



Alaska Maternal and Child Health FY 2015 Title V Block Grant

National Performance Measure #1:

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.

Last year's accomplishments:

The percentage of infants receiving the newborn metabolic screen was 98.6% in CY2013. The children who did not receive this screening were found to have opted out of testing through the parent refusal process. Quality assurance continues to capture an accurate number of infants who receive their first newborn screen.

Data on the number of disorders continued to be compiled. Infants identified with fatty acid oxidation disorders and organic acidemia disorders needing specialty follow-up were referred to the Genetics and/or Metabolic Clinics conducted by the State of Alaska. Infants identified with hypothyroidism and congenital adrenal hyperplasia were referred to the Alaska-based pediatric endocrinology clinic and started on treatment. Infants needing confirmatory testing for, or identified with cystic fibrosis were referred to the local pediatric pulmonologist.

The Newborn Metabolic Screening (NBMS) Advisory Committee held its regular meetings three times per year and included a presentation by a pediatric hematologist on hemoglobinopathies and the chair of the committee, a local pediatrician, gave an overview of specimen retention and research utilizing blood spots and what we might expect in the future on this hot topic. The advisory committee consists of many of the pediatric specialists who care for children identified with disorders through this program.

Ongoing educational efforts included presentations to physicians, nurses, and laboratory personnel at hospitals and professional organizations regarding the screening program, proper collections techniques, and proper follow-up testing of presumptive positive screens. Practice profile reports regarding specimen collection errors were shared quarterly with designated birthing center staff, with additional follow-up when indicated. In collaboration with the NBMS program, the committee chair of the Alaska NBMS Advisory Committee, a local pediatrician, presented on NBMS at pediatric grand rounds.

The Alaska Native Tribal Health Consortium (ANTHC), Oregon Health and Sciences University (OHSU), and the Alaska NBMS program continued to partner on efforts related to CPT-1A testing and education. The metabolic consultant from OHSU continued to work on improving the testing algorithm to reach 100% ascertainment.

The Critical Congenital Heart Defects (CCHD) steering committee of pediatric cardiologists, pediatricians, nurses, and nurse midwives continued to implement pulse oximetry screening in Alaska. Alaska began work with the Children's National Medical Center on adapting their tool kit to meet the needs of Alaska. In collaboration with the committee, the NBMS program created and a toolkit for birthing centers and hospitals which included the following information: State of Alaska position statement on pulse oximetry screening, resources on equipment and referrals, training information, screening algorithm, and patient information resources. Many hospitals had implemented screening already and others were in varying stages towards implementation. A law passed requiring newborn screening for CCHD in birthing facilities. This is an unfunded mandate with no support for personnel or data systems. WCFH does not have a program



to track abnormal results, but will collect semi-annual data on the number of births, number of children screened, total number of abnormal results, and the number of refusals.

Current activities: (character limit: 1,500)

The NBMS program welcomed a new co-manager. The NBMS co-managers continued quality assurance activities and education. A presentation on NBMS and specimen collection for nursing staff was held at a local birthing facility. The Alaska NBMS brochure was updated.

The NBMS is creating a training video on specimen collection, handling, and transport in collaboration with the public information team and a local birthing facility. The NBMS program also distributed a webinar on specimen collection.

The NBMS advisory committee held three meetings which included presentations on NBMS program updates, CPT-1A, cystic fibrosis, SCID, and congenital hypothyroidism.

Cut-offs for CPT-1A changed resulting in more children being identified on the first screen. The DVD for CPT-1A was updated and distributed.

Legislation for CCHD began 1/1/14. The NBMS staff updated regulations and reporting went into effect. The CCHD Steering Committee met and members continue to promote pulse oximetry screening. A CCHD toolkit for birthing facilities was created and distributed across the state.

The NBMS co-managers visited the State Public Health Lab, the backup site in the event of a disaster.

Alaska continued work with the EHDI database vendor and Oregon Public Health Laboratory (OPHL) to ensure NBMS data goes into the integrated database. Quality improvement activities on the birth matching process continue and provide better data on refusals and screening coverage.

Plans for the coming year: (character limit: 3,000)

The Alaska NBMS program will continue to provide education and outreach related to disorders identified by screening, proper specimen collection and transport, and changes to the program. Children identified with metabolic disorders will continue to be referred to the appropriate specialist and to the Alaska Genetics and/or Metabolic clinics for any needed follow-up.

The newborn metabolic advisory committee will hold three meetings in the upcoming year which will include presentations of interest to the group as well as provide program updates and discuss new developments of interest to the NBMS community.

It is anticipated that SCID will be added to our state newborn screening panel in January 2015. To facilitate this, fees will increase for newborn metabolic screening. The program will continue to collaborate with a local pediatric immunologist on outreach related to this disorder.

Alaska will continue to collaborate with ANTHC and OHSU on the testing algorithm for CPT-1A and will be exploring more opportunities to learn more about this disorder and the possible effects on Alaska children. As the testing evolves and more information on the disorder is obtained, the program will outreach to Alaska Native communities where



children are most affected by this disorder. The increase in ascertainment will also result in an increase in infants identified with CPT-1A. The Western State Genetics Services Collaborative has joined the other partners in a new CPT-1A long term follow-up project which is under development. The NBMS program will continue to be an active partner as this study progresses.

Continuing on work from SFY14, the NBMS program aims to use an integrated database for both the Alaska NBMS program and the hearing screening program for tracking and follow-up. The Alaska NBMS will continue quality assurance activities. The matching process will continue to ensure all newborns receive screening, provide better data on refusals, streamline the process, and decrease duplication for birthing centers and program staff. Practice profiles will continue to be distributed, and the program managers will continue to visit birthing center staff and provide education to providers.

The program will also continue to collaborate with the Western States Genetics Services Collaborative on efforts related to newborn metabolic screening and genetic services in Alaska.

The Alaska State Public Health Laboratory and the NBMS program will create a memorandum of understanding to ensure all needed space, supplies, and equipment are available in the event of a disaster.

Activities – NPM 1	Pyramid Level of Services			
	DHC	ES	PBS	IB
1. Continue with education and outreach to providers on tandem mass spectrometry and disorders identified through newborn metabolic screening				X
2. Continue education and monitoring of specimen quality to assure a high level of screening is conducted				X
3. Provide community education through presentations at hospitals, birthing centers, professional organization meetings, health fairs, and grand rounds				X
4. Refer infants identified with disorders detected through the screening program to State-sponsored Genetics and/or Metabolic clinics		X		
5. Provide information on reportable conditions identified through newborn screening to the Alaska Birth Defects Registry on a quarterly basis			X	X
6. Convene the Newborn Metabolic Screening Advisory Committee three times per year to review program activities and policies				X



7. Continue to work with the EHDI web-based database vendor to enhance the reporting and searching function of the metabolic integration				X
8. Prepare for implementation of SCID screening and plan educational activities on this addition			X	
9. Continue active participation on the Western States Genetic Services Collaborative to improve access to and education surrounding genetics services in Alaska		X	X	X
10. Continue collaboration with Alaska Native Tribal Health Consortium and Oregon Health & Science University to educate families and healthcare providers regarding CPT-1A and distribution of the DVD and information card		X		X
11. Continue quality improvement activities surrounding the birth matching process to ensure accurate data and that no children miss their newborn screen.				X
12. Collect data on CCHD screening from birthing facilities			X	



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National Performance Measure #2:

The percentage of children with special health care needs age 0-18 whose parents' partner in decision-making at all levels and were satisfied with the services they receive.

Last Year's Accomplishments:

The Section of Women's Children and Family Health (WCFH) represented and conducted Title V initiatives in the State of Alaska (SOA) within the Division of Public Health. WCFH supported families of children and youth with special healthcare needs (CYSHCN) in decision-making, ensuring satisfaction with the services they receive by aligning with the MCH pyramid goals of building infrastructure, population-based services, enabling services, and direct services. Several key project areas were successfully integrated and families partnered in decision-making.

WCFH on-going advisory committees continued for families and youth. They were the Early Hearing Detection & Intervention (EHDI), Newborn Metabolic Screening (NBMS), Youth Alliance for a Healthier Alaska (YAHA), and the Alaska Health and Disabilities Committee (AHDC).

The Statewide Family Advisory Committee (SFAC) effort to include families in decision making was a continued collaboration with the State's Family Voices representative from Stone Soup Group (SSG) and the Children's Hospital at Providence (TCHAP) Parent Services Manager. During FY13, families voiced concern that the tribal health organizations and rural health care issues did not have adequate representation and recommended getting a staff leader from Alaska Native Medical Center (ANMC). Late in FY13, the committee successfully recruited a tribal and rural health leader from ANMC. In an effort to broaden the statewide family perspective, the SFAC leaders continued to recruit family members whose children had genetic disorders, chronic health conditions, or disabilities. During trimester meetings, each agency had 20 minutes to ask a family partnership question; this resulted in family input on institutional decision-making at all levels.

The SSG trialed "Community Conversation to Solutions Circles" in four locations. These forums gave WCFH a comprehensive community snapshot of family and youth needs. SSG's written report validated the need for comprehensive care coordination, subspecialty services, and home care or respite as top priorities. These needs and gaps served as a strong reminder to continue a focused effort on expanding these services.

During the community scan and site visits of the thirteen pediatric neurodevelopmental (PND) outreach clinics, families and providers both voiced a strong need for intensive and focused community-based training on early screening and identification, improved family driven communication for schools and medical providers, behavioral intervention skills, and advocacy skill building.

Another significant initiative in FY13 was the community-based assessment by the Alaska Health and Disabilities Committee (AHDC). They contracted with an agency which conducted two comprehensive community scans. Two reports were written which summarized the needs of youth and adults with disabilities and also a summary of needs for the community providers that served them. The WCFH AHDC managed and ensured the report was successfully distributed to stakeholders.

The successful placement of two pediatric care coordinators through the D-70 medical home project also provided direct family input. The medical home project, as a demonstration grant, modeled family integration. Because each site valued the services, both considered creating full time permanent positions post projects.



The SSG agency continued to serve in a primary role as a liaison for parents of CYSHCN seeking services under a SOA grant for parent navigation during the outreach clinics.

Post-clinic evaluations were conducted at the CL/P, genetic/metabolic, and neurodevelopmental clinics to measure family satisfaction with overall services and family expectations. Responding to the question of overall services or expectations, respondents rated the CL/P clinic as 82.5% satisfied or extremely satisfied; respondents for the genetic clinics were 78% satisfied or extremely satisfied. For the neurodevelopmental clinics, 94% respondents would recommend or highly recommend the clinic to others. WCFH continued to hold quarterly meetings with the SSG parent navigators to refine and improve service delivery; WCFH considered options for improving return rates.

Current activities: FY14

During FY14, successful projects that continue because of their effective integration and partnership with families include the committees on EHDI, NMBS, YAHA, and AHDC issues. The "Community Conversations to Solutions Circle" is now offered as part of a menu of training options for the PND outreach clinic week. The medical home care coordinators continue to develop site specific processes and procedures for involving families which confirms the importance of the family and child as the centerpiece for health care. With the inclusion of an ANMC leader, the SFAC continues to recruit and expand outreach to parents to participate in trimester calls. In response to the family expression of better training, the APSM expanded training in FY14 during the neurodevelopmental clinics. WCFH, responding to the report on Alaskans with Disability and Health created materials addressing emergency preparedness for at home and in schools. WCFH continues to partner with the ANMC to fund a full-time genetic counselor to provide services to families. The MCH block grant continues to fund parent navigation services at the outreach clinics which help to efficiently serve families in their home community and support referrals at the local level. The AHDC committee identifies lifespan concerns of CYSHCN. WCFH holds special events annually for families, specifically hosting events for families of children experiencing phenylketonuria (PKU).

Plan for the Coming Year: FY 15

Seeing the strength and success of the family forums, focus groups, and committees, WCFH will continue with and expand the numbers of family and youth participants in the SFAC, EHDI, NBMS, YAHA, and AHDC committees. They will specifically try to enroll families with younger children and CYSHCN.

The SFAC will use input provided by family members at the four organizations to improve care delivery. The family's opinions are expected to serve as a guide for new projects and program expansions. There will be a special emphasis on the recruitment of families who are tribal health beneficiaries now that ANMC has joined the committee. The committee is also considering inclusion of the Center for Human Development's LEND Family Leadership Fellows to provide direction on family leadership skill development.

A menu of training options will provide intensive and customizable training and awareness activities for providers in each of the respective PND sites. Offering a menu allows for each community to identify their unique needs. The expected outcome will be improved relationships and a targeted focus on the child's needs when families and staff of both the health and educational systems can access training and become more engaged. An example is the paired training for providers - "Advocates, Not Adversaries" and for families - "Advocacy into Action." These courses are taught by CHD – Alaska's AUCD. Other trainings will include strategies for children with challenging behaviors, dispelling myths, effective early identification and screening, medical home model, and state-wide services.

WCFH anticipates continued collaboration with SSG family programs, especially the annual parent summit, statewide "Community Conversation to Solutions Circles," and community-based trainings during neurodevelopmental clinics.



Parent navigation services will continue for the CL/P and neurodevelopmental clinics and for infant and families participating in the EHDI program.

Continued collaboration is expected with ANMC to ensure a full-time genetic counselor is available.

WCFH staff will continue to participate in the Association for Maternal Child Program (AMCHP) family and youth leadership committee, the annual conference committee (ensuring family workshops are available), and the Family Mentor project. Partnering with SSG and CHD, WCFH staff will continue to investigate organized programs for family leadership beyond the local Parents in Policy Making and LEND Fellowship. Examples include the national Family Leadership Training Institute (CT) and the MCH Navigator – the online learning portal.

The Health and Disabilities Project is expected to complete and publish their long-range plan, and WCFH staff will support the identified goals to improving access for youth and adults with disabilities for better nutrition, exercise opportunities, specific smoking cessation tools, and health screening activities. Other goals include improvement and access to oral health and safety.

NPM 2 FY 2015 Activities <i>CYSHCN who partner in decision making</i>	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identify a minimum of 5 new families and enroll them as a member of the SFAC, EHDI, NBMS, YAHA, or AHDP committees			X	
2. In partnership with Alaska's Family Voices/SSG continue "Community Conversation to Solutions Circles" during PND clinic week to gain information from families on service needs and solutions to barriers.			X	
3. Explore the value of and potentially develop an online survey tool to increase return rates for the genetic, PND, and CL/P clinics			X	
4. Streamline the Training Menu ensuring a minimum of 75% of clinic sites participate.		X		
5. Provide a parent navigator (PN) for CL/P and PND clinics; offer PN for children with newly diagnosed hearing loss.		X		
6. Continue joint effort to maintain a fulltime genetic counselor with ANMC			X	
7. Finalize the 5-year plan for the Health and Disabilities project; support access goals for improved nutrition, exercise, smoking cessation opportunities.				X
8. Investigate family leadership training programs				X



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National Performance Measure #3:

The percentage of children with special health care needs age 0-18 who receives coordinated, ongoing, comprehensive care within a medical home.

Last Year's Accomplishments:

WCFH is the lead agency for a HRSA funded "D70" Pediatric Medical Home program to improve the system of care for children and youth with special health care needs. The program focuses on three primary goals: promoting Medical Home "Model Clinic Sites" through comprehensive care coordination for CYSHCN, expanding provider access to medical home concepts and tools, partnering with Medicaid to integrate "Bright Futures" into clinical practice, and to integrate and adopt quality measures from related statewide initiatives for sustainability and continuous quality improvement.

Identification of a well-known community leader as WCFH's Physician Champion for PCMH was a major highlight of the previous year's activities. Integral to this program, two WCFH hired care coordinators continued their work in partner clinics with the Children's Hospital at Providence (TCHAP) Pediatric Sub-Specialty Clinic and a rural Federally Qualified Health Center (FQHC). Specific activities focused on the use of these clinic-based care coordinators to develop capacity for pediatric screening and well-child visit monitoring, link families with needed services and referrals, and provide community outreach and resource development. Program staff provided technical assistance to increase use of evidence-based tools for early identification such as the Ages and Stages Questionnaire and the Modified Checklist for Autism in Toddlers in collaboration with the state EPSDT coordinator, public health nurses and the program's partner clinics.

The section has continued collaborative work on multiple patient-centered medical home PCMH capacity building and demonstration projects including:

The All Alaska Pediatric Partnership (AAPP)'s "First 1000 Days" which provides a primary partnership for WCFH's PCMH related work. The AAPP is a private-public partnership agency working to link services through collaborative opportunities. The organization is utilizing the Collective Impact model of strategic planning and implementation to focus on four core areas of early childhood health and development with a focus on PCMH and care coordination. A workgroup has been established in which the WCFH D70 program manager is co-chair along with the D70 program's Physician Champion.

Tri-State Children's Health Improvement Consortium (TCHIC) operates the CHIPRA program in partnership with Oregon and West Virginia to explore and develop pediatric PCMH capacity

The Alaska Patient-Centered Medical Home Initiative (AK-PCMH-I) is a dually funded initiative (Alaska Department of Health and Social Services with the Alaska Mental Health Trust Authority) in partnership with the Alaska Primary Care Association to promote PCMH development, payment reform, and policy change.

WCFH identified, collaborated, and educated primary care providers to promote the medical home model of care during outreach clinics on resources and tools available for CYSHCN. Efforts focused on successful linkages, public information efforts, and marketing support for Stone Soup Group's (SSG) training opportunities with partners in regional hubs.



Ongoing outreach activities were conducted, including another successful annual direct mailing to parents of newborns containing developmental milestone and early childhood resources. This is the fourth year of this mailing which began originally as an activity through the “Learn the Signs, Act Early” campaign funded by HRSA/CDC in 2010. The mailing is a collaborative effort with the state’s Part C Early Intervention program and this year included an additional partnership with the University of Alaska’s Center for Human Development; the state’s University Center for Excellence in Developmental Disabilities. The materials included in the mailing seek to educate parents on developmental milestones and encourage families to link back to their medical homes for on-time well child care as well as any developmental concerns. Approximately 10,000 families were reached directly in this year’s mailing.

Current Activities

In partnership with Boston Children’s Hospital, the American Academy of Pediatrics, the All Alaska Pediatric Partnership, AAPP, and the University of Alaska, a national training curriculum for pediatric care coordination was adapted and formatted for distance-based delivery as a continuing education class through the University. Coordination of this effort was led by WCFH’s D70 program manager along with the AAPP and included focus group participation of families of children with special health care needs as well as people currently acting as care coordinators within clinical settings throughout the state. The class was designed to provide a standard level of basic training for a variety of staff that provides care coordination services within a primary care setting.

Two pediatric care coordinators continued to work on the partner clinics.

WCFH is working on a new HRSA grant application for funding to continue D70 program work. WCFH would work with stakeholders to increase the proportion of children with special health care needs who receive integrated care through a patient/family-centered medical home approach by 20% over 2009/2010 levels.

AAPP’s PCMH workgroup activities include plans for payment reform advocacy and ongoing public education on the PCMH concept. Additionally, this group will form the foundation of an advisory/oversight committee for future WCFH lead activities related to PCMH.

Plan for the Coming Year:

The new distance-based Pediatric Care Coordination Training Program is a ten week class that consists of eight weekly modules and a two week final project. Weekly modules include the following:

1. Introduction/Overview of care coordination and concepts of PCMH
2. Communication and its impact on care coordination and health of patients and families
3. Understanding social determinants of health – building and connecting community resources
4. Care coordination as a continuous partnership
5. Family partnerships in care coordination
6. What are health-related social services
7. Integrating care coordination into our everyday work
8. Care coordination measurement, outcomes and evaluation

The class will be piloted in summer 2014 with a cohort of 25 students. It will likely be offered at least once annually thereafter.

CYSHCN systems integration work will continue with a PCMH focus into the next year and beyond. The Pediatric Medical Home Program Manager and WCFH will continue to act as a central collaborator with the state’s PCMH



Physician Champions, Medicaid, Behavioral Health, Tribal Health, the All Alaska Pediatric Partnership and other central stakeholders to continue promotion and further development of the PCMH model for Alaska's children.

WCFH will sponsor conferences, webinars, and workshops as needed based on input from WCFH led family advisory groups. Comprehensive patient centered service delivery will continue across all the clinics. Ensuring continuity of care, the Early Hearing Detection and Intervention (EHDI) Program Manager will continue to ensure providers have the most current and accurate information available for children diagnosed with hearing loss and encourage families and stakeholders to embrace the PCMH model of care for these children. The Autism and Parent Services Manager will continue to conduct site visits to ensure current contacts are correct and to distribute brochures on topics including autism, EPSDT and the PCMH model. The Maternal, Infant, and Early Childhood Home Visitation (MIECHV) and Healthy Start home visiting programs will continue to promote the importance and value of the medical home with families.

Parent Navigation services will continue to be offered in collaboration with Stone Soup Group (the state's Family to Family Information Center and Family Voices agency) in Title V sponsored clinics and the EHDI program along with the distribution of contact information for families to continue to access parent navigation services via a toll-free number.

Additional planned activities include the PCMH standardized "CAHPS Patient Experience" survey and Family Voices Provider Survey in partnership with up to four community based clinics. The evaluation of Pediatric Care Coordination Training Program is planned for 2015. And finally the statewide primary care community mapping of PCMH readiness (LEND fellow partnership) will also be implemented.

FY 2014 Activities NPM3 <i>Coordinated and comprehensive care through medical home</i>	Pyramid Level of Service			
	DHC	ES	PBS	IS
1. Link community partnerships and support policy development through identification of PCMH Physician Champion and identified leadership in public and private sectors				X
2. Surround and support integration of care coordinators on the CYSHCN team for the 2 pediatric medical home pilot sites		X		
3. Conduct site visits and distribute emergency preparedness, Autism, EPSDT materials at 11 regional outreach clinics		X		
4. Support and maintain 100% access to parent navigation services for parents of children with CL/P, hearing loss, and neurodevelopmental disorders		X		
5. Educate primary care providers regarding newborn hearing screening regulations and the protocol regarding infants/children identified with hearing loss			X	
6. Enhance workforce capacity and competency through development of pediatric care coordination curriculum				



				X
7. Sponsor primary care and behavioral health provider training activities to encourage integrated care for CYSHCN		X		
8. Medical home will continue to be addressed with families in the two home visiting programs		X		



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National Performance Measure #4

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

Last Year's Accomplishments:

Women's Children and Family Health (WCFH) collected and tracked insurance payments for children accessing the MCH Block Grant supported and State-sponsored services for children and youth with special healthcare needs (CYSHCN). WCFH staff documented billings, the number of families who self-pay, do not have insurance, or are unable to pay for services despite a sliding fee scale. Families with no insurance were offered sliding fee scales and payment plans. Services were delivered to children regardless of their ability to pay through a combination of SOA general and MCH Block grant funds. The largest percentages of unpaid fees (across all clinics) were for those who were self-pay.

The Data Resource Center for Child and Adolescent Health 2009/10 survey reported that nearly 11% of Alaskan children have special healthcare needs, affecting nearly 18% of Alaska households. In this survey, families reported 96% of CYSHCN were insured but that a significant portion of the households (43%) also reported that the insurance wasn't consistent or adequate. The 2011/12 NSCH National Chart book profiles add that 77% of Alaska's children used preventative care visits versus 84% nationwide. Only 72% versus 77% nationwide received preventative dental care. Alaska however surveyed better in developmental screenings, 32% versus 30% nationwide.

Alaska did not accept Medicaid expansion through the Affordable Care Act. WCFH staff worked to and ensured that the needs of CYSHCN were met. A contract with the Alaska Native Tribal Health Consortium (ANTHC) provided Indian Health Services (IHS) funds as payer of last resort for genetics and specialty clinics services. United Healthcare (formerly Department of Defense Tri-Care) covered the cost of clinic visits for military dependents referred to state-sponsored clinics.

WCFH billed Medicaid/Denali Kid Care (DKC), private insurance providers, United Healthcare, IHS and families without insurance for CL/P, genetic/metabolic, and pediatric neurodevelopmental clinics (PND):

1. Cleft Lip/Palate Clinic: 65% billed to Medicaid/Denali Kid Care; 15% was billed to private insurance providers; 7% billed as self-pay; 9% billed to IHS; and 4% billed to United Healthcare.
2. Pediatric Neurodevelopmental outreach clinic: 62% billed to Medicaid/Denali Kid Care; 22% billed to private insurance providers; 8% billed as self-pay; 5% billed to IHS; and 3% billed to United Healthcare.
3. Metabolic/Genetics clinic: 50% billed to Medicaid/Denali Kid Care; 34% billed to private insurance providers; 7% billed as self-pay; 2% billed to IHS; and 7% billed to United Healthcare.

The table below lists the total billed percentage by payer and the total collected annually for all clinics. This provided the ability to conduct a comparative review.



BILLED to:	FY12	FY13	PAID by:	FY12	FY13
Private insurance	22%	28%	Private insurance	14%	17%
United Healthcare (DOD)	8%	6%	United Healthcare (DOD)	8%	6%
Medicaid/DKC	54 %	55%	Medicaid/DKC	68 %	67%
I.H.S.	5%	4%	I.H.S.	4%	5%
Self-pay	11%	7%	Self-pay	10%	5%

These numbers indicated an increase in Medicaid/DKC billings followed by private insurance providers. Families who are uninsured or have no other access are fewer and found it harder to pay for these services.

The Providence Autism Diagnostic Network received money through WCFH from the State of Alaska (SOA) for infrastructure building. They continued to provide quarterly reports which documented funding sources for the medical diagnosis of autism. Of patients seen for a full diagnostic workup, 58% had Medicaid/DKC; 10% had military benefits; 0% were self-pay; 22% used private insurance; and 9% used IHS as their primary source of insurance.

Families, advocates, and the Governor’s Council on Disabilities and Special Education (GCDSE) were successful in the passage during FY12 of SB74, a bill ensuring private payers include autism therapies and services, specifically applied behavior analysis. In FY13, an amendment was successfully passed to extend the implementation deadline. The original bill had an aggressive deadline to establish policy. This extension, though difficult for families, was designed to ensure a thoughtful and comprehensive policy would be written.

Collaboration continued with ANTHC and the Division of Health Care Services to ensure family needs were met. The Early Hearing Detection and Intervention program has a supply of hearing aids for families lacking another funding source.

Current Activities:

The amendment for SB74 included the creation of an Autism Legislative Task Force (ALTF) to design and write insurance implementation policy and procedure for private providers licensed in the state. The ALTF receives direction and support from the GCDSE Autism Ad Hoc Committee and WCFH staff. WCFH actively participated in the ALTF creation of a white paper which was a “State of the State” for Alaska autism services.

WCFH staff monitored the trends indicating a significant decline in both the ability to bill and collect from private insurance providers. Staff will also monitor and design strategies for successful self-pay collections to ensure the limited resources are appropriately allocated.

WCFH continues to maintain a seat on the “Commission on Young Children,” a group dedicated to the on-going and coordinated effort of improving access to quality information and education on early childhood care programs for young children and families. WCFH continues to partner with the Division of Healthcare Services to evaluate reimbursements rates for EPSDT, supporting the standardized and evidence-based practice of earlier identification during the crucial early years. Efforts are made to work with the Division of Public Assistance to streamline the processing of applications of newly pregnant women seeking healthcare.



WCFH continues to wait for direction from the State of Alaska's Governor regarding insurance access through the implementation of the Affordable Care Act.

Plans for the Coming Year:

Stone Soup Group (SSG) parent navigators for the outreach clinics and the information and referral specialists in the SSG main office will continue community surveillance of provider insurance billing policies. SSG uses staff to survey local providers semi-annually on current billing practices and maintains an information bank for families and local agencies to get accurate information. For example, some providers temporarily suspend accepting new Medicaid patients to balance reduced collections. SSG is a "first call" to determine who is currently accepting new patients with Medicaid. Gathering information from parent navigators and from parents directly during the Statewide Family Advisory Council, WCFH will monitor the challenges families are facing accessing and paying for services.

WCFH staff will continue to meet with Medicaid/DKC and ANTHC to provide needed services for CYSHCN who are tribal health beneficiaries. The statewide genetic, metabolic, CL/P and neurodevelopmental outreach clinics will continue to provider services on a sliding fee scale. The SOA will work to cover additional formulas for infants identified with metabolic disorders. Additionally, a popular program that was established by the Mental Health Trust to provide hearing aids for loaning purposes was discontinued. As a result, the Early Hearing Detection and Intervention (EHDI) program is investigating alternative funding for hearing aids to newly diagnosed young children with deafness/ hearing loss. WCFH will continue to work to streamline the process of newly pregnant women to obtain health care and to collaborate with ANTHC to provide needed services for tribal health beneficiaries. Collaboration will continue and through advocacy new diagnostic codes may be secured with funding from the SOA Medicaid services with ANTHC continuing to provide IHS funds as payer of last resort for specialty clinic services.

To improve documentation and tracking of billing and payment information, WCFH continues to work with the IT department to develop software to simplify billing and collections. The new software package will improve record-keeping related to patient demographics, scheduling, and billing. This implementation across all the clinics will enable WCFH to have more efficient processes to query and update patient demographics, especially those patients who are seen at multiple SOA clinics.

Alaska's military families continue to report a significant number of claim denials as a result of the change from Tri-Care to United Healthcare. SSG continues to be a pivotal agency to conduct training specifically for active duty military families to advocate and access resources through special education services.

Through the GCDSE, WCFH will continue to provide information to the ALTF for the implementation of SB74, an autism bill for private insurers to pay for intensive early intervention and treatment of autism.



FY15 NPM#4 Activities <i>Adequate funding sources to pay for services</i>	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collect and track insurance information for all children accessing state-sponsored CYSHCN services				X
2. Continue relationship with parent-centered SSG to determine trends associated with families on insurance issues		X		
3. Contract with ANTHC to provide IHS funds as payer of last resort for specialty clinics services		X		
4. Provide genetics, metabolic, CL/P, and neurodevelopmental clinics services regardless of ability to pay; offer sliding scale or reduced fees to low-income or self-pay families		X		
5. Continue to work with Medicaid to cover additional formulas for infants identified with metabolic conditions			X	
6. Seek alternate funding for hearing aids for deaf or hard-of hearing children if families do not have third-party coverage		X		
7. Work with the Division of Public Assistance to streamline and improve the processing of the applications of newly pregnant women seeking healthcare			X	
8. Through the GCDSE, conduct research and provide factual information to ALTF for the implementation of SB74.				X



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National Performance Measure #5:

The percentage of children with special health care needs ages 0-18 years whose families report that the community based services system are organized so they can use them easily.

Last Year's Accomplishments: FY 2013

The State of Alaska (SOA) Title V staff used FY13 to implement many of the reorganizational efforts of the previous year and continued to focus on infrastructure building within our Unit to improve systems of care. From the National Data Center for Child and Adolescent Health and the 2009/10 National Survey of Children and Youth with Special Healthcare Needs (CYSHCN), Alaska has worked to improve CYSHCN access to community based services. Using the MCH Pyramid as a platform, we refreshed and continued improvement efforts using culturally sensitive, evidence-based standard of care. The Perinatal and Early Childhood Health Unit (PECHU) continued to mature as the new internal structure for Women's Children and Family Health (WCFH) programs associated with perinatal services and CYSHCN. The PECHU integrated and coordinated with other units and provided community-based services by focusing on specific programs for the CYSHCN populations through the medical home project, genetic/metabolic clinics, neurodevelopmental (PND) outreach clinics, Cleft/Lip Palate clinics, Early Hearing Detection, and Intervention (EHDI) program, the Oral Health Program, the Maternal, Infant & Early Childhood Home Visiting (MIECHV) program, and the School and Adolescent Health Programs. The MCH EPI and the Adult Health Units continued to compliment PECHU efforts.

WCFH demonstrated collaborative working relationships with community partners as well. The Title V Director, PECHU Manager, and the program managers of the Specialty clinics and Parent Services program, School Health Nursing, EHDI, Adolescent Health, and Oral Health actively participated in a wide variety of planning meetings with peers statewide which ensured that limited resources were effectively coordinated.

Alaska is uniquely challenged with an overlapping, yet distinct health care delivery systems - tribal health, military, public health centers, and private health systems are each organized to serve specific populations or beneficiaries. Using the Home Visiting Program as an example, early identification and intervention across the life span was a unifying Title V focus during FY13. Though families continued to be challenged as they moved between healthcare systems and services, progress was made through strengthened relationships with the Early Intervention/Infant Learning Program (EI/ILP), Public Health Nursing (PHN), Stone Soup Group (SSG), Special Education Service Agency (SESA), Department of Education and Early Development(DEED), the military, Alaska Native Tribal Health Corporation (ANTHC), home visiting programs, the Alaska Native Medical Center (ANMC), The Children's Hospital at Providence (TCHAP), All Alaska Pediatric Partnership (AAPP), Mental and Behavioral Health Systems, Adolescent Health, Medicaid, University of Alaska Anchorage (UAA) Center for Human Development (CHD), schools districts, and Federally Qualified Health Centers (FQHC).

Many states and territories across the nation experience retention concerns for a highly skilled workforce. However, Alaska's continued to be challenged to hire and retain CYSHCN providers. The strongest need was for physicians, therapists (OT, PT, speech/language, mental or behavioral health) and skilled respite providers. Specialty providers are especially difficult to recruit and retain because these providers often face being a solo itinerant practitioner in rural Alaska. The AAPP kept focus and reported on subspecialists needs and made recommendations to key health system leaders. Last year, WCFH co-hosted a pediatric neurodevelopmental specialist. WCFH continued to support pediatric dental residents and provided



opportunities for clinical training through the CL/P clinics. SOA continued to support the EI/ILP occupational therapy program. LEND Fellows continued to be placed during the PND outreach and genetic clinics. WCFH continued to collaborate and cost-share with ANTHC for the full-time salary of a genetics counselor. SSG, through staff changes and new initiatives, made significant improvements to their service delivery. Families of CYSHCN reported improved access to parent navigators.

This Year's Accomplishments:

During FY13, work to improve the system of care for CYSHCN was conducted on several levels. WCFH program work consistently compliments the Governor's Council on Disabilities and Special Education (GCDSE) 5-year plan which places a high priority on community based access to services, early intervention, transitions and healthcare in rural Alaska. WCFH staff actively participates in Association of Maternal Child Health Programs (AMCHP) initiatives that focus on improving systems of health care. WCFH staff participated in a work group to produce a white paper from the National Consensus Framework for Systems of Care for CYSCHN. WCFH is nearly ready to release a comprehensive Disabilities and Health Wellness Plan in June 2014. This plan will include recommendations on obesity reduction and prevention, smoking cessation, environmental accessibility, and community inclusivity. Other projects this year include successful inclusion of care coordinators for 2 medical home projects, on-going LEND Fellow placement in outreach clinics, the inclusion of a rural health representative on the Statewide Family Advisory Council, emergency preparedness materials for CYSHCN and schools. The PND clinic succeeded in increasing a return rate for satisfaction surveys from 20 to 25%. Interpreters and non-English resources continue to be considered when producing materials. ANTHC and WCFH continue to successfully co-support a genetic counselor.

Plan for the Coming Year: FY 15

WCFH will continue to work on community-based workforce development projects which will improve local access to care. Examples of ongoing projects include the outreach clinics, the LEND fellow placements in outreach clinics, care coordination curriculum, statewide school health initiatives, adolescent health projects, oral health, genetic counseling, translation services, bilingual materials, and emergency preparedness.

WCFH staff will also continue to conduct community assessments through a trimester meeting for a Statewide Family Advisory Council (SFAC) which provides direct input on needs within a community-based system of care. Clinic staff will continue to provide interpreters and consider alternative languages for material and electronic educational tools.

Collaborative efforts will continue with SSG, SESA, and CHD to provide educational opportunities to meet needs across the lifespan through presentations coordinated by the PND clinic staff. In the coming year, PND clinic staff goal is to increase from 60% to 75% the number of the rural communities seeking training from a menu of educational opportunities. Training opportunities include improving communication between families and providers, community conversations, behavioral management of children and adults, autism resources and outreach, care coordination techniques, early identification and intervention, etc.

Along with the announcement by the CDC of an increase in autism rates in March 2014 and the anticipated retirement of the sole pediatric neurodevelopmental specialist in Alaska, WCFH is actively working collaboratively with the Providence Autism Diagnostic Network and Providence Behavior Health center to design a program reflective of families and children's needs in the system of care for autism.



The Genetics Clinic will continue to collaborate with the Western States Genetics Services Collaborative on the evaluation project regarding parent experiences and beliefs of the services provided in the outreach clinics. This information will be used to better assess the need and also client satisfaction of services.

Within WCFH, the MCH EPI and the Adult Health Units, along with the PECHU, efforts will be made to implement the long-range plan that was finalized in 2014 for the Alaska Health and Disability Committee. Health, wellness, and emergency preparedness for children, youth, and adults with disabilities will work to develop meaningful tools for emergency preparedness, wellness, and health activities.

FY15 Activities NPM 5 <i>community based services system are organized</i>	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintain or expand a 25% return rate for PND clinic by implementing an electronic evaluation tool.				X
2. Improve survey return rate for the CL/P and the genetics clinic ensure parent feedback is incorporated				X
3. Conduct the evaluation project in collaboration with Western States Genetics Services Collaborative to better learn the experiences and thoughts of families related to WCFH Genetics Clinics.				X
4. Provide medically-trained interpreter for non-English speaking families during clinics.		X		
5. Maintain and update non-English resources for families to understand the medical conditions of their affected child				X
6. Continue service delivery by co-supporting a genetic counselor who is based at the ANMC and WCFH		X		
7. Identify and match LEND Fellows to meaningful leadership projects within WCFH programs				X
8. Maintain a statewide family advisory council		X		
9. Increase from 50% to 60% the number of communities requesting training from a menu of educational opportunities for rural medical and education staff, community providers and families during PND outreach clinic.				X
10. Improve community based services for families and children experiencing autism by integrating family input into a new autism diagnostic center program			X	X



Alaska Maternal and Child Health FY 2015 Title V Block Grant

National Performance Measure #6:

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.

Last Year's Accomplishments:

Women's Children and Family Health (WCFH) staff in FY13 continued efforts for building a system of care that successfully transitioned a child or youth with special healthcare needs (CYSHCN) into all aspects of adult life. Multiple agencies continued to address transition issues based on the Governor's Council on Disabilities and Special Education (GCDSE) 2011-2016 Statewide plan. That plan included provisions which addressed the successful transition in areas of advocacy, leadership, community choices and support, housing, transportation, employment, early intervention, education, and health.

Title V focused on MCH issues; Stone Soup Group offered the consumer voice; the Center for Human Development (CHD) offered innovation programs; the Mental Health Trust served as a financial provider for innovative programs. SOA Departments that focused on education, healthcare, work, and independence included the Department of Labor (DOL), Department of Education (DEED), Division of Vocational Rehabilitation (DVR), Disability Law Center (DLC), Division of Business Partnerships (DVP), Division of Public Assistance (DPA), Employment Security Division (ESD), Senior and Disabilities Services (SDS), Special Education Service Agency (SESA), and the Mental Health Trust Authority (MHTA).

Projects that continued included the "I Vote, I Count" tutorials; the Self-Determination Toolkit for self-determination in home, school, and the community settings. Guardianship / Conservatorship classes were taught. SESA ended their Educational Transitions Support Project in FY13 but continued to offer trainings for parents and providers on transition and employment for kids/adults with autism. The GCDSE Rural Ad Hoc Committee disbanded.

Bring The Kids Home (BTKH) started in 2004 and ended as a formal initiative FY13. The primary goal was to decrease out-of-state residential psychiatric treatment center (RPTC) admissions for children with serious emotional and behavioral disorders. BTKH achieved this goal. They established new care coordination and review processes; built new in-state services; introduced evidence-based practices; and engaged stakeholders, providers and state employees in working together to improve services. BTKH decreased out-of-state admissions by 85.1% and decreased total by 42% admissions to RPTC and reduced Medicaid expenditures for RPTC.

During FY13, the TAPESTRY program ran at full capacity with 20 students (29 since inception). The process was refined to include faculty notification in audited classes which continued to have a positive effect on students and faculty across campus. Partnerships with DVR and Nine Star provided employment and educational support to students in the program. CHD's program was one of few programs nation-wide to partner with a Workforce Investment Act for Youth program and leverage funds for subsidized internships which ensured youth in the program were all earning above the minimum wage.

The SSG's continued their Transitional Services and Support Program 3 goals (increased community capacity, increased peer-to-peer support, and self-advocacy development). CHD's and SSG's piloted "friendship & dating" curriculum proved highly successful and continue.



Per the GCDSE, there are approximately 16-17,000 students receiving special education services in Alaska's schools. They did not meet their stretch goal of a 20% increase in graduation rate. Alaska's largest school district, the Anchorage School District (ASD) focused on social emotional growth to reach academic potential. In FY13, the ASD ACE program (alternative career education) and ACT program (Adult Community Transition) continued as post-secondary community-based instructional programs for adult students 18-21 needing additional transitional support. These programs are offered after completing required core credits in their neighborhood school.

Current Activities:

Project SEARCH is an internationally recognized high school transition program CYSHCN. For students enrolled, days are spent learning job skills at a business. The local school district provides a teacher and job coach; DVR provides job development; the GCDSE provides technical assistance; and the business provides the learning experiences and jobs. There are 4 Project SEARCH sites in Alaska and all are based in local hospitals (Anchorage, Fairbanks, Mat-Su, and Kenai). Over 60% are employed at least 20 hours per week in a competitive, integrated job with two of the sites reaching 100% employment annually.

Tapestry's first cohort of students graduated in FY14 and has a 75% employment rate. FY14 focus will be sustainability.

Other FY14 transition projects include CHD's psychosocial development project (skill development for those with a history of victimization); DLC's Client Assistance Program (intervention to improve access for independent living services). CHD and GCDSE continue to provide workshops and training. SSG will continue to provide training on guardianship, employment, nutrition, housing, legal, and financial issues as well as the Friendship and Dating class. The Microenterprise project is reviewing their last set of applications, with approximately \$7,000 left to award. WCFH staff work on adult community inclusion issues, medical home care coordination, and with the Genetic Collaborative FY14 priority project - transition to adult health care.

Plan for the Coming Year: FY2015

Using guidance from the GCDSE 5-year plan, the SOA and community-based agencies will continue to focus work during FY15 to implement transitional programs for housing, transportation, employment, education, and healthcare access for youth and adults with disabilities. CHD's Tapestry project will focus on sustainability and will implement a newly approved Comprehensive Transition Program so students can use PELL funds to defray costs of tuition and fees and set a goal of another 12 graduates which are successfully employed. CHD is considering program efforts for an employment network with Social Security to support students after graduation to maintain their employment. Project Search FY15 priority is to maintain the 4 sites and add a 5th site in Juneau. BTKH's FY15 goals are to maintain progress by continuing collaboration to implement best practices through technical assistance to stakeholders. SSG plans to continue serving their 20 teens / young adults in the teen "friendship and dating" class as well the teen Wii club.

Ticket to Work (TTW) project staff will meet with Statewide DVR office managers, local job center managers, and the Disability Resource Coordinators to implement a collaborative plan to increase referrals. The TTW FY15 goal is to improve collaboration statewide with DVR coordinators, securing their agreement to meet more frequently.

During FY15, DVR will send job centers literature; additionally, staff of DVR Business Services team, Anchorage Business Connection, MASST coordinator, and US DOL's Veteran Employment and Training Director will coordinate outreach, marketing and promotion of "Individuals with Disability" project to federal contractors who work under the rules of



Section 503. Continuing to communicate via email, this committee will share information and resources to ensure outreach and staff training materials are developed with a consistent message about a qualified applicant for placement. The GCDSE career fairs and CHD's employing creativity forums (fairs for careers in the arts for individuals with disabilities) are unique projects and these events will continue. DVR's will continue initiatives from their 5-year plan focusing on writing cooperative agreements with Alaska's 54 school districts to implement youth transition plans and the use of school nurses to identify students in need of transition services.

DLC will continue their mission to ensure full access to inclusive educational programs, financial entitlements, healthcare, accessible housing, and productive employment opportunities.

WCFH Youth Advisory Committee's will continue to recruit CYSHCN members. The WCFH Health and Disability Program will continue to focus on community inclusions efforts. During outreach clinics community forums, learn from families transitional needs issues throughout rural Alaska. Based on family interest, PKU educational workshops will be considered

FY 2015 Activities NPM 6 transitions to all aspects of adult life	Pyramid Level of Service			
	DHC	ES	PBS	IB
Increase the percentage of AK's CYSHCN who report having the services necessary to make transitions to adult life from 42.2% to 47% by 2015 in the National Data Center Survey for CYSHCN		X		
Support GCDSE leadership and maintain membership on committees promoting successful transitions				X
Respond to requests to participate from GCDSE, CHD, SSG, DVR, DLC training or program opportunities				X
Incorporate health related concerns of transitioning CYSHCN into the SOA Health and Disabilities plan				X
Support Bring the Kids Home Initiative, ensuring children have the services they need to be served in Alaska		X		
Consider activities for youth with PKU to help them transition to adulthood		X		
Through the SFAC and outreach clinics site visits, provide information on programs that support transitioning CYSHCN			X	



Alaska Maternal and Child Health FY 2015 Title V Block Grant

National Performance Measure #7

Percentage of children 19-35 months who have received a full schedule of age appropriate immunizations for measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Haemophilus influenza and hepatitis B.

Last year's accomplishments:

The three-year state funding to increase access to vaccine for underinsured children continues through June 2015. Interagency and section work groups continued to meet and address immunizations.

The third biennial statewide Alaska Maternal Child Health (MCH) and Immunization Conference occurred September 27-28, 2012.

Healthy Alaskans 2020 (HA 2020) conducted two stakeholder surveys to gather public input toward the identification of 25 leading health indicators. The first community survey ran from September 17th through October 22, 2012 and the second ran from January 14th through February 28, 2013. One objective identified was to increase the proportion of Alaskans protected from vaccine-preventable diseases. The HA 2020 target for indicator 17 is that 75% of children 19-35 months receive the ACIP recommended vaccination series.

Media campaigns such as such as radio PSAs, an annual Iditarod immunization campaign, and National Infant Immunization Week (NIIW) occurred. State Public Health Nursing Centers waived sliding scale fees during NIIW. Social media campaigns targeted influenza vaccination for children, adolescents, and adults. A separate radio PSA promoted getting ready for back-to-school early during the summer of 2013.

The VacTrAK immunization registry enrollment continued to increase. WCFH continued to use VacTrAK to screen the immunization status of children attending WCFH specialty clinics and subsequently notified parents and the medical home if the child was due for vaccinations.

The Alaska Immunization Program (AIP) perinatal hepatitis B surveillance and case management program continued to assure that children born to hepatitis B positive women received the birth dose of hepatitis B and completed the vaccination series.

WCFH promoted a Bright Futures prenatal visit with a health care provider for the baby as a way to promote infant immunizations. Brochures that promoted the importance of well child visits, according to the Bright Futures periodicity schedule, continued to be widely distributed across the state, such as health fairs and in hospital newborn packets. WCFH also distributed *Baby and Me* books to prenatal providers for their pregnant clients. These books promote well child visits and immunizations.

Public health nurses outreached and immunized children in public health centers, off-site clinics, and via itinerant public health nursing (PHN) services across the state. PHNs provided training and consultation with medical providers and community health aides (CHAs), especially where staff turnover is common such as in rural areas of the state. PHNs were active with vaccine coalitions and health fairs.

The Maternal, Infant, & Early Childhood Home Visiting (MIECHV) program began serving clients. The nurse home visitors promote well-child visits and immunizations with clients and distributed materials. They also monitor vaccine coverage



data of infants in the program. All the nurse home visitors received training on immunizations and vaccine hesitancy in Alaska.

Current activities:

The 2012 National Immunization Survey showed 67.3% had the recommended vaccine coverage. A CDC team came to Alaska to interview key informants, identify challenges, and make recommendations. The AIP is conducts visits with VFC providers.

The statewide immunization conference occurred in October.

The 2012 CUBS toddler survey showed 27% of mothers delayed or did not vaccinate their child, down from 33% the year prior. WCFH worked with the All Alaska Pediatric Partnership (AAPP) to publish and distribute rack cards with credible vaccine websites. The State is testing vaccine messaging with parents via focus groups and phone interviews.

Collective Impact sessions at the annual AAPP pediatric conference resulted in the "First 1,000 Days" campaign to promote early childhood health. Immunization and medical home work groups meet regularly. A HA 2020 work group developed actions for the immunization indicator. Interagency and section work groups continue to address immunizations.

Alaska launched new regulations related to religious exemptions and the requirement to record all administered vaccines in VacTraK. A VacTraK Quick Start Guide was developed, tested, and posted for provider use. Legislation passed authorizing alternative funding where private insurers will contribute funding toward the purchase of vaccines.

WCFH screens the immunization status of children attending specialty clinics and informs parents and providers of needed vaccines. PHN provides outreach and immunizations.

Plans for the coming year:

As a result of legislation passed, the Commissioner of the Department of Health and Social Services will appoint an eight member Vaccine Council. Private insurers will contribute to a new Vaccine Assessment Account, which becomes effective in January 2015.

The statewide Alaska MCH and Immunization conference, "*Advancing Wellness across the Lifespan*," will be held September 2014 in Anchorage. A subcommittee is planning immunization related topics, including maternal vaccinations to protect mothers and babies, human papilloma virus impact and challenges, and provider tools for immunizations. The Vaccinate Alaska Coalition (VAC) will hold its annual membership meeting during the conference.

Alaska will launch a year-long campaign to convey vaccine messaging identified by Alaska parents through focus groups and interviews conducted in June 2014. The VAC and the AIP will promote the importance of vaccination through the annual Iditarod "*I Did It by TWO!*" campaign.

The AAPP will continue the *First 1,000 Days Campaign* with work groups focusing on immunizations and the medical home. HA 2020 will track progress related to identified actions and expected outcomes. Interagency immunization work groups will continue to meet.



Nurse Consultants in the sections of WCFH and Epidemiology will work to promote the birth dose of Hepatitis B vaccination through the promotion of the Immunization Action Coalition's (IAC) Hepatitis B Birth Dose Honor Roll. Currently, no Alaska birth facility has made this national honor roll.

WCFH plans to survey health care providers regarding the prenatal pediatric preventive visit as indicated on the Bright Futures Periodicity Schedule. WCFH will continue to integrate the importance of newborn and infant vaccines into our existing programs. Discussions are under-way regarding the development of a potential new parent brochure with a combined message of important firsts including newborn hearing and metabolic screening, critical congenital heart disease, and hepatitis B vaccination at birth.

The WCFH MCH Epi Unit will conduct the annual CUBS survey. WCFH will continue to promote immunizations and well child visits within the context of the medical home, and with programs and groups serving children. The Medicaid program will continue to send EPSDT outreach letters and informational newsletters containing information about immunizations.

Public health nursing will continue to work with partners in their communities to promote immunizations. Several communities have re-ignited local vaccine coalitions or informal networks to address immunizations. Public health nurses are on the frontlines outreaching and vaccinating children, and serve as immunization experts in their communities.

The Alaska Immunization Program will continue its work providing consultation related to immunizations and vaccine preventable diseases, conducting visits with VFC providers, and providing leadership related to VacTrAK.

Activity	Pyramid Level of Service			
	DHC	ES	PBS	IB
Increase access to vaccines for underinsured children via limited 3-year state funding (July 2012 through June 2015)		X		
Utilize media to promote childhood immunizations such as immunization rack card and well-child visit brochures			X	
Promote group work focusing on increasing immunization rates			X	X
Increase enrollment in the VacTrAK registry			X	X
Provide perinatal hepatitis B surveillance and case management			X	
Provide outreach and immunizations by PHNs across the state and train and support tribal CHA/Ps and private providers in the provision of immunization services			X	
Promote well child visits within a medical home		X	X	
Provide immunization education through conferences, trainings and consultation			X	X
Promote vaccines and well-child visits in the Healthy Start and MIECHV home visiting programs		X		



Alaska Maternal and Child Health FY 2015 Title V Block Grant

National Performance Measure #8

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

Last year's accomplishments:

The birth rate for teenagers aged 15-17 years in Alaska in 2012 was 13.5 births per 1,000 which were significantly lower than the Healthy People 2020 target of 36.2 per 1,000. Alaska's teenage birth rate trends are on par with U.S rates as they both show declines in teen birth rates since 2007. While reasons for the declines are not clear, teens seem to be less sexually active, and more of those who are sexually active seem to be using birth control compared to previous years.

Title V continued to fund nurse practitioners to provide comprehensive reproductive health services, including comprehensive education and counseling, at the Kodiak Public Health Center (PHC) and the Juneau High School Teen Health Centers.

The WCFH Family Planning Program (FPP) continued to administer the Title X Family Planning Services grant in FY13, offering high quality, low cost family planning and related preventive health services to low income women, men, and teens in communities in the Mat-Su Valley and the lower Kenai Peninsula. The FPP Title X services promoted parental involvement in teen decisions to seek family planning services and offered comprehensive sexuality education and counseling, including encouraging abstinence, as a core part of their service delivery.

The Section of WCFH continued work under an interdepartmental agreement with the Division of Public Assistance with the goal of reducing teen and non-marital pregnancy in Alaska. The women's and reproductive health nurse consultant provided skill-building counseling trainings including counseling about unhealthy relationships. The nurse consultant served on the Statewide Sexual Assault Response Team Steering Committee (SART) which developed SART Guidelines for the state.

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 focusing 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 nurse consultant updated the Reproductive Health Partnership contraceptive education kit materials and provided 24 kits to Community Health Centers, Public Health Nurses and Tribal Health Clinics including family practice and pediatric outpatient service units. The nurse consultant conducted one training for clinical staff of the Anchorage based Southcentral Foundation pediatric and primary care outpatient clinics. Southcentral Foundation is the largest Tribal health outpatient facility in the state.



A limited supply of long-acting reversible contraceptives was provided to young women in over 46 rural and remote Alaskan communities. The need for clinicians to be proficient in counseling and provision of long acting reversible contraceptives for adolescents' remains the leading challenge for assuring comprehensive reproductive health services for adolescents.

Current activities:

Most FY13 projects are continuing during FY14.

The WCFH FPP continues to administer the Title X Family Planning Services grant in the Mat-Su Valley and the lower Kenai Peninsula and both sites continue to promote parental involvement in teen decisions to seek family planning services and offered comprehensive sexuality education and counseling, including encouraging abstinence as a core part of their service delivery.

The AHP continues to manage grants to communities on youth development and teen pregnancy prevention. The AHP continues its social marketing campaign on birth spacing. The AHP is continuing 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.

In March 2014, the perinatal nurse consultant and Norton Sound Health Corporation Healthy Start staff met with Kawerak Tribal leaders from the Nome Bering Straits area to address rapid repeat pregnancies. Healthy Start provides perinatal education and case management services for young people living in the Nome census area, including Nome and the fifteen surrounding villages in the Bering Straits. Clinical providers' skills in counseling and provision of effective contraction, especially for adolescents, were identified as a critical need. Plans were made for Healthy Start to fund two practitioners to participate in skill based clinical training for this.

Plans for the coming year:

In FY15, Title V will continue to fund nurse practitioner positions in the school-based Juneau Teen Health Centers to provide reproductive health services. However, the nurse practitioner contract in Kodiak will be discontinued as of June 30, 2014. Instead, WCFH will work with the Section of Public Health Nursing and the Kodiak Community Health Center (an FQHC) to improve their capacity for reproductive health and family planning services to teens in this community.

Title X services will continue in the Mat-Su Valley and the lower Kenai Peninsula. Furthermore, as required by this federal program, FPP Title X service sites will continue to promote parental involvement in teen decisions to seek family planning services and to offer comprehensive sexuality education and counseling, including encouraging abstinence, as a core part of their service delivery.

The Healthy Start perinatal nurse consultant will continue to collaborate with Norton Sound Health Corporation. Healthy Start staff met with Kawerak Tribal leaders from the Nome Bering Straits area in order to address their concerns about teen pregnancy, especially rapid repeated teen pregnancy. As part of this effort the nurse consultant will work with Healthy Start and Norton Sound clinicians to secure clinical training in provision of comprehensive contraceptive care services for teens living in the area. In addition, the nurse consultant will continue to collaborate with the Nome regional Division of Public Assistance to provide training in motivational interviewing to facilitate referral of young female clients at risk of rapid repeat pregnancy.



All Adolescent Health FY 14 projects will continue in FY 15.

Activity	Pyramid Level of Service			
	DHC	ES	PBS	IB
Provide funding for nurse practitioners to offer reproductive health services at the Juneau High School Teen Health Centers.	X			X
Form and administer youth advisory committee focused on pregnancy prevention and violence prevention		X		X
Provide fiscal, administrative and clinical oversight to two Title X Family Planning clinics				X
Offer professional educational opportunities on topics relevant to teen reproductive health for health care workers from areas with the highest rates of births to teens				X
Provide administrative and technical support to for four community grantees and multiple schools for two federal teen pregnancy prevention grants				X
Create unintended pregnancy prevention brochure in additional languages- social marketing campaign			X	X
Provide administrative and technical support to two community partners for Youth Development as a Teen Pregnancy Prevention Strategy grants				X

NOTE: **DHC**=Direct Health Care **ES**=Enabling Services **PBS**=Population Based Services **IB**=Infrastructure Building.



Alaska Maternal and Child Health FY 2015 Title V Block Grant

National Performance Measure #9:

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

Last Year's Accomplishments:

In SFY 2011, the Oral Health Program (OHP) completed the third statewide dental assessment of 3rd grade children using the "Basic Screening Survey (BSS)" method. The dental assessment process included state estimates on dental sealants on at least one permanent first molar. The sealant utilization for the 2010/2011 BSS was 46.8% (down from 55.3% in the 2007 BSS and the 2004 BSS at 52.4%). The confidence interval for the 2010/2011 BSS for sealant utilization ranged from 42.9% - 50.8%. Sealant utilization was down for all racial/ethnic groupings and for 3rd graders whose parents reported Medicaid eligibility in the 2010/2011 BSS. The decrease in dental sealant utilization from 2007 was statistically significant, however the sample method utilized also likely influenced the lower rates. The 2010/2011 sample utilized a sample of schools proportional to size to reduce costs associated with travel to small rural schools to conduct the dental assessments – previous BSS projects have found higher sealant utilization in Alaska Native students in these schools. Additionally, several of the urban schools in the 2010/2011 sample had very low student participation in the BSS due to lack of returned parental consent forms. Sealant utilization for racial/ethnic groups and 3rd graders reported to be enrolled in Medicaid was as follows in the 2010/2011 BSS:

Dental Sealants Present:

Total (n=628)	46.8% (42.9, 50.8)
American Indian/Alaska Native (n=157)	57.3% (49.2, 65.2)
White (n=279)	47.0% (41.0, 53.0)
<u>All Other (n=192)</u>	38.0% (31.1, 45.3)
Medicaid/Denali KidCare (n=195)	44.1% (37.0, 51.4)

SFY2013:

The OHP and Coalition continued to provide training on child abuse and neglect awareness and reporting requirements (PANDA Project) at least once per year at the University of Alaska Anchorage. The OHP continued to support Medicaid with implementation of preventive dental and enhanced restorative services for enrolled adults (includes coverage for pregnant women). The OHP collaborated with the Anchorage Neighborhood Health Center on the 4th year of a dental sealant pilot program at an elementary school (where more than 50% of children are eligible for the free and reduced school lunch program) and expanded the project to three additional schools with the community health center (CHC) dental programs. The sealant program activities were assisted with funding from HRSA Bureau of Health Professions which also supported organization of four continuing dental education workshops for community health center dental programs. Workshop topics were focused on increasing services for special needs populations.



Planned work with the Medicaid program to develop a separate dental periodicity schedule (EPSDT) and change dental exam guidance from an age 3 to an age 1 (earlier if medically necessary) was delayed due to staffing changes in the Division of Health Care Services.

Current Activities

In FY14, the OHP received HRSA funding to support the dental sealant Program Coordinator. The non-federal match to the grant supported the school sealant programs in 4 schools. These programs were developed in collaboration with community health centers (CHC) and targeted low-income children. Dental workshops were conducted in May for CHC/Tribal dental staff. These workshops included geriatric issues, information from Indian Health Service dental assessments, managing periodontal disease in low-income adults, denture fabrication and implications of the Affordable Care Act for CHC dental programs.

The OHP in collaboration with the oral health coalition continues to work on implementation of priority state oral health recommendations such as: education on water fluoridation, expanding dental sealant programs, education of dental providers on treating special needs populations, developing Medicaid reimbursement incentives for treatment of special needs populations (without use of general anesthesia), and implementing the collaborative practice model for dental hygienists to expand preventive dental services in underserved settings (e.g., schools and long-term care settings). Education on fluoridation was provided to the Anchorage Assembly in hearings leading to their September 2013 vote to continue support of fluoridation in that community.

The Dental Officer submitted a “Medicaid Dental Action Plan” with a focus on increasing preventive dental services.

Plans for the Coming Year

The OHP will continue working with Medicaid to address private dental issues with the program to encourage broader dental participation, develop the EPSDT dental periodicity schedule and seek to change EPSDT guidance to an age 1 dental exam. The OHP and Medicaid will assess progress on the Dental Action Plan aimed at increasing child utilization of preventive dental services and increased use of dental sealants on permanent molars for 6-9 year olds enrolled in Medicaid. The action plan and OHP education activities will continue to educate on the need for improved medical/dental integration to reduce the prevalence and consequences of early childhood caries.

The OHP will maintain the 4 school sealant programs and seek to expand the programs to 1-2 more schools (funding permitting). The OHP will develop additional continuing dental education workshops planned for the spring/summer of 2015.

The OHP will continue efforts to educate on the need to maintain/develop community water fluoridation in water systems where it is feasible to implement this evidence-based approach to reducing dental decay.

Activities	DHC	ES	PBS	IB
1. Support and promote community water fluoridation in all communities of Alaska capable of implementing fluoridation.				X



2. Identify funding to support a statewide dental sealant coordinator.			X	
3. Collaborate with 330 funded Community Health Centers to establish a dental sealant programs.			X	
4. Support coalition activities and the implementation of the comprehensive state oral health plan.				X
5. Collaborate with Tribal programs including Head Start and Environmental Health to support dental access, education, sealant application and water fluoridation.				X
6. Maintain program web site for dental access, oral health information and coalition activity.				X
7. Continued technical assistance on information to parents/providers on reducing risks of enamel fluorosis (while still supporting water fluoridation to reduce dental decay).			X	
8. Maintain oral disease burden document describing oral diseases in Alaska and the impact of those diseases on the state.				X
9. Work with Commissioner's Office and Alaska Dental Action Committee for continued implementation of adult dental Medicaid services and report findings to the legislature.				X
10. Work with the Alaska Dental Action Coalition and dental hygienists association to support implementation of dental hygienist practice under collaborative agreements to expand access to preventive dental services in underserved settings.				X
11. Work with Medicaid/CHIPRA program on increasing access to dental sealants for 6-9 year olds and increase access to preventive dental visits for all enrolled children.				X



Alaska Maternal and Child Health FY 2015 Title V Block Grant

National Performance Measure #10:

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

Last Year's Accomplishments

Alaska's Injury Prevention (IP) program, located in the Division of Public Health's Section of Chronic Disease Prevention and Health Promotion, realigned its focus areas to better reflect the current level of injury and prevention efforts across the state. Child passenger safety is no longer a primary focus area at this time. The program continues its supporting role to other child passenger seat programs throughout the state such as the Alaska Child Passenger Safety Coalition (CPSC), in a supporting role. The IP program has one member on the coalition who participated in two local car seat checks and attended quarterly CPSC meetings. The program also distributed reflective and educational materials statewide upon request from individuals and/or community programs.

From 2009 to 2011, the rate of deaths to children aged 14 years or young caused by motor vehicles was 4.1. This is a decrease from the previous four year cycle, 2008 to 2010(4.6%).

Current Activities

The Injury Prevention program continues to provide support to the CPSC as in the previous year, both as a member of the coalition and a member of two working committees. One child seat technician attends two car seat checks each year.

A "Be Safe Be Seen" project (funded through Alaska Highway Safety Program, Safe Routes to School) was initiated and provides materials and technical assistance to communities statewide upon request. This project promotes safe biking and walking within various communities across Alaska.

Plan for Coming Year

It is anticipated that plans will remain similar for the upcoming year. The Injury Prevention program will continue to support the CPSC through membership and participating in committee work. The IP program will support a car seat technician to attend two car seat checks this year and to assist in a Car Seat Technician Training course in Juneau.

The Be Safe Be Seen project will continue throughout FY15 to provide technical assistance and supplies to communities engaged in safe biking and/or walking projects for 0-14 year old children.

Activities	Pyramid Level of Service			
	DHC	ES	PB	IB
Support coalition strategic planning and support Coalition Leadership to meet 4 times and Coalition Membership to meet 1 time			X	
Provide site-appropriate outreach, education & seat safety			X	



checks				
Partner with existing partners to augment Safe Routes to School and Bike initiatives			X	X



Alaska Maternal and Child Health FY 2015 Title V Block Grant

National Performance Measure #11:

The percent of mothers who breastfeed their infants at 6 months.

Last Year's Accomplishments

Provisional 2010 National Immunization Survey (NIS) showed 58.1% of mothers breastfed their infants at 6 months old, an increase from the previous year. The WCFH MCH Epidemiology unit provided data on maternal and child health issues which were used in planning and evaluating programs and guiding public health policy, including breastfeeding data.

During this year, State of Alaska WIC breastfeeding rates were 84% at initiation, 44% at six months duration, and 37% at twelve months duration. Statewide breastfeeding rates reported by the 2013 National Immunization Survey (NIS) were 84.7% at initiation, 58.1% at six months duration, and 37.4% at twelve months duration.

Using Loving Support Breastfeeding Peer Counseling Program (BFPCP) was provided by eight agencies statewide. Roughly 7,666 breastfeeding peer contacts were made statewide.

The University of Alaska Anchorage (UAA) training program supported a listserv for breastfeeding peer counselors, provided online training of the *Using Loving Support* BFPC, facilitated a quarterly interactive training teleconference and published a quarterly newsletter on breastfeeding. Quarterly teleconferences were offered to BFPCP managers.

The WIC breastfeeding coordinator and WCFH Alaska Breastfeeding Initiative (ABI) staff served as board members for the Alaska Breastfeeding Coalition (ABC), which is a member of the US Breastfeeding Coalition. This collaboration promoted common goals and objectives. Efforts included planning and participating in the annual ABC lactation symposium which was attended by 100 clinicians from all over the state. ABI provided scholarships for 14 nurses to attend the symposium.

Forty clinicians attended the advanced practices in clinical lactation support training made possible by the WIC-ABI collaboration. 130 clinicians participated in lactation training in Anchorage, Fairbanks and Juneau. ABI provided funds to offset travel for those working in off road hospitals and clinics. During these trainings, Mother-Baby nurse managers from delivery hospitals not having Baby-Friendly accreditation anecdotally described a lack of knowledge about CDC's voluntary national *Maternity Practices in Infant Nutrition and Care* survey. For example, many of the nurse managers had not seen the survey questions and did not know which staff person in their facility had provided the responses to the questions about lactation practices in their units. The survey measures include: use of supplements in hospital, providing accurate information about breastfeeding, rooming-in and post-discharge follow-up. The report recommends delivery hospitals adopt policies supportive of best practices in lactation care and that staff be trained and provide that evidence-based care.

ABC advocated for the Alaska Blood Bank to pursue establishing a human milk bank as part of their service. ABI relied upon the Alaska Women's Health Program clinical network list serve and offered three online trainings in best practices in lactation. ABI relied upon the Alaska Women's Health Program webpages to promote breastfeeding information by



posting links to breastfeeding information from the Office on Women's Health and CDC's Nutrition program for mothers and others.

The Healthy Start and Maternal, Infant & Early Childhood Home Visiting (MIECHV) programs provided services. Breastfeeding initiation and continuation were a focus indicator and also a training priority for nurses in the MIECHV Nurse-Family Partnership program.

ABI established a lactation room for Division of Public Health staff working in the Anchorage Frontier Building. Mothers using the room have expressed their approval.

Approximately 75% of all babies born in Alaska were born in hospitals without Baby-Friendly accreditation. Public health programs had limited data describing lactation practices in these 20 hospitals. Published literature on lactation described the strength of impact of lactation care from delivery hospital staff on breastfeeding exclusivity and duration rates.

ABI adopted and promoted Alaska's CDC *Maternity Practices in Infant Nutrition and Care Survey*, *Academy of Breastfeeding Medicine* and the *2011 Surgeon General's Call to Action on Breastfeeding* and resources provided by the US Breastfeeding Coalition as essential guides for future activities.

Current Activities

WIC and UAA provided newsletters, teleconferences and a breastfeeding Facebook page. BFPC modules were updated and posted online.

WIC and ABI served as board members for the ABC. This collaboration facilitated common goals and objectives including hosting the annual ABC lactation symposium and advanced clinical lactation training. The WIC-ABI partnership made possible two trainings on improving hospital lactation policies and practices with 90 clinician participants. ABI provided funds to offset travel for those from off road hospitals and clinics.

The ABC advocated for the Alaska Blood Bank to pursue establishing a human milk bank. ABI offered three trainings on best practices in lactation over the Alaska Women's Health Program clinical network list serve and promoted evidence-based breastfeeding information on the Alaska Women's Health Program webpages. WIC and ABC lactation consultants volunteered their expertise to support trainings in lactation support for *Thread, Alaska's child care resource center*. ABI funded four days of onsite training in lactation care for clinicians of the Yukon-Kuskokwim Delta Regional Hospital staff in Bethel.

The lactation room for Division of Public Health staff in Anchorage was maintained.

With the help of ABC, ABI identified La Leche League as a partner wanting to collaborate to improve workplace lactation support by working with Rotary and the Chamber of Commerce.

Plan for the Coming Year

The WCFH MCH Epidemiology unit will provide data on maternal and child health issues which will be used in planning and evaluating programs and guiding public health policy.



Reduced funding for BFPC will leave only six grantees operational. WIC will offer BFPC trainings online and in quarterly teleconferences, newsletters, and Facebook. A new information system called SPIRIT will improve efficiency and accuracy supporting BFPC to improve charting on lactation, track inventory (breast pumps) and track breastfeeding exclusivity. These enhanced features will augment previous efforts to support tracking statewide breastfeeding rates.

WIC will receive funding for a breastfeeding poster project to target breastfeeding initiation rates in Hmong women and duration of Alaska Native breastfeeding women. Professional pictures will be taken in four locations around the state for posters along with a breastfeeding message geared to these groups. Pictures will be made available on a national web site for use in national breastfeeding campaigns.

WIC will support and promote breastfeeding through its use of policies, procedures, breast pump loan and BFPC programs. WIC's goals will continue to be maintaining/increasing breastfeeding initiation and duration rates at 6 and 12 months.

WIC and WCFH ABI staff will serve as board members for the ABC. This collaboration will facilitate and forward their common goals and objectives including hosting the annual ABC lactation symposium, one advanced practices in clinical lactation training, advocating for the Alaska Blood Bank to establish a human milk bank and support to *Thread, Alaska's* child care resource network.

ABI will promote best practices in lactation by sharing distance education offerings over the Alaska Women's Health Program clinical network listserv and offering evidence-based breastfeeding information on WCFH webpages.

The Frontier building lactation room will remain available for Division of Public Health staff.

The MIECHV and Healthy Start programs will continue to promote breastfeeding. The MIECHV program will continue to provide training and measure breastfeeding as a continuous quality improvement initiative.

With support from ABC, ABI will work with La Leche League members to undertake a full effort on improving workplace lactation support. La Leche League and ABI will utilize the *Break Time for Nursing Mothers* and *Investing in Workplace Breastfeeding Program and Policies* programs to begin this work. Meetings with Rotary and the Chamber of Commerce are initially planned. WCFH will explore distributing the US Department of Labor workplace wallet cards for mothers to pediatric, family practice and prenatal care providers and encourage they provide these to each pregnant and lactating mother in their care. Hospitals will also be give supplies of the workplace wallet cards for mothers so that these may be placed in each take home birth packet. WCFH will explore doing this at no cost to the providers.

NPM # 11	Pyramid Level of Service			
	DHC	ES	PBS	IB
Maintain the Using Loving Support Breastfeeding Peer Counseling Program			X	X
Sustain WIC breast pump loan program and support services for breastfeeding women		X		



Support the Alaska Association of WIC Coordinators Breastfeeding Committee and state agency collaborations				X
Alaska Breastfeeding Initiative collaborates with local, regional, and national partners				X
Continue data collection and monitoring through the Alaska WIC Management Information System				X
WCFH ABI perinatal nurse consultant provides consultation for WCFH perinatal programs on breastfeeding issues				X
Plan the 2014 MCH and Immunization Conference				X
Administer regional Healthy Start and MIECHV services		X		
Maintain a designated room for Division of Public Health breastfeeding mothers working in the Frontier building in Anchorage				X
Utilize a Plan Do Study Act cycle for continuous quality improvement surrounding breastfeeding initiation and continuation in the MIECHV Nurse-Family Partnership program		X		
Perinatal Nurse Consultant and WCFH Epidemiologist participate in a community workgroup of the All Alaska Pediatric Partnership on increasing breastfeeding initiation and continuation				X



Alaska Maternal and Child Health FY 2015 Title V Block Grant

National Performance Measure #12:

Percentage of newborns who have been screened for hearing before hospital discharge.

Last Year's Accomplishments FY 2013

The focus of the Early Hearing Detection and Intervention (EHDI) Program was to increase the number of children tracked successfully through the National 1-3-6 Goals: newborn hearing screening by one month, diagnostic assessment by three months and intervention services by six months. Emphasis was on reducing the number of children lost to follow-up/documentation after not passing their final screening.

In CY 2012, 96% of all infants born in Alaska had newborn hearing screenings and 96.2% of those screened passed their screening before one month of age. This met the national benchmark. The screening rate for infants born in hospitals was 99%.

Alaska has a 6% out of hospital birth (OOH) rate. The EHDI Program continued receiving a monthly birth list of children born out of hospital from the Bureau of Vital Statistics. This list is checked against the EHDI database and letters were sent to parents of children not recorded as having a screening. In CY2011, hearing screeners were placed in two midwifery centers and the OOH screening rate improved statewide from 38% to 60%. At the beginning of FY 2013 public health nursing, which had three screening sites, began charging a nursing fee associated with the screening. Although the fee was on a sliding scale, there was misinformation about the fee and the screening rate for OOH births for the first half of FY2013 dropped to 51%. Screening equipment was placed with two additional midwifery centers (for a total of four midwifery centers with screening equipment) and the screening rate for OOH births rose to 71% for the second half of FY2013. EHDI brochures targeting OOH births were distributed to all midwives/midwifery centers.

The EHDI Program participated with thirteen other states in the NICHQ's virtual summary conference, Improving Hearing Screening and Intervention Systems (ISIS). As a result of participation in the NICHQ Learning Collaborative the following changes were noted at the Alaska Native Medical Center (ANMC), the statewide tribal health birthing facility with the state's second largest birthing census: 1) reduction in the "refer rate" which reduced the rate of loss to follow-up, 2) distribution of a "Do and Don't Say" card for birth screeners, and 3) improved communication with sub-regions. Other improvements were a decrease in the rate of loss to follow-up documentation at military birthing facilities, a process for earlier notification of newborn hearing screening for out of hospital births and an audiology packet to be distributed to audiology providers.

As a result of participation in the National Initiative for Children's Health Care Quality (NICHQ), the EHDI Program began notifying the medical home of children needing follow-up by fax instead of letter. This resulted in a more timely response by physicians to EHDI regarding the follow-up status of children in their practice. Letters were sent to parents who had a missed or failed screening, as well as the infant's medical home.



The EHDI Program developed a process with the Early Intervention/Infant Learning Program (EI/ILP) for matching data of children diagnosed with hearing loss to determine their enrollment status in early intervention. A referral generated from the database facilitated referrals to EI/ILP by audiology and notified EHDI that a referral was made.

Enhancements were added to the AKEHDI statewide database to assist with tracking and follow-up. The “diagnostic report” provided a complete picture of a child’s diagnostic status to support follow-up activities. “Hearing Reminders” were utilized at the state level to send letters or faxes to parents, primary care providers, audiologists and early interventionists. Notifications were customized depending on the child’s health care system, i.e. private, tribal health, or military.

The EHDI Program identified the Hmong population as having a high rate of loss to follow-up with audiology and enrollment in early intervention. A presentation was made to the EHDI Advisory Committee by a psychology doctoral student “Hmong Population in Alaska: Cultural Values and Beliefs around Health and Wellness”. She presented culturally insightful information regarding interaction with Hmong families.

The AAP Chapter Champion continued to be an active member of the EHDI Advisory Committee, which has a diverse group of stakeholders. The parent navigator assigned to EHDI from the Stone Soup Group (SSG) continued to outreach to new families.

Current Activities FY 2014

This year’s focus is to continue to decrease the number of children lost to follow-up. The new round of HRSA funding targets a 5% reduction in loss to follow-up per year.

The EHDI Advisory Committee is participating in a SWOT (Strengths, Weaknesses, Opportunities and Strengths) analysis as a mechanism to describe the program. A quality improvement team is convened to guide activities.

EHDI meets with ANMC to improve timeliness of follow-up for infants in remote regions. A revised protocol involves administering an audiology diagnostic evaluation before infants return to remote communities. Changes in loss to follow-up are being tracked.

The EHDI Program is partnering with EI/ILP to track children from diagnosis to intervention services by matching named, unduplicated data. This assists both programs in identifying issues related to loss to follow-up.

Hearing reminders are prompting earlier letter notification to parents. The medical home is sent fax alerts resulting in a quick response by physicians to EHDI regarding the child’s status.

EHDI is working with large birthing facilities to report electronically into the database to improve timeliness and accuracy of data reporting.

EHDI continues to monitor the OOH birth screening rate.

A perpetual calendar with hearing, developmental, immunization and medical home information is distributed to all new mothers throughout the state.



Parent navigation and parent- to-parent support is ongoing.

Plan for the Coming Year

The EHDI program will continue to focus on the National 1-3-6 Goals by addressing children lost to follow-up after final screening and ensuring children receive timely diagnostic and early intervention services. The goal is a 5% reduction in loss to follow-up per year.

A quality improvement team will continue to meet and identify improvement projects utilizing “small tests of change”. Plan-Do-Study-Act (PDSA) cycles will be employed to study if an activity led to change. The EHDI Advisory Committee will prioritize the SWOT (Strengths, Weaknesses, Opportunities and Strengths) analysis and results will be incorporated into quality improvement activities. Data will also be utilized to identify areas with high rate of loss to follow-up and guide activities.

The revised *Pediatric Audiology Guidelines* will be distributed to audiologists statewide along with the *CDC Decision Guide for Parents*. The decision guide will promote parents receiving consistent, unbiased information no matter where they reside. EHDI will continue to distribute the updated developmental calendar for new parents.

The EHDI Program will continue to partner with EI/ILP to track children from diagnosis to intervention services by matching named, unduplicated data. The programs will analyze if there are cultural groups more likely to decline services and explore opportunities for change. The Memorandum of Agreement (MOA) between the two programs will be reviewed to improve communication and timeliness of a match.

The EHDI Program will continue to partner with ANMC and regional hubs to implement protocols that lead to earlier diagnostic assessment and reduce loss to follow-up. Change in the rate of loss to follow-up after screening will be tracked. Regions with higher rates of loss to follow-up will be identified.

EHDI will monitor the change in the rate of OOH births that receive newborn hearing screenings and explore new opportunities for educating midwives on the benefits of newborn hearing screening. Quarterly reports will be sent to midwifery centers. EHDI will analyze trends in OOH populations that opt out of newborn hearing screening.

The EHDI Program will continue to work with military facilities to improve tracking of infants from screening through diagnosis, data reporting to EHDI, and adherence to the operations manual.

The Center for Disease Control and Prevention (CDC) will be distributing new “*Just in Time*” materials for physicians. EHDI will work with the AAP Chapter Champion to explore avenues for distributing materials to the medical home.

Improving support to parents of children diagnosed deaf or hard of hearing will be ongoing. Opportunities for introducing the parent navigator to families will be examined, as well as working effectively with different cultural groups.

The EHDI Advisory Committee will continue to meet three times a year. A broad group of stakeholders will continue to participate and provide input on quality improvement projects.



NPM 12 Activities	Pyramid Level of Services			
	DHC	ES	PBS	IB
1. Assure accurate and complete utilization of the internet-based reporting system through ongoing monitoring of data entry and training of new hospital staff, public health nurses, audiologists, early intervention staff and parent navigators				X
2. Utilize a fax back system with birth screeners to track infants in need of follow-up			X	X
3. Develop quality improvement projects to target the process from screening to diagnosis to intervention services for children in the EHDI system				X
4. Contact parents of infants born out of hospital regarding importance of newborn hearing screening and provide focused education and training to midwifery centers				X
5.. Monitor data entry by the audiology community in reporting diagnostic information in the database				X
6. . Partner with the Stone Soup Group parent navigators to provide parent-to-parent support and resource information for families of children who are deaf or hard of hearing		X		
7. . Collaborate with the Early Intervention/Infant Learning Program to match unduplicated and named data for identification of systems issues.				X
8. . Communicate with outlier communities with implemented newborn hearing screening programs and assure adherence to EHDI protocol and linkages to EI, medical home and audiology			X	X
9.. Partner with AAP Chapter Champion on EHDI presentations and materials to primary care providers				X
10. Monitor the database for quality assurance and follow-up for children who refer on screening or are diagnosed with hearing loss				X



Alaska Maternal and Child Health FY 2014 Title V Block Grant

National Performance Measure #13:

Percent of children without health insurance.

Last Year's Activities

In December 2012 (FFY 13 Qtr 1), the Department received its fourth Children's Health Insurance Program Reauthorization Act (CHIPRA) performance bonus payment totaling more than \$4,000,000 for eligibility streamlining and simplifications.

In July 2011 (SFY 12), two in-state grantees were awarded under the CHIPRA Tri State Children's Health Improvement Consortium (T-CHIC) grant with OR and WV. The two new grantees awarded were SouthCentral Foundation and Peninsula Community Health Services, joining Iliuliuk Family Health Services which was awarded funding as a waived grantee and began its work in 2011. Project implementation work began on patient centered medical home (PCMH) and the development of an online reporting tool for our pilot sites by Child and Adolescent Health Measurement Initiative (CAHMI- HRSA MCH funded) that enabled the collection of baseline data and ongoing data that supports the evaluation of PCMH progress across the three states. Work with the grantees to support collection and reporting on a subset of the CHIPRA core children's quality measures. Learning collaborative meetings have been held and are supporting the care coordination component of PCMH standards. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) PCMH patient experience of care work was initiated in 2011/2012 at the practice and state levels and the survey will again be fielded in fall 2014 with the three T-CHIC grantees in addition to the 3 non-TCHIC grantees supported by the Women Children's Family Health (WCFH) care coordination (CC) grant funding. A learning collaborative(s) will be held in late 2014 or early 2015 to support the practices who are participating in this work to facilitate quality improvement (QI) work at the practice level. The Alaska Medicaid agency will draw a pseudo sample frame of Medicaid children to use as a part of the CHIPRA CAHPS requirement. The CHIPRA quality improvement demonstration funding has been leveraged with the maternal child health (MCH) care coordination grant funding to improve patient experience and access. MCH will be applying for a similar continuation grant related to care coordination which will extend the practice and state level work begun under both TCHIC and the first round of care coordination funding, thus for summarizing the past and present under this subsection.

The MCH Title V/CSHCN, children with special health care needs, staff coordinated with Medicaid/Children's Health Insurance Program (CHIP) staff and assured that both programs are more effectively meeting the requirements for outreach and education around Early Periodic Screening Diagnosis and Treatment (EPSDT) services and Medicaid coverage including additional simplifications to the eligibility and enrollment processes. Initial work was done on developing developmental screening policy under EPSDT to support reliable measurement of the developmental screening children's measure, one of the core CHIPRA children's quality metrics to meet National Quality Forum (NQF) standards and to support Assuring Better Child Development (ABCD) efforts. In addition Title V, Infant Learning Program (ILP-early intervention), Early Childhood Comprehensive Systems (ECCS) and Medicaid/CHIP worked with the CAHMI at Oregon Health Sciences University (OHSU) through our T-CHIC project (CAHMI is a partner to Oregon and collaborates with AK and WV) to implement the policies and procedures necessary to effectively collect and measure data related to the CHIPRA core children's quality measures including developmental screening, at both the state level and practice levels, utilizing administrative claims data.



Current Year's Activities

The Department received its fifth CHIPRA performance bonus payment in the amount of nearly \$3,000,000 for meeting both enrollment targets and streamlining and simplifying its eligibility policies.

The Title V Care Coordination grant is working collaboratively with the Health Planning and Systems Development Section in the Division of Public Health under their CHIPRA T-CHIC grant with OR and WV to address children's care coordination in AK primary care practices. Earlier this year, the T-CHIC project coordinator and Health Planning and Systems Development Unit, Division of Public Health, assisted in planning a session related to navigating primary care practice redesign in 2014 of the Alaska Rural Health Conference and coordinated with Dr. Lyle (L.J.) Fagnan from Oregon to facilitate the conference session. Through Maternal Child Health Bureau (MCHB) Family Voices cooperative agreement funding, Dr. Antonelli developed the pediatric medical home care coordination curriculum. WCFH has worked with the University of Alaska Anchorage to establish a care coordination curriculum, which was borne from the collaboration with the WCFH care coordination grant, T-CHIC grant and the curriculum and training presented by Dr. Antonelli. Jimael Johnson, WCFH, Care Coordination Program Manager, also presented along with the Executive Director of the All Alaska Pediatric Partnership (AAPP), Stephanie Monahan, on new developments related to patient centered models of care.

Next Year's Activities

It is hoped that Senator Rockefeller's newly introduced legislation in June 2014 will extend CHIPRA funding beyond September 30, 2014 which includes a provision for continued performance bonus payments to states who streamline, simplify and enroll eligible children as the Alaska (AK) Department of Health and Social Services (DHSS) has relied on those annual bonuses since 2009 to support children's QI among other enhanced health and social service initiatives in the Department. In addition, additional child QI work is also addressed in the legislation.

It is anticipated that the MCH Health Resources Services Administration (HRSA) pediatric medical home care coordination grant and the T-CHIC CHIPRA AK pilot projects will continue their collaborative work on care coordination begun in 2012. It is hoped that the process improvements related to PCMH, children's quality measures and associated health information technology (HIT) advancements will be shared with other pediatric providers/stakeholders through additional learning collaborative workshops. The AAPP in collaboration with the AK Chapter of the American Academy of Pediatrics (AAP) have targeted PCMH as one of their main objectives and is collaborating with Title V, Medicaid and other programs to make this work meaningful in Alaska. One pediatric practice in Anchorage is the recipient of funding from a Primary Care Association PCMH Initiative to pilot PCMH and care coordination within the practice and to begin to focus on proposing payment reforms to fund this model of care. While the other practices are family/CHCs (community health centers), it is exciting that one pediatric practice has been selected and it is hoped that the lessons learned by the Title V care coordination grant funding and the T-CHIC work will be utilized especially with regard to identification of children and youth with special health care needs through the CAHMI screener which utilizes the MCH definition of children with special health care needs. In addition, the Medicaid Agency is participating in a National Governors' Association (NGA)/National Academy of State Health Policy (NASHP) collaboration on work with super utilizers. More than half of these super utilizers identified in Alaska Medicaid are children and we are also hoping to build in sustainability from the T-CHIC CHIPRA children's demonstration and adaptive reserve to support and advance this work as well.



The MCH Title V/CSHCN Director and staff members will continue to focus attention in working with the Medicaid/CHIP and assuring that both programs are more effectively meeting the requirements for outreach and education around EPSDT services and Medicaid coverage. Title V dollars will continue to provide gap-filling services in the area of pediatric specialties including genetics and metabolic clinics, neurodevelopment/autism screening services, cleft lip and palate assessment and evaluation, neurology services, and parent navigation.



Alaska Maternal and Child Health FY 2014 Title V Block Grant

National Performance Measure #14:

Percentage of children, ages 2 to 5 years, receiving WIC services with Body Mass Index (BMI) at or above the 85th percentile. For Alaska, it will be measured at or above the 95th percentile.

Last Year's Activities

Alaska's Women, Infants and Children (WIC) program rates for obese children decreased slightly from 22% in 2012 to 21.5% in 2013. The indicator measured children ages 2-5 years at or above the 95th percentile. The Family Nutrition Program's strategic plan <http://dhss.alaska.gov/dpa/Pages/nutri/default.aspx> continued to include obesity prevention in all WIC grantees' requests for proposals. The federal WIC program data collection measures do not include the collection of data at the 85% percentile.

Thirteen Alaska WIC local agency grantees continued to include the goal of reducing the prevalence of overweight and obesity among Alaskan children and adolescents in their nutrition education and services plans. They continued utilizing Alaska WIC's nutrition themes: "*Family Meals and Breastfeeding...So Good for Me,*" "*Playtime.... So Good for Me*" and "*Water, Water... So Good for Me!*" and newly developed nutrition theme materials "*Alaska Fruits and Vegetables...So Good for Me!*" in outreach and other program activities. Nutrition education WIC funds were used to provide nutrition theme materials to local agencies. Those materials are available on the Division of Public Assistance's Family Nutrition, WIC-Nutrition Education website: <http://dhss.alaska.gov/dpa/Pages/nutri/wic/wiceducation.aspx>. Dissemination of nutrition theme materials also continued through the State Nutrition Action Plan (SNAP) Committee's program activities.

Changes to the WIC food package during SFY 2011 continued to help WIC families eat more nutritious meals regularly while also fostering a life-long consumption of healthy foods. In SFY 2013, WIC once again offered Farmers' Market coupons to purchase produce grown locally in various parts of the state. Farmers and farm markets in areas such as Sitka, Bethel and Dillingham were actively involved in providing healthy, local produce to WIC participants. There were 106 farmers, 30 roadside stands, and 14 Farmer Markets in the state providing fresh produce for WIC clients.

Additionally, WIC Vendors across the state were monitored assuring a variety of healthy WIC foods and produce were made available in remote areas of the state. In those areas without approved WIC vendors, the mail out vendor (MOV) service continued to provide clients with nutritious, healthy food options.

Alaska WIC continued training on nutrition assessment and participant-centered education to help support the WIC program's initiatives to reduce overweight and obesity among Alaskan children and adolescents. WIC continues to utilize Alaska WIC nutrition reports for quality assurance, program planning, and to identify coordinated national objectives that promote healthy eating and active lifestyles.

Two breastfeeding public service announcements were developed and played statewide on radio stations emphasizing the importance of breastfeeding and the return to work. Alaska WIC has noted breastfeeding rates for initiation rising while duration rates remain the same.

The 2013 WIC strategic plan continued to have its core purpose defined around providing quality nutrition and education. The long term goal is no increase in the percentage of obese WIC kids across Alaska.



Current Year's Activities

The Alaska WIC program implemented a new automated benefit system, SPIRIT, which collects data on all WIC participants. Reports on obesity and breastfeeding rates are being developed to help monitor and track these indicators in the WIC program. Alaska WIC continues to monitor and train on the participant-centered education model to provide services to all WIC clients. Clinic staff access WIC nutrition reports for quality assurance and program planning efforts. WIC monitors obesity rates monthly and directs resources accordingly. WIC shares data with the Division of Public Assistance (DPA) and publishes data online to raise awareness about obesity in Alaska.

The WIC Farmer's Market program provides \$25 to each participant to purchase fresh fruits and vegetables from local farmers and farmer markets during the summer months.

WIC continues 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 the WCFH staff. The WIC breastfeeding peer counseling (BFPC) program staff receives quarterly evidence-based breastfeeding training to help reduce overweight and obesity in children. The current Breastfeeding Peer Counselor (BFPC) online training is updated to provide a quality training mechanism for our BFPC program. The BFPC program has access to bi-monthly newsletters and a BFPC Facebook page for education and support to peer counselors across the state.

Next Year's Activities

Alaska WIC local agency grantees will continue to infuse the goal of reducing the prevalence of overweight and obesity among Alaskan children and pregnant adolescents in their nutrition education and service plans. Local agency grantees will incorporate all four nutrition themes and the revised WIC strategic plan while providing their clients' counseling and education.

Participant-centered education will be used to engage participants in setting their own nutritional goals and encouraging them to incorporate WIC foods into their daily meals. Alaska will implement updated nutrition risks criteria per a USDA mandate during SFY 2013. Alaska will adopt the "At Risk of Overweight" nutrition risk criteria. The USDA risk criteria will include a weight-related risk that covers infants and children less than 24 months, "High Weight-for-Length (Infants and Children < 24 Months of Age)," which Alaska will also implement. Both risk criteria will help WIC identify, educate, and track data specific to overweight and obesity in Alaska. Identifying children at younger ages supports the program's overall goal to reduce overweight and obesity in children.

The Section of Women's, Children's and Family Health (WCFH) will continue efforts to prevent and reduce the burden of obesity throughout the life course. They will continue to address healthy pregnancy weight in the Healthy Start and Maternal, Infant, and Early Childhood Home Visiting (MIECHV) programs they administer, which includes a focus on breastfeeding promotion and nutrition for toddlers.

WCFH staff will be active in the Alaska Breastfeeding Coalition and will collaborate with WIC to support breastfeeding and reduce obesity. Ongoing education will be offered again in the next state fiscal year to hospital staff and health care providers on strategies to help hospitals and birthing centers become more Baby Friendly, even if they do not wish to attain full Baby Friendly status. Breastfeeding promotion in the community and amongst business leaders will also be a part of the strategies to improve breastfeeding rates after 8 weeks. The "Business Case for Breastfeeding" will be the



framework used for this work. WCFH will continue efforts to promote the dedicated space for breastfeeding moms who work in the Anchorage Frontier Building. WIC will continue 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 the WCFH staff.

Activities	Pyramid Level of Service			
	DH	ES	PBS	IS
Adapt participant-centered education model training and implementation			X	
Use WIC nutrition reports for quality assurance/program planning			X	
Identify coordinated objectives to promote healthy eating and active lifestyles				X
Disseminate nutrition themes via SNAP			X	
Incorporate revised strategic plan's purpose and goals into local area WIC grants				X
Share WIC data with DPA and DPH				X

NOTE: **DHC**=Direct Health Care **ES**=Enabling Services **PBS**=Population Based Services **IB**=Infrastructure Building.



Alaska Maternal and Child Health FY 2014 Title V Block Grant

National Performance Measure #15:

Percentage of women who smoked in the last 3 months of pregnancy

Last year's accomplishments:

The percentage of women who smokes in the last three months of pregnancy has continued to decrease since 2007 according to Pregnancy Risk Assessment Monitoring Data (PRAMS). No PRAMS data is available for 2011 due to the required database change for PRAMS.

The WCFH MCH Epidemiology unit continued to provide reliable data on maternal and child health issues which were used in planning and evaluating programs, preventing poor health outcomes, and guiding public health policy.

The Alaska Quit Line was promoted on the State of Alaska website and by the State Tobacco program. Services of the Alaska Quit Line were provided at no cost. Two printed books that cover tobacco risks and information about quitting were widely distributed at no cost to clinics or parents statewide. *"A Pregnant Woman's Guide to Quit Smoking"* was developed with input from Alaska Native women, and *"Baby and Me"* which is a comprehensive perinatal resource guide that covers tobacco risks. Text4baby for Alaska, which includes tobacco-related messages, continued to be posted on the State of Alaska webpage.

The Alaska Infant Safe Sleep Initiative continued to distribute the infant safe sleep pamphlets and posters statewide. Both resources cover tobacco risks.

Distance education offerings for clinicians working with pre-conception, pregnant and postpartum women were offered over the Alaska Women's Health Program clinical network list serve. During this year one training on tobacco cessation was offered.

Evidence-based preconception, prenatal and interconceptional health clinical resources were offered on the WCFH Alaska Women's Health Program and perinatal webpages.

Both webpages also include evidence-based resources on women's health topics for clinical care providers. The perinatal health program used the WCFH Alaska Women's Health Program webpages to deliver evidence-based pre-conception, prenatal and interconception health information to Alaskan women through a life course framework. Evidence-based support for mothers needing information about tobacco risks and cessation was offered on the Alaska Women's Health Program webpages where links to current information from the Office on Women's Health and Alaska's Quit Line were available.

WCFH administered the Maternal, Infant & Early Childhood Home Visiting (MIECHV) program in Anchorage and Healthy Start in the Nome census area. Both programs promoted tobacco cessation, screened clients for tobacco use, and made appropriate referrals to the Alaska Quit Line. Preliminary data from the MIECHV program, located at Providence In-Home Services and using the Nurse-Family Partnership (NFP) model, showed that 6/11 women had quit smoking tobacco at 36 weeks of pregnancy.



Current activities:

The Alaska Quit Line is promoted on State of Alaska webpages. Printed books covering risks and quitting guidance were distributed at no cost to clinics or parents statewide including *"A Pregnant Woman's Guide to Quit Smoking"* and *"Baby and Me"*.

Text4baby for Alaska, which includes tobacco-related messages, is posted on the State of Alaska webpages.

The Alaska Infant Safe Sleep Initiative distributed infant safe sleep pamphlets and posters statewide. Both cover tobacco risks.

Planning for the 2014 Alaska MCH and Immunization Conference includes having a perinatal nurse from the Alaska Native Tribal Health Consortium and a WCFH epidemiologist will present a session entitled: *"Strategies for Reducing Infant Mortality in Alaska"*.

One training on tobacco cessation was offered on the Alaska Women's Health Program clinical network list serve.

Evidence-based support for mothers needing information about tobacco risks and cessation is offered on the perinatal and Alaska Women's Health Program webpages with links to current information from the Office on Women's Health and Alaska's Quit Line.

WCFH administers the MIECHV program in Anchorage and Healthy Start in the Nome census area. Both programs promote tobacco cessation, screening for tobacco use, and made appropriate referrals to the Alaska Quit Line.

Plans for the coming year:

The Alaska Quit Line will be promoted on the State of Alaska website and by the State Tobacco program. *"A Pregnant Woman's Guide to Quit Smoking"* will be widely distributed at no cost to clinics or parents statewide.

The most recently published edition of *Baby and Me* is dated, having been published 2006. During the coming year and as quantities decrease of the book, the WCFH perinatal program will research and select a comprehensive, up to date, and evidence-based, perinatal resource guide that includes information on tobacco risks and quitting.

Text4baby for Alaska, which includes tobacco-related messages, will continue to be posted on the State of Alaska webpage.

The Alaska Infant Safe Sleep Initiative will continue to distribute the infant safe sleep pamphlets and posters statewide. Both resources cover tobacco risks.

The 2014 Alaska MCH and Immunization Conference will be held in September. A perinatal nurse from the Alaska Native Tribal Health Consortium will partner with the WCFH epidemiologist to present a session entitled: *Strategies for Reducing Infant Mortality in Alaska*. Data and strategies relevant for tobacco use reduction will be shared. Planning for the 2016 conference will begin soon after the 2014 conference is held.



Distance education offerings for clinicians working with preconception, pregnant and postpartum women will be offered over the Alaska Women’s Health Program clinical network list serve.

Evidence-based support for mothers needing information about tobacco risks and cessation will continue to be offered on the perinatal and Alaska Women’s Health Program webpages where links to current information from the Office on Women’s Health and Alaska’s Quit Line will be available.

WCFH will continue to operate MIECHV in Anchorage and Healthy Start in the Nome census area. Both programs will promote tobacco cessation, screen for tobacco use, and make appropriate referrals to the Alaska Quit Line. Both programs will be monitoring and reporting data related to tobacco use.

NPM # 15	DHCS	ES	PB	IB
Distribute provider and consumer education materials on tobacco and pregnancy			X	X
Educate parents about the risk of tobacco through infant safe sleep initiative materials			X	
Provide Alaska Quit Line services			X	X
Deliver Regional Healthy Start and MIECHV services		X		
Post text4baby in Alaska on State website				X
Planned the 2014 MCH/Immunization Conference				X



Alaska Maternal and Child Health FY 2015 Title V Block Grant

National Performance Measure #16:

The rate (per 100,000) of suicide deaths among youths ages 15 through 19.

Last year's accomplishments:

In FY13, the Division of Behavioral Health's (DBH) Comprehensive Behavioral Health Prevention & Early Intervention Services (CBHPEIS) Program completed its second year of a new three-year grant cycle. The CBHPEIS is the largest prevention program that serves Alaskan communities addressing a variety of behavioral health problems and conditions such as substance abuse, domestic violence and suicide. From 2009 to 2011, the rate per 100,000 of suicide deaths among youth ages 15 through 19 was 23. This was a significant decrease of suicide deaths (28.6) from the previous four year cycle from 2008 to 2010.

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. Examples of these strategies included healthy recreation programs, teen centers, sports activities, mentoring, and cultural activities, e.g., subsistence, beading, carving, drumming, and Alaska Native and Eskimo dance. 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.

As a result of the grant period, accomplishments were enhanced integrating suicide prevention programs with other behavioral health prevention strategies. Short term outcomes showed increases in protective factors such as social/emotional skills development, family, school and community connectedness, meaningful activities, cultural knowledge and practices, and identity development. Focus on reduction of risk factors including drug, tobacco and alcohol use, problems associated with depression, bullying, lack of family and community engagement, social isolation and self-destructive behaviors.

DBH also completed its first year of the SAMHSA, Garrett Lee Smith (GLS) youth suicide prevention grant. The Alaska Youth Suicide Prevention Project is refocusing its efforts to enhance and expand the Alaska Gatekeeper Training statewide by incorporating QPR (Question, Persuade, Refer) component as nationally recognized best practice. So far we have trained approximately 100 trainers and over 500 participants in the model. Additional progress has been made on implementing our Alaska Careline "Text 4help to 839863" service. Text volume is still relatively low, approximately 10-15 texts per month, but we see incremental growth targeting youth populations who are more likely to text than use the Alaska Careline call center phone number, 1-866-277-4357 or the national Lifeline.

DBH hosted a statewide Connect Postvention Training of Trainers workshop and certified 16 trainers in the nationally recognized Connect model which adhere to standards set by the Suicide Prevention Resource center. Areas of focus included clergy and schools. Most of the trainers went on to complete a postvention training in their respective communities.

Current Activities:

DBH is currently in the last year of the CBHPEIS three-year grant program. Regional and statewide plans include expansion of trainings, enhanced suicide prevention awareness campaigns, coordination with the state for development



of community postvention planning and survivor outreach supports, and increased linkages and access to services. This includes promotion of Careline, Alaska's statewide crisis call center.

DBH also continues to disseminate and deliver postvention (after a suicide) resources to grantees, groups and communities who are seeking technical assistance, support and guidance in responding to completed suicides. Considering Alaska is among the states with the highest suicide rate in the nation, it is imperative that postvention resources are widely available. Dissemination of training and technical resources have been targeted to both rural and urban communities with some discernible results in numbers of postvention trainings, community planning, outreach and response to suicide events.

DBH will be hosting its third annual Connect Postvention Training of Trainers workshop with the addition of 8 newly certified 8 trainers. This year the areas of focus will include mental health and law enforcement. Additional postvention efforts include the release of our revised Alaska Postvention Resource Guide "Preparing to Heal". Plans are now being developed to determine how the state can best distribute the resources to communities and health providers.

Plans for the coming year:

In FY15, the Division plans to award a new cohort of Comprehensive, Behavioral Health, Prevention grants that will continue to focus on suicide prevention in addition to substance abuse and poor mental health. Changes to the grant will require applicant agencies to work with coalitions and complete full community assessments using a data driven approach. Efforts in the past have required a strategic planning approach but little attention has been paid to conducting the strategic planning process with fidelity. We anticipate this will allow our communities to develop strategies and outcomes that have a stronger likelihood of achieving results and saving lives in the process. However, we also know that this requires a multifaceted and sustained community approach. Grantees will receive stronger technical assistance to better prescribe evaluation plans that target community and population level outcomes. This will help to ensure cultural responsiveness and sustainability.

We will continue our 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. In addition, a postvention DVD project has begun and will be a companion to the resource guide and supplemental resource to our postvention materials.

DBH will also continue to place emphasis on capacity development to support sustainable community efforts. To accomplish this, partners will include the Statewide Suicide Prevention Council, Education and Early Development, Division of Juvenile Justice, Alaska Native Tribal Health Consortium, University of Alaska Anchorage, Trust Training Cooperative and other youth serving agencies, stakeholder and community groups. The statewide suicide prevention web-portal www.stopsuicidalaska.org will continue to be used as a resource to strengthen statewide coordination.



Activities	DHC	ES	PBS	IB
Provide for community-based suicide prevention grants			X	X
Develop a statewide mechanism for delivery of the Alaska Gatekeeper suicide prevention training curriculum				X
Promote the use of the evidence-based youth suicide prevention program				X
Participate and present at a number of statewide conferences				X
Disseminate Alaska Suicide Prevention Plan and Alaska Postvention Resource Guide				X
Implement SAMHSA Alaska Youth Suicide Prevention Project (3-year grant project)		X	X	X
Develop post intervention resources and provide for technical assistance and training				X

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Alaska Maternal and Child Health FY 2015 Title V Block Grant

National Performance Measure #17:

Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Last year's accomplishments:

WCFH continued to utilize the perinatal listserv to disseminate information to stakeholders and healthcare providers. The content of the perinatal health program webpage was reviewed and updated. *Baby and Me* books were distributed as a prenatal/newborn resource for parents. It addresses low birth weight among other perinatal topics. Evidence-based preconception, prenatal and interconceptional health clinical resources were offered on the WCFH Alaska Women's Health Program and perinatal webpages. Both webpages included evidence-based resources on women's health topics for clinical care providers.

WCFH administered the Maternal, Infant & Early Childhood Home Visiting (MIECHV) program in Anchorage and the Healthy Start case management program in the Nome census area. Both programs worked with pregnant women to encourage healthy behaviors and emphasize the importance of prenatal care. The MIECHV program is located at Providence In-Home Services in Anchorage and uses the Nurse-Family Partnership model of home visiting. The MIECHV program began tracking data on low birth weight infants. The nurse home visitors utilized in-person and online training related to having a healthy pregnancy.

Healthy Start served pregnant clients in Nome. Because of Nome's distance from services for high-risk pregnant women (including cesarean sections), there is an ongoing concern around appropriately transporting women to a larger medical center for obstetrical and neonatal care. The Healthy Start program will track the location of birth for clients and look at issues related to appropriate transport for pregnant women, such as to the one Level III NICU in Anchorage for the birth of very low birth weight babies.

Current activities:

The perinatal nurse consultants continue to distribute perinatal materials in a variety of ways. The *Baby and Me* book continues to be distributed widely and feedback has been extremely positive.

Text4baby, which includes content related to preterm birth and low birth weight, is promoted on the State of Alaska websites.

WCFH prepared for the 2014 Alaska Maternal Child Health and Immunization Conference.

Under leadership from the Division of Public Health and the Alaska Native Tribal Health Consortium, the perinatal program convened a statewide Healthy Alaskans 2020 workgroup tasked with identifying critical strategies for improving first trimester prenatal care. The workgroup included medical leadership from tribal health, State medical, and Alaska Chapters of ACOG and the American Academy of Family Physicians (AAFP) as well as rural and urban primary care providers. WCFH Epidemiology staff supported the work with data such as PRAMS. Notable among the outcomes of the work was the recommendation that a perinatal health improvement task force be established. This will replace the former perinatal advisory committee and keep is action oriented and results focused.



WCFH administered the MIECHV and Healthy Start programs and monitor data on low birth weight infants.

Plans for the Coming Year

The WCFH MCH Epidemiology unit will continue to provide reliable data on maternal and child health issues which will be used in planning and evaluating programs, preventing poor health outcomes and guiding public health policy. They plan to release a new databook which will take a lifecourse approach and include information on entry into prenatal care and low birth weight infants.

MIECHV and Healthy Start will continue to deliver services. Healthy Start will outreach to women at risk for pregnancy and in need of education about the importance of early care for those who are pregnant. Case management services for at-risk pregnant women will continue and will facilitate access to quality care.

The 2014 Alaska MCH and Immunization Conference will be held in September.

The perinatal program will collaborate with Division of Public Health and Alaska Native Tribal Health Consortium leadership to help forward their mutual goals for Healthy Alaskans 2020 and the strategies proposed by the early prenatal care workgroup.

SPM # 17	DHCS	ES	PB	IB
Continue to distribute information on prevention of low birth weight via various forms of communication				X
Continue to promote text4baby in Alaska				X
Planning the 2014 Alaska Maternal Child Health and Immunization Conference				X
Continue MCH Epidemiology surveillance activities and publish databook using the lifecourse approach				X
Continue to administer the MIECHV and Healthy Start programs encouraging health behaviors and prenatal care		X		
Distributed consumer education materials covering evidence-based guidelines for preconception, interconception and prenatal care (online and in print)				X



Alaska Maternal and Child Health FY 2015 Title V Block Grant

National Performance Measure #18:

Percent of infants born to pregnant women receiving prenatal care beginning in first trimester

Last year's accomplishments:

The WCFH MCH Epidemiology unit provided reliable data on maternal and child health issues which were used in planning and evaluating programs, preventing poor health outcomes and guiding public health policy.

Evidence-based preconception, prenatal and interconceptional health clinical resources were offered on the WCFH Alaska Women's Health Program and perinatal webpages.

Both webpages included evidence-based resources on women's health topics for clinical care providers. The WCFH Alaska Women's Health Program webpages delivered evidence-based preconception, prenatal and interconception health information to Alaskan women through a life course framework. Women were guided to topics such as nutrition, where they could locate information about nutrition for themselves while pregnant, planning a pregnancy, or spacing between pregnancies. The WCFH perinatal listserv also continued to distribute information and updates on perinatal topics to a large number of stakeholders. *Baby and Me*, a comprehensive prenatal resource guide, was distributed statewide at no cost for women or health care providers. This book provided information about the importance of early prenatal care and encouraged those who have not yet accessed care to do so.

The WCFH Alaska Women's Clinical Network listserv shared evidence-based distance trainings and online resources on women's health with an emphasis on guidelines for preventive health care, healthy nutrition, physical activity, mental health, sexually transmitted diseases, intimate partner violence, and breastfeeding. Web-based trainings were resourced from nationally recognized expert organizations, including the Office on Women's Health, the Center for Disease Control and Prevention, and the American Academy of Family Physicians.

WCFH administered the Maternal, Infant & Early Childhood Home Visiting (MIECHV) program in Anchorage and the Healthy Start case management program in the Nome census area. Both programs worked with pregnant women to encourage and facilitate early prenatal care. The MIECHV program is located at Providence In-Home Services in Anchorage and uses the Nurse-Family Partnership model of home visiting. Preliminary data from the MIECHV program showed that clients were receiving an adequate number of prenatal care visits per American College of Obstetricians and Gynecologists (ACOG) guidelines.

Current activities:

Evidence-based prenatal health resources are offered on the WCFH Alaska Women's Health Program and perinatal webpages. The perinatal health program utilized the WCFH Alaska Women's Health Program webpages to deliver evidence-based pre-conception, prenatal and interconception health information to Alaskan women through a life course framework. The WCFH Women's Clinical Network list serve shared four distance trainings and online resources covering preconception and prenatal care.

Baby and Me books were distributed at no cost.



MIECHV and Healthy Start continued services. Healthy Start requested support to use the national *Show Your Love* materials for preconception and prenatal care. Some re-design was planned to improve cultural relevance.

WCFH staff planned the 2014 Alaska Maternal Child Health and Immunization Conference.

Under leadership from the Division of Public Health and the Alaska Native Tribal Health Consortium, the perinatal program convened a statewide Healthy Alaskans 2020 workgroup tasked with identifying critical strategies for improving first trimester prenatal care. The workgroup included medical leadership from tribal health, State medical, and Alaska Chapters of ACOG and AAFP as well as rural and urban primary care providers. WCFH Epidemiology staff supported the work with data such as PRAMS. Notable among the outcomes of the work was the recommendation that a perinatal health improvement task force be established.

Plans for the coming year:

The WCFH MCH Epidemiology unit will continue to provide reliable data on maternal and child health issues which will be used in planning and evaluating programs, preventing poor health outcomes and guiding public health policy. They plan to release a new databook which will take a lifecourse approach and include information on entry into prenatal care.

Evidence-based prenatal health resources will continue to be offered on the perinatal and WCFH Alaska Women's Health Program webpages. Both will include evidence-based resources on women's health topics for the public and clinical care providers. The WCFH Alaska Women's Clinical Network list serve will share evidence-based distance trainings and online resources covering preconception and prenatal care.

The most recently published edition of *Baby and Me* is dated, having been published 2006. As quantities decline in the coming year, the WCFH perinatal program will research and select a comprehensive, up-to-date, evidence-based, perinatal resource guide that includes information on the importance of early prenatal care. Current users and perinatal partners will be solicited for input and recommendations on products they believe will best serve their perinatal clients.

MIECHV and Healthy Start will continue to deliver services. Healthy Start will outreach to women at risk for pregnancy and in need of education about the importance of early care for those who are pregnant. Case management services for at-risk pregnant women will continue and will facilitate access to quality care.

The perinatal program will support the Healthy Start request to adopt and use the national *Show Your Love* campaign materials in their work in promoting preconception, early prenatal and interconceptional care. The materials will be re-designed to meet the needs of the program and those it serves.

The 2014 Alaska MCH and Immunization Conference will be held in September. A perinatal nurse from the Alaska Tribal Health Consortium will partner with the WCFH Epidemiologist to present a session titled: *Strategies for Reducing Infant Mortality in Alaska*. Data and strategies relevant for tobacco use reduction will be shared. Planning for the 2016 conference will begin soon after the 2014 conference is held. WCFH staff will collaborate with all relevant partners to conduct



The perinatal program will collaborate with Division of Public Health and Alaska Native Tribal Health Consortium leadership to help forward their mutual goals for Healthy Alaskans 2020 and the strategies proposed by the early prenatal care workgroup.

For FY 2013

NPM # 18	DHCS	ES	PB	IB
Distributed consumer education materials covering evidence-based guidelines for preconception, interconception and prenatal care (online and in print)			X	
Distributed provider education materials covering evidence-based guidelines for preconception, interconception and prenatal care (online)				X
Delivered Regional Healthy Start and MIECHV services		X		
Plan the 2014 MCH/Immunization Conference				X



Alaska Maternal and Child Health FY 2015 Title V Block Grant

State Performance Measure #1:

% of women who recently had a live-born infant and reported having one or more alcoholic drinks in an average week during the last 3 months or pregnancy.

Last year's accomplishments:

There is no new Pregnancy Risk Assessment Monitoring System (PRAMS) data for 2012 due to the mandatory data system change. The MCH Epidemiology Unit continues to administer surveys such as PRAMS and the Childhood Understanding Behaviors Survey (CUBS). Both include questions on prenatal substance abuse.

The life course framework is used to organize work in the perinatal health program. Primary prevention and its power to improve birth outcomes and life's trajectory is the program's focus, and well suited to the issue of alcohol use during pregnancy.

Information and materials continue to be distributed such as *Baby and Me* and the MCH Epidemiology Unit databooks. *Baby and Me* includes information regarding alcohol use during pregnancy.

The Alaska Birth Defects Registry (ABDR) program continued to conduct medical abstractions at health care facilities for birth defects, such as fetal alcohol syndrome (FAS).

WCFH administered the Maternal, Infant & Early Childhood Home Visiting (MIECHV) program in Anchorage and the Healthy Start case management program in the Nome census area. The MIECHV program is located in Anchorage and utilizes the Nurse-Family Partnership model of home visiting. Data is collected on substance abuse during and after pregnancy.

Current activities:

A new Perinatal Nurse Consultant was added to the Perinatal and Early Childhood Health Unit. Information and materials continues to be distributed such as *Baby and Me* and the MCH Epidemiology Unit databooks.

A long-time medical abstractor for the ABDR program retired. The MCH Epidemiology Unit coordinated a presentation from the University of Alaska-Anchorage to WCFH staff on FASD/FAS screening, diagnosis, and characteristics of the conditions.

The MIECHV and Healthy Start programs continue to address substance abuse and healthy choices to program participants.

WCFH and the Alaska Native Tribal Health Consortium prepared for the 2014 Alaska Maternal Child Health (MCH) and Immunization Conference which will include a presentation on neonatal abstinence syndrome by a neonatologist.

Plans for the coming year:

MIECHV home visitors and Healthy Start case managers will continue to be trained about alcohol use during pregnancy so that they have skills needed to educate and motivate clients to choose healthy behaviors. Substance abuse during



pregnancy has been highlighted as a priority training topic for nurse home visitors in the upcoming year. WCFH will partner with the Division of Behavioral Health on this training.

WCFH and the Alaska Native Tribal Health Consortium will hold the 2014 Alaska MCH and Immunization Conference which will include a presentation on neonatal abstinence syndrome by a neonatologist.

The MCH Epidemiology Unit will publish and distribute an Epi-Bulletin related to prenatal substance exposure as well as publish the new databook. The WCFH Epidemiology Unit will also continue to establish a new electronic database for the ABDR and explore changing how FAS and FASD are abstracted from medical records.

The most recently published edition of *Baby and Me* is dated, having been published 2006. As quantities decline in the coming year, the WCFH perinatal program will research and select a comprehensive, up-to-date, evidence-based, perinatal resource guide that includes information on alcohol use during pregnancy. Current users and perinatal partners will be solicited for input and recommendations on products they believe will best serve their perinatal clients.

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
Plan for the 2014 MCH and Immunization Conference, including a presentation on neonatal abstinence syndrome				X
Continue to distribute relevant information to providers and consumers				X
Continue implementing MIECHV and Healthy Start programs that include comprehensive perinatal topics, including FASD prevention		X		
Compile data for the newest MCH Epidemiology databook which will include a lifecourse approach				X
Explore new database for the ABDR program			X	X
The WCFH Epidemiology Unit will explore changing how abstraction for FAS and FASD are done				X
Create an Epi-Bulletin on prenatal exposure to alcohol and other substances				X



Alaska Maternal and Child Health FY 2015 Title V Block Grant

State Performance Measure #2:

Rate of reports of maltreatment per thousand children 0 - 9 years of age

Last year's accomplishments:

The program manager position for the Surveillance of Child Abuse and Neglect (SCAN) program remained vacant from August 2011 until May of 2013. WCFH renewed a data sharing agreement with the former program manager, who is pursuing a doctoral degree in Injury Prevention at the University of North Carolina-Chapel Hill, to continue analysis of Alaska data. However, the focus of these analysis projects were directed and focused, opposed to assessing general incidence/prevalence. WCFH renewed a data sharing agreement with the Office of Children's Services and the Anchorage Police Department to share data relating to child maltreatment.

The SCAN manager position was filled in May of 2013 and a well-defined direction of the program has been established. The SCAN program now has three specified projects that will be developed; 1) Comprehensive cross-jurisdictional child maltreatment incident surveillance, 2) Magnitude assessment of child maltreatment, and 3) Longitudinal population based prospective birth cohort study.

The SCAN program recently published a comprehensive assessment of Abusive Head Trauma (AHT) by linking multiple data sources. Through the linkage process and applying the (corrected CDC AHT broad definition) the SCAN program was able to identify and count 49% more cases than relying on any single system alone. This work was published in a State Epidemiology Bulletin and presented at the International Circumpolar Health Conference. The SCAN program manager has interpreted, developed, and improved upon the original CDC International Classification of Diseases (ICD) coding suggestion that was utilized for this project and applied to an additional project for national estimation using the Kid's Inpatient Database (KID) and North Carolina Hospital Discharge data.

Collaborations with other organizations remained an important activity. WCFH maintained membership on the Children's Justice Act Task Force (CJATF). Collaboration with CJATF has been useful in identifying future areas of research and data analysis, and has from the inception of SCAN served as the steering committee. Additional relationships were built between SCAN and the Alaska Trauma Center, The Alaska Children's Trust, Division of Behavioral Health, child advocacy centers, and the children's hospital at Providence.

WCFH continues to support the Maternal, Infant, Early Childhood Home Visiting Program (MIECHV) and other home visiting programs throughout the state of Alaska.

Current activities:

The SCAN program is currently updating the AHT statewide estimates by including 2 additional years of data. Data collection is currently underway with 3 of the 5 required sources having already delivered the data for linkage and assessment.

We are currently implementing a prospective cohort study using the PRAMS sample as the basis of the population, to assess the life course impact of various adverse childhood experiences. Furthermore this cohort will allow for the assessment of dynamic risk factors over time to improve prediction of various adverse childhood events enabling a focused Public Health effort on upstream primary prevention activities.



A data sharing agreement between the SCAN program and the Alaska State Troopers can still not be implemented because the Troopers system still has bugs in their new software system, therefore, no electronic data can be retrieved. Thus a focus is on developing sentinel surveillance sites to compile local comprehensive data, and then weighted to the population for statewide estimation.

All of the current activities of the SCAN program are centered on developing quality data to inform action with regards to the prevention and early intervention work supported by the WCFH section. Furthermore, with a more complete understanding of child maltreatment from a public health perspective can identify target populations in need of additional supports, areas to leverage resources, and innovate novel prevention activities and evaluate impact.

Plans for the coming year:

The State Systems Development Initiative (SSDI) federal grant program will continue to be a vital component of funding and be used to stretch MCH funding by partially supporting a research analyst position within MCH-Epidemiology. This will increase WCFH capacity for linking data sets to analyze longitudinal data around health outcomes and domestic violence and support the SCAN program. Through data linkage and integration, we are better able to conduct fiscally efficient research and assessments, and provide cross-jurisdictional understanding of maltreatment and its impacts in Alaska.

This coming year, we plan on initiating sentinel surveillance and near death child reviews to expand our surveillance capacity and ability to identify maltreatment related injuries. The near death child reviews will be limited to the prospective cohort population and weighted to represent the Alaska birth population.

Additional will be conducted to understand the interrelationship of violence (i.e. the cyclical nature). This is largely being conducted through assessing the relationship between maternal historical self-reported IPV prior to the birth of a child and subsequent child harm. While the causal etiology of maltreatment and violence is multifaceted, with many key mediators and modifiers, focusing on systems of transmission may elucidate target populations and/or key intervention/prevention windows of opportunity.

WCFH will continue to insure that programmatic activities shift toward building infrastructure, supporting the implementation of primary prevention efforts, and understanding the impacts of child maltreatment. WCFH was not a recipient of the CDC "Essentials for Childhood" grant, but has chosen to partner with the Children's Trust to initiate parts of the proposed collaborative efforts framework.

WCFH applied for a CDC (Council of State & Territorial Epidemiologists) CSTE fellow to help support the SCAN program through directed research activities. This fellow will also help support the Anchorage Child Advocacy Center (CAC) to develop an Adverse Childhood Experience study (ACE), to assess the weight of the problem on the population being served and to aid in informing practice.

The SCAN system will continue to be refined to improve quality of data, timeliness and consistency. The former SCAN program manager has returned to WCFH in his former capacity and as the senior research advisor.

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
Alaska CJATF activities - maintain partnerships				X



Continue work on the SCAN data system: Develop partnerships and data sharing agreements, participation on the CJATF, publications, linking data sets and data analysis, and developing indicators				X
Operate the Family Preservation and Family Support programs through the OCS and provide training for grantees				X
SOA Public Health Nurses to continue conducting screening for domestic/intimate partner violence with their clients	X	X	X	
Administer the Maternal, Infant, and Early Childhood Home Visitation (MIECHV) program using the Nurse-Family Partnership (NFP) model	X	X	X	X
Administer the Healthy Start program which focuses on case-management of high-risk pregnant women and their infants, interconceptional women, and community building	X	X	X	X
Conduct the Alaska Safe Sleep Initiative social marketing campaign			X	X
Conduct and coordinate the Alaska Maternal and Infant Mortality Review Committee				X

DHC=direct health care services

ES=enabling services

PBS=population-based services

IB= infrastructure building services



Alaska Maternal and Child Health FY 2015 Title V Block Grant

State Performance Measure #3:

Percent of mothers who report tooth decay in their 3-year old children.

Last year's accomplishments:

This indicator is from the Childhood Understanding Behaviors Survey (CUBS) on mothers reporting a health care provider has indicated their child has tooth decay or cavities (for 3-year old children). CUBS data from 2012 indicated 16.2% of mothers reported they had been told by a health care provider that their 3-year old had dental decay – as compared with 17.3% in 2011, 17.0% in 2010, 14.8% in 2009 and 13.4% for this indicator in 2008. 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 or 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 and 2012 CUBS data is related to reported increases in the percent of children receiving a dental check-up or teeth cleaning (55.2% in 2012 and 56.7% in 2011 as compared with 45.5% in 2010). Dental assessments utilizing the Basic Screening Survey (BSS) protocol for Alaskan kindergarten children, an older age group than for this indicator, found 48% had a caries experience (treated or untreated dental decay) in 2005; 41% had caries experience in the 2007 BSS; and 41% with the 2010/2011 BSS.

Caries is the most common chronic disease among U.S. children – 5 times more common than asthma and 7 times more common than hay fever. Caries also is a frequent unmet health need especially in young children as first dental visits often occur in the 3-5 years age range. Early childhood caries (ECC) is a rapidly progressing form of the disease associated with active caries in the caregiver and transmission of bacteria associated with caries and feeding practices. ECC is not only costly to treat since children require undergoing dental treatment in an operating room under general anesthesia, but can affect speech development and learning, nutrition, behavior management issues and the child's quality of life. Due to these concerns, it is typically recommended that a child receive a dental exam with the eruption of the first tooth and no later than age one in order for early detection of ECC risk and provision of information to parents on nutrition, feeding practices, and oral hygiene.

In July 2010 Medicaid began reimbursement coverage for oral evaluation (caries risk assessment) for children under the age of three and fluoride varnish application for all children conducted by trained physicians, nurse practitioners and physician assistants. Children enrolled in Medicaid are typically at higher risk for caries and ECC development due to factors related with lower income-status of the families.

The Oral Health Program (OHP) has continued working with Head Start, SOA Public Health Nursing (PHN) and community partners to develop key messages for health programs to provide to parents and caregivers on water fluoridation, use of topical fluorides and reducing risk for dental decay in young children. Education activities provided to community partners on water fluoridation in SFY2013 included: provision of educational information and testimony with Municipality of Anchorage Assembly meetings. In September 2013, the Anchorage Assembly voted to support continued fluoridation of that community's public water supply.

Current activities:

The OHP continues to provide educational information on fluoridation to community leaders and will provide information when DHHS adopts new guidelines on fluoride concentration levels (proposed 0.7 mg/L vs. current 0.7–1.2 mg/L).



The OHP is convening an advisory group to develop a dental periodicity schedule for Medicaid and to promote earlier dental visits as part of initiatives in the August 2013 "Medicaid Dental Action Plan" (prepared in collaboration with the Division of Health Care Services). The project will include discussion of change in EPSDT (Early Periodic Screening, Diagnosis, & Treatment) guidance from an age 3 to an age 1 dental exam. The OHP presents/discusses the need for early dental visits with pediatric dentists and Tribal dental programs to reduce the prevalence/severity of ECC in Alaska.

With HRSA funding support, the OHP conducted four school-based sealant programs this year in schools with high percentages of children from low-income families.

The OHP and Alaska Dental Action Coalition (ADAC) revised the oral disease burden document and state oral health plan (July 2012). ADAC priorities included: expanding school sealant programs, increasing Medicaid reimbursement for dental treatment of special needs populations, support dental hygienist collaborative practice to expand access to preventive services in underserved settings and support of community water fluoridation. Current surveillance data, including 2010/11 BSS data, was used to update the disease burden document and state plan. (See attachment)

ATTACHMENT

Basic Screening Survey data for 2010/2011 for kindergarteners is as follows:

Caries Experience (Kindergarteners with treated or untreated dental decay):

Total (n=648)	41.4% (37.6, 45.3)
American Indian/Alaska Native (n=128)	63.3% (54.3, 71.6)
White (n=293)	28.0% (22.9, 33.5)
All Other (n=227)	46.3% (39.6, 53.0)
Medicaid/Denali KidCare (n=200)	45.5% (38.5, 52.7)
American Indian/Alaska Native (n=49)	69.4% (54.6, 81.7)
White (n=67)	29.9% (19.3, 42.3)
Other (n=84)	44.0% (33.2, 55.3)

Untreated Caries:

Total (n=648)	21.3% (18.2, 24.7)
American Indian/Alaska Native (n=128)	29.7% (21.9, 38.4)
White (n=293)	12.6% (9.0, 17.0)
All Other (n=227)	27.8% (22.0, 34.1)
Medicaid/Denali KidCare (n=200)	20.5% (15.1, 26.8)
American Indian/Alaska Native (n=49)	26.5% (14.9, 41.1)
White (n=67)	11.9% (5.3, 22.2)
Other (n=84)	23.8% (15.2, 34.3)



Plans for the coming year:

The program will continue to educate on the role of water fluoridation, fluorides and dental sealants in reducing dental decay. The OHP will continue to seek opportunities to encourage medical provider involvement with caries risk assessment and early childhood caries prevention along with encouraging dental visits by age one (especially for children at high risk for caries). OHP staff will be working collaboratively with FQHC dental programs to expand school sealant pilot programs and organize health professional workshops to improve training for treating special needs populations and collaboration with medical providers to address caries risk assessment and early childhood caries (ECC) prevention (HRSA grant activities.)

The program will be working with Medicaid on adoption of the separate dental periodicity schedule for the EPSDT Program – along with information, and/or changes in EPSDT guidelines, to encourage early dental visits.

OHP will continue the collaboration with community health center dental programs for provision of dental sealants in four elementary schools where fifty percent or more of the children are eligible for the free and reduced price school lunch program. The OHP will look for opportunities to expand the school-based dental sealant programs to other schools as funding permits.

OHP is working with the State Primary Care Office on development of data collection on hospital general anesthesia cases for treatment of ECC as part of the oral health surveillance system. It is hoped this information will assist with increased collaboration and initiatives to reduce the prevalence and/or severity of early childhood caries in Alaskan children.

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
Support community water fluoridation			X	
Collect maternal reporting of dental decay on their 3 year old children				X
Conduct dental assessments utilizing the ASTDD “Basic Screening Survey” protocol (kindergarten & third grade)			X	X
Provide information on appropriate fluoride use (water fluoridation and topical fluorides)				X
Support Medicaid reimbursement for oral evaluation (< 3 year old children) and fluoride varnish application for medical providers		X		



Alaska Maternal and Child Health FY 2015 Title V Block Grant

State Performance Measure #4:

Percentage of women who recently delivered a live birth and are not doing anything now to keep from getting pregnant.

Last year's accomplishments:

Clinical care providers were offered birth spacing materials at a variety of venues including *Alaska Breastfeeding Initiative* events, WIC and public health nursing meetings. The Nurse Family Partnership program utilizes birth spacing pamphlets with clients and measures and discusses contraceptive use during Continuous Quality Improvement meetings.

The nurse consultant promoted *CDC's US Medical Eligibility for Contraceptive Use 2010 and Revised Recommendations for the Use of Contraceptive Methods During the Postpartum Period* at all trainings she conducted as well as on the women's health clinical network listserv and Alaska Women's Health Program website. The Reproductive Health Partnership contraceptive education kit materials were updated. Twenty-four kits were provided to Community Health Centers, Public Health Nurses and Tribal Health Clinics including family practice and pediatric outpatient service units. One training was conducted for staff of the Anchorage-based Southcentral Foundation pediatric and primary care outpatient clinics. Southcentral Foundation is the largest Tribal health outpatient facility in the state.

Barriers to women's access for reliable contraception continued to be the high cost of those contraceptives and clinical care providers' lack of clinical skills for offering them. A limited number of primary care providers have skill and experience providing hormonal implants and intrauterine contraceptive devices, particularly for postpartum women. With funds provided by the state Division of Public Assistance, the Reproductive Health Partnership continued to provide long-acting reversible contraceptives to clinical care providers serving at-risk women in regions of the state where both numbers and rates of non-marital and teen births are higher than the state average. The nurse consultant continues to search for clinical training opportunities covering evidence-based counseling and skills in provision of effective contraception.

The nurse consultant conducted two motivational "Interviewing" trainings for Division of Public Assistance staff from Anchorage and Fairbanks. The trainings covered effective referral of clients in need of women's health care services, including contraceptive care. Division of Public Assistance clients are primarily young, at-risk pregnant and postpartum women. The training model included a simple guide to support each client to develop a personalized contraceptive care plan. The federal *Healthy Start Show Your Love!* pamphlets were tested with this group and input will be used to make revisions deemed necessary for use with the population they serve. The Division of Public Assistance requested additional trainings for their staff as well as education seminars for their clients. The nurse consultant met and collaborated with leadership from Division of Public Assistance and the Adolescent Health Program and some initial plans for carrying this work forward were made. Planned Parenthood has taken the lead for reproductive health education sessions for Alaska Division of Public Assistance clients.

Current activities:



Birth spacing materials are shared by the *Alaska Breastfeeding Initiative*. Preliminary revisions to *Show Your Love!* pamphlets are drafted. The nurse consultant is collaborating with staff of the Healthy Start Norton Sound Health Corporation, located in the Nome census area, to complete final revisions of the pamphlets.

CDC's Revised Recommendations for the Use of Contraceptive Methods During the Postpartum Period are shared widely. The Reproductive Health Partnership contraceptive education kits and training are provided to Community Health Centers and Tribal Health Clinics.

In March 2014, the nurse consultant and the Norton Sound Health Corporation Healthy Start program staff met with Kawerak Tribal leaders from the Nome Bering Straits area. These leaders expressed concern about the number of women experiencing rapid repeat pregnancies and they asked Healthy Start to address this issue. Healthy Start provides perinatal education and case management services for pregnant and postpartum women living in the Nome census area which includes the city of Nome and the fifteen surrounding villages in the Bering Straits. This region of the state has one of the highest rates of births to teens as well. Clinical provider skill in counseling and provision of effective contraception, especially for postpartum women, is identified as a critical need. Healthy Start will fund 2 practitioners to participate in skill based clinical training for this.

The nurse consultant and Healthy Start staff are collaborating with the Nome regional Division of Public Assistance to provide training in motivational interviewing to facilitate referral of clients at risk of rapid repeat pregnancy.

Plans for the coming year:

The *Show Your Love!* pamphlet revisions will be completed and implemented with women at risk of rapid repeat pregnancy who live in the Nome and Bering Straits area. The nurse consultant will train staff of the Healthy Start and Nome Division of Public Assistance in effective use of the pamphlet as a support for client referral to contraceptive care.

The nurse consultant will continue to incorporate birth spacing and reproductive health program materials into all activities of the newly formed *Alaska Breastfeeding Initiative*. She will collaborate with health and social service providers in communities across the state to assure efficient and practical dissemination of birth spacing, reproductive health and breastfeeding messages for the population served. *CDC's US Medical Eligibility for Contraceptive Use, 2010*, and *Revised Recommendations for the Use of Contraceptive Methods During the Postpartum Period* will be shared at all clinical venues, especially those likely to have clinical care providers with interconception clients in their caseload.

Training in use of motivational interviewing for birth spacing referral and support for Public Assistance case managers, working with pregnant and postpartum women, will be scheduled in the Nome Division of Public Assistance regional office. Feedback from case managers will be used to modify the existing training model as needed. The nurse consultant will continue to work with Nome Division of Public Assistance leadership staff to support their self-described need for these trainings to become a reality.

The Healthy Start perinatal nurse consultant will continue to collaborate with Norton Sound Health Corporation Healthy Start staff that met with Kawerak Tribal leaders from the Nome Bering Straits area in order to address their concerns about rapid repeated pregnancies among the women living there. Clinical care providers responsible for provision of comprehensive contraceptive care services for women living in the area will continue to receive skills-based training on this topic. In addition, the nurse consultant will continue to collaborate with the Nome regional Division of Public



Assistance to provide training in motivational interviewing to facilitate referral of young women clients at risk of rapid repeat pregnancy. Women living in the area will be surveyed about their satisfaction with these services.

Activities Table for Current Year

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
Disseminate educational materials to care providers (contraception, breastfeeding, condoms, risk of pregnancy during postpartum period)				x
Train clinical care providers on counseling about contraception, breastfeeding, condoms, risk of pregnancy during postpartum period				x
Promote and disseminate birth spacing media campaign materials			x	
Promote use of CDC's <i>US Medical Eligibility for Contraceptive Use, 2010</i> & Update on Use of Contraceptives During Postpartum Period				x
Skills building trainings for Public Assistance staff to promote birth spacing among their clients				x

NOTE: **DHC**=Direct Health Care **ES**=Enabling Services **PBS**=Population Based Services **IB**=Infrastructure Building.



Alaska Maternal and Child Health FY 2015 Title V Block Grant

State Performance Measure #5:

Percent of students who were hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend during the 12 months before the survey.

Last year's accomplishments:

The Adolescent Health Program (AHP) served as an active member of a 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 is consistently collaborated and planned future work.

The AHP helped plan and sponsor a statewide youth leadership event entitled, Lead On! 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.

The AHP continued endorsing The Fourth R, a Canadian curriculum which focuses on establishing healthy relationships as a way to reduce substance abuse, violence and teen pregnancy. Several teacher trainings were held, where teachers were trained in the implementation of the Fourth R curriculum. The AHP is managing a federal PREP grant using The Fourth R curriculum: teachers throughout Alaska are using it to teach in schools.

The AHP continued to work with the Youth Alliance for a Healthier Alaska, an 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.

In 2010, 12% of students were hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend during the 12 months before the survey.

Current activities:

All AHP projects started in FY 13 continued into FY 14.

The AHP manager served on various committees working to address intimate partner violence among young adults including the Governor's 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. The AHP team presented at the Statewide DVSA Prevention Conference on December 2013 regarding the intersection between teen dating violence and unintended pregnancy.

In February 2014, the AHP received the Rape Prevention Education Program grant from the Centers for Disease Prevention and Control for the primary prevention of sexual assault. The work of this grant will also address intimate partner violence among young adults and healthy relationships.



The AHP is conducting fidelity monitoring for quality assurance in the implementation of The Fourth R curriculum with teachers across the State and including the federally required evaluation component of The Fourth R.

Plans for the coming year:

All ongoing projects from FY 14 will continue through FY 15.

The Rape Prevention Education Program grant funds will support efforts to promote parental engagement activities that support healthy youth relationships, healthy relationships learning for young boys and men, youth development activities at the youth leadership conference, the Stand Up Speak Up media materials, and primary prevention training for school counselors in FY15.

Principals, teachers, teacher’s aides, substitute workers, school nurses, and other interested school staff from alternative schools in Anchorage and the Mat-Su Valley will be offered training on healthy adolescent relationships and communicating effectively with teens. These staff members are mandatory reporters of sexual abuse of minors who spend at least six hours each day working with and around at-risk teens. Increasing the knowledge for adults who have so much contact with at-risk youth is a critical need.

Activities Table for Current Year

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
Implement Stand Up, Speak Up campaign				X
Youth Alliance Conduct for a Healthier Alaska youth group	X			X
Promote The Fourth R curriculum in Alaska schools and manage PREP grant			X	
Evaluate The Fourth R in Alaska schools				X
Distribute birth spacing materials			X	X
Give presentations on dating violence prevention		X		
Administer grant to ANDVSA for youth engagement to prevent violence	X		X	

NOTE: **DHC**=Direct Health Care **ES**=Enabling Services **PBS**=Population Based Services **IB**=Infrastructure Building.



Alaska Maternal and Child Health FY 2015 Title V Block Grant

State Performance Measure #6

Prevalence of intimate partner violence before, during or after pregnancy, among women who recently delivered a live birth.

Last year's accomplishments:

The Alaska Family Violence Prevention Project (AFVPP) conducted a train-the-trainers on adolescent brain development, substance abuse, dating violence and Adverse Childhood Experiences with multidisciplinary teams from around the state which also included content on relationship violence and unintended pregnancy. The AFVPP continued to provide technical support and training resources on dating violence prevention to train-the-trainer teams. The AFVPP clearinghouse continued to distribute resources throughout Alaska including safety cards on intimate partner violence and pregnancy.

Current Activities

The AFVPP continues to distribute resources including safety cards on intimate partner violence, unhealthy relationships and reproductive and sexual coercion. The AFVPP conducted several workshops on intimate partner violence (IPV) that addressed reproductive and sexual coercion and the connection between IPV and unintended pregnancies for teens and adult women. The AFVPP is working with the Alaska Native Tribal Health Consortium to conduct regional trainings, using the Alaska safety card on intimate partner violence that includes content on reproductive and sexual coercion.

Plans for the coming year:

The AFVPP will continue to operate our clearinghouse and acquire up-to-date resources to share with communities. We will continue work with the Alaska Native Tribal Health Consortium to develop a safety card on healthy and unhealthy relationships for adolescents that will include content on sexual and reproductive coercion. The AFVPP will recruit several multidisciplinary teams from across the state to participate in another train-the-trainers that will include content on teen relationship violence and unintended pregnancy. The AFVPP will conduct trainings on adverse childhood experiences (ACEs) for schools, communities and service providers with content on intimate partner violence, dating violence and unintended pregnancy.

Activities Table for the Current Year

Activities	Pyramid Level of Services			
	DHC	ES	PBS	IB
Continue operating the clearinghouse to disseminate resources on intimate partner violence and reproductive coercion throughout Alaska		X	X	X
Conduct two trainings on intimate partner violence and reproductive and sexual coercion for Alaska Native Health corporations , Public Health Nursing and other service				X



providers				
Provide technical support and resources to our training teams				X
Conduct eight trainings on Adverse Childhood Experiences at annual conferences, schools, community-based organizations with content on intimate partner violence, teen dating violence and unintended pregnancy				X
Conduct training for home visitation programs with content on intimate partner violence, dating violence, unintended pregnancy and reproductive and sexual coercion				X

NOTE: **DHC**=Direct Health Care Services **ES**=Enabling Services **PBS**=Population Based Services **IB**=Infrastructure Building Services.



Alaska Maternal and Child Health FY 2015 Title V Block Grant

State Performance Measure #7

Percentage of women who delivered a live birth and had a provider talk to them about postpartum depression since their new baby was born.

Last year's accomplishments:

The number of women who report having a provider talk to them about postpartum depression has continued to increase according to PRAMS data. No PRAMS data is available for the current FY14.

WCFH continued to focus efforts related to perinatal depression on the two five-year home visiting grants for the 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. Providence In-Home Services (PI-HS) is the contractor providing the Nurse-Family Partnership (NFP) model of home visiting in the Municipality of Anchorage as a part of the MIECHV program. Both programs provided screening and referral for clients during the prenatal and postpartum periods. Healthy Start utilized the Edinburgh Postnatal Depression Scale, and Providence NFP utilized the PHQ-9 screening tool. PI-HS began serving clients in January 2013. 100% (11/11) of the women enrolled in the program who had reached eight weeks postpartum by the end of this time period were screened using this tool. Providence home visitors also have a referral relationship to Providence mental health services if there is concern regarding depression. The tribal MIECHV Southcentral Foundation home visiting program, Nutaqsiivik, also used the NFP model and served families in Anchorage and the MatSu Valley.

WCFH continued to distribute *Baby and Me* parent resource books to health care providers. The book contains content related to maternal depression. WCFH's perinatal website promoted text4baby. Text4baby message content includes mental health.

The WCFH's MCH Epidemiology Unit conducted the annual Pregnancy Risk Assessment Monitoring System (PRAMS) and the Childhood Understanding Behaviors Survey (CUBS) surveys, which both include questions related to maternal depression. These findings are published on the WCFH website and also distributed to stakeholders across the state.

Current activities:

The Healthy Start and NFP programs continued to screen women for symptoms of maternal depression. NFP and Healthy Start staff received in-person training on maternal depression from a content expert. A few Public Health Nursing (PHN) Centers offer postpartum outreach or home visitation and screen women for symptoms of depression.

An interagency developmental screening work group meets monthly to promote policy development around the use of standardized screening tools. The group is working to develop a website with resources for providers. The site will provide a menu of standardized screening tools, including those for maternal depression.

WCFH contributed to the Northwest Bulletin Spring 2014 edition article, "*Early Identification of Developmental Delays and Maternal Depression*". The article highlights Alaska's collaborative efforts around developmental screening, including maternal depression screening.



WCFH co-presented a session on home visiting in Alaska at the statewide PHN conference.

WCFH continues to distribute perinatal materials such as the *Baby and Me* books and distribute the HRSA booklet "Depression During and After Pregnancy." WCFH's perinatal website promotes text4baby which includes message content related to mental health.

The WCFH's MCH Epidemiology Unit conducted the annual PRAMS and CUBS surveys and worked on a new databook using the lifecourse model.

Plans for the coming year:

WCFH will continue to distribute printed educational materials and information about maternal depression as well as the promotion of text4baby through the perinatal website.

The NFP and Healthy Start home visiting programs will continue using evidence-based tools to screen for maternal depression. The programs will continue to monitor screening and referral data. PHN will continue to offer existing postpartum outreach or home visitation, which includes screening for symptoms of depression.

The interagency developmental screening work group will continue work to develop a policy around the use of standardized screening tools. The group will continue their work to create a provider website with a menu of screening tools, including maternal depression screening tools.

The fourth biennial statewide Alaska Maternal and Child Health (MCH) and Immunization conference, "*Advancing Wellness across the Lifespan*," will be held September 24–25, 2014 in Anchorage. A panel will present a session on home visiting in Alaska. The conference will also include a presentation by a physician on maternal mental health and depression.

DHC (Direct Health Care Services) - Basic health services and health services for Children with Special Health Care Needs (CSHCN). DO NOT CHECK THIS CATEGORY FOR ANY ACTIVITY.

ES (Enabling Services) - Transportation, translations, outreach, respite care,

health education, family support services, purchase of health insurance, case management coordination with Medicaid, WIC, and Education.

PBS (Population Based Services) - Newborn screening, lead screening, immunization, sudden infant death syndrome counseling, oral health, injury prevention, nutrition, and

outreach/public education.

IS (Infrastructure Services) - Needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, systems of care, and information systems.



SPM # 07:				
Activities	DHC	ES	PBS	IB
Distribute educational materials			X	X
Plan for MCH Immunization Conference presentation on maternal depression				X
Incorporate screening for postpartum depression into Nurse Family Partnership and Healthy Start programs		X		
Conduct annual PRAMS and CUBS surveys			X	
Write article on standardized screening for Northwest Bulletin				X
Conduct intra-departmental workgroup on standardized screening				X



Alaska Maternal and Child Health FY 2015 Title V Block Grant

State Performance Measure #8

% of mothers who recently delivered a live birth with home environmental factors associated with SIDS/unexplained asphyxia. (Includes laying baby down to sleep on side or stomach; baby sleeping with pillows, plush toys, etc.; smoking allowed in home; bed-sharing.)

Last year's accomplishments:

The Alaska Infant Safe Sleep Task Force continued to meet and finalized the Alaska Infant Safe Sleep toolkits for distribution to birthing facilities statewide. The Section of Women's Children's and Family Health (WCFH) continued statewide distribution of publications such as infant safe sleep brochures and posters, and "Baby and Me" books. The "Baby and Me" book is a comprehensive resource of prenatal/newborn information, including infant safe sleep.

WCFH continued to administer grants for Healthy Start and the Maternal, Infant, & Early Childhood (MIECHV) home visitation programs, which also address infant safe sleep. The sections of WCFH and Public Health Nursing trained new public health nurses using Bright Futures, including information about infant safe sleep in Alaska. A former Perinatal Nurse Consultant also conducted a training session on infant safe sleep for child care facilities in Alaska.

Text4Baby includes many health related messages from pregnancy through infancy, including infant safe sleep. One Alaska cellular phone system reported that they participate in Text4Baby, but information was not included on their website or on the national text4baby website.

Current activities:

WCFH distributed Infant Safe Sleep toolkits to birthing facilities statewide and posted the materials online. The toolkit aids facilities in developing safe sleep policies. Three large birthing hospitals are fully participating in the initiative. A Perinatal Nurse Consultant conducted phone surveys with birthing centers who were not fully participating in the project. Several facilities had infant safe sleep practices in place prior to receiving the toolkit. Four tribal health facilities were using the National Institutes of Health *Healthy Native Babies* toolkit and had their own Infant Safe Sleep work groups.

WCFH met with THREAD, the Alaska child care resource and referral agency. THREAD shared information regarding a crib replacement project which placed 950 cribs in 22 communities. Child care facilities that accepted new cribs agreed to dispose of old cribs. During a second phase, child care centers received fitted sheets.

The Section Chief presented on Alaska's Infant Safe Sleep project at an ASTHO meeting. ASTHO interviewed the Perinatal Nurse Consultants for an article regarding Alaska's project.

WCFH MCH Epidemiology Unit staff is writing an article for the *Alaska Epidemiology Bulletin*, which will report on the decline of fetal and infant mortality rates in Alaska.

WCFH continues to distribute infant safe sleep posters and brochures as well as "Baby and Me" books. The Healthy Start and MIECHV home visitation programs continue to address infant safe sleep practices.



Plans for the coming year:

The biennial Maternal Child Health and Immunization Conference, *Advancing Wellness across the Lifespan*, will be held on September 24-25, 2014 in Anchorage. Cheryl Prince, PhD, MPH, MSN and Marilyn Pierce-Bulger, FNP, CNM, MN will present “Strategies for Reducing Fetal and Infant Mortality in Alaska, 2004-2011.” The session will discuss the potential impact of the *Healthy Native Babies* project that began in 2006 and the Alaska Infant Safe Sleep initiative which started in 2009. The final Alaska Infant Safe Sleep Taskforce meeting will coincide with the conference. Pierce-Bulger, a consultant trained in *Healthy Native Babies*, will offer training as a post-session. This will be an opportunity for up to 24 health care providers, such as Community Health Aides and nurses, to receive infant safe sleep training developed for Native populations.

WCFH will continue to work with THREAD, the Alaska child care resource and referral agency, to promote model policies for infant safe sleep in child care centers. WCFH will also assist THREAD with offering webinar trainings for child care providers according to their topics of interest.

WCFH will continue to distribute infant safe sleep kits, posters, and brochures, as well as “Baby and Me” books. In addition, the sections of WCFH and Public Health Nursing will continue to provide child health trainings for new public health nurses which includes education about infant safe sleep in Alaska.

WCFH will continue to promote text4baby and will encourage the Alaska cellular phone company to include a notice on their website and to work with national text4baby to list their name. This will help increase awareness for Alaska customers about the availability of free health related text messaging through their carrier. Text4baby will also be advertised on the Division of Public Health’s website.

A perinatal nurse consultant will continue to attend infant death reviews by the Maternal and Infant Mortality Review Committee.

The Healthy Start and MIECHV programs will continue to serve low-income, at-risk women and their families. Infant safe sleep will continue to be a part of the curriculum. The MIECHV program will continue to distribute the safe sleep brochures, and any new nurse home visitors will receive training on safe sleep from a Perinatal Nurse Consultant.

Activities (FY 15)	Pyramid Level of Service			
	DHC	ES	PBS	IB
Distribute infant safe sleep materials to health care providers				X
Plan for presence at the Alaska MCH and Immunization Conference in September				X
Continue conducting the MIMR process				X
Present infant safe sleep content to a variety of audiences				X
Implement Alaska infant safe sleep content and materials in Healthy Start and MIECHV programs		X		



Outreach to child care resource agency to promote model policies for infant safe sleep				X
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Alaska Maternal and Child Health FY 2015 Title V Block Grant

State Performance Measure #9:

Percentage of mothers who report their 3-year-old child had a BMI greater than the 85th percentile (overweight and obese).

Last year's accomplishments:

2012 Childhood Understanding Behaviors Survey (CUBS) data showed 43.4% of mothers responded that their child was either overweight or obese, an increase from the prior year.

The Alaska Obesity Prevention and Control Program (OPCP) maintained and expanded the "[Play Every Day](#)" campaign. The campaign delivers strategic, Alaska-specific, high-impact messages focused on raising awareness about childhood obesity in Alaska and encouraging parents and families to prioritize 60 minutes of physical activity every day for good health. The multimedia campaign featured TV, radio, print, events, earned media, weekly blog post, social media and other types of communication.

Through a financial contribution and partnership with the Division of Agriculture, the Division of Public Assistance, and the UAF Cooperative Extension Service, OPCP implemented the Alaska Farmers' Market-Quest Card Program to assist farmers' markets in accepting Food Stamp Electronic Benefit Transfer (EBT) cards. This year the program expanded from five markets to ten markets. This initiative makes healthy, local products more accessible to low-income Alaskans and increases overall farmers' market sales. Almost 900 Quest transactions occurred at the markets, adding over \$29,746 of a new funding source for the vendors. The EBT machines also allowed the markets to accept debit and credit cards. This generated an additional \$85,000 for vendors.

OPCP provided funding and leadership to the Alaska Food Policy Council (AFPC). The intent of the AFPC is to provide recommendations and information regarding comprehensive policies that improve Alaska's food system. Today, over 200 individuals from federal and state agencies, tribal entities, university programs, farmers, fisheries, and food systems businesses, participate in the AFPC.

The Healthy Alaskans 2020 (HA 2020) collaboration between the State of Alaska and the Alaska Native Tribal Health Consortium identified 25 leading health indicators based on two surveys completed by the public in October 2012 and February 2013. Alaskans expressed an interest in reducing the proportion of Alaskans who are overweight or obese and increasing the proportion of Alaskans who are physically active.

The Section of Women's Children's and Family Health (WCFH) conducted the annual Childhood Understanding Behaviors (CUBS) toddler survey and disseminated the results. The survey provided data related to a variety of health topics, including healthy weight and nutrition of young children.

WCFH administered grants for Healthy Start and the Maternal, Infant & Early Childhood Home Visiting (MIECHV) programs addressing healthy pregnancy weight, breastfeeding, and toddler nutrition.

Current Activities:

OPCP provides funding and leadership to the AFPC. AFPC worked to improve food access during emergencies, increase local production, and educate decision makers and the public on food system issues.



OPCP provides surveillance related to obesity and risk factors and disseminates reports and evidence-based prevention recommendations. The program also works to expand monitoring systems.

The OPCP brought together stakeholders to create the State childhood obesity prevention strategic plan and the Alaska Alliance for Healthy Kids. Priorities identified center on quality physical and health education, evidence-based guidelines to address the prevention and treatment of overweight and obesity from pregnancy through adolescence, access to healthy choices and environments, and public education.

The All Alaska Pediatric Partnership launched the “*First 1,000 Days*” campaign focusing on early childhood with one priority being breastfeeding. A breastfeeding room remains available for public health staff in Anchorage.

HA 2020 began work groups to address indicators such as reducing the proportion of children who are overweight or obese, to 15% and 14% respectively.

WCFH conducts the CUBS toddler survey and disseminates results. WCFH continues administering grants for Healthy Start and the MIECHV programs.

New public health nurses (PHNs) receive training on using growth charts as part of child health training, continue to screen children’s growth, and provide anticipatory guidance.

Plans for the coming year:

The OPCP will continue to work on policy, system, and environmental change to improve access and affordability of healthy foods and access to physical activity for all Alaskans. The robust social marketing campaign will continue to encourage youth and families to be more active but will also work to decrease sugar sweetened beverage consumption. Plans include: hiring and funding two new VISTAs for the Alaska Farmers’ Market-Quest Program and the Alaska Food Policy Council; partnering with the WIC and Senior Farmers’ Market Nutrition Program to promote all farmers’ market nutrition assistance programs to low income Alaskans; and continue planning and implementing the Alaska Food Policy Council Town Halls and food systems conference.

The OPCP will continue to monitor the prevalence of obesity and related risk factors and disseminate related reports, including evidenced-based prevention recommendations.

WCFH will continue efforts to prevent and reduce the burden of obesity throughout the life course. They will address healthy pregnancy weight in the Healthy Start and MIECHV grants they administer, which includes a focus on breastfeeding promotion and nutrition for toddlers.

WCFH staff will continue to be active in the Alaska Breastfeeding Coalition and will collaborate with WIC to support breastfeeding and reduce obesity. WCFH and PHN will maintain the employee breastfeeding room in the Anchorage Frontier Building. These two sections will continue to train new public health nurses using the Bright Futures Periodicity Schedule and the use of the World Health Organization (WHO) growth charts up to 24 months of age during child health trainings. PHNs will continue to screen the growth of children and provide 5-2-1-0 anticipatory guidance (5-fruits and vegetables, 2-hours or less of screen time, 1-hour of physical activity, 0-sugary drinks).

The next Alaska MCH and Immunization Conference, *Advancing Wellness across the Lifespan*, will be September 24 – 25, 2014 in Anchorage. Professionals from the Alaska Native Tribal Health Consortium will present “*The Traditional Pregnancy and Infant Feeding Guide*”, and the State of Alaska will present on “*Obesity Prevention*”.



Activities Table for Current Year

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
Expanding the social marketing campaign to increase children's physical activity.			X	
Increasing access to more locally grown and harvested foods.				X
Expanded the Alaska Farmers' Market-Quest Card Program.				X
Monitoring the prevalence of obesity and related risk factors and disseminate related reports including evidenced-based prevention recommendations and work to expand monitoring systems to improve the quality of our information				X
Conduct annual Childhood Understanding Behaviors (CUBS) Survey				X

NOTE: **DHC**=Direct Health Care Services **ES**=Enabling Services **PBS**=Population Based Services **IB**=Infrastructure Building Services.



Alaska Maternal and Child Health FY 2015 Title V Block Grant

State Performance Measure #10:

% of early term births at 37 completed weeks of gestation to 38 completed weeks of gestation

Last year's accomplishments:

The WCFH MCH Epidemiology unit provided reliable data on maternal and child health issues which were used in planning and evaluating programs, preventing poor health outcomes and guiding public health policy.

WCFH distributed information on prematurity to health care providers and the public. The Healthy Start and MIECHV programs provided client education around late preterm birth and near term birth for the regions of the state in which they deliver services.

The largest birthing hospital in Alaska did not adopt a hard stop policy but did make significant steps to have a quality assurance process and review regarding early elective deliveries.

The WCFH Alaska Women's Health Program webpages delivered evidence-based prenatal health information to Alaskan women through a life course framework. Women were guided to topics such as having a healthy pregnancy and the important growth in the last weeks. The WCFH perinatal listserv continued to distribute information and updates on perinatal topics to a large number of stakeholders. Both webpages also include evidence-based resources on women's health topics for clinical care providers. The WCFH Alaska Women's Clinical Network listserv shared evidence-based distance trainings and online resources on women's health with an emphasis on guidelines for preventive health care, healthy nutrition, physical activity, mental health, sexually transmitted diseases, intimate partner violence and breastfeeding. Web-based trainings were resourced from nationally recognized expert organizations, including the Office on Women's Health, CDC and the American Academy of Family Physicians.

Baby and Me, a comprehensive prenatal resource guide, was distributed statewide at no cost to women or health care providers. This book provides information about having a healthy pregnancy and the importance of the last weeks of pregnancy for baby's development and growth.

March of Dimes experienced a hiring freeze, so the work they planned was stalled.

Current activities:

Evidence-based prenatal health resources continued to be offered on the perinatal and WCFH Alaska Women's Health Program webpages. Both included evidence-based resources on women's health topics for clinical care providers. Evidence-based pre-conception, prenatal and interconception health information to Alaskan women was distributed through a life course framework.

Baby and Me includes information about the importance of carrying to term. It was distributed statewide at no cost.

MIECHV and Healthy Start continued their services. Healthy Start requested support to adopt and use the national *Show Your Love* campaign materials to support preconception and prenatal care, including carrying to term. Some re-design of the materials was planned in order to make them culturally relevant.



WCFH staff planned the 2014 MCH and Immunization Conference.

The March of Dimes hiring freeze continued until May 2014, so the work they planned was stalled. In May 2014, a new Anchorage March of Dimes coordinator was hired.

Plans for the coming year:

The WCFH MCH Epidemiology unit will continue to provide reliable data on maternal and child health issues which will be used in planning and evaluating programs, preventing poor health outcomes, and guiding public health policy.

Evidence-based prenatal health resources will continue to be offered on the perinatal and WCFH Alaska Women's Health Program webpages. Both will include evidence-based resources on women's health topics for clinical care providers. The WCFH Alaska Women's Clinical Network list serve will share evidence-based distance trainings and online resources covering prenatal care.

The most recently published edition of *Baby and Me* is dated, having been published in 2006. During the coming year as quantities diminish, the WCFH perinatal program will research and select a comprehensive, up-to-date, and evidence-based perinatal resource guide that includes information on the importance of healthy term pregnancy. Current users and perinatal partners will be solicited for input and recommendations on products they believe will best serve their perinatal clients.

MIECHV and Healthy Start will continue to deliver services which will include educating women about healthy pregnancy including the importance of healthy term pregnancy.

The 2014 Alaska MCH and Immunization Conference will be held in September. A perinatal nurse from the Alaska Tribal Health Consortium will partner with the WCFH Epidemiologist to present a session titled: *Strategies for Reducing Infant Mortality in Alaska*. Data and strategies relevant for promoting term births will be shared. Planning for the 2016 conference will begin soon after the 2014 conference is held. WCFH staff will collaborate with all relevant partners to conduct the 2016 Alaska MCH and Immunization Conference.

The perinatal program will collaborate with Division of Public Health and Alaska Native Tribal Health Consortium leadership to help forward their mutual goals for improving perinatal health as set under the for Healthy Alaskans 2020 initiative.

In May, a new Anchorage March of Dimes coordinator was hired. WCFH anticipates partnering in order to advance common goals.

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
Distributed consumer education materials covering evidence-based guidelines for preconception, interconception and prenatal care (online and in print)			X	



Distributed educational materials to providers covering evidence-based guidelines for preconception, interconception and prenatal care (online)				X
Administer regional Healthy Start and MIECHV services		X		
Plan the 2014 MCH/Immunization Conference				X