
9. Monitor progress for impact on outcomes
10. Report back to stakeholders

Alaska's FY 2015-2019 Title V Needs Assessment was completed in February 2015. For a detailed description of the Needs Assessment process and how priorities were selected, see *Section* II.C. *State Selected Priorities*. In addition to the 5-Year Needs Assessment, WCFH leadership staff assess Alaska’s MCH needs on an on-going basis by reviewing annual data, conducting special analyses, and obtaining feedback and input from over a dozen community advisory committees and coalitions. We believe this strategy is more flexible, efficient, timely, and responsive than one singular effort every five years. In addition, our ongoing assessment activities include participating in other organizations' committees; partnering with other agencies on program implementation; and surveillance and research. The information gleaned from their formal and informal assessments helps to inform the Title V MCH/CYSCHN program on the magnitude and severity of each issue, as well as how it compares with competing priorities.

One of the most important coalitions that Title V staff members actively participate in is the All Alaska Pediatric Partnership (AAPP), a coalition of several hospitals in the state who care for children and pregnant women, representatives from the Municipality of Anchorage, tribal entities, and behavioral health systems. Meetings and

community forums are held in around the state throughout the year during which time information is collected on needs and challenges. Attendees are often parents of children and youth with special needs and chronic conditions as well as local pediatricians, family practice physicians and other representatives of community agencies. These assessments collect information on specialty health care needs and system challenges that family's experience. The information is shared back with the executive committee members to assist in planning and evaluation of programs.

In many ways, Alaska's MCH Title V priorities have not changed since the 2010 Needs Assessment. The issues of mental health, substance abuse, child maltreatment and healthy relationships persist in Alaska and therefore are maintained as priorities. New priorities focus on expanding preventative health care services to Alaskans and their families. Strategies to address these priorities are discussed in the Five Year Action Table.

State priorities for 2015 - 2020 are:

1. Reduce substance abuse among families, including alcohol, tobacco and drugs.
2. Reduce the rate of child maltreatment.
3. Improve system of care for families with children and youth with special health care needs.
4. Increase access and services to reproductive health care.
5. Increase access and preventative health care services to Alaskan and their families.
6. Increase healthy relationships.
7. Increase evidence based screening for all MCH populations for behavioral and mental health problems.

Current and Emerging Issues/ State statutes and regulations with relevance to Title V program authority

There are numerous emerging issues that have relevance to the Title V authority. They also are significant in understanding current or projected strengths and needs of the Alaska MCH population. These are discussed in more depth in Section F.5. *Emerging Issues* and are only listed briefly here.

- Alaska continues to have challenges related to provider shortages, particularly in rural Alaska and in pediatric specialty fields. There continues to be challenges in recruiting both primary care and specialty providers to the state. The state's only pediatric neurodevelopmental physician retired at the end of June 2016. A new pediatric developmental behavioral physician has been hired and will start September 1, 2017 at the Children's Hospital at Providence.
- Cuts to the state general funds related to Maternal Child Health will continue to be a barrier to overcome. Cuts in SFY 17 and 18 will reduce capacity to meet the needs of children with special health care needs and data capacity. The Section of Public Health Nursing which provides the safety net of primary and secondary intervention to the state's most vulnerable residents continues to face more budget cuts. In FY17, Public Health Nursing eliminated positions and closed health centers in the state. In SFY 17, the Section of WCFH reduced their staff by 10% with a reduction of 5 positions.
- The increase of chronic conditions among school age children, such as asthma, autism, or diabetes, require school districts to develop capacity to meet the medical needs of the children during the school day. Currently the capacity does not exist in the smaller school districts and many school districts have no school nurses or are reducing the number of school nurses in their districts.
- In November 2014, Alaska voters approved an initiative legalizing recreational marijuana use. Medical marijuana has been legal in Alaska since 1998. Even prior to legalization, prenatal marijuana use in some Alaska populations was almost as high as prenatal cigarette use (PRAMS).
- The State of Alaska declared an emergency disaster regarding opioids and a bill, SB 91 was submitted by the Governor and was signed into law at the end of March 2017. The declaration authorizes the Commissioner and the State Medical Officer of the Department of Health and Social Services to coordinate a response to the crisis.

From 2009 to 2015, the number of heroin-associated deaths more than quadrupled in Alaska. This law allows for the chief medical officer of the Department of Health and Social Services to issue a standing order for the distribution of opioid overdose reversal drugs (naloxone) and provides ongoing dates of approval to distribute this medication statewide based on the number of overdoses in the state. The response creates a statewide Overdose Response Program and allows for a greater number of Alaskans to dispense and administer naloxone, specifically this has involved the MCH Title V funded School Health Nurse Coordinator in WCFH who has assisted with the education and response from school nurses and schools. Without this legislation, the disaster would have had an automatic termination date. A second bill, HB 174 was submitted which extends the governor's declaration of a disaster emergency to address the opioid epidemic and support additional resources to work at the community level. See the following data highlighted on the web site: *Heroin & Opioids in the Last Frontier:* http://dhss.alaska.gov/dph/Director/Pages/heroin-opioids/data.aspx

- The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children (SACHDNC) continues to expand the number of conditions on the recommended uniform screening panel (RUSP). As conditions such as Severe Combined Immunodeficiency Disorder (SCID) and Pompe Disease are added, additional costs are incurred to state NBMS programs and state public health laboratories. These new conditions carry additional costs related to the technology associate with the testing. As the conditions are added, the corresponding fees for birthing facilities, and ultimately families, increase. In 2017, the program will be piloting the use of a courier service and Alaska Airlines Goldstreak services to improve the timeliness of specimens reaching the processing lab in Portland, Oregon to the lab. Much work has already been done within facilities to improve processes and specimen collection practices. Public health labs across the country will also be challenged to meet the timeliness measures given budget constraints. As the emphasis moves to newborn screening labs operating seven days a week, this will be challenging to support financially.
- Active promotion of long-acting reversible contraceptives (LARCs) to public and private providers, as well as working with AK Medicaid to assure removal of any logistical or cost barriers to access to LARCs for Medicaid-eligible women continues to be a priority.
- During 2004-2014, the percentage of Alaskan women aged 21-65 years who reported on the BRFSS that they received a Pap test within the last 3 years decreased from 91% to 78%. Due to changes in the United State Preventive Surveillance Task Force (USPSTF) recommendations, the BRFSS data has been changed to reflect women 21-64. The 2014 BRFSS survey indicates a further reduction to 77.9% of women ages 21-64 have received a Pap test in the last 3 years.

II.B. Five Year Needs Assessment Summary and Updates

FY 2018 Application/FY 2016 Annual Report Update

II.B MCH Population Needs

Women's/Maternal Health

The top three needs identified for the Women/Maternal health domain in Alaska's 2015 Needs Assessment were unhealthy relationships; behavioral/mental health problems; and reproductive health (RH) concerns (preventing sexually-transmitted infections, birth control methods, and infertility). Alaska relies on health care providers to provide affordable, culturally competent, comprehensive RH and related preventive health services to women in their childbearing years, and the counseling, education, clinical services essential to assuring that they have the tools and information necessary to make healthy choices. Accordingly, the NPM selected for this domain is "The percent of women with a past year preventive visit" (NPM #1).

In 2015, 55.6% of Alaska women ages 18-44 years of age reported having had a past-year preventive health visit (a routine check-up that was not for injury, illness or a condition) (BRFSS), roughly the same percent as the previous year. In 2014, the most recent year the question was asked, 77.9% of Alaska women aged 21-65 received recommended cervical cancer screening, a decline from the prior year. Cervical cancer screening was less common among Alaska Native women (70.3%) compared to White women (81.4%) and remains below the HP2020 target of 93.0%. Similarly in 2014, 68.4% of Alaska women aged 50-74 received breast cancer screening (mammogram) at least once every 2 years, compared to 74.5% in 2012 and the HP2020 target of 81.1%. These proportions indicate a continuing decline over the past 5 years in these important cancer screenings in Alaska. This decline coincides with changing national recommendations that lengthened the intervals for both cervical and breast cancer screenings and likely contributed to confusion and reduced screenings overall among Alaska women.

Alaska's Medicaid expansion in September 2015 and ongoing improvements to Alaska's health insurance systems provide promising opportunities for Alaska women to have increased access to low-cost and subsidized health care insurance options that, hopefully, will stem the tide of decline in seeking critical preventive health services in coming years.

In support of the findings of the 5-year NA, WCFH Adult Health Unit staff continue to collaborate with other DPH sections and the Alaska Primary Care Association in efforts to establish baselines for comprehensive RH service provision and related preventive health services to Alaska women in their childbearing years.

Perinatal/Infant Health

Alaska's 2014 infant mortality rate (IMR) was 6.6 per 1,000 births, compared to 5.8 for the U.S. The neonatal and postneonatal mortality rates were 3.0 and 3.6 per 1,000 respectively, compared to national rates of 3.9 and 1.9.

The Alaska Native and non-Native disparity in Sudden Unexpected Infant Death (SUID) rates persists, particularly in rural areas. Substance use and unsafe sleep practices are leading contributing factors for infant mortality. Among the 60 infant deaths reviewed by the Maternal Child Death Review (MCDR) committee during 2016, the committee determined 43% (n=26) were due to SUID. Prior published data from the MCDR program indicated that over 90% of Alaskan infant deaths in a sleep environment during 2012-2014 occurred among families with low socioeconomic status, the majority occured in an unsafe location and involved sharing a sleep surface, and almost half involved caregivers who were using alcohol, tobacco or other substances at the time of death.

An emerging issue of concern for the perinatal population is opioid use. From 2004 to 2015, the annual rate of Neonatal Abstinence Syndrome among Alaskan Medicaid-eligible births increased from 2.7 per 1,000 to 18.4 per 1,000 live births.

Since the last Block Grant application was submitted, the Title V program has begun a partnership with the Healthy Native Babies project to adapt the national curriculum to Healthy Alaska Babies, which will be a universal tool to be promoted statewide and reflect the 2016 updated AAP Guidelines for Infant Safe Sleep. The program is also formally partnering with Cribs for Kids and will promote the use of their national Safe Sleep Hospital Certification program for hospitals.

Alaska's MCDR committee continues to conduct activities to improve timeliness of reviews and the dissemination of findings related to primary prevention. Participation in the national SUID case registry system has helped to standardize information collected by the program and enabled Alaska's data to be comparable to other states, as well as improved the timeliness of Alaska's data. A key action taken as a result of the September 2016 annual meeting was the delivery of a letter to the State Medical Director to encourage the consideration of mothers and Neonatal Abstinence Syndrome in the statewide taskforce responding to the opioid abuse epidemic.

Child Health

In 2015, there were 197,625 children ages 0-18 years in Alaska, comprising 26.8% of the total population. About 27% of the population in this age group is Alaska Native children (Alaska Department of Labor, 2015).

Reducing the rate of child maltreatment and increasing access to preventive health services for Alaskans and their families are the priority needs for this domain. The rate of unique substantiated child maltreatment victims per 1,000 children aged 0-17 years was 15.6 per 1,000 children in 2015 (NCANDS). The leading cause of fatal injuries among Alaska children ages 1-4 during 2011-2015 was assault, followed by drowning, while drowning was the leading cause of fatal injury among children ages 5-9 (Alaska Health Analytics and Vital Records).

According to Alaska CUBS, the percent of 3-year-olds who have seen a health care provider for routine medical care such as a well-child check-up or physical exam has not significantly changed in the past five years, and was 90.2% in 2015. Three-quarters of mothers indicated that they completed a questionnaire or a health care provider went through a checklist of questions with her about her child's development during the past 12 months (CUBS 2015).

WCFH's Pediatric Medical Home Program supports linkages to medical home and preventative care services for all children, to include developmental screening, assessment and referral to a needed specialist and community-based services. This program partners with the HRSA/MCHB Early Childhood Comprehensive Systems (ECCS) grant and other state and community-based programs to promote the use of the online ASQ developmental screening tool available statewide through Alaska's Part C Early Intervention/Infant Learning Program (EI/ILP).

Title V is exploring Medicaid CHIP Health Services Initiative options related to universal developmental screening promotion. Title V staff have also begun participating in the Alaska Resilience Initiative led by the Alaska Children's Trust and the Alaska Statewide Violence and Injury Prevention Partnership.

Adolescent Health

Changes in the strengths and needs of the adolescent population were analyzed using the 2015 Youth Risk Behavior Survey (YRBS) results. The percentage of students feeling sad or hopeless has been increasing and was 34.2% in 2015. There has also been a corresponding increase in the percentage of students who say they feel alone (25.0% in 2015) and the percentage of students seriously considering suicide (20.5% in 2015). The Adolescent Health Team assisted with the selection of questions for the 2017 YRBS and the 2018 Lead Health Education Teacher School Health Profiles survey.

Changes in Title V program capacity and established program collaborations and partnerships included continued collaboration with the Association of State and Territorial Health Officials (ASTHO) and the CDC Division of Violence Prevention, National Center for Injury Prevention and Control to strengthen the State's ability to prevent sexual violence. In addition, the Adolescent Health Program received a supplementry Rape Prevention Education Program

grant to assist with evaluation efforts. A new collaboration/partnership was established with the Alaska Section of Chronic Disease and Health Promotion to assist with implementation of a small portion of the CDC Preventive Health and Health Services Block Grant, specifically in the prevention of sexual violence among child and youth in Alaska and the dissemination of and training dedicated to the Alaska Safe Children's Act Tool Kit/Resource Guide for Schools.

Activities to operationalize the three major adolescent health needs identified in the NA process included hosting a statewide youth leadership summit focused on healthy relationships called Lead On! The Adolescent Health Program implemented an evidence-based intervention, *Bringing in the Bystander,* at the University of Alaska Anchorage that reached over 1000 students from August 2016 – May 2017 and multiple teen pregnancy prevention/sexual health education curriculas. The Adolescent Health Program staff worked extensively with the Alaska Safe Children's Act Taskforce, which is providing recommendations to the Department of Education and Early Development on new legislation that stipulate that school districts in Alaska must train employees and students on sexual abuse prevention (K-12) and dating violence and abuse prevention (grades 7-12). The *Alaska Fourth R Healthy Relationship Program* for grades 7-9 that teaches healthy relationship skills and empowers adolescents to make healthier decisions about relationships, sexual behavior, and substance use continued to expand. Over 300 school staff and community partners throughout Alaska are trained to teach the *"Fourth R"* and 81 schools have received the curricula and training materials.

Children and Youth with Special Health Care Needs

Approximately 11% Alaskan children, or 19,916, have special health care needs according to the 2009/2010 National Survey of Children with Special Health Care Needs (NSCSHCN). Alaskan families of CYSHCN face a host of daunting challenges. Many lack awareness of the medical and specialty care resources that are available, or even if they are aware, they don't have access to these resources. Unfortunately, many health care providers, especially those in the private sector, lack the resources to implement care coordination services in a way that will benefit children/youth with special health care needs.

Alaska selected NPM 11 for the CYSHCN domain (percent of children with and without a special health care need having a medical home). The National Survey of Children's Health (2011/2012) reports that 51.9% of all Alaska's children have a medical home compared to 42.8% of CYSHCN according to the National Survey of Children and Youth with Special Healthcare Needs (2009/2010). In 2015, 8% of mothers of 3-year-olds indicated that their child needs or uses more medical care, mental health, or educational services than is usual for most children of the same age, and 4% said that their child is limited in his or her ability to do things most children of the same age can do (CUBS). Additional primary care practice and statewide Medicaid data have been gathered through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. A summary of available data on Alaska Children with Special Health Care Needs was published online in March 2017.

Life Course

Alaska's 2016 high school graduation rates (76.1%) remain below the U.S graduation rate of 83.2% (National Center for Education Statistics & Alaska Department of Education and Early Development 2016). Relative to the general U.S population in 2015, proportionately fewer Alaskan's lived in poverty (10.3% vs. 14.7%); however, there is a disparity between the Alaska Native population (24.2%) compared to the White population (6.6%) (Census Bureau, American Community Survey). In 2017, the Alaska MCH Epi Unit began tracking life course indicators such as these that measure social, economic, and environmental determinants of health as part of a new partnership with the Alaska Children's Trust and the national Kids Count Data Center.

The two life course National Performance Measures Alaska chose were Oral Health and Smoking during Pregnancy/Household Smoking. A State Performance Measure on women reporting discussions with a health care worker during prenatal care about depression was added to address the priority to increase screenings for all MCH

populations for behavioral and mental health problems.

Overall, 20% of Alakan women of childbearing age (18-44 years) are current cigarette smokers (2015 BRFSS). Maternal cigarette use during pregnancy in Alaska has decreased significantly from 20.5% in 1996 to 12.5% in 2015. Although prenatal cigarette use by Alaska Native mothers has also decreased, it remains over twice the average of all Alaskan mothers at 29.4% in 2015 (Alaska Health Analystics and Vital Records). Additionally, prenatal smokeless tobacco use was reported by 17.5% of Alaska Native women who delivered a live birth in 2012-2014, compared to 1% of Non-Native women (PRAMS). The ongoing partnership with the March of Dimes on tobacco cessation activities among pregnant women was recently impeded by the retirement of the Alaska MCH Director for MOD in May 2017 and the suggestion that the position may not be filled in the foreseeable future.

Alaska CUBS data show that 18.1% of mothers reported tooth decay in their 3-year-old child in 2015. This is an increase of 35% since 2008. In 2011-2012, 19.2% of children ages 1 through 17 had decayed teeth or cavities in the past 12 months (NSCH). The Medicaid regulations encouraging a dental visit with the eruption of the 1st tooth and no later than age 1 took effect on April 1st, 2016 and should increase preventive dental visits. Only about 20.9% of children aged 1-2 enrolled in Medicaid for at least 90 continuous days had a preventive dental service in FFY 2015 (AK MMIS CMS-416) .

The bacteria associated with caries are usually passed mother to child so managing dental caries in pregnant women is crucial to targeting at risk children for early dental care. PRAMS data indicate some small increases in oral health indicators among women who recently delivered a live birth in Alaska. The percent of women who had insurance to cover dental care during their pregnancy decreased 79.3% in 2013 to 78.5% in 2014. The prevalence of women who reported getting their teeth cleaned in the 12 months before getting pregnant increased from 60.4% in 2013 to 62.5% in 2014.

In 2014, 75.9% of Alaska women delivering a live birth reported that a health care worker talked with her during any of her prenatal care visits about what to do if she feels depressed during pregnancy or after her baby was born (PRAMS). Additional PRAMS data indiate in 2014, 86.7% of women reported a provider talked with them about post-partum depression, a significant increase from 80.4% in 2009.

Women's/Maternal Health

The top three needs identified for the Women/Maternal health domain in Alaska's 2015 NA were unhealthy relationships; behavioral/mental health problems; and reproductive health (RH) concerns (preventing sexually-transmitted infections, birth control methods, and infertility). Alaska relies on health care providers to provide affordable, culturally competent, comprehensive RH and related preventive health services to women in their childbearing years, and the counseling, education, clinical services essential to assuring that they have the tools and information necessary to make healthy choices. Accordingly, the NPM selected for this domain is "The percent of women with a past year preventive visit" (NPM #1).

In 2014, 53.8% of Alaska women over 18 years of age reported having had a past-year preventive health visit (a routine check-up that was not for injury, illness or a condition) (BRFSS), down from 55.2% the previous year. Also 2.8% of Alaska women who recently gave birth indicated they were physically abused by their husband/partner 12 months pre-pregnancy (PRAMS). Finally, in 2014, 77.9% of Alaska women aged 21-64 received recommended cervical cancer screening compared to 70.3% for Alaska Native women, and the HP2020 target of 93.0%. Similarly in 2014, 68.4% of Alaska women aged 50-64 received breast cancer screening at least once every 2 years, compared to 76% in 2012 and the Healthy People 2020 target of 81.1%. These proportions indicate a continuing decline seen over the past 5 years in these important cancer screenings in Alaska. This decline coincides with changing national recommendations that lengthened the intervals for both cervical and breast cancer screenings and likely contributed to confusion and reduced screenings overall among Alaska women.

With implementation of the provisions of the Affordable Care Act beginning in 2014, and Alaska's Medicaid expansion in September 2015, Alaska women have increased access to low-cost and subsidized health care insurance options that, hopefully, will stem the tide of decline in seeking critical preventive health services in coming years.

In support of the findings of the 5-year NA, WCFH Adult Health Unit staff continue to collaborate with other DPH sections and the Alaska Primary Care Association in efforts to establish baselines for comprehensive RH service provision and related preventive health services to Alaska women in their childbearing years.

Perinatal/Infant Health

Alaska's 2013 infant mortality rate (IMR) was 5.7/1,000 births, compared to 5.96 for the U.S. IMR for neonates was 2.6 and 3.1 for post-neonates; compared to U.S. rates of 4.4, and 1.93 respectively. In 2014, Alaska's IMR increased to 6.6/1,000; with neonatal and post-neonate rates at 3.0; and 3.6, respectively.

In 2014, 5.9% of all Alaskan births were low birth weight (< 2,500 grams) and 0.9% were very low birth weight (< 1500 grams). In 2014, 74.5% of Alaskan infants weighing less than 1,000 grams were born in a hospital level III+ Newborn Intensive Care Unit. In the same year, 10.2% of births were preterm and 1.5% were early preterm. After increasing during 1989-2006, the proportion of infants born preterm has remained relatively stable in Alaska since 2007.

The Alaska Native and non-Native disparity in Sudden Unexpected Infant Death (SUID) rates persists, particularly in rural areas. Substance use and unsafe sleep practices are leading contributing factors for infant mortality. From 2012 through 2014, 66 Alaskan infants died in a sleep environment. Over 90% of these deaths occurred among families with low socioeconomic status; 85% occurred in an unsafe location; 67% involved sharing a sleep surface; and 44% involved a caregiver who was using alcohol, tobacco, or other substances at the time of death. From 2005 to 2014, the annual rate of Neonatal Abstinence Syndrome among Medicaid-eligible births increased from 1.0 per 1,000 to 6.4 per 1,000 births.

Alaska Maternal Infant Mortality Review (MIMR) committee conducts ongoing activities to improve timeliness of reviews and the dissemination of findings related to primary prevention. For example, participation in the national SUID case registry system, and coordinating a two day "blitz" case review in May 2015, which resulted in 22 individual recommendations. Public comment from the 2015 Needs Assessment indicated a desire for more home visiting services. The Maternal, Infant, and Early Childhood Home Visiting program expanded to serve the Mat-Su Borough in addition to Anchorage. This will provide services to an additional 100 at-risk, low-income first time mothers and their children.

Finding of the five year needs assessment were operationalized into the Infant Mortality CoIIN, and include activities around substance use, smoking cessation, safe sleep practices, and pre and interconception health. These efforts are described throughout the Plan for the Application Year and Annual Report.

Child Health

Reducing the rate of child maltreatment and increasing access to preventive health services for Alaskans and their families were identified in our FY2016 Block Grant application as the priority need for this domain. The rate of unique substantiated child maltreatment victims per 1,000 children aged 0-17 years has been on a downward trend since 2008, although the rate of 13.3 in 2014 was a slight increase compared to 13.0 in 2013 (NCANDS). The leading cause of fatal injuries among Alaska children ages 1-4 during 2010-2014 was assault, followed by drowning, while drowning was the leading cause of fatal injury among children ages 5-9. Recent NSCH data on the percentage of children who have received a developmental screening (NPM #6) is currently unavailable. According to Alaska CUBS, the percent of 3-year-olds who have seen a health care provider for routine medical care such as a well-child check-up for physical exam has not significantly changed in the past five years, and was 83.5% in 2014.

WCFH reorganized its units and combined the child and adolescent populations into one unit. This will help assure that the needs of school-aged children are considered along the continuum as they move into adolescence. The School Nursing and School Health program has continued to support improving health outcomes for school-aged children. This program also initiated a statewide data collection system with schools that employ school nurses to collect information on the types of special needs their students have, the numbers of visits to school nurses and the disposition of that visit among other data. The CUBS survey continues to collect population-based data from mothers of 3-year-olds. New partnerships for the SCAN program include data sharing agreements with 9 out of the 12 Child Advocacy Centers operating in Alaska, resulting in increased collaboration and data sharing.

Adolescent Health

Changes in the strengths and needs of the adolescent population were analyzed using the 2015 Youth Risk Behavior Survey results. Many of the indicators did not have a statistically significantly change, however, both short-term and longer term trends show an increase in the percentage of students feeling sad or hopeless (33.6% in 2015). There has also been a corresponding increase in the percentage of students who say they feel alone (24.8% in 2015). As well, between 2013 and 2015 there was an increase in the percentage of students seriously considering suicide (20.1% in 2015).

Changes in the Title V program capacity and established program collaboration/partnerships included acceptance into the Child Safety CoIIN, supported by the Children's Safety Network to prevent interpersonal violence, specifically bullying and suicide prevention. Alaska was one of four states in the nation selected to collaborate with the Association of State and Territorial Health Officials (ASTHO) and the CDC Division of Violence Prevention, National Center for Injury Prevention and Control to strengthen the State's ability to prevent sexual violence. As a capacity building strategy, the Title V program submitted an application to receive a CDC Public Health Associate Program associate to focus on bullying prevention work in Alaska starting in fall of 2016 but was not selected.

Activities to operationalize the three major adolescent health needs identified in the NA process included hosting a statewide youth leadership summit focused on healthy relationships called Lead On! in November 2015 and launching an evidence-based intervention, *Bringing in the Bystander,* at the University of Alaska Anchorage that reached over 400 students from August 2015 – April 2016. The Adolescent Health Program staff worked extensively with the Alaska Safe Children's Act Taskforce, which is providing recommendations to the Department of Education and Early Development on new legislation that stipulate that school districts in Alaska must train employees and students on sexual abuse prevention (K-12) and dating violence and abuse prevention (grades 7-12). The *Alaska Fourth R Healthy Relationship Program* for grades 7-9 that teaches healthy relationship skills and empowers adolescents to make healthier decisions about relationships, sexual behavior, and substance use continued to expand. Over 300 school staff and community partners throughout Alaska are trained to teach the *"Fourth R"* and 81 schools have received the curricula and training materials

Children and Youth with Special Health Care Needs

Alaska selected NPM 11 for the CYSHCN domain (percent of children with and without a special health care need having a medical home). The National Survey of Children's Health (2011/2012) reports that 51.9% of all Alaska's children have a medical home compared to 42.8% of CYSHCN according to the National Survey of Children and Youth with Special Healthcare Needs (2009/2010). Although no new national data is available on the CYSHCN population in Alaska, statewide activities continue to assess needs and response to activities using Title V Block Grant Needs Assessment, program evaluation and quality improvement methodology. Additional primary care practice and statewide Medicaid data were gathered in the past year through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. CAHPS data has been aggregated and will be analyzed for further insight into Alaska's CYSHCN population by the WCFH MCH Epidemiology Unit staff who are heavily supported by Title V block grant funding.

Alaska's Title V Block Grant also supports Parent Navigation services provided by the Stone Soup Group. This organization is Alaska's Family to Family Health Information Center is a peer mentorship model used to help guide families of children with new diagnoses through the complex system of care and funding streams to obtain needed services and supports.

Life Course

Life Course Theory is a framework for conceptualizing health and disease patterns over a lifetime and across generations by studying a broad array of both risk and protective factors, such as social, economic, and environmental determinants. The data listed below reflects some of Alaska's life course related population status indicators.

- Alaska's high school graduation rates (71%) have remained below the U.S graduation rate of 82.3% (National Center for Education Statistics)
- Relative to the general U.S population in 2014, proportionately fewer Alaskan's lived in poverty (11.2% vs. 14.8%). However, there is a disparity between the Alaska Native population (22.1%) compared to the White population (7%) who lived in poverty. (Census Bureau, American Community Survey)
- In 2014, 5.2% of Alaskan mothers of 3-year-olds were homeless at some point since their child was born (CUBS)

The two life course National Performance Measures Alaska chose were NPM#13, percent of women who had a dental visit during pregnancy and children who had a preventative dental visit in the last year and NPM#14, percent of women who smoked during pregnancy and percent of children who live in households where someone smokes.

According to 2013 PRAMS data, 13.36% of women reported they smoked cigarettes during the last three months of pregnancy and 2.5% of women said they allowed smoking inside their home.

In February 2015, marijuana became legal for recreational use. In 2013, while marijuana was still illegal, 14% of women who had recently delivered a live birth reported smoking marijuana or hash during the 12 months prior to getting pregnant. Among women receiving WIC benefits during their pregnancy and who delivered their infant during 2013, 9.6% smoked marijuana prenatally and 21.8% smoked cigarette tobacco during pregnancy, 2.5 and 3.3 times higher than non-WIC respondents, respectively.

Alaska CUBS data showed that 17.5% of mothers reported tooth decay in their 3 year old child in 2014. This is an increase over the past 5 years. In 2011-2012 18.8% of children ages 1 through 17 had decayed teeth or cavities in the past 12 months (NSCH). The Medicaid regulations encouraging a dental visit with the eruption of the 1st tooth and no later than age 1 took effect on April 1st, 2016 and should increase preventive dental visits. Only about 19% of children aged 1-2 enrolled in Medicaid for at least 90 continuous days had a preventive dental service in FFY2014. The US Preventive Health Services Task Force released recommendations for fluoride varnish by primary care providers in 2014 which would allow for coverage in insurance plans.

The bacteria associated with caries are usually passed mother to child so managing dental caries in pregnant women is crucial to targeting at risk children for early dental care. Studies showing parents with access to dental care are more likely to seek dental care for their children. PRAMS data indicate some small increases in oral health indicators among women who recently delivered a live birth in Alaska. The percent of women who had insurance to cover dental care during their pregnancy increased from 77.1% in 2012 to 79.3% in 2013. The prevalence of women who reported getting their teeth cleaned in the 12 months before getting pregnant increased from 57.8% in 2012 to 60.4% in 2013. Likewise the prevalence of women who had their teeth cleaned during pregnancy was 47.9% in 2012 and 52.0% in 2013.

PRAMS data shows that women who recently delivered a live birth and had a provider talk to them about post-partum depression since their baby was born has been improving. In 2013, 86.1% of women reported a provider talked with them about post-partum depression which significantly increased from 80.4% in 2009. Also, in 2013, 6.73% of Alaska women reported that they often or always felt down, depressed, or hopeless after giving birth.

Five-Year Needs Assessment Summary
(as submitted with the FY 2016 Application/FY 2014 Annual Report)

II.B.1. Process

Goals and Framework

In Alaska, the Title V program is managed by the Department of Health and Social Services (DHSS), Division of Public Health (DPH), Section of Women's Children's and Family Health (WCFH). The programs in WCFH are guided by the maternal and child health (MCH) pyramid of health services, and stress improving health status, assuring health service access, and eliminating health disparities in present and future generations of Alaskans. Our target populations include pregnant women and infants, children and adolescents, children and youth with special health care needs, those with low income status and those with limited access to health services.

Every 5 years, each state receiving Title V funds conducts an assessment of MCH needs to reconfirm or realign its priorities for the next 5 years. The ultimate goals of the Needs Assessment (NA) are improved outcomes for MCH populations and strengthened partnerships. To achieve these goals, the federal MCH Bureau identified ten steps as part of the State Title V MCH NA Framework. More information about the Framework is available here.

In addition to the 5-Year NA, WCFH leadership staff assesses Alaska's MCH needs on an on-going basis. Our ongoing assessment activities revolve around meeting with advisory committees; participating in other organizations' committees; partnering with other agencies on program implementation; and surveillance and research.

Stakeholder Involvement

WCFH works with and sponsors numerous advisory committees composed of health care providers, parents, consumers, coalition members, and public health staff from across Alaska. They meet on a regular basis to provide input on programs' needs, assess quality, and provide ideas for future directions. In the 2015 NA, the NA Coordinator began by meeting with the Advisory Committees for School Nursing, Newborn Metabolic Screening, and Patient Centered Medical Home to conduct focus groups to get qualitative data on health concerns and ideas for improvement. Similar qualitative questions as well as quantitative questions were included in an online survey implemented Oct - Dec 2014. The survey yielded 1,065 individual responses and over 3,500 total comments. Respondents self-identified as health care professionals (24%), state health department employees (21%), Alaska residents (17%), parents/guardians (15%), community service providers (14%), employees of other state agencies (4%), advisory council or coalition members (3%), and consumers of local health services and programs for pregnant women, infants, children or youth (2%). The majority (54%) lived in the Anchorage/Mat-Su region, while the rest were from the Southeast (16%), Gulf Coast (12%), Interior (11%), Southwest (5%), and Northern (3%) regions.

Quantitative and Qualitative Methods

For each domain, the survey asked respondents to rank the top 3 major health concerns, as well as to indicate where improvement was needed for a variety of relevant health services. Qualitative data was collected through comment boxes, as well as two questions that asked what the state maternal child public health system is doing well and what one intervention they would choose to improve any of Alaska's MCH populations. All comments were reviewed by two WCFH staff who pulled out major themes into a summary document that was shared with WCFH Leadership. The quantitative data were summarized by Survey Monkey with additional manipulation by an MCH Epidemiologist. Full survey results are attached.

Additional qualitative information is collected on an ongoing basis from WCFH advisory committees year-round and feedback is solicited at presentations at conferences or meetings and during community visits across Alaska. As part of the grant application process, WCFH requests partners to report on activities supporting the MCH priorities and progress made towards the state and national performance measures. The narratives and data provide documentation of how activities and partnerships are supporting MCH priorities.

Data Sources

Other data sources for the NA included surveillance programs managed by the MCH Epidemiology ("Epi") Unit in WCFH (Alaska PRAMS, the Alaska Childhood Understanding Behaviors Survey - CUBS, MCH Indicators, Surveillance of Child

Abuse and Neglect - SCAN, the Alaska Birth Defects Registry - ABDR, and the Maternal-Infant Mortality Review-Child Death Review - MIMR-CDR). Epidemiologists regularly access, link and analyze data from the Bureau of Vital Statistics, WIC, Office of Children's Services (OCS), and Medicaid. Other major data sources were:

- Trauma Registry
- Behavioral Risk Factor Surveillance System (BRFSS)
- Youth Risk Behavior Survey (YRBS)
- Alaska Oral Health Survey
- Department of Labor population estimates
- National Survey of Child Health (NSCH)

The 2014 Alaska MCH Data Book: Life Course Edition summarized data from many of the above sources and informed the NA process.

Finalization

The above data informed the NA process and were integral to the selection and finalization of the state's priority needs. The WCFH Leadership Team worked in groups organized by population domain to complete a prioritization matrix based on Hanlon method criteria. The prioritization process is discussed in detail in Section II.C *State Selected Priorities*. The Leadership Team then used the state priorities and selected National Performance Measures to develop the 5 year Action Plan. This is further discussed in Section II.F.1 *State Action Plan and Strategies.*

II.B.2. Findings

II.B.2.a. MCH Population Needs

Women's/Maternal Health

During 2009-2011, 9.2% of Alaska women reported that they often or always felt down, depressed, or sad after giving birth. This was reported more often among Alaska Native women (12.5%) than White women (8.1%). In 2011, 3.5% of Alaska women who recently gave birth indicated they were physically abused by their husband/partner 12 months pre-pregnancy, and 2.7% reported physical abuse during pregnancy. In 2012, 76% of Alaska women aged 50-64 received breast cancer screening at least once every 2 years, compared to the Healthy People 2020 target of 81.1%. In the same year, 86% of Alaska women aged 21-64 received recommended cervical cancer screening, compared to the HP2020 target of 93.0%. The top 3 needs identified for the Women/Maternal health domain in Alaska's 2015 5-year NA were: 1) unhealthy relationships; 2) behavioral/mental health problems; and 3) reproductive health (RH) concerns (preventing sexually-transmitted infections, birth control methods, and infertility). The NA process identified the priority need to increase access to RH services that adhere to national best practice guidelines. The new administration elected in 2015 is committed to expand Alaska's Medicaid program, which will relieve some of the financial barriers to access to care if implemented. Furthermore, inclusion of RH care in the Essential Health Benefits package under the Affordable Care Act also helped to increase access to affordable preventive health care.

The NPM selected for this domain is "The percent of women with a past year preventive visit" (NPM #1). In 2013, 62.3% of Alaska women over 18 years of age reported having had a past-year preventive health visit (a routine check-up that was not for injury, illness or a condition) (BRFSS). This measure is linked with a range of National Outcome Measures including severe maternal morbidity and mortality, low and very low birth weight, preterm birth, and infant mortality which represent priorities in Alaska and are discussed later in the application. Alaska relies on health care providers to provide affordable, culturally competent, comprehensive RH and related preventive health services to women in their childbearing years and the counseling, education, screening and clinical services essential to assuring that they have the tools and information necessary to make healthy choices.

Alaska remains among the highest in the nation in the rate of Chlamydia trachomatis, with an incidence rate of 778 cases per 100,000 persons in 2014. Of these, 68% were in females, of whom 1% developed pelvic inflammatory disease (PID), and 81% were in persons ≤29 years old. Chlamydia rates were highest in non-Hispanic American Indian/Alaska Native (AI/AN) people, Native Hawaiian/Pacific Islanders, and Blacks. Increasing the availability of culturally competent RH care providers throughout Alaska, particularly in rural and remote parts of the state, is the best way to reach women in their

childbearing years.

Low-/no-cost, comprehensive well-visits, including family planning services, contraceptive methods, STD testing and treatment, RH-related counseling and patient education, and referral to a medical home are provided through contracts with Advanced Practice Registered Nurses (APRNs) in only two communities of Alaska for women < 21 years old using Title V funds; and to two additional communities via the State's Title X grant for individuals of all ages. In addition to direct services, education is offered to reduce teen pregnancy through healthy relationships education and prevention of date rape, unintended pregnancy and reproductive life planning. Other rural and remote communities rely on itinerant APRNs and some Physician's Assistants, but with frequent staff turnover, access is inconsistent and oftentimes, the providers are not experienced in comprehensive adolescent and women's health, including the use of LARCS and preventive health strategies.

WCFH Adult Health Unit staff continue to collaborate with other DPH sections and the Alaska Primary Care Association on efforts to: provide access to clinical education on RH and related preventive health topics for Community Health Center (CHC) staffs; offer technical assistance to CHCs in systems improvement and expansion of their women's health services within the primary care setting; and share data/data collection tools for monitoring health care system capacity, gaps, and resources. With over 150 CHCs in Alaska, there still remains a significant amount of work.

Perinatal/Infant Health

In 2012, Alaska's infant mortality rate (IMR) was 5.18 per 1,000 births, significantly lower than the national rate of 5.98. Postneonatal mortality rates in Alaska are consistently higher than national rates, while neonatal mortality rates are lower. During 2009-2012, 67% of infant deaths occurred among infants who were low birth weight (< 2,500 g). In 2013, 5.8% of Alaska births were low birth weight and 1% were very low birth weight (VLBW = < 1500 g.), while 8.5% were preterm and 2.2% were early preterm; 79% of VLBW infants were born in a hospital with a level III+ NICU.

The MIMR-CDR committee convenes regularly to review out-of-hospital infant deaths, and as of Dec 2014 had reviewed 100% of all postneonatal deaths through 2012. The leading cause of non-hospitalized infant deaths ascertained by MIMR-CDR is sudden unexpected infant death (SUID). The committee assesses whether substance use contributed to each death based on evidence of impairment in the time immediately preceding the death. During 2008-2012, the committee determined that substance use contributed, probably contributed, or possibly contributed to 67 deaths reviewed (36%). Of the known causes of death, substance use was most likely to have contributed to deaths with a cause of SUID. The committee identified alcohol as contributing to 37 deaths, tobacco to 34, marijuana to 19, and heroin, methadone or other opioids as contributing to 12.

The 2015 NA identified four needs for Alaska's Perinatal/Infant Health domain: 1) child maltreatment; 2) substance abuse among families; 3) poor nutritional health; 4) vaccine preventable diseases. WCFH staff identified child maltreatment as a life course cross cutting health issue and so it will be addressed in that domain. The priority need that Alaska identified through the NA process for the Perinatal/Infant Health domain is to reduce substance abuse among families, including alcohol, tobacco, and drugs. This need is strongly associated with child maltreatment. Alaska selected three NPMs associated with this priority: 1) Percent of VLBW infants born in a hospital with a level III+ Neonatal Intensive Care Unit (NPM#3); 2) Percent of infants placed to sleep on their backs (NPM#5); 3) Percent of women who smoke during pregnancy and percent of children who live in households where someone smokes (NPM#14). All three are related to NOMs for infant mortality (including age- and cause-specific infant mortality rates), while NPM#14 is also associated with NOMs for maternal morbidity and mortality, preterm birth, and the health of children.

Data shows that 13.6% of women in Alaska smoked during pregnancy in 2013 (NVSS) and 29.5% of children lived in a household where someone smokes during 2011-2012 (NSCH). Access to screening, referral, and treatment for women who use alcohol, tobacco and other substances, is not consistently available statewide. DPH and the Alaska Native Tribal Health Consortium (ANTHC) convened an Early Prenatal Care work group in 2014. This group recommended that Medicaid be expanded and that alcohol, tobacco, and other substance screening and referral services should be made available for women of reproductive age and pregnant women. This group further recommended that those desiring to avoid pregnancy be assisted to receive both contraceptive care and alcohol, tobacco, and/or substance treatment prior to the time when they planned to become pregnant.

The disparity in infant mortality between Alaska Native and non-Native people has improved since the early 1980s but still

persists, particularly in rural areas.

An annual report with the findings of MIMR reviews of infant deaths during 2008-2012 was published in summer 2015. MIMR is currently conducting quality improvement activities to increase the timeliness of reviews and the dissemination of findings related to primary prevention. The Maternal, Infant & Early Childhood Home Visiting (MIECHV) and Healthy Start Programs provide case management and home based services for pregnant women and mothers with babies up to two years of age for families living in Anchorage and the rural Nome census areas, respectively. The NA identified these programs as providing needed and beneficial services. MIECHV program will expand into the Matanuska-Susitna region beginning in mid-2015. However, with lack of HRSA funding, the Healthy Start program will terminate services in mid-2016, leaving no rural prenatal-infant program of this kind in place. In addition, state funding for other short term home visiting programs such as Parents as Teachers and Early Head Start has been dramatically cut or entirely eliminated.

See more information on efforts to improve health status in this domain in the “Emerging Issues” section.

Child Health

In 2011-2012, 88.5% of Alaska children were in excellent health, compared to 84.2% nationally (NSCH). However, chronic conditions in children and youth are on the rise nationally. In the 2014-15 school year in the Anchorage School District (with a student population of 48,154), 14% of students had a diagnosis of asthma, 3% had Type 1 diabetes, .05% had Type 2 diabetes, 1.3% were diagnosed with a seizure disorder, and 3% had a life-threatening, anaphylactic allergy. In 2013, 12% of youth in the Anchorage School District had a mental health diagnosis, such as depression. In 2013, 33% of Alaska students were obese or overweight (YRBS), and during 2008-2012, 40.7% of 3-year-olds were overweight or obese (CUBS). In 2012, overweight or obesity was more common among Alaska Native 3-year-olds (63.4%) compared to White 3-year-olds (37.0%).

The 3 major child health needs identified in the 5 year NA survey were 1) behavioral and mental health problems, 2) child maltreatment, and 3) obesity. Increasing access and preventive health services to Alaskans and their families was selected as the priority need for this domain. The selected NPM is percent of children ages 9 - 71 months receiving a developmental screening using a parent-completed screening tool (NPM#6). This is associated with NOMs related to child health and school readiness. During 2011 to 2012, 32.6% of Alaska children ages 9 - 71 months received a developmental screening using a parent-completed screening tool. In the same years, 63.2% of children with a mental or behavioral condition received treatment or counseling.

The state’s Title V program has historically chosen to focus efforts on improving the oral health status of children as well as work to support school nursing and school health programs that have a significant impact on the outcomes of health for school aged children. In addition, Title V works in collaboration with the Early Childhood Comprehensive Systems (ECCS) program to promote developmental screening at all ages and with the Medicaid EPSDT program to promote well child visits, particularly after age 5, at which time there is a dramatic decline in the number of children who seen for annual preventive health care.

School districts struggle to meet financial burdens with diminishing state funding. Most school nursing services are funded from school district budgets and these services may be decreased as districts look for programs to cut. Many districts do not employ school nurses, and gaps in health services for students in these districts are numerous. Currently, approximately 235 school nurses provide health services in 17 of the 54 districts across Alaska. The Department of Education and Early Development (DEED) indicates that 131,875 students are enrolled for school year 2014-2015. Approximately 70% of these students have some degree of school nursing services to attend to their healthcare needs at school. However, in 8 of the 17 districts, the nurse-to-student ratio is lacking with one school nurse covering up to 8 schools. Another 15,000 Alaska students have no access to a school nurse. MCH collaboration and partnership with the DEED and other agencies/organizations serves to educate school districts, legislators and other entities regarding the cost-benefit of school nursing programs.

The September 2000 Surgeon General’s Report on “Oral Health in America” noted that despite the role of water fluoridation and later topical fluorides and dental sealants in reducing dental decay, tooth decay remains the most common chronic disease of childhood. Dental assessments conducted by the Alaska Oral Health Program in the 2010/2011 school year found 41% of kindergartners and 62% of third-graders had experienced dental decay. The prevalence of dental decay was higher in AI/AN children at 63% for kindergarteners and 83% for third-graders. Prevalence also was higher in students from other racial/ethnic minority groups.

While there has been increased interest in water fluoridation in some rural areas of the state, this public health approach has faced opposition in a number of urban areas. Several larger communities, including Fairbanks and Juneau, have discontinued fluoridation over the past eight years. In addition, access to dental care remains a significant issue in remote villages which may only see dental therapists or itinerant dental teams a few weeks each year. Title V support for development of school-based sealant programs and access to dental services offers an opportunity to address prevention and early intervention programs to provide dental services for underserved children, including those without a “dental home”.

Adolescent Health

Compared to traditional U.S. high school students, Alaska youth are more likely to report not attending a daily physical exercise class, though they are less likely to report drinking at least one soda per day (YRBS). Alaska youth also are less likely to report being a current cigarette smoker and current alcohol drinker.

In 2013, Alaska had a teen birth rate of 29.7 births per 1,000 young women aged 15-19, which is above the national teen birth rate of 26.6 births per 1,000. In 2013, Alaska reported substantial geographic variation in adolescent childbearing, with teen birth rates among women aged 15-19 at 65.3 births per 1,000 in the northern region and 59.9 births per 1,000 in the southwest region. Likewise, youth are overrepresented in the gonorrhea and chlamydia cases in Alaska.

Intentional self-harm is a leading cause of fatal injuries and attempted suicide is the leading cause of non-fatal hospitalized injuries for ages 15-34. Alaska Native men ages 15-24 have the highest rate of suicide among any demographic in the country, with an average of 141.6 suicides per 100,000 each year between 2000 and 2009. Youth who are exposed to suicide or suicidal behaviors are more at-risk for attempting suicide. In 2013, 22% of Alaska males and 11% of females reported that they had seriously considered attempting suicide in the past 12 months (YRBS).

While the majority of Alaskan youth are in healthy relationships, in 2013, 14.7% of alternative high school students and 9.1% of traditional high school students reported being physically hurt on purpose one or more times in the last 12 months by someone they were dating or going out with (YRBS). Additionally, 5.3% of the male and 13.2% of the female high school students reported being forced to have sexual intercourse. These numbers increased for alternative high school students with 8.1% of males, and 24.9% of females reporting being physically forced to have sexual intercourse.

There were three major adolescent health needs identified in the NA process: 1) unhealthy relationships, 2) child maltreatment, and 3) behavioral and mental health. The priority need that Alaska identified for the Adolescent Health domain is to increase healthy relationships. The NPM selected is percent of adolescents, ages 12-17, who are bullied (NPM#9). This is linked to NOMs of adolescent mortality and adolescent suicide.

Adolescent health needs include addressing peer-to-peer maltreatment, including teen dating violence, bullying, and cyber bullying. Other important issues include homelessness, “throw away” youth, and sex trafficking. Strengths include the collaborative efforts across the state to promote and support prevention activities; however, efforts are not always well coordinated and intervention services are not readily available in all communities. Behavioral and mental health services are needed across the state for adolescents. Inpatient and outpatient treatment services are spotty and not available in all communities. In addition, community health care providers often lack the knowledge on how best to treat adolescents who experience mental and behavioral health issues, especially when mixed with substance abuse. Finally, there is a lack of health care services in rural Alaska to address the specific needs of youth.

The Adolescent Health Program (AHP) works to promote positive youth development and prevent or reduce negative health outcomes. This program successfully partners with communities and manages grants to prevent and reduce unintended pregnancy, youth violence, and sexually transmitted infection. The AHP staff works across the state to promote healthy relationships and reduce risky behaviors in the lives of adolescents and to encourage family, school and community involvement in the lives of youth through technical assistance, trainings, and resources. With CDC Rape Prevention Education Program funds, the AHP implements primary prevention strategies to reduce the prevalence of sexual assault at universities and to train school counselors. The Fourth R curriculum teaches healthy relationship skills and empowers adolescents to make healthier decisions about relationships, sexual behavior, and substance use. With HHS Office of Adolescent Health funds a teenage pregnancy prevention program with trained peer educators. New and enhanced strategies/program efforts are needed to widely disseminate Alaska specific information about adolescents. In the coming year the AHP will update their website and include fact sheets and resources to better communicate the unique needs of

adolescents and the unique role of the AHP.

TANF funding allows the AHP to initiate programming on healthy relationship development, pregnancy prevention, and RH training and services offered to regions in the state with the highest rates of teen and out of wedlock births. Sadly, the funding for this effort supplied by the Division of Public Assistance (DPA) was cut by 25% for the coming year and likely will suffer further cuts due to the state's fiscal crisis.

Children and Youth with Special Health Care Needs

Children ages 0-18 years comprise approximately 26% of Alaska's population. In 2011-2012, approximately 14% of Alaska's children had special health care needs (NSCH). Alaskan families of children and youth with special health care needs (CYSHCN) face a host of challenges. Many lack awareness of, or access to, available medical and specialty care resources. Navigating between separate health care, social services and educational systems can be overwhelming. Some families go without needed services due to the lack of availability of specialty practitioners (i.e. OT, PT, speech, behavioral). Many families have limited or no access to family support services and experience caregiver fatigue and/or employment issues.

Health disparities are exacerbated by the lack of resources in rural areas and the general lack of specialty services available in the state. The geographic isolation of rural communities means significant challenges in assuring CYSHCN have access to preventive, acute, and specialty care. Turn-over for primary health care providers and community health aides in non-urban practices poses a challenge to providing routine care; continuity in care and access to specialized services for CYSHCN is nearly non-existent.

The top three major health concerns identified on the NA survey were: 1) behavioral and mental health problems, 2) social isolation, and 3) bullying. Respondents also expressed a high level of concern regarding the availability of specialty health care and family support/respite care. Although the topic of CYSHCN "transition" did not rank in the top areas of concern, gaps in this area were noted in survey comments. The priority need identified was to improve systems of care. The need for systems integration is consistent with previous Title V priorities and current activities. The NPM selected for the CYSHCN domain is percent of children with and without a special health care need having a medical home (NPM#11). This was 39.6% of children in 2011-2012 (NSCH), and is associated with a variety of NOMs around child health, including vaccination status.

Strengths of the system referenced in survey comments include the high quality of specialty services, when available. Additional strengths are Title V partnerships with a variety of CYSHCN advocacy agencies such as the Stone Soup Group (Alaska's Family Voices and Family to Family Health Information Center) and the Governor's Council on Disabilities and Special Education. Three parent navigator positions at Stone Soup Group (funded through Title V) provide general information and family resources as well as tailored care coordination for families served by state sponsored pediatric clinics. Stone Soup Group provides support and training to approximately 900-1000 families of CYSHCN statewide annually.

Clinics (neurodevelopmental screening, genetics, metabolic, and cleft lip and palate) coordinated by Title V for underserved rural regions allow CYSHCN to be seen in Alaska and decrease the family and payer out-of-state travel burden. During SFY14, 82 children were screened in neurodevelopmental, 193 children were seen in genetics, 54 in metabolic, and 114 in cleft clinics. While these clinics meet a significant need in the community, Title V is does not have the capacity to meet the demand for clinic appointments, and wait times for appointments, particularly in the area of neurodevelopmental conditions, is sometime more than 4-6 months. Title V and CYSCHN staff are working with partners such as the Mental Health Trust Authority, Early Intervention/Infant Learning Program (EI/ILP), Children's Hospital at Providence leadership, Stone Soup Group, and the Alaska LEND program to investigate other models for diagnosis as well as community models for early intervention and intensive treatment. This work is particularly critical as the state's only pediatric neurodevelopmental physician has cut back to half time and is planning to retire at the end of December.

Patient-centered medical home (PCMH) program development directly impacts the stated priority "to improve systems of care for CYSHCN." The fee-for-service environment is a challenge to medical home funding. Strong partnerships and current efforts funded by HRSA continue to build and integrate pediatric systems and facilitate family involvement. The PCMH Program currently has 5 family steering committee members and actively recruits and welcomes additional families of CYSHCN. These families collaborate with program staff and partner on community resource development, state planning and training development. Families are offered an honorarium when participation falls outside of their paid professional role.

Families of CYSHCN experience disparity in emergency preparedness. Alaska is at risk for eight significant types of natural and man-made disasters. Due to the size of the state and distance from the contiguous United States, emergency supplies

and response may take days to arrive if a disaster occurred. Less than 20% of families of CYSHCN have a written plan and only 50% have enough supplies (e.g. food, water, and medication) to shelter in place for three days. The Alaska Health and Disability Program has a 60% participation rate of families (27 of 45 members) on the steering committee. These families are involved in the majority of activities and were instrumental in the development of the strategic plan. Families are not compensated.

Life Course

Life Course Theory is a population-focused framework that is firmly rooted in social determinants of health and social equity models. Poverty and high school graduation are two key indicators of life course health, as they reflect economic experiences, social capital, and health trajectories. Relative to the general U.S population in 2012, proportionately fewer Alaskans lived in poverty (10.1% vs. 15.9%). However, there is a disparity between the Alaska Native population (22.4%) compared to the White population (6.6%) who lived in poverty. Poverty contributes to stress for families as well as barriers to provision of an optimal environment for young children. During 2012-2013, 3.4% of Alaskan mothers of 3-year-olds were homeless at some point since their child was born (CUBS). High school graduation rates continue to increase in Alaska, with 71.8% of students graduating in 2013. Graduation rates are associated with early educational success and proficiency. In 2013, Alaska's fourth grade students were less proficient in both reading (27%) and math (37%) than U.S students (34% and 42%) (National Center for Education Statistics).

There is emerging evidence that positive mental health is associated with improved health outcomes across the life course. In 2012, CUBS surveyed mothers of 3-year-olds on their experience of emotional trauma, defined as any report of the following: being diagnosed with depression, someone close had a problem with drinking or drugs, someone close was depressed, mentally ill or suicidal, or someone close died. Overall, 41.7% reported some form of emotional trauma since their child was born (63.2% of Alaska Native mothers and 34.9% of White mothers). In 2013, 35.7% of Alaska high school females and 19.0% of high school males "felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months" (YRBS).

Alaska's 2015 NA identified two priority needs that were cross-cutting or life course: reducing rates of child maltreatment and increasing evidence-based screening for all MCH populations for behavioral and mental health problems. Availability of services was also identified as a need across all MCH populations. The NPM associated with the priority to reduce child maltreatment is the rate of injury-related hospital admissions per population ages 0 through 19 years (NPM#7). This is linked to NOMs for adolescent and child mortality. The two NPMs associated with the priority to increase screening for behavioral and mental health problems are: 1) percent of children ages 9-71 months, receiving a developmental screening using a parent-completed screening tool (NPM#6), and 2) percent of adolescents ages 12 through 17 years who are bullied (NPM#9). These are linked to NOMs for child health, school readiness, and adolescent mortality.

The National Child Abuse and Neglect Data System collects case-level data on all allegations of abuse and neglect that receive a response from state Child Protective Service agencies (OCS in Alaska). In 2012, there were 15.6 reports of substantiated maltreatment per 1,000 children aged 0-18 years in Alaska, compared to 9.2 per 1,000 children nationally.

The MIMR committee assesses whether abuse, neglect, or negligence contributed to each death. Among the 184 reviewed infant deaths from 2008-2012, the committee found that 64 (35%) were associated or probably associated with at least one type of maltreatment. The proportion of reviewed deaths associated with maltreatment varied within cause of death categories, ranging from 13% of deaths due to congenital anomalies and preterm births to 82% of deaths due to injury. During 2004-2012, the overall infant mortality trend has significantly declined, while the maltreatment-related trend has remained flat at nearly 1.0 per 1,000 live births.

Adverse childhood experiences (ACEs) are negative incidents of emotional, physical, or sexual abuse, and household dysfunction experienced prior to age 18 years old. The accumulation of ACEs puts individuals at risk for a wide variety of mental physical and emotional health problems in adulthood. During 2011-2012, Alaskan children aged 0-17 years were more likely than U.S children to have experienced two or more ACEs (25.8% vs. 22.6%).

Comprehensive access to behavioral and mental health services in Alaska is lacking across all populations. Screening for behavioral health issues is inconsistent and not always performed using evidenced based tools. When identified, services are frequently unavailable or inappropriate for pregnant and postpartum women, children or CYSCHN populations. For women, there can be negative health effects of poor mental health that impact the women but these effects can also be

transmitted to subsequent generations. For example, perinatal depression which occurs among women during pregnancy or within a year after delivery is also associated with chronic disease, substance abuse, suicide and negative impacts on child development.

Title V supports strong efforts to collect data related to life course indicators, in particular through SCAN, PRAMS, and CUBS. The Alaska MCH Data Book 2014: Life Course Edition, published by the MCH Epi Unit in WCFH in September 2014, has received positive anecdotal reviews and feedback. No formal evaluation has been done, so it is unknown how the data book is being used.

Multiple collaborative efforts and partnerships support the life course work for child maltreatment prevention and the development of behavioral health screening. The SCAN program has partnered closely with the Anchorage Community Mental Health Clinic to improve the translation of data into clinical practice. This partnership has resulted in multiple combined presentations with both epidemiologic and clinical information being shared to inform practice. WCFH collaborates with the Children's Justice Act Task Force to improve the system responding to child maltreatment, focusing on improving laws, educating mandatory reporters, and supporting the development of multi-disciplinary teams for evaluating suspected child sexual and severe physical abuse.

Integrated strategies and program efforts to address factors that impact health across the life course are needed. These factors include community influences such as poverty, household food insecurity, homelessness, homicide and community violence, incarceration, and school readiness, as well as policies such as support for baby-friendly hospitals and water fluoridation.

II.B.2.b Title V Program Capacity

II.B.2.b.i. Organizational Structure

Alaska's DHSS is one of 15 departments comprising the Executive Branch of Alaska's state government. The Governor directs the activities of each of these departments through appointed cabinet level commissioners. DHSS is organized into Divisions with an appointed director to oversee all activities. DPH is charged with primary responsibility for MCH programs. The responsibility for some of the state's MCH Title V programs and the positions of Title V and CYSHCN Directors reside in the DPH Section of WCFH. However, two significant programs reside in OCS (EI/ILP) and the Division of Public Assistance (WIC). Organizational charts and a document describing programs in WCFH are attached.

Decisions regarding funding allocations for the Title V grant are made by the MCH Title V /CYSHCN Director with review from the DPH Director and approval from the DHSS Commissioner.

MCH programs located in WCFH and funded by Title V include: Oral Health; School Health/School Nursing; family planning and RH services for women who do not qualify for Medicaid; and specialty clinics (clef lip and palate, genetics). Also, Title V funds are used for specific activities such as breastfeeding and safe sleep promotion, and the Collaborative Improvement and Innovation Network (CoIIN) to Reduce Infant Mortality work around preconception health, tobacco and substance use. Surveillance programs located in WCFH and fully or partially funded by Title V include ABDR, SCAN, PRAMS, CUBS, MCH Indicators, and MIMR-CDR.

State general funds spent on EI/ILP provide a large portion of the state maintenance of efforts required for Title V. While DHSS is the umbrella organization for both DPH and OCS, there will continue to be a coordinated effort to provide information required for the Block Grant application both programmatically and fiscally. No Title V MCH Block grant dollars directly support this program.

Some state funds support WIC in team nutrition grants; however the bulk of funding comes from the USDA.

II.B.2.b.ii. Agency Capacity

(a)

There are three critical issues the state faces in providing comprehensive care: geographic isolation, low population density, and shortages in workforce capacity particularly with the delivery of specialty clinical services. The key factors in building

capacity within the state are the collaborations and partnerships among state agencies as well as between the state and the private sector, tribal entities, the non-profit sector, local communities, other public agencies, and families.

Women/Maternal Health

The Adult Health Unit promotes health screens and comprehensive women's and men's health visits as a part of their outreach with community health centers statewide. Recommendations for health screens are integrated into RH and Breast and Cervical Health Check (BCHC) program activities. BCHC also uses their relationship with providers to link women of reproductive age with providers to ensure access to contraception or prenatal care if needed. Additional funding has been sought from CDC to expand a life course approach to care for low income men.

Services and programs for women of childbearing age are provided as a complementary mix of pregnancy prevention and RH services along with screening and referral services once a woman becomes pregnant. Title V works with partners to expand the availability and training of clinicians for comprehensive RH services. Providers statewide have been trained and encouraged to screen all women for depression, substance abuse, and domestic violence. Referral systems for treatment are frequently minimal, at capacity and often not located in the woman's home community or available for women with children. WCFH is working with the Division of Behavioral Health (DBH) to expand the service network and to train additional clinicians in rural communities. Improving eligibility processing for the pregnant women's application to Medicaid is the focus of the Title V's QI initiative working as a part of Cohort 2 of the MCHB's MCH Workforce Development program. See II.F.5. *Emerging Issues* for more discussion. This effort has enhanced the collaboration between Medicaid, Public Assistance and the Title V program.

Perinatal/Infant Health

The CoIIN project has focused work on four strategic areas (previously described) to reduce infant mortality, and has absorbed ongoing infant safe sleep initiative work. WCFH continues to operate the newborn metabolic and hearing screening programs as a part of state mandates. MIECHV and Healthy Start funds have allowed WCFH to work on items such as breastfeeding promotion, having a healthy pregnancy, screening for maternal depression and domestic violence, and promoting well child visits with at-risk populations. Using funds from ASTHO, WCFH provided training assistance to promote breastfeeding within birthing facilities.

Children and Youth with Special Health Care Needs

Pediatric outreach clinics for neurodevelopmental/autism screening, genetics, metabolic, and cleft lip and palate disorders function as a gap filling service as Alaska continues to have a shortage of pediatric specialty providers. The HRSA D70 medical home grant gives WCFH capacity to further the implementation of patient-centered medical homes for CYSHCN, to work with stakeholders to create a statewide plan for this population, and to start a "Help Me Grow" program which will connect at-risk children with services they need.

The Alaska Health and Disability Program (AHDP) in WCFH ensures that families of CYSHCN have access to resources to assist them in their preparedness efforts, have a disaster plan in place, and have adequate supplies to sustain them for at least one week during a disaster. AHDP also builds capacity statewide to focus on physical activity among CYSHCN through the Teaming for Success Adapted Physical Activity Project.

Of the nearly 12% of Alaskan CYSHCN who receive Medicaid, many may benefit from or require rehabilitation services that are not covered under Medicaid. Providers statewide have acknowledged these gaps and have developed capacity using several methods and resources. The State of Alaska partners with many social service agencies to provide funding for these types of services. In the example of a child who would benefit from structured extracurricular activities, the DBH has developed Individualized Services Agreements that will provide funding to cover the cost of extracurricular activities that would increase the child's social skills and ability to remain in a community setting. A partnership between the State and the Alaska Center for the Blind and Visually Impaired (ACVBI) addresses the needs of a child with a visual impairment who requires training to use a cane for walking. Through a grant from the State, ACBVI provides free training, skill development, and tailored educational services to children with visual impairments.

Child Health

Access to a pediatric medical home has been a key area of focus. Title V collaborates with ECCS to implement online use of the Ages and Stages screening tool, and with the Section of Public Health Nursing (SOPHN) trains nurses to offer

comprehensive well child screens in remote communities. Frequent turnover of health aides in many villages presents challenges in maintaining trained staff and thus preventive health visits are of lower priority. Capacity for the Title V program has been enhanced with the HRSA D70 grant award.

WCFH has used Title V funds to develop a robust School Nursing/School Health (SNSH) program as a means to improve the health of the school aged population across the state. The SNSH Consultant works with nurses and other school health personnel, public health nurses and school district administrators statewide to support and strengthen health and nursing services in schools through development of standards and guidelines and the dissemination of evidence-based resources and professional development opportunities.

The Oral Health Program manages community water fluoridation and collaborates with the Alaska Dental Action Coalition, professional organizations and the state's Medicaid/Denali KidCare Program to educate and promote policies to increase access to topical fluorides for at-risk children and dental sealants on permanent molars. The Oral Health Program works collaboratively with the Tribal Health System to continue expansion of the Dental Health Aide program. Dental Aides have become a pivotal workforce in bridging service delivery and addressing problems early in home communities.

Adolescent Health

Financial support from the HSS Office of Adolescent Health, the HSS Administration for Children and Families, the CDC National Center for Injury Prevention and Control, and the Alaska DPA have increased the capacity of the AHP to promote and protect the health of adolescents in Alaska. AHP staff provides technical assistance and trainings on healthy relationships, teen pregnancy prevention, youth development, and more for parents, teachers, or adolescent service providers. The staff also disseminates data, reports, and resources on adolescent health. While involving youth in program planning and decisions, staff manage, support, and evaluate adolescent health programs across Alaska.

Cross-cutting/Life Course Health

Alaska has pioneered and developed novel data collection systems and processes to inform and evaluate statewide efforts to prevent child maltreatment. Data sharing and access have been streamlined between public health and child protection, local child advocacy centers, behavioral health, and law enforcement agencies. Data on the incidence, predictors, and outcomes are being organized, and ACEs data is being collected statewide. Alaska has competent researchers and an injury epidemiologist capable of conducting complex assessments. These efforts, in combination with multiple partnerships have the ability to pursue data driven primary prevention efforts.

(b)

1) *Collaboration with other state agencies and private organizations*: WCFH and SOPHN have long been partners in identifying and providing needed services for women, children, and CYSCHN populations at public health centers (PHCs) statewide and through itinerant nurses that serve remote/frontier communities without a health center. Title V funding is utilized to support RH service access in the two Juneau Douglas High schools and in the public health nursing center on Kodiak Island. In addition, Title V dollars are used to partially support technical assistance by an APRN to the other APRN's in SOPHN to assure consistency in the delivery of RH services.

The State, through its maintenance of effort, offers grants funded with state and federal funds to local health care organizations to deliver direct services to women and children. These locally based efforts bring culturally competent care to predominately Alaska Native communities in remote areas of the state, are offered as a part of a larger collaborative effort within DHSS, and include working relationships as well as braiding of funding with DBH, Juvenile Justice and Disability Services, sections within DPH, OCS, the Governor's Counsel on Special Education and Disability Services and the Mental Health Trust Authority. Title V has provided over the years seed money to start these interdepartmental collaborations and oftentimes, Title V dollars are leveraged for additional dollars after initial start-up.

The EPSDT coordinator in the Division of Health Care Services-the state's Medicaid agency- works on EPSDT/well child preventive health information and coordination of care. This activity is heavily promoted by Title V funded Nurse Consultants. The MCH Title V Director frequently facilitates communication between private health care providers seeking specialty care for their pediatric patients and the Medicaid agency.

WCFH collaborates with and supports funding for the All Alaska Pediatric Partnership (A2P2) partially through Title V dollars. Current information about the organization and its priorities can be found at http:://a2p2.org.

2) S*upport for communities*: The State assists regional tribal health corporations by collaborating on grants and providing expertise, education and training, and creating and participating on multi-agency advisory committees. Title V dollars often provide an initial base of support for professional education or training and provide dollars to back fill when state general fund allocations are reduced.

3) *Coordination with community-based systems*: Title V dollars have helped to promote immunizations and well child visits to hard-to-reach populations, offering incentives to complete all scheduled immunizations by age 2.

Title V provides funding through staff technical assistance and sponsorship of pediatric specialty clinics for MCH populations served by the military health system.

4) *Coordination with other services at the community level*: The CYSCHN program collaborates with community health providers to offer Cleft Lip/Palate treatment planning clinics, Metabolic care clinics, Genetics clinics, and Autism/Neurodevelopmental screening clinics. Public health nursing centers, as well as the family to family information network are key to assuring families are connected with treatment services, understand and apply for funding support, and follow through with treatment plans. Title V/CYSCHN clinic staff members assure that the child's medical home is in the loop prior to and after an appointment to assure awareness of treatment goals. Tribal health centers and regional care centers are also included in the communication of diagnosis, recommendations for lab or treatment plans as they are oftentimes the primary health care providers for the child.

II.B.2.b.iii. MCH Workforce Development and Capacity

(a)

An organizational chart illustrating nearly 50 FTEs within WCFH and its 5 units is attached. Current staffing, with qualifications of senior level management and program staff is described below:

- **Section Chief/Title V MCH Director** – Stephanie Wrightsman-Birch RN, MPH, MSN, FNP, Chief of Operations and strategic planning for all Title V and CYSCHN programs. She is a member of the DPH senior leadership team. She has over 33 years of nursing experience and over 20 years of executive level leadership and management experience. She also works part time as a Family Nurse Practitioner in a privately owned ANP practice.
- **Deputy Section Chief/CYSHCN Director** – Rebekah Morisse RN, MPH, Unit Manager for the Perinatal Early Childhood Health Unit and MIECHV coordinator. Ms. Morisse has worked in public health for 10 years, first as a public health nurse in Wisconsin and then as the Program/Clinic Manager of the Anchorage Reproductive Health Clinic. She has previous experience in hospital nursing.

MCH Epidemiology Unit: **14.0 FTEs**

- Margaret Young, MPH, Unit Manager and a senior Epidemiologist. Ms. Young is a graduate of the CSTE/CDC Applied Epidemiology Fellowship program and has worked for the MCH Epi Unit for 10 years.
- Jared Parrish, MS, oversees research and evaluation activities for WCFH and advises other projects within DPH. He expects to receive a PhD in Epidemiology in 2016. Mr. Parrish is a graduate of the CDC PHPS fellowship program and has worked for the MCH Epi Unit for 8 years.
- Kathy Perham-Hester, MS, MPH, has served as coordinator and senior epidemiologist for Alaska PRAMS for over 20 years.
- Daniella DeLozier, MPH is the MCH Indicators manager and oversees the MCH Block Grant preparation.
- Abigail Newby-Kew, MPH, has over 5 years of experience with complex statistical analysis and health data management.

Women's and Adult Health Unit: **8.0 FTEs**

- Kelly Keeter, MPH, Unit Manager and Title X administrative manager. Ms. Keeter has over 20 years in public health program management and senior leadership.

School Age and Adolescent Health Unit: 9.0 FTEs

- Mollie Rosier, MPH, in transition to become Unit Manager. Ms. Rosier has 12 years of experience as a public health

specialist and manager.
- Brad Whistler, DMD, MPA, Dental Health Official for the State of Alaska and manager for the Oral Health program.

Early Childhood and Perinatal Health Unit: 13.0 FTEs

Section Operations Support: 3.0 FTEs

(b)

All data collected by MCH Epi surveillance programs can be linked with birth certificate data on maternal and paternal race. The Unit regularly analyzes and publishes data by race (typically White, Alaska Native, and Other). Primarily due to discussions between WCFH and ANTHC, DPH established an informal agreement to enable courtesy reviews by ANTHC of manuscripts on health topics that include AI/AN populations to ensure references to this population are culturally appropriate and sensitive.

PRAMS and CUBS phone interviewers are trained in cultural sensitivity as part of routine training for new hires.

WCFH recruits diverse membership on advisory committees and seeks opportunities to engage diverse opinions in conversations and focus groups especially when designing health prevention or promotion materials or media. Collaboration with organizations such as the YWCA whose mission is to outreach to a diverse group of women and girls, has been helpful.

During FY16, Title V funds will be used to translate the infant safe sleep brochure into Spanish.

MIECHV home visitors receive cultural diversity training.

II.B.2.c. Partnerships, Collaboration, and Coordination

Strong partnerships and a collaborative approach are critical for systems development, implementation, service delivery and, ultimately, achieving the mission of Title V. All of the programs and services within WCFH are delivered in collaboration and partnership with others.

i. Other MCHB investments: WCFH administers State Systems Development Initiative (SSDI), CYSHCN D70 State Systems Implementation of Pediatric Medical Home, MIECHV, Healthy Start, Universal Newborn Hearing, Oral Health, and MCH Title V Block Grant. WCFH also received an MCHB technical assistance opportunity for Workforce Development.

ii. Other Federal investments: WCFH administers CDC Early Hearing Detection & Identification (EHDI), PREP, Teen Pregnancy Prevention, Title X Family Planning, and BCHC.

iii. Other HRSA programs: WCFH collaborates with federally qualified health centers throughout the state.

iv. State and local MCH programs: There are only two local governmental agencies in Alaska (North Slope Borough and Municipality of Anchorage); both have interpreted their health powers very narrowly. Title V funds are braided with TANF funds to purchase contraceptives for village clinics through the Reproductive Health Partnership. Using Title V monies, WCFH collaborates with the Borough of Juneau to fund nurse practitioners to offer RH and well child visits in the two local high schools.

v. Other programs within DHSS: These partnerships are described extensively in the Annual Report. Key examples are listed briefly below:

- Contraceptives and nurse practitioner contracts are funded through Title V to support RH services provided by the PHCs and other private providers. SOPHN is contacted when following up on abnormal screens for children identified through EHDI or NBMS. Some PHCs act as case coordinators when children in their communities are diagnosed with a condition.
- WCFH has data sharing agreements with the Bureau of Vital Statistics, OCS, and DBH, and regularly accesses data from Medicaid, WIC, and the Division of Juvenile Justice.
- DPH and OCS have an agreement to link the EHDI program with EI/ILP.
- The CYSHCN Director serves on the Strengthening Families Leadership Team in OCS.
- WCFH works with DPA on improving the Medicaid application process for TEFRA and pregnant women and collaborates with WIC on breastfeeding promotion.

- A WCFH staff member works with DPH Disaster management staff to assure MCH populations are considered in disaster planning.
- WCFH provides health information to Medicaid/Denali KidCare recipients. WCFH also provides data to the Medicaid program to support operations. The WCFH Section Chief is working with DPH and tribal staff to improve outreach for EPSDT exams and services.
- The SN/SH Consultant partnered with the YRBS program in the Section of Chronic Disease Prevention and DEED to develop the social development school health module.

vi. Other government agencies:

- WCFH has data sharing agreements with the Department of Revenue (Alaska Permanent Fund database), the Department of Public Safety (State Trooper database), and the court system.
- WCFH continues to lead the implementation of statewide clinics for autism/neurodevelopmental early identification, training and expansion by collaborating with the Governor's Council on Developmental Disabilities and Special Education, as well as other agencies.
- The SN/SH consultant is a member on the steering committee charged with developing the school health track for DEED's statewide education plan.

vii. Tribes, Tribal Organizations:

Collaboration with ANTHC includes:

- Co-sponsoring the Alaska MCH and Immunization Conference
- Participating on the ANTHC EpiCenter Scientific Advisory Committee
- ANTHC providers participate on many WCFH advisory committees

viii. Public health and health professional educational programs and universities:

The Section Chief serves on the advisory program for the University of Alaska Anchorage (UAA) MPH program and the steering committee for the doctorate of nursing practice. UAA's Center for Human Development (CHD) is a close collaborator in developing programs for CYSHCN and conducts phone interviews for PRAMS and CUBS. WCFH will partner with CHD in coordinating the neurodevelopmental/autism screening clinics in FY16. The UAA Institute of Social & Economic Research is the contractor for the MIECHV Expansion Grant research project.

ix. Family and consumer partnership and leadership programs:

Family/Consumer voice, input, and participation is found in programs/initiatives such as the Youth Alliance for a Healthier Alaska, NBMS and EHDI Advisory Committees, the pediatric specialty clinics, the D70 Medical Home Steering Committee, Alaska Health and Disabilities Committee, MIECHV, and in the Title V Block Grant NA.

x. Other organizations that serve the MCH population:

- WCFH actively participates and is a leader in A2P2 (previously described).
- WCFH works with providers from Seattle Children's Hospital and Oregon Health Sciences University to hold genetics and metabolic specialty clinics statewide.
- WCFH invites coalitions and non-profit agencies to participate in advisory committees and stakeholder meetings such as the March of Dimes; Planned Parenthood; the Association of Women's Health, Obstetric and Neonatal Nursing; AAP-Alaska chapter; Stone Soup Group; Broken Sparrow; and YWCA.
- WCFH collaborates with Primary Care Associates, a private group of providers, to promote medical homes and RH initiatives.
- Community level grantees deliver direct services for WIC, EI/ILP, and BCHC screening and outreach.
- WCFH funds parent navigation services provided by Stone Soup Group for the autism diagnostic center as well as the neurodevelopmental outreach clinics, EHDI and families of children with cleft lip and palate conditions.

II.C. State Selected Priorities

No.	Priority Need
1	Reduce substance abuse among families, including alcohol, tobacco and drugs.
2	Increase access and preventative health care services to Alaskans and their families.
3	Increase healthy relationships.
4	Increase access to reproductive health services that adhere to national best practice guidelines.
5	Improve system of care for families with children and youth with special health care needs
6	Reduce the rate of child maltreatment
7	Increase evidence based screening for all MCH populations for behavioral and mental health problems

II.C. State priorities for 2015 – 2020:

1. Reduce substance abuse among families, including alcohol, tobacco and drugs.
2. Reduce the rate of child maltreatment
3. Improve system of care for families with children and youth with special health care needs.
4. Increase access and services to reproductive health care.
5. Increase access and preventative health care services to Alaskan and their families.
6. Increase healthy relationships
7. Increase evidence based screening for all MCH populations for behavioral and mental health problems.

Rationale for selection

The Needs Assessment Leadership Committee, composed of WCFH Program Managers, MCH Epidemiology staff and the WCFH Section Chief, convened after the statewide needs assessment survey results were compiled and analyzed to develop state priorities. The survey results and themes from each population were presented to the overall group and the Committee was divided into five sub-groups, one for each population domain except for life course, by their respective area of expertise. Each group was tasked with completing a prioritization matrix based on the criteria defined below with the goal of determining seven total state priorities.

For each domain, the left column of the matrix was pre-populated with the top three health concerns identified from the online Needs Assessment survey, and may have included a fourth issue if one emerged as a strong theme in the comments. The groups were also asked to apply the rating criteria to a health/service gap, which was also identified from the survey results. Finally, they could add an additional category of their choosing if they felt the survey was missing a key issue they wanted to prioritize for their population domain.

Following a modified Hanlon method of prioritizing health problems, the following criteria were used to develop new priorities or reconfirm current priorities. For each of these criteria, group members were asked to rate the health or system issue on a scale of 1-10.

1. Needs Assessment Survey Result: These fields in the prioritization matrix were pre-populated based on the results of the statewide needs assessment survey. Respondents to the survey selected and ranked their top three health concerns and service needs. All responses were combined and the top three health concerns were identified as those which had the most respondents who selected that health concern as one of their top three. On the matrix, a score of 10= #1 Priority identified (i.e., the most people selected this as one of their top three), Score of 8= #2 Priority identified, and Score of 6=#3 Priority identified.
2. Size of problem (% of population with health problem with an emphasis on the percentage of the population at risk for the problem. Indicator data was provided by the MCH Epidemiology Unit for reference.)
3. Encompasses Life Course (Does this health concern appear in multiple MCH populations? Has this health indicator, if pervasive, been shown to negatively impact the life trajectory of the individuals experiencing them and increase the potential for inter-generational familial adversity?)
4. Seriousness of Health Problem (Morbidity rates, mortality rates, economic loss, and the degree to which there is urgency for intervention. Does it require immediate attention? Is there public demand? What is the impact on quality of life?)

Below is an example of the Prioritization Matrix used by the Needs Assessment Leadership Committee:

Proposed priority based on NA Survey Results Population: Infants	Needs Assessment Survey Results	Size of problem (# of individuals affected)	Encompasses Life Course	Seriousness of problem	Priority Score
P=[A+B+(2C)]*D	A	B	C	D	P
Child Maltreatment	10				
Poor Nutrition	8				
Vaccine Preventable Diseases	6				
Parental Substance Abuse, FAS, FASD	6				
Access to Well baby and Preventative Health Care Services	6				
Other?	6				

Each sub-committee utilized the standardized criteria in the table below to score each priority for the categories of "size of problem," "encompasses life course" and "seriousness of problem". These rating criteria provided a standardized source for all of the domains for classifying and interpreting the prioritization matrix. The scores based on the needs assessment survey results were pre-propagated for all populations.

The Hanlon Method: Rating Criteria			
Rating	**Size of Problem (% of population with health problem)**	**Encompasses Life Course**	**Seriousness of Health Problem**
9 or 10	>25% (e.g. STD's)	Has very significant impact on one's life course and across generations	Very Serious (e.g. HIV/AIDS)
7 or 8	10% - 24.9%	Impacts one's life course and across generations	Relatively Serious
5 or 6	1% - 9.9%	Impacts life one's life course but does not necessarily have multi-generational impact	Serious
3 or 4	.1% - .9%	Little impact on life course, no multi-generational impact	Moderately Serious
1 or 2	.01% - .09%	Very little impact on life course, no multi-generational impact	Relatively Not Serious
0	<.01% (e.g. Meningococcal Meningitis)	No impact on life course	Not Serious (e.g Teen Acne)

Finally, the priority scores were calculated using the Formula **P=[A+B+(2C)]*D** for each population. The original Hanlon method bases the scores on the size of the problem (a), seriousness of the problem (b), and effectiveness of

interventions(c) using the formula **d=[a+ 2b)]*c,** where d= the priority score. Under this methodology the multiplier "c" has the primary weight which drives the overall score. We modified the method to expand the Hanlon method to include the results of the Needs Assessment survey, and rather than focus on effectiveness of interventions we replaced it with a life course emphasis. Finally, we placed the most weight of the score on the multiplier "seriousness of the problem". The rational for this modification was two-fold; first, we wanted to directly score the needs assessment results into the prioritization, second we wanted to prioritize the seriousness of the problem. We excluded the effectiveness of interventions from this prioritization due to a desire to identify pressing needs regardless of our ability to currently address them.

The WCFH Leadership Committee decided ahead of time to choose two Life Course priorities. Child Maltreatment and Behavioral and Mental Health were identified within the top three priorities of four of the MCH populations in the statewide needs assessment survey results. The Committee initially assigned these two priorities to the Life Course domain, however the most appropriate NPM for child maltreatment was NPM 7 – rate of hospitalization for non-fatal injury. This NPM is assigned by HRSA to the child health domain. After feedback from the block grant reviewers, we moved the child maltreatment priority to the child health domain. To come up with seven final priorities, a single priority need for each of the five population domains was chosen.

Throughout the prioritization process, the Leadership Committee tried to identify priority needs that were not already being addressed by any other groups or agencies in the state, and were also unlikely to be addressed by others in the future. Some needs that were ranked high on the public survey but which did not get selected after the above prioritization exercise was completed by the WCFH Leadership Committee include vaccine preventable diseases and poor nutrition for infants, obesity for children, and social isolation and bullying for CYSHCN. For infants, there was extended discussion about including infant nutrition and breastfeeding promotion as a priority. Alaska already has high breastfeeding initiation rates but continuation rates are not as strong. Because breastfeeding is not included in the CoIIN activities, the group decided not to include it as a priority for WCFH during the next five years so that we could focus efforts on a limited number of issues. However, if additional funding to support sustained breastfeeding became available, such as the AMCHP Workplace Breastfeeding Project announced in summer 2016, Alaska would pursue the opportunity. Vaccine preventable diseases were not prioritized high because the DPH Section of Epidemiology runs the immunization program whose mission is to prevent and control vaccine preventable disease in Alaska. Similarly, obesity was not given a high priority because the Section of Chronic Disease Prevention and Health Promotion has a program that promotes exercise (and active "play") as well as healthy foods with the goal of reducing obesity rates. After discussion, the CYSHCN group decided that addressing social isolation and bullying for CYSHCN was not clearly actionable for a public health agency, and their selected priority of improving systems of care could more appropriately be addressed by Title V. In addition, social isolation and bullying could be addressed through work around behavioral and mental health.

In many ways, state priorities have not changed since the 2010 Needs Assessment. The issues of mental health, substance abuse, child maltreatment and healthy relationships persist in Alaska and therefore are maintained within our state priorities. New priorities focus on expanding preventative health care services to Alaskans and their families. Strategies to address these priorities are discussed in the Five Year Action Table.

The following table compares the priorities selected during the 2015 Needs Assessment with the state priorities for 2010-2014.

Table. Comparison of Prior and New State Priorities

State Priorities, 2010 - 2014	State Priorities, 2015 - 2019	Rationale for changes
Reduce substance abuse among families, including alcohol, tobacco and drugs.	Reduce substance abuse among families, including alcohol, tobacco and drugs.	No change
Reduce child maltreatment and bullying.	Reduce the rate of child maltreatment	Child maltreatment was clearly a strong priority among all populations based on the results of the Needs Assessment survey so we decided to focus this

		priority solely on this issue. Decreasing bullying is included as an objective to reach the priority of increasing healthy relationships.
Collaborate with families to work toward a system of integrated services for families with infants, children, and teens, and especially those with special health care needs.	Improve system of care for families with children and youth with special health care needs.	Refined measure very similar to prior priority
Reduce the risks associated with unintended pregnancy and teen pregnancy.	Increase access and services to reproductive health care.	New priority focused on a broader need. Teen pregnancy and unintended pregnancy will be reduced if access and services to reproductive health care are increased.
Reduce dental caries in children 0 - 21 years of age.	Increase access and preventative health care services to Alaskans and their families.	Activities to reduce dental caries are a strategy to address the broader priority of increased access and preventative health care services.
Reduce intimate partner violence (IPV) including teen dating violence.	Increase healthy relationships	Healthy relationships encompasses IPV and bullying and uses more positive terminology to frame the issue
Increase universal screening for postpartum depression in women.	Increase evidence based screening for all MCH populations for behavioral and mental health problems.	The new priority is broader and does not focus only on women. Mental and behavioral problems were identified as a major health issue for almost all population domains.
Reduce preventable post-neonatal mortality due to SIDS/asphyxia.		Because so many preventable post-neonatal deaths in Alaska due to SIDS/asphyxia are associated with substance use, activities to address the priority of reducing substance abuse among families will affect this prior priority. We selected NPM 5 – percent of infants placed to sleep on their backs – as our performance measure for the priority of reducing substance

		abuse, and have continued work begun during the previous grant cycle to address infant mortality due to SIDS/asphyxia.
Support communities to increase family and youth resiliency.		Youth resiliency is included in increasing healthy relationships.
Reduce the prevalence of obesity and overweight throughout the lifespan.		This is a priority of the Section of Chronic Disease and Health Promotion and we decided to focus our priorities only on issues that no other agency in the State is already addressing or may potentially address.
Strengthen quality school-based health care and health promotion.		School-based health care will be included in our new priority of increasing access and preventative health care services to Alaskans and their families.
Implement standardized screening for developmental delay and behavioral health in children 0 - 21 years.		This is a strategy to increase access and preventative health care services to Alaskans and their families
Develop capacity to help families navigate the health care system		This is part of the priority to improve systems of care for families with children and youth with special health care needs.
Acknowledge the importance of men in MCH programs		Many of the new priorities focus on “families”, which include men.
Reduce late preterm cesarean sections		This could be included in the priority to increase access to reproductive health services that adhere to national best practice guidelines. Additionally, hospitals in Alaska are starting to implement policies that address this issue.

II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

- NPM 1 - Percent of women with a past year preventive medical visit
- NPM 5 - Percent of infants placed to sleep on their backs
- NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool
- NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19
- NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others
- NPM 11 - Percent of children with and without special health care needs having a medical home
- NPM 13 - A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year
- NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

The MCH Title V and CSHCN Directors along with WCFH leadership and MCH Epidemiology staff selected the above National Performance Measures based on the state priorities identified by the Needs Assessment Leadership team and informed by indicator data available from the MCH-Epi Unit's surveillance programs.

During this process, each of the 15 possible NPMs were discussed by the group in terms of how the performance measure would support the state priority need. If one of the NPMs did not adequately fit any of the priorities identified, it was eliminated. In addition, there were some state needs identified, i.e. child maltreatment, that did not have a directly correlating NPM. In this case, the group made a list of possible state performance measures to be further discussed in Fall 2015 that have more accurate indicator data i.e. Alaska's Surveillance of Child Abuse and Neglect (SCAN) program.

During FY 2016, while reviewing our State Action Plan and developing ESMs and SPMs, we realized that NPM 13 (oral health) was a more appropriate match for our current activities than the original selection of NPM 3 (Low birth weight births in hospitals with a Level III NICU). Although we continue to follow and have an interest in maintaining Alaska's current level of perinatal care regionalization, this is not an area where WCFH is actively pursuing strategies, conducting activities or funding initiatives. Alaska has been doing well on this indicator for many years as a result of work done to develop a regionalized perinatal/neonatal system of care in the 1980s and 1990s.

The NPM 13 for oral health correlates with the activities of our Oral Health program and state priority to increase access to preventative health care services. Due to the ongoing high incidence of dental caries and tooth loss, oral health for children and adults remains a priority issue in Alaska. This NPM is therefore a more appropriate indicator for us to monitor as we implement strategies to respond to the aforementioned issues. In addition, with the change in federal funding available to states for oral health, the Title V MCH Block grant funds over 75% of the dental health official's position and any costs of implementing oral health strategies.

Below is a table that shows the cross linkage and rationale between the seven identified state priorities and the eight chosen NPMs.

Title V MCH Services Block Grant

No.	National Performance Measures
1	Percent of women with past year preventative visit
5	Percent of infants placed to sleep on their backs
6	Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool
7	Rate of injury-related hospital admissions per population, ages 0 through 19 years
9	Percent of adolescents, ages 12 through 17 years, who are bullied.
11	Percent of children with and without special health care needs having a medical home.
13	A.) Percent of women who had a preventative dental visit during pregnancy and B.) Percent of infants and children, ages 1 to 17 years, who had a preventative dental visit in the last year.
14	A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes.

Cross Linkage:

1. D *(Increased access to reproductive health care services may increase # of preventative visits.)*
5. A *(Parental substance use increases risk of infant death in a sleep environment.)*
6. B *(Increased access to well-child visits will results in increased developmental screenings.)*
7. F *(Injury related hospital admissions can be used as an indicator for child maltreatment. (See additional State Performance Measure to address child maltreatment.)*
9. C *(Unhealthy relationships also encompasses bullying)*
G *(Bullying can lead to behavioral and mental health problems)*
11. E *(Medical home is essential for families with CYSHCN)*
13. *B. (Increased access to preventative health care services including dental care)*
14. A *(Tobacco is a substance commonly used in Alaska, which has some of the highest rates of all states among pregnant women)*
D (Access to reproductive health care may reduce smoking during pregnancy)

	Alaska Priority Needs
A	Reduce substance abuse among families, including alcohol, tobacco and drugs.
B	Increase access and preventative health care services to Alaskans and their families.
C	Increase healthy relationships.
D	Increase access and services to reproductive health care.
E	Improve system of care for families with children and youth with special health care needs.
F	Reduce the rate of child maltreatment
G	Increase evidence based screening for all MCH populations for behavioral and mental health problems

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

- SPM 1 - Percent of women (who delivered a live birth and were trying to get pregnant) who had one or more alcoholic drinks in an average week during the 3 months before pregnancy.
- SPM 2 - Percent of students who report that they would feel comfortable seeking help from at least one adult besides their parents if they had an important question affecting their life.
- SPM 4 - Percent of women who report being screened for depression during prenatal care
- SPM 5 - Percent of deaths among children ages 0-17 years classified as maltreatment-related by the MCDR committee

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

The MCH Title V and CYSCHN Directors along with the MCH Epidemiology Unit Manger and Title V Block Grant Coordinator met with each program manager and selected Alaska's State Performance Measures based on the state priorities identified by the Needs Assessment Leadership team and informed by indicator data available from the MCH Epi-Unit's surveillance programs. The group considered the availability of data for the proposed measures, the likelihood a change in the measure would be seen during the five year grant period, and how closely linked the measure was to actual work being done by the Title V program.

During this process, the group identified areas in which the available National Performance Measures did not adequately cover or address the intent of the state identified priorities. For example, although the priority of substance abuse was aligned with NPM 14 related to tobacco use, this did not address other substances of public health importance in Alaska. Due to high rates of alcohol use among many Alaskan populations, the detrimental effects of alcohol use during pregnancy, and the availability of high quality data from PRAMS, we decided to create an SPM around alcohol use using Alaska PRAMS data. None of the NPMs were related to our priorities of behavioral and mental health problems or child maltreatment, so these also necessitated an SPM to be created. Each proposed SPM was discussed by the group in terms of how the performance measure would support the state priority need.

SPM 3 related to child maltreatment submitted in the FY17 application was "Rate of substantiated reports of child maltreatment per thousand children 0-17 years of age." After further discussions about this indicator and the difficulties of interpreting a trend or change in the measure over time, we are revising the measure in our FY18 application. Although preventing child maltreatment occurrence is important, statewide efforts, let alone those specific to Title V, would also likely need to be substantially increased if we expected to see a decrease in overall maltreatment. The new measure will be the percent of deaths among children ages 0-17 classified as maltreatment-related by the Alaska Maternal Child Death Review committee. This new measure more closely matches and measures the current efforts supported by Title V in Alaska, and will be more responsive to these efforts.

Alignment of the work of programs funded by Title V and other funding sources focused on improving outcomes for women, all children and their families is critical for us as we assure transparency of our work, reduce duplication and work to breakdown silos. This is also a priority of Alaska's Department of Health and Social Services leadership. As we reviewed potential measures and selected our SPMs, we referred to the Division of Public Health 2016-2020 strategic plan to guide our work. In April 2017, a section-wide full day retreat was held to reconnect with and align our mission and priorities with the division wide strategic plan.

To follow is a table that shows the cross linkage and rationale between the seven identified state priorities and the four SPMs. The strategies and programmatic activities to address our priorities through these measures are discussed in Section II.F.1 Five Year State Action Plan Application.

State Performance Measure	Cross Linkage:	Alaska Priority Needs
1. Percent of women (who delivered a live birth or were trying to get pregnant) who had one or more alcoholic drinks in an average week during the 3 months before pregnancy.	*1. A (Alcohol use while trying to become pregnant and during pregnancy is a type of substance use that can have detrimental effects on babies and families. Alaska has high rates of prenatal alcohol use among some populations.)*	A. Reduce substance abuse among families, including alcohol, tobacco and drugs. B. Increase access and preventative health care services to Alaskans and their families. C. Increase healthy relationships. D. Increase access and services to reproductive health care. E. Improve system of care for families with children and youth with special health care needs. F. Reduce the rate of child maltreatment G. Increase evidence based screening for all MCH populations for behavioral and mental health problems
2. Percent of students who report that they would not feel comfortable seeking help from at least one adult besides their parents if they had an important question affecting their life.	*2. C (Increasing students who seek help from adults will result in healthier relationships)*	
3. Percent of deaths among children ages 0-17 years classified as maltreatment-related by the MCDR committee.	*3. F (There is no good measure specifically for the rate of child maltreatment. This SPM uses our best available data from an expert consensus review to measure the "tip of the iceberg.")*	
4. Percent of women delivering live births who report being screened for depression during prenatal care.	*4. G (Prenatal and postpartum depression is a mental health problem for the MCH population that has negative outcomes for mom, baby and family)*	

II.F. Five Year State Action Plan

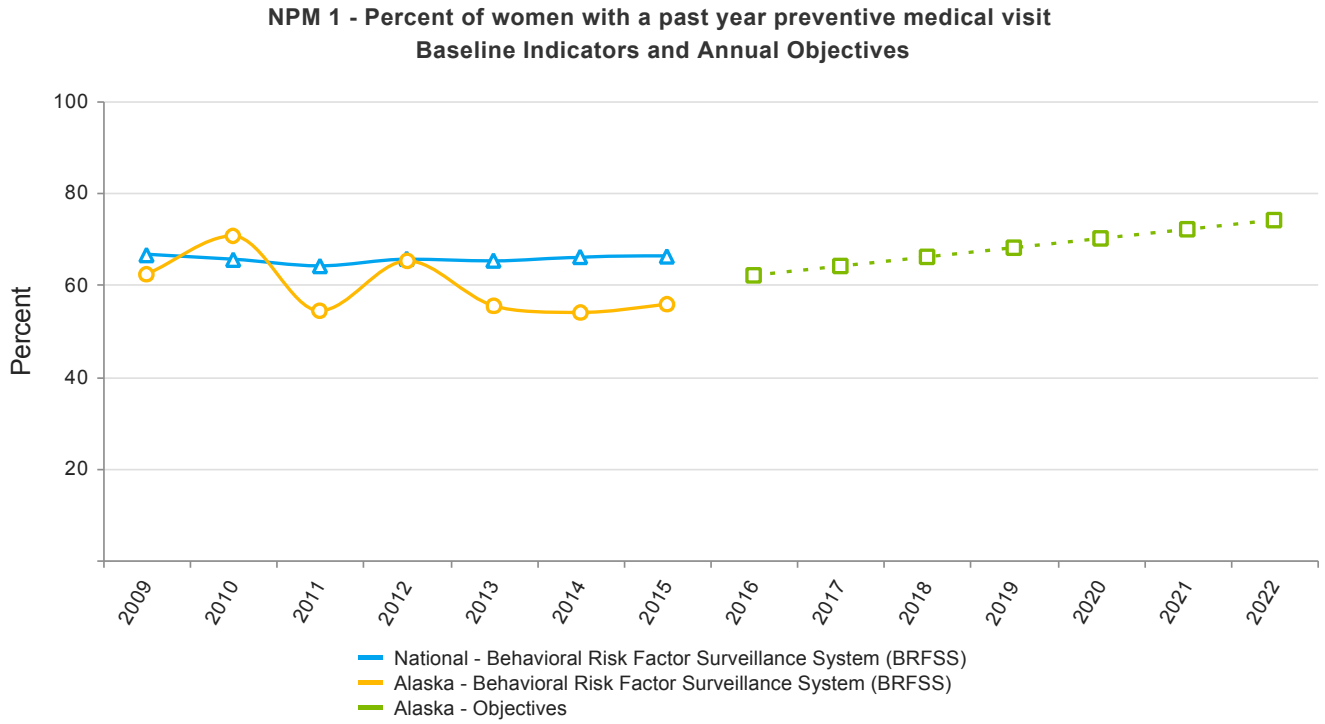
II.F.1 State Action Plan and Strategies by MCH Population Domain

Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2012	176.3	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS	Data Not Available	NPM 1
NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2015	5.8 %	NPM 1
NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)	NVSS-2015	0.9 %	NPM 1
NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)	NVSS-2015	4.9 %	NPM 1
NOM 5.1 - Percent of preterm births (<37 weeks)	NVSS-2015	9.0 %	NPM 1
NOM 5.2 - Percent of early preterm births (<34 weeks)	NVSS-2015	2.1 %	NPM 1
NOM 5.3 - Percent of late preterm births (34-36 weeks)	NVSS-2015	6.8 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2015	24.9 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2014	5.0	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	6.7	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2014	3.1	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	3.6	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2014	96.6	NPM 1

National Performance Measures



Federally Available Data	
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)	
	2016
Annual Objective	62
Annual Indicator	55.6
Numerator	71,071
Denominator	127,889
Data Source	BRFSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	64.0	66.0	68.0	70.0	72.0	74.0

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Ratio of rarely or never screened women who are newly enrolled in the BCHC program.

Measure Status:	Inactive - ESM 1.1 was revised to more accurately measure the number of rarely or never screened women who receive a Pap test, as this provides opportunity for t

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0.3
Numerator	731
Denominator	2,467
Data Source	Breast and Cervical Health Check Database
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	50.0	50.0	50.0	50.0	50.0	50.0

ESM 1.2 - Percent of all WIC clients referred to agency reproductive health or primary care providers who receive services.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	1
Data Source	NA
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	0.0	0.0	0.0	0.0	0.0

ESM 1.3 - Percent of rarely or never screened women who receive a Pap smear paid for by the Breast and Cervical Health Check (BCHC) program.

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	50.0	50.0	50.0	50.0	50.0	50.0

State Action Plan Table

State Action Plan Table (Alaska) - Women/Maternal Health - Entry 1

Priority Need

Increase access to reproductive health services that adhere to national best practice guidelines.

NPM

Percent of women with a past year preventive medical visit

Objectives

By 2020, increase to 70% the percent of Alaska women with a past year preventative medical visit.

Strategies

NPM 1.1 Partner with the YWCA to provide patient navigation and health education information to disparate populations to increase the number of women who are rarely or never screened for cervical cancer through the BCHC program.

NPM 1.2 Work with Anchorage-based WIC program to increase access to preventative healthcare visits by using "One Key Question" to identify WIC clients who may need reproductive health services. Referrals to the agency's reproductive health or primary care providers are facilitated for appropriate clients. Agency staff records how many of the referrals receive services.

NPM 1.3: Identify and partner with Federally-Qualified Health Centers (FQHCs) statewide to improve and expand their reproductive health services to adhere to the national QFP standards by providing QFP continuing education, conducting follow-up to assess compliance with QFP, and providing technical assistance to FQHCs who do not meet national standard.

NPM 1.4 Review all pregnancy-associated deaths through the Maternal-Infant Mortality and Child Death Review

NPM 1.5 (NEW) Collect PRAMS Phase 8 data on women receiving "regular checkup" health care visits at a doctor's or OB/GYN's office, or "visits for family planning or birth control" in the 12 months before getting pregnant.

ESMs	Status
ESM 1.1 - Ratio of rarely or never screened women who are newly enrolled in the BCHC program.	Inactive
ESM 1.2 - Percent of all WIC clients referred to agency reproductive health or primary care providers who receive services.	Active
ESM 1.3 - Percent of rarely or never screened women who receive a Pap smear paid for by the Breast and Cervical Health Check (BCHC) program.	Active

NOMs
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations
NOM 3 - Maternal mortality rate per 100,000 live births
NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)
NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)
NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)
NOM 5.1 - Percent of preterm births (<37 weeks)
NOM 5.2 - Percent of early preterm births (<34 weeks)
NOM 5.3 - Percent of late preterm births (34-36 weeks)
NOM 6 - Percent of early term births (37, 38 weeks)
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.2 - Neonatal mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.4 - Preterm-related mortality rate per 100,000 live births

PLAN FOR THE APPLICATION YEAR: OCT 2017- SEPT 2018

NPM 1: The percent of women with a past year preventative medical visit

Strategy 1.1: The State of Alaska's Breast and Cervical Health Check (BCHC) Program is working to increase the number of women receiving services through the program who are rarely or never screened for cervical cancer. Women who have not had cervical cancer screening in over 5 years are 60% more likely to be diagnosed with cervical cancer, and low income women are more likely to not have received a Pap test in over 5 years.

The program developed an ArcGIS map to better visualize the breast cancer screening rates by census areas with the goal of engaging partners in community work related to increasing those rates. The project included predictive analysis in order to show the potential women needing breast cancer screening in communities based on available data. This work was very successful in creating focused partnerships in which non-profits, imaging centers and community partners could work together to identify and reach out to women who are rarely or never screened for breast cancer. The next phase of this project is to develop an ArcGIS map that will show the cervical cancer screening rates by census area in Alaska. Unlike the breast cancer screening map, this map will include Federally Qualified Health Center locations to help engage their involvement and to increase their cervical cancer screening rates as well. The plan will include providing "barrier relief" funds for women in remote locations to assist with access to care.

Alaska has revised the numerator and denominator of the original ESM 1.1 (now ESM 1.3) to more accurately monitor annual progress in our efforts to ultimately increase the number of women with a past year preventive medical visit. The language of the ESM is being changed to measure the ratio of rarely or never screened women in BCHC who received their first BCHC-paid Pap test (instead of "enrolled") because the Pap test is the driver for the preventive health visit, not simply being enrolled.

Strategy 1.2: Because most women are physiologically able to get pregnant as soon as four to six weeks after giving birth, contraception plays an important role in the postpartum period. Birth-to-pregnancy intervals of less than two years increase the risk of negative health outcomes for mothers and babies. Only 62.3% of births had a pregnancy spacing interval of more than 18 months, among Alaskan women delivering a second or higher order singleton birth in 2015; 18.1% had an interval of less than 12 months (Alaska MCH Epi Unit analysis of vital statistics data). The prevalence of Alaska women who recently delivered a live birth who reported not doing anything postpartum to keep from getting pregnant (i.e., not using birth control) has not changed since 2009 and was 19.1% in 2014. Alaska is working to increase the number of women enrolled in the Women, Infants and Children (WIC) program who are referred for and receive reproductive health and related preventive health services. The State of Alaska WCFH Adult Health Services Unit staff previously planned to collaborate with the Municipality of Anchorage (MOA) WIC clinic and Reproductive Health (RH) Clinic staffs to implement *One Key Question* ("Do you plan to get pregnant in the next year?") to identify postpartum WIC clients at risk of unintended pregnancy and refer them to the RH clinic for reproductive and related preventive health services and screenings (e.g., cervical cancer screenings). However, due to staffing shortages and turnover of key roles in the MOA WIC Program, WCFH staff instead are reaching out to partners in the Alaska Native Health System (ANHS) to test this same model in one of their WIC clinics in FFY2018. Since reproductive health services are a driving force for entry into the health care system for women of reproductive age, linking low income women with low cost reproductive health services will allow low cost providers to offer the full range of preventive health services and screenings. This work will be conducted by the Nurse Consultant II for Perinatal and Reproductive Health who is funded 75% of her time by the MCH Title V Block grant. As a result, the language of ESM 1.2 has been modified slightly to allow for this same work at multiple locations.

These strategies and ESMs utilize evidence-based practices (i.e., ArcGIS mapping to locate disparate populations, patient navigators, barrier relief, One Key Question) to identify underserved low income women and link them with low cost primary care providers in their communities.

Strategy 1.3: As stated above, for the large majority of women of reproductive age, family planning and related reproductive health needs are the driving force for entry into the health care system; this relationship with their family planning provider is essential to addressing the other critical preventive and primary health needs of women in their reproductive years. Therefore, Alaska's strategy is to increase access to comprehensive reproductive health and related preventive health services that adhere to national best practice standards, i.e., the *Providing Quality Family*

Planning Services (QFP) guidelines. WCFH Women's Health staff will continue to partner with the Alaska Primary Care Association and FQHCs statewide to improve and expand their reproductive health and related preventive health services to meet the QFP standard by offering continuing education opportunities regarding QFP at provider conferences, and partnering with interested FQHCs to provide the necessary technical assistance to bring them up to the national standard.

Strategy 1.4: The Alaska Maternal and Child Death Review (MCDR) program, which is largely funded by Title V, has been reviewing all pregnancy-associated deaths in Alaska since 1990. Pregnancy-associated mortality refers to a death that occurs within a year of a woman's having been pregnant, regardless of the proximal cause of death. The most recent comprehensive analysis of MCDR data on pregnancy-associated deaths in Alaska found that many were related to underlying factors such as alcohol abuse, druge abuse, mental health disorders, and domestic violence. Similar to national data, Alaska has been experiencing an increase in the number of maternal deaths due to chronic conditions.

The Alaska MCDR program is based on a national evidence-based model that systematically and comprehensively reviews deaths using a multi-disciplinary consensus decision making approach. As part of the strategy to review all pregnancy-associated deaths, Alaska's Title V program will continue to support the committee in developing and disseminating recommendations to improve the health of women and mothers in the state. During FFY 2018, the MCDR program will continue to explore the use of MMRIA, the Maternal Mortality Review Information App, a database developed by CDC in CY 2016 to assist states in their review of maternal deaths and provide a platfore to collect consistent, high quality, and comparable information. MMRIA has the potential to make the MCDR data on maternal deaths more usable and easier to analyze.

Strategy 1.5: Starting with 2016 births, the Alaska PRAMS Phase 8 Survey is collecting data on receipt of health care visits by adult women in the 12 months before getting pregnant, including "regular check-ups at their family doctor's office or their OB/GYN's office", or "visits for family planning or birth control". The results will provide population-based and weighted data that directly and specifically measures utilization of preventive health visits by women prior to becoming pregnant. Since the two questions on the Phase 8 Survey are among the core questions, comparison data from other states will be available as well.

Women/Maternal Health - Annual Report

REPORT FOR THE APPLICATION YEAR: OCT 2015- SEPT 2016

In 2015, 55.6% of women in Alaska indicated that they had a preventive health visit in the past year. This indicator has not changed significantly since 2009. Among all groups examined using 2015 data, a past year preventive health visit was least common among women who were uninsured (38%), had a disability with activity limitations (41%), had less than a high school education (48%), or were ages 18-24 years (48%), although these findings should be interpreted with caution due to small numbers and large confidence intervals on the estimates. Women who were married were more likely than unmarried women to have a past year preventive health visit (63% vs. 50% in 2015).

One strategy to address Alaska's objective to increase the number of women with a past year preventive medical visit is the utilization of patient navigators to reach disparate populations in Alaska. The State of Alaska's Breast and Cervical Health Check (BCHC) Program utilized ArcGIS mapping technology to identify communities in the state with the highest proportion of low income women who are rarely (> 5 years since last screening) or never screened for cervical cancer, and utilized YWCA's patient navigators to provide health education information, relief for barriers to accessing services (e.g., referrals to low cost child care, transportation vouchers, appointment scheduling, etc.), and referral to local providers for screening. The BCHC Program, funded by the Centers for Disease Control and Prevention, pays for cervical cancer screening services and referral to Medicaid for women 21-64 with incomes ≤ 250% FPL. During this reporting period, the project provided health information to hundreds of women in the Kenai Peninsula area. Due to a lag in data collection, we are unable yet to identify how many more women were actually screened as a result of these efforts. However, BCHC did see success from this strategy by identifying partners who are willing to collaborate and are already scheduled for future health fairs in the Kenai Peninsula area for the upcoming year.

Alaska proposed ESM 1.2 to increase the number of women enrolled in the Women, Infants and Children (WIC) program who are referred for and receive reproductive health and related preventive health services, in order to increase the number of women with adequately-spaced (> 24 months interval) repeat pregnancies. The State of Alaska WCFH Adult Health Services Unit staff partnered with the Municipality of Anchorage (MOA) WIC clinic and Reproductive Health (RH) Clinic staffs to implement *One Key Question* (OKQ) ("Do you plan to get pregnant in the next year?") to identify WIC clients at risk of unintended pregnancy and refer them to the RH clinic for reproductive and related preventive health services and screenings (e.g., cervical cancer screenings). Using the Quality Improvement Model (i.e., "Plan-Do-Study-Act" or "PDSA" model) to perform short-cycle evaluations and improvements to this referral process, the team identified a barrier with the WIC counselors to provide referrals to the reproductive health clinic. After two attempts to engage the WIC counselors to provide referral information, there was a management turnover. The new manager is excited to provide more training and information to the WIC counselors and identify a champion to try another PDSA cycle. With this cycle, the counselor will track the time involved in using OKQ to determine if this project is feasible for the future. Therefore, although the current data for ESM 1.2 is 0%, far below our objective of 50%, we remain hopeful that this will increase in the upcoming year.

During this reporting period, Alaska analyzed the results of a statewide Primary Care Needs Assessment and established a baseline of publicly-funded providers (i.e., Federally-Qualified Health Centers - FQHCs) that currently meet the QFP standard (i.e., the national *Providing Quality Family Planning Services* (QFP) guidelines), as well as identifying those providers who fall short of this standard. These results will facilitate targeted work with interested FQHCs in the coming year.

During this reporting period, Title V funds allowed WCFH to maintain contracts to fund Advanced Practice Registered Nurses (APRNs) to provide comprehensive reproductive health and well-adolescent services, including education and counseling, at the Kodiak Public Health Center (PHC) and the four Juneau High School Teen Health Centers. During this reporting year, the APRNs continued to make efforts to connect clients with an appropriate medical home in their community, whenever appropriate, without breaching the teens' confidentiality. Furthermore, language in the contracts continued to encourage and allow payment for well-teen visits in addition to reproductive health services, as recommended in the national QFP guidelines. Additional work has been focused on educating all providers both private and public about the QFP standards and offering them strategies to make clinic visits more comprehensive and teen friendly.

After reviewing circumstances surrounding pregnancy-associated deaths during 2000-2011, the Alaska MCDR Committee found that about 70% could have been prevented by addressing underlying factors such as alcohol

abuse, drug abuse, mental health conditions, and domestic violence. At the annual MCDR meeting in September 2016, committee members stressed the importance of prioritizing pregnant women for substance-abuse treatment programs, as maternal opioid-related deaths appear to be increasing in Alaska.

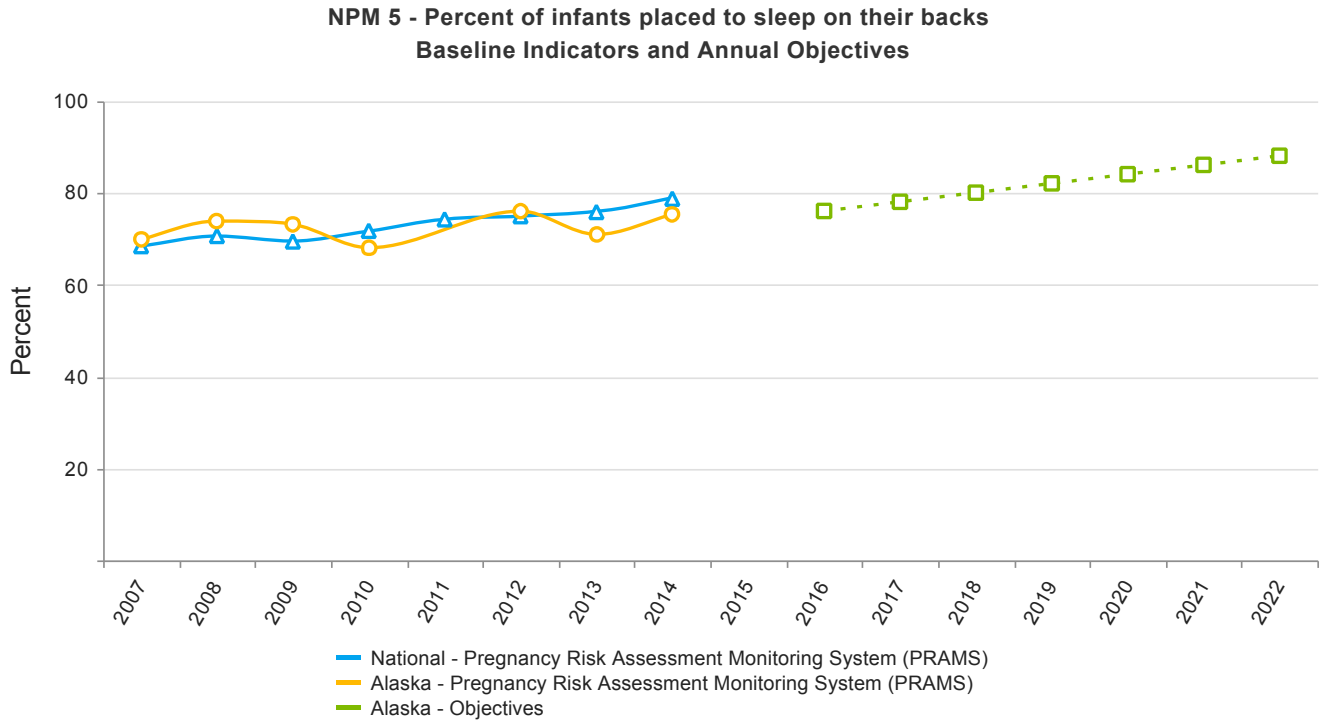
In the prior grant application, Alaska proposed to support MCH Epidemiology staff in creating pre/post tests for the training events, regarding the importance of, and national recommendations for, preventive health screenings to caregivers and other staffs at agencies serving women with disabilities, in order to measure the effectiveness of such trainings among recipients. Unfortunately, Alaska did not receive continued funding of the State's Health and Disability Program (HDP), resulting in elimination of the position that coordinated this work. However, WCFH continues to include an emphasis on reaching all underserved populations, including women with disabilities, in all efforts to increase access to preventive health services.

Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	6.7	NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	3.6	NPM 5
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2014	263.3	NPM 5

National Performance Measures



Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2016
Annual Objective	76
Annual Indicator	75.4
Numerator	7,980
Denominator	10,583
Data Source	PRAMS
Data Source Year	2014

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	78.0	80.0	82.0	84.0	86.0	88.0

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - Number of hospitals/birthing facilities using the Alaska Infant Safe Sleep Toolkit.

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	5
Numerator	
Denominator	
Data Source	Alaska Infant Safe Sleep Program Records
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	5.0	5.0	6.0	6.0	7.0	7.0

ESM 5.2 - Percent of Alaska births that occur at a hospital that has implemented at least one component of the Alaska Infant Safe Sleep Toolkit.

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	53.4
Numerator	6,011
Denominator	11,248
Data Source	Alaska Infant Safe Sleep Program Records
Data Source Year	2014
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	53.0	55.0	57.0	59.0	61.0	63.0

ESM 5.3 - Percent of SUID cases reviewed in prior year with complete SUID Investigation Reporting Forms

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	80
Numerator	20
Denominator	25
Data Source	Maternal Child Death Review (MCDR) database
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	80.0	80.0	83.0	85.0	87.0	90.0

ESM 5.4 - Percent of SUID cases reviewed in prior year classified using CDC categories

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	96
Numerator	24
Denominator	25
Data Source	Maternal Child Death Review (MCDR) database
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	94.0	94.0	95.0	95.0	95.0	96.0

ESM 5.5 - Number of birthing facilities with a Safe Sleep Certification from Cribs for Kids in Alaska.

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.0	3.0	5.0	6.0	7.0

ESM 5.6 - Percent of infants born at a facility with Cribs for Kids Safe Sleep Certification or a safe sleep policy in place and has initiated the certification process.

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	53.0	53.0	55.0	57.0	59.0	61.0

ESM 5.7 - Percent of SUID cases reviewed in prior year and classified using CDC categories that agree with CDC post-hoc classification.

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	50.0	60.0	70.0	80.0	90.0	95.0

State Performance Measures

SPM 1 - Percent of women (who delivered a live birth and were trying to get pregnant) who had one or more alcoholic drinks in an average week during the 3 months before pregnancy.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	27.9
Numerator	1,578
Denominator	5,649
Data Source	AK PRAMS Phase 7 Q38. 2014 data most recent avail
Data Source Year	2014
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	26.0	25.0	24.0	23.0	22.0	21.0

State Action Plan Table

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

Priority Need

Reduce substance abuse among families, including alcohol, tobacco and drugs.

NPM

Percent of infants placed to sleep on their backs

Objectives

Increase the percent of Alaska infants placed to sleep on their backs to 86% by 2021.

Strategies

NPM 5.1. Promote the Alaska Infant Safe Sleep Toolkit among hospitals and birthing facilities statewide (includes NICHD (National Institute of Child Health and Human Development) nurse education module, crib audits, and an infant safe sleep policy).

NPM 5.2 Sudden Unexplained Infant Death (SUID) cases are reviewed by the Alaska MIMR-CDR team using the CDC SUID Investigation Reporting form and classification system

NPM 5.3 Collaborate with a facility that has adopted the Toolkit to evaluate the Toolkit by implementing P-D-S-A cycles.

NPM 5.4 Partner with programs serving low socioeconomic families to provide infant safe sleep education (WIC, Medicaid, home visitation, or other programs)

ESMs	Status
ESM 5.1 - Number of hospitals/birthing facilities using the Alaska Infant Safe Sleep Toolkit.	Inactive
ESM 5.2 - Percent of Alaska births that occur at a hospital that has implemented at least one component of the Alaska Infant Safe Sleep Toolkit.	Inactive
ESM 5.3 - Percent of SUID cases reviewed in prior year with complete SUID Investigation Reporting Forms	Active
ESM 5.4 - Percent of SUID cases reviewed in prior year classified using CDC categories	Inactive
ESM 5.5 - Number of birthing facilities with a Safe Sleep Certification from Cribs for Kids in Alaska.	Active
ESM 5.6 - Percent of infants born at a facility with Cribs for Kids Safe Sleep Certification or a safe sleep policy in place and has initiated the certification process.	Active
ESM 5.7 - Percent of SUID cases reviewed in prior year and classified using CDC categories that agree with CDC post-hoc classification.	Active

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

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

Priority Need

Reduce substance abuse among families, including alcohol, tobacco and drugs.

SPM

Percent of women (who delivered a live birth and were trying to get pregnant) who had one or more alcoholic drinks in an average week during the 3 months before pregnancy.

Objectives

SPM#1. Among Alaska women who delivered a live birth and reported that they were trying to get pregnant, decrease the percent who indicated that they had one or more alcoholic drinks in an average week during the 3 months before pregnancy to 22% by 2021.

Strategies

SPM 1.1 Promote use of SBIRT (Screening, Brief Intervention, and Referral to Treatment) among health care providers, especially those serving Medicaid clients

SPM 1.2 Promote use of One Key Question tool among health care providers, especially those serving Medicaid clients

Perinatal/Infant Health - Plan for the Application Year

PLAN FOR THE APPLICATION YEAR: OCT 2017- SEPT 2018

Over the past 30 years, the Alaska Title V program has focused time, resources and effort to reverse the infant mortality rate, a traditional key indicator of the health of an MCH population. In the early 1980's, Alaska ranked 49th out of 50 states and had one of the highest infant mortality rates in the nation. Efforts such as perinatal regionalization, maternal and neonatal transport systems, the development of a Level III/B and level II neonatal units, and the development of a high-risk perinatal unit led to a significant decrease in infant mortality. Alaska has had one of the lowest neonatal mortality rates of all states for many years and was 5th in the nation in 2014 (the most recent year with available national data). However, Alaska's post neonatal mortality has remained high and has not attained the HP 2020 performance objective nor improved in standing in comparison to national rates. To that end, WCFH with its Title V-funded staff chose to focus recent and future efforts on behaviors that impact post neonatal mortality, including prioritizing parental tobacco, alcohol and drug use reduction strategies. As the national CoIIN efforts wind down and end in August 2017, Alaska's infant safe sleep program will strive to maintain activities and partnerships begun under the CoIIN model as capacity allows.

Infant Safe Sleep - Percent of infants placed to sleep on their backs (NPM 5)
Sudden Unexplained Infant Death (SUID) continues to be a primary contributor to Alaska's postneonatal mortality as well as overall infant mortality. Data from the Maternal Child Death Review (MCDR), indicate that these deaths are related to a variety of environmental risk factors, including but not limited to infant sleep position (the focus of NPM 5). At the 2016 MCDR annual meeting, the SUID group determined that focusing education efforts on Alaska Native communities, especially in rural areas, should be a priority. WCFH is updating its infant safe sleep (ISS) goals and strategies in light of the recent American Academy of Pediatrics' updated guidelines. This presents an opportunity to partner with Healthy Native Babies and the Alaska Native Medical Center (ANMC) to support the MCDR recommendations. Alaska is partnering with Cribs for Kids' National Safe Sleep Hospital Certification Program to promote safe sleep activities in birthing facilities. While the Alaska safe sleep toolkit for hospitals will continue to inform efforts, WCFH will work with facilities to help them obtain certification through the national program by providing training, technical assistance, or other requests. The Cribs for Kids' program reflects current guidelines, and the organization offers multiple levels of engagement for facilities to aim for in their certification goal. This transition will provide facilities with national recognition, a more robust certification process, and the support of both WCFH and Cribs for Kids. It also helps WCFH to maximize limited resources. WCFH expects at least one facility to obtain national certification this year, with at least two others beginning the process. A Title V-funded Nurse Consultant and MCH Epidemiologists will continue to offer presentations on safe sleep to professionals, including foster care providers, day care facilities and homes, home visitors, birthing hospitals, and birth centers. WCFH is partnering with Healthy Native Babies and the ANMC to develop an infant safe sleep rack card that is culturally appropriate, reflects current guidelines, and is universally applicable. Input from target populations will be obtained through talking circles at ANMC. WCFH and Healthy Native Babies will be conducting a pilot project that involves a webinar-based training for hospital staff at a tribal health facility. WCFH is contracting with a communications specialist to adapt the Healthy Native Babies curriculum to "Healthy Alaska Babies" that will include a 90-minute interactive training session. This will be piloted and evaluated with staff at two non-tribal hospitals. WCFH has already begun to outreach to tribal health facilities to recruit participants.

All infant safe sleep activities will be funded by the MCH Title V grant.

The MCH Epidemiology Unit, including the PRAMS and the MCDR programs, will collect data, analyze and report on infant sleep-related data that will be used to plan and evaluate the ISS program and guide future efforts to reduce infant mortality in the sleep environment. Alaska will continue to use Title V as the primary funding source for Alaska's MCDR program and help the committee to develop, disseminate, and implement prevention recommendations. A CDC grant for Improving SUID Review Quality and Timeliness in Alaska also partially funds this work. MCDR will continue to contribute to the National SUID Case Registry in the upcoming year, and staff will continue to promote the use of the SUID Investigation Reporting Forms with infant death investigators, including assisting the Medical Examiner's office with education efforts as needed. The program plans to re-apply for the Sudden Unexpected Infant Death Case Registry: Building Capacity and Implementation CDC grant. The project period for the current grant is through August 31, 2018.

WCFH is tracking four ESMs related to NPM 5. Two ESMs will help to monitor progress on the adoption of Cribs for Kids' national certification. By measuring the number of hospitals/birthing facilities holding a certification, WCFH will

be able to track an increase in use of this tool. The second ESM will measure the percent of births that occur at a hospital that has an infant safe sleep policy and is working towards certification. This will allow WCFH to measure the proportion of infants born in the state who are “touched” by a facility that has made an effort to create institutional change around the topic of safe sleep and will help to target further outreach towards facilities where a greater number of births occur. The third and fourth ESMs will measure the completeness, quality and consistency of the MCDR data on SUID deaths.

Substance Use - Percent of women who delivered a live birth and were trying to get pregnant who had one or more alcoholic drinks in an average week during the 3 months before pregnancy (SPM 1)

Alcohol use in pregnancy increases the risk for fetal alcohol spectrum disorders, low birth weight, and SUID. Substance Abuse and Mental Health Services Administration's (SAMHSA) screening, brief intervention, and referral to treatment (SBIRT) for alcohol misuse is an evidence-based intervention for reducing the risk of alcohol misuse among adolescents and adults, including women of reproductive age and those who are pregnant. The *4P’s Plus* screening tool has been validated for use to screen pregnant women for use of all substances, including alcohol and tobacco. Supporting women of reproductive age to avoid alcohol exposed pregnancy may be facilitated by addressing pregnancy plans for those at risk of pregnancy and currently using or misusing alcohol. Oregon’s *One Key Question* (OKQ) tool is a promising communication tool for clinical care staff to employ in pregnancy planning counseling. Use of *OKQ*, in tandem with SBIRT*/4P’s Plus* may help avert alcohol exposed pregnancies among women at risk, whether by facilitating abstinence from alcohol or by providing effective contraception when desired. The Alaska Division of Behavioral Health’s (DBH) central purpose is to provide a continuum of statewide behavioral health (mental health and substance use) services including prevention, screening, and brief intervention. DBH will continue to fund WCFH to implement a pilot project to screen approximately 5,000 pregnant women for use of all substances, including alcohol and tobacco, in four to five communities in Alaska during 2017-2018. OKQ will be integrated into these screenings. These women will also be screened for Intimate Partner Violence (IPV) and depression. Data collected from these screenings, along with demographic information, will be finalized into a summary report by the end of 2018. It is hoped that the summary report information will be used to inform Alaska DHSS about the needs of pregnant women with regard to substance use, IPV and depression, including treatment resources needed in the communities where the project is conducted. Alaska PRAMS is surveying women who recently delivered a live birth about their use of opioids and other illicit all substances, including alcohol and tobacco. PRAMS data will be used to track progress on this effort.

Alaska’s objective for this measure is, among women who delivered a live birth and reported that they were trying to get pregnant, decrease the percent who indicated that they had one or more alcoholic drinks in an average week during the 3 months before pregnancy to 22% by 2021 from the current level of 30% in 2014. This was selected as an SPM because no other NPM directly aligned with the state-identified priority of reducing substance use among families. While the NPM is focused on alcohol, both the 4P’s Plus/OKQ and PRAMS data sets will collect data on all substances, including marijuana and opioids, both prescribed and those obtained illegally.

REPORT FOR THE APPLICATION YEAR: OCT 2015- SEPT 2016

Infant Safe Sleep - Percent of infants placed to sleep on their backs (NPM 5)

The percent of women who reported on PRAMS placing their infant to sleep on their backs has been slowly increasing since 2000. In the most recent year of available data, 2014, 75% of Alaska women reported that they most often placed their infant to sleep on his or her back. Among all of the stratifier groups examined using 2014 data, placing infants to sleep on their backs was least common among women with less than a high school education (60%), women who were on Medicaid (69%), non-Hispanic American Indian/Alaska Native women (70%), women who participated in WIC (70%), and unmarried women (71%).

During the reporting period, WCFH continued to promote the use of the Alaska Infant Safe Sleep toolkit amongst hospitals and birthing facilities. WCFH used a change of staff (due to the retirement of a Nurse Consultant) to reintroduce safe sleep initiatives to facilities in the process of new staff establishing contacts. While no additional facilities fully implemented the tool kit in the report year, several additional hospitals began the process, including two tribal health/IHS facilities for the first time. The number of hospitals with at least partial implementation (ESM5.1.b) is up to nine. Between July and September 2016, WCFH staff conducted seven education and training sessions with hospital staffs and five with other community agencies serving high risk populations, including Maternal, Infant, & Early Childhood Home Visiting (MIECHV) home visitors, child care providers and foster families (strategy 5.4). WCFH also presented at various statewide conferences on safe sleep and included safe sleep in discussions with birthing facilities at newborn screening site visits. WCFH worked with one hospital in developing a recertification process for toolkit participants. This facility also updated their hospital-wide safe sleep policy to reflect that safe sleep practices are required for all admitted infants under 12 months of age, regardless of unit or reason for admission (strategy 5.3).

During 2016, the MCDR program reviewed 143 deaths among children ages 0-17 years, among which 42% were infant deaths (<365 days). Among the 60 infant deaths reviewed during 2016, the committee determined 43% (n=26) were due to SUID. All of these cases were fully abstracted and information was entered into the national SUID Case Reporting System. For this estimate two ESM (5.2a and 5.2b) are in place to track the improvement of MCDR reviews related to SUID deaths. Obtaining the SUIDI form substantially improves SUID case classification. During 2016, 82% of the SUID deaths had a SUIDI form, which was substantially greater than the expected 60%. This was largely due to multiple law enforcement agencies that adopted the use of these forms and work with the Medical Examiner to educate and promote the use of these forms. We had anticipated more difficulty in obtaining these but had minimal issues. We therefore have revised our anticipated objectives. Additionally, we updated ESM5.2b from simply using the CDC SUID case classification matrix to our accuracy with CDC. For a subset of classified SUID cases during 2016, CDC provided our consistency which was 57.1%. The MCDR program will therefore seek to improve the accuracy and use of the CDC case classification matrix. At the MCDR annual meeting on September 29, 2016, a multi-disciplinary team reviewed SUID cases and made recommendations based on the findings, which will be implemented in the next reporting year.

WCFH staff continued to participate in NICHQ CoIIN activities related to infant safe sleep. A Title-V funded Nurse Consultant and MCH Epidemiologist participated in media interviews and a radio show sharing infant safe sleep data and recommendations. In light of the American Academy of Pediatrics' updated infant safe sleep guidelines, published in October 2016, Alaska will be shifting some strategies for the next plan year, including retiring ESMs 5.1a and 5.1b.

WCFH collaborated with the State's MIECHV program, which utilizes the Nurse-Family Partnership (NFP) model, on a continuous quality improvement project related to safe sleep (strategy 5.4). Nurse home visitors in the program voiced that they were struggling with clients who choose to sleep in bed with their babies for a variety of reasons. To better communicate with clients and to better understand the risks, the nurses piloted a safe sleep risk assessment tool that was adapted from a Title V program in another state. The nurse home visitors felt that that tool helped them to facilitate the conversation of safe sleep better with their clients.

Alcohol and substance use during pregnancy - Percent of women who delivered a live birth and were trying to get pregnant who had one or more alcoholic drinks in an average week during the 3 months before pregnancy (SPM 1)

PRAMS has conducted surveillance of mothers' use of alcohol and tobacco for over ten years. Among Alaska women who delivered a live born infant in 2014 and indicated that they were trying to get pregnant, 27.9% said that they had one or more alcoholic drinks in an average week during the three months they became pregnant. These rates varied significantly by maternal education level, pre-pregnancy health insurance, maternal age, and race, with the highest percents of pre-pregnancy alcohol use among college graduates (33%), women ages 25-29 (33%) and 30-34 (31%), White women (32%), and women with any insurance other than Medicaid (31%). In 2016, Alaska PRAMS began surveillance of mothers' use of opioids and other substances, both prior to and during pregnancy.

The *"Tobacco, alcohol and marijuana are legal in Alaska. Legal is not the same as safe"* rack cards were distributed among all partners, including: WIC, Alaska Division of Behavioral Health, Alaska Breastfeeding Coalition, University of Alaska Artic SBIRT program, Alaska Native Tribal Health Consortium (ANTHC), South Central Foundation's Nutaqsiivik program, the Governor's Council on Disabilities and Special Education-Fetal Alcohol Workgroup, the Alaska DHSS Marijuana Work Group, the Alaska DPH and ANTHC Tobacco programs, and 130 primary care clinics statewide. Availability of the cards is posted on the WCFH webpages where anyone can order a supply at no cost. Title V dollars were used to fund the development, printing and distribution of the rack cards.

"Healthy Pregnancy and Beyond" cards, with links to evidence-based resources and information about healthy pregnancy, were also distributed among these same partners and are also available for order at no cost on the WCFH webpages. Title V dollars were also used to create these materials.

The perinatal listserv distributed 23 postings on evidence-based information about substance and alcohol use, mental health disorders and domestic violence among its 868 recipients.

The MIECHV program continued to promote healthy pregnancy behaviors among their clients in Anchorage and the Matanuska-Susitna Borough. During FY16 the MIECHV program worked with 236 families.

Alaska Medicaid and hospital discharge data show a dramatic increase in the incidence of Neonatal Abstinence Syndrome (NAS) babies born in Alaska from 2004-2015. The MCH Epidemiology Unit published an Epidemiology *Bulletin* describing this increase in February 2016. This has pressed the State resources to focus on the opioid epidemic. Strategies selected in 2015 continue to be best suited for addressing use of all substances, including opioids and alcohol, among women of reproductive age, including those who are pregnant. These evidence-based strategies are Screening, Brief Intervention, and Referral to Treatment for substance use (SBIRT) and Oregon's *One Key Question* tool to support effective pregnancy planning, especially among those using substances. Clinician use of *One Key Question*, in tandem with SBIRT, may help avert substance-exposed pregnancies among women at risk, whether by facilitating abstinence from substances or by providing effective contraception when desired.

In April 2016, the PRAMS coordinator and one of the WCFH Nurse Consultants presented on Substance Use in Breastfeeding for the Alaska Breastfeeding Coalition Symposium. About 200 service providers attended the conference.

The September 2016 Maternal Child Health and Immunization Conference hosted a panel of experts, including an OB/GYN, neonatologist, nurses, Medicaid policy director, and social services staff covering the use of SBIRT and *One Key Question* as well as implications of alcohol and opioid use for Alaska's perinatal population. WCFH also supported a presentation by the PRAMS coordinator which covered use of alcohol, tobacco, and marijuana during pregnancy and breastfeeding. Approximately 100 service providers from around the state attended the conference.

In December 2016, a WCFH Nurse Consultant presented on substance use and breastfeeding at the Public Health Nursing Conference.

Over the course of the year in 2016, the Alaska DBH, the Community Perinatal Task Force, and WCFH developed a collaborative partnership aimed at promoting use of SBIRT and *One Key Question* among clinicians caring for women admitted to five birthing centers in Fairbanks, the Mat-Su Borough, Anchorage, Juneau, and Kenai. This project will implement the use of *One Key Question* and 4P's Plus screening tools, using an SBIRT approach, to screen and collect surveillance data on approximately 5,000 women during 2017. These partners also collaborated with the State Office of Child Services (child welfare agency) to plan an April 2017 conference on substance use in pregnancy.

The WCFH Nurse Consultant participated in the State Department of Health and Social Services Opioid Work

Group and the Division of Public Health Marijuana Work Group. These work groups produced fact sheets for providers and pregnant and breastfeeding mothers, as well as websites with a comprehensive array of resources related to these substances and their potential impacts on pregnant women, breastfeeding mothers and their children. The fact sheets and rack cards have been key items used in educating agencies and provides across the state as a part of the Governor's Emergency Disaster Declaration on Opioids.

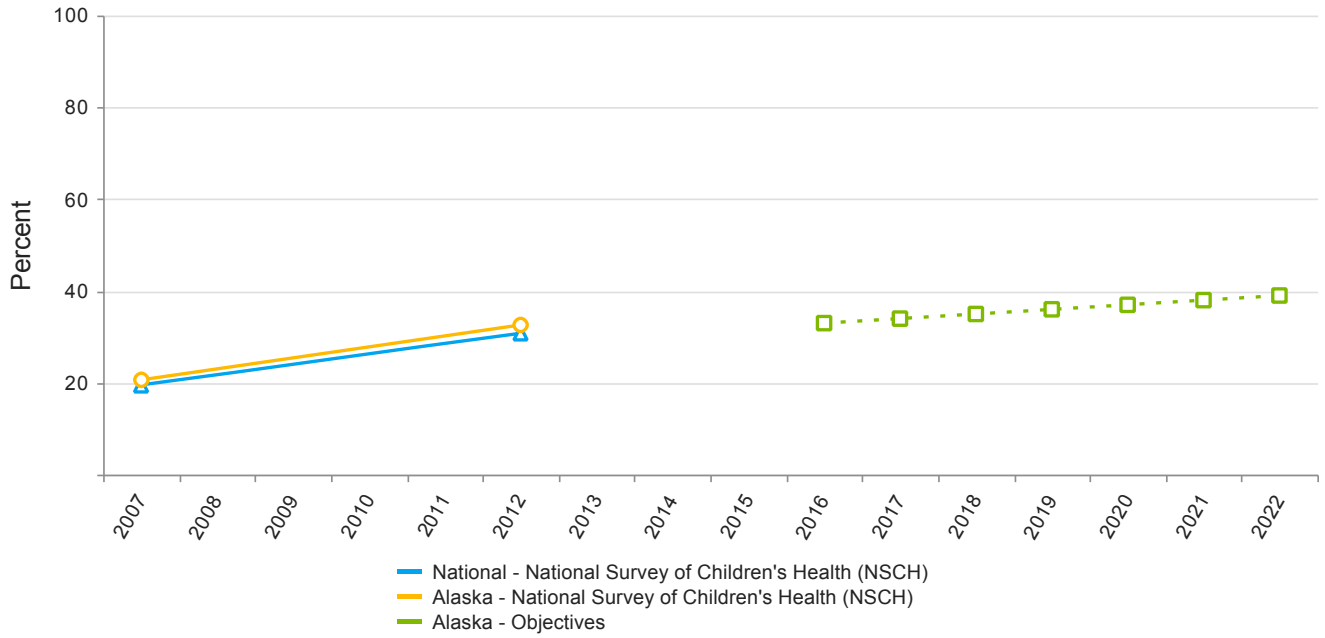
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available	NPM 6
NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000	NVSS-2015	35.4	NPM 7
NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000	NVSS-2015	45.3	NPM 7
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000	NVSS-2013_2015	7.5	NPM 7
NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000	NVSS-2013_2015	37.5	NPM 7
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	88.5 %	NPM 6

National Performance Measures

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



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	33
Annual Indicator	32.6
Numerator	15,812
Denominator	48,525
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	34.0	35.0	36.0	37.0	38.0	39.0

Evidence-Based or –Informed Strategy Measures

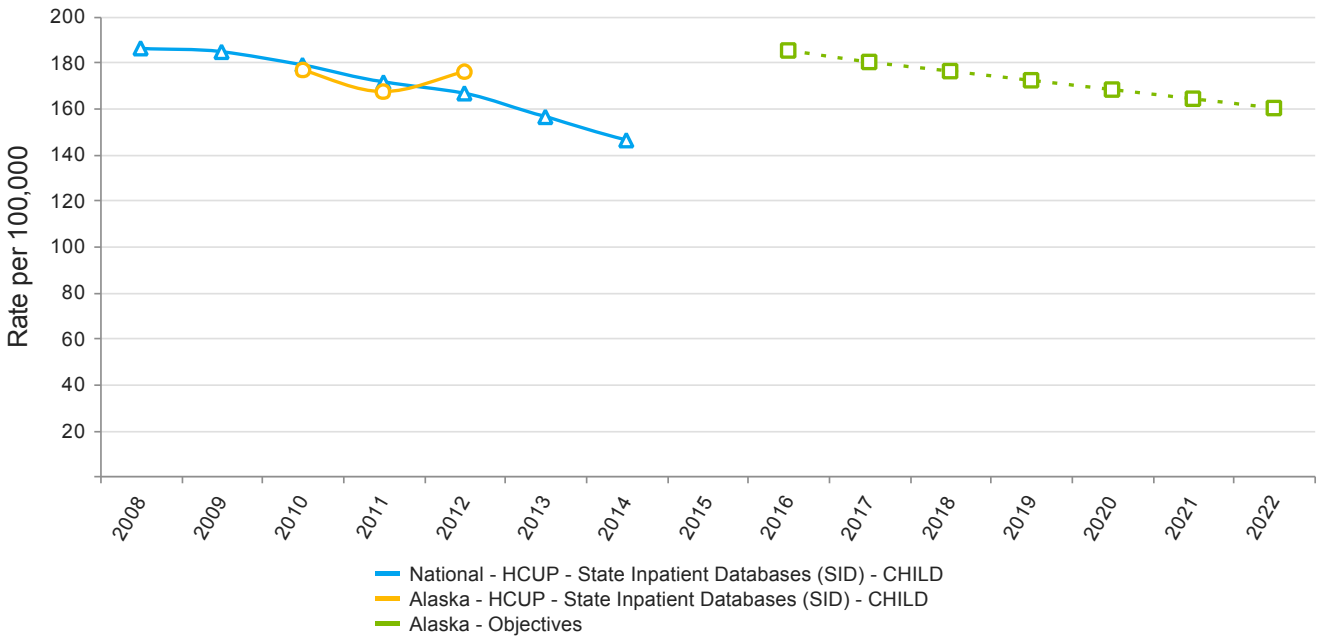
ESM 6.1 - Percent of children enrolled in home visiting with a timely screen for developmental delays using a validated parent-completed tool

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	93.4
Numerator	114
Denominator	122
Data Source	Nurse Family Partnership Program Data
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	94.0	94.5	95.0	95.5	96.0	96.5

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19
Baseline Indicators and Annual Objectives



NPM 7 - Child Health

Federally Available Data	
Data Source: HCUP - State Inpatient Databases (SID) - CHILD	
	2016
Annual Objective	185
Annual Indicator	175.5
Numerator	188
Denominator	107,097
Data Source	SID-CHILD
Data Source Year	2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	180.0	176.0	172.0	168.0	164.0	160.0

Evidence-Based or –Informed Strategy Measures

ESM 7.1 - Number of annual Child Death Review recommendations developed related to the prevention of child injury and/or child maltreatment

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	11
Numerator	
Denominator	
Data Source	MCDR Annual Recommendations Report
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	8.0	10.0	10.0	10.0	10.0	10.0

State Performance Measures

SPM 3 - Rate of substantiated reports of child maltreatment per thousand children 0-17 years of age in Alaska

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	15.6
Numerator	2,898
Denominator	186,266
Data Source	Child Maltreatment 2015 complied from the National
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	13.0	13.0	12.0	12.0	12.0	12.0

SPM 5 - Percent of deaths among children ages 0-17 years classified as maltreatment-related by the MCDR committee

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	20.0	19.0	18.0	17.0	16.0	15.0

State Action Plan Table

State Action Plan Table (Alaska) - Child Health - Entry 1

Priority Need

Increase access and preventative health care services to Alaskans and their families.

NPM

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

Objectives

Increase the percentage of children ages 9-71 months who receive a developmental screening using a parent-completed screening tool to 37% by 2021.

Strategies

NPM 6.1. Support existing Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program to complete the Ages and States Developmental Screening tool on time, as outlined by the Bright Futures periodicity schedule.

NPM 6.2. Partner with Medicaid and participate in the ECCS CoIIN to promote the use of the online Ages and Stages Questionnaire developmental screening tools with health care providers as well as the use of the bill code 96110 (CPT code for a developmental screen) and modifier 33 to track use of standardized tools.

NPM 6.3: Develop and expand Help Me Grow Alaska as a statewide system to support providers, educators and community based service agencies in use of standardized screening tools.

ESMs	Status
ESM 6.1 - Percent of children enrolled in home visiting with a timely screen for developmental delays using a validated parent-completed tool	Active

NOMs

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

NOM 19 - Percent of children in excellent or very good health

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

Priority Need

Reduce the rate of child maltreatment

NPM

Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Objectives

By 2021, decrease the rate of injury related hospital admissions among children 0-9 years to 164 per 100,000.

Strategies

NPM 7.1 Review all child deaths up to age 18 through the Alaska Maternal-Infant Mortality and Child Death Review program

NPM 7.2. (NEW) Participate in and provide leadership for the Alaska Statewide Violence and Injury Prevention Partnership (ASVIPP)

NPM 7.3. Support existing Nurse Family Partnership Home Visiting Program with data and evaluation needs

NPM 7.4 Provide parental education to families participating in Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program regarding prevention of child injuries including topics such as safe sleeping, shaken baby syndrome or traumatic brain injury, child passenger safety, poisonings, fire safety (including scalds), water safety, playground safety, etc.

ESMs	Status
ESM 7.1 - Number of annual Child Death Review recommendations developed related to the prevention of child injury and/or child maltreatment	Active

NOMs

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

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

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

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

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

Priority Need

Reduce the rate of child maltreatment

SPM

Percent of deaths among children ages 0-17 years classified as maltreatment-related by the MCDR committee

Objectives

Reduce the percentage of child maltreatment related deaths (as specified by the MCDR program) occurring in Alaska among children ages 0-17 to 15% by 2021.

Strategies

SPM 5.1. (NEW) Develop a single (or series) of info graphics that describe the incidence proportion of child maltreatment in Alaska in conjunction with ACES, and child welfare prevalence data.

SPM 5.2: (NEW) Improve the reliability of maltreatment-related mortality classifica-tions (particularly those related to child neglect and negligence) by constructing and testing a standardized classification process (patterned after the CDC SUID process) and back end algorithm for consistent identification. Prior research in Alaska documented a need for improved consistency. This will require the identification of a small additional grant to support contracting with a national expert, and convening research reviews.

SPM 5.3: (NEW) Improve the tracking of maltreatment deaths that are based on the various jurisdictional definitions to allow for timely and comprehensive response to media, legislative, researcher, and other public inquires.

SPM 5.4: (NEW) Expand the ALCAN link project by acquiring and linking in parental histories with Juvenile Justice, Child Welfare, Law Enforcement, Corrections, and Behavioral Health. Continue to pursue educational records.

SPM 5.5: (NEW) Identify funding to support the establishment of a flexible data plat-form for these linked data to reside. Transition from the current MS Access platform to improve transferability to other PRAMS jurisdictions.

SPM 5.6: (NEW) Support local/state based initiatives working to prevent maltreat-ment by providing and interpreting data.

SPM 5.7: (NEW) Improve public access to child welfare data by making count and rate data available through the IBIS system. This system will allow users to extract information they need to support efforts and make decisions and reduce the burden data requests made to child welfare and public health.

SPM 5.8: (NEW) Partner with the Mental Health Board, Alaska Children's Trust, and Child Welfare to develop a centralized website that describes child wellbeing in Alaska using ACES, child welfare, and public health data.

Child Health - Plan for the Application Year

PLAN FOR THE APPLICATION YEAR: OCT 2017- SEPT 2018

The WCFH leadership team identified the state priorities for child health as 1) increase access and preventative health care services to Alaskans and their families and 2) reduce the rate of child maltreatment. The needs assessment identified major issues for children, especially preschool and school age, including age appropriate physical growth, cognitive and socioemotional development and school readiness. The effects of poor health in childhood and adverse childhood experiences, including abuse and neglect, can be life long.

Alaska's child domain objectives are to, 1) Increase the percentage of children ages 9-71 months who receive a developmental screening using a parent-completed screening tool to 37% by 2020; and 2) By 2020, decrease the rate of injury related hospital admissions among children 0-19 years to 164 per 100,000. A third objective that Alaska added in this second year of Title V reporting is, 3) Reduce the percent of deaths among children ages 0-17 years classified as maltreatment-related by the MCDR committee from 20% during 2016 to 15% by 2022 (SPM 3). This was modifed from the prior SPM (rate of substantiations of child maltreatment) as it more closely matches and measures the current efforts supported by Title V in Alaska, and will be more responsive to these efforts.

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

Screening for physical, developmental and behavioral health conditions is a foundational activity for all children and should occur according to the recommended periodicity schedule developed by the American Academy of Pediatrics in their Bright Futures document. Three strategies that will address Alaska's objective to increase developmental screening are:

1) Support the existing Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program to complete the Ages and Stages Questionnaire (ASQ) Developmental Screening tool on time, as outlined by the Bright Futures periodicity schedule.
2) Partner with Medicaid and participate in the Early Childhood Comprehensive Systems (ECCS) CollN to promote the use of the online ASQ Developmental Screening tools with health care providers as well as the use of the bill code 96110 (CPT code for a developmental screen) and modifier 33 to track use of standardized tools.
3) Develop and expand Help Me Grow Alaska as a statewide system to support providers, educators and community-based service agencies in the use of standardized screening tools.

The MIECHV program continues to contract with Providence In-Home Services to implement the evidence-based Nurse-Family Partnership (NFP) program in the communities of Anchorage and Mat-Su. This program uses Registered Nurse Home Visitors and serves clients from pregnancy until the child is age two. The NFP curriculum includes the ASQ screening tool and nurses refer to an Early Intervention program when there is a concern. The nurses in the program complete ASQ screening according to the Bright Futures periodicity schedule and have been trained on using this evidence-based tool, along with the ASQ:Social Emotional. The ESM for the child health domain will measure the percent of eligible screening time points at which an ASQ screen is completed by the NFP nurses. The goal of the ESM is to monitor the frequency of developmental screenings in children served by the MIECHV program as an ongoing quality assurance check.

WCFH's Pediatric Medical Home Program (aka Systems Integration Grant for CYSHCN) supports linkages to medical home and preventative care services for all children with or without a special health care need. This includes developmental screening, assessment and referral to a needed specialist and community-based services. This

program partners with the HRSA/MCHB Early Childhood Comprehensive Systems (ECCS) grant and other state and community-based programs to promote the use of the online ASQ developmental screening tool available statewide through Alaska's Part C Early Intervention/Infant Learning Program (EI/ILP). WCFH staff work closely with the ECCS program manager to support statewide spread of the ASQ online tool and needed linkage to Part C and other supportive services and are developing QI processes within Part C agencies to ensure a more effective feedback loop between medical homes and EI programs. WCFH staff that includes Title V leadership and funded staff are leading planning efforts with a broad group of stakeholders to adapt the "Help Me Grow" model as a 'shared resource' in Alaska for a comprehensive approach to developmental screening, gap-filling care coordination, and linkage to services. Help Me Grow Alaska will use the Ages and Stages Questionnaire to broadly promote universal developmental screening through a centralized call center available to families and providers, as well as provider and community outreach. Initial pilot communities include Norton Sound, the Mat-Su Borough and Kodiak. WCFH staff will work closely with these communities through Help Me Grow Alaska implementation in 2017 and future statewide expansion to promote healthy child development through screening and linkage to services and resources. The All Alaska Pediatric Partnership will lead implementation efforts in the pilot communities.

The Governor's Council on Disabilities and Special Education has identified universal developmental screening as a priority through its Autism Ad Hoc Committee. In the coming year, the Council will convene a broad stakeholder group, including representatives of Title V, Part C, tribal health, the University LEND program, and many others to determine the best course for universal developmental screening in the state and across sectors to reduce redundancy and increase data sharing and analytic capacity.

Title V will explore Medicaid CHIP Health Services Initiative options related to universal developmental screening promotion. Such an initiative could further integrate and leverage state and federal resources related to screening through home visitation (MIECHV), other community-based services, Help Me Grow, and others. A concept paper is currently in development and will be presented to state health department leadership within the coming months to potentially present to CMS as a Health Services Initiative within the next year.

As part of Alaska's Title V work, WCFH staff including Title V leadership, will work to identify and reduce barriers to Early and Periodic Screening, Detection and Treatment (EPSDT) provider participation through establishment of an EPSDT workgroup to explore policy and practice level barriers to quality preventative care provision and measurement. A workgroup will convene led by program staff and experienced Medicaid staff such as the EPSDT Coordinator, the state Children's Health Insurance Program (CHIP) Director, the ECCS Coordinator in addition to family and provider champions. Provider feedback on EPSDT practice level barriers will be collected, analyzed and recommendations will be developed for policy and practice implications, including provider education on the availability and use of the established developmental screening billing code, 96110. Quality improvement processes will then be implemented using EPSDT workgroup recommendations to increase EPSDT participation and quality of provider reporting as well as improved family engagement and experience.

The Alaska Early Childhood Coordinating Council (AECCC) also has a workgroup called "Healthy Start, Healthy Families" that consists of home visitors and other early childhood advocates. The 2017 priority for this workgroup is to improved developmental screening rates and increase the number of children receiving EPDST screenings. The Providence NFP program also continues to encourage well-child visits according to the Bright Futures schedule. Additionally, the WCFH School Nurse Consultant funded by Title V works with schools across the state regardless if they have a school nurse or not, to promote the importance of well child visits on an annual basis for children who are in preschool or are school aged.

NPM 7: Rate of hospitalization for non-fatal injury per 100,000 children ages 0 to 9 and adolescents 10 through 19

Strategies that will address the objective to decrease injuries among children and adolescents include:

1) Continue to review all child deaths up to age 18 through the Alaska Maternal Child Death Review (MCDR) program.
    a. Develop recommendations for injury prevention
2) Participate in and provide leadership for the Alaska Statewide Violence and Injury Prevention Partnership (ASVIPP)
3) Support existing Nurse Family Partnership Home Visiting Program with data and evaluation needs
4) Provide parental education to families participating in the MIECHV program regarding prevention of child injuries.

The MCDR program will continue to review all maternal, infant, and child deaths over the next year. Increased efforts will be at improving timeliness of data collection, and the involvement of behavioral health professionals at reviews. Expansion of agencies represented at the monthly reviews and/or the annual meeting will also continue. This is vital to ensuring recommendations developed are applicable to the diverse situations and challenges faced by communities across the state. Further, this increases the distribution of information into these agencies to inform practice. The ESMs created for this NPM are related to improving the data quality, timeliness, and recommendations developed by the MCDR program. Mortality continues to be a strong indicator of overall child health, and although it only represents the most severe outcome of injury, it does allow for a clear systematic process for review and the identification of recommendations for prevention. Some issues (e.g. suicide) however, must also consider nonfatality data, as the mechanism (and ultimately, the lethality) of injury can be differential by subpopulations (e.g. sex). To augment the mortality data, MCDR will expand parternships with the Alaska Trauma Registry, Medicaid, and hospital inpatient/outpatient (emergency room) discharge data stewards. By expanding these partnerships, mortality data can be interpreted in the context of all injury data and prevention efforts moved “upstream”.

The school nurse consultant, whose position is 100% funded by the Block Grant, will continue to participate in the MCDR monthly review meetings to assess school aged child deaths and opportunities for school nurses to receive additional training for interventions and recognition of signs/symptoms that may be preventable. (suicide, illness, child maltreatment/neglect, etc.)

Title V will continue to support the ASVIPP and the recommendations made by this group. Due to multiple efforts that were underway, the launch of the child injury CoIIN was ultimately unsuccessful. The ASVIPP is a natural and more expansive effort and thus important for Title V to support. The Public Health Scientist in the MCH Epidemiology Unit, partially funded by Title V, will continue to co-lead ASVIPP in the coming year. By engaging with ASVIPP, MCH priorities will continue to be represented (e.g. IPV, child maltreatment, drowning, and suicide).

Title V will continue to support the Nurse Family Partnership Program by providing data and evaluation necessary for maintaining model fidelity and improvements. This includes maintaining access to child welfare data and linking records from multiple systems. The NFP curriculum includes direct one-on-one education as well as handouts given to families on injury-prevention topics including safe sleep, shaken baby syndrome or traumatic brain injury, child passenger safety, poisonings, fire safety (including scalds), water safety, and playground safety. As a a part of quality improvement, the program plans to do more education with families on playground safety in the upcoming year. An NFP staff member has also become certified on car seat safety.

SPM 3 Percent of deaths among children ages 0-17 years classified as maltreatment-related by the MCDR committee

In the prior year, SPM 3 was the “Rate of substantiated reports of child maltreatment per thousand children 0 to 17 years of age in Alaska.” It was changed to the above measure due to: 1) the limitations with the old measure, and 2) to more closely align with the current efforts supported by Title V. Child maltreatment is a substantial public health issue yet the population level interventions necessary require comprehensive prevention/intervention efforts across

multiple domains. Changes in trends of substantiated reports are sensitive to internal policy changes of the child welfare system and are thus difficult to interpret or even move at the state level. The measure was modified to be based on data from the MCDR due to these limitations, as well as the desire to have a SPM that is potentially susceptible to efforts supported by Title V, informative on the status of the most extreme form of child maltreatment, and resistant (in large part) to internal policy changes. Evaluating maltreatment as a causal or contributing factor to each death affords a sensitive and comprehensive assessment of shared factors that if prevented may have eliminated the death. For example, a maltreatment-related death could be a teen suicide by gun shot with a long history of child sexual abuse.

Although not directly funded by Title V, staff and programs supported by Title V will continue to engage with locally based initiatives, various targeted interventions (e.g. First 1,000 days), and the Alaska Resilience Initiative.

Title V will continue to be leveraged to improve the identification and classification, and ultimately the prevention of maltreatment-related child deaths. Fatalities where maltreatment is related to the death are preventable and represent the most severe outcome of maltreatment, thus prevention of these events (which are the tip of the iceberg) is crucial from both an immediate and life course perspective.

Specific strategies that will be implemented and directly supported by Title V over the next year and that align with the Alaska Statewide Violence and Injury Prevention Partnership (ASVIPP) strategic plan to decrease child maltreatment include the following:

1) Develop a single (or series) of info graphics that describe the incidence proportion of child maltreatment in Alaska in conjunction with ACES, and child welfare prevalence data.
2) Improve the reliability of maltreatment-related mortality classifications (particularly those related to child neglect and negligence) by constructing and testing a standardized classification process (patterned after the CDC SUID process) and back end algorithm for consistent identification. Prior research in Alaska documented a need for improved consistency. This strategy may require the identification of a small grant to support contracting with a national expert, and convening research reviews.
3) Improve the tracking of maltreatment deaths that are based on the various jurisdictional definitions to allow for timely and comprehensive response to media, legislative, researcher, and other public inquiries.
4) Expand the ALCANlink project by acquiring and linking in parental histories with Juvenile Justice, Child Welfare, Law Enforcement, Corrections, and Behavioral Health. Continue to pursue educational records.
    a. Transition from the current MS Access platform to improve transferability to other PRAMS jurisdictions. Funding would likely need to be identified to support the establishment of a flexible data platform on which these linked data could reside.
5) Support local/state based initiatives working to prevent maltreatment by providing and interpreting data.
6) Improve public access to child welfare data by making count and rate data available through the IBIS system. This system will allow users to extract information they need to support efforts and make decisions and reduce the burden data requests made to child welfare and public health.
7) Partner with the Mental Health Board, Alaska Children's Trust, and Child Welfare to develop a centralized website that describes child wellbeing in Alaska using ACES, child welfare, and public health data.

To accomplish the above strategies, one focus will be on expanding comprehensive partnerships and programs aimed at supporting families, such as the safe sleep initiative, public health nursing, child welfare, and education. MCDR data will be used to help these partners connect the dots between prevention and mortality and the role of an attentive and healthy caregiver on the overall safety of the child. Further, we will continue to support the federal Maternal, Infant and Early Childhood Home Visiting (MIECHV) program using the Nurse-Family Partnership model. We will also find ways to partner more closely with the Strengthening Families initiative, including having WCFH staff participate in the two day Strengthening Families Trainings as they are available. Additionally, the SCAN program will continue to work with it many established partners (e.g. Alaska Children's Trust, Children' Justice Act Task Force,

Office of Children's Services) to develop a data resource website that documents prevention efforts and services, as well as current trends and informative data.

Additionally, the Surveillance of Child Abuse and Neglect (SCAN) program will continue to improve the quality and comprehensiveness of statewide child maltreatment data. SCAN has partnered closely with the state child welfare agency (OCS), many of Alaska's child advocacy centers, law enforcement, and the MCDR to link and develop cross-jurisdiction measures. Efforts will be made to continue to expand these surveillance activities and develop timely annual reports that can be made available on the state IBIS system. Within the SCAN program, the Alaska Longitudinal Child Abuse and Neglect Linkage (ALCANLink) project that integrates the 2009-2011 PRAMS cohort with multiple administrative datasets will continue to be expanded to better understand the factors that contribute to the occurrence of maltreatment from a child's life course perspective. An emphasis will be on synthesizing and distributing these data to influence policy and promote a clear need for an organized public health approach. Infographics will be one method used for synthesizing and communicating the key findings. The SCAN program also plans to conduct additional linkages of the PRAMS data with child welfare/OCS to develop an annual incidence proportion indicator of child maltreatment to track over time.

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

In 2011-2012, 33% of Alaska children ages 9-71 months had received a developmental screen using a parent completed screening tool, up from 21% in 2007. Among all of the stratifier groups examined using 2011-2012 data, developmental screening was least common among children who lived in a non-metropolitan statistical area (i.e., rural) (15%) and had a household income-poverty ratio of <100% (22%).

WCFH conducted ongoing activities to increase developmental screening, described further in the Plan for the Application Year narrative. These included distributing Bright Future's guidebooks and ASQ tool kits to interested providers and collaborating with the ECCS coordinator and other state and community-based programs on enhancement and implementation of this statewide work. In 2016, the State of Alaska was awarded a 5-year competitive award for ECCS. Developmental screening is the main focus of the new funding cycle. WCFH partnered with the new ECCS coordinator to integrate the ECCS grant into other maternal child health programs such as the D70 Systems Integration and MIECHV grants. The MIECHV program at Providence NFP continued to utilize the ASQ as the evidence-based tool for developmental screening. All new nurse home visitors received training from a nurse consultant on the use of this tool. If there were concerns with an ASQ score, the nurse made a referral to the primary care provider and to the EI program.

The ESM associated with NPM 6 is the percent of children enrolled in the MIECHV program with a timely screen for developmental delays using a validated parent-completed tool. Because of the long-term relationship home visiting nurses establish with the families they serve, they are in a unique position to observe and screen children at risk for developmental problems and refer them for further evaluation when indicated. The developmental screening process empowers families by giving them anticipatory guidance on developmental tasks and allowing them to appreciate their child's unique way of accomplishing developmental milestones. During FY16, 93% of children (114 out of 122) who were enrolled in home visiting and eligible for a screening received one at the appropriate time point. Even when formal development screening points are missed, home visiting nurses closely monitor infant development, conduct additional development screening as needed, and work to connect families to any services they may need.

NPM 7: Rate of hospitalization for non-fatal injury per 100,000 children ages 0 to 9 and adolescents 10 through 19

In 2015, the rate of injury-related hospital admissions was 175 per 100,000 children ages 0-9 years and 266 per 100,000 adolescents ages 10-19. Compared to 2012, the last year of available data, there was no change in the rate among young children. However, among adolescents the rate increased from the 2012 rate of 208 per 100,000. Hospital discharge reporting was not mandatory in Alaska until 2015. Thus, data voluntarily reported between 2001 and 2012 represent the majority, but not the entirety, of Alaska's discharges, and information from many rural hospitals is missing which could particularly impact indicators such as injury-related admissions.

The Maternal Child Death Review (MCDR; formerly known as the Maternal Infant Mortality and Child Death Review Program) began reviewing all child deaths among children under 18 years of age for 2016 deaths. Prior to this the program limited reviews of neonatal deaths and did not review deaths over age 14. This was a function of capacity and poor organizational structure. With the transition to the National Case Reporting System (CRS) the MCDR program has been able to drastically improve efficiencies and standardizations. Title V funds have been instrumental in dedicating resources into improving our knowledge and understanding of the factors that contribute to early mortality among these populations. Specific areas of improvement included: expanding the number and expertise of

reviewers participating in monthly mortality review, transitioning to the CSR system, increasing the focus on SUID deaths (in conjunction with the CDC SUID classification improvement grant), and improvements to data quality. During 2016, the MCDR committee reviewed 143 deaths among children ages 0-17 years.

As a direct result from Title V funding and support, the MCDR has started holding annual review and recommendations meetings. This effort was initiated to directly respond to the need to increase the diversity and breadth of recommendations made for preventing early mortality in Alaska. During the 2016 meeting (held in late fall), the MCDR focused reviews and recommendations on suicide, SUID, maternal deaths related to opioid exposure, and drownings. These areas of focus were driven by reviews of the accumulated deaths during CY2016.

Some key recommendations and actions taken as a result of the meeting were:

1. Writing a letter to the State Medical Director to encourage the consideration of mothers and Neonatal Abstinence Syndrome in the statewide taskforce responding to the opioid abuse epidemic;
2. The need for the boater safety and Kids Don't Float programs to adjust language to recognize that nearly all child drownings in Alaska occur around open water, not while boating; and
3. The need for youth peer-to-peer programs for suicide prevention.

To focus on reducing injury-related mortality in Alaska, the ESM for NPM 7 tracks the number of injury-related prevention recommendations made by the MCDR committee. This ESM uses the number of recommendations developed at the annual review and recommendations meeting due to both the implications of importance and potential for movement/implementation of the recommendations. During the 2016 meeting eleven (11) injury related recommendations were made (3 from the drowning group, 1 each from the suicide and maternal groups, and 6 from the SUID group). Additionally, among all cases reviewed during 2016, for each death reviewed the MCDR committee identifies interventions or actions that, if implemented, could have likely prevented the death. Among all deaths reviewed during 2016 (n=143), 43 unique recommendations related to injury/maltreatment prevention were made.

Title V directly supported key personnel to participate on the Alaska Statewide Violence and Injury Prevention Partnership (ASVIPP). The ASVIPP plan focuses on unifying efforts of injury prevention from across the state and among agencies. By raising awareness about the multiple efforts and recognizing that many injury prevention efforts ultimately target similar people with shared risk and protective factors, a more comprehensive approach can be adopted by individual agencies.

Alaska initially participated in the child injury CoIIN, but efforts and energy was maxed resulting in overall limited success. Due to Alaska's high rates of sexual assault and domestic violence among the 10-19 age group, and the results of the statewide needs assessment, WCFH selected reducing intimate partner violence as an important focus area for the CoIIN. IPV CoIIN efforts over the next year focused on training pediatricians, family practitioners, home visitors, community health workers, youth workers, and school social workers on evidence-based early identification, assessment, and referral of mental health problems, trauma, and risk of interpersonal violence.

The school nurse consultant, whose position is 100% funded by the Block Grant, participated in the MCDR reviews to assess school aged child deaths and opportunities for school nurses to receive additional training for interventions and recognition of signs/symptoms that may be preventable. (suicide, illness, child maltreatment/neglect, etc.)

SPM 3 Percent of deaths among children ages 0-17 years classified as maltreatment-related by the MCDR committee

During the past year the Surveillance of Child Abuse and Neglect (SCAN) program which focus on public health surveillance of child maltreatment developed Anchorage incidence estimates by combining data from child welfare, Anchorage police, and the Anchorage Child Advocacy Center. This resulted in a more comprehensive understanding

of the annual burden occurring in Anchorage and a template for expanding to other jurisdictions across the state. Additionally the SCAN program finalized the implementation of the Alaska Longitudinal Child Abuse and Neglect Linkage (ALCANLink) project. This project links the 2009-2011 PRAMS respondents to multiple administrative data sources in Alaska. This longitudinal data set has been used to calculate the incidence proportion of being reported to child welfare among the birth cohort and has been engaged in a variety of predictive and etiologic research endeavors. The ALCANLink project has increased the number of agencies whose data are linked with the system and has obtained more detailed data from child welfare which will allow for focused assessments on removals, substance use and mental health, and caregiver relationships.

A major finding of the ALCANLink data is that while during a single year approximately 10% of children ages 0-6 years are reported to child welfare and 2% substantiated, over a child's lifetime, before age 7 years 31% will be reported to child welfare and 9% substantiated. This child development perspective based on the incidence proportion (cumulative risk) vs a systems burden perspective using annual prevalence is more consistent with the life course model and stresses the need for early intervention. Stratified by Alaska Native and White race groupings we identified that nearly 1 in 2 births to Alaska Native mothers and approximately 1 in 5 births to White mothers will be reported the CPS before age seven. This disparity of an approximately 3-fold risk stresses the need for improved targeted efforts. However, after adjusting for known modifiable factors (e.g. income, substance use, and life stressors) the risk among Alaska Native births drops to 1.5 times the risk. This clearly demonstrates that race doesn't define risk, rather the disproportionate load of risk factors that are modifiable and preventable. Using the ALCANLink data and partnering with multiple academic institutions multiple etiologic and predictive assessments have been completed. Some of these studies have highlighted target populations in need of additional prevention efforts (such as families on public assistance and women reporting intimate partner violence). These data have been instrumental in ensuring that early childhood, specifically the 0-3 age, is retained in the discussion of the 1115 behavioral health demonstration waiver project for targeting at risk families.

This year we updated our ESM for our maltreatment priority to more closely align with many of the current programmatic efforts across the state. This new measure (infant/child deaths classified as maltreatment-related by the MCDR committee) will be much more reflective and responsive to the efforts of Title V. During 2016 the MCDR program reviewed 143 deaths among children ages 0-17 years. The table below describes the distribution of maltreatment-related mortality deaths in Alaska. These data suggest that maltreatment, poor/absent supervision, or negligence contribute substantially to all deaths occurring in these age groupings (caution should be used as these are small numbers) and persist throughout childhood. Overall, among the 143 deaths reviewed in 2016 the MCDR felt that nearly 20% of the deaths were related to maltreatment of some form, and when poor or absent parental supervision was included it increased to almost 50% of all deaths reviewed. In attempts to prevent early negative life experiences and support families/communities to promote child wellbeing, Title V will continue to engage in multiple activities to reduce early mortality. Partnering with the safe sleep initiative, child welfare, office of boater safety, and other agencies will continue to be a mainstay to reduce maltreatment-related mortality.

ESM 7.1 by Age Groups. Maltreatment-related mortality classified by the Alaska MCDR committee among deaths reviewed during 2016 for children ages 0-17 years (N=143)

Age Group	Number of deaths reviewed by the CDR committee	Number of deaths classified as maltreatment related by the CDR committee*	Number of deaths classified as maltreatment related by the CDR committee including poor/absent caregiver supervision and other negligence**
0-3	90	16 (17.7%)	40 (44.4%)
4-9	17	4 (23.5%)	11 (64.7%)
10-14	15	4 (26.7%)	6 (40.0%)
15-17	21	4 (19.0%)	10 (47.6%)
*Includes deaths classified as Yes or Yes Probably Abuse or Neglect caused or contributed **Includes all deaths classified as Yes or Yes Probably Abuse, Neglect, Poor/Absent supervision, or Other negligence caused or contributed			

As a direct result of increasing the availability of high quality data that comprehensively measures child wellbeing in Alaska, multiple agencies and organizations have requested information to help direct efforts. The SCAN program contributed information to the Alaska Resilience Initiative, Strengthening Families Initiative, and local collective impact efforts. Through Title V supported efforts the Division of Behavioral Health and Division of Public Health are working at unifying efforts to centralize data and information as well as strategically targeting prevention efforts. The expanding of partnerships is leading to increased reach of these data and distilling of the life course approach into multiple efforts that have identified the shared risk and protective factors.

A senior MCH Epidemiologist participated in the 2017 fellowship class of the Informatics Training in Place Program (I-TIPP) during June 2016-June 2017. The I-TIPP program is designed for individuals with an interest in gaining more training and experience in public health informatics. This one-year applied training program provided an overview on various public health informatics topics with a particular emphasis on meaningful use, surveillance system improvement, and antimicrobial resistance. The two projects that Alaska's MCH Epidemiologist worked on throughout the fellowship were 1) improving the Anchorage Child Maltreatment Incidence Study by incorporating Medicaid linkages and expanding the project to other pilot communities, and 2) putting child maltreatment data online through the Alaska Indicator Based Information System (AK-IBIS) and Instant Atlas. Both of these projects supported the Title V priority of reducing child maltreatment.

In addition, as part of a Doris Duke fellowship, the Public Health Scientist (50% Title V funded) has provided guidance to the National Commission to eliminate child abuse and neglect fatalities draft recommendations related to measurement, served on the National Child Death Review (CDR) Quality workgroup, and worked on a CDR team maltreatment classification reliability study.

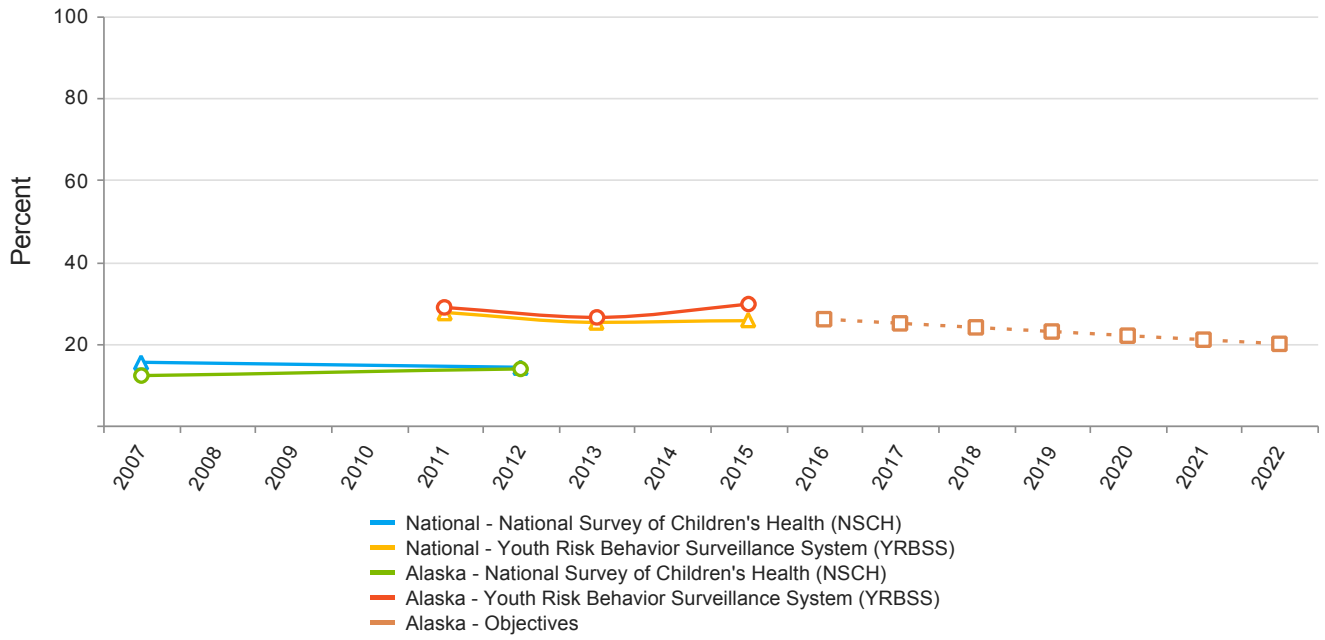
Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000	NVSS-2015	45.3	NPM 9
NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000	NVSS-2013_2015	37.5	NPM 9

National Performance Measures

NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others
Baseline Indicators and Annual Objectives



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	26
Annual Indicator	13.9
Numerator	8,187
Denominator	59,024
Data Source	NSCH
Data Source Year	2011_2012

Federally Available Data	
Data Source: Youth Risk Behavior Surveillance System (YRBSS)	
	2016
Annual Objective	26
Annual Indicator	29.8
Numerator	9,053
Denominator	30,353
Data Source	YRBSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	25.0	24.0	23.0	22.0	21.0	20.0

Evidence-Based or –Informed Strategy Measures

ESM 9.1 - Number of Alaskan students participating in the 4th R for healthy relationships program in the last school year.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	2,216
Numerator	
Denominator	
Data Source	Data is currently being collected via Section of W
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1,558.0	1,947.0	2,434.0	3,042.0	3,802.0	4,752.0

State Performance Measures

SPM 2 - Percent of students who report that they would feel comfortable seeking help from at least one adult besides their parents if they had an important question affecting their life.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	85.7
Numerator	1,182
Denominator	1,379
Data Source	CDC Youth Risk and Behavioral Surveillance
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	86.1	86.3	86.5	86.7	87.0	87.3

State Action Plan Table

State Action Plan Table (Alaska) - Adolescent Health - Entry 1

Priority Need

Increase healthy relationships.

NPM

Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Objectives

Decrease the percentage of Alaska students in grades 9-12 who report that they were bullied on school property or electronically during the past 12 months to 21% by 2021 (YRBS) NPM 9.2. Decrease the percentage of Alaska adolescents ages 12-17 who are reported by a parent/guardian to bully others in the past month to 12% by 2021 (NSCH)

Strategies

NPM 9.1. Promote and disseminate evidence-based healthy relationship programming, including the Fourth R, 3R's, Bringing in the Bystander, Alaska Promoting Health Among Teens, Healthy Relationships Plus.

NPM 9.2. Provide expertise on healthy relationship risk and protective factors

NPM 9.3. Increase program implementation that uses a positive youth development framework

NPM 9.4. Tailor the Fourth R for Healthy Relationships curricula to be culturally relevant and fit the Alaskan context.

ESMs	Status
ESM 9.1 - Number of Alaskan students participating in the 4th R for healthy relationships program in the last school year.	Active

NOMs

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

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

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

Priority Need

Increase healthy relationships.

SPM

Percent of students who report that they would feel comfortable seeking help from at least one adult besides their parents if they had an important question affecting their life.

Objectives

Decrease the percentage of Alaska students in grades 9-12 who report that they were bullied on school property during the past 12 months to 87.3% by 2022 (YRBS).

Strategies

SPM 2.1: Develop a Fourth R for Healthy Relationships Parent Engagement Toolkit. Toolkit will include information about the Fourth R topics and tips for parents/caregivers to facilitate healthy relationships conversations with their children.

SPM 2.2: (NEW) Create fact sheets and promotional materials related to the five focus areas of the Alaska Adolescent Health Program: violence and bullying prevention, unintended pregnancy and sexually transmitted infections prevention, substance use and abuse prevention, mental health and wellness promotion, and positive youth development and resiliency promotion.

SPM 2.3: (NEW) Support implementation of the Alaska Safe Children's Act recommendations for age-appropriate model curricula and teacher training materials related suicide prevention training, sexual abuse and sexual assault awareness training and prevention, dating violence and abuse awareness training and prevention, alcohol and drug related disabilities training and education.

Adolescent Health - Plan for the Application Year

PLAN FOR THE APPLICATION YEAR: OCT 2017- SEPT 2018

NPM 9: Percent of adolescents, ages 12-17 years who are bullied or who bully others

The overall priority of the adolescent domain is to increase healthy relationships. The state's selected ESM, to increase the number of Alaskan students participating in the Fourth R (4R) for Healthy Relationships program in the previous year, was selected based on its relevance and reach. The Fourth R program is an evidence-based violence prevention curricula aimed at promoting healthy relationships via life skills development (e.g. healthy communication, negotiation, and decision-making skills). The program is taught by trained school teachers or other school staff (such as nurses or counselors), and/or community members (such as public health nurses or violence prevention partners). Typically, the 21-lesson course is taught in 7th, 8th and/or 9th grade health class, but the curriculum can be taught in a variety of settings. The more Alaskans that participate in evidence-based programs and practices such as the Fourth R, the greater their protective factors and fewer their risk factors will be and thus, the greater chance at reaching our increased healthy relationships goal. The target is to increase the number of students participating by 25% each year. Because of the comprehensiveness of the Fourth R program, several of our other NPMs and SPMs may be positively affected by the Fourth R program. The Fourth R lessons focus on skills to prevent bullying and to increase parent-child communication. The School Nurse Consultant, whose position is funded by Title V, supports the Fourth R program by educating School Nurses about the program and encouraging them to become trained facilitators. An incentive for School Nurses to attend Fourth R trainings are they can receive Continuing Nursing Education contact hours at the School Health & Wellness Institute or through the Alaska School Nurses Association.

In partnership with national and local organizations, the Adolescent Health Program (AHP) aims to promote positive youth development and reduce negative health outcomes for all young Alaskans ages 10-25 years old. In partnership with the Alaska youth advisory committee, the AHP will create fact sheets and promotional materials related to the five focus areas of adolescent health: violence and bullying prevention, unintended pregnancy and sexually transmitted infections prevention, substance use and abuse prevention, mental health and wellness promotion, and positive youth development and resiliency promotion. Each focus area includes a related outcome measure and information on the current implementation of promising strategies.

The Alaska legislature passed House Bill 44, which included the "Alaska Safe Children's Act." The Act, which goes into effect June 30, 2017, ensures that Alaskan students and school staff implement policies that provide training to staff and students on sexual abuse prevention education for grades K-12 (known as Erin's Law) and dating abuse awareness and prevention education for grades 7-12 (also known as Bree's Law). House Bill 44 required that an Alaska Safe Children's Act Task Force , made up of ten members, be established to provide recommendations to the Department of Education & Early Development regarding model curricula and training materials for school districts. The Task Force—with the support of teachers, counselors and other stakeholders—released its recommendations on June 30, 2016. The Fourth R for Healthy Relationships program was recently added to this list of approved/recommended curricula to meet Alaska Safe Children's Act criteria. We anticipate Fourth R enrollment will increase due to the passage of this law and, most importantly, Alaska will see a improvement in related health outcome measures (e.g. dating violence, mental health issues, teen pregnancy, substance abuse, etc.). Title V staff will support implementation of the Alaska Safe Children's Act recommendations for age-appropriate model curricula and teacher training materials related suicide prevention training, sexual abuse and sexual assault awareness training and prevention, dating violence and abuse awareness training and prevention, alcohol and drug related disabilities training and education.

AHP program staff will continue to train and provide technical assistance supporting the Healthy Relationships Plus

Program which is a companion program of the Fourth R for Healthy Relationships Program. The Healthy Relationships Plus Program is a 14-lesson curricula for youth ages 12-18 which focuses on violence, substance use, and suicide prevention education and skill-building.

NPM 7: Rate of injury related hospital admissions per population 0 thru 19 years.

Alaska's planned activities related to injury prevention among both children and adolescents are described in the Child Health domain.

SPM 3: Percent of students who report that they would feel comfortable seeking help from at least one adult besides their parents if they had an important question affecting their life.

Having supportive relationships with adults besides a parent is a recognized protective factor against a variety of public health challenges, including bullying, teen dating violence, and teen pregnancy. In 2014, the CDC released its *Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence* report. In it, a list of shared risk and protective factors which research demonstrated either increased the likelihood (risk factor) or decreased the likelihood (protective factor) of experiencing and/or perpetrating multiple forms of violence were summarized. Family support/connectedness, connection to a caring adult and connection/commitment to school were listed as protective factors against child maltreatment, teen dating violence, youth violence, bullying and/or suicide. For this reason, we selected the existing YRBS protective factor measure as one of our SPMs.

Programs implemented by WCFH section staff within our strategy include promotion and dissemination of evidence-based healthy relationship programming, including the Fourth R, 3R's, Bringing in the Bystander, Alaska Promoting Health Among Teens, Healthy Relationships Plus. All are listed on evidence-based programs' databases such as the Office of Adolescent Health Evidence-Based Programs or SAMHSA's National Registry for Evidence-Based Programs and Practices. We hope to reach our goal of increasing healthy relationships among Alaskan youth by increasing protective factors through implementation of evidence based programs and practices such as the programs mentioned above.

This work is funded through TANF funds transferred from the Division of Public Assistance and federal grant dollars awarded primarily from Administration for Children and Youth and the Centers from Disease Control and Prevention. While no Title V dollars are used to support the program activities, Title V dollars do support MCH Epi staff who provide ongoing data support and analysis such as regional teen pregnancy data. MCH Epi staff published a state Epidemiology *Bulletin* on the decline in teen birth rates in May 2016. The Title V-funded School Nurse also provides technical support for the adolescent health program and helps to promote its activities.

REPORT FOR THE APPLICATION YEAR: OCT 2015- SEPT 2016

NPM 9: Percent of adolescents, ages 12-17 years who are bullied or who bully others

In 2011-2012, 13.9% of Alaska adolescents ages 12-17 years sometimes, usually, or always bullied or were cruel to others (NSCH). Among all of the stratified groups examined using 2011-2012 data, bullying others was most common among children of parents not born in the U.S. (25%), children who had special health care needs (23%), who lived in households where the highest educational attainment of a parent was high school graduate (22%), and children currently using Medicaid or other public insurance (20%). Bullying was less common among non-CYSHCN (12%), children who had a parent who was a college graduate (9%), who had private insurance (11%), and whose parents were born in the U.S. (12%). In 2015, 30% of Alaska students in grades 9-12 reported *being* bullied on school property or electronically (YRBS). Being bullied was more common among 9th graders (38%) compared to older students. Female students were more likely to report bullying than male students (36% vs. 25%). The trend in the percent who reported being bullyied on school property during the past year has shown no change in risk among Alaska traditional high school students during 2009-2015, however there has been a trend of increasing risk among Alaska alternative high school students.

SPM 3: Percent of students who report that they would feel comfortable seeking help from at least one adult besides their parents if they had an important question affecting their life.

In 2015, 85.7% of Alaska students at traditional high schools and 83.8% of students at alternative high schools reported that they would feel comfortable seeking help from one or more adults besides their parents if they had an important question affecting their life. There is no significant trend in this indicator since 2009 for either traditional or alternative high school students. Among traditional high school students in 2015, more female than male students reported feeling comfortable (89.6% vs. 82.1%).

The Adolescent Health Program (AHP) accomplished many activities related to promoting healthy relationships in Alaska's teens. The AHP provided administrative support for three grants to communities aimed at involving youth in the prevention of teen pregnancy and unhealthy relationships. The AHP managed two federal teen pregnancy prevention grants, both focused on teen pregnancy prevention, healthy relationships and STD/HIV prevention. The AHP manager served as an active member of a domestic violence and sexual assault prevention steering committee, linking violence prevention and pregnancy prevention for teens. The AHP planned and implemented teen pregnancy prevention mini summits that were attended by Alaskan peer educators and service providers.

The AHP continues to manage grants to communities on youth development, healthy relationships, and teen pregnancy prevention. The AHP continues to fund and sponsor work with the Youth Alliance for a Healthier Alaska, an advisory committee comprised of all youth that advise the State on important matters relevant to teens.

The AHP issued two new three-year competitive community grants to agencies in Alaska for teen and unintended pregnancy prevention and healthy relationships activities. The Teen and Unintended Pregnancy Project, funded entirely through a reimbursable services agreement (RSA) with the Division of Public Assistance (DPA) supports the Kachemak Bay Family Planning Clinic and the Municipality of Anchorage Department of Health and Human Services in the implementation of evidence informed relationship and sexual health interventions. This project also aims to refer and connect youth to sexual and reproductive health services.

In FY 2016, TANF funds were used to bolster youth friendly clinics. Work was conducted to survey, assess, and develop an evaluation to determine effectiveness. Clinicians were offered training on best practices in talking with

youth, screening for unhealthy relationships and reporting incidences of domestic violence and sexual assault. In addition to this work, public health and school health nurses have requested access to comprehensive sexual health curricula that is free, easily accessible, medically accurate, and age appropriate. The AHP provides information on culturally sensitive materials that fulfill this need statewide.

In addition, the AHP collaborates with the Alaska Network on Domestic Violence and Sexual Assault (ANDVSA) to provide evidence-based and positive youth development approaches to the initiation of the Lead On for Peace and Equality Youth Leadership summit and funds community action projects on Youth Pregnancy and Violence Prevention mini-grants for community dispersement. The mini-grant project also provides communities with planning, implementation, initiation, and evaluation technical assistance. This work is also funded by an RSA with DPA and does not receive Title V grant funds. However, MCH Epi staff, who are supported with Title V dollars, provided ongoing data support to the AHP.

The Youth Alliance for a Healthier Alaska (YAHA) is the AHP's advisory group and community partnership. The YAHA members provide feedback on strategic planning, provide public input for the MCH Block Grant, and review the YPVP mini-grants, in addition to creating interventions for young Alaskan health issues. The YAHA membership is beginning its ninth year in including youth voice in public health.

In November of 2015, the AHP staff collaborated with ANDVSA to conduct the Lead-On a pre-summit for Healthy Relationships and Sexuality. The topics that were covered were shown to increase participant knowledge of STIs, HIV and pregnancy prevention, increase healthy relationships skills, including bullying prevention, and strengthen concepts of consent.

The Adolescent Health Program (AHP) served as an active member of the statewide domestic violence and sexual assault prevention steering committee, providing guidance on the prevention of dating violence. The AHP established a wide network of collaborating agencies with which it consistently collaborated and planned future work.

The AHP is managing a federal PREP grant using The Fourth R and Healthy Relationships Plus curriculum, which focuses on establishing healthy relationships as a way to reduce substance abuse, violence, and teen pregnancy. In FY16 approximatly 79 teachers were trained to implement this evidence based interventions and 1246 Alaska youth participated in this intervention. From April 1, 2016 – March 31, 2017 the program was more successful than anticipated and reached 2,216 youth, already surpassing our 2018 goal of 1,947 youth due to increased awareness of the intervention and strong program management and promotional work.

Though rape prevention is not a state priority identified through the Five-Year Needs Assessment WCFH AHP manages the Rape Prevention Education (RPE) program and works collaboratively with diverse stakeholders, including state sexual violence coalitions, educational institutions, law enforcement entities, rape crisis centers, community organizations and others to guide implementation of sexual violence prevention activities. Evidence-based sexual violence prevention interventions share primary prevention strategies to the new adolescent NPM focused on bullying prevention such as engaging bystanders, educating youth about healthy relationships, and changing social norms and addressing common risk and protective factors.

NPM 7: Rate of injury related hospital admissions per population 0 thru 19 years.
In 2015, the rate of injury-related hospital admissions among adolescents was 266 per 100,000 adolescents ages 10-19. This was an increase over 2012, the last year of available data, when the rate was 208 per 100,000. Hospital discharge reporting was not mandatory in Alaska until 2015. Thus, data voluntarily reported between 2001 and 2012 represent the majority, but not the entirety, of Alaska's discharges, and information from many rural hospitals is missing which could particularly impact indicators such as injury-related admissions.

The majority of Alaskan youth are in healthy relationships, but in 2015 17.0% of alternative high school students and 9.5% of traditional high school students reported being physically hurt on purpose by someone they were dating or going out with one or more times in the last 12 months (Alaska Youth Risk Behavior Survey). This data is similar to the national reported rate of teen dating violence and not statistically different from the 2013 Alaska data.

The Alaska Rape Prevention Education (RPE) Program grant from the Centers for Disease Prevention and Control was overseen by the AHP to provide primary prevention of sexual assault. The work of this grant addresses intimate partner violence among young adults, bullying prevention, and healthy relationships by implementing Bringing in the Bystander at University of Alaska Anchorage. As well, funds supported the Statewide Domestic Violence and Sexual Assault Prevention Summit to support primary prevention of sexual assault prevention activities in rural communities and with youth.

A further discussion of activities related to injury prevention among both children and adolescents can be found in the Child Health domain annual report.

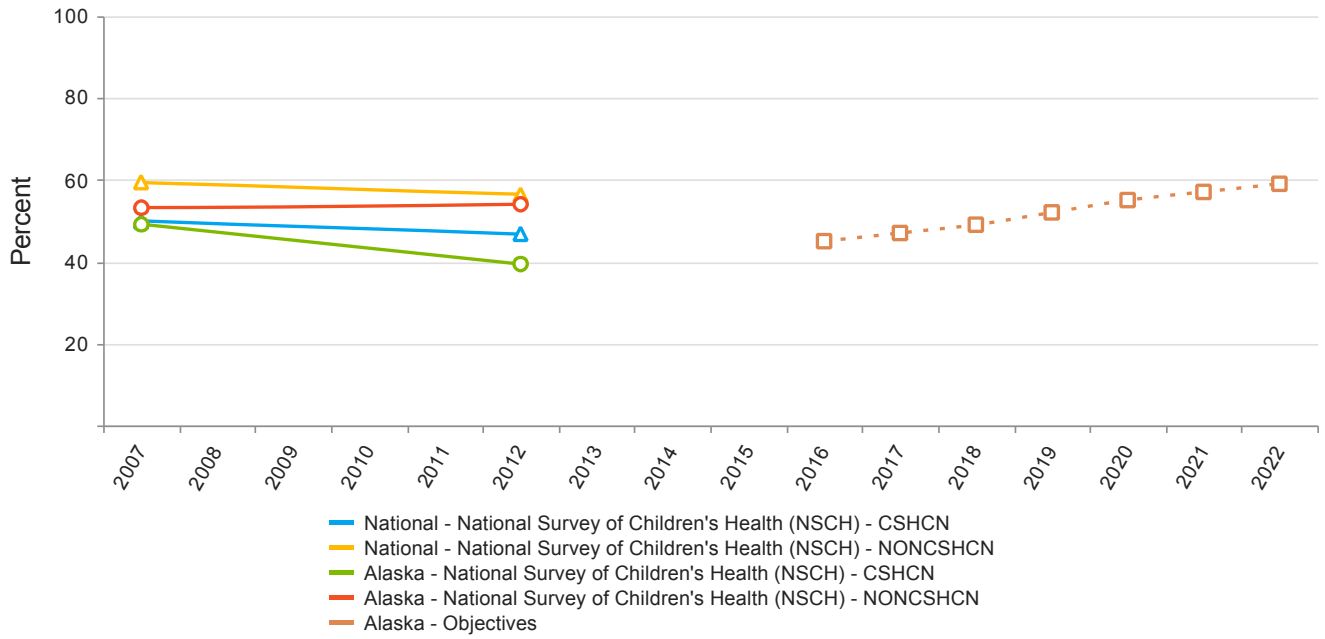
Children with Special Health Care Needs

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system	NS-CSHCN-2009_2010	13.3 %	NPM 11
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	88.5 %	NPM 11
NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)	NIS-2015	66.3 %	NPM 11
NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza	NIS-2015_2016	47.9 %	NPM 11
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISF-2015	57.1 %	NPM 11
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISM-2015	41.6 %	NPM 11
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2015	69.7 %	NPM 11
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2015	55.7 %	NPM 11

National Performance Measures

NPM 11 - Percent of children with and without special health care needs having a medical home
Baseline Indicators and Annual Objectives



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2016
Annual Objective	45
Annual Indicator	39.6
Numerator	10,398
Denominator	26,280
Data Source	NSCH-CSHCN
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	47.0	49.0	52.0	55.0	57.0	59.0

Evidence-Based or –Informed Strategy Measures

ESM 11.1 - Percent of CYSHCN in School Nurse Pilot Project elementary pilot schools and partner practices with Shared Plan of Care

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	12.1
Numerator	4
Denominator	33
Data Source	School Nurse- Care Coordination Pilot Project reco
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.2	0.2	0.2	0.2	0.2	0.2

ESM 11.2 - Number of families/providers who obtain needed support from Help Me Grow Alaska for a needed specialist, support or service.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	1
Data Source	Help Me Grow Alaska database
Data Source Year	NA
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.5	0.6	0.6	0.7	0.7	0.8

State Action Plan Table

State Action Plan Table (Alaska) - Children with Special Health Care Needs - Entry 1

Priority Need

Improve system of care for families with children and youth with special health care needs

NPM

Percent of children with and without special health care needs having a medical home

Objectives

By 2021, increase the proportion of CYSHCN who receive integrated care through a patient/family centered medical/health home approach by 20% over Alaska's reported 2009/10 levels of 42.8%.

Strategies

NPM 11.1. Increase CYSHCN access to cross-systems care coordination using the Shared Plan of Care concept

NPM 11.2. Develop and expand a shared resource for families and primary care providers of CYSHCN using the Help Me Grow centralized system model

NPM 11.3. Implement state CYSHCN Plan priorities such as transition to adult care.

NPM 11.4. Expand provider access to medical home concepts and tools through education and statewide technical assistance

NPM 11.5. (NEW) Partner with tribal health and UAA Center for Human Development to implement project ECHO related to autism and other developmental disabilities by contracting with the University of Massachusetts to develop with the SOA an online curriculum to train primary care providers to diagnose children at high risk for autism and/or ADHD.

NPM 11.6 (NEW): Improve the quality and availability of data related to the CYSHCN population (including CAHPS survey, birth defects surveillance, etc)

NPM 11.7 Partner with statewide family leadership agencies to revise and implement Family Navigation services.

NPM 11.8 (NEW) Partner with audiologist and Early Intervention to increase referrals and enrollment by 6 months of age for children diagnosed with a hearing loss.

NPM 11.9: (NEW) Update the Oral Health Dental Guide for Families with CYSHCN.

ESMs	Status
ESM 11.1 - Percent of CYSHCN in School Nurse Pilot Project elementary pilot schools and partner practices with Shared Plan of Care	Active
ESM 11.2 - Number of families/providers who obtain needed support from Help Me Grow Alaska for a needed specialist, support or service.	Active

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system
NOM 19 - Percent of children in excellent or very good health
NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)
NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

PLAN FOR THE APPLICATION YEAR: OCT 2017- SEPT 2018

Alaska's Title V CYSHCN program continues to support systems integration efforts through collaborations and partnerships with community, medical, university and state agency based partners.

NPM 11: By 2021, increase the proportion of CYSHCN who receive integrated care through a patient/family centered medical/health home approach by 20% over Alaska's reported 2009/10 levels. In 2011-2012, 43% of Alaska children with special health care needs and 54% of children without special health care needs had a medical home.

Strategies:

11.1 Increase CYSHCN access to cross-systems care coordination using a Shared Plan of Care

WCFH staff (both Title V and non-Title V funded) will continue to facilitate a pilot program for a small cohort of identified CYSHCN through a contract with a clinically integrated network in Anchorage and in partnership with the Anchorage School District. A clinically integrated network is an active and ongoing program to evaluate and modify practice patterns by the networked provider participants creating a high degree of interdependence and cooperation among the physicians to control costs and ensure quality. School nurses will have access to individual child records relevant to school based care and participate in family-centered "shared plan of care" development. A shared plan of care is a guide for family-centered care coordination using a clear summary of information and a team approach. A shared plan of care includes:

a. Medical Summary – which details child/ family demographic information; current medical care facts; lead team members and contacts; and core child and family knowledge including their personal preferences and goals.

b. Negotiated Actions – highlights personal and clinical goals and joint strategies to address and /or achieve goals with timelines, responsibilities and accountabilities.

The program will continue to utilize ESM 11.1 to measure the percent of CYSHCN in pilot schools with a shared plan of care. Data collected for this ESM will allow the primary care practices, schools, and Title V to monitor increases in shared plan of care access among the pilot program population. Additional family and nurse experience data will be collected and analyzed as part of this initiative for quality improvement purposes and to measure short and medium term outcomes of having a shared plan of care. As this is a pilot project and the first of its kind in Alaska, objectives and available resources are expected to change over the action plan period. Results will be disseminated widely throughout the state as well as nationally through the HRSA Systems Integration Grant for CYSHCN cohort.

In summer 2017, two student interns from the National MCH Workforce Development Center will join Title V to develop and refine a toolkit to replicate and spread successful components of the School Nurse Care Coordination (SNCC) model statewide. The graduate level MCH students will assist in identification and adaptation of materials and processes to be included in the toolkit such as family-centered medical home brochures, sample shared plans of care, and quality improvement tools. The MCH students will research and design appropriate evaluation methodologies to measure impact and sustainability of SNCC activities. Currently, the SNCC pilot project is limited to one Anchorage-based pediatric practice, however Title V staff are working to identify additional practices to promote this SNCC model. Dependent on the level of engagement by summer 2017, students may be assigned to work with individual practices to establish and test the newly developed SNCC toolkit. The model and toolkit have the potential to become a resource used by Title V programs in other states. In addition, another cloud based service to coordinate care through shared electronic health records will be explored. The Title V funded School Nurse Consultant will provide ongoing technical assistance and advisory support for this project.

11.2 Develop and expand a shared resource for families and primary care providers of CYSHCN using the Help Me Grow centralized system model

Help Me Grow (HMG) is a system that connects children and families with the services they need. Experts agree that early detection and connection to services lead to the best outcomes for children with developmental and/or behavioral challenges. HMG is a centralized system for improving access to existing resources and services for children 0 to 8. HMG is a system that builds collaboration across sectors, including health care providers, early child care, education, family support, and community resources. Through comprehensive provider and community outreach and a centralized information and referral center (call center), families are linked with needed programs and services. Ongoing data collection and analysis help identify gaps in and barriers to the system for constant improvement.

Title V led planning efforts for implementing HMG in Alaska through 2016 and early 2017 and in March 2017 awarded a contract to the All Alaska Pediatric Partnership to lead implementation. WCFH staff will continue to be integral to the HMG Alaska leadership team and is a key partner in the developmental screening component of the program, in collaboration with the Early Comprehensive Childhood Systems coordinator and the three place-based communities identified by that initiative in 2016 (Kodiak, Norton Sound and Matanuska-Susitna). Statewide expansion planning will begin within the year.

The ESM will measure the number of families and providers who contact Help Me Grow Alaska and are able to obtain the needed support requested. This data will be collected after the soft launch of the program and preliminary reporting will be available in mid to late 2017.

11.3 Implement state CYSHCN state plan priorities such as transition to adult care

The CYSHCN State Plan will be regularly visited and strategies developed through family and stakeholder engagement. Alaska's five year CYSHCN State Plan is based on broad stakeholder input using the National Standards for CYSHCN as a framework. Statewide assessment of the system of care was conducted through a process including systems level input in early 2015 and culminated with a series of stakeholder and individual conversations in late 2015. Additional assessment of the system will be conducted in 2017 using additional data as identified and will be incorporated into the subsequent work plan and CYSHCN State Plan updates. AMCHP technical assistance was accessed throughout the process and continues to offer guidance and resources in planning and implementation of the National Standards document.

The state plan focuses on six of the ten National Standard domains for CYSHCN:

1. Screening, Assessment and Referral
2. Access to Care
3. Medical Home
4. Community-based Services and Supports
5. Family Professional Partnerships
6. Transition to Adulthood

The plan continues to support the three AIM statements from Alaska's current CYSHCN Systems Integration Grant. Activities are aligned with the Autism Ad Hoc Committee's five year Autism State Plan and are integral to related Early Childhood Comprehensive Systems (ECCS) efforts, among others.

The next year will highlight an increased focus on Transition to Adulthood which is an identified need within the state. Partnership with the Governor's Council on Disabilities and Special Education, Stone Soup Group (Family Voices/Family to Family Health Information Center), and the Title V Family Leader will support these efforts, along with engagement with the Got Transition National Center as appropriate. WCFH has already had preliminary discussions with providers, Got Transition, the Governor's Council, and other stakeholders on what the needs are related to this issue and how Title V can be most impactful with limited resources. Possibilities include the creation of a work group looking at this issue, education for providers, among others.

11.4 Expand provider access to medical home concepts and tools through education and statewide technical assistance

Alaska's distance delivered, university-based "Principles of Pediatric Care Coordination" continuing education course was adapted from the Boston Children's Medical Center and Maternal Child Health Bureau's "Care Coordination Curriculum" by Title V and the All Alaska Pediatric Partnership in 2014. The course is about to enter its third cohort and now has established leadership within the tribal health system to ensure sustainable and experienced instructors with nurse case management experience working within tribal health and other pediatric systems.

The care coordination course was used as a foundational curriculum for Family Navigation training which will support medical home and specialty services for CYSHCN. The new family navigation course was piloted in spring 2017 and is currently in revision for future offerings.

11.5 Partner with tribal health and UAA Center for Human Development and the University of Missouri to implement project (Extension for Community Healthcare Outcomes (ECHO) related to autism and ADHD. In addition, contract with the University of Massachusetts to develop with the WCFH an online curriculum to train primary care providers to diagnose children autism and/or ADHD.

WCFH will continue to partner with the UAA Center for Human Development, tribal health, and physicians from the Universities of Missouri and Massachusetts to implement a Project ECHO for autism and ADHD in Alaska. Project ECHO is a tele-education model originating from the University of New Mexico and uses video conferencing to do case-based learning and didactic presentations. Participants are able to get feedback and learn from a hub team of experts on questions they have related to diagnosing or caring for children in their practice who experience autism, ADHD and other neuro-behavioral conditions. ECHO Autism/ADHD is currently being piloted in May and June of 2017 with a scheduled hiatus for July and August. The ECHO clinic will restart in September of 2017

In addition, WCFH contracted with the University of Massachusetts to develop an online asynchronous set of 6 modules for licensed health care providers to train them in the skills for diagnosing autism and ADHD for populations of kids that have a relatively straightforward diagnosis. The modules will be piloted beginning in August of 2017 and will be fully marketed and launched in the fall of 2017. This workforce development activity will enhance and increase the number of licensed providers to diagnose autism and ADHD and will improve the referral process to the developmental-behavioral pediatrician who will be coming to the state of Alaska in August of 2017. WCFH will continue to provide non-Title V funding to support these two workforce development activities ... Since Alaska has a shortage of providers who can make an autism diagnosis, WCFH felt that this would be a way to connect providers and increase knowledge in Alaska regarding caring for this population. UAA will continue to host the program, provide CME, and coordinate both the on-line training and ECHO clinics in partnership with tribal health.

11.6 Improve the quality and availability of data related to the CYSHCN population (including CAHPS survey, birth defects surveillance, etc.)

Title V will continue to partner with the state Children's Health Insurance Program (CHIP) Director to support the Consumer Assessment of Healthcare Provider Systems (CAHPS) patient experience survey. The survey was designed specifically to engage pediatric population feedback with an added module to identify CYSHCN. Both Title V and Medicaid agencies plan to continue fielding this survey with community practices as well as through a statewide Medicaid sample population to help identify trends in family/patient experience of care including access and quality.

Title V epidemiologists will continue to work with CYSHCN program staff to identify data sources to compile and disseminate internally and to external partners for ongoing monitoring and quality improvement initiatives related to CYSHCN. Title V and Medicaid (CHIP) are working to identify sustainable data analysis capacity options for specialized analysis of the CAHPS and other Medicaid. A long term vision for partnership would be to leverage state and federal CHIP funds through one or more Health Services Initiatives to improve child and maternal health. These options will be explored in the coming year.

The Alaska Birth Defects Registry (ABDR) data are used to inform the overall system of care for Alaska's MCH population, in particular services for children with special healthcare needs resulting from birth defects. ABDR is a passive surveillance system with registrants obtained from reporting health care providers/centers treating or diagnosing a list of specified birth defects. The ABDR provides data to local health care providers/researchers that are interested in better understanding the populations they serve. Additionally, legislative requests are often interested in the prevalence of specific conditions. Although the ABDR program has been in existence since the early 90's, the availability of information from this system has been both suspect and difficult to aggregate. Bolstering this registry is a priority to ensure that these CYSHCN are adequately resourced.

ABDR staff participated in a strategic planning meeting in April 2017 and will be implementing activities throughout the upcoming year based on the one-year work plan that was the result of the meeting. The major issue impacting the reliability of ABDR data is related to the collection of reports from the multiple agencies

across the state. Thus, activities in the work plan primarily revolve around improving and simplifying the reporting process, such as obtaining and analyzing linkable hospital discharge data (HDD) and public health nursing data, pursuing insurance claims data, and conducting a coverage assessment of reports solely from HDD, PHN, and Medicaid claims. ABDR has developed a systematic process for evaluating this effort which if implemented could drastically improve the reliability and timeliness of these data. Because data aggregators are not explicitly defined in statute regulations, an update to these will be required to encourage the participation of private insurance groups. ABDR plans to continue to publish comprehensive data on the newly updated website and complete medical records review of a sample of all 43 nationally reportable conditions. All ABDR staff are partially or fully funded by Title V.

11.7 Partner with statewide family leadership agencies to revise and implement Family Navigation services

Title V Block grant funds continue to support contracted Parent (Family) Navigation services provided by Alaska's Family to Family Health Information Center (Stone Soup Group). Title V support of these services in pediatric specialty clinics (neurodevelopmental, cleft lip and palate), children identified through the Early Hearing Detection and Intervention (EHDI) program, and other CYSHCN is ongoing. Current performance measures for the parent navigation services include increased family involvement in Title V advisory committees, including work related to patient/family centered medical home and CYSHCN systems integration. The coming year will focus on embedding quality improvement methodology into parent navigation practice. Title V will provide training and support to Stone Soup Group to develop internal quality improvement capacity and establish quality improvement targets related to parent navigation and family support services.

Title V will continue to lead and be engaged over the next year to further develop the Family Navigation training program piloted by the University of Alaska's Center for Human Development in 2017 to increase parent/family navigation capacity statewide. Family Navigation activities will focus on establishing the "Alaska Family Involvement Network" which will be led by the LEND Family Advisory Council faculty who has over 20 years of experience as a parent-professional with a child who experiences autism. The network will be based on an Oregon model which supports family-professional partnerships in medical practices. This model will support increased Family Navigation capacity of statewide family service agencies and streamline family-professional partnership activities to ensure enhanced medical home linkage for CYSHCN, in addition to advocacy and family-policy involvement. The model will focus on professional development and develop a sustainability plan for Family Navigation and Advocacy recruitment and training. Competencies for standardized, clinically-based Family Navigation training have been developed and will be enhanced and implemented over the next 1-2 years using quality improvement methodology to improve the curriculum and engage families in sustainability activities. The development of the curriculum has been funded by WCFH general fund dollars. Title V staff will be heavily involved in Family Navigation program development to ensure sustainability and cohesiveness with other related Title V and statewide activities. Other state and federal resources will be leveraged to both initiate and sustain Family Involvement Network activities.

11.8 Partner with audiologists and Early Intervention (Part C) to increase referrals and enrollment by 6 months of age for children diagnosed with a hearing loss

In Alaska, most audiologists see patients from across the lifespan and their experience of diagnosing a pediatric patient may be rare, only occurring once or twice a year. Based on this information and in response to a request from audiologists, a pediatric diagnosis checklist and training for audiologists is being created. The checklist has been trialed with three audiologists which resulted in increased referrals to Early Intervention/Infant Learning Program (EI/ILP). The checklist is being updated to include feedback from audiologists and will be introduced in a training which will include information on the availability and value of EI/ILP services and on the EI/ILP referral process. Beginning June 2017, the team will conduct trainings in partnership with EI/ILP staff for audiologists statewide on the pediatric checklist. After the initial trainings the team will conduct a post training survey to measure satisfaction with the use of the checklist and solicit input for improvement. The trainings will be updated based on that feedback and then will be offered as needed when new audiologists join the Alaska system of care.

11.9 Update the Children's Oral Health Information Packet for Families with CYSHCN.

WCFH staff will be updating the Children's Oral Health Information Packet in spring 2017. The packet has Alaska-specific information and was originally made in 2009 but uses educational materials and infographics from other states and national organizations. After the updates are completed, WCFH staff and the Stone Soup

Group (SSG) will present the new guide to parent leaders (MAP Program), and survey them for feedback regarding the usefulness of the guide. Families will also be asked about other educational materials that are needed and could be helpful in providing oral health care to a child with special needs. If better materials are suggested the Title V staff along with the SSG will explore new options.

REPORT FOR THE APPLICATION YEAR: OCT 2015- SEPT 2016

Alaska's Title V CYSHCN program continued to engage with stakeholders and families statewide for systems planning and implementation efforts to improve care and health outcomes for children. Primary partnerships included the state's Part C Early Intervention program, the Early Childhood Comprehensive Systems program, the All Alaska Pediatric Partnership, the University of Alaska LEND program, the Governor's Council on Disability and Special Education, and the Stone Soup Group, among others. Funding and human resources were leveraged to reduce gaps and duplication in efforts, though many systems issues persist due to provider shortages and the state's fee for service reimbursement model. Title V infrastructure and leadership are essential to the ongoing pursuit of systems integration for CYSHCN in Alaska, and have focused on improving access to primary care through the patient/family centered medical home model (with a focus on prevention, developmental screening, and early identification and treatment) to lead broader and more comprehensive reform efforts.

NPM 11: By 2021, increase the proportion of CYSHCN who receive integrated care through a patient/family centered medical/health home approach by 20% over Alaska's reported 2009/10 levels. In 2011-2012, 43% of Alaska children with special health care needs and 54% of children without special health care needs had a medical home.

Strategies to achieve this objective included:

1. **Increase CYSHCN access to cross-systems care coordination using a Shared Plan of Care**

   WCFH staff (both Title V and non-Title V funded) convened a pilot program for a small cohort of identified CYSHCN through a contract with a practice integrated network in Anchorage and partnership with the Anchorage School District. The pilot intends to develop shared plans of care for eligible CYSHCN within five pilot schools.

   In the past year, the primary care practice developed plan of care components and eligibility criteria for CYSHCN within five elementary schools. WCFH staff developed HIPAA and FERPA compliant consent forms, a Title V to school district MOA, outreach materials and a press release to support recruitment and community awareness. Delays related to electronic medical record data accuracy and access for school nurses have required flexibility in some areas of the project design, but preliminary feedback from school nurses and the practice based care coordinator indicate a high level of satisfaction with the increased communication and improved continuity of care for children and their families. Barriers to progress included unanticipated technology issues in the clinical setting which have not allowed for the intended electronic health record sharing originally envisioned. However, the practice care coordinator and school nurses still report a high level of satisfaction with the pilot due to increased collaboration and access to information through a basic shared plan of care.

   The ESM measures the number of eligible CYSHCN in pilot schools and the partner practice with a shared plan of care. Currently 12% of eligible CYSHCN have a shared plan of care, with a target by the end of 2017 of 20%. Data collected for this ESM will allow practices, schools, and Title V to monitor increases in shared plan of care access among the pilot program population.

1. **Develop a shared resource for families and primary care providers of CYSHCN using the Help Me Grow centralized system model**

   Title V continued to lead HMG Alaska planning efforts through workgroups and Leadership Team guidance to develop implementation and sustainability recommendations based on the four core components of HMG. Staff worked closely with local partners and the Help Me Grow National center at Connecticut Children's Hospital to develop a "roadmap to replication." Local workgroups informed the road mapping process. Statewide and community level buy-in for increased standardized developmental screening and the Help Me Grow model generally were an additional focus of the past year. Broad community partnerships, including the primary implementation agency, the All Alaska Pediatric Partnership, were fostered. Title V staff supported the newly hired Early Childhood Comprehensive Systems (ECCS) state coordinator in a successful competitive ECCS grant award in 2016 in which Help Me Grow Alaska was centrally featured. The new ECCS coordinator has been a central partner in Help Me Grow Alaska sustainability planning and offers resources and content knowledge as

a former Medicaid policy expert that will be invaluable for Help Me Grow Alaska and CYSHCN/early childhood initiatives broadly.

Data for ESM 11.2 are not yet available since the call center is not yet established, but will measure the number of families and providers who contact Help Me Grow Alaska and are able to obtain the needed support requested.

2. **Assess CYSHCN systems of care to integrate families and create a state plan**

   Alaska's State Plan for CYSHCN created in 2015-2016 was published in January 2016 and was used for numerous planning, educational, outreach, and recruitment efforts (including neurodevelopmental pediatrician recruitment). The plan is publicly available on the newly developed Title V CYSHCN webpage. Many stakeholders engaged during the planning process continued to be involved in priority areas identified during planning, and preliminary evaluation of family involvement indicated a high level of satisfaction with the opportunities to engage in a meaningful way.

   The state plan focuses on six of the ten National Standard domains for CYSHCN:

   1. Screening, Assessment and Referral
   2. Access to Care
   3. Medical Home
   4. Community-based Services and Supports
   5. Family Professional Partnerships
   6. Transition to Adulthood

3. **Expand provider access to medical home concepts and tools through education and statewide technical assistance**

   Alaska's distance delivered, university-based "Principles of Pediatric Care Coordination" continuing education course was adapted from the Boston Children's Medical Center and Maternal Child Health Bureau's "Care Coordination Curriculum" by Title V and the All Alaska Pediatric Partnership in 2014. Primary care practices from around the state, primarily tribal health entities, enrolled twelve individuals with case management/care coordination roles into the spring 2016 cohort 2 courses. Participants reported overall satisfaction with the course and valued the opportunity to network with peers in a constructive setting to share resources and tools to improve their care coordination practice.

   The Alaska Primary Care Association partnered with Title V to host a NCQA medical home expert training in fall 2016 to increase the number of practices in the state familiar with NCQA medical home requirements. The majority of these practices are seeking medical home recognition and are currently either initiating or maintaining practice transformation strategies.

4. **Improve the timely receipt and feedback loop following the initial referral of a CYSHCN by a medical home using a written agency level agreement between Title V and Part C programs**

   This strategy faced many challenges during the past year, primarily due to Part C changes in leadership and an agency shift within the Department of Health and Social Services (formerly in the Office of Children's Services, moved to the Division of Senior and Disabilities Services in 2016). Part C provider agencies from around the state were interviewed to identify common referral and intake practices. Findings showed that while there is not a consistent or formalized feedback loop process, most Part C agencies feel they are adequately providing referral feedback, if parental consent is available. At this time, however, no agency is using a HIPAA/FERPA compliant parental consent form as part of their intake process. Ongoing discussion with the state Part C office with Title V will explore future options, but due to time limitations related to the CYSHCN Systems Integration Grant, it was determined that this strategy would be discontinued and replaced by a feedback loop focus built into the Help Me Grow Alaska contract and system.

5. **Analyze results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) medical home patient experience survey**

   Title V has, since 2014, partnered with the state CHIP Director to support the Consumer Assessment of

Healthcare Provider Systems (CAHPS) patient experience survey. The survey was designed specifically to engage pediatric population feedback with an added module to identify CYSHCN. Both Title V and Medicaid agencies plan to continue fielding this survey with community practices as well as through a statewide Medicaid sample population to help identify trends in family/patient experience of care including access and quality.

The specific version of Alaska's CAHPS survey was cross walked with the National Standards for CYSHCN to determine if this particular dataset could be used in the future to analyze systems of care. While at this time it was determined to have limited capacity, the crosswalk will be revisited with both future surveys as well as future versions of the Standards to identify future opportunities.

6. **Partner with Stone Soup Group (Alaska's Family to Family Health Information Center) to offer Parent Navigation services**

   Title V Block grant funds supported contracted Parent Navigation services, provided by Alaska's Family to Family Health Information Center (Stone Soup Group). Title V continued support of these services in pediatric specialty clinics (neurodevelopmental, cleft lip and palate), children identified through the Early Hearing Detection and Intervention program, and other CYSHCN is ongoing. Performance measures for the parent navigation services included increased family involvement in Title V advisory committees, including work related to patient/family centered medical home and CYSHCN systems integration. A previous performance measure related to family experience/satisfaction was found to have no current data collection methods in place, so very little experience or outcome data is available related to parent navigation services. This will be addressed in the coming year.

Cross-Cutting/Life Course

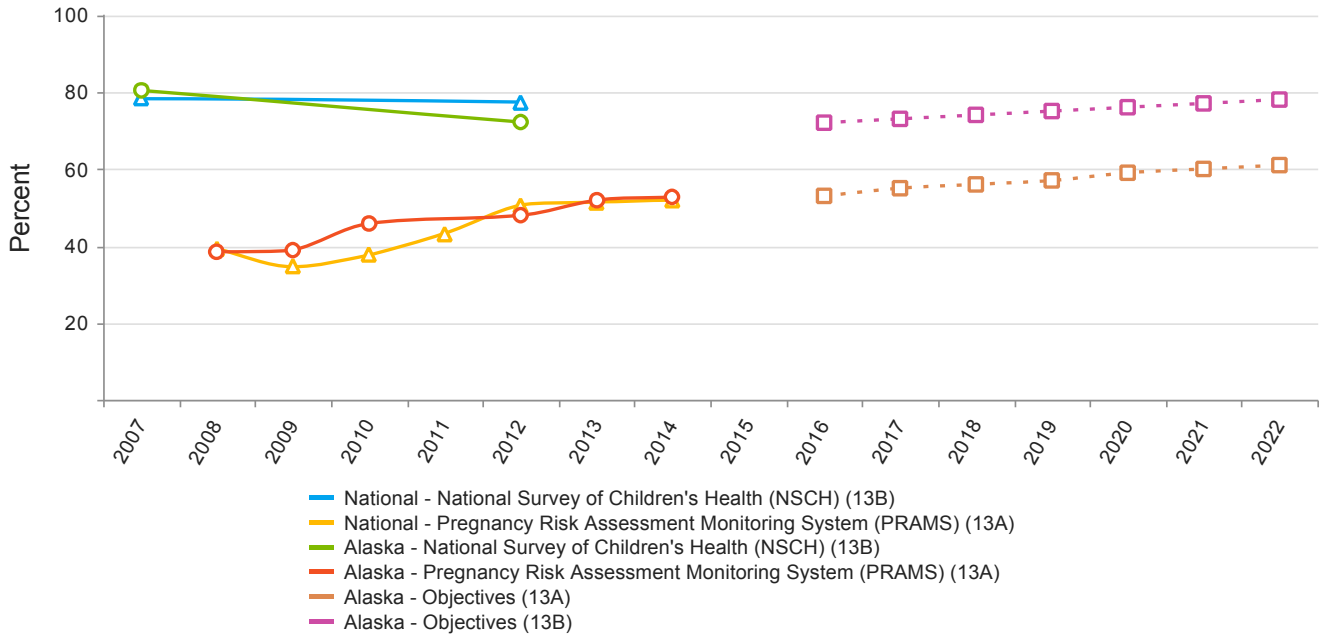
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2012	176.3	NPM 14
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS	Data Not Available	NPM 14
NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2015	5.8 %	NPM 14
NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)	NVSS-2015	0.9 %	NPM 14
NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)	NVSS-2015	4.9 %	NPM 14
NOM 5.1 - Percent of preterm births (<37 weeks)	NVSS-2015	9.0 %	NPM 14
NOM 5.2 - Percent of early preterm births (<34 weeks)	NVSS-2015	2.1 %	NPM 14
NOM 5.3 - Percent of late preterm births (34-36 weeks)	NVSS-2015	6.8 %	NPM 14
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2015	24.9 %	NPM 14
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2014	5.0	NPM 14
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	6.7	NPM 14
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2014	3.1	NPM 14
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	3.6	NPM 14
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2014	96.6	NPM 14
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2014	263.3	NPM 14
NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months	NSCH-2011_2012	19.2 %	NPM 13
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	88.5 %	NPM 13 NPM 14

National Performance Measures

NPM 13 - A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Baseline Indicators and Annual Objectives



NPM 13 - A) Percent of women who had a dental visit during pregnancy

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2016
Annual Objective	53
Annual Indicator	52.7
Numerator	5,749
Denominator	10,909
Data Source	PRAMS
Data Source Year	2014

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	55.0	56.0	57.0	59.0	60.0	61.0

NPM 13 - B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	72
Annual Indicator	72.1
Numerator	125,411
Denominator	173,948
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	73.0	74.0	75.0	76.0	77.0	78.0

Evidence-Based or –Informed Strategy Measures

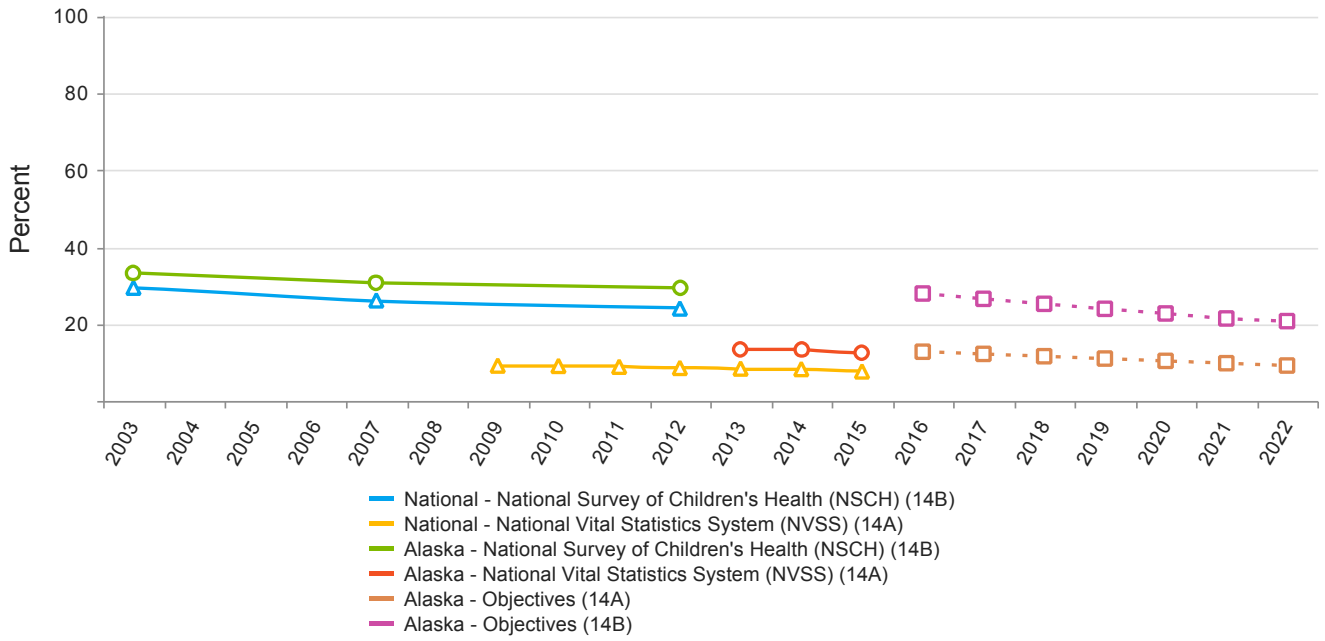
ESM 13.1 - Number of oral health pocket guides distributed

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	30
Numerator	
Denominator	
Data Source	Alaska Oral Health Program
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	300.0	300.0	500.0	650.0	800.0	950.0

NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes
Baseline Indicators and Annual Objectives



NPM 14 - A) Percent of women who smoke during pregnancy

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2016
Annual Objective	12.9
Annual Indicator	12.5
Numerator	1,357
Denominator	10,838
Data Source	NVSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	12.3	11.7	11.1	10.5	9.9	9.3

NPM 14 - B) Percent of children who live in households where someone smokes

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	28
Annual Indicator	29.5
Numerator	54,636
Denominator	185,403
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	26.6	25.3	24.0	22.8	21.5	20.8

Evidence-Based or –Informed Strategy Measures

ESM 14.1 - Number of women currently pregnant or planning pregnancy enrolled in Alaska Quit Line

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	40
Numerator	
Denominator	
Data Source	Alaska Quit Line
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	52.0	57.0	62.0	67.0	72.0	77.0

State Performance Measures

SPM 4 - Percent of women who report being screened for depression during prenatal care

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	75.9
Numerator	8,217
Denominator	10,824
Data Source	PRAMS Phase 7 (with Phase 8, 2016 births, the SPM
Data Source Year	2014
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	77.5	80.0	80.5	81.0	81.5	82.0

State Action Plan Table

State Action Plan Table (Alaska) - Cross-Cutting/Life Course - Entry 1

Priority Need

Increase access and preventative health care services to Alaskans and their families.

NPM

A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Objectives

NPM 13.1. Increase the percentage of Alaska women who had a dental visit during pregnancy to 60% by 2021. NPM 13.2. Increase the percent of Alaska children ages 1-17 years who had a preventative dental visit in the past year to 77% by 2021.

Strategies

NPM 13.1 Distribute the Oral Health Pocket Guide to all providers who have the opportunity to promote children's oral health

NPM 13.2 Collaborate with Division of Health Care Services to improve preventative dental visit with children ages 1-20 enrolled in Medicaid program. Track dental visit with eruption of first tooth no later than 12 months. Break out preventative dental visits by Alaska Native health corporation with a plan to conduct targeted education to medical and dental providers in tribal programs

NPM 13.3 Analyze Alaska-specific oral health data and write up results for publication online in Epidemiology Bulletins or other similar reports, including Medicaid data on dental-related emergency department visits and CUBS survey data

NPM 13.4 Develop an oral health strategy with school nurses and examine opportunities for school nurses to connect students to services.

NPM 13.5 Explore working with MODA and other health insurance providers (including Medicaid) in Alaska to create and distribute “Alaskanized” fact sheets and other educational materials that explain and promote the use of additional oral health coverage that is available for pregnant women to address untreated dental decay and assist with cleaning/root planning and scaling and periodontal maintenance.

ESMs	Status
ESM 13.1 - Number of oral health pocket guides distributed	Active

NOMs

NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

NOM 19 - Percent of children in excellent or very good health

State Action Plan Table (Alaska) - Cross-Cutting/Life Course - Entry 2

Priority Need

Reduce substance abuse among families, including alcohol, tobacco and drugs.

NPM

A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Objectives

NPM 14.1. Decrease the percent of Alaska women who smoked cigarettes during pregnancy to 10.5% by 2020. NPM 14.2. Decrease the percent of Alaska children ages 1-17 years who live in households where someone smokes to 22.8% by 2020.

Strategies

NPM 14.1.a. Partner with March of Dimes for tobacco cessation activities using the SCRIPT model among women of reproductive age and pregnant women (including sharing PRAMS data)

NPM 14.1.b. Partner with the Section of Chronic Disease Tobacco Quit Line to promote provider referrals of pregnant women to the Quit Line that includes permission to receive a call from the quit line within 48 hours of the referral.

NPM 14.2 Provide parental education to families participating in Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program about household smoke exposure to children

ESMs	Status
ESM 14.1 - Number of women currently pregnant or planning pregnancy enrolled in Alaska Quit Line	Active

NOMs

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

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

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

NOM 5.1 - Percent of preterm births (<37 weeks)

NOM 5.2 - Percent of early preterm births (<34 weeks)

NOM 5.3 - Percent of late preterm births (34-36 weeks)

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

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

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

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

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

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

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

NOM 19 - Percent of children in excellent or very good health

State Action Plan Table (Alaska) - Cross-Cutting/Life Course - Entry 3

Priority Need

Increase evidence based screening for all MCH populations for behavioral and mental health problems

SPM

Percent of women who report being screened for depression during prenatal care

Objectives

SPM 4.1. By 2021, increase the proportion of Alaska women who report being screened for depression during prenatal care to 81.5%.

Strategies

SPM 4.1. Increase partnerships with the division of behavioral health to identify evidence based screening tools

SPM 4.2. Screen women enrolled in Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program for depression up to three months after delivery.

PLAN FOR THE APPLICATION YEAR: OCT 2017- SEPT 2018

NPM 13A Percent of women who had a preventive dental visit during pregnancy
The Oral Health Program staff are working with the Perinatal/Women's Health nurse consultants in WCFH to modify documents on perinatal oral health developed by the Oral Health Resource Center (OHRC). They will be adapted to Alaska (e.g., feature pictures Alaska Native children) and distributed to parents/caregivers, through links to these resources on the Section's website. Additionally, a survey will be developed and distributed to perinatal health care providers to gain knowledge of their understanding regarding the importance of perinatal oral health care as well as educational and training needs. The following resources will be presented and shared at appropriate conferences or venues:

- Tips for Good Oral Health During Pregnancy
- Promoting Oral Health During Pregnancy
- Access to Oral Health Care During the Perinatal Period: A Policy Brief
- Oral Health Care During Pregnancy: A National Consensus Statement
- Oral Health Care During Pregnancy: A Resource Guide
- AMCHP's pregnancy and oral health video

The MCH Epidemiology Unit will begin annual data analysis to assess preventive dental visits for pregnant women enrolled in Medicaid utilizing dental claims data. Guidance will be sought on this analysis both from the Medicaid program as well as epidemiologists in other states who have conducted similar analyses. Additionally, PRAMS data will be collected and data analyses updated to monitor trends during each reporting period. Unit staff plan to publish an Epidemiology *Bulletin* specifically focusing on perinatal oral health data and current recommendations for providers.

WCFH staff will continue to provide presentations on the importance of preventive dental visits for pregnant women and children, utilizing the Bright Futures Oral Health Pocket Guides to assist providers on education and referral for dental services for pregnant women and children.

Section staff will seek opportunities to increase collaboration with the Women Infants and Children Supplemental Nutrition Program (WIC) as a means to educate on the need for preventive dental visits during pregnancy and assist with referral to dental providers.

Nurse consultants will continue distribution of information (e.g., fact sheets) on perinatal oral health and provide presentations on perinatal oral health where appropriate (e.g., All Alaska Pediatric Partnership meetings). The Section will also look for opportunities to improve integration of perinatal oral health in education/communication resources for the public/beneficiaries (e.g., Medicaid/Denali KidCare and state employee dental insurance plans).

The Section will explore resources for inclusion of state-added periodontal disease questions on a future Behavioral Risk Factor Surveillance Survey (e.g., 2020 BRFSS).

NPM 13B Percent of infants and children, ages 1-17, who had a preventive dental visit in the last year
In partnership with the Division of Health Care Services, the Section will continue to monitor and report on preventive dental visits for children enrolled in the Medicaid/Dental KidCare program (CHIP Medicaid expansion) from the annual CMS 416 reports. MCH Epidemiology staff, funded by Title V, will do additional analysis of claims data utilized to generate the CMS 416 report to assess regional differences in dental utilization (Native health corporation regions), differences in race/ethnicity and other demographic factors to improve targeting of education and Section activities to improve preventive dental visits for children. The results of this analysis may be shared with and disseminated by partners at ANTHC, or at the Dental Chiefs annual meeting in Anchorage in Fall 2017.

The MCH Epidemiology Unit will analyze CUBS data to monitor trends in dental access for young children. The CUBS program, funded by Title V, has been collecting oral health data from mothers of 3-year-old children since its inception in 2006. Current oral health questions include if a health care provider has ever told the mother the child has tooth decay or cavities, if the child has ever been to a dentist or dental care provider, timing of first visit to a dentist or dental care provider, and dental care received. Additional questions ask about behaviors that affect oral

health, such as consumption of sugar-sweetened beverages. During survey revision years, Title V priorities and activities are used to guide the selection of all CUBS questions, including those on oral health topics. MCH Epidemiology staff are currently working on a study of CUBS oral health data and factors that are associated with early dental visits, which will be published in an Epidemiology *Bulletin* in early Fall 2017.

WCFH staff will also track trends with dental visits in the less than 12 month and 12-24 month age groups enrolled in Medicaid with the May 1, 2016 adoption of American Academy of Pediatric Dentistry guidelines for EPSDT (first dental visit within six months of eruption of first tooth no later than 12 months). Additionally, WCFH staff are working with analysts in the Section of Health Analytics and Vital Records to review emergency department data on dental-related visits for children, as reported to the Health Facilities Data Reporting Program (formerly known as the Hospital Discharge Dataset).

Section staff will continue to provide education and information related to community water fluoridation as water fluoridation is the most cost-effective approach to reducing dental decay in children and adults.

Children and adolescents with poorer oral health status are more likely to experience oral pain, miss school, and perform poorly in school compared to their counterparts with better oral health status. (Jackson, et al; American Journal of Public Health, 2011). Under the new education law, Every Student Succeeds Act (ESSA), states are required to include chronic absenteeism on their state report cards, which will likely lead to a greater awareness of the impact of tooth decay and gum disease in childhood on not just general health but also other life course outcomes. The Title V funded School Health Nurse Consultant will continue to develop and refine an oral health strategy with school nurses located in school districts across the state through the State School Health Nurse Advisory Committee. At the April 2017 meeting, nurses determined that they can provide strong support to their schools and communities when there are health fairs/dental fairs, and other oral health activities in their communities by providing information, brochures, and flyers to students, parents and staff. They can also highlight oral health issues in the Nurses' Corner of their school newsletters. Some schools and districts are exploring partnerships with local providers who would come to schools and provide sealants to all students in primary grades regardless of insurance coverage.

The Oral Health Program received a two-year grant from the CDC Division of Oral Health to collaborate with the Obesity Prevention and Control Program to reduce child consumption of sugary drinks. The grant budget period is from September 1, 2016 – August 31, 2018. The grant will assist in funding media, including social media and social marketing, to educate and increase awareness of the role of sugary drinks as a major contributor to child obesity and tooth decay. The grant activities also include engaging dental professionals to educate and counsel children and their parents to reduce sugary drink consumption.

NPM 14A Percent of women who smoke during pregnancy

The Alaska Division of Public Health has a robust tobacco prevention and control program located in the Section of Chronic Disease Prevention and Health Promotion (CDPHP). Through the Tobacco Cessation CoIIN collaborative initiated in FY14 and coordinated by Title V staff, WCFH has focused efforts on decreasing the percent of Alaska women who use tobacco during pregnancy. The CoIIN project formalized a partnership between WCFH, March of Dimes (MOD), CDPHP Tobacco Quit Line program, the Section of Public Assistance WIC program, the Section of Behavioral Health, and the Alaska Native Tribal Health (ANTHC) Consortium Tobacco program to promote provider referrals to the Tobacco Quit Line among women currently pregnant or planning pregnancy and breastfeeding women. This includes promoting the ability of providers to request permission from the patient to receive a call from the quit line within 48 hours of the referral, rather than the patient having to make the call themselves. WCFH will continue to monitor data trends from the Tobacco Quit Line to guide programming activities. In April 2016, the Quit Line began offering participants the ability to pick and choose from a service menu in order to tailor interventions which includes 2 week Nicotine Replacement Therapy (NRT) starter kit, web coaching and TXT to Quit options in additional to the all access phone based program.

WCFH is also continuing to partner with CDPHP through the CoIIN collaborative to develop a streamlined SCRIPT (Smoking Cessation & Reduction in Pregnancy) based 1 page guide in response to rural health staff wanting a more concise resource. This guide will be circulated at Tobacco Prevention & Control (TPC) Grantee meetings, beginning in the northern region. The option to contract with the former March of Dimes Director to provide SCRIPT train-the-trainer events in regions of Alaska with the highest rates of smoking during pregnancy will also be explored in partnership with CDPHP.

Planning is already underway for the September 2018 Alaska Maternal Child Health & Immunization conference

cosponsored and co-organized by WCFH using Title V funds. This 2018 conference will include sessions related to tobacco use among women and reducing tobacco use across Alaska.

NPM 14B Percent of children who live in households where someone smokes

To decrease the percent of Alaska children ages 1-17 years who live in a household where someone smokes, WCFH will continue to administer the MIECHV program which provides parental education to families about household smoke exposure to children.

When applicable projects related to household exposure to smoke arise, the Title V-funded School Nurse/School Health Consultant will continue to work with the Alaska Asthma Coalition and attend Coalition meetings.

The PRAMS and CUBS programs will analyze and share tobacco indicators for the Alaska maternal and child population in a variety of ways, including producing additional Indicator Reports on the online Indicator Based Information System (AK-IBIS), and presenting data at the Tobacco Prevention and Control Program annual grantee and region-specific trainings. These trainings are a way to introduce tobacco prevention program staff in the field to the wealth of tobacco-related information on the Alaska MCH population that can be found in both PRAMS and CUBS, as well as birth certificate data.

SPM 4 Percent of women delivering live births who report being screened for depression during prenatal care

Early identification and referral of behavioral and mental health problems is essential for improving the overall health and wellbeing of all cross-cutting populations. WCFH elected to add an SPM related to prenatal screening for depression, as the Title V leadership felt that none of the NPMs directly aligned with the state priority of increased evidence-based screening for all MCH populations for behavioral and mental health problems. Although this will only measure a small percentage of the total Alaskan population who is at risk for mental and behavioral health problems, we selected a measure that focuses on prenatal depression because of the availability of reliable and high quality data through Alaska PRAMS. Assessing maternal mental health and referring for treatment can improve personal health as well as that of their children and families.

As the broad category of behavioral and mental health screening is a new priority for WCFH, the key activities within the action plan are on systems improvement, partnering, and providing technical support. WCFH will partner with the Division of Behavioral Health to identify evidence-based screening tools and disseminate the information. This list will be made available to providers and educators and they will be encouraged to adopt the use of the identified tools. WCFH currently partners with DBH in the form of data sharing. Additional ideas for future strategies include: 1) develop and disseminate a survey to health care providers regarding the implementation and use of evidenced based screening tools; 2) evaluate data and disseminate with said providers; 3) research and develop needed educational tools and share with those providers requesting this type of assistance. The goal of a survey is to help identify the evidence-based tool that works best for providers in Alaska and for WCFH to provide training and technical assistance to providers on these tools.

WCFH will continue to screen pregnant and postpartum women enrolled in the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program for symptoms of maternal depression using the evidence-based Patient Health Questionnaire-9 (PHQ-9). The nurse home visitors have received training in maternal depression and refer clients as appropriate to counseling services at Providence Behavioral Health or other entities. Alaska is also a part of a Home Visiting Innovation grant with WA, OR, and ID to enhance professional development for home visitors across our state. Maternal depression is one of the key focuses of this grant. Mental health concerns are of the three main challenges that home visitors face with their clients. It is anticipated that this grant will provide training and technical assistance to home visitors on maternal depression to better serve families.

Alaska PRAMS will continue to collect data from women who recently delivered a live birth and respond to requests for data on the prevalence of maternal postpartum symptoms of depression and screening for depression to program managers, the media, and health care providers. Similarly, Alaska CUBS will continue to collect data from mothers of 3-year-olds on symptoms of depression and respond to data requests.

REPORT FOR THE APPLICATION YEAR: OCT 2015- SEPT 2016

NPM 13A Percent of women who had a preventive dental visit during pregnancy
Among Alaska women who delivered a live birth in 2014, 53% had their teeth cleaned by a dentist or dental hygienist during their pregnancy (52% in 2013, Alaska PRAMS). This indicator has increased from 38% in 2008. Factors that were significantly related to not having a teeth cleaning included: lower educational attainment (39% for less than high school compared to 65% for a college graduate), lack of health insurance or insured through Medicaid (41% and 44%, respectively, compared to 61% for private insurance), unmarried marital status (41% vs. 58%), non-Hispanic Alaska Native/American Indian race compared to non-Hispanic White (42% vs. 59%), and WIC participation (46% vs. 57%)

To increase the percent of Alaska pregnant women and children who have had a preventive dental visit, WCFH distributed Bright Futures Oral Health Pocket Guides at relevant meetings or trainings to providers, who have the opportunity to promote the oral health of pregnant women and children. The Bright Futures Oral Health Pocket Guide is a resource for all health professionals (medical and dental) that discusses oral health and dental care for pregnant and post-partum women, infants, children and adolescents. The guide highlights the benefits of getting oral health care during pregnancy, the need for early dental visits and aspects for subsequent dental visits, assessment of caries risk, education on factors to reduce risk of early childhood caries, appropriate oral health interview questions and anticipatory guidance/education at each stage for the above populations. The pocket guide information supports provider referral or provision of appropriate preventive dental services. These guides were received from the National Maternal Child Oral Health Resource Center (OHRC) in September 2016 and 30 guides were distributed at the Alaska MCH & Immunization Conference that month. Distribution that occurred at the All Alaska Pediatric Partnership meeting, the Tribal Dental Chiefs meeting, the Alaska Health Summit and other meetings after September 2016 will be reported next year.

NPM 13B Percent of infants and children, ages 1-17, who had a preventive dental visit in the last year
In 2011-2012, 72% of Alaska children ages 1-17 had a preventive dental visit in the past year (NSCH), a decline from the 81% reported in 2007. Among all of the stratified groupings examined using 2011-2012 data, having a preventative dental visit was least common among children who were ages 1-5 years (45%), were uninsured (48%), lived in a household with an income-poverty ratio <100% (58%), lived in a household where English was not the primary language (58%), and whose parents were high school graduates or had not completed high school (60%). CSHCN were more likely to have had a preventative dental visit compared to non-CSHCN (83% vs. 70%). Children with private insurance were more likely than those with Medicaid or no insurance to have a preventative dental visit (78% vs. 67% and 48%, respectively).

The CMS 416 report showed a relatively small change in preventive dental visits for children aged 1-20 enrolled in Medicaid - 45.6% in FFY2014 to 45.9% in FFY2015. Preventive dental visits for children aged 1-2 years enrolled in Medicaid has been slowly increasing but there remains room to improve given the high prevalence of early childhood caries in Alaska – preventive dental visits for this age group in FFY2014 increased from 18.9% to 20.9% in FFY2015.

Oral Health Program staff updated the list of pediatric dental practitioners in Alaska through a survey, and also collected information on the practice acceptance of Medicaid/CHIP, seeing children before age 1 and children/youth with special health care needs (CYSHCN). This information was provided to the Providence Nurse-Family Partnership program, medical providers seeing young children and parents/caregivers for CYSHCN. This list will also be posted on the Section's website in summer 2017.

Oral health materials: *Oral Health & Learning, When Children's Oral Health Suffers So Does their Ability to Learn, and Promoting Oral Health in Schools, A Resource Guide* were both provided to the School Health Nurse Advisory Committee for assessment. The State School Health Nurse Consultant also presented oral health information at the Alaska School Nurse Conference in April 2017 about how school nurses across the state might better support kids' oral health needs in their schools.

NPM 14A Percent of women who smoke during pregnancy
In 2015, 12.5% of Alaska women smoked tobacco during their pregnancy, as reported on the birth certificate. This

was similar to the 13% who reported smoking during the last three months of pregnancy on Alaska PRAMS in 2013. A higher prevalence of prenatal smoking was associated with lower educational attainment (33% among women with less than high school education vs. 1% for college graduates), use of Medicaid (24% among women on Medicaid vs. 4% among those with private insurance), unmarried marital status (26% vs. 5%), younger maternal age (17% for women less than 25 years of age vs. 7% for women ≥35), American Indian/Alaska Native race and Multiple race (32% and 20%, respectively, vs. 8% for non-Hispanic White women), non-metropolitan area residence (21% vs. 9% for small/medium metropolitan residence), and participation in WIC (20% vs. 9%).

The Alaska Division of Public Health has a robust tobacco prevention and control program located in the Section of Chronic Disease Prevention and Health Promotion (CDPHP). Through the Tobacco Cessation CoIIN collaborative initiated in FY14 and coordinated by Title V staff, WCFH has focused some efforts on decreasing the percent of Alaska women who use tobacco during pregnancy. The CoIIN project formalized a partnership between WCFH, March of Dimes (MOD) and the CDPHP Tobacco Quit Line program, the Section of Public Assistance WIC program, the Section of Behavioral Health, and the Alaska Native Tribal Health (ANTHC) Consortium Tobacco program to promote provider referrals to the Tobacco Quit Line among women currently pregnant or planning pregnancy and breastfeeding women. This includes promoting the ability of providers to request permission from the patient to receive a call from the quit line within 48 hours of the referral, rather than the patient having to make the call themselves. From October 1, 2015 to September 30, 2016, there were 40 women currently pregnant or planning pregnancy and 15 currently breastfeeding women who were enrolled in the Alaska Tobacco Quit Line. Additional services are offered through the Quit Line to help pregnant women stop tobacco use which includes five additional coaching calls from staff in the Section of Chronic Disease Prevention and Health Promotion (CDPHP). Also a fact sheet titled *Tobacco Use During Pregnancy* was created and was distributed at the annual Maternal Child Health & Immunization conference, Tobacco Prevention & Control (TPC) grantees, CoIIN coalition and is located on the Tobaccofree.alaska.gov website.

Title V Block grant funds supported printing a supply of rack cards titled: *Legal is not the same as safe.* The cards describe the risks of using tobacco, alcohol and marijuana during pregnancy and breastfeeding. The cards were developed following a request from the State Division of Public Assistance's WIC program for assistance to address marijuana use among their clients. The images and messages were evaluated by focus groups including WIC staff and clients, clients and community members of the Healthy Start program, staff of State and Tribal tobacco programs and on Facebook. The cards are now widely distributed to WIC clinics, primary care clinics, where the vast majority of pregnant and breastfeeding mothers and infants seek care.

NPM 14B Percent of children who live in households where someone smokes

In 2011-2012, 29% of Alaska children ages 0-17 lived in households where someone smoked (NSCH), a decline from the 33% reported in 2003. Among all of the stratifier groups examined using 2011-2012 data, living in a household where someone smoked was most common among children in households with an income-poverty ratio <100% (53%), non-Hispanic American Indian/Alaska Native race (49%) or non-Hispanic multiple race (46%), children whose parents were high school graduates (47%) or had less than a high school education (45%), and children whose primary insurance was Medicaid (45%) or who were uninsured (41%), and children whose parents were unmarried (44%).

WCFH continued to administer the MIECHV program which provides parental education to families about household smoke exposure to children. In addition, the nurses are trained on the Alaska Tobacco Quitline and screen and refer clients to cessation counseling. The Title V-funded School Nurse/School Health Consultant in WCFH is an active member of the Alaska Asthma Coalition which is coordinated by the American Lung Association in Alaska (ALAA) and regularly attended the Asthma Coalition meetings. WCFH partnered with ALAA and AAFAA to bring asthma/allergy education in the form of conference sessions at the spring 2016 ASNA (Alaska School Nurses Association) Conference and SHWI (School Health and Wellness Institute) as well as promoting AAFAA webinars to school nurses. The School Nurse Consultant arranged for a speaker to provide an asthma/allergy webinar for school and public health nurses in the Hot Topics series of public health webinars in May 2016.

The September 2016 MCH and Immunization conference co-sponsored and co-organized by WCFH using Title V funds included the following session related to exposure to smoking: "Environmental Influences on Respiratory and Skin Infections."

Activities around reducing tobacco use among Alaskans and reducing children's exposure to smoke in the home were primarily accomplished by Alaska's Tobacco Prevention and Control Program (TPC), located in the Section of Chronic Disease Prevention and Health Promotion (CDPHP) and is described in Other Programmatic Activities.

From October 1, 2015 to September 30, 2016, 15 currently breastfeeding women were enrolled in the Alaska Tobacco Quit Line, a small indication of women receiving tobacco cessation assistance whose children were likely being exposed to smoke in their home.

SPM 4 Percent of women delivering live births who report health care worker discussions about depression during prenatal care

In 2014, 75.9% of Alaska women delivering a live birth reported that a doctor, nurse, or other health care worker talked with her during any of her prenatal care visits about what to do if she feels depressed during pregnancy or after her baby is born (PRAMS). This is slightly higher than the PRAMS national aggregate estimate from 2011 of 72.2%, and an improvement from the Alaska estimate of 74% in 2009. Among all of the stratifier groups examined using 2014 data, having health care worker discussions during prenatal care about depression was significantly associated only with maternal race, and was more common among women with Other or White race compared to Alaska Native/American Indian women (79% and 78% vs. 70%).

As part of efforts to increase provider capacity around prenatal depression screening, the September 2016 MCH and Immunization Conference co-sponsored and co-organized by WCFH using Title V funds included the following sessions: “Understanding the Features of Treatment Options for Postpartum Depression as Well as How Professionals and Society may Improve Support Offered to Women and Infants” and “Integrated Perinatal Prevention: Targeting Parent Mental Health, Family Violence, and the Children’s Outcomes.” Additionally, a lunch panel plenary session was led by the SBIRT/One Key Question trainers, who tied in the high points of the issue of substance use in Alaska and the need for evidence-based screening, assessment and referral for the perinatal population.

Alaska PRAMS continued to collect data from women who recently delivered a live birth and respond to requests for data on the prevalence of maternal postpartum symptoms of depression and screening for depression to program managers, the media, and health care providers. During 2015-2016, Alaska PRAMS data on postpartum depressive symptoms were featured in a series of online video segments produced by a local television station about postpartum depression, and were shared by the TV reporter with one of Alaska’s senators who ended up signing legislation related to supporting women experiencing postpartum depression and quoting Alaska data on the Senate floor. Similarly, Alaska CUBS continued to collect data from mothers of 3-year-olds on symptoms of depression and respond to data requests.

WCFH continued to screen pregnant and postpartum women enrolled in the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program for symptoms of maternal depression using the evidence-based Patient Health Questionnaire-9 (PHQ-9). The nurse home visitors have received training in maternal depression and refer clients as appropriate to counseling services at Providence Behavioral Health or other communities. During FY16, 87% of clients who delivered a live birth were screened for depressive symptoms at infancy 1-8 weeks. For those clients not screened, this was primarily due to missed home visits.

Other Programmatic Activities

WOMEN/MATERNAL HEALTH

WCFH Family Planning staff continued to manage the federal Title X Family Planning Services grant program, which funds direct clinical family planning services in two areas of Alaska. Per the federal requirements for this program, sites were actively involved in health insurance Outreach and Enrollment activities to assist Title X clients in obtaining insurance coverage. Since Alaska data showed that women with health insurance are more likely to have received a preventive health visit in the past year than uninsured women (see “Plan for the Application Year”, Women/Maternal Domain, NPM 1), these outreach and enrollment activities play a key role in assuring women receive preventive health services and screenings.

In October 2016, WCFH staffs began participating in a national Learning Community, hosted by The Association of State and Territorial Health Officials (ASTHO) with the support of the Centers for Disease Control and Prevention’s, Division of Reproductive Health (DRH) and other federal organizations, with the intent of expanding focus on implementing the use of Long Acting Reversible Contraception (LARC) through state level policy changes and operationalizing the logistics associated with providing access to the most effective contraception available. The learning community provides support in technical assistance (TA) needs and promising practices to assist state leaders in addressing access to highly effective contraception. WCFH staffs, positions that are partially funded with Title V funding, were uniquely positioned for this work by Alaska’s expansion of its State Medicaid program in July 2015 to include childless adults with incomes up to 133% of the federal poverty level. With fairly robust coverage of family planning services and contraceptive methods already in place prior to expansion, the extension of Alaska’s Medicaid coverage to this new population opened the door for new and innovative efforts to increase provider and patient awareness and coverage of, and access to the most effective birth control methods in US history. One of the efforts that WCFH staff have spearheaded through this project is to increase capacity for placement of LARC methods immediately postpartum. The Alaska Native Medical Center (ANMC) hospital, located in Anchorage, and several sub-regional hospitals in the Alaska Native health system in other communities of the state, have already initiated this practice with preliminary data showing a resulting decrease in closely spaced births and unintended pregnancies. Discussions are currently underway to address necessary modifications to Alaska’s Medicaid reimbursement for LARCs in the postpartum setting to facilitate adoption of this practice in Alaska’s private hospitals. WCFH’s engagement in this national initiative to increased use of LARC methods will contribute significantly to improved maternal and infant health outcomes in Alaska.

PERINATAL/INFANT HEALTH

Since 2014, Alaska has participated in the national Collaborative Improvement and Innovation Network (CoIIN) to reduce infant mortality. Staff from Title V staff, tribal health organizations, private and public sector, child protection, the American Academy of Pediatrics Alaska Chapter, Alaska Primary Care Association, and MCH stakeholders share innovations in quality improvement and evidence based practices to improve birth outcomes and reduce disparities through policy and practice change. The CoIIN approach aims to reduce infant mortality by focusing on SIDS/SUID/Safe Sleep, Smoking Cessation and Preconception/Interconception Health.

HRSA funds continue to support the Alaska MIECHV program. WCFH continues to partner with Providence In-Home Services to implement the NFP model. Services are provided within the Municipality of Anchorage and Mat-Su Borough. As of 2017, the program has capacity for 200 families. NFP focuses on improving outcomes around breastfeeding, early and continuous prenatal and well-child visits, rapid repeat pregnancies, maternal depression, intimate partner violence, developmental screening, tobacco use, and more. Recent data showed success in educational and employment levels of the mother, insurance coverage, well-child visits, and postpartum check-ups. The MIECHV program continues to partner with the University of Alaska-Anchorage Institute of Social & Economic Research (ISER) on a study examining the father engagement strategies of the nurses in the NFP program.

Almost 100% of newborns in Alaska continue to receive at least the first bloodspot at 24-48 hours of age. Among those screened in CY16, 100% of the infants who screened positive received timely follow-up to definitive diagnosis

and clinical management for the condition(s). When applicable, children were referred either to the Alaska Metabolic or Genetics clinics or to another local pediatric specialist. In July 2016, Alaska's newborn bloodspot screening panel was updated to include testing for severe combined immune deficiencies (SCID) and DNA for CPT1A Arctic Variant. The Arctic Variant is the most common finding in Alaskan newborns – 7% of Alaskan infants are homozygous for the variant. The Newborn Bloodspot Screening (NBS) program continued to partner with the Alaska Native Medical Center to send an educational DVD to the family of each newborn identified with this variant. A survey of parents who received the DVD was conducted to better understand if this process was effective and whether or not the information was reviewed and understood by families. A PDSA cycle at the Alaska Native Medical Center will be conducted to test the use of families watching the DVD at the two-week well child visit.

The NBS program worked with a local immunology practice, and a team of partners from hospitals and tribal health, to develop and implement a risk assessment tool for SCID. The Alaska Newborn Bloodspot Advisory Committee continued to meet two times a year and helps to inform program policy. In 2016, a new policy for the release and use of dried blood spots was established.

In 2016, Alaska applied for and was awarded a funding opportunity with NewSteps 360 which is located at the University of Colorado and the Association of Public Health Laboratories, as a pass-through entity of HRSA. The goal of this effort is to improve the quality of bloodspot specimens and decrease the transit time Oregon State Public Health lab.

HRSA and CDC funds continue to support the newborn hearing screening program. During CY16, the hospital screening rate for newborn hearing was 98.9% and was 96% statewide overall. The out of hospital screening rate improved from 59% in CY 2014 to 62.63% in CY2016. As a part of continued continuous quality improvement activities, the Early Hearing Detection & Intervention (EHDI) program conducted a PDSA cycle with a midwifery to pilot the use of OAE screeners in the out of hospital setting. This successful PDSA allowed for more children to be screened. An additional AABR screener was also placed at another local midwifery. Despite the growing number of these births (8.03% statewide in 2016), the screening rate remained stable for this population. The EHDI program also continues to track and provide feedback to birthing facilities and midwiferies through quarterly screening reports and more frequent informal reminders to improve the follow up of infants who do not pass their newborn hearing screening. The EHDI program is focusing more efforts on improving the timeliness of diagnosis and early intervention services for children identified with hearing loss.

In July 2016, WCFH was awarded a grant from ASTHO to promote workplaces that are friendly to breastfeeding mothers and ensure eligible businesses are in compliance with the federal law. WCFH awarded sponsorships (~$1,000) to approximately ten businesses to support these efforts. As a part of receiving this funding, the business also developed a workplace breastfeeding policy. WCFH was also awarded funding from AMCHP to support workplace breastfeeding. A Mamava (www.mamava.com) lactation pod was purchased and awarded to University of Alaska (UAA) through a competitive request for proposals process. The lactation pod was placed at UAA in March 2017 and usage is being tracked with a sign-in sheet and qualitative data is being collected with surveymonkey.

In 2016, the State of Alaska also collaborated with the Providence Pediatric Sub-Specialty clinic to transition the Genetics Clinic to be under the coordination of Providence beginning 1/1/2017. The State of Alaska will continue to use Title V dollars to fund a 0.5 FTE board-certified pediatric genetic counselor to work at the Providence clinic.

The State transitioned the Cleft Lip and Palate Clinic (CLP) to South Central Foundation (SCF) and Alaska Native Medical Center (ANMC) in October 2016. Both SCF and ANMC have long been partners in the delivery of services at the Alaska CLP Clinic. The SCF CLP program will offer its case planning and treatment services to non-tribal health beneficiaries. The State continues to support parent navigation for the clinic through a grant with a community agency.

A WCFH Nurse Consultant participates on the Perinatal Hospital-Community Task Force (PHCTF), whose current focus is on substance use, and particularly opioid use, among women of reproductive age, especially those who are pregnant. The MCDR committee recommended universal screening for substance use among pregnant women. The PHCTF concurred, researched evidenced-based tools for screening, with the *4 Ps Plus* screening tool, which screens for all substances, being the tool of choice. The PHCTF asked the DHSS Opioid Working Group for leadership support to both fund and coordinate development and implementation of a *4 Ps Plus* pilot project. The DHSS Opioid Working Group granted this request and, in December 2016, the Division of Behavioral Health provided funding for the WCFH Nurse Consultant to coordinate the project. The project will begin screening and collecting data from Community Hospitals in Anchorage, Juneau, Fairbanks and the Matanuska-Susitna regions in May 2017.

CHILD HEALTH

Title V funded staff in the MCH Epidemiology Unit supported childhood obesity prevention activities led by the Alaska Obesity Prevention and Control Program (OPCP) in the Section of Chronic Disease Prevention and Health Promotion. The PRAMS and CUBS Survey Operations Manager presented data on maternal and child obesity-related indicators at the annual Alaska Public Health Summit in February 2016. The CUBS Coordinator provided comprehensive trend and regional data on BMI percentile, tv/screen time, consumption of sugary drinks, and consumption of types of milk to the OPCP for their 2016 Obesity Facts report. Unfortunately, due to shrinking budget, the production of this annual report was cut and it has not been published online as planned. However, OPCP staff used the data for internal program planning for the Health Drinks for Healthy Drinks project and COICES projects. In particular, OPCP used CUBS data on juice intake for designing messaging around drinking less 100% juice.

In September 2016 the Oral Health Program received a two-year grant from the CDC Division of Oral Health to collaborate with the OPCP on activities to reduce child consumption of sugary drinks. The grant is supporting expanded media, social marketing and education efforts on child consumption of sugary drinks with risk for diabetes, dental decay and weight gain in children. The funding is also supporting pilot projects involving dental professionals in education and counseling of parents and child patients on sugary drink consumption using the 5 A's approach utilized with tobacco counseling: Ask, Advise, Assess (willingness for change), Assist (education materials and nutrition counseling) and Arrange (schedule follow-up contact for progress on change in behavior).

Alaska's CUBS program, which is fully funded by Title V, spent several months during CY2016 cleaning and organizing weighted data from 2012-2014 so that it could be included online in a queryable system on the Alaska Indicator Based Information System (AK-IBIS). The system allows users to find CUBS results for specific populations of interest, such as by region, maternal race, or maternal education level, without having to send a specific data request to the CUBS Coordinator. CUBS successfully launched within AK-IBIS in January 2017.

ADOLESCENT HEALTH

The Section of WCFH continued work under an interdepartmental agreement with the Division of Public Assistance focused on the goal of reducing teen and non-marital pregnancy in Alaska. The women's and reproductive health nurse consultant provided skill-building resources and trainings on long-acting reversible contraception.

The AHP program staff have a strong partnership with the State Department of Education and Early Development. This partnership is critical to advance maternal and child health. The partnership aids in effective statewide program participation, providing access and information to teachers and school administrators that the Department of Health and Social Services would otherwise not have.

The AHP and DPA partnership is essential in the advancement of maternal, paternal, adolescent and child indicators, especially NPM 9 and SPM 3 as indicated in this report. While Temporary Assistance for Needy Families (TANF) block grant is not commonly thought of as a "youth-serving" program, one-third of adult recipients of TANF benefits are under age 25.[1] Through education, positive youth development, increased pro-social opportunities, connection to supportive adult relationships and through the projects funded through TANF, the AHP is supported to provide culturally appropriate and evidence-based best practices long term that benefit all Alaskans. PREP, RPE, and TANF are building blocks to new MCHB NPMs (bullying and hospital admissions) by implementing evidence based curricula and strategies, reducing violence, increasing access to youth-friendly services and increase youth participation in positive youth development programming.

The AHP provided significant contributions to the work of the Alaska Safe Children's Act Taskforce recommendations and statewide implementation support. The Alaska's Safe Children's Act consists of two different pieces of legislation - also known as Erin's Law and Bree's Law. These laws stipulate that school districts in Alaska

must train employees and students on sexual abuse prevention (K-12), dating violence and abuse prevention (grades 7-12). Alaska Safe Children's Act Task Force was created to provide recommendations to the Department of Education & Early Development regarding model curricula for use by school districts. Beginning July 1, 2017 the areas of mandated areas focus will include:

- Suicide prevention training (for staff)
- Sexual abuse and sexual assault awareness training and prevention (staff and students K-12)
- Dating violence and abuse awareness training and prevention (staff and students grades 7-12)
- Alcohol and drug related disabilities training required for teachers and staff
- Alcohol and drug abuse education (for students K-12)

The AHP will continue to work closely with the Association of State and Territorial Health Officials (ASTHO) and the CDC's Division of Violence Prevention, National Center for Injury Prevention and Control, to strengthen health departments' ability to prevent sexual violence.

The AHP identified this work as the quality improvement and action plan approach for youth violence prevention in place of the Child Safety CoIIN, in part because, Dr. Jay Butler the Alaska Chief Medical Officer and DPH Director is the current ASTHO President.

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

In 2016, the Title V program began partnering with the UAA Center for Human Development, tribal health, and physicians from the Universities of Missouri and Massachusetts to implement a Project ECHO for autism in Alaska. Project ECHO is a tele-education model originating from the University of New Mexico and uses video conferencing to do case-based learning and didactic presentations. Participants are able to get feedback and learn from a hub team of experts on questions they have related to diagnosing or caring for children with autism. Since Alaska has a shortage of providers who can make autism diagnosis, WCFH felt that this would be a way to connect providers and increase knowledge in Alaska regarding caring for this population. UAA will host the program and provide coordination of ECHO clinics in partnership with tribal health. The program has recruited a hub team of efforts, adapted a curriculum from the University of Missouri to meet Alaska needs, conducted outreach on the ECHO model, and conducted mock sessions in preparation for a live launch in May/June 2017. Title V dollars were used to support the launch of this project. In addition, WCFH has been working with a pediatric neurodevelopmental physician from the University of Massachusetts to develop an online curriculum for screening, diagnosis, and caring for children with autism. It is anticipated this curriculum will be piloted in June 2016 and will be facilitated out of the Center for Human Development.

The Alaska Birth Defects Registry (ABDR) is statutorily mandated to collect and maintain a registry of all birth defects (as defined in statute) occurring in Alaska. Title V funds support this registry and the work conducted through it. During the reporting period ABDR activities included:

1. Using historical ABDR data including subsets of conditions with medical records review and confirmation to develop informative priors to adjust reported condition estimates. The program is focusing on the current 43 nationally reportable conditions to develop posterior odds of defect prevalence estimates based on received reports. These methods allow for more accurate estimation of the prevalence of the condition in the state as well as improved timeliness.

2. Developing a new website to provide data and statistics about the occurrence of birth defects in Alaska. The data presented on the website are integrated with the underlying research tables through *Rmarkdown* which allows easy annual updates when a new year of data is closed out.

CROSS CUTTING/LIFE COURSE

As Alaska's number one cause of preventable death continues to be tobacco use, estimated at 573 deaths in 2012, the Tobacco Prevention & Control (TPC) program continues to engage communities, tribes and stakeholders through education and effective policy efforts. The TPC program partners with other sections in the Division such as WCFH, as well as the Alaska Tobacco Control Alliance (ATCA), Alaskans for Tobacco-Free Kids (ATFK), and many healthcare organizations, schools, communities, non-profit organizations and private businesses that support a tobacco-free Alaska. The TPC program follows the best practices comprehensive tobacco control program

identified by the Center for Disease Control and Prevention (CDC). To decrease the percent of Alaska children ages 1-17 who live in a household where someone smokes, CDPHP created a fact sheet titled *Tobacco Use and Motherhood* and was distributed at the annual MCH conference, Tobacco Prevention & Control (TPC) grantees, CoIIN coalition and is located on the Tobaccofree.alaska.gov website. Presentations by CDPHP were also made to Statewide WIC case workers to encourage screening for tobacco use and exposure to second hand smoke and provide Quit Line materials to their clients. In addition, local and statewide media was developed and placed about health harms associated with second hand smoke exposure in the home and car environments among youth.

[1] http://www.clasp.org/resources-and-publications/publication-1/Young-Adults-and-TANF.pdf

II.F.2. MCH Workforce Development and Capacity

There is a chronic shortage of pediatric subspecialists in Alaska. While the state's only children's hospital has been successful in recruiting a number of subspecialists to the state, many are represented by only one clinician in that specialty. One critical shortage is Pediatric Neurodevelopmental-Behavioral specialty care. The state's only PND retired in December of 2016. Children's Hospital at Providence and tribal health have actively engaged in recruitment and hiring. As of the writing of this narrative, we have tentative confirmation of a new Pediatric Developmental-Behavioral Pediatrician will be moving to the state in August 2017. In addition, tribal health is actively engaged in conversations with a Developmental-Behavioral Pediatrician. Without the presence of this specialty in Alaska, children needing a diagnostic evaluation face long flights to Seattle or Portland and a 6-9 month waiting list. In addition, many of the existing resources are concentrated in Anchorage and the state's approximately 75 pediatricians are concentrated in the three largest cities (Anchorage, Fairbanks and Juneau). Access to these resources from other areas often entails high transportation costs many times borne by the Medicaid program. Telemedicine is being used increasingly in rural and frontier Alaska, but is limited to tribal health care centers where the mix of patients is predominantly tribal health beneficiaries. Infrastructure availability and use in the private sector is limited and tends to be within the corporation and service area. One exception to this is the E-ICU, Providence provides coverage from their tertiary medical center to secondary hospitals outside of Anchorage. Billing on a fee for service model with no managed care, lengthy waits for licensure, and siloed telecommunication systems and practice models are three significant impediments to expansion of this technology.

In an effort to assure the provision of culturally and linguistically appropriate services and coordination of health care for vulnerable populations, a draft policy has been proposed to require that all grants and contracts issued by DPH contain language requiring sub-recipients to assure that 1) services rendered are sensitive to the unique cultural aspects of the population served under these agreements; all agreements must include the official definition of cultural competency, as well as the hyperlink to training resources, guides, etc., found on the Office of Minority Health website; and 2) translation services are available for clients with Limited English Proficiency (LEP), and must be appropriate for the services rendered under that grant or contract, e.g., if medical services are being provided under the grant or contract, a medical translation service must be obtained. WCFH staff will work with the DPH Director's office to pursue adoption of this policy for all Division grants and contracts.

Actions taken to improve capacity

- The Section of Women's, Children's and Family Health (WCFH) uses Title V funds to organize and co-sponsor with the Alaska Native Tribal Health Consortium the biennial Alaska MCH and Immunization Conference. The conference brings rural and urban health professionals together to learn about best practices, tools, and surveillance data related to the prevention, diagnosis, and treatment of women's, children's, and adolescent health issues. The conference was held for the fifth time in September 2016 and offered continuing education credits for physicians, nurses, and tribal community health aides. There were 239 people attended the conference with over 80 of the attendees being registered nurses. Others included MCH program managers, researchers, physicians, and community health aides. Presentations were selected from a statewide abstract submission process as well as through targeted outreach to experts to support training and educational needs on emerging topics.

- Title V funds are used annually to sponsor the All Alaska Pediatric Partnership (AAPP) Conference. This statewide conference attracts pediatricians, sub specialists and nurses from hospitals, schools and public health agencies and addresses "just in time topics" pertinent to improving health outcomes for Alaska's children and teen population. The conference was held in Anchorage in November 2016 and attracted over 100 attendees.
- The Title V-funded School Nurse Consultant serves on the planning committees of the School Health & Wellness Institute and the Alaska School Nurses Association annual meeting, both of which provide Continuing Nursing Education contact hours. With frequent school nursing leadership turnover, this position mentors the new nursing directors weekly to help them develop as leaders and in turn, to develop leadership skills among their nursing staff. In addition, the Advisory Committee was able to work with the Alaska Board of Nursing to define a role for licensed practical nurses (LPNs) as an assistant school nurse. Approval was granted by the Board to allow LPNs to practice in the school setting using a protocol that clearly defines the LPN scope of practice and supervision by the RN. This should help districts be able to have skilled nurses but save costs at the same time and maintain safety at school for students with chronic and acute health conditions.

- The Health Program Associate for the EHDI program (Alaska's Title V Family Delegate) continues to participate as a mentor in the Family Leaders cohort of the 2017 AMCHP Leadership Lab. WCFH has identified "strong family and support systems" as priorities of our section's strategic plan with the specified goal of ensuring that the family/consumer voice is represented on advisory and planning boards at the program level and that family inclusion and perspective are consistently exemplified in the programs and services we provide

- Ongoing professional and leadership development is a part of the annual evaluation process and staff are encouraged and supported to gain new skills and try new programs as opportunities present themselves. Title V leadership has been supportive of staff taking full advantage of AMCHP's MCH Leadership Competencies and Workforce trainings and Leadership Development opportunities. WCFH staff readily access the Innovation Station and Georgetown University's MCH Navigator for additional training. Multiple staff members have had the opportunity to participate in AMCHP's Next Generation Leaders Cohort, Family Leaders Cohort, or MCH Epi Peer-to-peer Cohort and attend the AMCHP Annual Conference for the first time. A senior MCH Epidemiologist participated in the June 2016-June 2017 fellowship class of the Informatics Training in Place Program (I-TIPP). Also in 2016, an epidemiologist with the Breast and Cervical Health Check program participated in a 6 month training presented by the Rice University to learn GIS mapping, including how to incorporate predictive analysis and social determinants into mapping presentations. Since September 2015, the Public Health Scientist has participated in a two year Doris Duke Fellowship which focuses on translating doctoral research into policy implications. Finally, Title V leadership supports all section staff to participate in the Alaska Division of Personnel and Labor Relations professional development trainings.

Changes to the workforce funded by Title V:
The Section of WCFH was composed of nearly 50 FTE's as of SFY17, however funding cuts to state general fund (GF) resulted in holding four positions vacant for most of the SFY. It is anticipated that this will continue for SFY18 as well as a freeze on hiring any positions that are not 100% federally funded. State GF is relied upon to supplement Title V and other federal grants for many of Alaska's MCH surveillance and public health programs. These programs are key to collecting data needed for the Title V Block Grant application and to support activities described in the 5 Year Action Plan, as well as to provide data for other federal grant applications and WCFH programs. Underfunding and cuts to GF can have a significant impact on many MCH programs.

WCFH staff members are well qualified to deliver services and programs required by Title V as well as our other grant and special funding streams. Thirteen staff members have a master's in public health or public administration, education, biostatics, planning, business or nursing. Seven staff members have double master's degrees, and two have a PhD. An additional five staff members are in the midst of or about to complete their master's degree. There are also several health care professionals on staff including one family nurse practitioner, 6 registered nurses, and a dentist.

Staff professional experience prior to coming to WCFH is impressively diverse, including executive leadership of a Children's Hospital, Peace Corps, public health nursing in rural Alaska, public health internships in third world countries, community planning, disability services, parent navigation, laboratory supervision, school nursing, genetic counseling and community health education.

- A Research Analyst (RA) III position in the MCH Epidemiology Unit was vacant for several months while the position was reclassed to an RAII. The new RAII supports data needs for CoIIN work, SSDI, and the Block Grant application, as well as other ad hoc requests, and is approximately 75% Title V funded. This position was filled in April 2016 through an internal promotion of the RAI who supported the CUBS and ABDR programs.
- The RAI position that was vacated was 100% Title V funded. This position has unfortunately experienced a significant amount of turnover. It was held vacant for several months while the state budget was being finalized, and was filled in October 2016. Since then, two people were hired into the position but only stayed for a few months each. The position was filled most recently in June 2017.
- A Health Program Associate position (100% Title V funded) that supports MCDR and the Alaska Birth Defects Registry (ABDR) left in May 2016. Her position was filled that same month.
- The 100% Title V funded School Nurse Consultant retired in August 2016. The position was filled by the director of Nursing and Health Services for the Anchorage School district for the past ten years. Anchorage is one of the 100 largest school districts in the country with about 49,000 students and about 100 schools.
- A Perinatal and Reproductive Health Nurse Consultant (70% Title V funded) was hired in January 2017. She

came with nearly 30 years of experience as a Registered Nurse, including 20 years of combined service as an Officer in the US Air Force and the Public Health Service and experience as the clinical coordinator of the nurse home visiting program at a tribal health organization. She holds two current specialty nursing certifications: Maternal Newborn Nurse and Nurse Coach Board Certified, as well as a Masters of Public Health. This position supports a variety of Title X and Title V programs for WCFH.

Critical workforce development and training needs of state Title V staff

As previously described, Alaska Title V staff have taken advantage of many workforce development and training opportunities provided by AMCHP, CDC, and other federal partners, and staff are familiar with seeking out resources available in this area. Additional workforce development and training needs for state Title V staff are described in section F.7. Technical Assistance.

II.F.3. Family Consumer Partnership

Alaska parents, providers, and communities are actively recruited to help set health care priorities and initiate activities on all levels of decision making. WCFH continues to partner with the state CHIP Director to support the Consumer Assessment of Healthcare Provider Systems (CAHPS) patient experience survey for ongoing data collection related to family/consumer experience of care. The survey was designed specifically to engage pediatric population feedback with an added module to identify CYSHCN.

The Adolescent Health program has an established family/consumer partnership through the Youth Alliance of Healthier Alaska (YAHA), which has diverse membership of youth from across the state. YAHA contributes to Title V priorities as an advisory committee and also assists with strategic and program planning and materials development. In 2016-2017, the group provided strategic planning feedback to a variety of agencies on a broad array of topics. Seven members were engaged in this partnership during the 2016-2017 school year from various areas of the state. Each member participated in a day and a half of orientation in September 2016 and then in seven 2-3 hour meetings per month, as well as additional individual work. Members of YAHA were trained in MCH core competencies; specifically they were trained in the public health model and were introduced to life course theory. The mission of the YAHA is to advise the adolescent health program and other health programs in Alaska and to create interventions designed to improve the lives of adolescents in Alaska. In 2016-2017, youth made decisions on campaigns, provided insight and advice on a wide spectrum of topics and engaged in their community with public health messages. They served as a review committee for materials created for teens by various health programs through the design and distribution stages. They partnered with community organizations to create community action plans to address healthy and unhealthy relationships and bullying. They advised DPH on issues such as sexual health promotion, violence prevention, suicide prevention, teen pregnancy prevention, mental health, nutrition, and fitness, which positively impacts programs and policies. This work is funded through the Division of Public Assistance TANF federal pass through funds. Their input and work is an important contribution to the priorities of the Title V Block grant.

Diagnostic neurodevelopmental clinics are offered in 7-8 communities around the state. All of the outreach clinics are scheduled during times of the year that are convenient to family traditions such as fish camp, hunting and school schedules. Providers visit CYSCHN in communities to alleviate the challenge of traveling to a large community and to assess the children in their home community where they are most comfortable. To assure that families are an active part of the team in decision making, family navigation services are offered at the clinics and encouraged to be used. The contracts for navigation services are funded in part with Title V MCH block grant funds. The metabolic clinic will continue to be offered three to four times a year in Alaska by the MCH Title V program to assure stability for nutritional and medical genetics continues for the children as they grow into their teen and adult years. This clinic is funded in part with MCH Title V funding as collected fees do not come close to covering the costs of holding specialty clinics.

All of the advisory committees for CYSCHN include at least one parent. Their participation is a valuable addition to assuring the voice of parents is included in policies, educational materials, and outreach. In addition, all specialty clinics conduct client satisfaction surveys during or after the clinics. As a part of WCFH's grant with the Western States Genetic Services Collaborative (WSGSC), the Genetics and Metabolic clinic participates in a project in which parent surveys collect data on parent thoughts and attitudes related to the services provided. The final report has been issued and has helped us better understand the quality of services provided and if the clinics are providing parents with the information they need. Information collected will be used to make improvements in service delivery and streamlining systems.

The clinic coordinator for the neurodevelopmental clinic also leads the LEND Family Advisory Council (LFAC), a parent driven council advocating for positive change through a unified voice. The mission of LFAC is to cultivate parents as professionals providing expertise about individuals who experience disabilities through collaboration, mentorship, leadership and education throughout our communities. Feedback from this council is critical to making systems changes in the care of children with special health care needs and will be used to shape the development of the online curriculum for family navigation training. Additionally, Alaska's Title V designated Family Leader, John Cartwright, was recently recruited as a LEND fellow through the University of Alaska's "LEND Without Walls" multidisciplinary program following his service on the LFAC. Mr. Cartwright works within the Title V newborn hearing

screening program as a professional in addition to his role as a parent of a child with special health care needs and a self-advocate as a person who experiences hearing loss.

The EHDI program advisory committee currently has 5 family/consumer members. These families/consumers collaborate with program staff and other advisory committee participants to take part in design, planning, implementation and evaluation of the NBHS program protocol, policy and quality improvement efforts. In FY16, the EHDI Health Program Associate became an AMCHP Family Delegate/Family Leader whose emphasis is family engagement.

Family engagement on the statewide and local community levels has been critical to the anticipated launch of Help Me Grow Alaska, a system that connects children and families with services through centralized outreach, screening, referral and care coordination services. The CYSHCN Systems Integration Grant and subsequent Early Childhood Comprehensive Systems project focus on family engagement through committee participation and quality improvement efforts using the Strengthening Families framework and with active participation with the state's primary family representation agency, Stone Soup Group.

In the Maternal, Infant, & Early Childhood Home Visiting program, parent/consumer involvement is valued. The nurse home visitors in the Providence Nurse-Family Partnership (NFP) program complete client satisfaction surveys during pregnancy and when their child turn one year of age. Clients have the option of completing the survey on their smartphone, online, or on paper. The most recent year of survey data demonstrated a 94% satisfaction rate for services received in the program. Parents, along with other family members or close friends, continue to participate in client events and graduations. In 2017, a current client of the NFP program joined the NFP Community Advisory Board. She has been attending quarterly meetings and has provided input into program implementation and materials.

II.F.4. Health Reform

In July 2015 Alaska's Governor announced a decision to expand Medicaid under executive authority. Medicaid expansion began September 1st, 2015 in Alaska. By April 30, 2017, 32,958 Alaskans were covered by Medicaid under expansion, according to DHSS figures. Expanding Medicaid will eventually give over 40,000 Alaskans access to affordable health care and help reduce over-utilization of emergency services. Those in the expansion population include individuals who are not offered affordable health insurance coverage by their employer, or may not be eligible for subsidized plans on the Health Insurance Marketplace and cannot afford to purchase an individual health insurance plan on their own. This "newly eligible" population includes all childless adults between 100% and 133% FPL. The Department publishes a monthly update on enrollment numbers and demographic. An updated dashboard on the redesign can be found online. There are 82,000 Alaska children who rely on Medicaid and Denali KidCare (CHIP) to access the care they need to be healthy. Children represent half (48%) of Medicaid/CHIP enrollment and Title V involvement in promoting well child visits and outreach as outlined in Section 504 of the Social Security Administration Act is critical to work by the Division of Public Assistance and the Division of Healthcare Services to reduce the eligibility backlog. The Division of Public Assistance (DPA) has connected the Health Insurance Marketplace for successful data transmission between the Marketplace and the AK DHSS, and began allowing the marketplace to make application determinations for the Alaska Medicaid expansion implemented in September 2015. Difficulties experienced with new data systems resulted in a decline and delay in Medicaid/CHIP child eligibility and enrollment, which the Department continued and will continue to work on and improve. However, Alaska has implemented Presumptive Eligibility options for hospitals to determine eligibility in 'real time' by giving uninsured people immediate temporary Medicaid if they appear to be eligible based on income, in an effort to streamline Medicaid and CHIP enrollment.

WCFH staff members are also working in collaboration with the state's 211 system that received federal funding to provide client navigation support for those looking to enroll in plans available on the Marketplace. Inquiries from callers to the 1-800 Title V line have been directed to 211 for assistance. This service plays a large support role during the fall enrollment period. Technical Assistance from the MCH Workforce Development Center at Chapel Hill has helped efforts to map out current processes and use QI tools to improve efficiency and accuracy with the goal of decreasing the length of time it takes to process an enrollment application for Medicaid coverage. This shared effort resulted in DPA engaging its staff in a total transformation as to how the application process for Medicaid and other social service programs occurs.

Moda Health, a private insurer, announced in January 2016 they would be leaving from Alaska's insurance marketplace, leaving 10,000 Alaskan's without insurance. The Alaska Division of Insurance is helping to facilitate the transfer of Moda's individual policyholders to another carrier. The only individual health insurer left in the Alaska marketplace is Premera Blue Cross Blue Shield.

The 2016 legislative session saw several bills aimed at Medicaid reform. The provisions of these bills were ultimately consolidated in Senate Bill (SB) 74 which was signed by Governor Walker in June 2016. As a review, the legislation, SB 74 included the following provisions to:

- 1115 demonstration waivers to receive federal authority to fund models of primary care case management and/or managed care/coordinated care organization delivery models;
- 1115 waiver to receive federal authority to fund a redesign of the Medicaid behavioral health system to provide specialized services to targeted populations;
- 1945 options under the Social Security Act for waivers to provide coordinated care for health homes and increase available federal match rates for the programs collaborative hospital project(s) for emergency room diversion and primary care coordination to address emergency-room super-utilizers;
- 1915(i) and 1915(k) waivers for the home and community based services program which provide additional federal match for support of these programs. As of SFY 2017, the 1915 (i) waiver is on hold
- Develop a collaborative project with the department and state hospital association to reduce emergency department usage with a focus on those that frequently utilize services;
- Direction to the department for demonstration projects on payment reforms case management models, workforce development and innovative service delivery models;
- Direction to the department to provide reimbursement and increase capability for telehealth including expanding use for primary care, behavioral health services and urgent care; and

- Develop coordinated care demonstration projects with one or more third parties with respect to improving efficacy of the health care delivery model, improving access to services and/or improving the quality of care for Medicaid recipients.

Sixteen subcommittees were formed at the end of 2016 to begin working on the 16 different components of the Medicaid redesign. The MCH Title V Director volunteered to participate on reviewing the coordinated care demonstration projects of which there were 9 responses to the RFP. In addition, the MCH Epidemiology Unit manager and the MCH Title V Director are working with the committee tasked with determining quality and cost effectiveness measures and targets. This committee focuses on initiatives to improve the effectiveness and efficiency of health care expenditures while improving the quality of care received by Medicaid recipients. The committee has been working with stakeholders to help identify quality and cost effectiveness measures and targets that can be monitored and reported to help improve the overall quality of the Medicaid program and the services received by Medicaid recipients.

Title V and other WCFH staff will continue to have a part to play in many of the Medicaid Redesign subcommittees as they move from concept to implementation. More information can be found online.

Sources:

- http://dhss.alaska.gov/Commissioner/Documents/medicaidstateplan/PDF_SP/SP_pgs/MAGI-SPA-S21-Hospital-Presumptive-Eligibility.pdf
- http://ccf.georgetown.edu/2017/02/06/snapshot-sources/

II.F.5. Emerging Issues

- Budget cuts: Cuts to state general funds continue to be a barrier and require strategic planning and program prioritization to ensure WCFH is utilizing resources in the most effective manner. Difficult decisions will need to be made that will affect service delivery to the state's MCH and CYSCHN population. The Section of Public Health Nursing, which provides the safety net of primary and secondary intervention to the state's most vulnerable residents, continues to face more budget cuts. In FY17, SOPHN eliminated positions and closed health centers in the state. To ensure WCFH activities are core public health functions and to prepare for budget cuts, Alaska worked to transition both the Genetics and Cleft Lip & Palate clinics to the private sector and to transition the neurodevelopmental clinic management to the Center for Human Development at the University of Alaska Anchorage.

- Workforce Development: Like many other states, Alaska is facing a turnover in experienced public health professionals as people move towards retirement. It will be important for public health to be innovative and looks for ways to recruit and retain qualified staffed, particularly with limited university level training in public health available in Alaska. Professional development opportunities and transition planning are a high priority.

- Immunizations: Although immunization rates have increased since 2012, Alaska still has a large vaccine hesitant population as well as children who are not fully immunized due to other barriers. The 2016-2020 Strategic Plan for DPH identified increasing the percent of children with on-time immunizations as a winnable battle. In recent years, rising vaccine costs and decreased federal funding have hindered DHSS's ability to supply vaccines for Alaskans. A vaccine assessment account was authorized as a long-term vaccine financing solution in 2014.

- Early Intervention (EI): Alaska is increasingly turning its focus on EI. Lack of funding continues to be a barrier to effectively implement all aspects of EI, including data collection and surveillance, evaluation of the program and reporting. Current laws and regulations that support EI include universal newborn bloodspot screening, newborn hearing screening, and critical congenital cardiac screening. Early screening for autism and other neurodevelopmental disorders is also a priority. The EHDI program conducts training on the program for both audiologists and Early Interventionists to increase awareness of the need for timely diagnosis and EI for infants with early hearing loss. WCFH also partners with EI on Help Me Grow and the medical home project.

- Newborn Bloodspot Conditions: The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children (SACHDNC) continues to expand the number of conditions on the recommended uniform screening panel (RUSP). As conditions such as Severe Combined Immunodeficiency Disorder (SCID) and Pompe Disease are added, additional costs are incurred to state programs and public health laboratories, and corresponding fees for birthing facilities, and ultimately families, increase. Alaska continues to have challenges with transport times of the bloodspot specimens. The State contracts with a public health lab outside of Alaska, as there is no financial capacity to do the screening in-state, which increases transport time. The large geographic area, along with harsh weather conditions, creates barriers to improving timelines. The Newborn Bloodspot Screening program is working on this issue in collaboration with birthing facilities using funding from the Association of Public Health Laboratories. In 2017, the program is piloting the use of a courier service and Alaska Airlines Goldstreak to send specimens to the lab. Much work has already been done within facilities to improve processes and specimen collection practices. As the emphasis moves to newborn screening labs operating seven days a week, this will be challenging to support financially.

- School health: Currently, the capacity does not exist in smaller school districts to meet the medical needs of all children with chronic conditions during the school day, and the capacity in some of the larger school districts is being compromised by budget cuts with decreases in school nursing services. In May 2017, the school health nurse consultant helped to create the LPN as Assistant School Nurse Protocol which was approved by the Alaska Board of Nursing in May of 2017. This allows schools to hire LPNs (Licensed Practical Nurses) as Assistant School Nurses. With this protocol, an LPN can be in a school to provide a higher level of service than an unlicensed school staff person. While this guidance will be helpful to schools faced with reductions in funding RNs in all schools, there will remain challenges for school districts in small communities with limited funding to hire an RN to supervise a very small number of LPN's statewide.

- Marijuana: Medical marijuana has been legal in Alaska since 1998. In 2014 voters approved legalizing recreational marijuana use with sale of marijuana by licensed retail businesses beginning in 2016. In 2014, 5.4% of Alaska women who delivered a live birth reported marijuana use during pregnancy and 4.8% reported postpartum use (PRAMS). Studies indicate that prenatal cannabis exposure is associated with an increased risk of neurobehavioral problems in offspring. In 2015, 12% of mothers of 3-year-olds reported that they had used marijuana during the past two years; among those women, 44% used it one or more days per week on average during the previous 30 days (CUBS). The adolescent health program in WCFH is working to educate parents and caregivers on this issue through websites, fact sheets, and a parent/caregiver guide. Educational rack cards were also developed targeting women of reproductive age and those already pregnant about the risks of marijuana ingestion during pregnancy and breastfeeding.

- Opioids: There is a growing concern about opioid use and increasing rates of Neonatal Abstinence Syndrome (NAS). MCH Epidemiology staff reviewed Hospital Discharge and Medicaid claims data and identified a significant increase in Alaska's NAS rates. The majority of these children are reported to the Office of Children's Services, placing an increased burden on this system. The State of Alaska declared an emergency disaster regarding opioids and a bill, SB 91 was submitted by the Governor and signed into law at the end of March 2017. This law allows the chief medical officer of DHSS to issue a standing order for the prescription of opioid overdose drugs and provide an effective date. Two other bills not yet passed extend the declaration, outline requirements for continuing education for all licensed providers and require all prescribers of controlled substances to be enrolled in the Alaska Prescription Drug Monitoring Program with additional requirements around the use of this system. DPH has also applied for and been rewarded a couple of large federal grants to improve screening, referral and treatment options for people addicted to opioids. WCFH staff have been involved in promoting strategies in the hospitals to screen women coming into deliver and to develop policies and referral strategies for babies born with NAS.

- Cervical Cancer: During 2004-2014, the percentage of Alaskan women aged 21-65 years who reported on the BRFSS that they received a Pap test within the last 3 years decreased from 91% to 78%. During 2013–2015, completion of the HPV 3-dose series increased from 28% to 37% for females aged 13-17 years. Both Alaska's BCHC program and the Title X Family Planning Services Grant Program are housed in WCFH and provide funding for breast and cervical cancer screening and diagnosis or referral for women with limited incomes who have little or no health insurance. Both programs will continue focus their efforts on novel ways, such as using spatial analytics, to identify and engage late or never screened women across the state.

- Behavioral Health and Primary Care Integration: Recent state Medicaid reform legislation prioritized integration of behavioral health and primary care services as of 2016. Title V CYSHCN staff continue to work with an interdepartmental workgroup to develop a briefing paper and information for policy and practice recommendations related to behavioral health and primary care integration to inform Medicaid reform workgroups. The new ECCS grant coordinator (housed in the Office of Children's Services) has worked with Title V to champion early childhood and MCH populations in the reform work.

II.F.6. Public Input

II.F.6 Public Input

WCFH, the Title V agency, relies on on-going, continuous engagement with stakeholders for meaningful public participation. WCFH works with and sponsors numerous advisory committees composed of health care providers, parents, consumers, coalition members, and public health staff from across Alaska. They meet on a regular basis, usually once per quarter, to provide input on program's needs, assess quality, and provide ideas for future directions. In addition, all the agencies within the Department of Health and Social Services who offer MCH services, including WCFH, maintain web pages of their programs. The web sites include contact information so that anyone reviewing the site can provide input on the work described.

WCFH used an online survey designed in Survey Monkey, and DHSS Facebook to solicit public comment on our Executive Summary that describes our Title V efforts and five year action plan. A link to the Alaska Title V webpage was provided, that contained links to prior applications and state and national performance measure narratives. http://dhss.alaska.gov/dph/wcfh/Pages/titlev/default.aspx. The Alaska Division of Public Health GovDelivery system was used to send the solicitation for public input to the following distribution lists:

- AK Public Health Alert network: 3,114 recipients
- DHSS Newsletter: 2,795 recipients
- Healthy Alaskans: 1,210 recipients
- Public Health Announcements: 2,781 recipients
- Chronic Disease Prevention and Health Promotion Announcements: 1,126 recipients
- Perinatal News: 838 recipients

An email containing the Executive Summary and survey link as also distributed by WCFH staff to members of the following advisory committees:

- Alaska Home Visiting Steering Committee
- Pediatric Medical Home Steering Committee
- Newborn Metabolic Screening Advisory Committee
- Pregnancy Risk Assessment Monitoring System (PRAMS) Steering Committee
- Childhood Understanding Behavior Survey (CUBS) Steering Committee
- Maternal Child Death Review Advisory Committee
- Alaska WIC Listerv
- Early Hearing Detection & Intervention (EHD) Advisory Committee
- Adolescent Health Steering Committee
- Community Health Center Program
- All Alaska Pediatric Partnership
- Alaska Early Childhood Coordinating Council

During June 2017, there were 84 respondents to the online survey who provided comments related to each population's priorities, strategies and major accomplishments/challenges. All comments are grouped by population domain and will be shared with WCFH Program Managers to review and analyze. A copy of the survey results and comments are attached in Supporting Documents.

II.F.7. Technical Assistance

F.7. Technical Assistance

Some potential areas of needed technical assistance as we work on our Action Plan strategies include:

- Training on querying and analyzing Medicaid claims data for MCH surveillance and evaluation.
- Short and long term planning support to gradually increase Culturally and Linguistically Appropriate Services (CLAS) standards competency among partners across the state
- Consultation and/or facilitation of a meeting of hospitals and health care providers in Alaska to formally kick off development of a Perinatal Quality Collaborative in Alaska.
- Expertise and guidance on changing Medicaid regulations to include payment for immediate postpartum provision of LARC.
- Assistance in developing a training or webinar for all providers on the importance of perinatal oral health.
- Assistance in developing a training/webinar for all providers on the importance of screening women for mental health issues, i.e. depression and anxiety, and brief intervention vs. referral to mental health services.
- Expertise or guidance in developing information on Adverse Childhood Experiences that can be shared with a variety of audiences, including the public, schools, etc.
- Technical assistance around working with FQHCs to improve their systems to increase access to preventive health services.
- Assistance developing a meaningful and feasible method for measuring family engagement and systems performance for CYSHCN.

Additional requests for technical assistance will be made as the needs arise.

III. Budget Narrative

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,008,498	$1,050,528	$1,043,564	$1,043,564
Unobligated Balance	$0	$0	$0	$0
State Funds	$14,766,425	$18,298,931	$14,504,339	$14,089,787
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$90,000	$113,148	$140,000	$100,000
SubTotal	$15,864,923	$19,462,607	$15,687,903	$15,233,351
Other Federal Funds	$6,441,474		$6,765,745	$4,428,446
Total	$22,306,397	$19,462,607	$22,453,648	$19,661,797

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2016		2017	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,050,528	$1,051,991	$1,050,524	
Unobligated Balance	$0	$0	$0	
State Funds	$14,471,700	$11,754,544	$14,169,000	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$100,000	$30,000	$30,000	
SubTotal	$15,622,228	$12,836,535	$15,249,524	
Other Federal Funds	$5,922,338	$6,667,176	$6,091,206	
Total	$21,544,566	$19,503,711	$21,340,730	

	2018	
	Budgeted	Expended
Federal Allocation	$1,051,157	
Unobligated Balance	$0	
State Funds	$11,490,000	
Local Funds	$0	
Other Funds	$0	
Program Funds	$0	
SubTotal	$12,541,157	
Other Federal Funds	$6,240,749	
Total	$18,781,906	

III.A. Expenditures

Expenditures (2017 Narrative for FFY 2016)

The Alaska Title V program experienced another decrease in state general funds in SFY17 by an additional 12.5% from the prior year in undesignated general fund dollars. The Title V Block grant totaled slightly over 1 million dollars and continues to be relied upon heavily for enabling and public health systems/infrastructure dollars. The Title V program dollars were budgeted in SFY17 to support the state priorities identified in the MCH 5 year needs assessment, program priorities and accompanying national outcome measures. State general fund maintenance of effort dollars come in large part from the appropriation for the infant Learning (Zero to Three), the Women, Infant and Child (WIC) nutrition, and Immunization program, as well as general funds for the childhood obesity prevention program. This year, specific funds for children's mental health services and some of the match for Medicaid SCHIP were included as a part of the Maintenance of Effort (MOE). Also included in the MOE reporting are dollars from a designated general fund/mental health appropriation for the Section of WCHF, a percentage of designated general fund appropriation for child protection, and program receipts collected.

Ongoing fee collection for the specialty clinics while important in the past has diminished significantly as the number of clinics hosted by the Section of Women's, Children's and Family Health has decreased during SFY17. The amount reported this year is $30,000 due to a reduction in the number of clinics days and the number of patient's seen. In FY 16 there was a transition of the Cleft Lip and Palate Clinic to South Central Foundation- the Anchorage based health arm for Tribal Health and the number of clinic days offered for autism decreased. This gross income when collected covers less than less 10% of the cost of providing these clinics across the state of Alaska. Fees charged are limited by state regulation to the Medicaid rate and do not reflect the actual cost of supporting these clinics or charges in the private health care sector. The Title V Block grant has been used to support the costs of hosting the clinics including contracts for the medical specialists and dollars to pay a small portion of the travel costs of getting the providers to rural communities. In addition, gap filling services such as these are supported through a combination of state general fund dollars, program fees, and Medicaid administrative claim dollars. Title V funds are not used to pay for Direct services as defined on Form 3b of the financial expenditures page.

It cannot be understated how important federal grants are to providing the infrastructure to carry forward the state's MCH priorities. The Alaska MCH/CYSCHN programs transitioned from direct service nearly 15 years ago and have since provided dollars for linking services, technical assistance and infrastructure support for data surveillance and analysis, and program evaluation. Gap filling services in the form of support and coordination have been offered in the areas of Cleft Lip and Palate clinics, metabolic, neurodevelopmental and genetic services. Our epidemiological infrastructure is crucial to measuring the effectiveness of service delivery not only in the programs delivered by WCFH, but also outside of the Division of Public Health and the Department. For example, partnerships such as Alaska Primary Care Association provide a critical venue to distribute information and link interested medical practices with our HRSA/MCHB grant focused on promoting and implementing pediatric medical homes. Work with the University of Alaska-Anchorage's Center for Human Development (Center of Excellence for People with Disabilities) has been an important partner in developing the workforce to deliver intensive early intervention applied behavioral analysis services to children diagnosed with autism. The structure implemented by the CoIIN initiative has been critical to develop programs focused on improving infant mortality. The data gleaned as a part of program evaluations assist in assuring we are implementing effective strategies for breastfeeding in the workplace, Alaska Infant Safe Sleep program, preconception health promotion, promotion of LARC post-delivery substance abuse programs and child injury prevention programs. The data also informs the Quality Improvement work done as a part of the CoIIN process.

Alaska's programs also received funds from other agencies such as the Division of Public Assistance through a reimbursable service agreement (RSA). The funding supports the Division of Public Assistance to meet their Temporary Aid to Need Families (TANF) requirements for teen and out of wedlock pregnancy prevention requirements. Small grants from the Association of Maternal Child Health Program (AMCHP) and Association of State and Territorial Health Officials (ASTHO) provide start up or pilot programs to "test interventions" on a smaller scale and entice smaller agencies to implement new and evidence based interventions on a smaller scale. We received our final year of funding in FFY 16 for Emergency and Disaster Planning to help build improved programs and systems for people with disabilities. The program has focused on pregnant women, infant and children/adolescents with special conditions in planning and sheltering in times of a disaster. The CDC funding ended in last FF16 and we are hopeful community changes that were implement for disaster and emergency planning will stay in place.

Continuing to maintain a positive outcome and programmatic missions will continue to pose significant challenges in the coming years, particularly if the legislature does not develop a more mixed revenue structure to support government services.

The Alaska Title V expenditures represent actual expenditures at the time the report was prepared.

III.B. Budget

Budget (2017 Narrative for the FFY 18 application)

Budget in FY 18

With the continued depression in the price of oil, the state is at a crossroads in decision making on how the state government will continue to function and what programs will continue. As stated above, WCFH experienced an additional 12.5% reduction in our state general fund appropriation in SFY17. With the state experiencing a $2-3 billion dollar deficit in SFY2018, state programs will continue to be under pressure to reduce their expenses. The legislature by the end of two special sessions has not yet finalized a long term strategic plan to support state government. A budget was finalized and voted on for SFY18 a few days before the end of the state fiscal year. It was transmitted to the governor at close of last business day of the state fiscal year. This allowed the state to be open on July 3rd, but state departments are waiting to hear what further cuts will be required over and above a 10% reduction submitted by the Governor. Leadership in the Section of Women's, Children's and Family Health prepared for cuts beginning in SFY2017 by combining programs, eliminating 5 positions and focusing on work that is funded or committed to in selected performance and outcome measures. The most notable change will be with the Oral health official. This position relied on state general fund dollars for 90% of its salary and expenses. The position was also located in Juneau and is not a position that can be relocated to Anchorage. A plan was put in place to divide the oral health work and have it be absorbed by three units with 2 nurse consultants and 2 program managers taking on content specific to their area of expertise. In addition, there are some dollars set aside to contract with a dentist or dental hygienist when clinical expertise is needed. A transition of duties began the first of calendar year 2017 with a full transition expected once the current Dental Official, Dr. Brad Whistler, retires at the end of August 2017.

The legislature will likely be called back for a third special session after a summer break It is anticipated that ongoing travel and hiring freezes will stay in effect for SFY18 and additional open positions not 100% federally funded will likely be terminated over time. Additional general fund reductions will result in challenges long term to meet the maintenance of effort required to receive the MCH Title V Block grant. While we are a ways out from this situation, caution is advised.

New rounds of federal funding were applied for in support programs that are in place. Final NGA's are slowly trickling in, but in some instances are less that the amount applied for due to federal reductions. In addition, some programs have only been awarded one year of funding which will necessitate another competitive submission in a few months. This is challenging for the staff that are under increased pressure to do more with less. Reapplying annually takes valuable time away from the program Implementation and supporting communities to fulfill program activities.

Thus far no layoffs have occurred in the Section of WCFH. The Section of Public Health Nursing however was markedly reduced in SFY17, experiencing a 25% reduction added to a 15% reduction in SFY16. This resulted in several layoffs of public health nurses throughout Alaska and the closing of a public health center. The impact of these reductions has already be felt especially in rural Alaska where there is heavy reliance on public health nurses to deliver public health services such as disease outbreak investigation, immunizations, emergency preparedness and gap filling services especially for children and pregnant women. The Section of Public Health Nursing (SOPHN) is faced with additional cuts by the legislature in the coming legislative session and a mandate to transition services over to community health centers in rural communities. SOPHN is working through a process and plan for changes to their delivery system to meet this mandate.

The budget for next reporting year was reduced slightly in anticipation of further reductions. The modest amount of $350,000 will likely be insufficient. More details will be shared in further reports in the next Title V Block grant submission

in FY 19.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Medicaid Title V MOU.pdf

V. Supporting Documents

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

Supporting Document #01 - CombinedOrgCharts2017.pdf

Supporting Document #02 - WCFH Strategic Plan and Program Descriptions.pdf

Supporting Document #03 - ComponentsofAlaskaMedicaidRedesign.pdf

Supporting Document #04 - 2017PublicCommentsSurveyMonkey.pdf

Supporting Document #05 - MCH Epi publications_June 2017.pdf

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Alaska

	FY18 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 1,051,157	
A. Preventive and Primary Care for Children	$ 315,592	(30%)
B. Children with Special Health Care Needs	$ 346,881	(32.9%)
C. Title V Administrative Costs	$ 105,100	(10%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 11,490,000	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 11,490,000	
A. Your State's FY 1989 Maintenance of Effort Amount $ 4,471,700		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 12,541,157	
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)	$ 6,240,749	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 18,781,906	

OTHER FEDERAL FUNDS	FY18 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 250,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 159,308
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 2,136,924
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 175,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 339,535
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	$ 249,447
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Unexpected Infant Death (SUID) Case Registry Program	$ 32,320
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 1,703,815
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Implementation Grants for Systems of Services for CYSHCN	$ 250,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 299,400
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 545,000

	FY16 Annual Report Budgeted		FY16 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 1,050,528		$ 1,051,991	
A. Preventive and Primary Care for Children	$ 325,663	(31%)	$ 315,600	(30%)
B. Children with Special Health Care Needs	$ 346,674	(33%)	$ 362,451	(34.4%)
C. Title V Administrative Costs	$ 105,052	(10%)	$ 105,199	(10%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0		$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 14,471,700		$ 11,754,544	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 100,000		$ 30,000	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 14,571,700		$ 11,784,544	
A. Your State's FY 1989 Maintenance of Effort Amount $ 4,471,700				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 15,622,228		$ 12,836,535	
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)	$ 5,922,338		$ 6,667,176	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 21,544,566		$ 19,503,711	

OTHER FEDERAL FUNDS	FY16 Annual Report Budgeted	FY16 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 250,000	$ 250,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 159,600	$ 159,600
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 145,300	$ 145,300
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 193,600	$ 193,600
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 1,000,000	$ 1,715,555
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health	$ 220,164	$ 249,447
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 95,374	$ 95,374
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000	$ 250,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 532,300	$ 532,300
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Breast and Cervical	$ 2,076,000	$ 2,076,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	$ 400,000	$ 400,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > D-70 grant for CYSHC	$ 300,000	$ 300,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Disabilities & Healt	$ 300,000	$ 300,000

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: The State of Alaska continues to experience serious short falls in revenue collections due to ongoing reliance on the oil revenues production and pricing. The oil revenue and now more recently the Marijuana taxes are what primarily fund our state general fund expenditures. The legislature has been unable to develop a long term fiscal plan that will help to support the state's general fund needs with new revenue. Instead, state government experiences cuts in appropriations annually. This modest reduction of $350,000 is likely too modest for FY 18, but it was our best guess at this time.	
2.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: In FY 17, The MCH Title V program/Section of Women's, Children's and Family Health transferred the sponsorship of two specialty clinics, Genetic and the Cleft, Lip and Palate treatment planning clinics to the private sector. The Genetics clinic was picked up by The Children's Hospital at Providence and the CLP clinic will be sponsored by South Central Foundation, the health are for the Cook Inset Tribal Council in partnership with Alaska Tribal Health Consortium. The CLP clinic will see children who are not tribal health beneficiaries. These two clinics over 90% of program income for MCH Title V. While we reported this as income, it was gross before expenses. Both clinics were heavily subsidized by a combination of Title V MCH block grant dollars and a large portion of state general fund dollars. Due to the need to reduce expenses in anticipation of a larger reduction in state general fund dollars, the planning to transition of these clinics to the private sector began during FFY16.	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Alaska

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Pregnant Women	$ 121,655	$ 85,286
2. Infants < 1 year	$ 161,929	$ 183,455
3. Children 1-22 years	$ 315,592	$ 315,600
4. CSHCN	$ 346,881	$ 362,451
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 946,057	$ 946,792

IB. Non Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Pregnant Women	$ 840,000	$ 865,887
2. Infants < 1 year	$ 1,100,000	$ 1,152,405
3. Children 1-22 years	$ 1,500,000	$ 1,609,622
4. CSHCN	$ 6,800,000	$ 6,874,777
5. All Others	$ 1,250,000	$ 1,251,853
Non Federal Total of Individuals Served	$ 11,490,000	$ 11,754,544
Federal State MCH Block Grant Partnership Total	$ 12,436,057	$ 12,701,336

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Form 3b
Budget and Expenditure Details by Types of Services

State: Alaska

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 236,514	$ 236,698
3. Public Health Services and Systems	$ 814,643	$ 815,293
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		$ 0
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
Direct Services Line 4 Expended Total		$ 0
Federal Total	$ 1,051,157	$ 1,051,991

IIB. Non-Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 9,421,800	$ 9,640,294
3. Public Health Services and Systems	$ 2,068,200	$ 2,114,250
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		$ 0
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
Direct Services Line 4 Expended Total		$ 0
Non-Federal Total	$ 11,490,000	$ 11,754,544

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIA. - 2. Enabling Services**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**

Field Note:
Enabling services for the coming federal fiscal year will include dollars in support of the MCH Title V performance measures not funded with federal grants. These include promotion of breastfeeding the workplace, recognition of hospitals attaining national recognition for the Infant Safe Sleep program, outreach and prevention messages for pregnant women who are smoking tobacco or using marijuana or illegal drugs.

2.	**Field Name:**	**IIA. - 3. Public Health Services and Systems**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**

Field Note:
Dollars will continue to be used for infrastructure in support of the Title V MCH performance measures including MCH epidemiology staff and surveillance programs (PRAMS, Childhood Understanding Behaviors Survey, ALCAN Link, Maternal, infant and child death review committee, and other evaluation and analysis capacity. Funds are also directed at School health program and school nurse consultant program, oral health for perinatal, school age and CYSHCN and systems developments focused on CYSHCN. A new nurse consultant position for perinatal and early childhood was added in FY 17 to support working on perinatal quality measures with health care providers and hospitals who care for pregnant and postpartum women. A perinatal quality collaborative will be co-led by this position along with leadership from one of the largest birthing facilities in Alaska.

3.	**Field Name:**	**IIA. - 2. Enabling Services**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**

Field Note:
Enabling services include family navigation services, dollars for newborn blood spot screening, oral health screening in schools limited to three Title I schools, outreach for the safe sleep initiative, supplies for children with cleft lip and palate, and payment for clinic space to support pediatric clinics are just a few of the examples.

4.	**Field Name:**	**IIA. - 3. Public Health Services and Systems**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**

Field Note:
Dollars were utilized infrastructure in support of the Title V MCH performance measures including MCH epidemiology staff and surveillance programs (PRAMS, Childhood Understanding Behaviors Survey, ALCAN Link, Maternal, infant and child death review committee, and other evaluation and analysis capacity. Funds are also directed at School health programs and the school nurse consultant program, oral health for perinatal, school age and CYSHCN and systems developments focused on CYSHCN. A new nurse consultant position for perinatal and early childhood was added in FY 17 to support working on perinatal quality measures with health care providers and hospitals who care for pregnant and postpartum women.

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

State: Alaska

Total Births by Occurrence: 11,095

1. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Core RUSP Conditions	11,075 (99.8%)	208	10	10 (100.0%)

Program Name(s)				
Cystic fibrosis	Critical congenital heart disease	Primary congenital hypothyroidism	Congenital adrenal hyperplasia	S,S disease (Sickle cell anemia)
S,C disease				

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
CPT1A Arctic Variant homozygosity by DNA (began testing 7/1/16)	5,548 (50.0%)	420	420	420 (100.0%)
CPT1A Arctic Variant enzyme elevations by MS/MS (through 6/30/16)	5,527 (49.8%)	81	81	81 (100.0%)
AK Early Hearing and Detection Intervention Program	10,688 (96.3%)	135	16	16 (100.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

The state of Alaska NBMS program follows infants from screening to diagnosis, and then referral to treatment. The program captures a treatment start date if applicable for certain disorders. The program does not do long term follow up, although WCFH manages metabolic clinic for all children in the state with a metabolic disorder, including those identified by newborn screening.

Form Notes for Form 4:

Total Core RUSP conditions does not include CPT1A Arctic Variant which is common in Alaska but is not a Core RUSP condition, however CPT1A is a Core RUSP condition. The testing for CPT1A Arctic Variant by DNA began on 7/1/16. The Northwest Regional Newborn Screening lab increased the reporting threshold for the acylcarnitine profile for CPT1A in consultation with metabolic consultants because Arctic Variant infants are now detected by DNA testing. Current testing only seeks to identify classic CPT1A, which is the Core RUSP condition. Infants who are identified both by DNA and acylcarnitine profile are only reported as presumptive positive under CPT1A Arctic Variant homozygosity by DNA under Other Newborn Screening.

Field Level Notes for Form 4:

1.	**Field Name:**	**Core RUSP Conditions - Receiving At Lease One Screen**
	Fiscal Year:	**2016**
	Column Name:	**Core RUSP Conditions**
	Field Note: In CY 2016 there were 13 refusals, and a small number of likely missed screens due to unattended home births with very late birth certificate registration.	
2.	**Field Name:**	**Core RUSP Conditions - Positive Screen**
	Fiscal Year:	**2016**
	Column Name:	**Core RUSP Conditions**
	Field Note: The number of presumptive positive screens, reflects all unduplicated children who had an abnormal result on either the first screen for a Core RUSP condition	
3.	**Field Name:**	**Core RUSP Conditions - Confirmed Cases**
	Fiscal Year:	**2016**
	Column Name:	**Core RUSP Conditions**
	Field Note: Alaska does not do follow up or receive confirmation of diagnosis for critical congenital heart disease. There are likely diagnosed cases of which we are unaware.	
4.	**Field Name:**	**Core RUSP Conditions - Referred For Treatment**
	Fiscal Year:	**2016**
	Column Name:	**Core RUSP Conditions**
	Field Note: All infants identified by bloodspot screening were referred. But Alaska does not collect data on critical congenital heart disease referrals.	

Data Alerts: None

Form 5a
Unduplicated Count of Individuals Served under Title V

State: Alaska

Reporting Year 2016

		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	0					
2. Infants < 1 Year of Age	0					
3. Children 1 to 22 Years of Age	205	32.0	0.0	47.0	12.0	9.0
4. Children with Special Health Care Needs	377	26.3	0.0	69.7	4.0	0.0
5. Others	0					
Total	582					

Form Notes for Form 5a:

No Title V dollars are used for direct services.

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2016**

Field Note:
There are no Title V dollars used to pay for direct or enabling services for pregnant women such as payment for prenatal, delivery or postpartum care, case management, or insurance eligibility insurance.

Primary Source of Insurance Coverage for Pregnant Women: Medicaid 39.7%, Private/other 55.7%, None 2.8%, Unknown 1.8% for Columns 1B - 1F. Data Source: Bureau of Vital Statistics. 2015 data is provisional. Column C- Alaska has never exercised the CHIP (Title XXI) state plan option to cover pregnant women at the higher enhanced FMAP for pregnant women above 185% of the FPL Guidelines, so we don't have pregnant women covered under Title XXI (CHIP). So all pregnant women of all ages are enrolled in DenaliCare and funded under Title XIX Medicaid at the regular Medicaid FMAP.

2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2016**

Field Note:
There are no Title V dollars used to pay for direct or enabling services for infants such a payment for well child visits, immunizations or case management.
Estimates for health insurance coverage for Infants from Medicaid are 32%, Private/other 47%, and None 12%. Source: Kaiser Family Health Foundation. Health Insurance Coverage of Children 0-18. 2014. http://kff.org/other/state-indicator/children-0-18/.

2C. CHIP and Medicaid coverage are combined and reported under column 2B.

3.	**Field Name:**	**Children 1 to 22 Years of Age**
	Fiscal Year:	**2016**

Field Note:
Title V dollars are used to pay for contracts for reproductive health services for adolescent aged clients in two communities in Alaska. The data represent the unduplicated client count for both clinics. The first clinics are located in the Juneau Douglas High schools (4 locations) which provide health and wellness exams, including contraception at the time of the visit or prescriptions to be filled for contraception. There were 131 clients seen at Juneau locations from October 1, 2015 to September 30th, 2016. The second community served is in Kodiak, Alaska, where reproductive health services are provided at the local Public Health Center, via contract with a private practitioner, and include an annual preventative health visit and contraceptive management with an emphasis to offer IUD and Nexplanon insertion. There were 74 clients seen in Kodiak from October 1, 2015 to September 30th, 2016.

4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2016**

Field Note:
This is an unduplicated count of clients diagnosed or referred from: cleft lip & palate clinics, autism outreach, genetics & metabolic clinics, and neurodevelopmental outreach. Data reported for 2016.

Primary Coverage Estimates: 4B - 4F. Data Source: National Survey of CSHCN. 2009/10. 55.2% had private insurance only, 14.5% had both public and private insurance.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2016**

Field Note:
There are no Title V dollars used to pay for direct or enabling services for “Others” such as payment for well-woman visits or education or family centered care provided to parents.

Form 5b
Total Recipient Count of Individuals Served by Title V

State: Alaska

Reporting Year 2016

Types Of Individuals Served	Total Served
1. Pregnant Women	11,736
2. Infants < 1 Year of Age	10,814
3. Children 1 to 22 Years of Age	90,061
4. Children with Special Health Care Needs	2,460
5. Others	6,838
Total	121,909

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2016**

Field Note:
It is estimated that 95% of pregnant women are served through Title V and/or Title V partners. Title V dollars funded staff time to:
• Promote evidence based screening for perinatal depression, smoking, and substance use.
• Analyze data related to low risk cesarean delivery and other perinatal issues and conditions
• Purchase incentives for PRAMS survey respondents
• Provide outreach to hospitals to institute safe sleep policies and substance use prevention educations materials
The number served (95%) was derived from the total number of pregnant women (12,354) which is all term pregnancies + ITOPS + fetal deaths counted. Data Source: Alaska BVS, reported for 2015. 2016 data available in late 2017.

2.	**Field Name:**	**Infants Less Than One Year**
	Fiscal Year:	**2016**

Field Note:
It is estimated that 100% of infants are served through Title V and/or Title V partners. Title V dollars funded staff time to:
• Administer the newborn screening program
• Outreach to hospitals to institute a safe sleep policy and distribute educational materials.
• Partner with home visiting programs to provide staff training and promote education on safe sleep practices.
• Support the Healthy Start grantee to implement a case management services
• Implement workplace breastfeeding promotion projects
The number served (100%) was derived from the total number of infants (10,814) which is all infants less than 1 year old. Data Source: Alaska Department of Labor Population Estimates as of July, 2016.

3.	**Field Name:**	**Children 1 to 22 Year of Age**
	Fiscal Year:	**2016**

Field Note:
It is estimated that 50% of children 1-22 yrs are served through Title V and/or Title V partners. Title V dollars funded staff time to:
• Promote programs and education targeting oral health, adolescent health-including wellness visits and dating violence reduction education, school health, child maltreatment prevention, and developmental screening.
• Administer the newborn screening program
The number served (50%) was derived from the total number of children (180,122) ages 1 to 22 yrs. Data Source: Alaska Department of Labor Population Estimates as of July, 2016.

4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2016**

Field Note:
This is an unduplicated count of clients that are served through Title V and/or Title V partners. The count includes clients diagnosed or referred from state funded clinics: cleft lip & palate clinics, autism outreach, genetics & metabolic clinics, and neurodevelopmental outreach. Data reported for 2016. Title V dollars also funded staff time to:
• Advance the medical home model among all pediatric providers
• Maintain the Alaska Birth Defects Registry
• Work on Systems of care for children with autism and other neurodevelopmental conditions

5.	**Field Name:**	**Others**
	Fiscal Year:	**2016**

Field Note:
This is an unduplicated count of clients that are served through Title V and/or Title V partners. The count includes clients of the Breast and Cervical Health Check Program who received breast and cervical screenings (4944), men and women served by Title X Reproductive Health Clinics who are 20 years and older (1753) and clients served in the MIECHV program in the age range of 22 to 44 (141).

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Alaska

Reporting Year 2016

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	11,065	6,213	342	2,158	698	294	1,151	209
Title V Served	11,065	6,213	342	2,158	698	294	1,151	209
Eligible for Title XIX	5,345	1,491	130	2,034	243	227	402	818
2. Total Infants in State	10,738	6,048	452	1,737	491	166	1,844	0
Title V Served	10,738	6,048	452	1,737	491	166	1,844	0
Eligible for Title XIX	7,304	2,295	215	2,321	442	364	699	968

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	9,874	982	209	11,065
Title V Served	9,874	982	209	11,065
Eligible for Title XIX	5,206	129	10	5,345
2. Total Infants in State	9,756	982	0	10,738
Title V Served	9,756	982	0	10,738
Eligible for Title XIX	7,051	228	25	7,304

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2016**
	Column Name:	**Total All Races**
	Field Note: Data Source: Alaska Health Analytics and Vital Records	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2016**
	Column Name:	**Total All Races**
	Field Note: Data Source: Alaska Health Analytics and Vital Records.	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2016**
	Column Name:	**Total All Races**
	Field Note: Data Source: Alaska Medicaid data linked to birth certficates	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2016**
	Column Name:	**Total All Races**
	Field Note: Provisional Data. Data Source: Alaska Department of Labor Population Estimates as of July 2016.	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2016**
	Column Name:	**Total All Races**
	Field Note: Provisional Data: Data Source: Alaska Department of Labor Population Estimates as of July 2016. All infants receive Title V services through infrastructure building and population based services such as Newborn Hearing and Metabolic Screening, and educational/outreach programs. A small portion receive direct care services and enabling services.	
6.	**Field Name:**	**2. Eligible for Title XIX**

Fiscal Year:	**2016**
Column Name:	**Total All Races**

Field Note:
Data Source: Alaska Medicaid Infant Medicaid data for CY2016. Infants are defined as 1 year or older on January 2016 and eligible for Medicaid in CY16.

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

State: Alaska

A. State MCH Toll-Free Telephone Lines	2018 Application Year	2016 Reporting Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 799-7570	(800) 799-7570
2. State MCH Toll-Free "Hotline" Name	Women's Children's & Family Health	Women's Children's and Family Health
3. Name of Contact Person for State MCH "Hotline"	Lindsay Reese	Lindsay Reese
4. Contact Person's Telephone Number	(907) 269-8073	(907) 269-8073
5. Number of Calls Received on the State MCH "Hotline"		188

B. Other Appropriate Methods	2018 Application Year	2016 Reporting Year
1. Other Toll-Free "Hotline" Names	NA	NA
2. Number of Calls on Other Toll-Free "Hotlines"		0
3. State Title V Program Website Address	http://dhss.alaska.gov/dph/wcfh/Pages/default.aspx	http://dhss.alaska.gov/dph/wcfh/Pages/default.aspx
4. Number of Hits to the State Title V Program Website		5,526
5. State Title V Social Media Websites	NA	NA
6. Number of Hits to the State Title V Program Social Media Websites		0

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Alaska

1. Title V Maternal and Child Health (MCH) Director	
Name	Stephanie Wrightsman-Birch
Title	MCH Title V Director
Address 1	3601 C Street, Suite 322
Address 2	
City/State/Zip	Anchorage / AK / 99503
Telephone	(907) 334-2424
Extension	
Email	stephanie.wrightsman-birch@alaska.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Rebekah Morisse
Title	CYSHCN Director
Address 1	3601 C Street, Suite 322
Address 2	
City/State/Zip	Anchorage / AK / 99503
Telephone	(907) 269-4762
Extension	
Email	rebekah.morisse@alaska.gov

3. State Family or Youth Leader (Optional)	
Name	John Cartwright
Title	Health Program Associate, Family Leader
Address 1	3601 C Street, Suite 322
Address 2	
City/State/Zip	Anchorage / AK / 99503
Telephone	(907) 269-3514
Extension	
Email	john.cartwright@alaska.gov

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Alaska

Application Year 2018

No.	Priority Need
1.	Reduce substance abuse among families, including alcohol, tobacco and drugs.
2.	Increase access and preventative health care services to Alaskans and their families.
3.	Increase healthy relationships.
4.	Increase access to reproductive health services that adhere to national best practice guidelines.
5.	Improve system of care for families with children and youth with special health care needs
6.	Reduce the rate of child maltreatment
7.	Increase evidence based screening for all MCH populations for behavioral and mental health problems

Form 9 State Priorities-Needs Assessment Year - Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Reduce substance abuse among families, including alcohol, tobacco and drugs.	Continued	
2.	Increase access and preventative health care services to Alaskans and their families.	New	
3.	Increase healthy relationships.	New	
4.	Increase access to reproductive health services that adhere to national best practice guidelines.	New	
5.	Improve system of care for families with children and youth with special health care needs	Continued	
6.	Reduce the rate of child maltreatment	Continued	
7.	Increase evidence based screening for all MCH populations for behavioral and mental health problems	New	

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10a
National Outcome Measures (NOMs)

State: Alaska

Form Notes for Form 10a NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	74.4 %	0.4 %	8,170	10,986
2014	72.6 %	0.4 %	7,829	10,778
2013	70.7 %	0.4 %	7,722	10,920

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 1 - Notes:

None

Data Alerts: None

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	176.3	15.5 %	132	7,489
2011	175.6	15.5 %	131	7,460
2010	192.5	16.3 %	143	7,428

Legends:

Indicator has a numerator ≤10 and is not reportable

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

NOM 2 - Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

State Provided Data	
	2016
Annual Indicator	6.3
Numerator	8
Denominator	127,125
Data Source	Alaska Maternal Child Death Review
Data Source Year	2000-2011

NOM 3 - Notes:

Numerator includes all deaths related to or aggravated by pregnancy and occurring within 42 days of the end of a pregnancy, identified by the Alaska Maternal Child Death Review committee after review of medical records, autopsy reports, and other information associated with the death.

Data Alerts: None

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	5.8 %	0.2 %	653	11,278
2014	5.9 %	0.2 %	672	11,385
2013	5.8 %	0.2 %	658	11,441
2012	5.7 %	0.2 %	632	11,167
2011	6.0 %	0.2 %	690	11,449
2010	5.7 %	0.2 %	651	11,459
2009	5.9 %	0.2 %	666	11,315

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 4.1 - Notes:

None

Data Alerts: None

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	0.9 %	0.1 %	105	11,278
2014	0.9 %	0.1 %	101	11,385
2013	1.0 %	0.1 %	110	11,441
2012	0.9 %	0.1 %	97	11,167
2011	0.9 %	0.1 %	108	11,449
2010	0.9 %	0.1 %	105	11,459
2009	1.0 %	0.1 %	113	11,315

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 4.2 - Notes:

None

Data Alerts: None

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	4.9 %	0.2 %	548	11,278
2014	5.0 %	0.2 %	571	11,385
2013	4.8 %	0.2 %	548	11,441
2012	4.8 %	0.2 %	535	11,167
2011	5.1 %	0.2 %	582	11,449
2010	4.8 %	0.2 %	546	11,459
2009	4.9 %	0.2 %	553	11,315

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 4.3 - Notes:

None

Data Alerts: None

NOM 5.1 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	9.0 %	0.3 %	1,008	11,268
2014	8.5 %	0.3 %	967	11,368
2013	8.5 %	0.3 %	968	11,333
2012	7.6 %	0.3 %	851	11,164
2011	8.9 %	0.3 %	1,010	11,369
2010	8.3 %	0.3 %	939	11,353
2009	9.0 %	0.3 %	1,010	11,243

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 5.1 - Notes:

None

Data Alerts: None

NOM 5.2 - Percent of early preterm births (<34 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	2.1 %	0.1 %	237	11,268
2014	2.1 %	0.1 %	237	11,368
2013	2.2 %	0.1 %	252	11,333
2012	2.1 %	0.1 %	231	11,164
2011	2.1 %	0.1 %	238	11,369
2010	1.9 %	0.1 %	220	11,353
2009	2.3 %	0.1 %	256	11,243

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 5.2 - Notes:

None

Data Alerts: None

NOM 5.3 - Percent of late preterm births (34-36 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	6.8 %	0.2 %	771	11,268
2014	6.4 %	0.2 %	730	11,368
2013	6.3 %	0.2 %	716	11,333
2012	5.6 %	0.2 %	620	11,164
2011	6.8 %	0.2 %	772	11,369
2010	6.3 %	0.2 %	719	11,353
2009	6.7 %	0.2 %	754	11,243

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 5.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	24.9 %	0.4 %	2,801	11,268
2014	25.4 %	0.4 %	2,882	11,368
2013	25.2 %	0.4 %	2,852	11,333
2012	25.3 %	0.4 %	2,829	11,164
2011	25.3 %	0.4 %	2,874	11,369
2010	24.8 %	0.4 %	2,812	11,353
2009	25.4 %	0.4 %	2,851	11,243

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 6 - Notes:

None

Data Alerts: None

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

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015/Q2-2016/Q1	3.0 %			
2015/Q1-2015/Q4	4.0 %			
2014/Q4-2015/Q3	3.0 %			
2014/Q3-2015/Q2	2.0 %			
2014/Q2-2015/Q1	1.0 %			
2014/Q1-2014/Q4	2.0 %			
2013/Q4-2014/Q3	3.0 %			
2013/Q3-2014/Q2	3.0 %			
2013/Q2-2014/Q1	4.0 %			

Legends:

Indicator results were based on a shorter time period than required for reporting

NOM 7 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	5.0	0.7 %	57	11,423
2013	4.4	0.6 %	51	11,477
2012	5.5	0.7 %	62	11,223
2011	4.6	0.6 %	53	11,492
2010	3.7	0.6 %	42	11,500
2009	4.2	0.6 %	48	11,352

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 8 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.7	0.8 %	76	11,392
2013	5.8	0.7 %	66	11,446
2012	5.1	0.7 %	57	11,187
2011	3.8	0.6 %	44	11,456
2010	3.6	0.6 %	41	11,471
2009	6.9	0.8 %	78	11,324

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	3.1	0.5 %	35	11,392
2013	2.6	0.5 %	30	11,446
2012	3.0	0.5 %	34	11,187
2011	2.2	0.4 %	25	11,456
2010	1.9	0.4 %	22	11,471
2009	2.7	0.5 %	31	11,324

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	3.6	0.6 %	41	11,392
2013	3.2	0.5 %	36	11,446
2012	2.1	0.4 %	23	11,187
2011	1.7 ϟ	0.4 % ϟ	19 ϟ	11,456 ϟ
2010	1.7 ϟ	0.4 % ϟ	19 ϟ	11,471 ϟ
2009	4.2	0.6 %	47	11,324

Legends:

🏴 Indicator has a numerator <10 and is not reportable

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

NOM 9.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	96.6	29.1 %	11	11,392
2013	87.4	27.6 %	10	11,446
2012	125.2	33.5 %	14	11,187
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	106.0	30.6 %	12	11,324

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	263.3	48.1 %	30	11,392
2013	157.3	37.1 %	18	11,446
2012	116.2	32.3 %	13	11,187
2011	87.3	27.6 %	10	11,456
2010	122.1	32.6 %	14	11,471
2009	291.4	50.8 %	33	11,324

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.4 %	0.9 %	695	10,891
2013	7.8 %	1.0 %	851	10,936
2012	6.6 %	1.0 %	705	10,688
2010	7.0 %	1.0 %	765	10,889
2009	5.6 %	0.8 %	606	10,864
2008	6.1 %	0.9 %	664	10,940
2007	5.1 %	0.8 %	545	10,627

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	13.2	1.3 %	99	7,490
2011	7.9	1.0 %	59	7,460
2010	9.3	1.1 %	69	7,428

Legends:

Indicator has a numerator ≤10 and is not reportable

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

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM 12 - Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	19.2 %	1.4 %	33,573	174,686

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	35.4	6.1 %	34	95,972
2014	25.1	5.1 %	24	95,484
2013	31.3	5.7 %	30	95,894
2012	18.9 ϟ	4.5 % ϟ	18 ϟ	95,022 ϟ
2011	21.1	4.7 %	20	95,013
2010	27.6	5.4 %	26	94,055
2009	25.0	5.2 %	23	92,116

Legends:

Indicator has a numerator <10 and is not reportable

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

State Provided Data	
	2016
Annual Indicator	29.8
Numerator	176
Denominator	591,565
Data Source	Alaska Bureau of Vital Statistics
Data Source Year	2015

NOM 15 - Notes:

Provisional 2015 data. This measure is reported as a 5 year moving average (2011-2015).

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	45.3	6.8 %	44	97,215
2014	40.4	6.4 %	40	98,952
2013	45.0	6.7 %	45	99,908
2012	36.9	6.1 %	37	100,332
2011	54.6	7.3 %	56	102,518
2010	56.3	7.4 %	58	102,957
2009	49.9	6.9 %	52	104,166

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013_2015	7.5	2.3 %	11	146,860
2012_2014	9.4	2.5 %	14	148,644
2011_2013	9.3	2.5 %	14	150,915
2010_2012	9.1	2.4 %	14	153,574
2009_2011	9.6	2.5 %	15	156,901
2008_2010	13.8	2.9 %	22	159,365
2007_2009	19.1	3.4 %	31	161,945

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013_2015	37.5	5.1 %	55	146,860
2012_2014	30.3	4.5 %	45	148,644
2011_2013	22.5	3.9 %	34	150,915
2010_2012	23.4	3.9 %	36	153,574
2009_2011	22.9	3.8 %	36	156,901
2008_2010	28.9	4.3 %	46	159,365
2007_2009	25.3	4.0 %	41	161,945

Legends:

Indicator has a numerator <10 and is not reportable

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

State Provided Data	
	2016
Annual Indicator	36.7
Numerator	54
Denominator	147,108
Data Source	Alaska Bureau of Vital Statistics
Data Source Year	2015

NOM 16.3 - Notes:

Provisional 2015 data. This measure is reported as a 3 year moving average (2013-2015).

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	14.4 %	1.2 %	26,939	187,218
2007	16.5 %	1.2 %	30,078	182,287
2003	16.0 %	1.0 %	30,021	188,239

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	13.3 %	1.7 %	2,318	17,453

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children diagnosed with an autism spectrum disorder

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	2.2 %	0.6 %	3,331	155,228
2007	0.7 %	0.2 %	1,045	151,415

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	5.5 %	0.8 %	8,431	153,701
2007	5.6 %	0.9 %	8,479	150,570

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	63.2 %	6.7 %	7,917	12,529
2007	60.4 %	6.8 %	5,955	9,864
2003	52.2 %	6.3 %	5,308	10,178

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children in excellent or very good health

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	88.5 %	1.1 %	165,753	187,218
2007	88.9 %	1.1 %	162,052	182,287
2003	88.2 %	1.0 %	165,845	188,133

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	29.9 %	2.3 %	23,220	77,559
2007	33.9 %	2.2 %	29,019	85,558
2003	30.7 %	1.8 %	25,746	83,880

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	36.9 %	0.7 %	2,049	5,552
2012	39.5 %	0.5 %	3,561	9,019
2010	40.2 %	0.5 %	4,061	10,108
2008	39.1 %	0.5 %	3,525	9,020

Legends:

Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	30.8 %	1.5 %	8,973	29,161
2013	26.2 %	1.4 %	7,608	29,098
2011	25.8 %	1.3 %	7,832	30,337
2009	26.2 %	1.5 %	8,491	32,358
2007	27.1 %	1.8 %	8,975	33,131

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	9.2 %	1.1 %	17,034	186,248
2014	12.2 %	1.4 %	22,710	185,701
2013	11.7 %	1.5 %	22,012	188,692
2012	13.4 %	1.7 %	24,672	184,564
2011	13.8 %	1.4 %	25,932	187,825
2010	9.3 %	1.1 %	17,626	188,833
2009	12.8 %	1.2 %	23,508	183,524

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	66.3 %	3.2 %	10,158	15,312
2014	67.3 %	3.7 %	10,040	14,909
2013	63.9 %	3.5 %	8,792	13,752
2012	59.5 %	3.5 %	7,822	13,146
2011	64.7 %	3.7 %	8,059	12,463
2010	58.4 %	3.5 %	7,299	12,505
2009	53.3 %	4.2 %	8,379	15,712

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

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

NOM 22.1 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2016	47.9 %	2.0 %	83,314	174,114
2014_2015	53.6 %	1.9 %	92,261	172,289
2013_2014	51.0 %	2.2 %	89,222	174,881
2012_2013	46.4 %	2.3 %	81,214	175,079
2011_2012	38.8 %	2.5 %	65,071	167,830
2010_2011	46.8 % ϟ	5.5 % ϟ	77,020 ϟ	164,573 ϟ
2009_2010	39.4 %	2.7 %	63,257	160,552

Legends:

⚑ Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

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

NOM 22.2 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen (Female)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	57.1 %	4.5 %	12,747	22,344
2014	48.7 %	4.5 %	11,157	22,903
2013	52.2 %	4.8 %	12,315	23,592
2012	56.1 %	4.8 %	13,780	24,551
2011	59.5 %	4.9 %	14,775	24,851
2010	40.9 %	4.7 %	10,188	24,942
2009	40.8 %	4.9 %	10,243	25,115

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

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

Data Source: National Immunization Survey (NIS) - Teen (Male)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	41.6 %	4.3 %	9,894	23,797
2014	37.9 %	4.4 %	9,135	24,135
2013	27.6 %	4.1 %	6,911	25,037
2012	14.1 %	2.9 %	3,632	25,687
2011	NR	NR	NR	NR

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

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

NOM 22.3 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	69.7 %	3.0 %	32,161	46,141
2014	73.8 %	2.8 %	34,730	47,037
2013	74.3 %	3.0 %	36,128	48,629
2012	77.1 %	2.6 %	38,740	50,238
2011	65.6 %	3.6 %	33,417	50,915
2010	63.9 %	3.1 %	32,983	51,601
2009	55.8 %	3.4 %	28,817	51,617

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

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

NOM 22.4 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	55.7 %	3.2 %	25,718	46,141
2014	57.0 %	3.1 %	26,786	47,037
2013	55.2 %	3.3 %	26,862	48,629
2012	52.7 %	3.2 %	26,488	50,238
2011	46.1 %	3.7 %	23,474	50,915
2010	41.0 %	3.3 %	21,129	51,601
2009	40.2 %	3.4 %	20,746	51,617

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

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

NOM 22.5 - Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)

State: Alaska

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

Federally Available Data	
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)	
	2016
Annual Objective	62
Annual Indicator	55.6
Numerator	71,071
Denominator	127,889
Data Source	BRFSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	64.0	66.0	68.0	70.0	72.0	74.0

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2016
Annual Objective	76
Annual Indicator	75.4
Numerator	7,980
Denominator	10,583
Data Source	PRAMS
Data Source Year	2014

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	78.0	80.0	82.0	84.0	86.0	88.0

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	33
Annual Indicator	32.6
Numerator	15,812
Denominator	48,525
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	34.0	35.0	36.0	37.0	38.0	39.0

Field Level Notes for Form 10a NPMs:

None

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19 (Child Health)

Federally Available Data	
Data Source: HCUP - State Inpatient Databases (SID) - CHILD	
	2016
Annual Objective	185
Annual Indicator	175.5
Numerator	188
Denominator	107,097
Data Source	SID-CHILD
Data Source Year	2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	180.0	176.0	172.0	168.0	164.0	160.0

Field Level Notes for Form 10a NPMs:

None

NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	26
Annual Indicator	13.9
Numerator	8,187
Denominator	59,024
Data Source	NSCH
Data Source Year	2011_2012

Federally Available Data	
Data Source: Youth Risk Behavior Surveillance System (YRBSS)	
	2016
Annual Objective	26
Annual Indicator	29.8
Numerator	9,053
Denominator	30,353
Data Source	YRBSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	25.0	24.0	23.0	22.0	21.0	20.0

Field Level Notes for Form 10a NPMs:

None

NPM 11 - Percent of children with and without special health care needs having a medical home

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2016
Annual Objective	45
Annual Indicator	39.6
Numerator	10,398
Denominator	26,280
Data Source	NSCH-CSHCN
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	47.0	49.0	52.0	55.0	57.0	59.0

Field Level Notes for Form 10a NPMs:

None

NPM 13 - A) Percent of women who had a dental visit during pregnancy

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2016
Annual Objective	53
Annual Indicator	52.7
Numerator	5,749
Denominator	10,909
Data Source	PRAMS
Data Source Year	2014

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	55.0	56.0	57.0	59.0	60.0	61.0

Field Level Notes for Form 10a NPMs:

None

NPM 13 - B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	72
Annual Indicator	72.1
Numerator	125,411
Denominator	173,948
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	73.0	74.0	75.0	76.0	77.0	78.0

Field Level Notes for Form 10a NPMs:

None

NPM 14 - A) Percent of women who smoke during pregnancy

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2016
Annual Objective	12.9
Annual Indicator	12.5
Numerator	1,357
Denominator	10,838
Data Source	NVSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	12.3	11.7	11.1	10.5	9.9	9.3

Field Level Notes for Form 10a NPMs:

None

NPM 14 - B) Percent of children who live in households where someone smokes

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	28
Annual Indicator	29.5
Numerator	54,636
Denominator	185,403
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	26.6	25.3	24.0	22.8	21.5	20.8

Field Level Notes for Form 10a NPMs:

None

Form 10a
State Performance Measures (SPMs)

State: Alaska

SPM 1 - Percent of women (who delivered a live birth and were trying to get pregnant) who had one or more alcoholic drinks in an average week during the 3 months before pregnancy.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	27.9
Numerator	1,578
Denominator	5,649
Data Source	AK PRAMS Phase 7 Q38. 2014 data most recent avail
Data Source Year	2014
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	26.0	25.0	24.0	23.0	22.0	21.0

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Annual objectives were adjusted due to a change in indicator measurement. Goals are conservative due to limited statewide activities on pre-pregnancy drinking prevention.	

SPM 2 - Percent of students who report that they would feel comfortable seeking help from at least one adult besides their parents if they had an important question affecting their life.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	85.7
Numerator	1,182
Denominator	1,379
Data Source	CDC Youth Risk and Behavioral Surveillance
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	86.1	86.3	86.5	86.7	87.0	87.3

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: 2022 goal based on 2007-2015 YRBS trend data.	

SPM 3 - Rate of substantiated reports of child maltreatment per thousand children 0-17 years of age in Alaska

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	15.6
Numerator	2,898
Denominator	186,266
Data Source	Child Maltreatment 2015 complied from the National
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	13.0	13.0	12.0	12.0	12.0	12.0

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Goal is to maintain a rate below the HA 2020 goal of 14.4 per 1,000 children aged 0-17. However this SPM has been revised.

SPM 4 - Percent of women who report being screened for depression during prenatal care

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	75.9
Numerator	8,217
Denominator	10,824
Data Source	PRAMS Phase 7 (with Phase 8, 2016 births, the SPM
Data Source Year	2014
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	77.5	80.0	80.5	81.0	81.5	82.0

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: 2014 most recent PRAMS data available.	
2.	**Field Name:**	**2017**
	Column Name:	**Annual Objective**
	Field Note: Goals based on 2007-2013 PRAMS trend data. The values since 2009 are 74.0%, 75.3%, 76.6%, 77.1%, and 77.5% in 2013.	

SPM 5 - Percent of deaths among children ages 0-17 years classified as maltreatment-related by the MCDR committee

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	20.0	19.0	18.0	17.0	16.0	15.0

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**Annual Objective**

Field Note:
In 2016 deaths 143 deaths were reviewed by MCDR and the goal is to see a decrease in the percent of deaths among children ages 0-17 years classified as maltreatment-related by the MCDR committee.

Form 10a
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Alaska

ESM 1.1 - Ratio of rarely or never screened women who are newly enrolled in the BCHC program.

Measure Status:	Inactive - ESM 1.1 was revised to more accurately measure the number of rarely or never screened women who receive a Pap test, as this provides opportunity for t

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0.3
Numerator	731
Denominator	2,467
Data Source	Breast and Cervical Health Check Database
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	50.0	50.0	50.0	50.0	50.0	50.0

Field Level Notes for Form 10a ESMs:

1. **Field Name:** **2016**

   Column Name: **State Provided Data**

   Field Note:
   Maintain ratio of never or rarely screened (> 5 years) clients in BCHC population served. (National target for proportion of rarely or never screened women enrolled in BCHC = 20%, so Alaska's BCHC program wants to maintain their proportion at 50%.)

ESM 1.2 - Percent of all WIC clients referred to agency reproductive health or primary care providers who receive services.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	1
Data Source	NA
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	0.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Due to staff turnover at the WIC clinic, this strategy was not implemented. This ESM has been revised and is discussed in depth in the 5 year action plan.

ESM 1.3 - Percent of rarely or never screened women who receive a Pap smear paid for by the Breast and Cervical Health Check (BCHC) program.

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	50.0	50.0	50.0	50.0	50.0	50.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**Annual Objective**

Field Note:
This ESM was revised to more accurately measure the number of rarely or never screened women who receive a Pap test, as this provides opportunity for the health care provider to address other preventative health need.

The goal is to maintain the ratio of never or rarely screened (> 5 years) clients in BCHC population served. (National target for proportion of rarely or never screened women enrolled in BCHC = 20%, so Alaska's BCHC program wants to maintain their proportion at 50%.)

ESM 5.1 - Number of hospitals/birthing facilities using the Alaska Infant Safe Sleep Toolkit.

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	5
Numerator	
Denominator	
Data Source	Alaska Infant Safe Sleep Program Records
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	5.0	5.0	6.0	6.0	7.0	7.0

Field Level Notes for Form 10a ESMs:

None

ESM 5.2 - Percent of Alaska births that occur at a hospital that has implemented at least one component of the Alaska Infant Safe Sleep Toolkit.

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	53.4
Numerator	6,011
Denominator	11,248
Data Source	Alaska Infant Safe Sleep Program Records
Data Source Year	2014
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	53.0	55.0	57.0	59.0	61.0	63.0

Field Level Notes for Form 10a ESMs:

None

ESM 5.3 - Percent of SUID cases reviewed in prior year with complete SUID Investigation Reporting Forms

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	80
Numerator	20
Denominator	25
Data Source	Maternal Child Death Review (MCDR) database
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	80.0	80.0	83.0	85.0	87.0	90.0

Field Level Notes for Form 10a ESMs:

1. **Field Name:** **2016**

Column Name: **State Provided Data**

Field Note:
This was the first year of this new ESM, and based the initial annual objectives on historical information. The Medical examiners office has stressed the importance of the SUID form to law enforcement and the MCDR program has improved in obtaining these completed forms. Combined, the result has been a drastic improvement in a short period of time. Based on this we've corrected our annual objectives and will center MCDR activities around maintaining relationships and identifying and building new ones.

ESM 5.4 - Percent of SUID cases reviewed in prior year classified using CDC categories

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	96
Numerator	24
Denominator	25
Data Source	Maternal Child Death Review (MCDR) database
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	94.0	94.0	95.0	95.0	95.0	96.0

Field Level Notes for Form 10a ESMs:

1. **Field Name:** **2016**

Column Name: **State Provided Data**

Field Note:
This indicator was modifed from simply the use of the CDC SUID death classification matrix to the accuracy/consistency in classification of SUID deaths with those classified post-hoc by the CDC. The new measure will track the proportion of correct classification by MCDR among cleaned and post-hoc reviewed cases by CDC. During the 2016 year only a limited number of cleaned cases were available for post-hoc review by CDC and provided to MCDR. Due to this inital limitation the subsequent year is subject to potentially large variation.

ESM 5.5 - Number of birthing facilities with a Safe Sleep Certification from Cribs for Kids in Alaska.

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	1.0	3.0	5.0	6.0	7.0

Field Level Notes for Form 10a ESMs:

None

ESM 5.6 - Percent of infants born at a facility with Cribs for Kids Safe Sleep Certification or a safe sleep policy in place and has initiated the certification process.

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	53.0	53.0	55.0	57.0	59.0	61.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**Annual Objective**

Field Note:
This goal is based on number of birthing facilities with a Safe Sleep Certification from Cribs for Kids in Alaska in ESM 5.5. Small increases are expected due to the small number of infants delivered at the majority of non-participating facilities.

ESM 5.7 - Percent of SUID cases reviewed in prior year and classified using CDC categories that agree with CDC post-hoc classification.

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	50.0	60.0	70.0	80.0	90.0	95.0

Field Level Notes for Form 10a ESMs:

None

ESM 6.1 - Percent of children enrolled in home visiting with a timely screen for developmental delays using a validated parent-completed tool

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	93.4
Numerator	114
Denominator	122
Data Source	Nurse Family Partnership Program Data
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	94.0	94.5	95.0	95.5	96.0	96.5

Field Level Notes for Form 10a ESMs:

None

ESM 7.1 - Number of annual Child Death Review recommendations developed related to the prevention of child injury and/or child maltreatment

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	11
Numerator	
Denominator	
Data Source	MCDR Annual Recommendations Report
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	8.0	10.0	10.0	10.0	10.0	10.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
The number of annual recommendations related to the prevention of child injury/maltreatment is based on those developed at the annual MCDR meeting. However, using the total number of recommendations made by the MCDR committee the number increases to 47 individual recommendations related to injury prevention.

ESM 9.1 - Number of Alaskan students participating in the 4th R for healthy relationships program in the last school year.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	2,216
Numerator	
Denominator	
Data Source	Data is currently being collected via Section of W
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1,558.0	1,947.0	2,434.0	3,042.0	3,802.0	4,752.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
WCFH Dashboard. Increase number of participating students by 25% each year.

ESM 11.1 - Percent of CYSHCN in School Nurse Pilot Project elementary pilot schools and partner practices with Shared Plan of Care

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	12.1
Numerator	4
Denominator	33
Data Source	School Nurse- Care Coordination Pilot Project reco
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.2	0.2	0.2	0.2	0.2	0.2

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Funding has not been identified for expansion so the annual objective is not anticipated to change.

ESM 11.2 - Number of families/providers who obtain needed support from Help Me Grow Alaska for a needed specialist, support or service.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	1
Data Source	Help Me Grow Alaska database
Data Source Year	NA
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.5	0.6	0.6	0.7	0.7	0.8

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Data not available. The Help Me Grow Alaska system entered the installation phase of implementation in early 2017 through a contract with the All Alaska Pediatric Partnership, but has not yet begun to provide family referral and support through a call center. The call center will be established by the end of 2017 with preliminary service linkage data anticipated in early 2018.

ESM 13.1 - Number of oral health pocket guides distributed

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	30
Numerator	
Denominator	
Data Source	Alaska Oral Health Program
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	300.0	300.0	500.0	650.0	800.0	950.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Booklets not obtained until September 2016 and travel restrictions including to attend state meetings/conferences

ESM 14.1 - Number of women currently pregnant or planning pregnancy enrolled in Alaska Quit Line

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	40
Numerator	
Denominator	
Data Source	Alaska Quit Line
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	52.0	57.0	62.0	67.0	72.0	77.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Increase number of women who are currently pregnant or planning pregnancy who are tobacco users and who register with the Quit Line during the calendar year by 10% each year.

Form 10b
State Performance Measure (SPM) Detail Sheets

State: Alaska

SPM 1 - Percent of women (who delivered a live birth and were trying to get pregnant) who had one or more alcoholic drinks in an average week during the 3 months before pregnancy.
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	Reduce poor birth outcomes related to alcohol use during pregnancy.
Definition:	

Numerator:	Number of women who responded yes to drinking any alcohol during the 3 months before pregnancy AND who said "yes" to the question, "when you got pregnant with your new baby, were you trying to get pregnant?"
Denominator:	Number of Alaska-resident women delivering a live-born infant who indicated on the survey that they were trying to become pregnant.
Unit Type:	Percentage
Unit Number:	100

Healthy People 2020 Objective:	MICH-11.1 Increase abstinence from alcohol among pregnant women MICH-11.2 Increase abstinence from binge drinking among pregnant women
Data Sources and Data Issues:	Pregnancy Risk Assessment Monitoring System (PRAMS)
Significance:	Since 1990, Alaska Pregnancy Risk Assessment Monitoring System (PRAMS) has conducted ongoing surveys of mothers of newborns. PRAMS collects population-based data on maternal attitudes and experiences before, during, and after pregnancy. Approximately one of every six mothers of newborns is selected for PRAMS. Mothers are randomly selected from birth records at the Bureau of Vital Statistics. Women from some groups are sampled at a higher rate to ensure adequate data are available in smaller but higher risk populations. Selected women are first contacted by mail approximately 2 to 6 months after delivery of their baby. If there is no response to repeated mailings, women are contacted and interviewed by telephone. Data collection procedures and instruments are standardized to allow comparisons between states. PRAMS survey asks these mothers about their intention to become pregnant and their use of alcohol in the 3 months prior to pregnancy and during the pregnancy of the current newborn. These data will effectively measure use of alcohol before and during pregnancy and allow for cross tabulation of alcohol use with pregnancy intention among those mothers. Strategies employed to address reduction of fetal exposure to alcohol in utero include promoting use of two tools among women of reproductive age: 1) Screening, Brief Intervention and Referral to Treatment (SBIRT), specifically, 4P's Plus screening tool, and 2) One Key Question. SBIRT/4P's Plus is a process that clinical care staff employ to reliably screen women who are misusing alcohol. SBIRT/4P's Plus relies upon use of evidence-based tools which clinicians are trained to use. One Key Question is an evidence-informed practice that clinicians use to identify women at risk of unintended pregnancy. The two strategies are paired to maximize appropriate interventions for women at risk for unintended pregnancy while misusing alcohol. SBIRT/4P's Plus employed singly is an effective strategy for screening and ref

SPM 2 - Percent of students who report that they would feel comfortable seeking help from at least one adult besides their parents if they had an important question affecting their life.
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	Increase healthy relationships. The goal is to reach 87% by 2021. The goal is based on 2007-2015 YRBS trend data.
Definition:	**Numerator:** Number of students who report they would feel comfortable seeking help from at least one adult besides their parents if they had an important question affecting their life. **Denominator:** Number of students who take the survey **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	AH-3.1 Increase the proportion of adolescents who have an adult in their lives with whom they can talk about serious problems
Data Sources and Data Issues:	Biennial CDC Youth Risk Behavioral Surveillance System
Significance:	The percent of students who report that they would feel comfortable seeking help from at least one adult besides their parents if they had an important question affecting their life data collected for SPM #2 is a recognized protective factor against a variety of public health challenges, including bullying/violence. In 2014, the CDC released its Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence report. In it, a list of shared risk and protective factors which research showed either increased the likelihood (risk factor) or decreased the likelihood (protective factor) of experiencing and/or perpetrating multiple forms of violence were summarized. Family support/ connectedness, connection to a caring adult and connection/commitment to school were listed as protective factors against child maltreatment, teen dating violence, youth violence, bullying and/or suicide. For this reason, we selected the existing YRBS protective factor measure as one of our SPMs. Programs within our strategy (Promote and disseminate evidence-based healthy relationship programming, including the Fourth R, 3R's, Bringing in the Bystander, Alaska Promoting Health Among Teens, Healthy Relationships Plus) are listed on evidence-based programs' databases such as SAMHSA's National Registry for Evidence-Based Programs and Practices (the Fourth R) and the Office of Adolescent Health Evidence-Based Programs website (Alaska Promoting Health Among Teens). The more Alaskan youth participate in these evidence-based programs and practices, the greater their protective factors and fewer their risk factors will be and thus, and the greater our chance of increasing healthy relationships.

SPM 3 - Rate of substantiated reports of child maltreatment per thousand children 0-17 years of age in Alaska
Population Domain(s) – Child Health

Measure Status:	Inactive - Replaced
Goal:	Track the effectiveness of statewide child maltreatment primary prevention efforts over time. Maintain a rate of substantiated child maltreatment below the Healthy Alaskans 2020 goal of 14.4 per 1,000 children aged 0-17.
Definition:	**Numerator:** Annual number of unique children ages 0-17 in Alaska with at least one substantiated report of maltreatment to the State Child Protective Services Agency. **Denominator:** Annual # of children ages 0-17 in Alaska **Unit Type:** Rate **Unit Number:** 1,000
Healthy People 2020 Objective:	IVP-37 Reduce child maltreatment deaths IVP-38 Reduce nonfatal child maltreatment
Data Sources and Data Issues:	The source of the data is the State Office of Children's Services (OCS) which is the state child protective services agency. The data is analyzed and organized by the Surveillance of Child Abuse and Neglect (SCAN) program within the Division of Public Health. Maltreatment includes physical and sexual abuse, mental injury, and neglect allegations.
Significance:	This is the most widely used indicator of child maltreatment. Research suggests that this estimate is an underestimate of the actual magnitude. If we can reduce overall maltreatment, the assumption is that substantiated maltreatment will also fall. This measure will allow us to compare Alaska's rates with the national standard and other states that have similar child welfare practices. A limitation of this measure is that the estimate could be influenced by policy and budgetary changes that may reduce the ability of OCS to fully investigate and substantiate all reported cases.

SPM 4 - Percent of women who report being screened for depression during prenatal care
Population Domain(s) – Cross-Cutting/Life Course

Measure Status:	Active
Goal:	Increase the percent of women delivering live births who are screened for depression during any of their prenatal care visits
Definition:	

Numerator:	Annual number of women reporting that a doctor, nurse, or other health care worker talked with her during any of her prenatal care visits about what to do if she feels depressed during pregnancy or after her baby is born
Denominator:	Annual number of women delivering a live birth in Alaska
Unit Type:	Percentage
Unit Number:	100

Healthy People 2020 Objective:	MCH-34 Decrease the proportion of women delivering a live birth who experience postpartum depressive symptoms
Data Sources and Data Issues:	PRAMS Phase 7 (with Phase 8, 2016 births, the ESM will change to Numerator: Annual number of women reporting that a doctor, nurse, or other health care worker asked her if she was feeling down or depressed during any of her prenatal care visits.)
Significance:	Perinatal depression occurs among women during pregnancy or within a year after delivery. Perinatal depression can exacerbate underlying depression or be triggered by stressful events, such as losing a baby, premature labor and delivery, having twins or triplets, having a baby who has a disability, or having a baby as a teenager. The negative health effects associated with perinatal depression include chronic disease, substance abuse, suicide, and negative impacts on child development. Consistent and standardized screening and referral for maternal depression during the postpartum period, newborn and pediatric periods can improve maternal and child health and developmental outcomes. Treatments may include individual and group psychotherapy, supportive counseling, and antidepressant medications.

SPM 5 - Percent of deaths among children ages 0-17 years classified as maltreatment-related by the MCDR committee
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Track the effectiveness of statewide child maltreatment primary prevention efforts over time.
Definition:	**Numerator:** Annual number of deaths classified as yes or yes probably Abuse or Neglect related among children ages 0-17 among cases reviewed. **Denominator:** Annual number of deaths reviewed by MCDR for children ages 0-17 in Alaska **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	IVP-37 Reduce child maltreatment deaths IVP-38 Reduce nonfatal child maltreatment
Data Sources and Data Issues:	Maternal Child Death Review (MCDR) program. To allow for annual reporting we report on the review data year opposed to the death year. This is due to limitations with lag in reviewing of some deaths that have a delay in data collection. 2016 was the first full year of data collection and review of all child deaths ages 0-17 years. For this indicator we combined all deaths where the committee believed maltreatment caused or contributed to the death and only that that were indicated as Abuse or Neglect. Additional information in the narrative describes the impact of poor parental supervision and age group differences.
Significance:	Child maltreatment is a substantial public health issue with family discord and trauma contributing to the situations that result in disproportionate infant/child mortality. Although preventing child maltreatment occurrence is important the statewide efforts let alone those specific to Title V will likely need to be substantially increased to be expected to see a decrease in overall maltreatment. For this reason we've changed the measure from maltreatment substations rate to maltreatment fatalities due to the multiple efforts currently supported by Title V, particularly the multiple CoIIN efforts, linkages with Medicaid and Child welfare on safe sleep and other fatality prevention efforts. Additionally, the emphasis on the first 1000 days leads to creating helping families create a positive environment for children to thrive and live. This indicator is much more timely and responsive to our interventions and much more reflective of the work supported by Title V in Alaska.

Form 10b
State Outcome Measure (SOM) Detail Sheets

State: Alaska

No State Outcome Measures were created by the State.

Form 10c
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Alaska

ESM 1.1 - Ratio of rarely or never screened women who are newly enrolled in the BCHC program.
NPM 1 – Percent of women with a past year preventive medical visit

Measure Status:	Inactive - ESM 1.1 was revised to more accurately measure the number of rarely or never screened women who receive a Pap test, as this provides opportunity for t
Goal:	Increase the number of women who seek preventive medical visits by using patient navigators and health education messaging to reduce barriers to breast and cervical cancer screening.
Definition:	

Numerator:	Number of women who report not having cervical cancer screening in the last 5 years who enroll in BCHC in a calendar year.
Denominator:	Total number of women newly enrolled in the BCHC program during a calendar year.
Unit Type:	Ratio
Unit Number:	1

Data Sources and Data Issues:	Breast and Cervical Health Check (BCHC) Database
Significance:	Women who have not had cervical cancer screening in over 5 years are 60% more likely to be diagnosed with cervical cancer. Low income women are more likely to not have received a Pap test in over 5 years. Patient navigators and outreach will be used to target low income women to provide health information about cervical cancer screening. This NPM strategy uses evidence based practices to identify low income women and link them with a practice that offers sliding fee schedules in order to make preventive screenings possible.

ESM 1.2 - Percent of all WIC clients referred to agency reproductive health or primary care providers who receive services.
NPM 1 – Percent of women with a past year preventive medical visit

Measure Status:	Active
Goal:	Increase the number of WIC clients receiving postpartum reproductive health services.
Definition:	

Numerator:	Number of WIC clients who receive services from agency reproductive health or primary care providers.
Denominator:	Number of postpartum WIC clients referred to agency reproductive health or primary care providers.
Unit Type:	Ratio
Unit Number:	1

Data Sources and Data Issues:	Anchorage based WIC and Reproductive Health Clinic Referrals and Family Planning Reports.
Significance:	Nearly half of all unintended pregnancies in Alaska are paid for by the AK Medicaid Program. Reproductive health needs are a driver for women in their reproductive years to seek health care. This NPM will use evidence based practices to link low income families to reproductive health services in a sliding fee schedule clinic in order to make preventive screenings possible. An Anchorage-based WIC clinic will adopt the One Key Question as a pilot project.

ESM 1.3 - Percent of rarely or never screened women who receive a Pap smear paid for by the Breast and Cervical Health Check (BCHC) program.
NPM 1 – Percent of women with a past year preventive medical visit

Measure Status:	Active
Goal:	Increase the number of women who seek preventive medical visits by using patient navigators and health education messaging to reduce barriers to breast and cervical cancer screening.
Definition:	

Numerator:	Number of women who report not having cervical cancer screening in the last 5 years who received their first BCHC-paid Pap test in a calendar year.
Denominator:	Total number of women who received a BCHC-paid Pap test in a calendar year.
Unit Type:	Ratio
Unit Number:	1

Data Sources and Data Issues:	Breast and Cervical Health Check (BCHC) Database
Significance:	Women who have not had cervical cancer screening in over 5 years are 60% more likely to be diagnosed with cervical cancer. Low income women are more likely to not have received a Pap test in over 5 years. Patient navigators and outreach will be used to target low income women to provide health information about cervical cancer screening. This NPM strategy uses evidence based practices to identify low income women and link them with a practice that offers sliding fee schedules in order to make preventive screenings possible.

ESM 5.1 - Number of hospitals/birthing facilities using the Alaska Infant Safe Sleep Toolkit.
NPM 5 – Percent of infants placed to sleep on their backs

Measure Status:	Inactive - Replaced
Goal:	Increase the proportion of Alaska infants placed to sleep on their backs by increasing the number of of facilities using Alaska Safe Sleep Toolkit by at least 2 facilities (from 4-6) by 2021
Definition:	

Numerator:	Number of hospitals and birthing facilities implementing the full Alaska Toolkit for Birthing Facilities, holding a STAR Birthing Facility Designation
Denominator:	Number of hospitals and birthing facilities in Alaska
Unit Type:	Count
Unit Number:	10

Data Sources and Data Issues:	Alaska Infant Safe Sleep Program Records
Significance:	Post-partum and infant nurses play a powerful role in teaching and modeling infant sleep practices. The first 24-48 hours following birth is the critical period to influence parents. Research shows that caregivers often use the same sleep position for their babies at home that they see being used at the hospital. Sources: https://www.nichd.nih.gov/publications/pubs/Documents/SIDS_QA_HealthCareProviders.pdf; Alaska Infant Safe Sleep Program Toolkit for Birthing Facilities

ESM 5.2 - Percent of Alaska births that occur at a hospital that has implemented at least one component of the Alaska Infant Safe Sleep Toolkit.
NPM 5 – Percent of infants placed to sleep on their backs

Measure Status:	Inactive - Replaced
Goal:	Increase the proportion of Alaska infants placed to sleep on their backs by increasing the number of facilities that has implemented at least one component of the Alaska Infant Safe Sleep Toolkit.
Definition:	**Numerator:** Number of births at hospitals and birthing facilities with a policy for infant safe sleep in place **Denominator:** Number of births at hospital and birthing facilities in Alaska **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	AK Safe Sleep Program Records and Bureau of Vital Statistics
Significance:	Post-partum and infant nurses play a powerful role in teaching and modeling infant sleep practices. The first 24-48 hours following birth is the critical period to influence parents. Research shows that caregivers often use the same sleep position for their babies at home that they see being used at the hospital. Sources: https://www.nichd.nih.gov/publications/pubs/Documents/SIDS_QA_HealthCareProviders.pdf; Alaska Infant Safe Sleep Program Toolkit for Birthing Facilities

ESM 5.3 - Percent of SUID cases reviewed in prior year with complete SUID Investigation Reporting Forms
NPM 5 – Percent of infants placed to sleep on their backs

Measure Status:	Active
Goal:	Increase the percent of SUID cases reviewed to 80% by 2021
Definition:	

Numerator:	Number of SUID cases reviewed with complete SUID Investigation Reporting Forms
Denominator:	All SUID cases reviewed
Unit Type:	Percentage
Unit Number:	100

Data Sources and Data Issues:	Maternal Infant Mortality Review database
Significance:	In order to prevent SUID deaths, it is necessary to understand the exact circumstances in which each such death occurs. Knowing these circumstances enables the Maternal Infant Mortality Review (MIMR) program to determine underlying risk factors and craft prevention measures. The SUID Investigation Reporting Form guides law enforcement personnel to collect data that are relevant and necessary to understand the cause, manner and circumstances of each death. By increasing the percentage of SUID deaths that have a completed SUID Reporting Form we can better understand the causes of such deaths and work to prevent them.

ESM 5.4 - Percent of SUID cases reviewed in prior year classified using CDC categories
NPM 5 – Percent of infants placed to sleep on their backs

Measure Status:	Inactive - Replaced
Goal:	Increase the percent of SUID cases reviewed to 95% by 2021
Definition:	
	Numerator: Number of SUID cases reviewed in prior year classified using CDC categories
	Denominator: All SUID cases reviewed
	Unit Type: Percentage
	Unit Number: 100
Data Sources and Data Issues:	Maternal Infant Mortality Review (MIMR) database
Significance:	The CDC categorization matrix for SUID deaths allows the Maternal Infant Mortality Review (MIMR) program to track how thoroughly SUID deaths are being investigated and how factors such as unsafe sleeping conditions contribute to such deaths. By increasing the number of SUID cases that are classified using the CDC categories, we will be able to identify gaps in our data, and track trends of risk factors. Doing so will enable us to improve our data collection methods and determine what risk factors should be targeted for strategic interventions.

ESM 5.5 - Number of birthing facilities with a Safe Sleep Certification from Cribs for Kids in Alaska.
NPM 5 – Percent of infants placed to sleep on their backs

Measure Status:	Active
Goal:	Increase the proportion of Alaska infants placed to sleep on their backs by supporting facilities in obtaining National Safe Sleep Certification, with 5 facilities certified by 2021
Definition:	**Numerator:** Number of birthing facilities with a Safe Sleep Certification from Cribs for Kids. **Denominator:** Number of birthing facilities in Alaska **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	Alaska Infant Safe Sleep Program Records
Significance:	Post-partum and infant nurses play a powerful role in teaching and modeling infant sleep practices. The first 24-48 hours following birth is the critical period to influence parents. Research shows that caregivers often use the same sleep position for their babies at home that they see being used at the hospital. Sources: http://www.cribsforkids.org/hospitalinitiative/. The State has elected to discontinue the Alaska Safe Sleep Toolkit, therefore ESM 5.1 has been replaced with ESM 5.5. ESM 5.5 activities encompass state Title V partnering with Cribs for Kids in promoting the use of its national hospital safe sleep certification program and tracking the number of facilities with a Cribs for Kids certification rather than the now-discontinued Alaska program. Cribs for Kids' program is more comprehensive than the Alaska toolkit, has more technical assistance capacity and is able to keep the certification up to date with best practices, and is endorsed by multiple national organizations due to its use of evidenced-based strategies to reduce sleep related infant death.

ESM 5.6 - Percent of infants born at a facility with Cribs for Kids Safe Sleep Certification or a safe sleep policy in place and has initiated the certification process.
NPM 5 – Percent of infants placed to sleep on their backs

Measure Status:	Active
Goal:	Increase the proportion of Alaska infants placed to sleep on their backs by increasing the number of facilities with a certification or policy and plan for certification from 53% to 65% by 2021.
Definition:	**Numerator:** Number of births at birthing facilities with a Safe Sleep Certification or with a safe sleep policy in place and certification process initiated. **Denominator:** Number of births in Alaska **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Alaska Infant Safe Sleep Program Records
Significance:	Post-partum and infant nurses play a powerful role in teaching and modeling infant sleep practices. The first 24-48 hours following birth is the critical period to influence parents. Research shows that caregivers often use the same sleep position for their babies at home that they see being used at the hospital. Sources: http://www.cribsforkids.org/hospitalinitiative/. The State has elected to discontinue the Alaska Safe Sleep Toolkit, therefore ESM 5.2 has been replaced with ESM 5.6. ESM 5.6 activities encompass state Title V partnering with Cribs for Kids in promoting the use of its national hospital safe sleep certification program and tracking the tracking the percentage of infants born at a facility with a Cribs for Kids certification rather than the same measure for the Alaska program. The Cribs for Kids' program is more comprehensive than the Alaska toolkit, has more technical assistance capacity and is able to keep the certification up to date with best practices, and is endorsed by multiple national organizations due to its use of evidenced-based strategies to reduce sleep related infant death.

ESM 5.7 - Percent of SUID cases reviewed in prior year and classified using CDC categories that agree with CDC post-hoc classification.
NPM 5 – Percent of infants placed to sleep on their backs

Measure Status:	Active
Goal:	Increase the accuracy of SUID classification among cases reviewed to 90% by 2021
Definition:	

Numerator:	Number of SUID cases reviewed in prior year and classified by MCDR using CDC categories that agree with CDC post-hoc classification
Denominator:	All cleaned SUID cases reviewed and classified by CDC
Unit Type:	Percentage
Unit Number:	100

Data Sources and Data Issues:	Maternal Child Death Review (MCDR) database
Significance:	The CDC categorization matrix for SUID deaths allows the MCDR to track how consistent SUID deaths are being classified and how factors such as unsafe sleeping conditions contribute to such deaths. By increasing the number of SUID cases that are accurately and consistently classified using the CDC categories, we will be able to identify gaps in our data. Doing so will enable us to improve our data collection methods and determine what risk factors should be targeted for strategic interventions.

ESM 6.1 - Percent of children enrolled in home visiting with a timely screen for developmental delays using a validated parent-completed tool
NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Measure Status:	Active
Goal:	Increase developmental screenings in children by supporting MIECHV program to provide Ages and Stages Developmental Screening tool with clients.
Definition:	

Numerator:	Number of children enrolled in home visiting with a timely screen for developmental delays using a validated parent-completed tool (ASQ tools)
Denominator:	Number of children enrolled in home visiting eligible for screening
Unit Type:	Percentage
Unit Number:	100

Data Sources and Data Issues:	Nurse Family Partnership Program Data
Significance:	The American Academy of Pediatrics recommends routine developmental screening for infants and young children based on the Bright Futures periodicity schedule. Home visiting nurses have ongoing opportunities to complete these screenings with parents. The Ages and Stages Questionnaire (ASQ) is a validated tool for use in infants and children from 4 to 60 months of age. The developmental screening process empowers families by giving them anticipatory guidance on developmental tasks and allowing them to appreciate their child's unique way of accomplishing developmental milestones.

ESM 7.1 - Number of annual Child Death Review recommendations developed related to the prevention of child injury and/or child maltreatment
NPM 7 – Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Measure Status:	Active
Goal:	Decrease the rate of injury related hospital admissions among children 0-9 years by reviewing all child deaths through the Alaska Maternal-Infant Mortality and Child Death review program.
Definition:	

Numerator:	Number of annual Child Death Review recommendations developed related to the prevention of child injury and/or child maltreatment
Denominator:	N/A
Unit Type:	Count
Unit Number:	11

Data Sources and Data Issues:	MIMR-CDR Annual Recommendations Report
Significance:	The Alaska Maternal Infant Mortality Review - Child Death Review (MIMR-CDR) program systematically and comprehensively reviews infant and child deaths using a multi-disciplinary, evidence based consensus approach. An expert committee reviews medical records, autopsy reports, death scene investigation reports, and other relevant information that is compiled for each death. The committee seeks to identify underlying causes and contributing factors to infant and child deaths in Alaska and develops recommendations to prevent future injuries and deaths. By understanding the etiology of infant and child deaths in Alaska the committee is able to set targeted priorities for prevention efforts. The number of recommendations are limited to ten because this is our capacity for addressing them.

ESM 9.1 - Number of Alaskan students participating in the 4th R for healthy relationships program in the last school year.
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	Decrease proportion of Alaskan students in grades 9-12 who report they were bullied on school property during the past 12 months by increasing the dissemination of evidence-based healthy relationship programming.
Definition:	**Numerator:** Number of students receiving the Fourth R program in the current year **Denominator:** Number of students who have received the Fourth R Program in the previous year. **Unit Type:** Count **Unit Number:** 5,000
Data Sources and Data Issues:	Data is currently being collected via Section of Women's, Children's and Family Health Dashboard process measures and for federal annual grant reports.
Significance:	The Fourth R for Healthy Relationships is an evidence-based program listed on SAMHSA's National Registry for Evidence-Based Programs and Practices. The Fourth R curriculum is a social-emotional learning program focused on teaching life skills such as healthy communication, decision-making and peaceful problem solving. The more Alaskan youth participate in evidence-based programs and practices such as the Fourth R, the greater their protective factors and fewer their risk factors will be and thus, the greater chance at reaching our increase healthy relationships goal. The target is to increase number of participating students by 25% each year.

ESM 11.1 - Percent of CYSHCN in School Nurse Pilot Project elementary pilot schools and partner practices with Shared Plan of Care
NPM 11 – Percent of children with and without special health care needs having a medical home

Measure Status:	Active
Goal:	Increase utilization of a medical home by increasing access to cross-systems care coordination using a Shared Plan of Care among the Anchorage CYSHCN population. By October 2017, achieve 20% targeted CYSHCN within the Anchorage School District who ha
Definition:	**Numerator:** Number of CYSHCN in pilot schools and partner practice with Shared Plan of Care **Denominator:** Number of children that attend pilot schools and are clients of partner practice **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	School Nurse- Care Coordination Pilot Project records, Anchorage School District, Lightbeam Electronic Health Record Care Coordination Module
Significance:	Students spend a 1/3 of their day in school. It would greatly benefit the CYSHCN if school nurses had access to a full list of medications and a complete list of medical problems that can help give them a better idea of the child's health and how to care for them at school. School nurses could check upcoming appointments and directly contact the medical home team with concerns. The best practice tool to achieve coordinated care for CYSHCN is a "care plan". Alaska's Title V program uses the Lucille Packard Foundation evidence-based model which uses the term Shared Plan of Care. A shared plan of care is a guide for family-centered care coordination using a clear summary of information and a team approach. A shared plan of care includes: - Medical Summary – which details child/ family demographic information; current medical care facts; lead team members and contacts; and core child and family knowledge including their personal preferences and goals. - Negotiated Actions – highlights personal and clinical goals and joint strategies to address and /or achieve goals with timelines, responsibilities and accountabilities. The data collected for this ESM will allow practices, schools, and Title V to measure the impact of shared plan of care access for families and child health. Additional family and nurse experience data will be collected and analyzed as part of this initiative and used for quality improvement purposes. As this is a pilot project, and the first of its kind in Alaska, annual objectives may be adjusted over the five year action plan period.

ESM 11.2 - Number of families/providers who obtain needed support from Help Me Grow Alaska for a needed specialist, support or service.
NPM 11 – Percent of children with and without special health care needs having a medical home

Measure Status:	Active
Goal:	Increasing utilization of a medical home by increasing access to resources for families and primary care providers of CYSHCN by using Help Me Grow model. By October 2017, 50% of families and medical home providers of CYSHCN contacting Help Me Grow Al
Definition:	**Numerator:** Number of families/providers who obtain needed support **Denominator:** Number of families/providers who contact Help Me Grow Alaska **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Help Me Grow database
Significance:	ESM 11.2: Help Me Grow Alaska is a free help line and community network that connects parents and providers with culturally appropriate resources, health care coordination, services and information to maximize healthy growth and development of children and families. Help Me Grow is an evidence-based system that connects at-risk children with the services they need. Help Me Grow builds collaboration across sectors and improves access by identifies gaps and barriers to access systems. The four core components of Help Me Grow are: • Child Health Care Provider Outreach (to support screening) • Family & Community Outreach (to identify resources) • A centralized telephone access point • Data Collection & Monitoring (including service gap analysis) The data collected for this ESM will measure the progress towards a streamlined screening and referral process for at-risk children. The role of Help Me Grow as a centralized resource and care coordination hub uniquely positions the program to link families with needed services and collect meaningful data. Data collected will help identify gaps and support ongoing pediatric systems development and quality improvement.

ESM 13.1 - Number of oral health pocket guides distributed
NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Increase percent of Alaska pregnant women and children who have had a preventative dental visit
Definition:	

Numerator:	Cumulative number of oral health pocket guides distributed
Denominator:	N/A
Unit Type:	Count
Unit Number:	1,000

Data Sources and Data Issues:	Alaska Oral Health Program data
Significance:	The Bright Futures Pocket Guide is a resource for all health professionals (medical and dental) that discusses oral health and dental care aspects for pregnant and post-partum women, infants, children and adolescents. The guide highlights the need for early dental visits (within 6 months of the eruption of the first tooth and no later than age 12 months) and aspects for subsequent dental visits, assessment of caries risk, education on factors to reduce risk of early childhood caries, appropriate oral health interview questions and anticipatory guidance/education at each stage for the above populations. The pocket guide information supports provider referral or provision of appropriate preventive dental services.

ESM 14.1 - Number of women currently pregnant or planning pregnancy enrolled in Alaska Quit Line
NPM 14 – A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Measure Status:	Active
Goal:	Reduce tobacco use among Alaska women during pregnancy by increasing the number of women who enroll in Quitline each year by 10% relative to the previous year
Definition:	

Numerator:	Number of women currently pregnant or planning pregnancy who are tobacco users and who register with the Quit Line during the calendar year
Denominator:	N/A
Unit Type:	Count
Unit Number:	100

Data Sources and Data Issues:	Alaska Quitline data
Significance:	Quitlines providing telephone counseling for smoking cessation derive from behavioral research and theory and have been shown to be effective when institionalized at state and national levels. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3169380/ The Alaska Quitline offers providers a referral form to fax in once a patient has been identified that is ready to quit in the next 30 days. The patient signs and agrees to receive a call from the quit line within the next 48 hours. Furthermore, providers are offered an Alaska Brief Intervention training. The AK Brief Intervention training is a comprehensive online based training for healthcare providers on how to perform the Brief Tobacco Intervention- Ask, Advise, Refer (AAR). This program outlines what AAR means, provides examples of Quitline calls, and outlines various pharmacotherapy options that can help patients quit. Upon successful completion of the online training the provider is granted a CE certificate.

Form 11
Other State Data

State: Alaska

The Form 11 data are available for review via the link below.

Form 11 Data

State Action Plan Table

State: Alaska

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

Abbreviated State Action Plan Table

State: Alaska

Women/Maternal Health

State Priority Needs	NPMs	ESMs	SPMs
Increase access to reproductive health services that adhere to national best practice guidelines.	NPM 1 - Well-Woman Visit	ESM 1.1 *Inactive* ESM 1.2 ESM 1.3	

Perinatal/Infant Health

State Priority Needs	NPMs	ESMs	SPMs
Reduce substance abuse among families, including alcohol, tobacco and drugs.	NPM 5 - Safe Sleep	ESM 5.1 *Inactive* ESM 5.2 *Inactive* ESM 5.3 ESM 5.4 *Inactive* ESM 5.5 ESM 5.6 ESM 5.7	
Reduce substance abuse among families, including alcohol, tobacco and drugs.			SPM 1

Child Health

State Priority Needs	NPMs	ESMs	SPMs
Reduce the rate of child maltreatment			SPM 5
Increase access and preventative health care services to Alaskans and their families.	NPM 6 - Developmental Screening	ESM 6.1	
Reduce the rate of child maltreatment	NPM 7 - Injury Hospitalization	ESM 7.1	

Adolescent Health

State Priority Needs	NPMs	ESMs	SPMs
Increase healthy relationships.	NPM 9 - Bullying	ESM 9.1	
Increase healthy relationships.			SPM 2

Children with Special Health Care Needs

State Priority Needs	NPMs	ESMs	SPMs
Improve system of care for families with children and youth with special health care needs	NPM 11 - Medical Home	ESM 11.1 ESM 11.2	

Cross-Cutting/Life Course

State Priority Needs	NPMs	ESMs	SPMs
Increase access and preventative health care services to Alaskans and their families.	NPM 13 - Preventive Dental Visit	ESM 13.1	
Reduce substance abuse among families, including alcohol, tobacco and drugs.	NPM 14 - Smoking	ESM 14.1	
Increase evidence based screening for all MCH populations for behavioral and mental health problems			SPM 4