

**Maternal and Child  
Health Services Title V  
Block Grant**

**Alaska**

**FY 2017 Application/  
FY 2015 Annual Report**

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## I. General Requirements

### I.A. Letter of Transmittal

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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

3601 C Street, Suite 322  
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Main: 907.269.3400  
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July 7, 2016

Maternal Child Health Bureau  
Health Services Resource Administration  
5600 Fishers Lane RM 18-31  
Rockville, MD 20874-0001

To Whom It May Concern:

Please accept this submittal for the Title V Maternal Child Health FY16 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 17, 2016.

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

Thank you for this opportunity to apply.

Sincerely,

A handwritten signature in cursive script that reads "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.

## **I.E. Application/Annual Report Executive Summary**

### **What is the Title V Maternal and Child Health Block Grant?**

The Title V Block Grant is a Federal-State partnership program to improve the health of mothers and children, including children and youth with special health care needs. 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). Please visit our website for more information here:

<http://dhss.alaska.gov/dph/wcfh/Pages/titlev/default.aspx>

The 2017 Title V Block Grant application for FFY is due July 15, 2017. Public comments on the application are welcome using any of the following options below:

- Online survey at : <https://www.surveymonkey.com/r/P6PTZPF>
- By emailing comments to [daniella.delozier@alaska.gov](mailto:daniella.delozier@alaska.gov)
- By mailing your comments to :

Section of Women's Children's Family Health  
Attn: Daniella DeLozier  
3601 C Street, Suite 358  
Anchorage, AK 99503

### **Title V Block Grant Application**

The Title V Block Grant program requires all states to report on maternal and child health (MCH) performance measures and outcomes every year. The application includes a comprehensive description of strategies and activities that support progress towards achieving national and state goals and data on performance measures and health outcomes.

### **How Are Alaska's Title V Funds Used?**

Services funded by Title V can be envisioned as a pyramid of three tiers consisting of:

- Direct Health Care Services
- Enabling Services
- Public Health Services and Systems

The framework for delivery of MCH services is based on the 10 Essential Public Health Services. Allocation of funds primarily supports the foundation of the Title V funding pyramid in the Public Health Services and Systems for MCH populations tier and is based on Alaska's 2015 statewide MCH needs assessment. Title V MCH Block grant funds awarded to Alaska are only applied in the levels of Enabling Services and Public Health Services and Systems

### **Needs Assessment**

Every five years an assessment of MCH needs, including children and youth with special health care needs (CYSHCN), is conducted. Alaska's 2015 Needs Assessment addressed national and state priorities for 2015-2019. Priorities established from the Needs Assessment guide the use of Title V grant dollars by WCFH. The Needs Assessment and corresponding performance measures address the six MCH population health domains: 1) Women's/Maternal Health; 2) Perinatal/Infant's Health; 3) Child Health; 4) CYSHCN; 5) Adolescent Health; and 6) Cross-Cutting/Life Course.

### **Title V Emerging Needs and 5 Year Action Plan**

Alaska's MCH Priorities for 2015-2019 are divided by population domain and described below, including the population-based national performance measures (NPMs) chosen to track prevalence rates 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. In 2016 Evidence Based Strategy Measures (ESMs) were developed to demonstrate the Title V program's impact and progress relative to the associated National Performance Measure. The National Outcome Measures below are the ultimate goals that the federal and state MCH programs are striving to achieve through their Title V program efforts. Please see the Five Year Action Plan Table to review Title V supported strategies planned by WCFH over the next 5 years.

## II. Components of the Application/Annual Report

### II.A. Overview of the State

**Principle Characteristics of Alaska's population** (ref. [Alaska Population Overview](#), Alaska Dept. of Labor and Workforce Development)

Alaska is a large, sparsely populated state. The land mass of the state encompasses 571,951 square miles, averaging a population density of just 1.1 persons per square mile. This is the lowest population density of any state. The July 2015 Alaska resident population was estimated at 737,625 by the Alaska Department of Labor and Workforce Development. This represented an increase of 271 people compared to 2014. There were 11,175 births in 2015. Alaska had 158,116 children less than 15 years of age (21% of the total population) and 146,379 women of childbearing age (15-44 years) in 2015 (20% 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 2015 was 38 years, and the median age for Alaska was 34.5.

In 2014, 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 (300,549), the City and Borough of Juneau (33,026), and the City of Fairbanks (31,721). These three areas were home to 50% 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 21,989 active duty military personnel in 2014, representing 3% of the state's population. The state also had 32,481 military dependents. Anchorage, Fairbanks, and Kodiak Island all have large active duty military and dependent populations.

According to the Department of Labor statewide projections, Alaska's statewide population is projected to increase from 714,142 in 2010 to 915,211 in 2035. 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 2014, 70% of Alaska's population were reported to be White, 17% Alaska Native/American Indian, 8% 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 such as housing, safe water and sanitation facilities, village clinics staffed by community health aides, 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 post-neonatal 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. About half the students in the Anchorage School District are ethnic minorities, speaking 98 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 FY 2015, Anchorage was identified as having 19 of the nation's most diverse schools in the nation (Anchorage Daily News, May 23, 2015).

### **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 2014, 62% of Alaskan adults aged 19-64 years were covered by employer or other private health insurance; 20% were covered by Medicaid or other public insurance.

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 2014, proportionately fewer Alaskans lived in poverty (10.1% compared to 14.8%); 13.8% of Alaskan children under 18 years lived in poverty. In 2014, 22.6% of the Alaska Native population in Alaska lived in poverty, compared to 6.7% 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 2013, Alaska's homicide rate per 100,000 individuals was 5.8, compared to 5.1 for the US. Overall, in 2011-2012, 10.6% 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 2013-2014 Alaska BRFSS found that 22% of Alaskans had at least one ACE, while 21% 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 2014, 22% of Alaska births occurred in hospitals that were designated Baby-Friendly. During 2008-2014, the Alaska population served by community water systems with fluoridated water dropped from 63% to 49.5% due to some cities discontinuing water fluoridation.

### **Factors Impacting Health Services Delivery**

Approximately 75% of Alaskan communities, including the capital city of Juneau, are not connected to the 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. 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 attachment #3. 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 – Office of Children's Services (OCS); Early Childhood Comprehensive Systems (ECCS) – OCS; Strengthening Families – OCS; WIC/Nutrition Programs – Division of Public Assistance

At one time these programs were housed within a single MCH section within DPH but were moved to other divisions in 2003 during a major DHSS reorganization. The period between 2005 and 2009 was one of administrative instability, marked by several turnovers at the Commissioner and DPH Division Director level. Despite organizational setbacks, efforts to increase intra-agency collaboration and grow MCH programs were made and continue today. DHSS is currently facing significant budget cuts and will be eliminating or significantly reducing programs over the next few years while trying to live within a budget that entirely depends on the price of oil and federal funding. The Division of Public Health is not well understood by the Legislature and thus is frequently the target of across the board cuts.

Two local governments, the Municipality of Anchorage and the North Slope Borough, 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 27 public health centers and itinerant nursing services.

Health care delivery in Alaska consists of three separate systems. 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 mid-level primary care at regional hospitals, and tertiary care at the Alaska Native Medical Center in Anchorage. ANTHC is funded by the Indian Health Service.

The two other systems of care include private non-profit and for profit secondary and tertiary care hospitals and private health care providers as well as the expansive military system and 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 Washington School of Medicine to train Alaska Native dental health technicians 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.

Priority 1) Health and Wellness across the Lifespan

- a. Protect and promote the health of Alaskans
- b. Provide quality of life in a safe living environment for Alaskans

Priority 2) Health Care Access, Delivery & Value

- c. Manage health care coverage for Alaskans in need
- d. Facilitate access to affordable health care for Alaskans

Priority 3) Safe & Responsible Individuals, Families & Communities

- e. Strengthen Alaska families
- f. Protect vulnerable Alaskans
- g. Promote personal responsibility and accountable decisions by Alaskans

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 2016-2020 Strategic Plan identified the following goals:

1. Serve as Alaska's chief strategists for existing and emerging public health issues.
  - Collaborate to achieve health equity for Alaskans
  - Engage communities to set and implement public health strategies and policies
  - Foster a culture of health for individuals, families, and communities
  - Translate data into policies and actions affecting population health
  - Communicate and promote wellness and the value of public health
  - Support quality improvement initiatives
2. Protect life, health, and safety through core public health functions.

- Monitor health status
  - Respond to outbreaks and disasters
  - Prevent or limit illness, injury, and premature death
  - Ensure health services for vulnerable populations
3. Serve as the trusted source of health information.
    - Collect and analyze public health data
    - Share timely public health information important to stakeholders
    - Communicate effective health messages
  4. Strengthen essential public health infrastructure, services, and partnerships.
    - Develop policies to improve the health of Alaskans
    - Support an adequate and competent health workforce
    - Leverage resources and collaborate with health partners
    - Integrate technology, informatics, and cross-sector partnerships into practice

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

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

Governor Walker was elected in 2014 in part due to his support of Medicaid expansion, after the previous governor had declined to expand Medicaid despite support from the majority of the state’s population. The Medicaid Expansion and Reform bill introduced by Governor Walker failed to make it through the Legislature during the 2015 session, however in July 2015 the Governor announced a decision to move forward with expansion under Executive authority. A Legislative lawsuit was filed claiming lack of authority to implement expansion without legislative approval, however the lawsuit was ended in June 2016. By May 2016, more than 17,700 Alaskans were covered by Medicaid under expansion.

Four bills were introduced at the beginning of the 2015 Alaska legislative session regarding Medicaid Expansion and Medicaid Reform. These bills stay active for two years. Medicaid reform was passed during the 2016 legislative session in the form of Senate Bill 74 (SB74), which incorporated aspects of some of the other related bills that did not pass.

- HB18: This bill proposed to expand Medicaid eligibility to persons < 65 years of age who are not pregnant and meet the income eligibility criteria (<133% FPL) for services reimbursed to Medicaid at the 90 fed/10 state match. This bill was did not pass.
- HB148: This bill was introduced by the Governor and proposed to implement Medicaid reform measures, including exploration of cost-saving measures, new partnerships with community and tribal partners, and consideration of waiver options; to implement a provider tax; to establish disease prevention and the primary model of health care in the state; to cooperate with the federal government (CMS) on several matters of adult public assistance; to implement measures to reduce “out-of-wedlock” pregnancies and induced terminations of pregnancy; strengthen audit and penalty procedures; to expand Medicaid

eligibility to persons < 65 years of age who are not pregnant and meet the income eligibility criteria (<133% FPL) for services reimbursed to Medicaid at the 90 fed/10 state match; and to actively care-manage and reduce “super-utilizers” of emergency care. This bill did not pass. Aspects of this bill were passed in SB74.

- SB74: This bill also addressed Medicaid reform measures, including requiring the DHSS to establish a personal health savings account for Medicaid recipients; requiring the DHSS to establish a managed care demonstration project; requiring the DHSS to establish and implement a demonstration project to reduce non-urgent use of ERs by Medicaid recipients; and requiring the DHSS to review the feasibility of privatizing certain services. Extensive in content and impact, this bill did pass during an extended legislative session and was signed into law June 22, 2016.

Many bills that the Division of Public Health monitored did not move from committee referrals. As of this writing, the legislature is in a special session in addition to having completed an extension of 120 days from their 90-day session. An operating budget has not yet been signed and a long term plan to turn around the fiscal crisis facing our state have not been forthcoming to the Governor’s satisfaction. The state is facing a 4-billion-dollar deficit for SFY18 that begins July 1, 2016 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 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 families 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 - 2019 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 will retire at the end of June 2016.
- Cuts to the state general funds related to Maternal Child Health will continue to be a barrier to overcome. Cuts in FY 16 and 17 will reduce capacity to meet the needs of children with special health care needs and data capacity. Cuts of 25% will be experienced by the Section of Public Health Nursing who provides the safety net of primary and secondary intervention to the state's most vulnerable residents. There will be at least one health center closing and several public health nursing positions will remain vacant or be eliminated due to the state general fund cuts.
- There continues to be a growing distrust in the government within Alaska. This likely impacts vaccine coverage rates along with survey response rates (such as for PRAMS and CUBS).
- 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.
- 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).
- There is a growing concern about Neonatal Abstinence Syndrome (NAS) and use of opioids during pregnancy and while parenting.
- 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.

- 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 2000-2012, the percentage of Alaskan women aged 18 years or older who reported on the BRFSS that they received a Pap test within the last 3 years decreased from 91.5% in 2000 to 87.0% in 2012. 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.

The 2015 legislative session saw several bills that discussed that affect Alaska's MCH population. These included:

- HB23/HB44/SB31/SB37: These bills formed the Safe Children's Act that stipulates that school districts in Alaska must train employees and students on sexual abuse prevention (K-12), dating violence and abuse prevention (grades 7-12). This bill passed in spring 2015 and will be enacted on July 1, 2017. The second major component focuses on dating violence, and is being called "Bree's Law." This bill provides a framework to develop curriculum and training for Alaska schools in an effort to reduce rates of child sexual abuse, suicide, and teen dating violence in elementary and high schools. The governor is expected to sign the bill and the program will be implemented beginning in 2017. Staff from WCFH are participating and helping to lead the implementation plan for this bill.
- SB89/SB191/HB156: These bills sought to limit who could provide comprehensive sexual health education in public schools, specifically restricting anyone who was affiliated with an organization that provides abortions. SB89 and SB191 did not pass, but the language was added to a bill focused on education testing (HB156) and did pass. It is currently waiting for the Governor's review.
- SB156: This bill requires healthcare insurers, including Medicaid services, to cover 12 months of prescriptive oral contraceptives at a time. This bill did not pass.

## **II.B. Five Year Needs Assessment Summary**

### **2016 Five-Year Needs Assessment Summary**

#### **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 significant 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 1<sup>st</sup> tooth and no later than age 1 took effect on April 1<sup>st</sup>, 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 (Submitted on July 15, 2015)**

### **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  $\leq 29$  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 kindergartners 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 ColIN 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, ACVBI 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) *Support 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

### **State priorities for 2015 - 2019 are:**

1. Reduce substance abuse among families, including alcohol, tobacco and drugs.
2. Reduce the rate of child maltreatment (Life Course)
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. (Life Course)

### **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 (ie, 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 rationale 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 based on the fact that 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. 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. 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**

<u>State Priorities 2010-2014</u>	<u>State Priorities 2015-2019</u>	<u>Rationale for changes</u>
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 towards 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 was identified as a major health issue for almost all population domains.
		Because so many preventable post-

Reduce preventable post-neonatal mortality due to SIDS/asphyxia.	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 expect to select a SIDS-related measure as a state performance measure linked to the priority of reducing substance abuse.
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

Below are the eight National Performance Measures chosen by Alaska for programmatic focus by our Title V program.

No.	Alaska's Chosen 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 dental visit during pregnancy and B) Percent of infants and children, ages 1 through 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

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 National Performance Measures were discussed by the group in terms of how the performance measure would support the state priority need. If one of the national performance measures 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 strong correlating National Performance Measure. 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.

In reviewing our State Action Plan and through conversations around developing ESMs and SPMs, we have realized that the selection of NPM 13 (oral health) is a more appropriate match for our current activities than 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. We feel this national performance measure 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 National & State Performance Measures.

## 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 result in increased developmental screenings.)
7. F (Injury related hospital admissions among children may be associated with child maltreatment.)
9. C (Unhealthy relationships also encompasses bullying)  
G (Bullying can lead to or be triggered by behavioral and mental health problems)
11. E (Medical home is an essential part of the system of care for CYSHCN)
13. B. (Increased access to preventative health care services includes dental care)
14. A (Exposure to prenatal and environmental smoke is hazardous to infants i.e. increases risk for death in a sleep environment)  
G (Smoking and abuse of other substances is associated with behavioral and mental health problems)

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 3 - Rate of substantiated reports of child maltreatment per thousand children 0-17 years of age in Alaska
- SPM 4 - Percent of women who report being screened for depression during prenatal care

Below are the four State Performance Measures chosen by Alaska for programmatic focus by our Title V program.

No.	Alaska's Chosen State Performance Measures
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.
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
3	Rate of reports of child maltreatment per thousand children 0-9 years of age in Alaska
4	Percent of women who report being screened for depression during prenatal care

The MCH Title V and CYSCHN Directors along with the MCH Epidemiology Unit Manager and Title V Block Grant Coordinator met with each program manager and selected the above 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.

During this process, the group identified areas in which the National Performance Measures did not cover state identified priorities as a result of the 2015 Five Year Needs Assessment. Each of the possible State Performance Measures was discussed by the group in terms of how the performance measure would support the state priority need.

The state performance measures selected also represent priorities included in the Division of Public Health strategic plan. As a part of the strategic plan, 6 Winnable Battles have been identified to guide our work over the next four years. These include:

1. Decrease Tobacco Use and Nicotine Dependence
  - a. Decrease use of smoking, chewing and vaping tobacco products
2. Decrease Colorectal and Cervical Cancer
  - a. Increase on-time HPV vaccinations
  - b. Increase appropriate cervical cancer screening
  - c. Increase colorectal screening among people aged 50 and over
3. Increase Access to Health Care

- a. Increase the proportion of Alaskans with a medical home
- 4. Improve Child and Adolescent Health
  - a. Increase the proportion of children who are at a healthy weight
  - b. Reduce the proportion of children who die before their first birthday
  - c. Increase the percent of children with on-time immunizations
  - d. Reduce the rate of teen pregnancy
- 5. Decrease Infection Disease
  - a. Reduce the rate of sexually transmitted infections
  - b. Decrease the rate of hepatitis C infection among injective drug users
- 6. Prevent Poisoning and Overdose
  - a. Decrease opioid overdose
  - b. Decrease childhood poisonings

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-all of which are priorities of Alaska's Department of Health and Social Services leadership

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



No.	State Performance Measure
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.
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.
3	Rate of reports of child maltreatment per thousand children 0-9 years of age.
4	Percent of women delivering live births who report being screened for depression during prenatal care

**Cross Linkage:**

1. *A (Reducing prenatal alcohol use will lead to improved birth outcomes)*
2. *C (Increasing students who seek help from adults will result in healthier relationships)*
3. *F (Reducing child maltreatment reports will reduce the rate of child maltreatment)*
4. *G (Increasing depression screening may help to identify symptoms early and reduce negative outcomes for mom, baby and family)*

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.F. Five Year State Action Plan**

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

**Women/Maternal Health**

**State Action Plan Table**

State Action Plan Table - 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 Breast and Cervical Health Check (BCHC) program.

NPM 1.2 Work with Anchorage 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 MOA Reproductive Health Clinic are provided to appropriate clients. MOA 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 Provide evidence-informed training to Hope Community Resources and other agencies serving women with disabilities about the importance of preventive screenings.

NPM 1.6 In partnership with the State of Alaska Section of Chronic Disease Prevention and Health Promotion and Peer Power of Alaska (self-advocacy group), disseminate best practices, educational materials, and trainings to health care providers, caregivers, and case managers on key preventive screenings for women with disabilities.

## ESMs

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

ESM 1.2 - Percent of all WIC clients referred to the Municipality of Anchorage Reproductive Health Clinic who receive services.

## 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

## Measures

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	62	64	66	68	70	72

**Data Source: Behavioral Risk Factor Surveillance System (BRFSS)**

Multi-Year Trend					
Year	Annual Indicator	Standard Error	Numerator	Denominator	
2014	53.8 %	2.4 %	69,853	129,880	
2013	55.2 %	2.4 %	72,852	131,880	
2012	65.2 %	2.1 %	81,184	124,534	
2011	54.2 %	2.6 %	66,741	123,102	
2010	70.5 %	3.5 %	83,556	118,529	
2009	62.1 %	3.4 %	75,765	122,058	

**Legends:**

- 🚩 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

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

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

**ESM 1.2 - Percent of all WIC clients referred to the Municipality of Anchorage Reproductive Health Clinic who receive services.**

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

**Women/Maternal Health - Plan for the Application Year**

NPM Strategy 1.1: The percent of Alaska women with a preventive health visit in the past year has declined from 62% in 2009 to 54% in 2014. Among all groups examined using 2014 data, a past year preventive health visit was least common among women who were uninsured (33%), had a household income <\$15,000 (33%), and were non-Hispanic multiple race (41%). Furthermore, 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. Alaska has proposed ESM 1.1 to increase the number of women with a past year preventive medical visit by utilizing patient navigators to reach disparate populations in Alaska. The State of Alaska’s Breast and Cervical Health Check (BCHC) Program will utilize 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 utilize YWCA's patient navigators to provide health education information and relief for barriers to accessing services (e.g., referrals to low cost child care, transportation vouchers, appointment scheduling, etc.). The BCHC Program funded by the Centers for Disease Control pays for cervical cancer screening services and referral to Medicaid for women 21-64 with incomes  $\leq$  250% FPL.

NPM 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. The prevalence of Alaska women who recently delivered a live birth who reported not doing anything to keep from getting pregnant (i.e., not using birth control) has not changed since 2009 and was 20.5% in 2013. Alaska has 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. The State of Alaska WCFH Adult Health Services Unit staff will partner 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 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 will replicate the successful model at other locations in Alaska serving low income individuals and families at risk of unintended pregnancy (e.g., other WIC locations, Child Protective Services, Public Assistance). 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.

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.

Although the following strategies do not yet have developed ESMs, they will contribute to the overall increase in women who receive routine preventive health visits.

NPM 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. The results of a statewide Primary Care Needs Assessment will be utilized to establish a baseline of publicly-funded providers (i.e., Federally-Qualified Health Centers - FQHCs) that currently meet the QFP standard, as well as identifying those providers who fall short of this standard. WCFH Women's Health staff will partner with 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.

NPM Strategy 1.4: The Alaska MIMR-CDR program, which is nearly exclusively funded by Title V, has been reviewing all pregnancy-associated deaths in Alaska since 1990. Pregnancy-associated mortality refers to the death of a woman while pregnant or within one year of pregnancy termination due to any cause, including accidental or incidental causes. Pregnancy-related mortality is the sub-set of pregnancy-associated mortality that refers specifically to deaths from causes related to or aggravated by the pregnancy or its management. After reviewing circumstances surrounding pregnancy-associated deaths that were not related to pregnancy during 2000-2011, the MIMR-CDR Committee found that about 2/3 could have been prevented by addressing underlying factors such as

alcohol abuse, drug abuse, mental health conditions, and domestic violence. Among the pregnancy-related deaths, Alaska has been experiencing an increase over the past 20 years in the number of deaths due to chronic conditions that were aggravated by pregnancy (such as heart disease). Screening and referral for these social and mental health conditions as well as management of chronic disease are standard parts of an annual well-woman visit, and past recommendations of the committee have alluded to the importance of these annual preventive health visits. The Alaska MIMR-CDR is based on a national evidence-based model to systematically and comprehensively review 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 support the committee in developing and disseminating recommendations to improve the health of women and mothers in the state.

NPMs Strategies 1.5 & 1.6: A sub-population in this domain being addressed by WCFH Health and Disability Program (HDP) staff is women who experience mobility limitations due to a specific disability. Among women with activity limitations due to disability, 47% reported a past year preventive health visit, compared to 55% of women with no activity limitations. WCFH HDP staff plan to provide trainings about the importance of, and national recommendations for, preventive health screenings to caregivers and other staffs at agencies serving women with disabilities (as well as to the women themselves). Title funds will be used to support WCFH Epidemiology staff in creating pre/post tests for the training events to measure their effectiveness among recipients.

### **Women/Maternal Health - Annual Report**

During this reporting period, WCFH staff worked with staff in the Section of Health Planning and Systems Development (HPSD), within the Division of Public Health, to develop and add women's health-specific questions to Alaska's statewide Primary Care Needs Assessment. HPSD staff worked diligently over the last year to collaborate with primary care providers in the public and private sectors to assure completion of the survey and key informant interviews so that Alaska will have a strong foundation of data on which to base its future work. However, this work required much more staff time than anticipated due to a lack of initial response from some of Alaska's largest health care entities. In the end, HPSD succeeded in obtaining a 100% response rate from publicly-funded agencies across the state, albeit results were delayed until Spring 2016. This delay has prevented WCFH staff from moving forward as of this date with plans to establish a baseline of primary care facilities that provide reproductive health and related preventive health services in adherence with QFP standards (see "Plan for the Application Year: NPM 1.3 strategy"). WCFH staff will begin analyzing results of the survey as soon as the data set is available.

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. The prevalence of Alaska women who recently delivered a live birth who reported not doing anything to keep from getting pregnant (i.e., not using birth control) has not changed since 2009 and was 20.5% in 2013 (retired SPM 4). Among women who did not use birth control after they delivered a live birth in 2013, the top two reasons were that they did not want to use birth control (37.5%) and they were worried about side effects (34.6%).

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 two Juneau High School Teen Health Centers. During this reporting year, a special emphasis was placed on assuring that the APRNs are making efforts to connect clients with an appropriate medical home in their community, whenever appropriate, without breaching the teens' confidentiality. Furthermore, language was broadened in the contracts 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.

In 2015, 79.8% of Alaska births were to mothers who received prenatal care beginning in the first trimester, similar to previous years (retired NPM 18). One of the known barriers to early prenatal care is access to health insurance, including Medicaid. In 2009-2011, Alaska PRAMS asked women who had recently delivered a live birth about their ability to obtain prenatal care when they wanted it, and the corresponding reasons if they were unable to. The most common reasons given for not getting prenatal care as early in their pregnancy as they wanted were they didn't know they were pregnant (36.5%), not having their Medicaid or Denali KidCare card (35.6%) and not being able to get an appointment when they wanted one (35.0%). In September 2015, Alaska's governor fully expanded Alaska's Medicaid program to cover all individuals with incomes  $\leq$  138% FPL, providing health coverage to a significantly larger population of the state's most vulnerable people. Title V funds supported WCFH Epidemiology staff to extract and analyze data from Alaska's BRFSS and PRAMS surveys to monitor changes in unintended pregnancy prevention efforts and health insurance coverage among Alaskan women, in addition to other trends affecting the Women/Maternal Health domain. Epidemiology staff will continue to analyze these data to monitor the effects of Medicaid expansion on key MCH indicators such as prenatal care utilization.

Other Title V activities during the reporting period related to the percent of births with early prenatal care, such as the development of *Healthy Pregnancy and Beyond* cards for distribution to clinical care providers statewide, are described in the Infant Domain annual report.

Another result of Medicaid expansion is that a larger proportion of individuals will be covered with Medicaid funds for breast and cervical cancer screening. WCFH Epidemiology staff can access Medicaid data to identify women currently covered by Medicaid, and the BCHC program will use these data to collaborate with the Medicaid program to expand and improve patient outreach and navigation services to those women who may need to access breast and cervical cancer screening services. The ultimate goal of WCFH is to assist AK Medicaid in more closely aligning their programs and payment practices with evidence-based Public Health strategies, including payment for preventive health services. (See section II.F.5. Emerging Issues for further discussion.)

## Perinatal/Infant Health

### State Action Plan Table

#### State Action Plan Table - 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

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

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.

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

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

## 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 - 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 16% 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

## Measures

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	76	78	80	82	84	86

### Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend					
Year	Annual Indicator	Standard Error	Numerator	Denominator	
2013	71.0 %	1.6 %	7,567	10,654	
2012	76.0 %	1.7 %	7,869	10,350	
2010	67.9 %	1.8 %	7,242	10,666	
2009	73.2 %	1.6 %	7,671	10,473	
2008	73.7 %	1.6 %	7,896	10,709	
2007	70.0 %	1.6 %	7,234	10,332	

**Legends:**

- 📄 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% and should be interpreted with caution

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	5.0	5.0	6.0	6.0	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.**

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

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	60.0	65.0	70.0	75.0	80.0

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

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

**Perinatal/Infant Health - Plan for the Application Year**

Alaska's Title V program has focused a tremendous amount of time, resources and effort over the last 30 years to reverse the infant mortality rate, a traditional key indicator of the health of an MCH population. In the early 1980's the state was ranked at the bottom in 49<sup>th</sup> place out of 50 with 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, the development of a high risk perinatal unit have led to the significant decrease in infant mortality with Alaska currently ranking at or near the top of all states with one of the lowest infant and neonatal mortality rates. The post neonatal mortality rate however does not meet the HP 2020 performance objective and exceeds the national rates. To that end, WCFH with its Title V funded staff has chosen to focus recent and future efforts on behaviors that impact postneonatal mortality, and thus prioritized parental tobacco, alcohol and drug use reduction strategies. These areas are also reflected in Alaska's COIIN strategy. Much of the planned activities for the coming year in the perinatal/infant health domain are related to work on the national COIIN to prevent infant mortality initiative. WCFH has established three focus areas for COIIN work: 1) infant safe sleep, 2) tobacco use, and 3) preconception and interconception health. The tobacco work group will focus not only on tobacco but alcohol and drugs.

### **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, and 71% of women reported placing their infant to sleep on their backs in 2013. Among all of the stratifier groups examined using 2012 data, placing infants to sleep on their backs was least common among non-Hispanic Asian mothers (66%), mothers who were uninsured (67%), and mothers <25 years of age (70%). In 2012, mothers who were college graduates (84%), did not enroll in WIC (80%), and married (78%) were more likely to report usually placing their infant to sleep on their backs compared to mothers without a college degree, unmarried mothers, and mothers who participated in WIC.

In the upcoming fiscal year, WCFH will use Title V funds to continue with and expand upon existing infant safe sleep work. A key strategy will be the promotion of the Alaska Infant Safe Sleep Toolkit that was created using Title V funds in 2013 and includes the NICHD nurse education module, a guide to conducting crib audits, and a guide for creating an infant safe sleep hospital policy. Facilities are encouraged to adopt all components of the Toolkit or at least one component depending on the environment and activities already in place. We expect that at least one additional birthing hospital will fully implement the Toolkit in the upcoming year. WCFH will also provide support to facilities that have already implemented the Toolkit to ensure ongoing compliance. Focus for further outreach and education efforts about the Toolkit will be placed on hospitals and birthing facilities serving Alaska Native and rural populations, as these groups have higher rates of postneonatal mortality. The toolkit will be updated to reflect recent Alaska data and evidence-based research.

Title V funded Nurse Consultants and MCH Epidemiologists will continue to offer presentations on safe sleep to professionals, including foster care providers, day care facilities and homes, birthing hospitals, and birth centers. The Municipality of Anchorage WIC and DHSS will work together on Plan-Do-Study-Act (PDSA) cycles promoting safe sleep through their breastfeeding classes. At least one child care facility will be assisted in developing a safe sleep policy and training for staff as part of a PDSA cycle. Scheduled perinatal site visits at birthing facilities in Bethel, Dillingham, Anchorage, and the Mat-Su Borough will include a safe sleep component. WCFH will continue to actively facilitate and participate in Collaborative Improvement & Innovation (CoIIN) safe sleep efforts. All infant safe sleep activities will be funded by the MCH Title V grant.

The MCH Epidemiology Unit, including PRAMS and the Maternal & Infant Mortality Review and Child Death Review (MIMR-CDR) program, will collect data, analyze and report on infant sleep-related data and these data 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 Maternal & Infant Mortality Review and Child Death Review (MIMR-CDR) program and help the committee to develop, disseminate, and implement prevention recommendations. MIMR-CDR 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.

WCFH plans to track four ESMs related to NPM 5. The first two ESMs will help to monitor progress on the strategy to promote the Alaska Infant Safe Sleep Toolkit among hospitals and birthing facilities statewide. By measuring the number of hospitals/birthing facilities holding a STAR Birthing Facility Designation, we will be able to track an increase in use of this tool. The second ESM related to the Toolkit will measure the percent of births that occur at a hospital that has an infant safe sleep policy, which is one component of the Toolkit. This will allow us 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 us 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 MIMR-CDR 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 sudden unexplained infant death. 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, including those who are pregnant. 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* tool is a promising communication tool for clinical care staff to employ in pregnancy planning counseling. Use of *One Key Question*, in tandem with SBIRT, in the primary care environment, may help avert alcohol exposed pregnancies among women at risk, whether by facilitating abstinence from alcohol or by providing effective contraception when desired. The University of Alaska Anchorage (UAA) Arctic SBIRT Training project is housed with the UAA Center for Behavioral Health and Research. The goal of Arctic SBIRT is to reduce the health consequences of substance abuse by preparing Alaska's workforce to provide early identification and intervention for substance misuse through the SBIRT model. The Alaska Division of Behavioral Health's central purpose is to provide a continuum of statewide behavioral health (mental health and substance use) services including prevention, screening, and brief intervention. Title V funded WCFH staff will partner with these two organizations to provide tools and skill-building trainings in use of this bilateral strategy for primary care clinical staff serving regions of the state where PRAMS data indicate reported use during pregnancy is high compared to the rest of the state. The chosen strategy is likely to be effective among women using opioids and other substances. All activities will encourage use of the strategy among all women of reproductive age, and so, regardless of the type of substance being misused, the aim will be the same: to use the strategy to help prevent misuse of substances among women seeking to become pregnant. Beginning with 2016 births, Alaska PRAMS will survey mothers about use of opioids and other illicit substances both prior to and during pregnancy. This will provide helpful measures of this problem. Title V funds will be used to support this work.

Alaska's objective for SPM 1, is to decrease the percent of women who delivered a live birth or that were trying to get pregnant, who indicated that they had one or more alcoholic drinks in an average week during the 3 months before pregnancy from the current level 20% in 2013 to 16% by 2021. This was selected as an SPM because we felt that none of the NPMs directly aligned with our state-identified priority of reducing substance use among families, including alcohol, tobacco and drugs. We selected a measure that focuses on the use of alcohol during the 3 months before pregnancy among the population of women who recently delivered and were trying to get pregnant for a few reasons: 1) The availability of reliable and high quality data on alcohol use among women who recently delivered a live birth through Alaska PRAMS; 2) the impact of alcohol on Alaskan families as a particular substance that is widely used and widely abused and has an adverse impact on many MCH outcomes; 3) women who are *trying* to get pregnant are particularly targeted for messages about reducing or eliminating alcohol use through the SBIRT/One Key Question work described above. We understand that this will only measure a small percentage of the total Alaskan population who use substances, and that the measure only focuses on alcohol and not the range of other substances, legal and illicit, that are impacting Alaskan families.

Alaska's efforts to reduce alcohol and other substance use may also impact safe sleep indicators, as impaired parents may fail to place their infant to sleep safely.

## **Perinatal/Infant Health - Annual Report**

### **Infant safe sleep - Percent of women who recently had a live-born infant and reported having one or more environmental factors in the home associated with SIDS/unexplained asphyxia (retired SPM 8)**

During 2009-2013, the percent of women who recently delivered a live birth who reported having one or more environmental factors in the home that are associated with SIDS/unexplained asphyxia declined significantly from 68.8% to 55.7%. This indicator is measured by survey questions that ask about five components of an infant sleep

environment. During the 5 year period, a steady decline was noted of the percent of women who reported three of these components, including that their baby sleeps with pillows (16.9% in 2009 to 10.0% in 2013), their baby sleeps with bumper pads (30.7% to 19.9%), and their baby sleeps with plush or thick blankets (31.7% to 20.8%). WCFH staff using Title V funds, continued to work on efforts related to the National CoIIN to decrease infant mortality. Activities for the safe sleep workgroup included outreach and partnering with agencies to reach the most at-risk families according to Alaska data. Educational presentations and trainings were given to multiple stakeholders (such as OCS and WIC) and birthing facilities. Along with other safe sleep marketing materials, the program continued to promote the use of the Alaska Infant Safe Sleep Hospital Toolkit. A perinatal nurse consultant also worked with an MCHB Graduate Student Epidemiology Program intern to conduct an evaluation of the toolkit implementation at a birthing facility. The intern also conducted an evaluation of the distribution of baby boxes by a health care facility in Alaska and disseminated those results.

WCFH continued to conduct MIMR committee reviews, which also included participation from a WCFH Nurse Consultant. In CY15, the MCH Epidemiology Unit conducted a blitz review of child deaths over a period of two days. The group assigned to sleep-related deaths created recommendations for public health to consider for implementation. These recommendations were compiled and disseminated. WCFH has implemented some of these recommendations.

Following a spike in sleep-related infant deaths in 2014, the MCH Epidemiology Unit conducted a case series analysis of all sleep-related infant deaths 2012-2014 and produced an [Epidemiology Bulletin](#) in June 2015 describing the study. Two Title V funded staff, an epidemiologist and a nurse consultant, presented the data from the study over 10 times to staff from WIC, OCS, Public Health Nursing, local childcare agencies, CoIIN work groups, and at two pediatric grand rounds.

Safe sleep education continued to be a component of both the Healthy Start and MIECHV program. MIMR-CDR began contributing to the National SUID Case Registry and using the CDC SUID classification categories to improve consistency of data collection and allow for national comparisons in January 2015.

### **Alcohol use during pregnancy - Percent of women (who delivered a live birth) who had one or more alcoholic drinks in an average week during the last 3 months of pregnancy (retired SPM 1)**

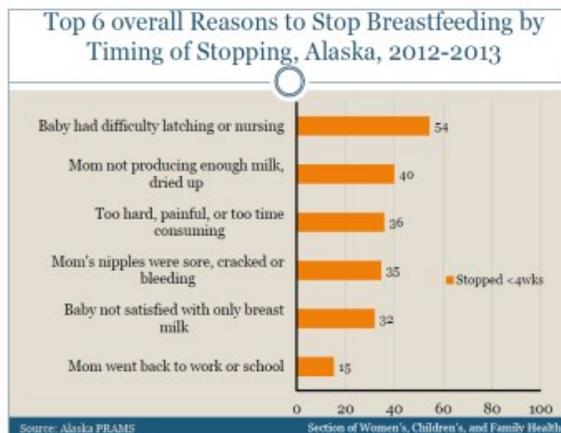
PRAMS data indicate that during 2009-2013, less than 2% of women delivering live births each year reported having one or more alcoholic drinks in an average week during the last three months of pregnancy. This percent has been fairly constant throughout this five year period. In 2013, 77.1% of women delivering a live birth reported that their prenatal health care provider advised them not to drink alcohol during their pregnancy. There has been no apparent trend in this indicator from 2004-2013.

During this reporting period, Title V Block grant funds supported CoIIN team development of rack cards titled: *Tobacco, alcohol and marijuana are legal in Alaska. Legal is not the same as safe.* The desired audience for the messages on the cards is pregnant and breastfeeding women. CoIIN partners for this effort included: WIC, Alaska Division of Behavioral Health, Alaska Breastfeeding Coalition, University of Alaska Artic SBIRT program, Alaska Native Tribal Health Consortium (ANTHC), South Central Foundation Nutaqsiivik program, Governor's Council on Disabilities and Special Education Fetal Alcohol Workgroup, Alaska DHSS Marijuana workgroup, and the Alaska DPH and ANTHC Tobacco programs. Title V funds supported development, printing and distribution of *Healthy Pregnancy and Beyond* cards, with links to evidence-based resources and information about healthy pregnancy. These were distributed to clinical care providers statewide. The perinatal listserv distributed evidence based information about substance and alcohol use, mental health disorders and domestic violence among its 866 recipients. PRAMS responded to multiple data requests and provided reliable data for this measure as well as other data on prenatal substance use to plan, guide and evaluate work related to prenatal alcohol use and prenatal substance use. An [Epidemiology Bulletin](#) on marijuana use among Alaska women who recently delivered a live birth was published in February 2015. Healthy Start and Maternal, Infant & Early Childhood Home Visiting (MIECHV) continued to promote healthy pregnancy behaviors among their clients in the Nome, Anchorage, and Matanuska-

Susitna regions of the state.

### **Breastfeeding - The percent of Alaskan mothers who breastfeed their infants at 6 months of age (retired NPM 11)**

The most recent data available for this measure is from the National Immunization Survey describing breastfeeding behaviors for infants born in 2012, when 63.1% of Alaska mothers indicated that breastmilk was at least one of the types of food their infant was fed at 6 months of age. CUBS asks mothers of 3-year-old children how long they breastfed and those results are similar. Among mothers of children born in 2009-2011, 57% reported that they breastfed for at least 6 months, according to CUBS. Because leading reasons for stopping breastfeeding, shown in the chart below and as reported by PRAMS mothers, are known to be effectively addressed by practices that align with the *Ten Steps*, WCFH addressed those practices.



From October 2014-September 2015, Title V supported evidence-based training in maternity care practices in which 14 birthing centers participated. Outcomes from the trainings include two maternity centers creating revised existing staff positions to include lactation consultant duties, one center established a policy requiring formula be given by prescription only, and the WIC program and Alaska Breastfeeding Coalition partnered with the Association for State and Territorial Health Officers to develop an award system for birthing centers that adopt evidence-based practices in lactation care.

Title V funds supported development, printing and distribution of *Healthy Pregnancy and Beyond* cards, with links to evidence-based resources and information about healthy pregnancy; these were distributed to clinical care providers statewide. Healthy Start, MIECHV and the infant safe sleep program continued to promote breastfeeding. During the reporting period, PRAMS and/or CUBS data on breastfeeding were shared with the Alaska Obesity Prevention and Control Program, the Alaska Native Tribal Health Consortium, and a regional PHN conducting a MAPP (Mobilizing for Action through Planning and Partnerships) project.

### **Preterm birth and low birth weight**

#### **Percent of births delivered at 37 - 38 completed weeks of gestation (retired SPM 10)**

In 2014, 25.2% of Alaska births were delivered at 37-38 completed weeks of gestation (early term), and preliminary data for 2015 indicate a similar percentage (24.7%). There has been no change in the prevalence of early term births in Alaska over the past decade. Healthy Start and MIECHV continued to promote healthy pregnancy behaviors among their clients in the Nome, Anchorage, and Matanuska-Susitna regions of the state. Title V funds supported development, printing and distribution of *Healthy Pregnancy and Beyond* cards, with links to evidence-based resources and information about healthy pregnancy; these were distributed to clinical care providers statewide. The perinatal listserv distributed evidence based information about factors known to affect early term birth, including tobacco, substance and alcohol use, among its 866 recipients.

The MCH Epidemiology Unit analyzed vital records data on trends in Alaska's overall preterm birth rates for several

internal and external stakeholders and provided technical assistance on interpretations of small increases in recent years. The Unit produced an [Epidemiology Bulletin](#) in January 2016 on preterm birth rates in Alaska and the implications of the national change from using the Last Menstrual Period (LMP) estimate of gestational age to the Obstetric Estimate. These data were used to plan and evaluate programs and guide public health policy.

**Percent of very low birth weight infants delivered at facilities for high risk deliveries and neonates (retired NPM 17)**

During 2013-2015, 70% of VLBW infants were delivered at facilities for high risk deliveries and neonates. In Alaska there is only one Level III facility that meets this qualification. This indicator has declined since 2010, when it was 79.0%. Healthy Start and MIECHV continued to promote healthy pregnancy behaviors among their clients in the Nome, Anchorage, and Matanuska-Susitna regions of the state. Title V Block grant funds supported development, printing and distribution of *Healthy Pregnancy and Beyond* cards, with links to evidence-based resources and information about healthy pregnancy; these were distributed to clinical care providers statewide. The perinatal listserv distributed evidence based information about factors known to affect very low birth weight, including tobacco, substance and alcohol use, and mental health disorders, among its 866 recipients. The MCH Epidemiology Unit analyzed data on maternal and child health issues. These data were used to plan and evaluate programs and guide public health policy.

**Newborn Metabolic and Hearing Screening**

**The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for conditions mandated by their State-sponsored newborn screening programs (retired NPM 1).**

Almost 100% of newborns in Alaska continue to receive at least the first bloodspot at 24-48 hours of age (98.5% in CY2013, 99.4% in CY 2014, and 99.2% in CY2015). Among those screened in CY15, 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. The condition most commonly found in Alaska continues to be CPT-1A Arctic Variant. The numbers for this condition increased when the testing methodology was changed. The newborn bloodspot screening program continued to partner with the Alaska Native Medical Center to send a DVD on this condition to the family of each newborn identified with CPT-1A.

During this reporting period, the program continued to work with a local pediatric immunologist on a committee preparing for the addition of Severe Combined Immunodeficiency Disease (SCID) to the Alaska panel. This involved discussion of follow-up, transport, and patient education. SCID and DNA testing for CPT-1A will be added to the Alaska panel on July 1, 2016 as the fee increases were signed by the Lt. Governor in May 2016. When DNA testing is implemented for CPT-1A, we anticipate to see approximately 750 cases of CPT-1A each year.

The Newborn Bloodspot Screening Advisory Committee continued to meet and inform the program. Quality Assurance activities continued which included site visits to birthing facilities and distributing quarterly practice profile reports. The program continued to promote the specimen collection video to decrease the number of unsatisfactory specimens. On July 1, 2015, the program began utilizing a BVS tool that enabled the program to match BVS birth certificate records with bloodspot results. Through this matching process, 50 parent refusals were identified.

**Percent of newborns who have been screened for hearing impairment before hospital discharge (retired NPM 12)**

The Alaska's Early Hearing Diagnosis and Intervention (EHDI) program tracks and provides 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. In CY 2015, the program instituted quality improvement activities which included a Plan Do Study Act (PDSA) cycle sending certified letters to families of

infants who had referred for follow-up testing and had no documentation of additional testing despite the EHDI program sending letters and contacting facilities and providers. The certified letters have helped the EHDI program to establish and document two-way communication between the family and the EHDI program. This has enhanced the data quality of the program and helps to define which families are unresponsive vs. lost to follow-up. There were also some infants who were re-screened as a result of a certified letter. This PDSA will be incorporated into the policy of the EHDI program. The electronic data upload project has been successfully implemented at a large birthing facility. Data since implementation demonstrates that the wait time between screening and the entry of results into the EHDI database decreased significantly. Currently they are uploading data within a week of birth screening. After the full implementation of the BVS matching tool, the numbers of births reported from BVS matched 100% with the births in the EHDI database.

The MOA between EHDI and Early Intervention/Infant Learning Program (EI/ILP) was signed in 2015 and has been partially implemented. The EI/ILP program has continued to have leadership changes and multiple vacancies so data sharing has been progressing slowly. The BVS matching tool was fully implemented on July 1, 2015 which has allowed for increased data quantity and quality. It has also increased the efficiency of the matching process between blood spots results and birth certificate records. In CY2015, the percentage of out of hospital (OOH) births grew to 7.4% statewide. Though they were a small percentage of total births, the OOH births accounted for 69% of the number of newborns who missed their newborn hearing screening. The loss to follow up rate at the birth screening stage improved from 42.6% in 2013 to 29.37% in 2014.

During CY15, the hospital screening rate for newborn hearing was 99.3%. The hospital screening rates remain high and stable. The out of hospital screening rate improved from 59% in CY 2014 to 63.8% in CY2015. The availability of screeners at midwiferies has continued to positively affect the OOH screening rate, therefore, the state will increase the number of screeners placed at midwiferies this year.

## Child Health

### State Action Plan Table

#### State Action Plan Table - 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 ECCS program to promote the use of the online Ages and Stages Developmental Screening tools with health care providers as well as the use of the bill code 96110 (CPT code for a developmental screen).

NPM 6.3. Provide system support to external partners and agencies to promote the use of standardized screening tools .

##### ESMs

ESM 6.1 - Percent of eligible screening time points with a completed Ages and Stages Developmental Screen, among families participating in MIECHV program

## 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 - 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. Participate in and provide leadership for the Alaska team for the national child injury CoIIN

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

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

## NOMs

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

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

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

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

## State Action Plan Table - Child Health - Entry 3

### Priority Need

Reduce the rate of child maltreatment

### SPM

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

### Objectives

SPM #3: Maintain a rate of substantiated child maltreatment below the Healthy Alaskans 2020 goal of 14.4 per 1,000 children aged 0-17.

### Strategies

SPM 3.1. Expand trauma informed service delivery for state based services

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SPM 3.2. Develop cross-sector comprehensive data to accurately measure child maltreatment in the population over time.

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SPM 3.3. Support local based initiatives with data needs (e.g. Triple P program, Mat-Su Community effort and others)

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SPM 3.4. Assess current primary prevention efforts of maltreatment and set a direction toward collective impact.

**Measures**

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	33	34	35	36	37	38

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

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	32.6 %	3.2 %	15,812	48,525
2007	20.7 %	2.5 %	10,172	49,247

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**ESM 6.1 - Percent of eligible screening time points with a completed Ages and Stages Developmental Screen, among families participating in MIECHV program**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	79.1	79.9	80.7	81.5	82.3

**NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19 (Child Health)**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	185	180	176	172	168	164

**Data Source: State Inpatient Databases (SID) - CHILD**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	173.7	12.7 %	188	108,236
2011	165.3	12.4 %	178	107,687
2010	183.6	13.5 %	186	101,302

**Legends:**  
 Indicator has a numerator ≤10 and is not reportable  
 Indicator has a numerator <20 and should be interpreted with caution

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

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

**Child Health - Plan for the Application Year**

The WCFH leadership team identified the state priorities for child health as 1) the need to 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.

The 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) Maintain a rate of substantiated maltreatment below the Healthy Alaskans 2020 goal of 14.4 per 1,000 Alaska children ages 0-17 years (SPM 3). This was selected as an SPM because we felt that none of the NPMs directly aligned with our state-identified priority of preventing and reducing child maltreatment.

**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. 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%). Three strategies that will address Alaska’s objective to increase developmental

screening are:

1. Support 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 Early Childhood Comprehensive Systems (ECCS) program 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).
3. Provide system support to external partners and agencies to promote 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 and until the child is age two. The NFP curriculum includes ASQ screening 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 these evidence-based tool. The proposed 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 linkage 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 needed specialist and community based services. This program partners with Early Childhood Comprehensive Systems (ECCS) 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 newly hired 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.

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.

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**

In 2012, the rate of injury-related hospital admissions was 174 per 100,000 children ages 0-9 years and 194 per 100,000 adolescents ages 10-19. There was no change in the rate among children during the three-year period 2010-2012, however there was a decline among adolescents from 290 per 100,000 in 2010. A limitation of this measure is that during 2010-2012 many rural hospitals did not report to the State Inpatient Database, so these rates may not accurately reflect the entire state. Strategies that will address the objective to decrease injuries among children and adolescents include:

1. Review all child deaths up to age 18 through the Alaska Maternal-Infant Mortality and Child Death Review (MIMR-CDR) program.
2. Participate in and provide leadership for the Alaska team for the national child injury CoIIN.
3. Provide parental education to families participating in the MIECHV program regarding prevention of child injuries.

The Alaska MIMR-CDR was established by the Commissioner of the Department of Health and Social Services in 1989. The program is housed in the MCH Epidemiology Unit of the Section of WCFH, and is funded primarily by the Title V Block Grant. After an initial pilot period, the program started comprehensive reviews of all infant deaths during 1992. The program expanded to include reviews of maternal deaths in 1999 and deaths of children ages 1 to 18 years (the Child Death Review) in 2004. MIMR-CDR is modeled on national evidence-based programs and has contributed data to the National Child Death Review Reporting System and Sudden Unexplained Infant Death Case Registry since 2015. As a result of quality improvement activities in 2015, the program expects that future recommendations will be more widely disseminated and will have a greater impact. As over half of all infant and child deaths are related to injury, many recommendations from the committee are relevant to preventing injury. In 2016, the program expects to collaborate more closely with the Alaska Suicide Prevention coalition and the Kids Don't Float program in the Office of Boating Safety to improve recommendations related to injury.

Alaska's Division of Public Health applied for and was selected to participate in the national Child Safety CoIIN in August 2015, with the effort led by WCFH staff partially funded by Title V. In Alaska the leading causes of non-fatal injury hospitalizations among the 0-9 age group are falls, poisoning, and burns. The mechanism of injury however is widely variable across this age group, largely due to the changes in mobility, cognition, and fine motor control development. Injuries that result in death or hospitalizations among the 0-9 age group often result from a lapse in adequate caregiver supervision, caregiver substance utilizations, or poor caregiver decision making. Among the 0-9 age group, the top opportunities for preventing injury-related mortality and morbidity are largely centered on increasing positive caregiver behaviors while decreasing negative behaviors, and educating caregivers on making better risk assessments. Title V support for efforts to increase awareness and address caregiver negligence are described below in the strategies to decrease child maltreatment. 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 will train 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.

### **SPM 2 Rate of substantiated reports of child maltreatment per thousand children 0 to 17 years of age in Alaska**

As previously described, the MIECHV NFP program provides nurse home visiting in the communities of Anchorage and Mat-Su. 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.

Strategies that will address the objective to decrease the rate of child maltreatment include:

1. Assess current primary prevention efforts of maltreatment and set a direction toward collective impact.
2. Develop cross-sector comprehensive data to accurately measure child maltreatment in the population over time.
3. Expand trauma informed service delivery for state-based services
4. Support local based initiatives with data needs (e.g. Triple P program, Mat-Su Community effort and others)
5. Administer federal Maternal, Infant and Early Childhood Home Visiting (MIECHV) program using the Nurse-Family Partnership model

Primary activities center on improving the quality and comprehensiveness of statewide child maltreatment data. As the public health model is built on a foundation of data, the Alaska Surveillance of Child Abuse and Neglect (SCAN) program within WCFH has continued to develop centralized cross-jurisdictional data on child maltreatment. Due to the multifaceted nature of maltreatment use of a single indicator to represent this complex issue is contraindicated. The SCAN program has three primary components 1) timely trend analysis, 2) comprehensive magnitude assessments, and 3) longitudinal risk factor and outcome assessment.

The SCAN program has partnered closely with the state child welfare agency (OCS), many of the child advocacy centers, law enforcement, and child death review program to link and develop cross-jurisdiction measures. The SCAN program has also initiated detailed sentinel surveillance for communities that have minimal resources. This surveillance method was developed in Anchorage and will next be implemented in Bethel (initial site visit complete). Collecting multiple endpoints (e.g. reported maltreatment, substantiated maltreatment, multi-agency maltreatment) enables a more comprehensive picture of the extent and magnitude of this issue in the population to be constructed. 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. Finally, initial development of a longitudinal linkage between the PRAMS survey and multiple data sources has been validated using a single PRAMS year (2009). This will be expanded to include 2010 and 2011 years to estimate the cumulative risk of maltreatment over time and conduct etiologic and associative evaluations to improve targeted prevention efforts. The SCAN program will utilize predictive analytics to identify modifiable risk factors and population characteristics at each level of the ecologic model. This information will be used to inform decision makers and focus resources.

As we increase the availability of quality and comprehensive data we will improve our impact on the strategies that we support indirectly through data. These include the development of the collective impact model, increase in state based trauma informed services, and local prevention efforts. Specifically, we support the Alaska Children's Trust with data as they take the lead agency role in developing a statewide collective impact model, as well localized collective impact efforts initiated by the Mat-Su Health Foundation. We also provide the division of behavioral health with data and statistical support to help document the need for increased trauma informed services.

The SCAN program will continue to work with our many partners (e.g. Alaska Children's Trust, Children' Justice Act Task Force, Child Protective Services) to develop a data resource website that documents prevention efforts and services, as well as current trends and informative data.

WCFH will also continue to administer the federal MIECHV program using the NFP model to provide home visiting services to first-time pregnant women and their children up to age 2 years in the Anchorage and Mat-Su Boroughs. In 2015, the State of Alaska was awarded a competitive expansion grant which doubled the capacity of the program to 200 families at any given time and expanded the service area to the Mat-Su Borough, an area of the state with high rates of child maltreatment. Randomized controlled trials conducted by Nurse-Family Partnership have demonstrated success in decreasing child abuse and neglect. The model helps to develop positive parenting skills and also creates knowledge and awareness of normal growth and development. Although MIECHV is not funded by Title V, the goals of the program align closely with Alaska's Title V priorities.

## Child Health - Annual Report

### Developmental screening

During FY15, 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 Early Childhood Comprehensive Systems (ECCS) and other state and community-based programs on enhancement and implementation of this statewide work. The MIECHV program at Providence NFP utilized 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 Early Intervention (EI) program.

### Injury (retired NPM 10, 16, SPM 2)

Injury prevention work led and funded by Title V primarily consisted of ongoing reviews by the MIMR-CDR program of all infant, child and maternal deaths in the state. During 2007-2009, according to MIMR-CDR committee findings, two of the top three causes of death among Alaska children ages 1-14 were related to injury: asphyxiation (21%) and motor vehicle collisions (18%). Unintentional injury was the most common manner of death among children ages 1-14 (50%), while maltreatment was associated with 9% and suicide with 4%. The MIMR-CDR program reviewed child deaths up to age 14 and developed recommendations for prevention, however a formal analysis of causes of all child death has not been published since 2012. During 2015 the program conducted an audit of activities and focused on improving efficiencies and quality improvement, expanded the age range for reviews up to age 18 years, and began contributing to the national Child Death Review Reporting System and SUID Case Registry.

[Recommendations from the May 2015 Annual Meeting](#) related to injury and homicide cases focused on leveraging existing injury data within the state for improved analyses and engagement of communities.

During 2015 100.9 children ages 0-9 per 1000 received at least one report of maltreatment (physical, mental, sexual, or neglect) that met the criteria to be screened-in by the Office of Children's Protective Services. This excludes duplicates and reports without a valid name or date of birth. In FY15, Title V staff collaborated with the OCS, multiple child advocacy centers, local law enforcement agencies, that Alaska Children's Trust, Children's Justice Act Task Force, Division of Behavioral Health, All Alaska Pediatric Partnership, Mat-Su Health Foundation, and other private and nonprofit agencies to improve services and prevention efforts by supplying quality maltreatment indicator data. The MIMR-CDR program produced an [Annual Report](#) detailing findings from reviews of infant deaths 2008-2012; 35% of all deaths were associated or probably associated with at least one type of maltreatment while 82% of the injury deaths were associated with maltreatment. Following a spike in sleep-related infant deaths in 2014, the MCH Epidemiology Unit conducted a case series analysis of all sleep-related infant deaths 2012-2014 and produced an [Epidemiology Bulletin](#) in June 2015 describing the study. Two Title V staff, an epidemiologist and a nurse consultant, presented the data from the study over 10 times to staff from WIC, OCS, Public Health Nursing, local childcare agencies, COLLN work groups, and at two pediatric grand rounds. The School Nurse Consultant participated in MIMR-CDR review meetings to provide the school perspective and shared resources on reporting and detecting child maltreatment with school nurses statewide.

The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children significantly declined from 9.3 in 1993-1995 to 1.9 in 2012-2014 (retired NPM 10). During this most recent 3 year time period, there were only 9 deaths in this category. In 2009 the Alaska State legislature passed new legislation requiring the use of booster seats for young children and clarified the use of child passenger restraints based on the national standards. This law makes information provided to the public more easily understood and assists law enforcement with enforcing the laws. Injury-prevention activities specifically around motor-vehicle crashes were primarily led by the Injury Prevention program in the Section of Chronic Disease Prevention and Health Promotion (CDPHP) and are described in Other Program Activities.

The rate of suicide deaths among teens aged 15-19 years appears to have increased in 2012-2014 after several years of general decline, and was 30.6 per 100,000 teens aged 15-19 years in 2012-2014 (compared to 22.7 per 10,000 in 2011-2013) (retired NPM 16). This was similar to the rates in the early 2000s. The Title V funded School Nurse Consultant collaborated with the Department of Education and Early Development to obtain Continuing Nursing Education contact hours for a newly developed suicide e-Learning module, [Responding to Suicide: Postvention Guidelines](#), and disseminated course information for school nurses. Additional partnerships between WCFH's Adolescent Health program and the Division of Behavioral Health on suicide prevention and other violence prevention initiatives is discussed in the adolescent domain Other Programmatic Activities.

### **Immunizations (retired NPM 7)**

In CY2014, 72.6% of Alaskan children ages 19 to 35 months had received a full schedule of age appropriate immunizations for DTP/DTAP, OPV, measles, mumps, rubella (MMR), H. influenza, and hepatitis B (retired NPM 7). This was not a significant increase over the 2013 level of 72.0%. There was also no significant change in the percent of Alaskans reporting any of the individual doses that make up this series. A perinatal nurse consultant in WCFH continued to work with birthing facilities to promote the birth does of Hepatitis B. In FY16, the first birthing facility in Alaska was awarded the designation by the Immunization Action Coalition's Hepatitis B Birth Dose Honor Roll for coverage rate achieved during CY14. This award recognizes birthing facilities that have attained high coverage rates for the first dose of this vaccine. The perinatal nurse consultant covered the importance of the birth dose of Hepatitis B during site visits to birthing facilities in Alaska. The nurse consultant also continued to actively participate in the All Alaska Pediatric Partnership's Immunization work group. In summer 2015, WCFH /Title V staff began working with colleagues at the Alaska Native Tribal Health Consortium to plan the biennial Alaska statewide MCH and Immunization Conference, to be held in September 2016. About a third of the presentations at the conference focus on immunization-related topics. The primary audience for the conference are health care providers, both rural and urban. The School Nurse Consultant continued to provide suggestions for professional development and continuing education on topics related to immunizations to be presented at the School Nurses Conference and for the School Health Nurse Advisory Committee.

### **Health insurance (retired NPM 13)**

The 2011-2012 National Survey of Child Health found that 5.8% of Alaska children ages 0-17 years did not have any kind of health care coverage (retired NPM 13). These data have not been updated since 2011-2012. The Kaiser Family Foundation reported that in 2014, 12% of Alaska children ages 0-18 years were uninsured (AN/Als are counted as uninsured in the Kaiser report). This was the second highest percent uninsured in the country in 2014, and had not changed from the Alaska rate in 2013.

The MCH Title V/CSHCN Director and staff members continued to work with the Medicaid/CHIP Agency to assure that both programs were effectively meeting the requirements for outreach and education around EPSDT services and access to Medicaid coverage. Title V, ILP, ECCS and Medicaid/CHIP continued to work together to implement the policies and procedures necessary to effectively collect and measure the CHIPRA core children's quality measures, including the CAHPS PCMH CG patient experience and access to care survey and the child developmental screening measure, at both the state and practice levels, both of which are included in the CMS children's core quality measure set.

This past year, the Medicaid/CHIP Agency continued to work collaboratively as part of the Title V HRSA Systems Integration grant planning team, and Title V is using the standardized hybrid CAHPS PCMH CG survey approved by CMS, AHRQ and NCQA as one of their standardized measures for evaluation of their Systems Integration Grant since CYSHCNs are identified in this hybrid survey and composites are available for this population. This past year, Title V used their Systems Integration funding to leverage funding with Medicaid/CHIP to pay for in-depth analysis of the CAHPS PCMH CG survey data, which, as mentioned previously, contains a sub-analysis on the CYSHCNs identified in this survey, which is the only mechanism that Medicaid/CHIP Agency has to look at the CYSHCNs

children's access to and experience of care as compared to the larger Medicaid/CHIP population. This enabled Title V to contract with the principal investigator of the CHIPRA T-CHIC demonstration (AK, OR and WV), Dr. Charles Gallia, to continue to work with Alaska on this CAHPS PCMH CG survey work at both the state and practice levels.

As a part of the Title V contract, Dr. Gallia also facilitated the learning collaborative with the Alaska practices that participated with the State Medicaid/CHIP Agency and Title V in this survey. One of the key findings during this learning collaborative was the decline in all the domains of children's patient experience/access over the previous year's survey, so with this finding, it is the hope of the Medicaid/CHIP and Title V agency to leverage health services initiatives funding to support the collection and analysis of the CMS children's core quality measures including the hybrid CAHPS PCMH CG survey and learning more about the reasons for the declines. If successful, our hope is to integrate DPH's Vac Track Immunization registry with Medicaid data to enable the reporting of immunization data for children and adolescents enrolled in Medicaid/CHIP that the DHSS has not been able to report on to date as part of the CMS children's core quality measures, which could possibly be used as performance measures as part of the health reform legislation referenced below.

The use of the hybrid CAHPS PCMH CG survey tool by Title V, the Medicaid/CHIP Agency (part of the CHIPRA requirement for states to report on patient experience/access for children), the incorporation of this survey as part of Alaska DHSS CMS Rate and Access Medicaid Review Monitoring Plan and the use of this survey instrument with practices to help them gain NCQA PCMH recognition has opened the path for the DHSS to use this standardized tool as a performance metric in the demonstrations included in health care reform legislation (SB 74) passed in Alaska in early 2016.

Title V and Medicaid/CHIP/EPSTDT section of the Medicaid Agency continues to work on informing providers on the status of the backlog of applications and renewals as this relates to children and pregnant women enrolled in DenaliCare (Medicaid) and the children enrolled in Denali KidCare (CHIP) as the priority for this measure is to reduce the number of uninsured children. DHSS implemented a dashboard last year which assists both internal and external stakeholders to be informed about Medicaid/CHIP enrollment -

<https://go.dhss.ak.local/pub/home/HealthyAlaska/Pages/dashboard.aspx>.

Children clearly represent the majority of Medicaid/CHIP enrollment and the Title V support is critical. The Division of Health Care Services continued to work on improving claims payments with the new Enterprise MMIS. In addition, the Division of Public Assistance (DPA) continued to work on reducing application and renewal backlogs, connected the Health Insurance Marketplace for successful data transmission between the HIM and the AK DHSS and began allowing the marketplace to make application determinations for the Alaska Medicaid expansion implemented in September 2015. The difficulties experienced with both new 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, so the collaboration between Title V, Medicaid and outside stakeholders is critical as together our agencies work toward reducing the eligibility backlog.

### **Obesity (retired NPM 14)**

In 2014, 39.0% of mothers of 3-year-olds reported a height and weight for their child that indicated the child was overweight or obese, as measured by BMI percentile categories (retired SPM 9). There was no significant trend during 2008-2014 in this indicator. WCFH has partnered with the Alaska Obesity Prevention and Control Program (OPCP) in the Section of Chronic Disease Prevention and Health Promotion for many years on activities to reduce childhood obesity in Alaska. The five components of OPCP are: public education; school partnerships; surveillance and evaluation; professional development for educators; and early care and education (ECE) partnerships. During FY15, Title V contributed to or partnered with OPCP in some way to the first three components, as described below. See the Other Programmatic Activities section for additional details on activities conducted by the OPCP and the Alaska WIC program to address childhood obesity.

The OPCP educates Alaskans using the techniques of social marketing to reduce the amount of sugary drinks parents serve their children. The sugary drink prevention efforts are a sub-campaign under the umbrella campaign, Play Every Day. The campaign used the results from CUBS to monitor child weight status and consumption of sugary drinks to inform its efforts and progress.

The school partnership component includes three Alaskan school districts working to improve their school nutrition and physical activity environments and policies. The Title V-funded MCH school health nurse consultant worked closely with the OPCP staff to develop school nursing protocol for the collection of student height and weight.

Outcomes of the school partnerships are monitored through the Student Weight Status Surveillance System (SWSSS). The School Nurse Consultant published and disseminated [Growth Screening & Referral Guidelines for School Nursing Services](#) as a result of a two-year pilot project with the Kenai Peninsula Borough School District school nurses in collaboration with the OPCP. These guidelines offer tools for school nurses to facilitate healthcare provider referrals for growth concerns and work with students and families on healthy lifestyles.

The OPCP monitors emerging issues and progress using a the following surveillance systems: PRAMS; CUBS; WIC-PC; YRBS; SWSSS, School Health Profiles; BRFSS; and mortality and morbidity. In February 2016, the Title V-funded PRAMS/CUBS Research Analyst II presented PRAMS and CUBS obesity-related data on children and pregnant women as part of a panel with OPCP staff at the Alaska Public Health Summit. The title of the presentation was "Monitoring Emerging Health Risks and Obesity Behaviors Across the Life Span." This was an update of a presentation done in 2012.

## Adolescent Health

### State Action Plan Table

#### State Action Plan Table - 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

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

## 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 - 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

Increase the percentage of Alaska students who report that they would feel comfortable seeking help from at least one adult besides their parents if they had an important questions affecting their life to 87% by 2021 (YRBS)

### Strategies

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.

## Measures

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

#### Annual Objectives

	2016	2017	2018	2019	2020	2021
Annual Objective	26	25	24	23	22	21

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

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	13.9 %	2.2 %	8,187	59,024
2007	12.2 %	1.7 %	8,205	67,305

**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: Youth Risk Behavior Surveillance System (YRBSS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	26.5 %	1.4 %	8,040	30,402
2011	28.9 %	1.5 %	9,090	31,459

**Legends:**  
 Indicator has an unweighted denominator <100 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

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

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

**Adolescent Health - Plan for the Application Year**

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

The first NPM measure for adolescents is the 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 2013, 26% of Alaska students in grades 9-12 reported *being* bullied on school property or electronically (YRBS). Being bullied was more common among 9<sup>th</sup> graders (33%) compared to older students. Female students were more likely to report bullying than male students (33% vs. 20%).

The overall priority of the adolescent domain Five Year Action Plan 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 7<sup>th</sup>, 8<sup>th</sup> and/or 9<sup>th</sup> 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. Last year, the program reached 1,246 Alaskan youth, therefore our aim is to reach 1,558 students next school 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.

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

The second NPM measure for adolescents is the rate of injury-related hospital admissions per population ages 10-19 years. In 2012, the rate of injury-related hospital admissions among adolescents was 194 per 100,000 adolescents ages 10-19. This rate declined from 291 per 100,000 in 2010. During 2010-2012 many rural hospitals did not report to the State Inpatient Database (or Hospital Discharge Database), so these numbers may not be reflective of the entire state. Alaska's 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.**

We chose this SPM as having supportive relationships with adults besides a parent 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 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 and 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 for Disease Control. While no Title V dollars are used to support the program activities, Title V dollars to 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 recent 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.

## **Adolescent Health - Annual Report**

### **The rate of birth (per 1,000) for teenagers aged 15-17 years (retired NPM #8)**

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 Adolescent Health Program (AHP) targeted the issues of teen pregnancy and unhealthy relationships by 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 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, including teen pregnancy and violence prevention.

The AHP issued two new three-year competitive community grants to agencies in Alaska for teen and unintended pregnancy prevention 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 2016, TANF funds are proposed to be utilized to pilot test and bolster youth friendly clinics. Work is being conducted currently to survey, assess, and develop an evaluation to determine effectiveness. Clinicians will also be 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 is working on resourcing 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 dissemination. 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 through teen birth data. In addition this data was presented or co-presented many times throughout Alaska.

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, participate in MCH Block Grant reviews, and review the YPVP mini-grants, in addition to creating interventions for young Alaskan health issues. The YAHA membership is beginning its eighth 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 utilizing continuation Teen Pregnancy Prevention Tier II funds from the Office of Adolescent Health (OAH). The topics that were covered were shown to increase participant knowledge of STIs, HIV and pregnancy prevention, increase healthy relationships skills, and strengthen concepts of consent. Inclusion of healthy sexuality training will continue to be an essential part of sexual and domestic violence prevention.

**The percent of students who were hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend during the 12 months before the survey. (retired SPM #5)**

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 helped plan and sponsor a statewide youth leadership event entitled, Lead On! For Peace and Equality. The event focused on teaching youth methods for community engagement to prevent dating violence.

The AHP collaborated with non-profit and State agencies to continue funding the multi-media Stand Up, Speak Up campaign aimed at reducing unhealthy relationships in teens and increasing youth leadership throughout the state.

AHP supported the development of a male healthy relationships curriculum and training called COMPASS. AHP supported the development and dissemination of parent conversation tools, called Talk Now Talk Often, designed to facilitate discussions around healthy relationships and violence reduction.

The AHP is managing a federal PREP grant using The Fourth R curriculum, which focuses on establishing healthy relationships as a way to reduce substance abuse, violence and teen pregnancy. Two trainings were held in October, one statewide training held in Anchorage and one regional training held in Soldotna. A total of 35 teachers and community members were to implement the Fourth R curriculum in their respective schools.

The AHP continued to work with the YAHA advisory committee comprised of all youth that advises the State on important matters relevant to teens, including violence prevention. The AHP funded the Alaska Network on Domestic Violence and Sexual Assault to distribute community grants to youth groups to conduct youth engagement for the prevention of dating violence activities at the community level.

AHP staff served on various committees working to address intimate partner violence among young adults including the Council on Domestic Violence and Sexual Assault (DVSA) Data Committee, DVSA Training and Infrastructure Committee, K-5 Social Emotional Learning Curriculum Workgroup, and Statewide Agency DVSA Prevention Committee, Safe Children's Act Taskforce workgroup.

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 and healthy relationships by implementing the Green Dot intervention in the Fairbanks community and at the University of Alaska Fairbanks. As well, 53 school counselors were trained in the Healthy Relationships Plus curriculum and funds supported the Statewide Domestic Violence and Sexual Assault Prevention Summit to support primary prevention of sexual assault prevention activities in rural communities.

Most projects from FY15 will continue through FY16. One noted change will be that RPE grant funds will move to support a sexual assault intervention called Bringing in the Bystander at the University of Alaska Anchorage.

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.

## Children with Special Health Care Needs

### State Action Plan Table

#### State Action Plan Table - 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 a shared resource for families and primary care providers of CYSHCN using the Help Me Grow centralized system model

NPM 11.3. Assess CYSHCN systems of care to integrate families and create a State Plan

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

NPM 11.5. 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

NPM 11.6 Analyze results of Consumer Assessment of Healthcare Providers and Systems (CAHPS) medical home patient experience survey

NPM 11.7 Partner with Stone Soup Group (Alaska's Family to Family Health Information Center), to offer the Parent Navigation program.

## ESMs

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

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

## 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

## Measures

### NPM 11 - Percent of children with and without special health care needs having a medical home

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	45	47	49	52	55	57

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

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	39.6 %	4.4 %	10,398	26,280
2007	49.0 %	4.2 %	14,185	28,929

**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: National Survey of Children's Health (NSCH) - NONCSHCN

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	54.0 %	1.9 %	83,530	154,750
2007	53.0 %	1.9 %	76,890	145,171

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	0.2	0.2	0.2	0.3	0.3

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

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

Children with Special Health Care Needs - Plan for the Application Year

Alaska's Title V CYSHCN program engages with stakeholders and families statewide for systems planning and implementation efforts to improve care and health outcomes for children. Primary partnerships include 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 are 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 recently 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 include:**

**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 facilitate a pilot program for a small cohort of identified CYSHCN through a contract with a newly established practice integrated network in Anchorage and partnership with the Anchorage School District. Through the practice network's common electronic health record, school nurses will have access to individual child records relevant to school based care and participate in family centered "shared plan of care" development using the Lucille Packard Foundation model promoted by the Maternal Child Health Bureau. 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 ESM will measure the number of CYSHCN in pilot schools and partner practices with a shared plan of care. 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. 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. The Title V funded School Nurse Consultant will provide ongoing technical assistance and advisory support for this project.

**2. Develop 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 at-risk children 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. However, families, pediatric health care providers, early care and education and social

service providers often have a difficulty recognizing early signs of developmental and behavioral concerns. Even when needs are identified, finding programs designed to address those needs can be confusing and time-consuming. HMG is a simple solution that builds on existing resources. It 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.

In January 2016 HMG Alaska hosted a broad family and stakeholder Community Meeting. Five workgroups convened in spring 2016 to develop implementation and sustainability recommendations based on the four core components of HMG. Workgroups will provide recommendations to the Leadership Team for the HMG Alaska strategic plan by September to prepare for a “soft launch” in late 2016 and statewide expansion in 2017. The five workgroups are:

- Child Health Provider Outreach
- Family and Community Outreach
- Centralized Phone Access Point
- Data Collection & Analysis
- Funding and Sustainability

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 upon the soft launch of the program in late 2016.

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

The CYSHCN State Plan created in 2015-2016 will be regularly visited and revised 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 2016 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 with the first four identified through activities of the AMCHP “Action Learning Collaborative on National Standards for CYSHCN.” Two additional priority domains were identified through the Title V Needs Assessment and families and stakeholder input. The following six domains were assessed in the broad context of services available statewide:

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 incorporates three AIM statements from Alaska's current CYSHCN Systems Integration Grant. Activities will be aligned with the Autism Ad Hoc Committee's five year Autism State Plan which was recently finalized in addition to statewide Early Intervention/Part C strategic planning , Alaska Immunization Program goals, and related Early Childhood Comprehensive Systems (ECCS) efforts, among others.

**1. 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. Alumni from the first two (2014 & 2016) and subsequent cohorts will be engaged by Title V and practice partners to lead efforts in to increase developmental screening and practice level care coordination capacity in tribal and rural clinics using the care integration framework recommended by the AAP. This course is being explored as a foundational curriculum for Family Navigation training which would support medical home and specialty services for CYSHCN.

**2. 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 will be addressed through activities led by Title V staff and a contracted evaluator for Alaska's CYSHCN Systems Integration Grant. Part C program referral patterns, processes and barriers will be investigated and quality improvement efforts implemented. A memorandum of agreement will be developed to improve communication between Title V, Part C and Part B programs and increase collaborative community level outreach related to developmental screening and early identification of CYSHCN.

**3. 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. For example, the 2015 survey results showed significant declines in a wide range of areas, from the patient perspective, for children. While reasons for this decline are unknown, consistent and meaningful data collection to monitor family/patient experience and identify areas for improvement are essential for CYSHCN systems integration and Title V activities related to pediatric medical home capacity building. Title V and Medicaid are working to identify sustainable data analysis capacity options since, to date, specialized analysis of the data has been contracted by an out of state vendor with limited availability. Exploring ways to support primary care providers in rural parts of the state who care for children and youth with special health care needs will be explored using Project ECHO (Extension for Community Healthcare Outcomes) which is a collaborative model of medical education and care management using cased based learning to support providers in rural and frontier communities started by Dr. Arora and the University of New Mexico.

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

Title V Block grant funds support contracted Parent Navigation services, historically provided by Alaska's Family to Family Health Information Center (Stone Soup Group). Title V support of these services in state sponsored speciality clinics (neurodevelopmental, cleft lip and palate), children identified through the Early

Hearing Detection and Intervention 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.

Additional funding and numerous partnerships will be engaged over the next year to develop, pilot and implement a rigorous Family Navigation training program that will 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 will be developed and implemented over the next 2-3 years using quality improvement methodology to improve the curriculum and engage families in sustainability activities. 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 resources will be leveraged to both initiate and sustain Family Involvement Network activities.

### **Children with Special Health Care Needs - Annual Report**

Alaska’s Title V program identified improving systems of care for families with CYSHCN as a State Priority. The national performance measure for this population is the percent of children with and without a special health care need having a medical home (retired NPM 11). To address this priority, Title V and partners have worked to increase the proportion of CYSHCN who receive integrated care through a patient/family-centered medical/health home (PCMH) approach by 20% over Alaska’s reported 2009/2010 levels (42.8% to 51.3%) by 2020. While there has been some progress on increasing this proportion (up from 39.3% in 2005), it is clear that further systems improvement is needed to provide more comprehensive access to this vital resource for CYSHCN. Children without special health care needs in Alaska are similarly affected by the lack of available medical homes but appear to be experiencing a slight decrease in availability based on the most recent NSCH data (from 52.3% in 2007 to 51.9% in 2011/2012).

Among all of the stratifier groups examined using 2011-2012 data *for CSHCN*, having a medical home was least common among children who used Medicaid or other public insurance (26%), who were non-Hispanic multiple race (27%), and whose parents were unmarried (29%). The percent who had a medical home declined as the child got older (51% among children ages 0-5, 44% among children ages 6-11, and 32% among children ages 12-17). Among all of the stratifier groups examined using 2011-2012 data *for non-CSHCN*, having a medical home was least common among children who were uninsured (25%), who lived in a non-English speaking household (25%), and where the highest education attainment of a parent was less than high school (27%). Non-Hispanic Asian and non-Hispanic American Indian/Alaska Native children were less likely to have a medical home compared to Hispanic, non-Hispanic multiple race, and non-Hispanic White children. Insurance status clearly had a significant effect on whether the child had a medical home; 25% of uninsured children had a medical home, compared to 48% of children who used Medicaid, and 60% of children with private insurance.

There has been no new data since 2009-10 on retired NPMs 2-6. Alaska-specific data collected on the National Survey of Children with Special Health Care Needs (NSCSHCN) in 2009-10 found that, 66.8% of families partnered in decision-making at all levels and were satisfied with the services they received (NPM 2); 42.8% of CSHCN received coordinated, ongoing, comprehensive care in a medical home (retired NPM 3); 56.7% of families had

adequate private and/or public insurance to pay for the services they needed (NPM 4); 55.2% of families reported that community-based service systems were organized so they could use them easily (retired NPM 5); and 45% of youth with special health care needs received the services necessary to make transitions to all aspects of adult life (retired NPM 6). It may be possible to redefine some of these measures in the future based on CAHPS survey data, but will be dependent on the sustainability of funding and the Title V/Medicaid partnership which currently supports survey data collection and analysis.

As noted, disparities in medical home access may be attributed to geographical location (rural vs. urban) as well as cultural and linguistic barriers, though it is also apparent that the state's fee for service model and lack of reimbursement for primary care practices to develop as functional medical homes is also a contributing factor. Alaska's Title V program has worked to engage providers and tribal health leadership through initiatives related to developmental screening, diagnosis and referral and to expand medical home access and improve quality of care and health outcomes for children statewide.

Title V funding is blended and braided with other sources to address the needs of Alaska's CYSHCN population. The goal to increase the proportion of children (with and without special health care needs) receiving care in a medical home is consistent with identified priorities and goals in past Title V needs assessments as well as current efforts related to systems integration and PCMH development. Three primary strategies are consistent with current activities already underway and supported by HRSA "Systems Integration for CYSHCN" funding and ongoing state efforts include:

1. Assess the CYSHCN systems of care to integrate families and create a state plan,
2. Develop a shared resource for families and primary care providers of CYSHCN using the "Help Me Grow" centralized system model, and
3. Expand provider access to medical home concepts and tools through education and statewide technical assistance.

Major activities related to the above named goals include the development of a **five year CYSHCN State Plan based on the "National Standards for CYSHCN"** document published in March 2014. Title V staff and a small group of tribal health, Medicaid, family and provider leaders attended the AMCHP sponsored "CYSHCN Standards Action Learning Collaborative" in 2014-2015 which helped guide the state planning process using the National Standards document as a guide.

Planning for **Help Me Grow Alaska** began in early 2015 as a group of dedicated stakeholders was convened as the Leadership Team. A segment of this team travelled to the 2015 Help Me Grow National Forum to learn from other state experiences and begin to shape the vision for an Alaska replication of this celebrated model of a centralized resource for families and health care providers to promote healthy growth and development of young children.

The **Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient/family experience survey** was fielded with a cohort of practices through a partnership between Title V and the state Medicaid program. Using a specially developed medical home version of the survey which includes questions to help identify CYSHCN, family experience data was collected to help individual practices as well as the state Children's Health Insurance Program and Medicaid identify potential quality improvement opportunities. Additionally, use of this validated survey supports primary care practices pursuing national medical home recognition and increased family involvement.

In the 2015-16 school year in the Anchorage School District (the largest in the state with a student population of 48,433), 14% of students had a diagnosis of asthma, 0.3% had Type 1 diabetes, 0.06% had Type 2 diabetes, 1.1% were diagnosed with a seizure disorder, and 3.6% had a life-threatening, anaphylactic allergy. The Title V funded School Nurse/School Health Consultant worked to address needs of children with chronic health conditions in the

school system statewide. During the past year she collaborated with the National Association of State School Nurse Consultants (NASSNC), the Centers for Disease Control and Prevention (CDC), and the National Association of Chronic Disease Directors (NACDD) to clarify the school nurse's role in planning for students with chronic conditions. A meeting in Atlanta in February 2016 focused on this important discussion and outcomes will include CDC/NACDD guidance documents and resources. Additionally, the School Nurse Consultant collaborated with the Certified Diabetes Educator for the Providence Pediatric Subspecialty Clinic to develop an addendum to the [Alaska Diabetes Individualized Healthcare Plan](#) (originally developed in 2013) for students using continuous glucose monitoring devices in schools. She is currently developing an addendum for diabetes care needed for students participating in out-of-the-school-day extracurricular activities.

Pediatric Medical Home program staff worked with MCH Epidemiology Unit staff on the development of questions for Phase V of CUBS (3 year old follow up survey to PRAMS) to include the CAHMI CYSHCN screener elements for additional state level data on the prevalence of CYSHCN. CUBS began implementing Phase V in July 2015.

Other information related to other CYSHCN programs, including the pediatric specialty clinics (some of which are supported by Title V funds) and the newborn screening programs, is described in further detail in the Perinatal/Infant domain.

The distance-based Pediatric Care Coordination Training Program, developed in partnership with the All Alaska Pediatric Partnership and the University of Alaska Anchorage, was offered to a second cohort of students in 2016. This ten week course was designed as a distance-based continuing education course consisting of eight weekly modules and a two week final project. The course was adapted from the Boston Children's Hospital curriculum and will continue to be offered at least once per year to train clinic based care coordinators in care coordination skills. The curriculum was adapted by the university and WCFH/Title V staff to promote cultural competency and improve care for Alaska's CYSHCN with a focus on rural health delivery and Alaska Native populations.

WCFH continued to leverage partnerships and funding to lead the planning and implementation of a new "Help Me Grow Alaska" program for Alaska. WCFH established a contract with Help Me Grow National to receive technical assistance on the implementation of this program. A stakeholder meeting consisting of partners from throughout Alaska was held in January 2016. Four workgroups, based on the four core components of Help Me Grow, have been developed and will continue to meet in the summer of 2016. It is anticipated a soft launch will occur in the upcoming year.

The Title V program completed work on the National MCH Workforce Development Center's Cohort 2 project to improve access to TEFRA for CYSHCN needs. The CYSHCN Director and Medical Home Program Manager led a team of people representing the Division of Public Assistance (DPA), a parent of CYSHCN, and a care coordinator for a local family medicine clinic. With technical assistance from the Association of Maternal Child Health Programs (AMHCP) and North Carolina State University, a systems mapping exercise was conducted on the TEFRA application process and recommendations were made to DPA. DPA is currently undergoing an overhaul of their business processes, some which is attributed to the team's project.

WCFH and TitleV funded staff continued to be involved with the Governor's Council on Disabilities and Special Education's Autism Ad Hoc Committee. This committee drafted a new Five Year Autism Plan for the state which includes a focus on improving health coverage and services for children who experience autism. The Title V program continued to partner with and fund the Providence Autism Diagnostic Center and also sponsored the Center for Human Development (CHD) in their continued work on increasing workforce development capacity around autism. The Title V program also convened an all-day meeting of stakeholders on development of a new system for Alaska regarding screening, diagnosis, and treatment for autism. The program will continue to work in the next year on such activities as the pediatric neurodevelopmental outreach clinic, developing an enhanced curriculum for primary care providers on autism, and implementing a Project ECHO on autism for Alaskan health care providers.

WCFH continued to offer and coordinate pediatric outreach clinics for neurodevelopmental, genetics, metabolic, and cleft lip and palate disorders. Title V dollars were used to support the genetics, metabolic and cleft lip/palate clinics. These clinics will continue to foster early identification and referral and decrease the burden on families to either travel outside of Alaska for diagnoses. WCFH continued to partner with the Alaska Native Tribal Health Consortium (ANTHC) to support the attendance of a genetic counselor in the genetics outreach clinics in Anchorage, Fairbanks, and southeast Alaska. To support community-based services, the outreach clinics continued to provide interpreter services, along with culturally appropriate materials. The Title V program began working with the SouthCentral Foundation on transitioning the cleft, lip & palate clinic over to that organization's sponsorship. WCFH continued to partner with CHD to have LEND fellow placed in outreach clinics.

WCFH continued to partner with the local parent leadership group at Stone Soup Group to strengthen parent support and navigation in rural and urban communities. Title V dollars were used to partially support this parent navigation grant. This grant provided parent navigation services for children seen in the CLP and neurodevelopmental clinic, along with children identified with hearing loss in the newborn screening program.

## Cross-Cutting/Life Course

### State Action Plan Table

#### State Action Plan Table - 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

ESM 13.1 - Number of oral health pocket guides distributed

## 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 - 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

NPM 14.3 Partner with the Alaska Lung Association and the Asthma Allergy Foundation of America Alaska Chapter on educational activities about dangers of household exposure to smoke and the relationship with childhood asthma. Partnership activities may include written guidelines on asthma management in schools for school nurses, that includes education for families, and presenting CUBS data on asthma to community groups and advocates as well as to health care providers who interact with children and families.

## ESMs

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

## 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 - 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.

## Measures

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	53.0	55.0	56.0	57.0	59.0	60.0

### Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	52.0 %	1.7 %	5,719	11,000
2012	47.9 %	1.9 %	5,137	10,730
2010	45.8 %	1.9 %	4,981	10,869
2009	39.0 %	1.7 %	4,228	10,842
2008	38.4 %	1.8 %	4,054	10,566

**Legends:**

- 🚫 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% and should be interpreted with caution

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	72.0	73.0	74.0	75.0	76.0	77.0

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

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	72.1 %	1.6 %	125,411	173,948
2007	80.5 %	1.3 %	136,526	169,556

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**ESM 13.1 - Number of oral health pocket guides distributed**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	300.0	400.0	600.0	800.0	1,000.0

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	12.9	12.3	11.7	11.1	10.5	9.9

**Data Source: National Vital Statistics System (NVSS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	13.3 %	0.3 %	1,469	11,034
2013	13.6 %	0.3 %	1,510	11,145

**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

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	28.0	26.6	25.3	24.0	22.8	21.5

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

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	29.5 %	1.6 %	54,636	185,403
2007	30.9 %	1.6 %	55,821	180,508
2003	33.2 %	1.4 %	52,520	158,131

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

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

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

## Cross-Cutting/Life Course - Plan for the Application Year

### **NPM 13A** Percent of women who had a preventative dental visit during pregnancy

Among women who delivered a live birth in 2013, 52% had their teeth cleaned by a dentist or dental hygienist during their pregnancy. This indicator has increased from 38% in 2008. Factors that were significantly related to not having a teeth cleaning included lower educational attainment, unmarried marital status, and younger maternal age. Among all of the stratifier groups examined using 2012 data, having a teeth cleaning during pregnancy was least common among women with less than a high school education (31%).

To increase the percent of Alaska pregnant women and children who have had a preventative dental visit, WCFH plans to distribute Bright Futures Oral Health Pocket Guides to all providers who have the opportunity to promote children's oral health. 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. These will be distributed at the September 2016 Maternal Child Health & Immunization Conference; the All Alaska Pediatric Partnership Pediatrics Conference in November 2016; the Tribal Dental Chiefs meeting in November 2016; the January 2017 Health Summit; , and meetings of the Alaska State Dental Hygienists' Association and American Academy of Pediatric Dentistry-Alaska Chapter when scheduled in 2017. The ESM will measure the number of Bright Future Oral Health pocket guides distributed to ensure all printed guides are distributed during the five year grant period.

WCFH will also 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. The National Oral Health Resource Center provides several materials and expert panel statements that will be used as a starting point for information. These include:

- [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](#)

### **NPM 13B** Percent of infants and children, ages 1-17, who had a preventative dental visit in the last year

In 2011-2012, 72% of Alaska children ages 1-17 had a preventative dental visit in the past year (NSCH), a decline from the 81% reported in 2007. Among all of the stratifier groups 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).

To increase the percent of Alaska children ages 1-17 years who had a preventative dental visit in the past year,

WCFH plans to collaborate with the Division of Health Care Services to improve preventive dental visits with children ages 1-20 enrolled in Medicaid program. 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 with eruption of first tooth no later than 12 months). Finally, WCFH will also annually review changes in preventive dental visits for children enrolled in Medicaid as reported on the CMS 416 EPSDT performance report – Title V MCH Epidemiology staff will further monitor trends by Alaska Native Health Corporation region in addition to the statewide data on the CMS 416 report. Information from the regional data will be utilized for education with medical and dental providers in Tribal programs aimed at improving education of parents in getting Alaska Native children in for routine dental care.

The MCH Epidemiology Unit staff funded by Title V will 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. 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. The most recent CUBS oral health data sheet is available [online](#).

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 will be 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 develop an oral health strategy with school nurses and examine opportunities for school nurses to connect students to services.

#### **NPM 14A Percent of women who smoke during pregnancy**

In 2014, 13% 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. Smoking was associated with lower educational attainment, use of Medicaid, unmarried marital status, American Indian/Alaska Native race and Multiple race, non-metropolitan area residence, and participation in WIC. Women who were born outside the US were also less likely to report smoking during pregnancy compared to women born in the US. One limitation of this indicator for Alaska is that tobacco use on the birth certificate does not include chew use, which is known to be high in some rural regions of the state.

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. The ESM will measure the number of women currently pregnant or planning pregnancy enrolled in the Alaska Quit Line, with the goal of a 10% increase each year relative to the previous year. An additional planned activity of the CoIIN team includes evaluating messages on wallet-sized cards about the risks of tobacco use during

pregnancy and while breastfeeding that were printed using Title V funds and distributed during FY15 to Division of Public Assistance's WIC clinics and other locations statewide. The cards were distributed to WIC clinics statewide and partners of Behavioral Health, the Quit Line and ANTHC tobacco programs. The messages on the cards will be evaluated in the coming year.

WCFH is also continuing to partner with MOD through its CoIN collaborative to provide an evidence-based tobacco cessation program, called "SCRIPT." MOD and WCFH staff have used the SCRIPT program to conduct train-the-trainer events in Nome and Barrow and continue to provide ongoing support for those trainers. MOD continues to work with Norton Sound Health Corporation and North Slope Borough Department of Health and Social Services to support them in implementing SCRIPT. Additionally, MOD is beginning work to develop a streamlined SCRIPT curriculum in response to input from rural health staff wanting a more concise resource.

The September 2016 MCH and Immunization conference co-sponsored and co-organized by WCFH using Title V funds will include the following sessions related to tobacco use among women: "Breastfeeding in the Last Frontier: What we know about breastfeeding and substance use," and "Efforts to Understand Tobacco Use and Increase Cessation Among Pregnant Women and Adults Across Alaska."

#### **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% (52%), 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%).

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. WCFH also plans to partner with the American Lung Association in Alaska (ALAA) and the Asthma Allergy Foundation of America Alaska Chapter on educational activities about dangers of household exposure to smoke and the relationship with childhood asthma. 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 ALAA. Partnership activities may include written guidelines on asthma management in schools for school nurses, that include education for families, and presenting or disseminating CUBS data on asthma to community groups and advocates as well as to health care providers who interact with children and families.

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

#### **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. We selected a measure that focuses on prenatal depression screening because of the availability of reliable and high quality data on this particular type and timing of mental health screening through Alaska PRAMS, although this will only measure a small percentage of the total Alaskan population who is at risk for mental and behavioral health problems.

Assessing maternal mental health and referring for treatment can improve personal health as well as that of their

children and families. In 2013, 77.5% of Alaska women delivering a live birth reported being screened for depression during prenatal care according to PRAMS data. 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, however we believe that further improvements are still needed and possible and our target is 82% by 2021.

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. The primary activity specified is partnering with the Division of Behavioral Health to identify evidence based screening tools and disseminating 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.

In conjunction with DBH, WCFH will provide technical support to providers and educators implementing the use of the screening tools to ensure that the use is standardized across agencies. The September 2016 MCH and Immunization Conference conference co-sponsored and co-organized by WCFH using Title V funds will include the following sessions related to screening for depression: “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”. In addition, WCFH is partnering with DBH and the UAA Arctic SBIRT program to coordinate a six hour workshop during the conference on Screening, Brief Intervention, Referral to Treatment (SBIRT)/One Key Question for primary care clinical staff, including a group of providers and referral partners that DBH is awarding grants to. A lunch panel plenary session will be led by the SBIRT/One Key Question trainers, who will tie 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 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.

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. The Nurse Consultant II leading this effort is funded in part by Title V Block grant Funds

## **Cross-Cutting/Life Course - Annual Report**

### **Percentage of women who smoke in the last 3 months of pregnancy (retired NPM 15)**

During 2013, the percent of women delivering live births who smoked during the last 3 months of pregnancy was 13.4%, similar to 2012. However, the prevalence of smoking during the last three months of pregnancy has significantly declined over the past decade, from 17.4% in 2004. WCFH prioritized tobacco use in pregnancy as one of its Infant Mortality Collaborative Improvement and Innovation Network (CoIIN) Learning Networks. The March of Dimes is leading this workgroup which is focused on promoting the State *QuitLine* among women of childbearing age living in Nome and the surrounding fifteen villages, where tobacco use in the third trimester of pregnancy is one of the highest in the state. Other partners included the Section of Public Assistance WIC program, Section of Behavioral Health, Section of Chronic Disease Tobacco Quit Line and the Alaska Native Tribal Health (ANTHC) Consortium Tobacco program.

WCFH staff developed wallet size *Healthy Pregnancy and Beyond* cards listing resources from March of Dimes, HRSA’s Office on Women’s Health, Alaska211 resource line and the State Department of Health on Facebook. Using Title V funds, 5,000 cards were printed and approximately 2,250 cards were distributed during 6/25/14 –

6/26/15 to 18 locations statewide, including WIC clinics and partners of the Behavioral Health, Quit Line and ANTHC tobacco programs.

**Protective Sealants - The percent of third grade children who have received protective sealants on at least one permanent molar tooth. (Retired NPM 9- Similar to new NPM 13)**

There has been no new data for this indicator since the 2010-2011 Basic Screening Survey, which found that 46.8% of Alaska's 3<sup>rd</sup> graders had received protective sealants on at least one permanent molar tooth. It is uncertain at this time when funds will be available to update the dental assessment information utilizing this visual dental assessment protocol.

Brad Whistler, Dental Official, participated in a number of calls with Dr. Theresa Dulski, pediatrician and AAP-Alaska Chapter Champion for oral health on encouraging pediatrician and family practice medicine offices to implement oral health assessments and fluoride varnish application as part of well child exams on young children. Drs. Dulski and Whistler jointly presented on this information at Pediatric Grand Rounds in Anchorage in September 2014 and Dr. Dulski worked with another pediatrician in Fairbanks in 2015 to encourage pediatricians in Fairbanks to take the online training and begin providing the oral assessments and fluoride varnish for young children in that community with the reimbursement support provided in the state's Medicaid program for those procedures. Dr. Dulski plans to do another training at a Pediatric Grand Rounds in the fall/winter of 2016/2017.

The Oral Health Program, in collaboration, with that state primary care association contacted the state Medicaid director with concerns on state regulations which effectively preclude Medicaid reimbursement to FQHC/CHC dental programs for dental services provided outside the facility – including for school-based dental sealant programs. The Oral Health Program conducted the pilot sealant programs for the final year with HRSA grant funding in January – March 2015. In December 2014, CMS released a clarifying “Dear State Medicaid Director” letter which removed restrictions from billing Medicaid for school-based health services, including dental services, even if children not enrolled in Medicaid are not billed for the services – this Medicaid “free care rule” had been a national barrier to school-based dental programs. Despite the letters to the Alaska Medicaid Director and a discussion of issues with the Division of Health Care Services in the winter of 2015/2016 the Division of Health Care Services declined to take action to change the state regulation which is serving as a barrier to continue the school-based sealant programs and the pilot programs have not continued in 2016.

OHP continued work with education on community water fluoridation in Alaska. Dr. Whistler participated in a joint meeting of the Alaska Native Tribal Health Consortium and the State Drinking Water Program in the fall of 2015 which looked at developing a mechanism of supervision and changes with certification testing that could assist fluoridation of some rural water systems where there is existing community support for implementation of water fluoridation. Dr. Whistler provided notice on the CDC final adoption of the 0.7 mg/L target concentration level of fluoride for community water fluoridation systems in August 2015. Dr. Whistler plans to provide education of water operators on daily operational guidelines on the range of acceptable variation in fluoride concentration when CDC adopts final guidelines on that aspect of water fluoridation – Dr. Whistler plans to encourage systems to improve the situation in some fluoridating systems in the state where daily readings on fluoride concentration are falling below 0.6 mg/L. In the 2015-2016 period none of Alaska's fluoridating systems discontinued fluoridation and the state saw the following systems resume with optimal fluoride levels for prevention of dental decay at: Fort Greely, Toksook Bay and Girdwood. The Municipality of Anchorage water system, Alaska's largest public water system, was offline for water fluoridation for several months the winter of 2015/2016 – the MOA water system was not optimal for calendar year 2015 due to this situation but has resumed operations with fluoridation in 2016 after repairs were completed.

**Tooth decay (3 yrs) - Percent of mothers who report tooth decay in their 3-year old child. (Retired SPM 3- Similar to new NPM 13)**

The indicator is from the Childhood Understanding Behaviors Survey (CUBS) for mothers reporting a health care provider has indicated their child has tooth decay or cavities (for 3-year old children). The CUBS program, including

both operational expenses and staff time, is funded by Title V. CUBS data from 2014 indicated 17.5% of mothers reported they had been told by a health care provider that their 3-year old had dental decay – which is similar to previous years. This indicator would typically under-report dental decay (caries) prevalence as many children under age 3 have not received a dental visit, the information would not include caries developed since a previous dental screening/exam and/or the mother may not remember what the child's health care provider indicated with respect to dental decay. However, it is likely part of the increase seen with 2011-2013 CUBS data is related to reported increases in the percent of children receiving a dental check-up or teeth cleaning (58.2% in 2014; 52.9% in 2013, 55.2% in 2012 and 53.8% in 2011 as compared with 42.8% in 2010, 45.4% in 2009 and 35.7% in 2008). Dental assessments utilizing the Basic Screening Survey (BSS) protocol for Alaskan kindergarten children, an older age group than for this indicator, found 48% had caries experience (treated or untreated dental decay) in 2005; 41% had caries experience in the 2007 BSS; and 41% with the 2010/2011 BSS.

The OHP in partnership with the State Primary Care Office completed the initial analysis on hospital general anesthesia (GA) cases for treatment of early childhood caries (ECC) from reporting hospitals in the state's hospital discharge database. During calendar year 2012 there were 1,523 of these cases for children through age 8 years in the reporting hospitals (the database did not include reporting from hospitals in Wrangell and Ketchikan or Tribally-operated hospitals besides the Alaska Native Medical Center in Anchorage). Since this report was generated, new requirements have been implemented for all hospitals to report to this database. The OHP plans to update reports on annual GA cases for ECC treatment for years with all facilities reporting and work with the MCH Epidemiology unit to prepare a disease bulletin on this topic. The OHP attempted to get similar information from Medicaid claims on GA cases for ECC treatment reimbursed by Medicaid, however the project is still ongoing at the time of this report.

#### **Postpartum depression - Percent of women who delivered a live birth and had a provider talk to them about postpartum depression since their new baby was born. (Retired SPM 7)**

The percent of women who delivered a live birth and who reported that a provider talked with them about postpartum depression since their new baby was born significantly increased during 2009-2013, and was 86.1% in 2013. The activities related to this retired SPM are discussed above, as it is very similar to new SPM 4.

WCFH continued to focus efforts related to perinatal depression on the two home visiting grants for Healthy Start and the Maternal, Infant & Early Childhood Home Visiting (MIECHV) programs. Healthy Start is located in Nome and administered by Norton Sound Health Corporation (this grant ended May 31, 2016). Providence In-Home Services provided the Nurse-Family Partnership (NFP) model of home visiting in the Municipality of Anchorage (MOA) and expanded to the Mat-Su Borough in 2015. These home visitation programs provided screening and referral for depression.

The MCH Epidemiology Unit in WCFH conducted the ongoing PRAMS and CUBS surveys, which include questions related to maternal depression, and responded to data requests.

#### **Other Programmatic Activities**

##### **Maternal/Women's 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 2014, the WCFH Adult Health Services Unit (ADHU) started a pilot project with Hope Community Resources (Hope) to better determine the breast cancer screening rate among women with intellectual disabilities. ADHU staff initially tried to access Medicaid data to determine if Alaskan women with disabilities have a different breast cancer screening rate than Alaskan women without disabilities. When that data couldn't be confirmed, Hope was interested and willing to participate in a health fair, coordinated by the University of Alaska Anchorage Nursing program that was designed to include all Hope clients with disabilities. Additionally, Hope nurses would conduct a chart review to determine the percentage of clients having received preventive health visits per recommended schedules. Upon completion of the project, it was determined that Hope clients were very engaged in the health fair, but that Hope staff did not have the time to coordinate the health fair each year. Also, the Hope nurses found that their charts did not include information regarding preventive health visits for their clients. The outcome of this project was the development of a form to be included in the charts of the Hope clients so, in the future, the staff could better determine whether or not preventive screenings were being completed on schedule.

The BCHC 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. (See "Plan for the Application Year", Women/Maternal Domain, NPM 1.) 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.

### **Perinatal/Infant Health**

Since 2014, Alaska has participated in the national Collaborative Improvement and Innovation Network (CoIIN) to reduce infant mortality. Staff from State Title V (STV), 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.

STV CoIIN reduces infant mortality by focusing on SIDS/SUID/Safe Sleep, Smoking Cessation and Preconception/Interconception Health. Also addressed are infant fatalities where impaired adults are a factor.

HRSA funds support the Alaska Maternal, Infant & Early Childhood Home Visiting (MIECHV) program. WCFH partners with Providence In-Home Services to implement the Nurse-Family Partnership (NFP) model. Services are provided in the Municipality of Anchorage and Mat-Su Borough. As of 2016, 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 well-child visits, educational attainment, referrals for intimate partner violence, and post-partum visits. Partnering with University of Alaska-Anchorage Institute of Social & Economic Research, Alaska MIECHV is doing a study of father engagement strategies used by the NFP nurse home visitors. The study will be completed in 2017. In collaboration with CoIIN, Alaska MIECHV conducted a PDSA cycle on a Safe Sleep Risk Assessment form which will be adopted by the program

HRSA funding for the Norton Health Sound Corporation Healthy Start program ends May 31, 2016. Some services will continue with Medicaid support.

In 2015, Title V was a part of a workforce development project funded by the National MCH Workforce Development Center. The goal was to help prepare states as they work through health care transformation. Alaska's focus was

assessing and improving the Medicaid application processes for pregnant women (MAGI) and children with special health care needs (TEFRA). STV assembled a team co-led by the CSHCN Director and the D70 Medical Home Program Manager. The team included participation from STV, Department of Public Assistance (DPA), a care coordinator at a local practice, and a parent of CSHCN. With technical assistance provided by AMCHP, NASHP, and North Carolina State University, the team conducted a value-stream mapping of both processes. The group created a list of recommendations for DPA advising training and PDSA cycles. The outcome was that DPA elected to do value-stream mapping exercises for all application processes. Now, in 2016, DPA has a timeline for implementation of a new application system.

### **Child Health**

Activities around the prevention of deaths to children aged 14 years and younger caused by motor vehicle (retired NPM #10 for reporting years FY2014-2015) were primarily accomplished by Alaska's Injury Prevention (IP) program, located in the Section of Chronic Disease Prevention and Health Promotion (CDPHP). The IP program continued its supporting role with the Alaska Child Passenger Safety Coalition (CPSC). The Bike-n-Walk Safely Alaska program continued to disseminate retro-reflective materials, but grew to include safety training in many other situations that require a safe balance between pedestrians, bicyclists and drivers. School demonstrations on safety were provided, as well as technical assistance to communities that want to improve safe conditions for their residents who walk and ride bicycles. In FY15 approximately 6,500 pieces of conspicuity and educational materials were distributed as well as 20+ toolkits.

The Obesity Prevention and Control Program (OPCP) in the Section of CDPHP had primary responsibility for activities not previously mentioned in the Annual Report section that addressed former SPM #9, overweight and obesity among 3-year-olds. The OPCS provided professional development (PD) opportunities to health and PE educators, school administrators, and school nurses. The PD focused on improving student health and academic achievement by passing policies that ensure quality PE, comprehensive physical activity opportunities, nutrition education, availability of healthy foods, and prohibit the sale of unhealthy foods. The Early Care and Education (ECE) component of the OPCS focused on improving physical activity and nutrition policies in child care centers to improve health.

The percent of children ages 2-5 years receiving WIC services who had a BMI at or above the 95th percentile was 23% in 2015, about the same level as in 2014 (former NPM 14). In FY15, Alaska WIC implemented additional changes to the food package to support goals of obesity prevention and reduction. Low-fat dairy, additional whole grains, yogurt and limited cheese provided through the food package helps further WIC's goal to reduce obesity with healthy food options. WIC continued to play a role at the state-level to increase breastfeeding rates, reduce obesity through partnerships with the Alaska Breastfeeding Coalition, local breastfeeding coalitions, and Title V staff.

### **Adolescent Health**

The AHP program staff will facilitate at least three Youth Mental Health First Aid 8-hour courses, training approximately 75-100 participants. Youth Mental Health First Aid is designed to teach parents, family members, caregivers, teachers, school staff, peers, neighbors, health and human services workers, and other caring citizens how to help an adolescent (age 12-18) who is experiencing a mental health or addictions challenge or is in crisis. The course introduces common mental health challenges for youth, reviews typical adolescent development, and teaches a 5-step action plan for how to help young people in both crisis and non-crisis situations. Topics covered include anxiety, depression, substance use, disorders in which psychosis may occur, disruptive behavior disorders (including ADHD), and eating disorders.

Additionally, 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.

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 the NPM and SPM 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. 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 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.

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.

Suicide prevention activities (retired NPM#16) are primarily accomplished through a partnership with the Division of Behavioral Health's (DBH) Comprehensive Behavioral Health Prevention & Early Intervention Services (CBHPEIS) Program. The CBHPEIS is the state's largest prevention program that serves Alaskan communities addressing a variety of behavioral health problems and conditions such as substance abuse, mental health and suicide. In FY14, seven grantees prioritized suicide as their leading prevention focus and employed strategies that were designed to create both short-term and long-term outcomes in reducing suicide. In addition, many of these grantees are working to increase protective factors, promote resiliency and community wellness. New peer leadership programs were also introduced in order to expand universally driven approaches that help to guide social norms and increase help-seeking behaviors especially among youth who may be at risk of suicide. DBH also continues to disseminate and deliver postvention resources to grantees, groups and communities who are seeking technical assistance, support and guidance in responding to completed suicides. The Division is also working on completion of a DVD, “Preparing to Heal” (a companion to our Alaska Postvention Resource Guide) which will be directed to outreach and care providers in order to support community postvention planning and response teams. DBH will continue media and information campaigns that increase awareness, reduce stigma associated with depression and suicide, and promote help-seeking behaviors. This will also include continuation of the “Text 4help” campaign. Although the AHP has been integral in the development of the Healthy Alaskans 2020 work on violence and suicide prevention, collaboration with the DBH on suicide prevention has included direct training of program staff on Youth Mental Health First Aid and consistent communications with DBH. This work impacts new NPM 7, rate of injury related hospital admissions per population 0 thru 19 years. This work has been funded through sources other than Title V.

### **Children with Special Health Care Needs**

The Alaska Health and Disability Program (AHDP) is co-located with Title V in WCFH and partnered with Title V to accomplish many activities that addressed the needs of CYSHCN during this reporting period. First, AHDP developed its three year strategic plan spanning state fiscal years 2015-2017. This plan was the culmination of two years of research (needs assessments), multiple periods of stakeholder input, and partnership building. Second,

AHDP responded to 117 technical assistance requests (a 400% increase from the previous reporting period) ranging from training to education to resources on topics such as emergency preparedness and health promotion. Additionally, AHDP conducted 25 trainings on the following topics: emergency preparedness for adults with disabilities and CYSHCN, men's health, sexual health, universal access, abuse prevention and intervention, preventive health screenings, diabetes and disability, and nutrition and physical activity. Finally, through a contract with a nationally certified Adapted Physical Activity Consultant, AHDP completed three adapted physical activity workshops for school staff in Juneau, Fairbanks, and Bristol Bay. These workshops resulted in 154 teachers, administrators, and other staff from 52 schools receiving training in adapted physical activity that will benefit approximately 2,000 CYSHCN.

The Alaska Birth Defects Registry (ABDR) is statutorily mandated to collect and maintain a registry of all birth defects occurring in Alaska. These data are used to inform the overall system of care for Alaska's MCH population, in particular services for children with special healthcare needs due to 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. Title V funds support this registry and the work conducted through it. During the reporting period ABDR activities included:

1. The development of new methodology to conduct birth defects surveillance. The prior methodology was archaic and resulted in suspect information with systematic reporting differences and a lengthy lag period (six-years) for reporting. These issues greatly limited the utility of these data. The new methodology that is being rolled out utilizes primary sources (such as Medicaid, Hospital Discharges, and major health care centers) and reduces the reporting period to 3 years.
2. Improvement and streamlining of data collection and storage to facilitate more timely annual report development and disparity investigations.
3. We enhanced the passive reports by sampling specific conditions and through medical abstraction determined the error in reported vs confirmed cases. Most recently we reviewed a sample of Microcephaly and found that our reported estimate indicated that Alaska had a rate twice the national average. After adjusting for the reporting error we found that the rates in Alaska are equivalent to the national average. This is incredibly important for some conditions that are susceptible to miscoding and misclassification to ensure we correctly allocate resources to address issues facing CYSHCN.
4. This system is also used to respond to legislative and media requests. Most recent data requests include fetal alcohol syndrome and congenital diaphragmatic hernia.
5. Finally, during this period we began developing an annual statewide and regional report that is based on geospatial mapping.

### **Life Course**

The Title V funded School Nurse Consultant assisted with Department-wide efforts to address the ongoing opioid epidemic and conducted research into whether school nurses should stock Naloxone and the associated logistics. 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). As Alaska's number one cause of preventable death continues to be tobacco use, estimated at 573 deaths in 2012, the 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).

## 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 making for long work hours and difficulty covering for vacations. One critical shortage is Pediatric Neurodevelopmental care. The state's only PND works part time and will be retiring in June 2016. Without this specialty in Alaska, children needing diagnoses could 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. For example E-ICU coverage is available between a tertiary medical center and secondary hospitals outside of Anchorage. Billing on a fee for service model, licensure requirements, and siloed telecommunication systems are three significant impediments to expansion of this technology.

### *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 will be held for the fifth time in September 2016 and will offer continuing education credits for physicians, nurses, and tribal community health aides. In 2014, 256 people attended the conference with over 100 of the attendees being nurses. Others included MCH program managers, researchers, physicians, and community health aides. This year's conference includes plenary presentations on the importance of preconception care, vaccine hesitancy and successes, family violence and parental mental health, and opioids. Presentations are selected from a statewide abstract submission process as well as through targeted outreach to experts to support training and educational needs on emerging topics such as Zika.
- A WCFH Nurse Consultant is coordinating a workshop on Screening, Brief Intervention, Referral and Treatment (SBIRT)/One Key Question that will be offered as a 6 hour course over two days during the MCHI Conference. The training is designed for primary care clinical staff and participants are being recruited by the Division of Behavior Health and the University of Alaska Anchorage Arctic SBIRT program. The training will provide an overview of the issue of substance use in Alaska and the need for evidence-based screening, assessment and referral for the perinatal population.
- 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.
- To address the pending retirement of the state's only Pediatric Neurodevelopmental specialist, during summer and fall 2015, Title V and other state staff, members of AAPP, a number of community pediatricians, agency staff and university staff worked by teleconference with physicians and LEND directors from the Universities of Massachusetts, Utah and Washington to develop a plan for training of primary care physicians, nurse practitioners and physician assistants to diagnose autism in children who are less complex and develop a

system of ongoing care supports to enable children with this diagnosis to stay in their home community and receive ongoing health care and treatment. National experts were invited to a face to face planning day in November 2016 to meet with the Alaska stakeholders. Two of the invited experts also presented at the AAPP Conference the following day.

- 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.
- WCFH looks for opportunities to align its work and priorities closely with tribal health entities. Recruitment of pediatric sub specialists and maternal fetal medicine specialists has occurred collaboratively between tribal leadership and the private sector health care institutions in part due to the ongoing encouragement and sponsorship of meetings by the MCH Title V Director.
- The CYSHCN Director completed AMCHP's Leadership Institute for new CYSHCN Directors and the New Director Mentor Program (NDMP). The Leadership Institute provides training and technical assistance to new Directors on leadership strategies along with developing knowledge, skills, and abilities related to CYSHCN.
- The MCH Epidemiology Unit Manager and the Health Program Associate for the EHDI program (Alaska's Title V Family Delegate) were accepted into the MCH Epi Peer-to-Peer cohort and the Family Leaders cohort of the 2016 AMCHP Leadership Lab. The Leadership Lab is a developmental activity for Title V staff from across the workforce to learn from each other and provides opportunities to learn from role-based peers. The Lab includes a one-day workshop following the AMCHP conference and multiple interactive webinars and teleconferences over a 10 month period.

#### *Changes to the workforce funded by Title V:*

The Section of WCFH was formed in 2005 with 15 FTE's and has expanded its staff to nearly 50 FTE's as of SFY15. Funding cuts to state GF resulted in holding four positions vacant most of SFY16. It is anticipated that this will continue for SFY17 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 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 are well qualified to deliver services and programs required by Title V as well as our other grant and special funding streams. Fifteen staff members have a master's in public health or public administration, education, biostatistics, planning or nursing. Seven staff members have double master's degrees, one staff member has her PhD and another is completing his PhD. There are also several health care professionals on staff including one family nurse practitioner, 5 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. Ongoing professional 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. All staff members regardless of their position or degree are provided training stipends for public health or clinical conferences.

- In June 2015 a senior epidemiologist with a nursing background and PhD in epidemiology retired. The Research Analyst III in the MCH Epi Unit, a Masters-trained epidemiologist, was promoted to replace her in September 2015. This position is 20% Title V funded.

- The RAIll position was vacant for several months while the Position Description was updated and the position was reclassified to an RAI. The RAI supports data needs for ColIN 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 another internal promotion.
- The longtime manager of the MIMR-CDR program retired in June 2015 and the position was reclassified as a Epidemiology Specialist I (ES I). An ES I from another section transferred to the position in September 2015. Although the MIMR-CDR manager position was previously 100% Title V funded, the MCH Epi Unit was awarded a grant from CDC to support the SUID Case Registry in September 2015, which covers 25% of the ES I salary while Title V funds the remaining 75%.
- A Health Program Associate position (100% Title V funded) that supports MIMR-CDR 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 will retire in August 2016. The position is anticipated to be filled prior to her departure.
- The Perinatal Nurse Consultant (20% Title V funded) retired in May 2016. The position was filled in the same month by a nurse who had been in Nome working for the Section of Public Health Nursing and had previous experience as a nurse home visitor. This position is the lead on the infant safe sleep project and assists with other Title V projects.

*Critical workforce development and training needs of state Title V staff*

- Leadership development for staff is a priority activity. Assuring that leaders are proficient coaches for employees is a need, in particular as more millennials are hired on as junior professional-level staff. Millennials want their work to make an impact; they are tech savvy, racially diverse, educated, like to collaborate, and expect constant coaching and feedback. In order to retain young staff and develop future leaders, current WCFH leadership could use additional training in coaching this next generation and inspiring others with a shared vision.
- Needs around understanding and being proficient in alternative communication platforms to receive and transmit information to younger audiences and staff (blogs, webcasts, webinars, social media, conference calls, and emails.)
- Ongoing needs include updates to strategies to monitor and evaluate programs and advanced analysis skills for epidemiologists to support the volume of data needed by WCFH program staff and to support ColIN activities. Training on using Medicaid data for MCH surveillance and evaluation purposes is needed.
- Technical assistance and training such as that offered by the MCH Workforce Development technical assistance grants on the use of quality improvement tools and real life application are extremely beneficial. Finding opportunities to carry out this work and include other federal grantees such as Title X, SAMSHA, Bureau of Primary Care and Centers for Medicaid and Medicare are also very important to linking this work with other funders who have similar goals and interests.

### **II.F.3. Family Consumer Partnership**

Alaska parents, providers, and communities are actively recruited to help set health care priorities. Since 2014, WCFH has 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 WCFH and the related programs funded by Title V as well as the Medicaid agency 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. For example, the 2015 survey showed significant declines from the patient perspective in a wide range of areas related to care for children. While reasons for this decline are unknown, consistent and meaningful data collection to monitor family/patient experience and identify areas for improvement are essential for MCH populations and activities funded by Title V and other sources. The Title V funded MCH Epi Unit and Medicaid are working to identify sustainable data analysis capacity options since, to date, specialized analysis of the data has been contracted by an out of state vendor with limited availability.

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 2015-2016, the group provided strategic planning feedback on bullying prevention and healthy relationships promotion through the Youth Health Resource Interviews, and in a separate assessment, through the Community Assessment on Resources for Healthy Relationships. Eight members were engaged in this partnership during the 2015-2016 school year from various areas of the state. Each member participated in a day and a half of orientation in September 2015 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 2015-2016, 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, 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.

Alaska continued to sponsor pediatric outreach clinics for autism and neurodevelopmental disorders, genetics, metabolic, and cleft lip and palate disorders. Family navigation services are provided at the Cleft and Neurodevelopmental Clinics using some block grant funds. All specialty clinics collect 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 participate in a project in which parent surveys collect data on parent thoughts and attitudes related to the services provided. The first report has been issued and helps to 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.

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. The EHDI program also employs a staff member who is the parent of a CYSHCN and also a member of The LEND Family Advisory Council. In FY16, he became an AMCHP Family Delegate/Family Leader whose emphasis is family engagement. The work of this committee helps to assure among other strategies, that children are screened and

diagnosed within the time frames set out by the Joint Committee on Hearing and Interventions and are linked with treatment and early intervention (zero to three) programs. Their input helps to improve ongoing systems building to assure access to well child visits and developmental screening, two of Alaska's Title V performance measures. The Alaska Health and Disability Program (AHDP) Committee continually reaches out to Alaskans with disabilities and family members of Alaskans with disabilities. Currently, 27 of the 57 members are Alaskans with disabilities or family members of Alaskans with disabilities.

As a part of the D70 Systems Integration grant, the Title V program developed a state plan for CYSHCN. This was done in collaboration with multiple stakeholders and with parent input. Along with parents who have historically worked with the Title V program, new parents were identified to be a part of this assessment and strategic planning effort, including foster parents and families from outside Anchorage. Their input helps to identify unknown gaps in service or system issues along with the planning efforts to launch Help Me Grow, a system that connects at-risk children and families with services.

In the Maternal, Infant, & Early Childhood Home Visiting program, parent/consumer involvement is valued. The nurse home visitors in the Providence Nurse-Family Partnership program complete client satisfaction surveys through the client's course of the program. The team conducted a PDSA cycle on using mobile technology to increase client participation in surveys. The survey results are used for quality improvement, professional development, and program planning activities. Parents, along with other family members or close friends, continue to participate in client events and graduations.

Family input and involvement was a core part of Alaska's 2015 Needs Assessment to advise priority setting for Title V activities for 2015-2019. An online survey was developed to solicit input. Among 1037 responses to the survey, 158 were from people who identified themselves as a "parent/guardian," and 172 identified as an "Alaska resident".

#### **II.F.4. Health Reform**

In July 2015 Alaska's Governor announced a decision to move forward with the Medicaid expansion under Executive authority. The Senate-House Legislative Council filed suit against the Governor claiming lack of authority to implement the Medicaid expansion without legislative approval. In March 2016, a Superior Court judge dismissed the lawsuit to halt the Governor's Medicaid expansion, concluding the state acted within the bounds of the law in doing the expansion. The 2016 legislative session did not result in action for legislative authorization of the expansion and included discussion by the members of the majority party to move forward with appeal of the Superior Court decision to the Alaska Supreme Court. On June 29, 2016, the Alaska Legislative Council voted to end its lawsuit challenging the expansion, opting not to pursue an appeal.

By May 2016, more than 17,700 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.

Children clearly represent the majority 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.

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 Alaska will be Premera Blue Cross Blue Shield.

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 the Division of Public Health 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 continue to work with the DPH Director's office to pursue adoption of this policy for all Division grants and contracts.

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. WCFH staff members that include the Title V staff will continue to present their ideas and accompanying data to help influence some of the proposed changes at the state moves forward.

SB 74 included provisions to:

- 1115 demonstration waivers to explore models of primary care case management and/or managed care/coordinated care organization delivery models;
- 1115 waiver focused on behavioral health services and continued support for Community Mental Health Clinics including shifting funds from state-funded behavioral health grants to Medicaid funding for the services;
- 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;
- 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.

#### II.F.5. Emerging Issues

- Budget cuts: Cuts to state general funds will continue to be a barrier. This requires strategic planning and program prioritization to ensure WCFH is utilizing resources in the most effective manner. Difficult decisions will need to be made in the next year that will affect service delivery to the state's MCH and CYSCHN population. Cuts of 25% will be experienced by the Section of Public Health Nursing which provides the safety net of primary and secondary intervention to the state's most vulnerable residents. There will be at least one health center closing in FY17 and several public health nursing positions will remain vacant or be eliminated due to the state general fund cuts.
- 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 the Division of Public Health 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: Alaska is increasingly turning its focus on early intervention. Current laws and regulations that support early intervention include universal newborn metabolic screening, newborn hearing screening and critical congenital cardiac screening. Early screening for autism and other neurodevelopmental disorders is also a priority. Early intervention can significantly improve a child's outcome for school readiness and general health. Lack of funding continues to be a barrier to effectively implement all aspects of early intervention, data collection and surveillance, evaluation of the program and reporting.
- 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. Challenges exist on how best to support families who may have a child with these conditions, which may not have a cure. Alaska will also continue to have challenges with transport times of the bloodspot specimens. WCFH does not have the financial capacity to cover the shipping costs of these specimens, as had been the case years ago. The State of Alaska must contract with a public health lab outside of the state, as there is no financial capacity to do the screening in-state, which increases transport time. The large geographic area of the state, along with harsh weather conditions, creates barriers to improving timeliness.
- School health: The increase of chronic conditions among school age children, such as asthma, life-threatening allergies, seizures, autism, and diabetes, will require school districts to develop capacity to meet the medical needs of children during the school day. Currently, the capacity does not exist in the smaller school districts and the capacity in some of the larger school districts will be compromised by current budget cuts with proposed decreases in school nursing services.
- Marijuana: Medical marijuana has been legal in Alaska since 1998. In November 2014, Alaska voters approved an initiative legalizing recreational marijuana use; in late 2016 sale of marijuana by licensed retail businesses will be legal. 2012 PRAMS data indicate that 4.9% of pregnant women reported use during pregnancy. Use reported among WIC pregnant clients was 8.5% and reported use among women living in the

Northern and Southeast regions was nearly twice that of statewide rates. Current studies indicate that prenatal cannabis exposure is associated with an increased risk of neurobehavioral problems in offspring, including issues with attention, memory, and problem solving. Additional studies are needed to determine the health impacts associated with marijuana use around the time of pregnancy. In addition to utilizing PRAMS to examine trends in marijuana use during pregnancy, the CUBS survey is adding a question to examine the behavior among mothers of 3-year-olds. During SFY16, the adolescent health program in WCFH educated parents/caregivers through [websites](#), [fact sheets](#), and a parent/caregiver guide about legalized recreational marijuana in Alaska and the potential consequences for young adults.

- Opioids: There is a growing concern about Neonatal Abstinence Syndrome (NAS) and use of opioids during pregnancy and while parenting. Title V MCH-EPI staff conducted a review of Hospital Discharge and Medicaid claims data and identified a statistically significant increase in Alaska's NAS rates. WCFH staff will continue to participate on a community-initiated NAS workgroup that seeks to address issues of opioid use among pregnant women. The MIMR-CDR committee recommended universal screening for substance use among this population. The NAS workgroup concurred with this recommendation and researched and proposed that the State work to have all birth centers use the evidence-based 4 Ps Plus screening tool for all women being admitted for delivery. In addition, the NAS group recommended the state provide leadership for screening and data collection to catalogue and describe this growing health problem.
- Cervical Cancer: During 2000-2012, the percentage of Alaskan women aged 18 years or older who reported on the BRFSS that they received a Pap test within the last 3 years decreased from 91.5% in 2000 to 87.0% in 2012. In 2014, the data was limited to women 21-64 in order to better fit the new USPSTF screening recommendations. The data showed that 77.9% of women 21-64 had received a Pap test in the last 3 years. Decreasing colorectal and cervical cancer was identified in the 2016-2020 Strategic Plan for the Division of Public Health as a winnable battle. Screening, through the Pap test and the human papillomavirus (HPV) test, significantly reduces mortality from cervical cancer through early detection and treatment. Alaska's Breast and Cervical Cancer Early Detection Program (BCHC) is housed in WCFH and provides funding for breast and cervical cancer screening and diagnosis for women aged 21-64 years with limited incomes who have little or no health insurance. Over the next couple of years, the BCHC program will focus their efforts on novel ways to identify late or never screened women across the state.
- Behavioral Health and Primary Care Integration: 2016 "Medicaid Redesign" legislation has prioritized integration of behavioral health and primary care services. Title V CYSHCN staff have been involved with an interdepartmental workgroup over the past year seeking to offer policy and practice recommendations related to behavioral health and primary care integration. Title V staff represent MCH populations to promote the overarching workgroup goal of "all Alaskans will have ready access to a full range of health care services regardless of the point of entry."

#### **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, DHSS Facebook and Twitter 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
- PRAMS Steering Committee
- EHDI Steering Committee
- School Health Nurse Advisory Committee
- March of Dimes Committee
- Stone Soup Group Families
- Community Health Center Program

A copy of the Executive Summary is attached in Chapter III. C. Executive Summary. During June and July 2016, 23 people responded to the online survey and provided feedback to questions about the strategies and objectives for each domain. All 23 public comments can be reviewed in Attachment 4, which organizes the comments by population domain. Each population is introduced by a visual “Wordle” representation of the most common words within the qualitative survey results.

#### **II.F.7. Technical Assistance**

Some potential areas of needed technical assistance as we work on our five-year Action Plan include:

- Training in understanding and becoming proficient in alternative communication platforms to receive and transmit information to younger audiences and staff (blogs, webcasts, webinars, social media, conference calls, and emails.) This would assist with work around promoting healthy relationships and protective factors among youth, as well as disseminating a population based campaign for the primary prevention of child maltreatment.
- Strategies to monitor and evaluate programs and advanced analysis techniques for epidemiologists to support the volume of MCH and CYSHCN data needed by WCFH program staff and to support the ColIN activities. The most effective use of funds would be to hire a consultant to come to Alaska who could conduct a training for multiple staff here, rather than sending Alaska staff to training courses elsewhere.
- Training on querying and analyzing Medicaid claims data for MCH surveillance and evaluation.
- Facilitation of a strategic planning process to align Healthy People and Healthy Alaskans 2020 with Title V Block Grant goals and strategies.
- Technical assistance to assess the current status of culturally and linguistically responsive services in Alaska’s MCH program and to identify potential strategies to address gaps. Potential cultural competence training (either by web or in person) could include writing publications and educational materials in “plain language”,

understanding MCH/adolescent/adult beliefs and practices of Alaska's most common ethnic minority populations (Alaska Native as well as other populations) as well as people with disabilities, and cultural humility.

Additional requests for technical assistance will be made as the needs arise.

### III. Budget Narrative

	2013		2014	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$1,091,900	\$1,009,552	\$1,008,498	\$1,050,528
Unobligated Balance	\$0	\$0	\$0	\$0
State Funds	\$17,372,096	\$16,294,188	\$14,766,425	\$18,298,931
Local Funds	\$0	\$0	\$0	\$0
Other Funds	\$0	\$0	\$0	\$0
Program Funds	\$100,000	\$100,000	\$90,000	\$113,148
SubTotal	\$18,563,996	\$17,403,740	\$15,864,923	\$19,462,607
Other Federal Funds	\$6,711,300	\$6,711,300	\$6,441,474	
<b>Total</b>	<b>\$25,275,296</b>	<b>\$24,115,040</b>	<b>\$22,306,397</b>	<b>\$19,462,607</b>

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.

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$1,043,564	\$1,043,564	\$1,050,528	
Unobligated Balance	\$0	\$0	\$0	
State Funds	\$14,504,339	\$14,089,787	\$14,471,700	
Local Funds	\$0	\$0	\$0	
Other Funds	\$0	\$0	\$0	
Program Funds	\$140,000	\$100,000	\$100,000	
SubTotal	\$15,687,903	\$15,233,351	\$15,622,228	
Other Federal Funds	\$6,765,745	\$4,428,446	\$5,922,338	
<b>Total</b>	<b>\$22,453,648</b>	<b>\$19,661,797</b>	<b>\$21,544,566</b>	

	2017	
	Budgeted	Expended
<b>Federal Allocation</b>	\$1,050,524	
<b>Unobligated Balance</b>	\$0	
<b>State Funds</b>	\$14,169,000	
<b>Local Funds</b>	\$0	
<b>Other Funds</b>	\$0	
<b>Program Funds</b>	\$30,000	
<b>SubTotal</b>	\$15,249,524	
<b>Other Federal Funds</b>	\$6,091,206	
<b>Total</b>	\$21,340,730	

### III.A. Expenditures

#### Expenditures (2016 Narrative for FFY 2015=SFY2016)

The Alaska Title V program experienced a decrease in state general funds in SFY16 by close to 15% 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 again budgeted in SFY16 to support the state priorities identified in the MCH 5 year needs assessment. State general fund maintenance of effort dollars come in large part from the appropriation for the infant learning program, the Women, Infant and Child (WIC) nutrition and Immunization program. Also included in the MOE reporting are dollars from a designated general fund/ mental health appropriation, Mental Health Trust authority, interagency receipts from the Division of Public Assistance, a percentage of designated general fund appropriation for child protection and program receipts.

Ongoing fee collection for the specialty clinics is important to the MCH Title V program and provides about 100K per year, however this covers less 20% of the cost of providing these clinics across the state of Alaska. Fees 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. In addition, gap filling services such as these are supported through a combination of state general fund dollars, program fees, and Medicaid administrative claims. Title V dollars are used to pay for staff to coordinate the clinic, travel staff and contracted physicians to the sites and for contracts for medical and other specialty providers. Title V funds are not used to pay for Direct services as listed on 3b of the financial expenditures page. With the state experiencing a \$4 billion dollar deficit in SFY2017 and a compounded deficit for SFY2018, state programs will be under increasing pressure to reduce their expenses by terminating programs and laying off employees. Affecting a positive outcome and maintaining programmatic missions will pose significant challenges in the coming years, particularly if the legislature does not develop a more mixed revenue structure to support government services.

It cannot be underestimated how important federal grants are to providing the infrastructure to carry forward the

state's MCH priorities. The Alaska MCH/CYSCHN programs moved away from direct services nearly 15 years ago and has since provided dollars for linking services, technical assistance and infrastructure support for data surveillance and analysis, and , program evaluation. Gap filling services have been offered in the areas of Cleft Lip and Palate, 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 Alaska Infant Safe Sleep program, preconception health promotion, 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 program 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. Funding from the Mental Health trust Authority supplements work on autism systems building efforts. Finally, funds are received via an RSA's from Emergency and Disaster Planning to help build improved programs and systems for people with disabilities. We have particularly focused on pregnant women, infant and children/adolescents with special conditions in the planning and sheltering in times of a disaster.

The Alaska Title V expenditures represent actual expenditures at the time the report was prepared.

### **III.B. Budget**

#### **Budget (2016 Narrative)**

#### **Budget in FY 17**

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 a 15% reduction in our state general fund appropriation in SFY16. A budget bill was signed for SFY2017 on the last day of the state fiscal year and the Section of WCFH experienced only a slight reduction. The legislature and the governor continue have divergent views on how to balance the state budget and what the long term fiscal strategy should be. The legislature is due to go back into a second special session beginning the middle of July. It is anticipated that ongoing travel and hiring freezes will stay in effect for the duration of SFY17 and that open positions will likely be terminated over time. Additional general fund reductions could 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.

Several new federal grants were applied for and as of this date, we were notified of one grant that was approved but not funded. Notification of other awards will not come until August and September. On a positive note, one of our sister agencies was awarded the highly competitive Early Childhood Comprehensive Systems grant (ECCS) with a significant boost to the base funding. The lone ECCS staff member is now co-located in our office which enables us to work closely with her and manage our programs in an even more collaborative manner.

Programs at risk include the Oral Health program which currently is funded with state general fund and the position is in place in a different community (Juneau) than the rest of the programs in WCFH. Long term funding for the position is in question once the long term staff member retires in SFY18. Several positions in the Section of WCFH were held vacant in anticipation of federal and state reductions in funding. 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 from the prior year where there were also 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 will 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 budget for next reporting year was kept fairly constant anticipating flat funding for the block grant and anticipated reductions in program receipts. The Cleft Lip/Palate clinic will be transitioned to South Central Foundation, the tribal health arm of Cook Inlet Tribal Council as of September 1, 2016. The tribal health entity will continue to offer multidiscipline team planning to all children regardless of their non Native Alaskan status. The transition of other clinic services is under heavy consideration. More about this will be reported on in the next Title V Block grant submission in FY 18. State general funds used for maintenance of effort were budgeted also at a slightly reduced level. The new state accounting system implementation has been challenging and has not provided expenditure tracking as hoped. Modifications are in the works that are anticipated to improve expenditure tracking.

#### **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 - [CombinedOrgCharts2016.pdf](#)

Supporting Document #02 - [MCH Epi publications\\_June 2016.pdf](#)

Supporting Document #03 - [WCFH.ProgramDescriptions.pdf](#)

Supporting Document #04 - [2016 Block Grant Public Comments - Alaska.pdf](#)

## VI. Appendix

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**Form 2**  
**MCH Budget/Expenditure Details**

**State: Alaska**

	FY17 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 1,050,524	
A. Preventive and Primary Care for Children	\$ 325,663	(31%)
B. Children with Special Health Care Needs	\$ 346,679	(33%)
C. Title V Administrative Costs	\$ 105,052	(10%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	\$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 14,169,000	
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)	\$ 30,000	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 14,199,000	
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)	\$ 15,249,524	
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)	\$ 6,091,206	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 21,340,730	

OTHER FEDERAL FUNDS	FY17 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)	\$ 161,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	\$ 193,600
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	\$ 2,000,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 95,374
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 250,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 545,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Implementation Grants for Systems of Services for CYSHCN	\$ 300,000

	FY15 Application Budgeted		FY15 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 1,043,564		\$ 1,043,564	
A. Preventive and Primary Care for Children	\$ 344,376	(33%)	\$ 325,663	(31.2%)
B. Children with Special Health Care Needs	\$ 365,247	(35%)	\$ 346,679	(33.2%)
C. Title V Administrative Costs	\$ 83,485	(8%)	\$ 104,000	(10%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	\$ 0		\$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 14,504,339		\$ 14,089,787	
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)	\$ 140,000		\$ 100,000	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 14,644,339		\$ 14,189,787	
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)	\$ 15,687,903		\$ 15,233,351	
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)	\$ 6,765,745		\$ 4,428,446	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 22,453,648		\$ 19,661,797	

OTHER FEDERAL FUNDS	FY15 Annual Report Expended
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)	\$ 2,076,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	\$ 145,300
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	\$ 220,164
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	\$ 400,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Implementation Grants for Systems of Services for CYSHCN	\$ 300,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 95,374
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 250,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 532,300

**Form Notes for Form 2:**

None

**Field Level Notes for Form 2:**

1.	<b>Field Name:</b>	<b>Federal Allocation, C. Title V Administrative Costs:</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	Indirect of 10:% was taken for administrative cost as allowable
2.	<b>Field Name:</b>	<b>6. PROGRAM INCOME</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	Program income from receipt support services did not meet returns as expected due to a decrease in the Medicaid billing rate

**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	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	\$ 128,464	\$ 88,183
2. Infants < 1 year	\$ 147,622	\$ 150,416
3. Children 1-22 years	\$ 325,663	\$ 325,663
4. CSHCN	\$ 346,679	\$ 346,679
5. All Others	\$ 13,967	\$ 28,623
Federal Total of Individuals Served	\$ 962,395	\$ 939,564

IB. Non Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	\$ 1,120,000	\$ 1,124,732
2. Infants < 1 year	\$ 1,500,000	\$ 1,436,400
3. Children 1-22 years	\$ 950,000	\$ 959,937
4. CSHCN	\$ 8,600,000	\$ 8,575,007
5. All Others	\$ 1,999,000	\$ 1,999,617
Non Federal Total of Individuals Served	\$ 14,169,000	\$ 14,095,693
Federal State MCH Block Grant Partnership Total	\$ 15,131,395	\$ 15,035,257

**Form Notes for Form 3a:**

None

**Field Level Notes for Form 3a:**

None

**Data Alerts: None**

**Form 3b**  
**Budget and Expenditure Details by Types of Services**  
**State: Alaska**

**II. TYPES OF SERVICES**

IIA. Federal MCH Block Grant	FY17 Application Budgeted	FY15 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	\$ 262,631	\$ 260,891
3. Public Health Services and Systems	\$ 787,893	\$ 782,673
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
<b>Federal Total</b>	<b>\$ 1,050,524</b>	<b>\$ 1,043,564</b>

IIB. Non-Federal MCH Block Grant	FY17 Application Budgeted	FY15 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	\$ 8,531,400	\$ 8,569,597
3. Public Health Services and Systems	\$ 5,667,600	\$ 5,520,190
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
<b>Non-Federal Total</b>	\$ 14,199,000	\$ 14,089,787

**Form Notes for Form 3b:**

None

**Field Level Notes for Form 3b:**

None

**Form 4**  
**Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated**  
**State: Alaska**

**Total Births by Occurrence: 11,175**

**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	11,082 (99.2%)	345	217	209 (96.3%)

Program Name(s)				
Classic phenylketonuria	Primary congenital hypothyroidism	Classic galactosemia	S,S disease (Sickle cell anemia)	Propionic acidemia
Biotinidase deficiency	Congenital adrenal hyperplasia	Medium-chain acyl-CoA dehydrogenase deficiency	Carnitine uptake defect/carnitine transport defect	Very long-chain acyl-CoA dehydrogenase deficiency
Cystic fibrosis	Carnitine uptake defect/carnitine transport defect			

**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
AK Early Hearing and Detection Intervention Program	10,721 (95.9%)	148	15	7 (46.7%)

**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 data if applicable for certain disorders. The program does not have the resources or staff to do any long term follow-up of outcomes past that point in time.

**Form Notes for Form 4:**

None

**Field Level Notes for Form 4:**

1.	<b>Field Name:</b>	<b>Core RUSP Conditions - Receiving At Lease One Screen</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Column Name:</b>	<b>Core RUSP Conditions</b>
	<b>Field Note:</b>	In CY 2015 there were 50 refusals, and no verified missed screens.
2.	<b>Field Name:</b>	<b>Core RUSP Conditions - Positive Screen</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Column Name:</b>	<b>Core RUSP Conditions</b>
	<b>Field Note:</b>	Column B, the No. of presumptive positive screens, reflects all unduplicated children who had an abnormal result on either the first, second, or repeat metabolic screen. It reflects both children who either had just an abnormal blood spot result and those children who need diagnostic testing.
3.	<b>Field Name:</b>	<b>Core RUSP Conditions - Confirmed Cases</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Column Name:</b>	<b>Core RUSP Conditions</b>
	<b>Field Note:</b>	In CY 2015 there were 50 refusals, and no verified missed screens.
4.	<b>Field Name:</b>	<b>Core RUSP Conditions - Referred For Treatment</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Column Name:</b>	<b>Core RUSP Conditions</b>
	<b>Field Note:</b>	Alaska doesn't have a follow-up program for CCHD like other newborn screening due to no program funding available. It is a passive reporting system and has incomplete data. The numbers are skewed due to some facilities not reporting data, including Providence Hospital which has the most births. Some facilities have had trouble with pulling records from the ER. We collect data per the regulations. Only screening data is available. There is no data on the number of confirmed cases.
5.	<b>Field Name:</b>	<b>AK Early Hearing and Detection Intervention Program - Receiving At Lease One Screen</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Column Name:</b>	<b>Other Newborn</b>

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**Field Note:**  
2015 data is provisional

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6. **Field Name:** **AK Early Hearing and Detection Intervention Program - Positive Screen**

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**Fiscal Year:** **2015**

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**Column Name:** **Other Newborn**

---

**Field Note:**  
148 did not pass final screen, 50 diagnosed with normal hearing, 15 diagnosed with hearing loss

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7. **Field Name:** **AK Early Hearing and Detection Intervention Program - Confirmed Cases**

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**Fiscal Year:** **2015**

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**Column Name:** **Other Newborn**

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**Field Note:**  
15 diagnosed with hearing loss

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8. **Field Name:** **AK Early Hearing and Detection Intervention Program - Referred For Treatment**

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**Fiscal Year:** **2015**

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**Column Name:** **Other Newborn**

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**Field Note:**  
Elgibility and referral data is unknown due to unavailability of EI/LP data exchange due to FERPA concerns.

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**Data Alerts: None**

**Form 5a**  
**Unduplicated Count of Individuals Served under Title V**  
**State: Alaska**

**Reporting Year 2015**

		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	0.0	0.0	0.0	0.0	100.0
2. Infants < 1 Year of Age	0	0.0	0.0	0.0	0.0	100.0
3. Children 1 to 22 Years of Age	0	0.0	0.0	0.0	0.0	100.0
4. Children with Special Health Care Needs	0	0.0	0.0	0.0	0.0	100.0
5. Others	0	0.0	0.0	0.0	0.0	100.0
Total	0					

**Form Notes for Form 5a:**

No Title V dollars are used for direct services

**Field Level Notes for Form 5a:**

1.	<b>Field Name:</b>	<b>Pregnant Women Total Served</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Field Note:</b>	No Title V dollars are used for direct services
2.	<b>Field Name:</b>	<b>Infants Less Than One YearTotal Served</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Field Note:</b>	No Title V dollars are used for direct services
3.	<b>Field Name:</b>	<b>Children 1 to 22 Years of Age</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Field Note:</b>	No Title V dollars are used for direct services
4.	<b>Field Name:</b>	<b>Children with Special Health Care Needs</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Field Note:</b>	No Title V dollars are used for direct services
5.	<b>Field Name:</b>	<b>Others</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Field Note:</b>	No Title V dollars are used for direct services
6.	<b>Field Name:</b>	<b>Total_TotalServed</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Field Note:</b>	No Title V dollars are used for direct services

**Form 5b**  
**Total Recipient Count of Individuals Served by Title V**  
**State: Alaska**

**Reporting Year 2015**

<b>Types Of Individuals Served</b>	<b>Total Served</b>
1. Pregnant Women	12,723
2. Infants < 1 Year of Age	10,738
3. Children 1 to 22 Years of Age	227,331
4. Children with Special Health Care Needs	2,580
5. Others	0
<b>Total</b>	<b>253,372</b>

**Form Notes for Form 5b:**

None

**Field Level Notes for Form 5b:**

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1.	<b>Field Name:</b>	<b>Pregnant Women</b>
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	<b>Fiscal Year:</b>	<b>2015</b>
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**Field Note:**  
All pregnant women receive Title V Services. Data Source: Alaska BVS. Reported for 2014. 2015 available in late 2016. All live births + ITOPS + fetal deaths counted.

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2.	<b>Field Name:</b>	<b>Infants Less Than One Year</b>
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	<b>Fiscal Year:</b>	<b>2015</b>
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**Field Note:**  
All infants receive Title V services through infrastructure building and population-based services such as education/outreach programs. A smaller proportion receive direct care and enabling services. 2A. Data Source: Alaska Department of Labor Population Estimates as of July, 2014. Estimates for 2015 are not available yet

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3.	<b>Field Name:</b>	<b>Children 1 to 22 Year of Age</b>
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	<b>Fiscal Year:</b>	<b>2015</b>
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**Field Note:**  
All children receive Title V services through infrastructure building and population-based services such as education/outreach programs. A smaller proportion receive direct care and enabling services. All infants receive Title V services through infrastructure building and population based services such as education/outreach programs. A smaller proportion receive direct care and enabling services. Data Source: Alaska Department of Labor Population Estimates as of July, 2014. Estimates for 2015 are not available yet.

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4.	<b>Field Name:</b>	<b>Children With Special Health Care Needs</b>
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	<b>Fiscal Year:</b>	<b>2015</b>
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**Field Note:**  
Data reported for 2014, 2015 is not available yet. This is an unduplicated count of clients diagnosed or referred from: cleft lip & palate clinics, EHDI clients diagnosed & referred for services, ILP part C and not part C, autism outreach, genetics & metabolic clinics, and neurodevelopmental outreach.

**Form 6**  
**Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX**

**State: Alaska**

**Reporting Year 2015**

**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	11,147	6,323	330	2,071	705	274	1,110	334
Title V Served	11,147	6,323	330	2,071	705	274	1,110	334
Eligible for Title XIX	5,213	1,611	125	1,793	266	225	417	776
2. Total Infants in State	10,590	5,869	438	1,816	467	149	1,851	0
Title V Served	10,590	5,869	438	1,816	467	149	1,851	0
Eligible for Title XIX	7,300	2,543	235	2,154	390	385	1,001	592

**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	10,164	799	184	11,147
Title V Served	10,164	799	184	11,147
Eligible for Title XIX	5,062	133	18	5,213
2. Total Infants in State	9,692	898	0	10,590
Title V Served	9,692	898	0	10,590
Eligible for Title XIX	6,835	327	138	7,300

**Form Notes for Form 6:**

None

**Field Level Notes for Form 6:**

1.	<b>Field Name:</b>	<b>1. Total Deliveries in State</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Column Name:</b>	<b>Total All Races</b>
	<b>Field Note:</b>	Data Source: Alaska Bureau of Vital Statistics
2.	<b>Field Name:</b>	<b>1. Title V Served</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Column Name:</b>	<b>Total All Races</b>
	<b>Field Note:</b>	Data Source: Alaska Bureau of Vital Statistics. All pregnant women and infants receive Title V services.
3.	<b>Field Name:</b>	<b>1. Eligible for Title XIX</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Column Name:</b>	<b>Total All Races</b>
	<b>Field Note:</b>	Data Source: Alaska Medicaid Data
4.	<b>Field Name:</b>	<b>2. Total Infants in State</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Column Name:</b>	<b>Total All Races</b>
	<b>Field Note:</b>	Provisional Data. Data Source: Alaska Department of Labor Estimates as of July 2014. Estimates for 2015 are not available yet.
5.	<b>Field Name:</b>	<b>2. Title V Served</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Column Name:</b>	<b>Total All Races</b>
	<b>Field Note:</b>	Provisional Data. Data Source: Alaska Department of Labor Estimates as of July 2014. Estimates for 2015 are not available yet. 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 smaller portion receive direct care services and enabling services.

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6. **Field Name:** 2. Eligible for Title XIX

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**Fiscal Year:** 2015

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**Column Name:** Total All Races

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**Field Note:**

Data Source: Alaska Medicaid Infant Medicaid data for CY 2015. Infants are defined as 1 year or older on January 2015 and eligible for Medicaid in CY15.

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

**State: Alaska**

<b>A. State MCH Toll-Free Telephone Lines</b>	<b>2017 Application Year</b>	<b>2015 Reporting Year</b>
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 and Family Health	Women's Children's and Family Health
3. Name of Contact Person for State MCH "Hotline"	Veronica Holmquist	Veronica Holmquist
4. Contact Person's Telephone Number	(907) 269-3462	(907) 269-3462
5. Number of Calls Received on the State MCH "Hotline"		94

<b>B. Other Appropriate Methods</b>	<b>2017 Application Year</b>	<b>2015 Reporting Year</b>
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	<a href="http://dhss.alaska.gov/dph/wcfh/Pages/default.aspx">http://dhss.alaska.gov/dph/wcfh/Pages/default.aspx</a>	<a href="http://dhss.alaska.gov/dph/wcfh/Pages/default.aspx">http://dhss.alaska.gov/dph/wcfh/Pages/default.aspx</a>
4. Number of Hits to the State Title V Program Website		7,845
5. State Title V Social Media Websites		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	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

**Form Notes for Form 8:**

None

**Form 9**  
**List of MCH Priority Needs**

**State: Alaska**

**Application Year 2017**

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**

<b>No.</b>	<b>Priority Need</b>	<b>Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)</b>	<b>Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure</b>
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
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: State Inpatient Databases (SID)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	178.9	15.6 %	134	7,489
2011	175.6	15.5 %	131	7,460
2010	193.9	16.3 %	144	7,428

**Legends:**  
 Indicator has a numerator  $\leq 10$  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.**

**NOM 3 - Notes:**

None

**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
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
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
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
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
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
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
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
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
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

State Provided Data	
	<b>2014</b>
<b>Annual Indicator</b>	5.8
<b>Numerator</b>	328
<b>Denominator</b>	56,952
<b>Data Source</b>	Alaska Bureau of Vital Statistics
<b>Data Source Year</b>	2015

**NOM 8 - Notes:**

Provisional 2015 data. This measure is reported as a 5 year moving average (2011-2015).

**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
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

State Provided Data	
	<b>2014</b>
<b>Annual Indicator</b>	5.7
<b>Numerator</b>	323
<b>Denominator</b>	56,740
<b>Data Source</b>	Alaska Bureau of Vital Statistics
<b>Data Source Year</b>	2015

**NOM 9.1 - Notes:**

Provisional 2015 data. This measure is reported as a 5 year moving average (2011-2015).

**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
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

State Provided Data	
	<b>2014</b>
<b>Annual Indicator</b>	3.0
<b>Numerator</b>	168
<b>Denominator</b>	56,740
<b>Data Source</b>	Alaska Bureau of Vital Statistics
<b>Data Source Year</b>	2015

**NOM 9.2 - Notes:**

Provisional 2015 data. This measure is reported as a 5 year moving average (2011-2015).

**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
2013	3.2	0.5 %	36	11,446
2012	2.1	0.4 %	23	11,187
2011	1.7 ⚡	0.4 % ⚡	19 ⚡	11,456 ⚡
2010	1.7 ⚡	0.4 % ⚡	19 ⚡	11,471 ⚡
2009	4.2	0.6 %	47	11,324

**Legends:**  
 📄 Indicator has a numerator <10 and is not reportable  
 ⚡ Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	<b>2014</b>
<b>Annual Indicator</b>	2.7
<b>Numerator</b>	155
<b>Denominator</b>	56,740
<b>Data Source</b>	Alaska Bureau of Vital Statistics
<b>Data Source Year</b>	2015

**NOM 9.3 - Notes:**

Provisional 2015 data. This measure is reported as a 5 year moving average (2011-2015).

**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
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
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
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: 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  $\leq 10$  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
2014	25.1	5.1 %	24	95,484
2013	31.3	5.7 %	30	95,894
2012	18.9 ⚡	4.5 % ⚡	18 ⚡	95,022 ⚡
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  
 ⚡ Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	<b>2014</b>
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
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
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
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	
	<b>2014</b>
<b>Annual Indicator</b>	36.7
<b>Numerator</b>	54
<b>Denominator</b>	147,108
<b>Data Source</b>	Alaska Bureau of Vital Statistics
<b>Data Source Year</b>	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
2012	39.5 %	0.5 %	3,564	9,024

**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
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
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
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)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
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 % ⚡	5.5 % ⚡	77,020 ⚡	164,573 ⚡
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  
 ⚡ 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) - Female**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
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) - Male**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
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)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
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)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
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**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	62.0	64.0	66.0	68.0	70.0	72.0

**Data Source: Behavioral Risk Factor Surveillance System (BRFSS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	53.8 %	2.4 %	69,853	129,880
2013	55.2 %	2.4 %	72,852	131,880
2012	65.2 %	2.1 %	81,184	124,534
2011	54.2 %	2.6 %	66,741	123,102
2010	70.5 %	3.5 %	83,556	118,529
2009	62.1 %	3.4 %	75,765	122,058

**Legends:**

-  Indicator has an unweighted denominator <30 and is not reportable
-  Indicator has a confidence interval width >20% and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	76.0	78.0	80.0	82.0	84.0	86.0

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	71.0 %	1.6 %	7,567	10,654
2012	76.0 %	1.7 %	7,869	10,350
2010	67.9 %	1.8 %	7,242	10,666
2009	73.2 %	1.6 %	7,671	10,473
2008	73.7 %	1.6 %	7,896	10,709
2007	70.0 %	1.6 %	7,234	10,332

**Legends:**

-  Indicator has an unweighted denominator <30 and is not reportable
-  Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% and should be interpreted with caution

### 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**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	33.0	34.0	35.0	36.0	37.0	38.0

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

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	32.6 %	3.2 %	15,812	48,525
2007	20.7 %	2.5 %	10,172	49,247

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**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)**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	185.0	180.0	176.0	172.0	168.0	164.0

**Data Source: State Inpatient Databases (SID) - CHILD**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	173.7	12.7 %	188	108,236
2011	165.3	12.4 %	178	107,687
2010	183.6	13.5 %	186	101,302

**Legends:**  
 Indicator has a numerator ≤10 and is not reportable  
 Indicator has a numerator <20 and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	26.0	25.0	24.0	23.0	22.0	21.0

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

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	13.9 %	2.2 %	8,187	59,024
2007	12.2 %	1.7 %	8,205	67,305

**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: Youth Risk Behavior Surveillance System (YRBSS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	26.5 %	1.4 %	8,040	30,402
2011	28.9 %	1.5 %	9,090	31,459

**Legends:**  
 Indicator has an unweighted denominator <100 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

None

**NPM 11 - Percent of children with and without special health care needs having a medical home**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	45.0	47.0	49.0	52.0	55.0	57.0

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

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	39.6 %	4.4 %	10,398	26,280
2007	49.0 %	4.2 %	14,185	28,929

**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: National Survey of Children's Health (NSCH) - NONCSHCN**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	54.0 %	1.9 %	83,530	154,750
2007	53.0 %	1.9 %	76,890	145,171

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	53.0	55.0	56.0	57.0	59.0	60.0

**Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	52.0 %	1.7 %	5,719	11,000
2012	47.9 %	1.9 %	5,137	10,730
2010	45.8 %	1.9 %	4,981	10,869
2009	39.0 %	1.7 %	4,228	10,842
2008	38.4 %	1.8 %	4,054	10,566

**Legends:**

-  Indicator has an unweighted denominator <30 and is not reportable
-  Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% and should be interpreted with caution

**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**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	72.0	73.0	74.0	75.0	76.0	77.0

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

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	72.1 %	1.6 %	125,411	173,948
2007	80.5 %	1.3 %	136,526	169,556

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	12.9	12.3	11.7	11.1	10.5	9.9

**Data Source: National Vital Statistics System (NVSS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	13.3 %	0.3 %	1,469	11,034
2013	13.6 %	0.3 %	1,510	11,145

**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

**Field Level Notes for Form 10a NPMs:**

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	28.0	26.6	25.3	24.0	22.8	21.5

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

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	29.5 %	1.6 %	54,636	185,403
2007	30.9 %	1.6 %	55,821	180,508
2003	33.2 %	1.4 %	52,520	158,131

**Legends:**

-  Indicator has an unweighted denominator <30 and is not reportable
-  Indicator has a confidence interval width >20% and should be interpreted with caution

**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.**

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

**Field Level Notes for Form 10a SPMs:**

None

**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.**

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

**Field Level Notes for Form 10a SPMs:**

1. **Field Name:** 2017

**Field Note:**

Source: Biennial CDC Youth Risk and Behavioral Surveillance Survey (YRBS) . 2021 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**

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

**Field Level Notes for Form 10a SPMs:**

1. **Field Name:** 2017

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**Field Note:**

Goal is to maintain a rate below the HA 2020 goal of 14.4 per 1,000 children aged 0-17

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2. **Field Name:** 2018

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**Field Note:**

Goal is to maintain a rate below the HA 2020 goal of 14.4 per 1,000 children aged 0-17

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3. **Field Name:** 2019

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**Field Note:**

Goal is to maintain a rate below the HA 2020 goal of 14.4 per 1,000 children aged 0-17

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4. **Field Name:** 2020

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**Field Note:**

Goal is to maintain a rate below the HA 2020 goal of 14.4 per 1,000 children aged 0-17

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5. **Field Name:** 2021

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**Field Note:**

Goal is to maintain a rate below the HA 2020 goal of 14.4 per 1,000 children aged 0-17

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

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

**Field Level Notes for Form 10a SPMs:**

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1. **Field Name:** 2017

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**Field Note:**

Source: PRAMS. 2021 goal 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.

**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.**

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

**Field Level Notes for Form 10a ESMs:**

- |    |                    |  |
|----|--------------------|--|
| 1. | <b>Field Name:</b> | <b>2017</b>  |
|    | <b>Field Note:</b> | Maintain ratio of newly enrolled BCHC clients who have not been screened in over 5 years. (National target for proportion of rarely or never screen women enrolled in BCHC = 20%, so Alaska's BCHC program wants to maintain their proportion to 50%.) |
| 2. | <b>Field Name:</b> | <b>2018</b>  |
|    | <b>Field Note:</b> | Maintain ratio of newly enrolled BCHC clients who have not been screened in over 5 years. (National target for proportion of rarely or never screen women enrolled in BCHC = 20%, so Alaska's BCHC program wants to maintain their proportion to 50%.) |
| 3. | <b>Field Name:</b> | <b>2019</b>  |
|    | <b>Field Note:</b> | Maintain ratio of newly enrolled BCHC clients who have not been screened in over 5 years. (National target for proportion of rarely or never screen women enrolled in BCHC = 20%, so Alaska's BCHC program wants to maintain their proportion to 50%.) |
| 4. | <b>Field Name:</b> | <b>2020</b>  |
|    | <b>Field Note:</b> | Maintain ratio of newly enrolled BCHC clients who have not been screened in over 5 years. (National target for proportion of rarely or never screen women enrolled in BCHC = 20%, so Alaska's BCHC program wants to maintain their proportion to 50%.) |
| 5. | <b>Field Name:</b> | <b>2021</b>  |
|    | <b>Field Note:</b> | Maintain ratio of newly enrolled BCHC clients who have not been screened in over 5 years. (National target for proportion of rarely or never screen women enrolled in BCHC = 20%, so Alaska's BCHC program wants to maintain their proportion to 50%.) |

**ESM 1.2 - Percent of all WIC clients referred to the Municipality of Anchorage Reproductive Health Clinic who receive services.**

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

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2017</b>
	<b>Field Note:</b>	Baseline of referred WIC clients who have received reproductive services will be established in Fall 2016. Increase by 5% for two years.
2.	<b>Field Name:</b>	<b>2018</b>
	<b>Field Note:</b>	Baseline of referred WIC clients who have received reproductive services will be established in Fall 2016. Increase by 5% for two years.
3.	<b>Field Name:</b>	<b>2019</b>
	<b>Field Note:</b>	Baseline of referred WIC clients who have received reproductive services will be established in Fall 2016. Increase by 5% for two years.
4.	<b>Field Name:</b>	<b>2020</b>
	<b>Field Note:</b>	Baseline of referred WIC clients who have received reproductive services will be established in Fall 2016. Increase by 5% for two years.
5.	<b>Field Name:</b>	<b>2021</b>
	<b>Field Note:</b>	Baseline of referred WIC clients who have received reproductive services will be established in Fall 2016. Increase by 5% for two years.

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	5.0	5.0	6.0	6.0	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.**

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

**Field Level Notes for Form 10a ESMs:**

1. **Field Name:** 2017  
  
**Field Note:**  
In 2014 there were 11,248 total births. 6011 (53.4%) occurred at Bartlett (n=368), Fairbanks Memorial (n=1121), Providence Alaska (n=2997), Elmendorf USAF Hospital (n=770) and Mat-Su Regional (n=755). Note: Of the 15 birthing hospitals in Alaska not presently participating, 11 completed just 0.20% to 2.10% of 2014 births. Only one accounts for more than 10% of total births. Small shifts in this data point are expected.

---

2. **Field Name:** 2018  
  
**Field Note:**  
In 2014 there were 11,248 total births. 6011 (53.4%) occurred at Bartlett (n=368), Fairbanks Memorial (n=1121), Providence Alaska (n=2997), Elmendorf USAF Hospital (n=770) and Mat-Su Regional (n=755). Note: Of the 15 birthing hospitals in Alaska not presently participating, 11 completed just 0.20% to 2.10% of 2014 births. Only one accounts for more than 10% of total births. Small shifts in this data point are expected.

---

3. **Field Name:** 2019  
  
**Field Note:**  
In 2014 there were 11,248 total births. 6011 (53.4%) occurred at Bartlett (n=368), Fairbanks Memorial (n=1121), Providence Alaska (n=2997), Elmendorf USAF Hospital (n=770) and Mat-Su Regional (n=755). Note: Of the 15 birthing hospitals in Alaska not presently participating, 11 completed just 0.20% to 2.10% of 2014 births. Only one accounts for more than 10% of total births. Small shifts in this data point are expected.

---

4. **Field Name:** 2020  
  
**Field Note:**  
In 2014 there were 11,248 total births. 6011 (53.4%) occurred at Bartlett (n=368), Fairbanks Memorial (n=1121), Providence Alaska (n=2997), Elmendorf USAF Hospital (n=770) and Mat-Su Regional (n=755). Note: Of the 15 birthing hospitals in Alaska not presently participating, 11 completed just 0.20% to 2.10% of 2014 births. Only one accounts for more than 10% of total births. Small shifts in this data point are expected.

---

5. **Field Name:** 2021  
  
**Field Note:**  
In 2014 there were 11,248 total births. 6011 (53.4%) occurred at Bartlett (n=368), Fairbanks Memorial (n=1121), Providence Alaska (n=2997), Elmendorf USAF Hospital (n=770) and Mat-Su Regional (n=755). Note: Of the 15 birthing hospitals in Alaska not presently participating, 11 completed just 0.20% to 2.10% of 2014 births. Only one accounts for more than 10% of total births. Small shifts in this data point are expected.

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	60.0	65.0	70.0	75.0	80.0

#### Field Level Notes for Form 10a ESMs:

1.	<b>Field Name:</b>	<b>2017</b>
	<b>Field Note:</b>	The MIMR-CDR program provides feedback and training to law enforcement agencies/first responders who complete the SUID form, therefore does not have direct control over whether the SUID form is complete or not
2.	<b>Field Name:</b>	<b>2018</b>
	<b>Field Note:</b>	The MIMR-CDR program provides feedback and training to law enforcement agencies/first responders who complete the SUID form, therefore does not have direct control over whether the SUID form is complete or not
3.	<b>Field Name:</b>	<b>2019</b>
	<b>Field Note:</b>	The MIMR-CDR program provides feedback and training to law enforcement agencies/first responders who complete the SUID form, therefore does not have direct control over whether the SUID form is complete or not
4.	<b>Field Name:</b>	<b>2020</b>
	<b>Field Note:</b>	The MIMR-CDR program provides feedback and training to law enforcement agencies/first responders who complete the SUID form, therefore does not have direct control over whether the SUID form is complete or not
5.	<b>Field Name:</b>	<b>2021</b>
	<b>Field Note:</b>	The MIMR-CDR program provides feedback and training to law enforcement agencies/first responders who complete the SUID form, therefore does not have direct control over whether the SUID form is complete or not

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

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

#### Field Level Notes for Form 10a ESMs:

1.	<b>Field Name:</b>	<b>2017</b>
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**Field Note:**

The MIMR-CDR program began collecting these data in September 2015 when the program began entering cases in the National CDR Case Reporting System. The program therefore does not have a full year of data available.

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2. **Field Name:** 2018

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**Field Note:**

The MIMR-CDR program began collecting these data in September 2015 when the program began entering cases in the National CDR Case Reporting System. The program therefore does not have a full year of data available.

---

3. **Field Name:** 2019

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**Field Note:**

The MIMR-CDR program began collecting these data in September 2015 when the program began entering cases in the National CDR Case Reporting System. The program therefore does not have a full year of data available.

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4. **Field Name:** 2020

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**Field Note:**

The MIMR-CDR program began collecting these data in September 2015 when the program began entering cases in the National CDR Case Reporting System. The program therefore does not have a full year of data available.

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5. **Field Name:** 2021

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**Field Note:**

The MIMR-CDR program began collecting these data in September 2015 when the program began entering cases in the National CDR Case Reporting System. The program therefore does not have a full year of data available.

### ESM 6.1 - Percent of eligible screening time points with a completed Ages and Stages Developmental Screen, among families participating in MIECHV program

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	79.1	79.9	80.7	81.5	82.3

#### Field Level Notes for Form 10a ESMs:

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1. **Field Name:** 2017

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**Field Note:**

2021 goals based on 2014-2015 Nurse Family Partnership Program data. 2014 was 77.7% and 2015 was 77.9%. Goal is .5% increase annually.

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2. **Field Name:** 2018

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**Field Note:**

2021 goals based on 2014-2015 Nurse Family Partnership Program data. 2014 was 77.7% and 2015 was 77.9%. Goal is .5% increase annually.

---

3. **Field Name:** 2019

---

**Field Note:**

2021 goals based on 2014-2015 Nurse Family Partnership Program data. 2014 was 77.7% and 2015 was 77.9%. Goal is .5% increase annually.

4. **Field Name:** 2020

**Field Note:**

2021 goals based on 2014-2015 Nurse Family Partnership Program data. 2014 was 77.7% and 2015 was 77.9%. Goal is .5% increase annually.

5. **Field Name:** 2021

**Field Note:**

2021 goals based on 2014-2015 Nurse Family Partnership Program data. 2014 was 77.7% and 2015 was 77.9%. Goal is .5% increase annually.

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

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

**Field Level Notes for Form 10a ESMs:**

None

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

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

**Field Level Notes for Form 10a ESMs:**

1. **Field Name:** 2017

**Field Note:**

Source: WCFH Dashboard. The objective for 2017 is to increase the number of participating students by 25% each year and is calculated as 25% more than the total number of Alaskan students who participated in FY2016 (1246 students).

2. **Field Name:** 2018

**Field Note:**

Source: WCFH Dashboard. The objective for 2018 is to increase the number of participating students by 25% each year and is calculated as 25% more than the total number of Alaskan students who participated in FY2017.

3. **Field Name:** 2019

**Field Note:**

Source: WCFH Dashboard. The objective for 2019 is to increase the number of participating students by 25% each year and is calculated as 25% more than the total number of Alaskan students who participated in FY2018.

4. **Field Name:** 2020

**Field Note:**

Source: WCFH Dashboard. The objective for 2020 is to increase the number of participating students by 25% each year and is calculated as 25% more than the total number of Alaskan students who participated in FY2019.

5. **Field Name:** 2021

**Field Note:**

Source: WCFH Dashboard. The objective for 2021 is to increase the number of participating students by 25% each year and is calculated as 25% more than the total number of Alaskan students who participated in FY2020.

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	0.2	0.2	0.2	0.3	0.3

**Field Level Notes for Form 10a ESMs:**

1. **Field Name:** 2017

**Field Note:**

Annual Objective: Increase proportion of targeted CYSHCN within Anchorage School District with a shared plan of care by 2% each year from 2017 baseline

2. **Field Name:** 2018

**Field Note:**

Annual Objective: Increase proportion of targeted CYSHCN within Anchorage School District with a shared plan of care by 2% each year from 2017 baseline

3. **Field Name:** 2019

**Field Note:**

Annual Objective: Increase proportion of targeted CYSHCN within Anchorage School District with a shared plan of care by 2% each year from 2017 baseline

4. **Field Name:** 2020

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**Field Note:**

Annual Objective: Increase proportion of targeted CYSHCN within Anchorage School District with a shared plan of care by 2% each year from 2017 baseline

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5. **Field Name:** 2021

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**Field Note:**

Annual Objective: Increase proportion of targeted CYSHCN within Anchorage School District with a shared plan of care by 2% each year from 2017 baseline

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

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

**Field Level Notes for Form 10a ESMs:**

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1. **Field Name:** 2017

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**Field Note:**

Annual Objective: Increase proportion of families and medical home providers of CYSHCN contacting Help Me Grow for a needed specialist, support or service will obtain a needed specialist, support or service by 5% each year from 2017 baseline

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2. **Field Name:** 2018

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**Field Note:**

Annual Objective: Increase proportion of families and medical home providers of CYSHCN contacting Help Me Grow for a needed specialist, support or service will obtain a needed specialist, support or service by 5% each year from 2017 baseline

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3. **Field Name:** 2019

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**Field Note:**

Annual Objective: Increase proportion of families and medical home providers of CYSHCN contacting Help Me Grow for a needed specialist, support or service will obtain a needed specialist, support or service by 5% each year from 2017 baseline

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4. **Field Name:** 2020

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**Field Note:**

Annual Objective: Increase proportion of families and medical home providers of CYSHCN contacting Help Me Grow for a needed specialist, support or service will obtain a needed specialist, support or service by 5% each year from 2017 baseline

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5. **Field Name:** 2021

**Field Note:**

Annual Objective: Increase proportion of families and medical home providers of CYSHCN contacting Help Me Grow for a needed specialist, support or service will obtain a needed specialist, support or service by 5% each year from 2017 baseline

**ESM 13.1 - Number of oral health pocket guides distributed**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	300.0	400.0	600.0	800.0	1,000.0

**Field Level Notes for Form 10a ESMs:**

None

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

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

**Field Level Notes for Form 10a ESMs:**

1. **Field Name:** 2017

**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

2. **Field Name:** 2018

**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

3. **Field Name:** 2019

**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

4. **Field Name:** 2020

**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

5. **Field Name:** 2021

---

**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**

<b>Goal:</b>	Reduce poor birth outcomes related to alcohol use during pregnancy.									
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #4F81BD; color: white;"><b>Numerator:</b></td> <td>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?"</td> </tr> <tr> <td style="background-color: #4F81BD; color: white;"><b>Denominator:</b></td> <td>Number of Alaska-resident women delivering a live-born infant</td> </tr> <tr> <td style="background-color: #4F81BD; color: white;"><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td style="background-color: #4F81BD; color: white;"><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	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?"	<b>Denominator:</b>	Number of Alaska-resident women delivering a live-born infant	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	
<b>Numerator:</b>	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?"									
<b>Denominator:</b>	Number of Alaska-resident women delivering a live-born infant									
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Healthy People 2020 Objective:</b>	MICH-11.1 Increase abstinence from alcohol among pregnant women MICH-11.2 Increase abstinence from binge drinking among pregnant women									
<b>Data Sources and Data Issues:</b>	Pregnancy Risk Assessment Monitoring System (PRAMS)									
<b>Significance:</b>	<p>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.</p> <p>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) and 2) One Key Question. SBIRT is a process that clinical care staff employ to reliably screen women who are misusing alcohol. SBIRT 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 employed singly</p>									



is an effective strategy for screening and referring to treatment those women who are misusing alcohol while pregnant

**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**

<b>Goal:</b>	Increase healthy relationships. The goal is to reach 87% by 2021. The goal is based on 2007-2015 YRBS trend data.									
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;"><b>Numerator:</b></td> <td>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.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Denominator:</b></td> <td>Number of students who take the survey</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Number:</b></td> <td>100</td> </tr> </table>		<b>Numerator:</b>	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.	<b>Denominator:</b>	Number of students who take the survey	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	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.									
<b>Denominator:</b>	Number of students who take the survey									
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Healthy People 2020 Objective:</b>	AH-3.1 Increase the proportion of adolescents who have an adult in their lives with whom they can talk about serious problems									
<b>Data Sources and Data Issues:</b>	Biennial CDC Youth Risk Behavioral Surveillance System									
<b>Significance:</b>	<p>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.</p> <p>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.</p>									

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

**Population Domain(s) – Child Health**

<b>Goal:</b>	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.									
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;"><b>Numerator:</b></td> <td>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.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Denominator:</b></td> <td>Annual # of children ages 0-17 in Alaska</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Type:</b></td> <td>Rate</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Number:</b></td> <td>1,000</td> </tr> </table>		<b>Numerator:</b>	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.	<b>Denominator:</b>	Annual # of children ages 0-17 in Alaska	<b>Unit Type:</b>	Rate	<b>Unit Number:</b>	1,000
<b>Numerator:</b>	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.									
<b>Denominator:</b>	Annual # of children ages 0-17 in Alaska									
<b>Unit Type:</b>	Rate									
<b>Unit Number:</b>	1,000									
<b>Healthy People 2020 Objective:</b>	IVP-37 Reduce child maltreatment deaths IVP-38 Reduce nonfatal child maltreatment									
<b>Data Sources and Data Issues:</b>	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.									
<b>Significance:</b>	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**

<b>Goal:</b>	Increase the percent of women delivering live births who are screened for depression during any of their prenatal care visits									
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>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</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Annual number of women delivering a live birth in Alaska</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	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	<b>Denominator:</b>	Annual number of women delivering a live birth in Alaska	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	
<b>Numerator:</b>	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									
<b>Denominator:</b>	Annual number of women delivering a live birth in Alaska									
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Healthy People 2020 Objective:</b>	MCH-34 Decrease the proportion of women delivering a live birth who experience postpartum depressive symptoms									
<b>Data Sources and Data Issues:</b>	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.)									
<b>Significance:</b>	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.									

**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 Measure (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**

<b>Goal:</b>	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.									
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of women who report not having cervical cancer screening in the last 5 years who enroll in BCHC in a calendar year.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Total number of women newly enrolled in the BCHC program during a calendar year.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Ratio</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>1</td> </tr> </table>	<b>Numerator:</b>	Number of women who report not having cervical cancer screening in the last 5 years who enroll in BCHC in a calendar year.	<b>Denominator:</b>	Total number of women newly enrolled in the BCHC program during a calendar year.	<b>Unit Type:</b>	Ratio	<b>Unit Number:</b>	1	
<b>Numerator:</b>	Number of women who report not having cervical cancer screening in the last 5 years who enroll in BCHC in a calendar year.									
<b>Denominator:</b>	Total number of women newly enrolled in the BCHC program during a calendar year.									
<b>Unit Type:</b>	Ratio									
<b>Unit Number:</b>	1									
<b>Data Sources and Data Issues:</b>	Breast and Cervical Health Check (BCHC) Database									
<b>Significance:</b>	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 the Municipality of Anchorage Reproductive Health Clinic who receive services.**

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

<b>Goal:</b>	Increase the number of WIC clients receiving reproductive health services.									
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of WIC clients who receive services at the MOA Reproductive Health Clinic</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of WIC clients referred to MOA Reproductive Health Clinic</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Ratio</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>1</td> </tr> </table>		<b>Numerator:</b>	Number of WIC clients who receive services at the MOA Reproductive Health Clinic	<b>Denominator:</b>	Number of WIC clients referred to MOA Reproductive Health Clinic	<b>Unit Type:</b>	Ratio	<b>Unit Number:</b>	1
<b>Numerator:</b>	Number of WIC clients who receive services at the MOA Reproductive Health Clinic									
<b>Denominator:</b>	Number of WIC clients referred to MOA Reproductive Health Clinic									
<b>Unit Type:</b>	Ratio									
<b>Unit Number:</b>	1									
<b>Data Sources and Data Issues:</b>	Municipality of Anchorage Family Planning Reports									
<b>Significance:</b>	<p>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. There is one WIC clinic in Anchorage that is adopting the One Key Question as a pilot project.</p>									

**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**

<b>Goal:</b>	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									
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;"><b>Numerator:</b></td> <td>Number of hospitals and birthing facilities implementing the full Alaska Toolkit for Birthing Facilities, holding a STAR Birthing Facility Designation</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Denominator:</b></td> <td>Number of hospitals and birthing facilities in Alaska</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Number:</b></td> <td>10</td> </tr> </table>		<b>Numerator:</b>	Number of hospitals and birthing facilities implementing the full Alaska Toolkit for Birthing Facilities, holding a STAR Birthing Facility Designation	<b>Denominator:</b>	Number of hospitals and birthing facilities in Alaska	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	10
<b>Numerator:</b>	Number of hospitals and birthing facilities implementing the full Alaska Toolkit for Birthing Facilities, holding a STAR Birthing Facility Designation									
<b>Denominator:</b>	Number of hospitals and birthing facilities in Alaska									
<b>Unit Type:</b>	Count									
<b>Unit Number:</b>	10									
<b>Data Sources and Data Issues:</b>	Alaska Infant Safe Sleep Program Records									
<b>Significance:</b>	<p>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:</p> <p><a href="https://www.nichd.nih.gov/publications/pubs/Documents/SIDS_QA_HealthCareProviders.pdf">https://www.nichd.nih.gov/publications/pubs/Documents/SIDS_QA_HealthCareProviders.pdf</a>; Alaska Infant Safe Sleep Program Toolkit for Birthing Facilities</p>									

**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**

<b>Goal:</b>	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.									
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of births at hospitals and birthing facilities with a policy for infant safe sleep in place</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of births at hospital and birthing facilities in Alaska</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>		<b>Numerator:</b>	Number of births at hospitals and birthing facilities with a policy for infant safe sleep in place	<b>Denominator:</b>	Number of births at hospital and birthing facilities in Alaska	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of births at hospitals and birthing facilities with a policy for infant safe sleep in place									
<b>Denominator:</b>	Number of births at hospital and birthing facilities in Alaska									
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Data Sources and Data Issues:</b>	AK Safe Sleep Program Records and Bureau of Vital Statistics									
<b>Significance:</b>	<p>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:</p> <p><a href="https://www.nichd.nih.gov/publications/pubs/Documents/SIDS_QA_HealthCareProviders.pdf">https://www.nichd.nih.gov/publications/pubs/Documents/SIDS_QA_HealthCareProviders.pdf</a>; Alaska Infant Safe Sleep Program Toolkit for Birthing Facilities</p>									

**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**

<b>Goal:</b>	Increase the percent of SUID cases reviewed to 80% by 2021									
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of SUID cases reviewed with complete SUID Investigation Reporting Forms</td> </tr> <tr> <td><b>Denominator:</b></td> <td>All SUID cases reviewed</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>		<b>Numerator:</b>	Number of SUID cases reviewed with complete SUID Investigation Reporting Forms	<b>Denominator:</b>	All SUID cases reviewed	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of SUID cases reviewed with complete SUID Investigation Reporting Forms									
<b>Denominator:</b>	All SUID cases reviewed									
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Data Sources and Data Issues:</b>	Maternal Infant Mortality Review database									
<b>Significance:</b>	<p>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.</p>									

**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**

<b>Goal:</b>	Increase the percent of SUID cases reviewed to 95% by 2021									
<b>Definition:</b>	<table border="1"> <tr> <td data-bbox="492 352 732 432"><b>Numerator:</b></td> <td data-bbox="732 352 1469 432">Number of SUID cases reviewed in prior year classified using CDC categories</td> </tr> <tr> <td data-bbox="492 432 732 485"><b>Denominator:</b></td> <td data-bbox="732 432 1469 485">All SUID cases reviewed</td> </tr> <tr> <td data-bbox="492 485 732 537"><b>Unit Type:</b></td> <td data-bbox="732 485 1469 537">Percentage</td> </tr> <tr> <td data-bbox="492 537 732 590"><b>Unit Number:</b></td> <td data-bbox="732 537 1469 590">100</td> </tr> </table>		<b>Numerator:</b>	Number of SUID cases reviewed in prior year classified using CDC categories	<b>Denominator:</b>	All SUID cases reviewed	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of SUID cases reviewed in prior year classified using CDC categories									
<b>Denominator:</b>	All SUID cases reviewed									
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Data Sources and Data Issues:</b>	Maternal Infant Mortality Review (MIMR) database									
<b>Significance:</b>	<p>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.</p>									

**ESM 6.1 - Percent of eligible screening time points with a completed Ages and Stages Developmental Screen, among families participating in MIECHV program**

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

<b>Goal:</b>	Increase developmental screenings in children by supporting MIECHV program to provide Ages and Stages Developmental Screening tool with clients.									
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;"><b>Numerator:</b></td> <td>Number of children enrolled in home visiting with a timely screen for developmental delays using a validated parent-completed tool (ASQ tools)</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Denominator:</b></td> <td>Number of children enrolled in home visiting eligible for screening</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Number:</b></td> <td>100</td> </tr> </table>		<b>Numerator:</b>	Number of children enrolled in home visiting with a timely screen for developmental delays using a validated parent-completed tool (ASQ tools)	<b>Denominator:</b>	Number of children enrolled in home visiting eligible for screening	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of children enrolled in home visiting with a timely screen for developmental delays using a validated parent-completed tool (ASQ tools)									
<b>Denominator:</b>	Number of children enrolled in home visiting eligible for screening									
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Data Sources and Data Issues:</b>	Nurse Family Partnership Program Data									
<b>Significance:</b>	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.									

**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**

<b>Goal:</b>	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.									
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;"><b>Numerator:</b></td> <td>Number of annual Child Death Review recommendations developed related to the prevention of child injury and/or child maltreatment</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Denominator:</b></td> <td>N/A</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Number:</b></td> <td>10</td> </tr> </table>		<b>Numerator:</b>	Number of annual Child Death Review recommendations developed related to the prevention of child injury and/or child maltreatment	<b>Denominator:</b>	N/A	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	10
<b>Numerator:</b>	Number of annual Child Death Review recommendations developed related to the prevention of child injury and/or child maltreatment									
<b>Denominator:</b>	N/A									
<b>Unit Type:</b>	Count									
<b>Unit Number:</b>	10									
<b>Data Sources and Data Issues:</b>	MIMR-CDR Annual Recommendations Report									
<b>Significance:</b>	<p>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.</p>									

**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**

<b>Goal:</b>	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.									
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;"><b>Numerator:</b></td> <td>Number of students receiving the Fourth R program in the current year</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Denominator:</b></td> <td>Number of students who have received the Fourth R Program in the previous year.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Number:</b></td> <td>5,000</td> </tr> </table>		<b>Numerator:</b>	Number of students receiving the Fourth R program in the current year	<b>Denominator:</b>	Number of students who have received the Fourth R Program in the previous year.	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	5,000
<b>Numerator:</b>	Number of students receiving the Fourth R program in the current year									
<b>Denominator:</b>	Number of students who have received the Fourth R Program in the previous year.									
<b>Unit Type:</b>	Count									
<b>Unit Number:</b>	5,000									
<b>Data Sources and Data Issues:</b>	Data is currently being collected via Section of Women's, Children's and Family Health Dashboard process measures and for federal annual grant reports.									
<b>Significance:</b>	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**

<b>Goal:</b>	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									
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;"><b>Numerator:</b></td> <td>Number of CYSHCN in pilot schools and partner practice with Shared Plan of Care</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Denominator:</b></td> <td>Number of children that attend pilot schools and are clients of partner practice</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Number:</b></td> <td>100</td> </tr> </table>		<b>Numerator:</b>	Number of CYSHCN in pilot schools and partner practice with Shared Plan of Care	<b>Denominator:</b>	Number of children that attend pilot schools and are clients of partner practice	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of CYSHCN in pilot schools and partner practice with Shared Plan of Care									
<b>Denominator:</b>	Number of children that attend pilot schools and are clients of partner practice									
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Data Sources and Data Issues:</b>	School Nurse- Care Coordination Pilot Project records, Anchorage School District, Lightbeam Electronic Health Record Care Coordination Module									
<b>Significance:</b>	<p>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:</p> <ul style="list-style-type: none"> <li>- 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.</li> <li>- Negotiated Actions – highlights personal and clinical goals and joint strategies to address and /or achieve goals with timelines, responsibilities and accountabilities.</li> </ul> <p>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.</p>									

**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**

<b>Goal:</b>	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 AI									
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of families/providers who obtain needed support</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of families/providers who contact Help Me Grow Alaska</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>		<b>Numerator:</b>	Number of families/providers who obtain needed support	<b>Denominator:</b>	Number of families/providers who contact Help Me Grow Alaska	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of families/providers who obtain needed support									
<b>Denominator:</b>	Number of families/providers who contact Help Me Grow Alaska									
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Data Sources and Data Issues:</b>	Help Me Grow database									
<b>Significance:</b>	<p>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.</p> <p>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:</p> <ul style="list-style-type: none"> <li>• Child Health Care Provider Outreach (to support screening)</li> <li>• Family &amp; Community Outreach (to identify resources)</li> <li>• A centralized telephone access point</li> <li>• Data Collection &amp; Monitoring (including service gap analysis)</li> </ul> <p>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.</p>									

**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**

<b>Goal:</b>	Increase percent of Alaska pregnant women and children who have had a preventative dental visit									
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Cumulative number of oral health pocket guides distributed</td> </tr> <tr> <td><b>Denominator:</b></td> <td>N/A</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>1,000</td> </tr> </table>		<b>Numerator:</b>	Cumulative number of oral health pocket guides distributed	<b>Denominator:</b>	N/A	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	1,000
<b>Numerator:</b>	Cumulative number of oral health pocket guides distributed									
<b>Denominator:</b>	N/A									
<b>Unit Type:</b>	Count									
<b>Unit Number:</b>	1,000									
<b>Data Sources and Data Issues:</b>	Alaska Oral Health Program data									
<b>Significance:</b>	<p>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.</p>									

**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**

<b>Goal:</b>	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								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of women currently pregnant or planning pregnancy who are tobacco users and who register with the Quit Line during the calendar year</td> </tr> <tr> <td><b>Denominator:</b></td> <td>N/A</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of women currently pregnant or planning pregnancy who are tobacco users and who register with the Quit Line during the calendar year	<b>Denominator:</b>	N/A	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of women currently pregnant or planning pregnancy who are tobacco users and who register with the Quit Line during the calendar year								
<b>Denominator:</b>	N/A								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	Alaska Quitline data								
<b>Significance:</b>	Quitlines providing telephone counseling for smoking cessation derive from behavioral research and theory and have been shown to be effective when institutionalized at state and national levels. <a href="http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3169380/">http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3169380/</a> 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 10d  
National Performance Measures (NPMs) (Reporting Year 2014 & 2015)**

**State: Alaska**

**Form Notes for Form 10d NPMs and SPMs**

None

**NPM 01 - The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.**

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	157	215	85	178	202
Denominator	157	215	85	178	202
Data Source	Alaska Newborn Metabolic Screening Program				
Provisional Or Final ?				Final	Final

**Field Level Notes for Form 10d NPMs:**

None

**Data Alerts: None**

**NPM 02 - The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)**

	2011	2012	2013	2014	2015
Annual Objective	54.0	54.0	55.0	68.0	68.0
Annual Indicator	52.0	52.0	66.8	66.8	66.8
Numerator					
Denominator					
Data Source	Child and Adolescent Health Measurement Initiative				
Provisional Or Final ?				Final	Final

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2015

**Field Note:**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** 2014

**Field Note:**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** 2013

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**Field Note:**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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4. **Field Name:** **2012**

**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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5. **Field Name:** **2011**

**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Data Alerts: None**

**NPM 03 - The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)**

	2011	2012	2013	2014	2015
Annual Objective	41.0	41.0	43.0	50.0	50.0
Annual Indicator	42.8	42.8	42.8	42.8	42.8
Numerator					
Denominator					
Data Source	Child and Adolescent Health Measurement Initiative				
Provisional Or Final ?				Final	Final

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2015

**Field Note:**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** 2014

**Field Note:**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** 2013

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**Field Note:**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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4. **Field Name:** 2012

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**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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5. **Field Name:** 2011

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**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Data Alerts: None**

**NPM 04 - The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)**

	2011	2012	2013	2014	2015
Annual Objective	63.0	64.0	66.0	59.0	61.0
Annual Indicator	62.0	62.0	56.7	56.7	56.7
Numerator					
Denominator					
Data Source	Child and Adolescent Health Measurement Initiative				
Provisional Or Final ?				Final	Final

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2015

**Field Note:**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** 2014

**Field Note:**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** 2013

**Field Note:**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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4. **Field Name:** 2012

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**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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5. **Field Name:** 2011

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**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Data Alerts: None**

**NPM 05 - Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)**

	2011	2012	2013	2014	2015
Annual Objective	86.0	86.0	87.0	60.0	65.0
Annual Indicator	85.0	85.0	55.2	55.2	55.2
Numerator					
Denominator					
Data Source	Child and Adolescent Health Measurement Initiative				
Provisional Or Final ?				Final	Final

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2015

**Field Note:**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** 2014

**Field Note:**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** 2013

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**Field Note:**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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4. **Field Name:** **2012**

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**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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5. **Field Name:** **2011**

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**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Data Alerts: None**

**NPM 06 - The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.**

	2011	2012	2013	2014	2015
Annual Objective	45.0	45.0	55.0	50.0	52.0
Annual Indicator	45.0	45.0	45.0	45.0	45.0
Numerator					
Denominator					
Data Source	Child and Adolescent Health Measurement Initiative				
Provisional Or Final ?				Final	Final

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2015

**Field Note:**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** 2014

**Field Note:**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** 2013

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**Field Note:**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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4. **Field Name:** **2012**

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**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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5. **Field Name:** **2011**

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**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Data Alerts: None**

**NPM 07 - Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.**

	2011	2012	2013	2014	2015
Annual Objective	60.0	65.0	78.0	70.0	73.0
Annual Indicator	75.5	67.3	72.6	72.6	72.6
Numerator					
Denominator					
Data Source	CDC National Immunization Program				
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2015

**Field Note:**

Data reported for 2014, most recent year available.

Note: For 2011, the annual objective was revised downward to be more in line with the actual achieved rate of 56.6% in CY 2009 (reported in 2010). In 2009 there was a national shortage of Hib and therefore this series was excluded, hence, the lower immunization rate. The achieved rate was later amended when data became available. However, it is no longer possible to change the 2011-2012 objectives in TVIS.

2. **Field Name:** 2014

**Field Note:**

Data reported for 2013, most recent year available.

Note:

For 2011, the annual objective was revised downward to be more in line with the actual achieved rate of 56.6% in CY 2009 (reported in 2010). In 2009 there was a national shortage of Hib and therefore this series was excluded, hence, the lower immunization rate. The achieved rate was later amended when data became available. However, it is no longer possible to change the 2011-2012 objectives in TVIS.

3. **Field Name:** 2013

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**Field Note:**

Updated in 2014 to reflect 2013 data, which just became available.

**Note:**

For 2011, the annual objective was revised downward to be more in line with the actual achieved rate of 56.6% in CY 2009 (reported in 2010). In 2009 there was a national shortage of Hib and therefore this series was excluded, hence, the lower immunization rate. The achieved rate was later amended when data became available. However, it is no longer possible to change the 2011-2012 objectives in TVIS.

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4. **Field Name:** 2012

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**Field Note:**

2011 is the latest data available.

Note: CY 2009 was entered incorrectly. The rate was 56.6%. Source: AK Dept. of Health & Social Services. Epi Bulletin No. 2, "Improving Immunization Coverage Rates in Alaska's Children", Feb. 17, 2011. Hib series was excluded from 2009 analysis due to a national shortage of this vaccine. This series was not included in the National Immunization Survey as was in prior years.

For 2011, the annual objective was revised downward to be more in line with the actual achieved rate of 56.6% in CY 2009 (reported in 2010). In 2009 there was a national shortage of Hib and therefore this series was excluded, hence, the lower immunization rate. The achieved rate was later amended when data became available. However, it is no longer possible to change the 2011-2012 objectives in TVIS.

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5. **Field Name:** 2011

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**Field Note:**

CY 2011: Source: CDC National Immunization Survey, 4:3:1:3:3 series. [http://www.cdc.gov/vaccines/stats-surv/nis/data/tables\\_2011.htm#overall](http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_2011.htm#overall). Accessed 5/3/2013

For 2011, the annual objective was revised downward to be more in line with the actual achieved rate of 56.6% in CY 2009 (reported in 2010). In 2009 there was a national shortage of Hib and therefore this series was excluded, hence, the lower immunization rate. The achieved rate was later amended when data became available. However, it is no longer possible to change the 2011-2012 objectives in TVIS.

**Data Alerts: None**

**NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.**

	2011	2012	2013	2014	2015
Annual Objective	15.0	15.0	12.0	11.5	11.0
Annual Indicator	13.5	12.3	11.0	9.6	9.6
Numerator	201	181	162	140	140
Denominator	14,900	14,702	14,668	14,531	14,531
Data Source	AK Bureau of Vital Statistics	AK Bureau of Vital Statistics	Alaska Bureau of Vital Statistics	Alaska Bureau of Vital Statistics	Alaska Bureau of Vital Statistics
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2015</b>
	<b>Field Note:</b>	2014 data is most recent available for age-specific birth rates.  2015 data will be reported in late 2016.  A coding error was discovered in 2015 that affected teen birth rates reported by Alaska Bureau of Vital Statistics. Corrected annual rates for 2009 through 2014 are 17.7%, 16.3%, 13.4%, 12.3%, 11%, 9.6%, respectively.
2.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Updated with 2014 data. A coding error was discovered in 2015 that affected teen birth rates reported by Alaska Bureau of Vital Statistics. Corrected annual rates for 2009 through 2014 are 17.7%, 16.3%, 13.4%, 12.3%, 11%, 9.6%, respectively.
3.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	Updated with 2013 data. A coding error was discovered in 2015 that affected teen birth rates reported by Alaska Bureau of Vital Statistics. Corrected annual rates for 2009 through 2014 are 17.7%, 16.3%, 13.4%, 12.3%, 11%, 9.6%, respectively.
4.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	Source: Alaska Bureau of Vital Statistics.
5.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b>	Source: Alaska Bureau of Vital Statistics. 2011 is the latest available data

Data Alerts: None

**NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.**

	2011	2012	2013	2014	2015
Annual Objective	60.0	60.0	55.0	55.0	60.0
Annual Indicator	55.4	46.8	46.8	46.8	46.8
Numerator	457	294	294	294	294
Denominator	825	628	628	628	628
Data Source	AK Oral Health Program, 2007 Oral Health Survey.	AK Oral Health Program, 2007 Oral Health Survey.	AK Oral Health Program, 2007 Oral Health Survey.	AK Oral Health Program, 2007 Oral Health Survey.	AK Oral Health Program, 2007 Oral Health Survey.
Provisional Or Final ?				Final	Final

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2015</b>
	<b>Field Note:</b>	2010/2011 BSS dental assessments
2.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	2010/2011 BSS dental assessments
3.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	2010/2011 BSS dental assessments
4.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	2010/2011 BSS dental assessments
5.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b>	Data source: AK Oral Health Program, 2007 Oral Health Survey. Available at <a href="http://www.hss.state.ak.us/dph/wcfh/Oralhealth/docs/2007_OralHealth_Children.pdf">http://www.hss.state.ak.us/dph/wcfh/Oralhealth/docs/2007_OralHealth_Children.pdf</a> . The next survey is awaiting funding.

**Data Alerts: None**

**NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.**

	2011	2012	2013	2014	2015
Annual Objective	3.5	3.5	3.5	2.5	2.5
Annual Indicator	4.1	3.0	2.5	1.9	2.1
Numerator	19	14	12	9	10
Denominator	467,322	472,795	476,961	476,637	476,637
Data Source	AK Bureau of Vital Statistics	AK Bureau of Vital Statistics	Alaska Bureau of Vital Statistics	Alaska Bureau of Vital Statistics	Alaska Bureau of Vital Statistics
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2015</b>
	<b>Field Note:</b>	2014 is most recent year available. Due to small numbers this rate is reported as a 3 year average, 2012-2014.
2.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Due to small numbers this rate is reported as a 3 year average, 2012-2014.
3.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	Due to small numbers this rate is reported as a 3 year average, 2011-2013.
4.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	Due to small numbers this rate is reported as a 3 year average, 2010-2012.
5.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b>	Due to small numbers this rate is reported as a 3 year average, 2009-2011.

**Data Alerts: None**

**NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.**

	2011	2012	2013	2014	2015
Annual Objective	60.0	60.0	60.0	60.0	60.0
Annual Indicator	57.1	57.1	64.3	64.3	63.1
Numerator					
Denominator					
Data Source	CDC National Immunization Program				
Provisional Or Final ?				Final	Final

**Field Level Notes for Form 10d NPMs:**

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1. **Field Name:** 2015
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- Field Note:**  
Data from 2012, most recent year available.
- Data obtained through the National Immunization Survey.  
[http://www.cdc.gov/breastfeeding/data/NIS\\_data/index.htm](http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm)
- 
2. **Field Name:** 2014
- 
- Field Note:**  
Data from 2011, most recent year available.
- Data obtained through the National Immunization Survey.  
[http://www.cdc.gov/breastfeeding/data/nis\\_data/](http://www.cdc.gov/breastfeeding/data/nis_data/)
- 
3. **Field Name:** 2013
- 
- Field Note:**  
Updated to reflect most recent data available, 2011.
- Data obtained through the National Immunization Survey.  
[http://www.cdc.gov/breastfeeding/data/nis\\_data/](http://www.cdc.gov/breastfeeding/data/nis_data/)
- 
4. **Field Name:** 2012

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**Field Note:**

Note: Indicator is now inaccurate. Final 2011 number is 64.3.

Source: [http://www.cdc.gov/breastfeeding/data/nis\\_data/](http://www.cdc.gov/breastfeeding/data/nis_data/)

/2013/ Source: 2007 National Immunization Survey, Centers for Disease Control and Prevention. Available at [http://www.cdc.gov/breastfeeding/data/NIS\\_data/index.htm](http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm). Data is given by child's birth cohort. The latest available data is for children born in 2007, Provisional data for 2009 cohort and final data for 2007-2008 will be added later by CDC. Accessed 5/03/2013. ywg

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5. **Field Name:** **2011**

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**Field Note:**

Note: Indicator is now inaccurate. Final 2011 number is 64.3.

Source: [http://www.cdc.gov/breastfeeding/data/nis\\_data/](http://www.cdc.gov/breastfeeding/data/nis_data/)

Source: 2008 National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services. No new data. Data is given by child's birth cohort. The latest available data is for children born in 2007, Provisional data for the 2008 cohort is not available yet. ywg 5/10/2012.

**Data Alerts: None**

**NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.**

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	97.6	97.9	99.0	99.0	99.3
Numerator	10,413	10,168	10,447	10,353	10,270
Denominator	10,673	10,387	10,555	10,459	10,342
Data Source	AK Newborn Hearing Screening Program				
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2015

**Field Note:**

Data Source: AK Bureau of Vital Statistics, AK Early Hearing and Detection Intervention Program

This indicator measures hospital births occurring in Alaska only. Approximately 6% of births in AK are out-of-hospital births.

2. **Field Name:** 2014

**Field Note:**

This indicator measures hospital births occurring in Alaska only. Approximately 6% of births in AK are out-of-hospital births.

3. **Field Name:** 2013

**Field Note:**

Data Source: AK Bureau of Vital Statistics, AK Early Hearing and Detection Intervention Program

This indicator measures hospital births occurring in Alaska only. Approximately 6% of births in AK are out-of-hospital births.

4. **Field Name:** 2012

**Field Note:**

Data Source: AK Bureau of Vital Statistics, AK Early Hearing and Detection Intervention Program

This indicator measures hospital births occurring in Alaska only. Approximately 6% of births in AK are out-of-hospital births.

**Data Alerts: None**

**NPM 13 - Percent of children without health insurance.**

	2011	2012	2013	2014	2015
Annual Objective	10.5	10.5	10.5	12.0	11.5
Annual Indicator	13.0	14.0	13.0	12.0	12.0
Numerator					
Denominator					
Data Source	Kaiser Family Foundation				
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2015  


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**Field Note:**  
 2015 is most recent data available. 2016 will be available in late 2016.

Data Source: Kaiser Family Foundation  
<http://kff.org/other/state-indicator/children-0-18/>
2. **Field Name:** 2014  


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**Field Note:**  
 2014 is most recent data available. 2014 will be available in late 2015.

Data Source: Kaiser Family Foundation  
<http://kff.org/other/state-indicator/children-0-18/>
3. **Field Name:** 2013  


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**Field Note:**  
 Updated with 2013 data.

Data Source: Kaiser Family Foundation  
<http://kff.org/other/state-indicator/children-0-18/>
4. **Field Name:** 2012  


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**Field Note:**  
 /2015/ Source: Henry Kaiser Family Foundation, State Health Facts online, Alaska: Health Insurance Coverage of Children 0 - 18, states (2011-2012). Based on American Community Survey. Numerators and denominators were not reported. Retrieved 3/19/2014 from <http://www.statehealthfacts.org/profileglance.jsp?rgn=3>.
5. **Field Name:** 2011

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**Field Note:**

/2014/ Source: Henry Kaiser Family Foundation, State Health Facts online, Alaska: Health Insurance Coverage of Children 0 - 18, states (2010-2011). Based on American Community Survey. Numerators and denominators were not reported. Retrieved 7/1/2013 from <http://www.statehealthfacts.org/profileglance.jsp?rgn=3>.

**Data Alerts: None**

**NPM 14 - Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.**

	2011	2012	2013	2014	2015
Annual Objective	20.0	20.0	20.0	20.0	20.0
Annual Indicator	21.4	22.0	21.5	24.1	23.4
Numerator	3,469	3,635	3,308	702	1,932
Denominator	16,192	16,525	15,382	2,917	8,249
Data Source	WIC program, Report #340.	WIC program	WIC program	WIC program	WIC program
Provisional Or Final ?				Final	Final

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2015</b>
	<b>Field Note:</b>	2015 data is a smaller subset of the SFY's data. WIC adopted a new data system (SPIRIT) during SFY 2014. The data reported here is April 2014-June 2014. Data can no longer be retrieved from the old system.
2.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Date: 2014 Source: WIC program  This year's data is a smaller subset of the SFY's data. WIC adopted a new data system (SPIRIT) during SFY 2014. The data reported here is April 2014-June 2014. Data can no longer be retrieved from the old system.
3.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	Date: 2013 Source: WIC program, Report #340. Data covers children 2-4 years, 5 year olds are not included because they are not part of the WIC program. The indicator measures children with a BMI at or above the 95th percentile. AK does not collect data on 85th %-ile. Note that growth curves for Alaska Native children may not be the same as for non-Native children.
4.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	Date: 2013 Source: WIC program, Report #340. Data covers children 2-4 years, 5 year olds are not included because they are not part of the WIC program. The indicator measures children with a BMI at or above the 95th percentile. AK does not collect data on 85th %-ile. Note that growth curves for Alaska Native children may not be the same as for non-Native children.

**Data Alerts: None**

**NPM 15 - Percentage of women who smoke in the last three months of pregnancy.**

	2011	2012	2013	2014	2015
Annual Objective	14.5	14.5	13.0	12.0	12.0
Annual Indicator	13.8		13.4	13.4	13.4
Numerator	1,517		1,464	1,464	1,464
Denominator	10,957		10,960	10,960	10,960
Data Source	PRAMS		AK PRAMS	AK PRAMS	AK PRAMS
Provisional Or Final ?				Provisional	Provisional

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2015</b>
	<b>Field Note:</b>	Source: AK PRAMS, Phase VI Q 31, Phase 7 Q34  2013 reported, most recent data available.
2.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Source: AK PRAMS, Phase VI Q 31, Phase 7 Q34  2013 reported, most recent data available.
3.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	Source: AK PRAMS, Phase VI Q 31, Phase 7 Q34  2013 reported, most recent data available.
4.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	Source: AK PRAMS, Phase VI Q 31. 2012 data not available.

**Data Alerts: None**

**NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.**

	2011	2012	2013	2014	2015
Annual Objective	22.0	22.0	22.0	21.0	21.0
Annual Indicator	23.0	23.6	22.7	30.6	36.7
Numerator	36	36	34	45	54
Denominator	156,509	152,631	149,510	147,108	147,108
Data Source	Alaska Bureau of Vital Statistics Vital Statistics	Alaska Bureau of Vital Statistics Vital Statistics	Alaska Bureau of Vital Statistics	Alaska Bureau of Vital Statistics	Alaska Bureau of Vital Statistics
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2015  
  
**Field Note:**  
Due to small numbers, this indicator is reported by 3-year moving averages.  
  
Most recent data available is 2012-2014; 2013-2015 will be reported in late 2015.

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2. **Field Name:** 2014  
  
**Field Note:**  
Due to small numbers, this indicator is reported by 3-year moving averages.

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3. **Field Name:** 2013  
  
**Field Note:**  
Due to small numbers, this indicator is reported by 3-year moving averages. (2011-2013)

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4. **Field Name:** 2012  
  
**Field Note:**  
Source: Alaska Bureau of Vital Statistics. The most recent data available is 2009 - 2011. This indicator is reported by 3-year moving averages.

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5. **Field Name:** 2011  
  
**Field Note:**  
Source: Alaska Bureau of Vital Statistics. The most recent data available is 2009 - 2011. This indicator is reported by 3-year moving averages.

**Data Alerts: None**

**NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.**

	2011	2012	2013	2014	2015
Annual Objective	86.0	90.0	90.0	90.0	90.0
Annual Indicator	76.9	71.1	61.8	74.5	74.1
Numerator	83	69	68	76	80
Denominator	108	97	110	102	108
Data Source	Alaska Bureau of Vital Statistics	AK Bureau of Vital Statistics	Alaska Bureau of Vital Statistics	Alaska Bureau of Vital Statistics	Alaska Bureau of Vital Statistics
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2015</b>
	<b>Field Note:</b>	2014 is most recent year available. 2015 is provisional data.
2.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	2014 is most recent year available.
3.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	Source: AK Bureau of Vital Statistics.
4.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b>	Source: AK Bureau of Vital Statistics. CY 2011 is most recent data available.

**Data Alerts: None**

**NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.**

	2011	2012	2013	2014	2015
Annual Objective	85.0	85.0	85.0	85.0	85.0
Annual Indicator	78.0	76.9	79.4	78.3	79.8
Numerator	8,432	8,088	8,563	8,516	8,667
Denominator	10,812	10,514	10,778	10,877	10,860
Data Source	Source: AK Bureau of Vital Statistics.	AK Bureau of Vital Statistics	Alaska Bureau of Vital Statistics	Alaska Bureau of Vital Statistics	Alaska Bureau of Vital Statistics
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2015</b>
	<b>Field Note:</b>	2014 data is most recent available.
2.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Updated with 2014 data.
3.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	Updated with 2013 data.
4.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	Source: AK Bureau of Vital Statistics.
5.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b>	Source: AK Bureau of Vital Statistics. CY 2011 is most recent data available

**Data Alerts: None**

**Form 10d**  
**State Performance Measures (SPMs) (Reporting Year 2014 & 2015)**  
**State: Alaska**

**SPM 1 - Percent of women women who recently delivered a live-born infant and reported having one or more alcoholic drinks in an average week during the last 3 months of pregnancy.**

	2011	2012	2013	2014	2015
Annual Objective	1.5	1.5	1.5	1.4	1.4
Annual Indicator	1.8		2.0	2.0	2.0
Numerator	198		214	214	214
Denominator	10,879		10,936	10,936	10,936
Data Source	PRAMS		Alaska PRAMS	Alaska PRAMS	Alaska PRAMS
Provisional Or Final ?				Provisional	Provisional

**Field Level Notes for Form 10d SPMs:**

- 
1. **Field Name:** 2015
- 
- Field Note:**  
2013 data most recent available.
- Source: AK PRAMS, Phase VI Q 36a, Phase 7 Q40
- 
2. **Field Name:** 2014
- 
- Field Note:**  
2013 data most recent available.
- Source: AK PRAMS, Phase VI Q 36a, Phase 7 Q40
- 
3. **Field Name:** 2013
- 
- Field Note:**  
2013 data most recent available.
- Source: AK PRAMS, Phase VI Q 36a, Phase 7 Q40
- 
4. **Field Name:** 2012
- 
- Field Note:**  
2012 data not available
- Source: AK PRAMS, Phase VI Q 36a.

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5.      **Field Name:**                      **2011**

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**Field Note:**

Data for 2011 is not yet available.

**Data Alerts: None**

**SPM 2 - Rate of reports of maltreatment per thousand children 0 - 9 years of age.**

	2011	2012	2013	2014	2015
Annual Objective	65.0	65.0	90.0	92.0	91.0
Annual Indicator	94.2	94.2	92.3	94.2	100.9
Numerator	10,037	10,037	9,978	10,125	10,817
Denominator	106,519	106,519	108,084	107,433	107,218
Data Source	Alaska Surveillance of Child Abuse and Neglect.	Alaska Surveillance of Child Abuse and Neglect.	Alaska Surveillance of Child Abuse and Neglect.	Alaska Surveillance of Child Abuse and Neglect	Alaska Surveillance of Child Abuse and Neglect
Provisional Or Final ?				Final	Final

**Field Level Notes for Form 10d SPMs:**

1. **Field Name:** 2015  
**Field Note:**  
Data revised for 2010-2015 due to improved adoption linkages and revised DOL population estimates.

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2. **Field Name:** 2014  
**Field Note:**  
The data are still provisional as the program continues to progress.

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3. **Field Name:** 2013  
**Field Note:**  
The data are still provisional as the program continues to progress.

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4. **Field Name:** 2012  
**Field Note:**  
Provisional. Accuracy of the indicator will be improved when more AK State Trooper and Child Advocacy Center data is included.

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5. **Field Name:** 2011  
**Field Note:**  
The definition of this performance measure was changed in the FY 2014 application to cover children 0-9 years. Data for 2010 was revised.

Source: Alaska Surveillance of Child Abuse and Neglect. This number includes any "valid" report – validity as determined by the agency and or meets the SCAN criteria of having a valid name and date of birth. Duplicates were excluded. The indicator represents the number of children ages 0-9 with at least one valid report of maltreatment (physical, mental, sexual, or neglect).

Data Alerts: None

**SPM 3 - Percent of mothers who report tooth decay in their 3-year old child.**

	2011	2012	2013	2014	2015
Annual Objective	10.0	10.0	15.0	15.0	14.0
Annual Indicator	17.3	16.2	16.5	17.5	17.5
Numerator	1,850	1,706	1,784	1,852	1,852
Denominator	10,705	10,546	10,827	10,588	10,588
Data Source	Alaska Childhood Understanding Behaviors Survey				
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d SPMs:**

1.	<b>Field Name:</b>	<b>2015</b>
	<b>Field Note:</b>	The latest data available are 2014. 2015 will be available in late 2016.
2.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	The latest data available are 2014. 2015 will be available in late 2016.
3.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	Updated with 2013 data.
4.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	Latest data is for 2011
5.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b>	Latest data is for 2011

**Data Alerts: None**

**SPM 4 - Percent of women who recently delivered a live-born infant and are not doing anything now to keep from getting pregnant.**

	2011	2012	2013	2014	2015
Annual Objective	16.0	15.0	15.0	15.0	15.0
Annual Indicator	18.2		20.5	20.5	20.5
Numerator	1,986		2,236	2,236	2,236
Denominator	10,893		10,923	10,923	10,923
Data Source	PRAMS		Alaska PRAMS	Alaska PRAMS	Alaska PRAMS
Provisional Or Final ?				Provisional	Provisional

**Field Level Notes for Form 10d SPMs:**

1.	<b>Field Name:</b>	<b>2015</b>
	<b>Field Note:</b>	Source: AK PRAMS, Phase V Q 58, Phase VI, Q 61, Phase 7 Q63
		2013 data most recent available.
2.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Source: AK PRAMS, Phase V Q 58, Phase VI, Q 61, Phase 7 Q63
		2013 data most recent available.
3.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	Source: AK PRAMS, Phase V Q 58, Phase VI, Q 61, Phase 7 Q63
		2013 data most recent available.
4.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	Source: AK PRAMS, Phase V Q 58, Phase VI, Q 61.
		2012 data not available

**Data Alerts: None**

**SPM 5 - Percent of high school students who were hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend during the previous 12 months.**

	2011	2012	2013	2014	2015
Annual Objective	8.0	8.0	12.0	12.0	10.0
Annual Indicator	12.0	12.0	9.1	9.1	9.6
Numerator					
Denominator					
Data Source	AK Youth Risk Behavior Surveillance System				
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d SPMs:**

1. **Field Name:** 2015  
  
**Field Note:**  
Source: AK Youth Risk Behavior Surveillance System. The YRBS is a biennial survey that is conducted only in odd years.

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2. **Field Name:** 2014  
  
**Field Note:**  
/2016/ AK Youth Risk Behavior Surveillance System. The YRBS is a biennial survey that is conducted only in odd years.  
  
Data reported for 2013.

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3. **Field Name:** 2013  
  
**Field Note:**  
/2014/Source: AK Youth Risk Behavior Surveillance System. Question changed to "among students who dated or went out with someone during the past 12 months who had been physically hurt on purpose by someone they were dating or going out with one or more times"

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4. **Field Name:** 2012  
  
**Field Note:**  
Source: AK Youth Risk Behavior Surveillance System. Available at Youth Online, <http://apps.nccd.cdc.gov/youthonline/App/Default.aspx>. Numerators and denominators are not reported. The measure applies to traditional high school students. The latest available data is for 2011. Accessed 5/3/2013. ywg

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5. **Field Name:** 2011

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**Field Note:**

Numerators and denominators for the YRBSS are not reported.

Source: AK Youth Risk Behavior Surveillance System. Available at Youth Online, <http://apps.nccd.cdc.gov/youthonline/App/Default.aspx>. Numerators and denominators are not reported. The measure applies to traditional high school students. The latest available data is for 2011. Accessed 5/3/2013. ywg

**Data Alerts: None**

**SPM 6 - Percent of women who recently had a live-born infant and experienced intimate partner violence during pregnancy.**

	2011	2012	2013	2014	2015
Annual Objective	4.1	4.1	4.1	4.1	3.9
Annual Indicator	4.4		5.5	5.5	5.5
Numerator	468		591	591	591
Denominator	10,618		10,806	10,806	10,806
Data Source	PRAMS		Alaska PRAMS	Alaska PRAMS	Alaska PRAMS
Provisional Or Final ?				Provisional	Provisional

**Field Level Notes for Form 10d SPMs:**

1.	<b>Field Name:</b>	<b>2015</b>
	<b>Field Note:</b>	Source: AK PRAMS, Phase VI Q. 39 & 71b, Phase 7 Q44 & 81b
		2013 data most recent available.
2.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Source: AK PRAMS, Phase VI Q. 39 & 71b, Phase 7 Q44 & 81b
		2013 data most recent available.
3.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	Source: AK PRAMS, Phase VI Q. 39 & 71b
		2012 data most recent available.
4.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	Source: AK PRAMS, Phase VI Q. 39 & 71b
		2012 data available now, but unable to update at this point.

**Data Alerts: None**

**SPM 7 - Percent of women who delivered a live birth and had a provider talk to them about post partum depression since their new baby was born.**

	2011	2012	2013	2014	2015
Annual Objective	88.0	88.0	88.0	88.0	90.0
Annual Indicator	82.8		86.1	86.1	86.1
Numerator	8,797		9,118	9,118	9,118
Denominator	10,623		10,585	10,585	10,585
Data Source	PRAMS		Alaska PRAMS	Alaska PRAMS	Alaskas PRAMS
Provisional Or Final ?				Provisional	Provisional

**Field Level Notes for Form 10d SPMs:**

1. **Field Name:** 2015

**Field Note:**

Data Source: AK PRAMS, Q 74d, Phase VI, Phase 7 Q80d

2013 data most recent available.

2. **Field Name:** 2014

**Field Note:**

Data Source: AK PRAMS, Q 74d, Phase VI, Phase 7 Q80d

2013 data most recent available.

3. **Field Name:** 2013

**Field Note:**

Data Source: AK PRAMS, Q 74d, Phase VI, Phase 7 Q80d

2013 data most recent available.

4. **Field Name:** 2012

**Field Note:**

Data Source: AK PRAMS, Q 74d, Phase VI  
2012 data now available but not able to update.

**Data Alerts: None**

**SPM 8 - Percent of women who recently had a live-born infant and reported having one or more environmental factors in the home that are associated with SIDS/unexplained asphyxia.**

	2011	2012	2013	2014	2015
Annual Objective	60.0	60.0	64.0	64.0	62.0
Annual Indicator	66.1		55.7	55.7	55.7
Numerator	7,051		5,950	5,950	5,950
Denominator	10,664		10,674	10,674	10,674
Data Source	PRAMS		Alaska PRAMS	Alaska PRAMS	Alaska PRAMS
Provisional Or Final ?				Provisional	Provisional

**Field Level Notes for Form 10d SPMs:**

1. **Field Name:** 2015

**Field Note:**

Source: AK PRAMS, Phase VI Q. 58, 59 c-f., Phase 7 Q60, 61c-f

2013 data most recent available.

HP 2020 Obj: Reduce infant deaths from sudden unexpected infant deaths (including SIDS, unknown cause, accidental suffocation and strangulation in bed) to 0.84 per 1,000 live births. 2006 US baseline: 0.93

2. **Field Name:** 2014

**Field Note:**

Source: AK PRAMS, Phase VI Q. 58, 59 c-f., Phase 7 Q60, 61c-f

2013 data most recent available.

HP 2020 Obj: Reduce infant deaths from sudden unexpected infant deaths (including SIDS, unknown cause, accidental suffocation and strangulation in bed) to 0.84 per 1,000 live births. 2006 US baseline: 0.93

3. **Field Name:** 2013

**Field Note:**

Source: AK PRAMS, Phase VI Q. 58, 59 c-f., Phase 7 Q60, 61c-f

2013 data most recent available.

HP 2020 Obj: Reduce infant deaths from sudden unexpected infant deaths (including SIDS, unknown cause, accidental suffocation and strangulation in bed) to 0.84 per 1,000 live births. 2006 US baseline: 0.93

4. **Field Name:** 2012

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**Field Note:**

Source: AK PRAMS, Phase VI Q. 58, 59 c-f.  
2012 data now available but unable to update.

HP 2020 Obj: Reduce infant deaths from sudden unexpected infant deaths (including SIDS, unknown cause, accidental suffocation and strangulation in bed) to 0.84 per 1,000 live births. 2006 US baseline: 0.93

**Data Alerts: None**

**SPM 9 - Percent of mothers who report their 3-year-old child had a BMI greater than the 85th percentile (overweight and obese).**

	2011	2012	2013	2014	2015
Annual Objective	25.0	25.0	36.0	36.0	35.0
Annual Indicator	39.0	43.4	36.6	39.0	39.0
Numerator	3,241	3,462	2,942	3,264	3,264
Denominator	8,317	7,979	8,029	8,376	8,376
Data Source	Alaska Childhood Understanding Behaviors Survey				
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d SPMs:**

1.	<b>Field Name:</b>	<b>2015</b>
	<b>Field Note:</b>	Latest data available for 2014. 2015 will be available in late 2016.
2.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Latest data available for 2014. 2015 will be available in late 2016.
3.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	Updated with 2013 data.
4.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	Updated with 2012 data.
5.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b>	Latest data is for 2011.

**Data Alerts: None**

**SPM 10 - Percent of preterm births at 34-36 weeks completed gestation.**

	2011	2012	2013	2014	2015
Annual Objective	5.0	5.0	5.0	25.0	24.5
Annual Indicator	6.7	25.3	24.9	25.2	24.7
Numerator	771	2,820	2,853	2,872	2,792
Denominator	11,436	11,148	11,451	11,398	11,285
Data Source	AK Bureau of Vital Statistics.	AK Bureau of Vital Statistics	Alaska Bureau of Vital Statistics	Alaska Bureau of Vital Statistics	Alaska Bureau of Vital Statistics
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d SPMs:**

1. **Field Name:** 2015

**Field Note:**

In 2012 this indicator was changed to measure 37-38 completed gestation weeks which we felt was more meaningful. This measure was used to support the March of Dimes '39 Week' campaign. For 2005 the percent was 24.6%, for 2006 it was 24.9%, for 2007 it was 26.2%, for 2008 it was 26.3, for 2009 it was 25.1%, for 2010 it was 24.5%, for 2011 it was 25.1%, and for 2012 it was 25.3%.

2. **Field Name:** 2014

**Field Note:**

In 2012 this indicator was changed to measure 37-38 completed gestation weeks which we felt was more meaningful. This measure was used to support the March of Dimes '39 Week' campaign. For 2005 the percent was 24.6%, for 2006 it was 24.9%, for 2007 it was 26.2%, for 2008 it was 26.3, for 2009 it was 25.1%, for 2010 it was 24.5%, for 2011 it was 25.1%.

3. **Field Name:** 2013

**Field Note:**

Updated with 2013 data.

In 2012 this indicator was changed to measure 37-38 completed gestation weeks which we felt was more meaningful. This measure was used to support the March of Dimes '39 Week' campaign. For 2005 the percent was 24.6%, for 2006 it was 24.9%, for 2007 it was 26.2%, for 2008 it was 26.3, for 2009 it was 25.1%, for 2010 it was 24.5%, for 2011 it was 25.1%.

4. **Field Name:** 2012

**Field Note:**

In 2012 this indicator was changed to measure 37-38 completed gestation weeks which we felt was more meaningful. This measure was used to support the March of Dimes '39 Week' campaign. For 2005 the percent was 24.6%, for 2006 it was 24.9%, for 2007 it was 26.2%, for 2008 it was 26.3, for 2009 it was 25.1%, for 2010 it was 24.5%, for 2011 it was 25.1%.

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5. **Field Name:** 2011

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**Field Note:**

The latest available data is for 2011.

**Data Alerts: None**

**Form 11**  
**Other State Data**  
**State: Alaska**

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the current application/annual report.

## State Action Plan Table

State: Alaska

Please click the link below to download a PDF of the full version of the State Action Plan Table.

[State Action Plan Table](#)

**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 ESM 1.2	

**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 ESM 5.2 ESM 5.3 ESM 5.4	
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 3
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