Maternal and Child Health Services Title V Block Grant

Alaska

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FY 2016 Application/ FY 2014 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

THE STATE of ALASKA
GOVERNOR BILL WALKER

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July 8, 2015

Maternal Child Health Bureau

Health Services Resource Administration

5600 Fishers Lane RM 18-31

Rockville, MD 20874-0001

To Whom it May Concern:

Please accept this submittal for the Title V Maternal Child Health FY16 application from the State of Alaska, Division of Public Health, Section of Women's, Children's and Family Health. We have met the requirements of 33% for preventative and primary care for children, and 33% for CYSHCN. We look forward to our application review scheduled in Seattle on August 13, 2013

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

Thank you for this opportunity to apply.

Stephanie Birch

Stephanie Birch, RN, MPH, MSN, FNP

MCH Title V Director

Section Chief

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix C of the 2015 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary

Alaska Maternal and Child Health Title V Block Grant

Executive Summary

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

The Title V Block Grant is a Federal-State partnership program to improve the health of mothers and children, including children and youth with special health care needs. In Alaska, the Title V program is managed by the Department of Health and Social Services (DHSS), Division of Public Health (DPH), Section of Women's Children's and Family Health (WCFH).

The 2016 Title V Block Grant application, covering FFY 2016, is due July 15, 2015.

Public comments on the application are welcome and should be directed to:

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Anchorage, AK 99503

Title V Block Grant Application

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

How Are Alaska's Title V Funds Used?

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

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

The framework for delivery of MCH services is based on the 10 Essential Public Health Services. Allocation of funds within these categories is based on the state's maternal and child health priorities, which were developed in 2015 following a needs assessment.

Needs Assessment

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

Title V Emerging Needs and 5 Year Action Plan

The MCH Priorities for FY2015-2019 are divided by population domain and described below, including the population-based national performance measures (NPMs) chosen to track prevalence rates and demonstrate impact. State performance measures (SPMs) will be reported in 2016. Current status and activities are summarized, as well as a sample of the Title V supported strategies planned by WCFH over the next 5 years.

Women's/Maternal Health

Priority: Increase access and services to reproductive health care.

Objective: By 2020, increase by 5% over baseline the number of health care providers offering reproductive health services who adhere to the national "Quality Family Planning Services" (QFP) guidelines.

Current Status of Performance Measures:

- **NPM 1:** In 2013, 55.2% of women reported to the Behavioral Risk Factor Surveillance System (BRFSS) that they had a past year preventative medical visit.

Current Title V Activities and Challenges: Currently, low-/no-cost, comprehensive well-visits are provided through contracts with Advanced Practice Registered Nurses in two communities of Alaska for women < 21 years old using Title V funds; and to two additional communities via the State's Title X grant for individuals of all ages. WCFH staff continue to collaborate with other DPH sections and the Alaska Primary Care Association on efforts to: provide access to clinical education on reproductive health and related preventive health topics for Community Health Center (CHC) staffs; offer technical assistance to CHCs in systems improvement and expansion of their women's health services within the primary care setting; and share data/data collection tools for monitoring health care system capacity, gaps, and resources.

5-Year Strategies and Planned Activities: Define the baseline number of providers offering reproductive health services who strictly adhere to the QFP guidelines. Provide professional education opportunities to increase knowledge and understanding of QFP. Survey providers to assess adherence to the QFP after professional education. Provide technical assistance to providers who do not meet national standards.

Perinatal/Infant's Health

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

Objectives:

- Increase health care provider access to tools that support screening women of reproductive ages for: 1) Use of alcohol, tobacco, and drugs, and 2) desire for conception in the coming year.
- Increase the percentage of Alaskans who currently do not use tobacco to 83% by 2020 (tied to Healthy Alaskans 2020 Indicator 3).
- Reduce the percentage of Alaskans who report binge drinking in the past 30 days.
- After gathering baseline data, demonstrate that 50% of Alaska Medicaid Providers caring for pregnant women and women of childbearing age, bill for screening for alcohol and/or substance use (other than tobacco) by 2020.

Current Status of Performance Measures:

- **NPM 3:** In 2014, 75.9% of very low birthweight infants were born in a hospital with a level III+ Neonatal Intensive Care Unit (Alaska Bureau of Vital Statistics).
- **NPM 5:** In 2010, 67.9% of infants were placed to sleep on their backs (PRAMS).
- **NPM 14:** In 2013, 13.6% of women smoked during pregnancy (National Vital Statistics System). In 2011-2012, according to the National Survey of Children's Health (NSCH), 29.5% of children live in households where someone smokes.

Current Title V Activities and Challenges: Currently, The MIECHV and Healthy Start Programs provide case management and home based services for pregnant women and mothers with babies up to two years of age for families living in Anchorage and the rural Nome census areas respectively. MIECHV will expand its services into the Matanuska-Susitna region beginning in mid-2015. In 2014 Alaska assembled a diverse team of MCH leaders to participate in the Collaborative Improvement and Innovation Network (CoIIN) to reduce infant mortality. One key CoIIN workgroup is tobacco use; which also focuses on alcohol and drugs.

5- Year Strategies and Planned Activities: Promote the use of Oregon's One Key Question tool among health care providers, especially those serving Medicaid clients. Promote self and provider referral to the Alaska QUIT line (1-800-QUIT-NOW). Promote use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) among health care providers, especially those serving Medicaid clients (Health Alaskans 2020 Indicator 14a, Strategy 1).

Child's Health

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

Objectives:

- Increase the percentage of children enrolled in Medicaid who receives a well-child exam and developmental screen at 9, 18, and 30 months of age using the Bright Futures Periodicity Schedule.
- Increase the number of children ages 1-3 who have an annual dental health visit.
- Increase the number of children ages 5-8 enrolled in Medicaid who receive an annual well-child visit.

Current Status of Performance Measures:

- **NPM 6:** In 2011-2012, 32.6% of children received a developmental screening using a parent-completed screening tool (NSCH).

Current Title V Activities and Challenges: Title partners with the ECCS program located in the Office of Children's Services to promote and educate health clinicians to use of the online version of Ages and Stages Developmental Screening tool as a part of the well child exam. The Pediatric Medical Home program funded by the MCHB D 70 grant is working with the AAP Alaska Chapter Champion for Medical Home

funded by the MCHB D-70 grant is working with the AAP-Alaska Chapter Champion for Medical Home promotion to promote the use of this tool. Alaska's Medicaid program is supportive of adding the billing code 96111 for approved providers to use with standardized tools such as Ages and Stages or PEDS. The Medicaid program is supporting the billing of preventative dental visits for children 1-3. The Dental Health officer works closely with the Tribal Health programs on the use of prevention strategies to promote oral health. The School Nurse Consultant works closely with the School Nurses to promote well child visits even after children have started school.

5-Year Strategies and Planned Activities: Promote the use of the online Ages and Stages Developmental Screening tools with health care providers as well as the use of the billing code 96111. Promote and educate parents on the importance of early dental screening of children 1-3 years of age. Continue to promote the use of fluoridation in the community water supply or the use of fluoride drops for children; as well as annual well child visits and immunizations.

Adolescent Health

Priority: Increase healthy relationships.

Objectives:

- Decrease the percentage of students who report that they would not feel comfortable seeking help from at least one adult besides their parents if they had an important question affecting their life.
- Decrease the percentage of students who had been bullied on school property during the past 12 months.

Current Status of Performance Measures:

- **NPM 9:** In 2013, according to the Youth Risk Behavior Surveillance System (YRBS), 26.5% of high school students are bullied or bully others.

Current Title V Activities and Challenges: Grant funds are being used to launch and support primary prevention of sexual assault interventions, specifically Green Dot and Bringing in the Bystander. Schools across Alaska have adopted the Fourth R for Healthy Youth Relationships strategies to teach sexual health, substance abuse prevention, suicide prevention, and bullying prevention. Alaska Promoting Health Among Teens, Positive Prevention, Healthy Relationships Plus are being implemented in and out of schools in communities across the state. Additionally, Alaska grown evidence-informed interventions are supported, such as Talk Now Talk Often, Stand Up Speak Up, COMPASS: A Guide for Men, and patient safety cards and clinical screening tools. The adolescent health program works with a positive youth development philosophy and supports the Lead On! for Peace and Equality youth leadership conference and the Youth Alliance for Healthier Alaskans.

5-Year Strategies and Planned Activities: Promote and disseminate evidence-based healthy relationship programming. Increase program implementation that uses a positive youth development framework. Provide expertise on healthy relationship risk and protective factors.

Children and Youth with Special Health Care Needs (CYSHCN)

Priority: Improve system of care for families with CYSHCN.

Objectives: By 2020, increase the proportion of CYSHCN who receive integrated care through a patient/family-centered medical/health home approach by 20%.

Current Status of Performance Measures:

- **NPM 11:** In 2011-2012, 39.6% of CYSHCN had a medical home (NSCH).

Current Title V Activities and Challenges: While the fee-for-service environment is a challenge to medical home funding, recent successes include a multi-disciplinary care coordination training course developed in partnership with the University of Alaska. In addition, Title V currently partners with a variety of CYSHCN advocacy agencies such as the Stone Soup Group (Alaska's Family Voices and Family to Family Health Information Center) and the Governor's Council on Disabilities and Special Education. The Stone Soup Group receives Title V Block Grant funding to support statewide parent navigation. Parent navigators provide general information and family resources as well as tailored care coordination for families served by state sponsored pediatric clinics. Title V also sponsors the specialty clinics for CYSHCN that fill a service gap based on community need and private sector capacity

5-Year Strategies and Planned Activities: Access CYSHCN systems of care to integrate families and create a State Plan. Develop a shared resource for families and primary care providers of CYSHCN using the Help Me Grow centralized system model. Expand provider access to medical home concepts and tools through education and statewide technical assistance.

Cross Cutting / Life Course

Priorities:

- **Reduce the rate of child maltreatment.**
- **Increase evidence based screening for all MCH populations for behavioral and mental health problems.**

Objectives:

- By 2020, decrease the rate of injury related hospital admissions among children 0-19 years by 15%; decrease the rate of injury related hospital admissions associated with parental neglect or negligence by 25%
- By 2020, increase the proportion of prenatal depression screening among pregnant women by 15%; increase the proportion of parents of children ages 9-71 months who complete a child-focused developmental screening by 25%; increase the proportion of children ages 12-17 years that are screened for being bullied.

Current Status of Performance Measures:

- **NPM 6:** In 2011-2012, 32.6% of children ages 10-71 months received a developmental screening using a parent-completed screening tool (NSCH).
- **NPM 7**: In 2012, there were 195.6 hospitalizations per 1,000 children ages 0-9 years and 215.3 hospitalizations per 1,000 adolescents ages 10-19 years (State Inpatient Databases).
- **NPM 9:** (See above, Adolescent Health)

Current Title V Activities and Challenges: Access to behavior and mental health services in Alaska was identified in the results of the state-wide needs assessment across all populations. Currently, Title V and partners collect data on perinatal depression, family stressors, and mental health through PRAMS (Pregnancy Risk Assessment Monitoring System), CUBS (Alaska Childhood Understanding Behaviors Survey), YRBS and BRFSS. Title V also operates Alaska's Surveillance of Child Abuse and Neglect Program (SCAN), the centralized source of child maltreatment data.

5-Year Strategies and Planned Activities: Expand trauma informed service delivery for state based services. Assess current primary prevention efforts of maltreatment and set a direction towards collective impact. Develop and target a population-based primary prevention campaign using cross-sector comprehensive data. Expand home visiting and support local based initiatives with data (e.g. Triple P program, Mat-Su community effort). Increase partnerships with the division of behavioral health to identify evidence based screening tools. Provide system support to external partners and agencies to promote the

use of standardized screening tools. Partner with the education system to implement screening for bullying.

For More Information: http://dhss.alaska.gov/dph/wcfh/Pages/titlev/default.aspx

II. Components of the Application/Annual Report

II.A. Overview of the State

Principle Characteristics of Alaska's population

Two defining characteristics of Alaska are the physical geography and the racial diversity of the population. Alaska is a large, sparsely populated state. The land mass of the state encompasses 571,951 square miles, averaging a population density of just 1.1 persons per square mile. This is the lowest population density of any state.

The July 1, 2014 Alaska resident population was estimated at 735,601 by the Alaska Department of Labor and Workforce Development. This represented a decline of 61 people compared to 2013; this was the first time since the late 1980s that Alaska's population declined and was mostly due to more people leaving the state than moving in. There were 11,351 births in 2014. The maternal and child health (MCH) population consists of children less than 15 years of age and women of childbearing age (15-44 years). Alaska's MCH population in 2014 was 304,901 and represents 41.4% of the total population.

Alaska's population is younger than the national average but the gap is narrowing, as Alaska has the fastest growing senior population in the U.S. The U.S. median age in 2013 was 37.6 years, and the median age for Alaska was 34.3.

Approximately 80% of people in Alaska lived in cities or places with populations of 2,500 or more in 2012. The Municipality of Anchorage, the City and Borough of Juneau, and the City of Fairbanks were home to 50% of Alaska's population in 2012. Alaska has a trend of migration from rural to urban areas that has remained fairly stable over the past 20 years. Over five-year periods, an average of 11% of the rural adult population moves to an urban area. In the same amount of time, an average of 2% of the urban adult population moves to a rural area. Of those who dwell in rural areas, the majority are Alaska Native people.

According the Department of Labor statewide projections, Alaska's statewide population is projected to increase from 714,142 in 2010 to 915,211 in 2035. As Alaska's population ages in the coming years, annual growth is expected to slow. Alaska's population aged 65+ is expected to grow at the fastest rate over the projection period, followed by the population aged 0-17. The population aged 18-64 is projected to increase at the slowest rate.

In 2013 (2014 data on race is not currently available), 67% of Alaska's population were reported to be White, 15% Alaska Native/American Indian, 6% Asian alone, 4% Black, 1% Native Hawaiian or other Pacific Islander, and 7 percent multi-race. Alaskans of Hispanic origin made up 7%.

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

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

infant mortality and infectious disease. However, research documents that continuing and significant disparities remain.

Compared to the non-Native population, the Alaska Native population has poorer health outcomes in post-neonatal mortality; child, adolescent, teen (especially teen suicide), and female mortality; and childhood dental caries experience (among third graders). As the Alaska Native population becomes increasingly urban or adopts western lifestyles and diet, whether by choice or not, chronic diseases such as diabetes and heart disease are of increasing concern.

Cultural diversity among the non-Native population is increasing. About half the students in the Anchorage School District are ethnic minorities and they speak 98 different languages. A culturally diverse workforce that reflects the culture, language and respects the traditions of the populations is a crucial strategy for reducing health disparities.

Factors Affecting Health Status (see the 2014 Alaska MCH Data Book for references)

Uninsured populations are less likely to access routine, preventive care and more likely to seek care when health problems are severe and require treatment. In 2012, 62% of Alaskan adults aged 19-64 years were covered by employer or other private health insurance; 14% were covered by Medicaid or other public insurance.

Poverty affects health both through decreased access to material resources, like health care and nutritional food, and through increased exposure to negative social and environmental factors, like violence, lead, and air pollution. It is associated with poor maternal health and birth outcomes such as infant mortality, low birth weight, and child maltreatment. Relative to the general US population in 2012, proportionately fewer Alaskans lived in poverty (10.1% compared to 15.9%).13.9% of Alaskan children under 18 years lived in poverty. In 2012, 22.4% of the total Alaska Native population in Alaska lived in poverty, compared to 6.6% of the White population.

Survivors of violent crimes are at risk for posttraumatic stress disorder, major depressive episodes, and drug abuse/dependence. Youth exposed to community violence have increased rates of anxiety, aggression, and future violent behavior. In 2010, Alaska's homicide rate per 100,000 individuals was 6.2, compared to 7.5 for the US. Overall, in 2011-2012, 10.6% of Alaska parents of children aged 0-17 years reported that their child was ever a victim or a witness of neighborhood violence.

Some examples of community policies that affect maternal and child health status are baby-friendly hospitals and water fluoridation. In 2013, 7.2% of US live births and 21.7% of Alaska live births occurred in hospitals that were designated Baby-Friendly. During 2008-2012, the Alaska population served by community water systems with fluoridated water dropped from 63% to 53% due to some cities in Alaska discontinuing water fluoridation in 2011.

Factors Impacting Health Services Delivery

Approximately 75% of Alaskan communities, including the state's capital city of Juneau, are not connected to the road system. Accessing "nearby health services" or specialized health care means travel by commercial jet, small plane, the state marine ferry system, all-terrain vehicles, small boats or snow machines. Some residents may travel distances equivalent to traveling from Washington, D.C. to New Orleans for even routine medical care. Moreover, severe weather can render travel impossible, creating especially critical situations in medical emergencies.

The geographic isolation of rural communities means significant challenges in assuring all MCH populations have access to routine preventive care, acute medical and specialty care. Specialty care, even in urban areas of the state, is limited. For example, the only Level III neonatal intensive

care facility is located in Anchorage. Many communities have no facilities equipped for childbirth so pregnant women must leave their homes 4 weeks before their due date. Even well-child check-ups, prenatal exams and regular dental exams are difficult to provide. Recruiting and retaining physicians and primary health care providers for non-urban practices is also a barrier to providing health care services.

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

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

Programs for the MCH and CYSCHN populations in Alaska are primarily managed within Sections of the Division of Public Health (DPH) located in DHSS. The Section of Women's, Children's and Family Health (WCFH) is the designated Title V and CYSCHN agency and is located in DPH. WCFH manages the following programs:

- Adolescent Health
- Women's Health
- Title X-Family Planning/Reproductive Health
- Breast and Cervical Cancer Screening (BCHC)
- Oral Health (Adult and Child)
- Newborn Metabolic , Hearing and Critical Congenital Cardiac Screening
- Pediatric Medical Home
- Genetics and Metabolic Clinics
- Neurodevelopmental Outreach and Autism Screening Clinic
- Emergency and Disaster Preparedness and health promotion for people with disabilities
- Cleft Lip and Palate Treatment planning clinics
- Perinatal Health
- School Nursing Consultation and School Health
- MCH Epidemiology:

  - Pregnancy Risk Assessment Monitoring Survey (PRAMS)
  - Childhood Understanding Behavior Survey (CUBS)
  - Surveillance of Childhood Abuse and Neglect (Alaska SCAN)
  - Alaska Birth Defects Registry (ABDR)
  - Maternal Infant Mortality Review and Child Death Review (MIMR-CDR)

- MCH Indicators

The Section of Chronic Disease Prevention and Health Promotion (CDPHP), DPH, manages the following MCH programs: Family Violence and Prevention; Injury Prevention: Child Passenger Safety, Bike-n-Walk Safely Alaska!, Kids Don't Float, Helmet Safety ; Obesity Prevention and Control: Play Every Day campaign, Healthy Futures Challenge, Alliance for Healthy Kids, Obesity Prevention School Grants; Youth Risk Behavior Survey (YRBS); Tobacco Prevention and Control

The Section of Epidemiology (SOE), DPH, manages the following MCH programs: Immunization

Other MCH programs are managed in other Divisions of DHSS: EPSDT Outreach - Division of Health Care Services (Medicaid agency); Infant Learning/Early Intervention Program - Office of Children's Services (OCS); Early Childhood Comprehensive Systems (ECCS) – OCS; Strengthening Families – OCS; WIC/Nutrition Programs- Division of Public AssistanceAt one time these programs were housed within a single MCH section within DPH but were moved to other divisions in 2003 during a major DHSS reorganization. Attempts to reunite MCH-related programs in the ensuing years were partially successful. The period between 2005 and 2009 was also one of administrative instability, marked by several turnovers at the Commissioner and the DPH Division Director level. Despite these organizational setbacks, the effort to increase intra-agency collaboration and grow MCH programs continued. These collaborations and ongoing program development continue today. DHSS is currently facing significant budget cuts and will be eliminating or significantly reducing programs over the next two years while trying to live within a budget that entirely depends on the price of oil and federal funding. The Division of Public Health is not well understood by the Legislature and thus is frequently the target of across the board cuts.

Two local governments, the Municipality of Anchorage and the North Slope Borough, operate local health departments with limited services and no strong MCH presence. The Alaska DHSS offers a wide range of health assessment and disease prevention services through 27 public health centers and itinerant nursing services.

Health care delivery in Alaska consists of three separate systems. The Alaska Native Tribal Health Consortium (ANTHC) is a consortium of tribal entities that provides several levels of medical care: primary care at village clinics, primary and mid-level primary care at regional hospitals, and tertiary care at the Alaska Native Medical Center in Anchorage. ANTHC is funded by the Indian Health Service.

The two other systems of care include private non-profit and for profit secondary and tertiary care hospitals and private health care providers including nurse practitioners, physician assistants and physicians as well as the expansive military system and the Veteran's Administration supporting the active duty and retired armed forces (army, air force and coast guard bases). Private sector physicians, health care providers and hospitals can serve any individual in the general population.

A number of innovative systems have been created to overcome barriers to health care delivery related to high transportation costs and lack of skilled resources in the small communities. The Community Health Aide Program is a network of about 500 tribal Community Health Aides/Practitioners (CHAPs) who work in village clinics to provide basic health care services and referrals. The CHAP program is a vital link in the Alaska Tribal Health System. The Alaska Dental Health Aide Therapist Initiative, another ANTHC program, is conducted in collaboration with the University of Washington School of Medicine to train Alaska Native dental health technicians for community-level dental disease prevention in underserved Alaska Native populations. The

Behavioral Health Aide Project aims to develop village-based behavioral health service capacity, focusing on prevention, early intervention and case management.

State priorities

The mission of the Alaska DHSS is to promote and protect the health and well-being of Alaskans. The Department's 2014 priorities span the breadth of the department and encompass the unique service-areas represented within.

Priority 1) Health and Wellness across the Lifespan

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

Priority 2) Health Care Access, Delivery & Value

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

Priority 3) Safe & Responsible Individuals, Families & Communities

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

DHSS, in partnership with ANTHC, developed Healthy Alaskans 2020 (HA2020) health priorities during a series of expert workgroup meetings and public input surveys 2012 and 2013. HA2020 is a science-based framework designed to guide efforts in Alaska over the next decade to improve health and ensure health equity for all Alaskans.

The 25 health priorities identified include reducing the rates of cancer, suicide, child maltreatment and interpersonal violence and sexual assault. Alaskans also wanted to see alcohol, tobacco and drug use curtailed, and an increase in disease prevention through vaccines, improved access to in-home water and wastewater services, and lowering Alaska's obesity rate. As well, there were three priorities around reducing the proportion of Alaskans without access to high quality and affordable healthcare, including increasing the percent of women who received prenatal care in the first trimester. Target goals for each of the 25 indicators have been established. The next step will be to initiate efforts, or increase existing efforts, to reach those goals. (http://hss.state.ak.us/ha2020/).

The Alaska DPH mission is to protect and promote the health of Alaskans; with a vision of healthy Alaskans today and tomorrow. The 2016-2020 Strategic Plan identified the following goals:

1. Serve as Alaska's chief strategists for existing and emerging public health issues.

   - Collaborate to achieve health equity for Alaskans
   - Engage communities to set and implement public health strategies and policies
   - Foster a culture of health for individuals, families, and communities
   - Translate data into policies and actions affecting population health

- Communicate and promote wellness and the value of public health
- Support quality improvement initiatives

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

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

- Increase appropriate cervical cancer screening
- Increase the proportion of children who are at a healthy weight
- Reduce the proportion of children who die before their first birthday
- Increase the percent of children with on-time immunizations
- Reduce the rate of teen pregnancy

The Title V/CYSHCN program works to integrate its goals into the department's to assure continuity of services and meet performance objectives.

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

The programs in WCFH are guided by the maternal and child health pyramid of health services, and stress improving health status, assuring health service access, and eliminating health disparities in present and future generations of Alaskans. Every five years each state receiving Title V funds conducts an assessment of maternal and child health needs to reconfirm or realign its priorities for the next five years. The ultimate goals of the Needs Assessment are: 1) improved outcomes for maternal and child health populations; and 2) strengthened partnerships. To achieve these goals, the federal Maternal and Child Health Bureau identified ten steps as part of the State

Title V Maternal and Child Health Needs Assessment Framework. These steps are:

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

Alaska's FY 2015-2019 Title V Needs Assessment was completed in February 2015. For a detailed description of the Needs Assessment process and the process used for selecting priorities, see the Needs Assessment Summary section B.1., and Section II.C. *State Selected Priorities*. In addition to the 5-Year Needs Assessment, WCFH leadership staff assess Alaska's MCH needs on an on-going basis by reviewing annual data, conducting special analyses, obtaining feedback and input from over a dozen community advisory committees and coalitions. We believe this strategy is more flexible, efficient, timely, and responsive than one singular effort every five years. In addition, our ongoing assessment activities include participating in other organizations' committees; partnering with other agencies on program implementation; and surveillance and research. The information gleaned from their formal and informal assessments helps to inform the Title V MCH /CYSCHN program on the importance, the magnitude, and the comparison of where the issue sizes up to competing priorities.

One of the most important coalitions that Title V staff members actively participate in is the All Alaska Pediatric Partnership (AAPP), a coalition of several hospitals in the state who care for children and pregnant women, representatives from the Municipality of Anchorage, tribal entities, and behavioral health systems. Meetings and community forums are held in several communities throughout the year during which time information is collected on needs and challenges. Attendees oftentimes are parents of children and youth with special needs and chronic conditions as well as local pediatricians, family practice physicians and other representatives of community agencies. These assessments collect information on specialty health care needs and system challenges that family's experience. The information is shared back with the executive committee members to assist in planning and evaluation of programs. See http://a2p2.org for more information.

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

State priorities for 2015 - 2019 are:

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

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

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

- Alaska continues to have challenges related to provider shortages, particularly in rural Alaska and in pediatric specialty fields. There continues to be challenges in recruiting both primary care and specialty providers to the state. It is anticipated that the only pediatric neurodevelopmental physician in the state will retire at the end of calendar year 2015.
- Cuts to the state general funds related to Maternal Child Health will continue to be a barrier to overcome. Cuts in FY 16 and 17 will reduce capacity to meet the needs of children with special health care needs and data capacity.
- There continues to be a growing distrust in the government within Alaska. This likely impacts vaccine coverage rates along with survey response rates (such as for PRAMS and CUBS).
- Chronic conditions in children are increasing. Tooth decay, asthma, and obesity are currently the most prevalent chronic health issue among children
- The increase of chronic conditions among school age children, such as asthma, autism, or diabetes, will require school districts to develop capacity to meet the medical needs of the children during the school day. Currently the capacity does not exist in the smaller school districts.
- Vaccination rates among Alaskan children have been decreasing. In recent years, rising vaccine costs and decreased federal funding have hindered the DHSS's ability to supply vaccines for Alaskans. In June 2014, Senate Bill 169 was signed into law, authorizing the formation of a vaccine assessment account, from which the Alaska Immunization Program will be able to purchase pediatric and adult vaccines at discounted rates for distribution to health care providers.
- In November 2014, Alaska voters approved an initiative legalizing recreational marijuana use. Medical marijuana has been legal in Alaska since 1998. Even prior to legalization, prenatal marijuana use in some Alaska populations was almost as high as prenatal cigarette use (PRAMS).
- The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children (SACHDNC) continues to expand the number of conditions on the recommended uniform screening panel (RUSP). As conditions such as severe combined immunodeficiency disorder (SCID) and Pompe Disease are added, additional costs are incurred to state NBMS programs and state public health laboratories. These new conditions carry additional costs related to the technology associate with the testing. As the conditions are added, the corresponding fees to birthing facilities, and ultimately families, will become costly. Challenges exist for state programs on how best to support families who may have a child with this condition as oftentimes there is no cure for the condition diagnosed.
- Sexual violence on college campuses is an emerging issue nationally and in Alaska.
- Active promotion of long-acting reversible contraceptives (LARCs) to public and private providers, as well as working with AK Medicaid to assure removal of any logistical or cost barriers to access to LARCs for Medicaid-eligible women continues to be a priority.
- During 2000-2012, the percentage of Alaskan women aged 18 years or older who reported on the BRFSS that they received a Pap test within the last 3 years decreased from 91.5% in 2000 to 87.0% in 2012.

- This year the Legislature passed the Alaska Safe Children's Act, HB44 in an extended session. The bill requires schools to provide age-appropriate education meant to prevent harm to children. The

bill requires schools to provide age-appropriate education meant to prevent harm to children. The section known nationally as "Erin's Law" teaches students about sexual abuse and helpful resources. The second major component focuses on dating violence, and is being called "Bree's Law." This bill provides a framework to develop curriculum and training for Alaska schools in an effort to reduce rates of child sexual abuse, suicide, and teen dating violence in elementary and high schools. The governor is expected to sign the bill and the program will be implemented beginning in 2017.

- HCR9: This bill proclaims April 19, 2015, as Congenital Diaphragmatic Hernia Action Day. The bill moved through both houses with speed and was permanently filed as a legislative resolve and the Governor read the resolution on April 18th. Infant born with congenital diaphragmatic hernias are more likely to die in the first week of life when the condition is not diagnosed. Early diagnosis increases the likelihood that infants will deliver at a high risk perinatal center with a level III NICU that includes pediatric surgery
- Physical Exams required for school entry was repealed in the legislation listed above HB 44. Schools will have the option to require physical exams prior to school entry or new to a district, but they will no longer be required. The impact is that school children who have significant health care needs such as asthma, obesity, developmental delays, dental decay, hearing or eye conditions for example will lose that opportunity to have them identified prior to the start of school. Their learning may be delayed due to the condition. If significant, the opportunity to develop an individual education plan (IEP) at the beginning of a school year will be affected.

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

Medicaid expansion has not been implemented in Alaska despite support from the majority of the state's population. Governor Walker was elected in the Fall 2014 in part due to his support of expansion. The Medicaid Expansion and Reform bill introduced by Governor Walker failed to make it through the Legislature during the 2015 session. These bills were proposed as strategies for both Medicaid reform and expansion.

Four bills (HB18, HB148, SB74, SB78) were introduced at the beginning of the 2015 Alaska legislative session regarding Medicaid Expansion and Medicaid Reform:

- HB18: This bill proposed to expand Medicaid eligibility to persons < 65 years of age who are not pregnant and meet the income eligibility criteria (<133% FPL) for services reimbursed to Medicaid at the 90 fed/10 state match. This bill was held in the House Health &Social Services committee.
- HB148: This bill was introduced by the Governor and proposes to implement Medicaid reform measures, including exploration of cost-saving measures, new partnerships with community and tribal partners, and consideration of waiver options; to implement a provider tax; to establish disease prevention and the primary model of health care in the state; to cooperate with the federal government (CMS) on several matters of adult public assistance; to implement measures to reduce "out-of-wedlock" pregnancies and induced terminations of pregnancy; strengthen audit and penalty procedures; to expand Medicaid eligibility to persons < 65 years of age who are not pregnant and meet the income eligibility criteria (<133% FPL) for services reimbursed to Medicaid at the 90 fed/10 state match; and to actively care-manage and reduce "super-utilizers" of emergency care. To date, this bill is being heard in the first special session.
- SB74: This bill also addresses Medicaid reform measures, including requiring the DHSS to establish a personal health savings account for Medicaid recipients; requiring the DHSS to establish a managed care demonstration project; requiring the DHSS to establish and implement a demonstration project to reduce non-urgent use of ERs by Medicaid recipients; and requiring the DHSS to review the feasibility of privatizing certain services. This bill was referred to the Senate Finance committee just prior to the close of the first regular session

referred to the Senate Finance committee just prior to the close of the first regular session and likely will continue in the 2nd session.

- SB78: This bill was introduced by the Governor and includes identical language to the original version of HB148. This bill was referred to S Finance just prior to the close of the first regular session and may continue in the 2nd session.

None of the bills passed out of committee for floor votes this session despite overwhelming supportive public testimony and letter/email to the legislators. It is unknown at this time if the Governor will call an additional special session to address Medicaid reform and expansion.

II.B. Five Year Needs Assessment Summary

II.B.1. Process

Goals and Framework

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

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

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

Stakeholder Involvement

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

Quantitative and Qualitative Methods

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

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

The narratives and data provide documentation of how activities and partnerships are supporting MCH priorities.

Data Sources

Other data sources for the NA included surveillance programs managed by the MCH Epidemiology ("Epi") Unit in WCFH (Alaska PRAMS, the Alaska Childhood Understanding Behaviors Survey - CUBS, MCH Indicators, Surveillance of Child Abuse and Neglect - SCAN, the Alaska Birth Defects Registry - ABDR, and the Maternal-Infant Mortality Review-Child Death Review - MIMR-CDR). Epidemiologists regularly access, link and analyze data from the Bureau of Vital Statistics, WIC, Office of Children's Services (OCS), and Medicaid. Other major data sources were:

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

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

Finalization

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

II.B.2. Findings

II.B.2.a. MCH Population Needs

Women's/Maternal Health

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

administration elected in 2015 is committed to expand Alaska's Medicaid program, which will relieve some of the financial barriers to access to care if implemented. Furthermore, inclusion of RH care in the Essential Health Benefits package under the Affordable Care Act also helped to increase access to affordable preventive health care.

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

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

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

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

Perinatal/Infant Health

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

The MIMR-CDR committee convenes regularly to review out-of-hospital infant deaths, and as of Dec 2014 had reviewed 100% of all postneonatal deaths through 2012. The leading cause of non-

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

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

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

The disparity in infant mortality between Alaska Native and non-Native people has improved since the early 1980s but still persists, particularly in rural areas.

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

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

Child Health

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

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

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

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

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

While there has been increased interest in water fluoridation in some rural areas of the state, this public health approach has faced opposition in a number of urban areas. Several larger communities, including Fairbanks and Juneau, have discontinued fluoridation over the past eight years. In addition, access to dental care remains a significant issue in remote villages which may only see dental therapists or itinerant dental teams a few weeks each year. Title V support for

development of school-based sealant programs and access to dental services offers an opportunity to address prevention and early intervention programs to provide dental services for underserved children, including those without a "dental home".

Adolescent Health

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

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

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

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

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

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

The Adolescent Health Program (AHP) works to promote positive youth development and prevent or reduce negative health outcomes. This program successfully partners with communities and manages grants to prevent and reduce unintended pregnancy, youth violence, and sexually transmitted infection. The AHP staff works across the state to promote healthy relationships and

reduce risky behaviors in the lives of adolescents and to encourage family, school and community involvement in the lives of youth through technical assistance, trainings, and resources. With CDC Rape Prevention Education Program funds, the AHP implements primary prevention strategies to reduce the prevalence of sexual assault at universities and to train school counselors. The Fourth R curriculum teaches healthy relationship skills and empowers adolescents to make healthier decisions about relationships, sexual behavior, and substance use. With HHS Office of Adolescent Health funds a teenage pregnancy prevention program with trained peer educators. New and enhanced strategies/program efforts are needed to widely disseminate Alaska specific information about adolescents. In the coming year the AHP will update their website and include fact sheets and resources to better communicate the unique needs of adolescents and the unique role of the AHP.

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

Children and Youth with Special Health Care Needs

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

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

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

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

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

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

Families of CYSHCN experience disparity in emergency preparedness. Alaska is at risk for eight significant types of natural and man-made disasters. Due to the size of the state and distance from the contiguous United States, emergency supplies and response may take days to arrive if a disaster occurred. Less than 20% of families of CYSHCN have a written plan and only 50% have enough supplies (e.g. food, water, and medication) to shelter in place for three days. The Alaska Health and Disability Program has a 60% participation rate of families (27 of 45 members) on the steering committee. These families are involved in the majority of activities and were instrumental in the development of the strategic plan. Families are not compensated.

Life Course

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

There is emerging evidence that positive mental health is associated with improved health outcomes across the life course. In 2012, CUBS surveyed mothers of 3-year-olds on their experience of emotional trauma, defined as any report of the following: being diagnosed with depression, someone close had a problem with drinking or drugs, someone close was depressed, mentally ill or suicidal, or someone close died. Overall, 41.7% reported some form of emotional trauma since their child was born (63.2% of Alaska Native mothers and 34.9% of White mothers).

In 2013, 35.7% of Alaska high school females and 19.0% of high school males "felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months" (YRBS).

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

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

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

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

Comprehensive access to behavioral and mental health services in Alaska is lacking across all populations. Screening for behavioral health issues is inconsistent and not always performed using evidenced based tools. When identified, services are frequently unavailable or inappropriate for pregnant and postpartum women, children or CYSCHN populations. For women, there can be negative health effects of poor mental health that impact the women but these effects can also be transmitted to subsequent generations. For example, perinatal depression which occurs among women during pregnancy or within a year after delivery is also associated with chronic disease, substance abuse, suicide and negative impacts on child development.

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

Multiple collaborative efforts and partnerships support the life course work for child maltreatment prevention and the development of behavioral health screening. The SCAN program has partnered closely with the Anchorage Community Mental Health Clinic to improve the translation of data into clinical practice. This partnership has resulted in multiple combined presentations with both epidemiologic and clinical information being shared to inform practice. WCFH collaborates with the Children's Justice Act Task Force to improve the system responding to child maltreatment,

focusing on improving laws, educating mandatory reporters, and supporting the development of multi-disciplinary teams for evaluating suspected child sexual and severe physical abuse.

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

II.B.2.b Title V Program Capacity

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

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

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

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

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

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

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

(a)

There are three critical issues the state faces in providing comprehensive care: geographic isolation, low population density, and shortages in workforce capacity particularly with the delivery of specialty clinical services. The key factors in building capacity within the state are the collaborations and partnerships among state agencies as well as between the state and the private sector, tribal entities, the non-profit sector, local

state agencies as well as between the state and the private sector, tribal entities, the non-profit sector, local communities, other public agencies, and families.

Women/Maternal Health

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

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

Perinatal/Infant Health

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

Children and Youth with Special Health Care Needs

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

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

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

Child Health

Access to a pediatric medical home has been a key area of focus. Title V collaborates with ECCS to implement online use of the Ages and Stages screening tool, and with the Section of Public Health Nursing (SOPHN) trains nurses to offer comprehensive well child screens in remote communities. Frequent turnover of health aides in many villages presents challenges in maintaining trained staff and thus preventive health visits are of lower priority. Capacity for the Title V program has been enhanced with the HRSA D70 grant award.

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

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

Adolescent Health

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

Cross-cutting/Life Course Health

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

(b)

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

The State, through its maintenance of effort, offers grants funded with state and federal funds to local health care organizations to deliver direct services to women and children. These locally based efforts bring culturally competent care to predominately Alaska Native communities in remote areas of the state, are offered as a part of a larger collaborative effort within DHSS, and include working relationships as well as braiding of funding with DBH, Juvenile Justice and Disability Services, sections within DPH, OCS, the Governor's Counsel on Special Education and Disability Services and the Mental Health Trust Authority

Governor's Counsel on Special Education and Disability Services and the Mental Health Trust Authority. Title V has provided over the years seed money to start these interdepartmental collaborations and oftentimes, Title V dollars are leveraged for additional dollars after initial start-up.

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

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

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

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

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

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

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

(a)

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

- **Section Chief/Title V MCH Director** – Stephanie Wrightsman-Birch RN, MPH, MSN, FNP, Chief of Operations and strategic planning for all Title V and CYSCHN programs. She is a member of the DPH senior leadership team. She has over 33 years of nursing experience and over 20 years of executive level leadership and management experience. She also works part time as a Family Nurse Practitioner in a privately owned ANP practice.

- **Deputy Section Chief/CYSHCN Director** – Rebekah Morisse RN, MPH, Unit Manager for the Perinatal Early Childhood Health Unit and MIECHV coordinator. Ms. Morisse has worked in public health for 10 years, first as a public health nurse in Wisconsin and then as the Program/Clinic Manager of the Anchorage Reproductive Health Clinic. She has previous experience in hospital nursing.

<u>MCH Epidemiology Unit</u>: 14.0 FTEs

- Margaret Young, MPH, Unit Manager and a senior Epidemiologist. Ms. Young is a graduate of the

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

Women's and Adult Health Unit: 8.0 FTEs

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

School Age and Adolescent Health Unit: 9.0 FTEs

- Mollie Rosier, MPH, in transition to become Unit Manager. Ms. Rosier has 12 years of experience as a public health specialist and manager.
- Brad Whistler, DMD, MPA, Dental Health Official for the State of Alaska and manager for the Oral Health program.

Early Childhood and Perinatal Health Unit: 13.0 FTEs

Section Operations Support: 3.0 FTEs

(b)

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

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

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

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

MIECHV home visitors receive cultural diversity training.

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

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

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

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

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

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

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

- Contraceptives and nurse practitioner contracts are funded through Title V to support RH services provided by the PHCs and other private providers. SOPHN is contacted when following up on abnormal screens for children identified through EHDI or NBMS. Some PHCs act as case coordinators when children in their communities are diagnosed with a condition.
- WCFH has data sharing agreements with the Bureau of Vital Statistics, OCS, and DBH, and regularly accesses data from Medicaid, WIC, and the Division of Juvenile Justice.
- DPH and OCS have an agreement to link the EHDI program with EI/ILP.
- The CYSHCN Director serves on the Strengthening Families Leadership Team in OCS.
- WCFH works with DPA on improving the Medicaid application process for TEFRA and pregnant women and collaborates with WIC on breastfeeding promotion.
- A WCFH staff member works with DPH Disaster management staff to assure MCH populations are considered in disaster planning.
- WCFH provides health information to Medicaid/Denali KidCare recipients. WCFH also provides data to the Medicaid program to support operations. The WCFH Section Chief is working with DPH and tribal staff to improve outreach for EPSDT exams and services.
- The SN/SH Consultant partnered with the YRBS program in the Section of Chronic Disease Prevention and DEED to develop the social development school health module.

vi. Other government agencies:

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

vii. Tribes, Tribal Organizations:

Collaboration with ANTHC includes:

- Co-sponsoring the Alaska MCH and Immunization Conference

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

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

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

ix. Family and consumer partnership and leadership programs:

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

x. Other organizations that serve the MCH population:

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

II.C. State Selected Priorities

	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1 .	Reduce substance abuse among families, including alcohol, tobacco and drugs.	Continued	
2 .	Increase access and preventative health care services to Alaskans and their families.	New	
3 .	Increase healthy relationships.	New	
4 .	Increase access to reproductive health services that adhere to national best practice guidelines.	New	
5 .	Improve system of care for families with children and youth with special health care needs	Continued	
6 .	Reduce the rate of child maltreatment	Continued	
7 .	Increase evidence based screening for all MCH populations for behavioral and mental health problems	New	

State priorities for 2015 - 2019 are:

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

Rationale for selection

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

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

population domain.

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

1. Needs Assessment Survey Result: These fields in the prioritization matrix were pre-populated based on the results of the statewide needs assessment survey. Respondents to the survey selected and ranked their top three health concerns and service needs. All responses were combined and the top three health concerns were identified as those which had the most respondents who selected that health concern as one of their top three. On the matrix, a score of 10= #1 Priority identified (ie, the most people selected this as one of their top three), Score of 8= #2 Priority identified, and Score of 6=#3 Priority identified.

2. Size of problem (% of population with health problem with an emphasis on the percentage of the population at risk for the problem. Indicator data was provided by the MCH Epidemiology Unit for reference.)

3. Encompasses Life Course (Does this health concern appear in multiple MCH populations? Has this health indicator, if pervasive, been shown to negatively impact the life trajectory of the individuals experiencing them and increase the potential for inter-generational familial adversity?)

4. Seriousness of Health Problem (Morbidity rates, mortality rates, economic loss, and the degree to which there is urgency for intervention. Does it require immediate attention? Is there public demand? What is the impact on quality of life?)

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

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

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

The Hanlon Method: Rating Criteria			
	Size of Problem (% of		

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

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

The WCFH Leadership Committee decided ahead of time to choose two Life Course priorities based on the fact that Child Maltreatment and Behavioral and Mental Health were identified within the top three priorities of four of the MCH populations in the statewide needs assessment survey results. To come up with seven final priorities, a single priority need for each of the five population domains was chosen.

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

In many ways, state priorities have not changed since the 2010 Needs Assessment. The issues of mental health, substance abuse, child maltreatment and healthy relationships persist in Alaska and therefore are

maintained within our state priorities. New priorities focus on expanding preventative health care services to Alaskans and their families. Strategies to address these priorities are discussed in the Five Year Action Table.

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

Table. Comparison of Prior and New State Priorities

State Priorities 2010-2014	State Priorities 2015-2019	Rationale for changes
Reduce substance abuse among families, including alcohol, tobacco and drugs.	Reduce substance abuse among families, including alcohol, tobacco and drugs.	No change
Reduce child maltreatment and bullying.	Reduce the rate of child maltreatment	Child maltreatment was clearly a strong priority among all populations based on the results of the Needs Assessment survey so we decided to focus this priority solely on this issue. Decreasing bullying is included as an objective to reach the priority of increasing healthy relationships.
Collaborate with families to work towarda system of integrated services for families with infants, children, and teens, and especially those with special health care needs.	Improve system of care for families with children and youth with special health care needs.	Refined measure very similar to prior priority
Reduce the risks associated with unintended pregnancy and teen pregnancy.	Increase access and services to reproductive health care.	New priority focused on a broader need. Teen pregnancy and unintended pregnancy will be reduced if access and services to reproductive health care are increased.
Reduce dental caries in children 0 - 21 years of age.	Increase access and preventative health care services to Alaskans and their families.	Activities to reduce dental caries are a strategy to address the broader priority of increased access and preventative health care services.
Reduce intimate partner violence (IPV) including teen dating violence.	Increase healthy relationships	Healthy relationships encompasses IPV and bullying and uses more positive terminology to frame the issue
Increase universal screening for postpartum depression in women.	Increase evidence based screening for all MCH populations for behavioral and mental health problems.	The new priority is broader and does not focus only on women. Mental and behavioral problems was identified as a major health issue for almost all population domains.
Reduce preventable post-neonatal mortality due to SIDS/asphyxia.		Because so many preventable post-neonatal deaths in Alaska due to SIDS/asphyxia are associated with substance use, activities to address the priority of reducing substance abuse among families will affect this prior priority. We expect to select a SIDS-related measure as a

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

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

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

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

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

	2016	2017	2018	2019	2020
Annual Objective	79	81	83	85	87

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

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

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

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

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

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

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

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

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

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

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

	2016	2017	2018	2019	2020
Annual Objective	12.9	12.3	11.7	11.1	10.5
Annual Objective	28	26.6	25.3	24	22.8

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

No.	Alaska's Chosen National Performance Measures
1	Percent of women with past year preventative visit
3	Percent of very low birth weight infants born in a hospital with a Level III+ Neonatal Intensive Care Unit
5	Percent of infants placed to sleep on their backs
6	Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool
7	Rate of injury-related hospital admissions per population ages 0 through 19 years
9	Percent of adolescents, ages 12 through 17 years who are bullied
11	Percent of children with and without special health care needs having a medical home
14	A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

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

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

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

Title V MCH Services Block Grant

No.	National Performance Measures
1	Percent of women with past year preventative visit
3	Percent of very low birth weight infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
5	Percent of infants placed to sleep on their backs
6	Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed

Cross Linkage:

1. D *(Increase access to reproductive health care services may increase # of preventative visits.)*
3. A *(Parental substance abuse may result in need for NICU)*
5. B *(Mother likely to receive education on how to place infant to sleep during well baby visit)*
6. B *(Increased access to well-child visits will results in increased developmental screenings)*
7. F *(Injury related hospital admissions can*

Alaska Priority Needs

A	Reduce substance abuse among families, including alcohol, tobacco and drugs.
B	Increase access and preventative health care services to Alaskans and their families.
C	Increase healthy relationships.
D	Increase access and services to reproductive

	screening using a parent-completed screening tool
7	Rate of injury-related hospital admissions per population ages 0 through 19 years
9	Percent of adolescents, ages 12 through 17 years who are bullied
11	Percent of children with and without special health care needs having a medical home
14	A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

be used as an indicator for child maltreatment. We plan to add additional State Performance measure to address child maltreatment in Fall 2015.)

9. C *(Unhealthy relationships also encompasses bullying)*

G *(Bullying can lead to behavioral and mental health problems)*

11. E *(Medical home is essential for families with CYSHCN)*

14. A *(Smoking is hazardous to infants ie: SIDS)*

D *(Access to reproductive health care may reduce smoking during pregnancy.*

	health care.
E	Improve system of care for families with children and youth with special health care needs.
F	Reduce the rate of child maltreatment
G	Increase evidence based screening for all MCH populations for behavioral and mental health problems

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

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

State Action Plan Table

Domain	State Priority Needs	Objectives	Strategies	National Performance Measures	National Outcome Measures
Maternal/ Women's Health	Increase access to reproductive health services that adhere to national best practice guidelines.	By 2020, increase by 5% over baseline the number of health care providers offering reproductive health services who adhere to the national "Quality Family Planning Services" (QFP) guidelines.	Define baseline: number of providers offering RH services who strictly adhere to the QFP. Provide professional education opportunities to increase knowledge/understanding of QFP. Survey providers to assess adherence to QFP after professional education. Provide technical assistance to providers who do not meet national standard (QFP).	NPM #1 Percent of women with a past year preventative visit.	2 4.1 5.1 8 9.1 9.2 9.4
Perinatal/ Infant's Health	Reduce substance abuse among families, including alcohol tobacco and drugs.	Increase health care provider access to tools that support screening women of reproductive age for: 1) use of alcohol, tobacco and drugs, and 2) desire for conception in the coming year.	Promote use of Oregon's One Key Question tool among health care providers, especially those serving Medicaid clients	NPM #3 Percent of very low birth weight infants born in a hospital with a level III+ Neonatal Intensive Care Unit.	2 4.1 5.1
		Increase the percentage of Alaskans who currently do not use tobacco to 83% by 2020 (Tied to HA2020, Indicator 3)	Promote self and provider referral to the Alaska QUIT line (1-800-QUIT-NOW) http://alaskaquitline.com/	NPM #5 Percent of infants placed to sleep on their backs.	8 9.1
		Reduce the percentage of Alaskans who report binge drinking in the past 30 days (based on the following criteria: 5 or more alcoholic drinks for men; 4 or more alcoholic drinks for	Promote use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) among health care providers, especially those serving Medicaid clients (HA2020	NPM #14 Percent of women who smoke during pregnancy and percent of children who live in	9.2 9.3 9.4

		women on one occasion) to 20% by 2020 (Tied to HA2020, Indicator 15a)	Indicator 15a, Strategy 1)	households where someone smokes.	9.5 19
		After gathering baseline data, demonstrate that 50% of Alaska Medicaid providers caring for pregnant women and women of childbearing age, bill for screening for alcohol and /or substance use (other than tobacco) by 2020.			
Child Health	Increase access and preventative health care services to Alaskans and their families.	Increase the percentage of children enrolled in Medicaid who receive a well child exam and developmental screen at 9, 18 and 30 months of age using the Bright Future Periodicity Schedule.	Promote the use of the online Ages and Stages Developmental Screening tools with health care providers as well as the use of the billing code 96111	NPM #6 Percent of children ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool.	13 19
		Increase the number of children 1-3 years of age who have an annual dental health visit.	Promote and educate parents on the importance of early dental screening of children 1-3 years of age		
		Increase the number of children ages 5-8 enrolled in Medicaid who receive an annual well child visit.			
Adolescent Health	Increase healthy relationships.	Decrease the percentage of students who report that they would not feel comfortable seeking help from at least one adult besides their parents if they had an important question affecting their life (2019 YRBS data).	Promote and disseminate evidence-based healthy relationship programming.	NPM #9 Percent of adolescents, ages 12 to 17 years who are bullied.	16.1 16.3
		Decrease the percentage of students who had been bullied on school property during the past 12 months (2019 YRBS data).	Increase program implementation that uses a positive youth development framework.		
			Provide expertise on healthy relationship risk and protective		

			factors.		
CYSHCN Health	Improve systems of care for families with children and youth with special health care needs.	By 2020, increase the proportion of CYSHCN who receive integrated care through a patient/family-centered medical/health home approach by 20% over Alaska's reported 2009/2010 levels of 42.8%	Assess CYSHCN systems of care to integrate families and create a State Plan. Develop a shared resource for families and primary care providers of CYSHCN using the Help Me Grow centralized system model. Expand provider access to medical home concepts and tools through education and statewide technical assistance.	NPM #11 Percent of children with and without a special health care need having a medical home.	17.2
Cross-Cutting / Life Course	Reduce the rate of child maltreatment.	By 2020, decrease the rate of injury related hospital admissions among children 0-19 years by 15%	Expand trauma informed service delivery for state based services. Assess current primary prevention efforts of maltreatment and set a direction towards collective impact.	NPM #7 Rate of injury related hospital admissions per population ages 0 thru 19 years.	15 16.1
		By 2020, decrease the rate of injury related hospital admissions associated with parental neglect or negligence by 25%	Develop and target population based primary prevention campaign using cross-sector comprehensive data. Expand home visiting and support local based initiatives with data (e.g. Triple P program, Mat-Su community effort and others).		
	Increase evidence based screening for all MCH populations for behavioral and	By 2020, increase the proportion of prenatal depression screening among pregnant women by 15%	Increase partnerships with the division of behavioral health to identify evidence based screening tools.	NPM #6 Percent of children ages 9 through 71 months, receiving a developmental screening using a	13 16.1 16.3

	mental health problems.			parent-completed screening tool.	19
		By 2020, increase the proportion of parents of children ages 9-17monts who complete a child focused developmental screening by 25%	Provide system support to external partners and agencies to promote the use of standardized screening tools.	NPM #9 Percent of adolescents ages 12 through 17 years who are bullied.	
		By 2020, increase the proportion of children ages 12-17 years that are screened for being bullied.	Partner with the education system to implement screening for bullying.		

Women/Maternal Health - Plan for the Application Year

Family planning is one of the top 10 greatest Public Health achievements of the 20th century. For the large majority of women in this age group, family planning and related reproductive health needs are the driving force for entry into the health care system; this relationship with their family planning provider is essential to addressing the other critical preventive and primary health needs of women in their reproductive years. Reproductive Health (RH) services provide women with the ability to choose if and when they want to become pregnant, how many children they want to have, and the healthy interval between pregnancies. Comprehensive RH services also include preconception/interconception counseling and reproductive life course planning; patient counseling, education, and treatment or referral for sexually-transmitted infections (STIs) and HIV, unhealthy relationships, and breast and cervical cancer screening; and early pregnancy diagnosis and referral for pregnancy-related services, including prenatal care. Helping women avoid unintended pregnancies helps reduce their risk of infection with STIs/HIV and resulting infertility, and exposure of a developing fetus to teratogens (alcohol, tobacco, drugs). Unintended pregnancies also are associated with increased risk of physical violence during pregnancy, delays in seeking prenatal care, maternal depression, preterm and low birth weight births, and negative educational and economic outcomes, especially for teen parents. Respondents to Alaska's five year needs assessment identified access to reproductive health services and mental/behavioral health screenings as priority concerns for the women's/maternal population domain.

Comprehensive, evidence-based RH care provided by a trained and qualified health care provider is essential to assuring that women in their reproductive years can effectively avoid unintended pregnancies and the related negative outcomes noted above, as well as assuring increased access to related preventive and primary health screenings and services. Therefore, Alaska has identified as its priority need for this population to increase access to RH services that adhere to national best practice standards. Accordingly, the planned objective is as follows: "By 2020, increase by 5% over baseline the number of health care providers offering reproductive health services who adhere to the national *Providing Quality Family Planning Services* (QFP) guidelines."

In order to achieve this objective, program staff will utilize the following strategies:

1. Define the baseline, i.e., the number of health care providers currently offering RH services who strictly adhere to the QFP guidelines, in both the private and public health care sectors, beginning with publicly-funded health care agencies.

2. Once the baseline is defined, program staff will coordinate professional education opportunities that target specific provider groups that offer RH services, in order to increase their knowledge and adoption of best practices described in the QFP.

3. After the targeted professional education efforts, program staff will survey providers to assess adherence to the QFP.

4. Program staff will offer technical assistance to those providers who continue to fall short of the national standard in their provision of RH services.

The National Performance Measure (NPM) for this population group is "Percent of women with a past-year preventive visit," (well-woman care). In 2013, just over half (55.2%) of Alaska women indicated on BRFSS that they had a past-year preventive visit. The percent was much lower (23.1%) among women who were uninsured compared to those who were insured (62.4%). Based on data from Healthy People (HP) 2020, a related indicator shows that only 86.4% of Americans of all ages had a specific source of ongoing care in 2008 (AHS-5.1), with the 2020 target being 95%. Other HP2020 indicators currently under development (no data or targets yet) that are related to this NPM include: the proportion of insured persons with coverage for clinical preventive services (AHS-2), and the proportion of persons who receive appropriate evidence-based clinical preventive services. Furthermore, one related Healthy Alaskans (HA) 2020 indicator shows that the percentage of adults reporting that they could not afford to see a doctor in the last 12 months was 14.7% in 2010, compared to the target of 14%. Studies show that health insurance coverage helps people get timely medical care and improves their health outcomes. Individuals without coverage may avoid seeking medical care, including preventive services, because of perceived or actual financial barriers.

Through federal mandates or programmatic priorities, publicly-funded health care providers (e.g., community health centers), including federally-funded family planning centers (e.g., Title X agencies), are required to participate in health insurance enrollment activities, either directly or through referral to enrollment agencies, and to act as, or directly link with, appropriate primary data from the Guttmacher Institute reports that "[nationally] more than 6 in 10 women who obtained care at a publicly-funded center that provides contraceptive services (2006-2010) considered the center their usual source of medical care, and 4 in 10 women who obtained care at a family planning center specializing in contraceptive care cite the center as their only source of

care." Therefore, Alaska's efforts to improve access to comprehensive, evidence-based reproductive health services will result in an increase in the number of women receiving appropriate preventive health services and screenings.

Women/Maternal Health - Annual Report

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

Annual Objectives

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

NPM # 15

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

Previous year's activities, accomplishments, challenges and revisions:	The Healthy Start and Maternal, Infant, & Early Childhood Home Visiting (MIECHV) programs screened and appropriately referred program clients in Anchorage, Nome, and the surrounding fifteen villages, to supportive services. The 2014 Alaska MCH and Immunization Conference was held in September. A perinatal nurse from the Alaska Tribal Health Consortium partnered with the WCFH Epidemiologist to present a session titled: *Strategies for Reducing Infant Mortality in Alaska.* Data and strategies relevant for tobacco use reduction were shared. To replace *Baby and Me*, WCFH staff researched and designed a wallet size *Healthy Pregnancy and Beyond* card which offers URLs to prenatal and interconceptional health information from March of Dimes, HRSA's Office on Women's Health, Alaska211 resource line and the State Department of Health on Facebook. Once printed, WCFH plans to distribute the cards at no cost to all clinical providers serving preconceptional, prenatal and interconceptional clients.
Analyses of effectiveness of current program activities:	The Healthy Start and MIECHV programs continue to screen, and appropriately refer program clients in Anchorage, Nome, and its fifteen surrounding villages, to supportive services. In July 2016, HRSA Healthy Start funding will end. Healthy Start plans to continue case management operations under their sustainability plan. Risks associated with tobacco use are discussed during infant safe sleep trainings. WCFH has prioritized tobacco use in pregnancy as one of its Infant Mortality Collaborative Improvement and Innovation Network (CoIIN) Learning Networks. The March of Dimes is leading this workgroup which is focused on promoting the State *QuitLine* among women of childbearing age and living in Nome and the surrounding fifteen villages, where tobacco use in the third trimester of pregnancy among Healthy Start clients is 43%, one of the highest in the state. Staff from WCFH and the March of Dimes conducted smoking cessation training for eleven clinical staff from the Norton Sound Regional

	cessation training for eleven clinical staff from the Norton Sound Regional Health Corporation, which houses Healthy Start and serves as the medical home for all people living in Nome and the surrounding fifteen villages. The *Healthy Pregnancy and Beyond* cards will be distributed at no cost to all clinical providers serving preconceptional, prenatal and interconceptional clients.
Plan for the coming year:	The tobacco use in pregnancy Infant Mortality CoIIN Learning Network will continue. The March of Dimes will continue to lead this work which will focus on promoting the State *QuitLine* and local tobacco cessation program among women of childbearing age and living in Nome and the surrounding villages. *Healthy Pregnancy and Beyond* cards will be distributed at no cost to all clinical providers with preconception, prenatal and interconception clients in their caseloads
Interpretation of data (FY14 & FY15):	There is no new Pregnancy Risk Assessment Monitoring System (PRAMS) data since 2012 due to the mandatory data system change. 2012 PRAMS data showed a decrease in the percentage of women who smoked in the last three months of pregnancy statewide. Healthy Start and MIECHV programs each have their own performance measures that will continue to be collected, tracked, evaluated and reported to HRSA regularly. The number of clients receiving services from Healthy Start quadrupled during this time period. Healthy Start will terminate data reporting to HRSA in July 2016, but plans to continue collecting, tracking, evaluating and reporting some performance measures to their stakeholders going forward. The MIECHV program in Anchorage reached capacity and then expanded by four home visitors. The percentage of women smoking in pregnancy in the MIECHV program decreased during FY14.
NPM # 18 Percent of infants born to pregnant women receiving prenatal care beginning in first trimester	
Previous year's activities.	The Healthy Start and Maternal, Infant, & Early Childhood Home Visiting (MIECHV) programs provided client education encouraging early prenatal care

activities, accomplishments, challenges and revisions:	(MIECHV) programs provided client education encouraging early prenatal care to clients in the Nome and Anchorage areas. To replace Baby and Me, WCFH staff researched and designed a wallet size Healthy Pregnancy and Beyond card which holds URLs to prenatal and interconceptional health information from March of Dimes, HRSA's Office on Women's Health, Alaska211 resource line and the State Department of Health on Facebook. Once printed, WCFH plans to distribute the cards at no cost to all clinical providers serving preconceptional, prenatal and interconceptional clients. 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.
Analyses of effectiveness of current program activities:	The Healthy Start and MIECHV programs continue to provide client education encouraging early prenatal care. Through technical assistance from MCHB, WCFH assembled a workgroup looking to improve the Medicaid application process for pregnant women. This group includes WCFH, Public Assistance, tribal health, and a perinatal case manager. The group will be doing a systems mapping exercise of the Medicaid application process for pregnant women and make recommendations to leadership on process changes. The goal is for women to have early access to prenatal care to ensure better birth outcomes. Healthy Pregnancy and Beyond cards will be distributed at no cost to all clinical providers with preconception, prenatal and interconception clients in their caseloads.
Plan for the coming year:	The Healthy Start and MIECHV programs will continue to provide client education encouraging early prenatal care for their program clients in the Nome

	and Anchorage areas. Healthy Start will terminate services in July 2016 when HRSA grant funding ends. WCFH will no longer be involved with the Nome region prenatal activities as they operate under their Healthy Start sustainability plan. Healthy Pregnancy and Beyond cards will be distributed at no cost to all clinical providers with preconception, prenatal and interconception clients in their caseloads.
Interpretation of data (FY14 & FY15):	This indicator has remained close to 80% since the mid-1990s. The number of clients receiving services from Healthy Start quadrupled during this time period. The MIECHV program in Anchorage reached capacity and then expanded by four home visitors. 83% of clients in the program received the ACOG recommended number of prenatal visits, an improvement from the previous year.

SPM#4

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

Previous year's activities, accomplishments, challenges and revisions:	In FY14, birth spacing materials were shared by the Alaska Breastfeeding Initiative. The federal Healthy Start Show Your Love! pamphlet, a simple guide to support clients to develop a personalized contraceptive care plan, were adapted for use in Alaska. The nurse consultant collaborated with staff of the Healthy Start Norton Sound Health Corporation, located in the Nome census area, to complete final revisions of the pamphlet. CDC's Revised Recommendations for the Use of Contraceptive Methods During the Postpartum Period were shared widely. The Reproductive Health Partnership contraceptive education kits and trainings were 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 skills in counseling and provision of effective contraception, especially for postpartum women, have been identified as a critical need. Healthy Start funded 2 practitioners to participate in skills-based clinical training for this. The nurse consultant and Healthy Start staff collaborated 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. In October 2014, the WCFH Family Planning Program hired a Women's Health Nurse Consultant with a modified role from her predecessor. The new NC is an Advanced Practice Registered Nurse whose new role entailed 1) continuing to provide clinical direction and oversight to the Title X Family Planning Program, and 2) acting as a subject matter expert in consultation to the Section of Public Health Nursing on all reproductive health related topics, to guide/improve clinical practice, clinic efficiency, and effectiveness in meeting the reproductive health needs of populations served by State Public Health Centers in Alaska. Finally, the WCFH Family Planning Program (FPP) continued to administer the Title X Family Planning Services grant in FY14, 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.
Analyses of effectiveness of current program activities:	Most FY14 activities are continuing in the current year. Also in the current year, staff in the WCFH Adult Health Services Unit and Family Planning Program (AH/FPP) have collaborated closely with State and non-profit partners working with federally-qualified health centers (FQHCs) in

	Alaska to provide continuing education opportunities to clinical and administrative staffs at FQHCs regarding nationally-recognized best practice guidelines and clinical service delivery systems improvements in women's and reproductive health. These efforts are helping to raise awareness of the need to better integrate women's preventive health services (including family planning and cancer screening) into publicly funded primary care settings that serve at-risk populations in Alaska. Additionally, AH/FPP staff are collaborating with the same partners to develop a Primary Care Needs Assessment that will be mailed out to all public and private primary care facilities and providers in Alaska and will assess current service delivery, staffing, facilities capacity and shortages, and community needs for a variety of primary and preventive care functions, including women's health and family planning services. This survey will be administered in the Spring 2015, with results available in Winter 2015/16. However, the need still remains for more clinicians to be proficient in counseling and provision of long acting reversible contraceptives to assure comprehensive reproductive health services.
Plan for the coming year:	As noted above, results of the Primary Care Needs Assessment will be available for analysis during FY16. Based on responses to the survey, AH/FPP staff will follow up with providers and agencies on further analysis of their current delivery, capacity, and shortages of women's and reproductive health service. This analysis will provide the foundation for establishing a baseline of the number of reproductive health services providers who adhere to the national "Providing Quality Family Planning Services" guidelines, the proposed objective for the next 5 years for the Women's/Maternal population (as noted in Section A above).
Interpretation of data (FY14 & FY15):	There is no new PRAMS data since 2012 due to the mandatory data system change. In 2012, 79.3% of Alaska women who recently delivered a live birth reported using birth control postpartum, compared to 81.8% in 2011. During 2012, the most common reason for not using birth control among women who recently delivered a live birth and were not trying to get pregnant was that they did not mind getting pregnant again (59.8%). During 2012, 22.7% of White women and 35.7% of Alaska Native women who were not using birth control when they got pregnant with their new baby

	who were not using birth control when they got pregnant with their new baby said that they did not know they could get pregnant at that time. Health care providers can support new mothers by encouraging them to think about family planning. According to the Association of Reproductive Health Professionals, choice of postpartum contraception should ideally take place in the prenatal period. However, contraceptive counseling should also be included in the 6-week postpartum visit. During 2012, 88.1% of Alaska women who recently delivered a live birth said that a health care worker talked with them, since their new baby was born, about birth control methods that can be used after giving birth. During 2012, 58.9% of Alaska women who recently delivered a live birth said that a health care worker talked with them, since their new baby was born, about how long to wait before getting pregnant again. During 2012, 8.9% of Alaska women who recently delivered a live birth indicated that they did not have enough money or insurance to pay for birth control.
Strategies and initiation of new efforts (if adequate progress not achieved):	Already described above.

SPM #1:

Percentage 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.

Previous year's activities, accomplishments, challenges and revisions:	The MCH Epidemiology Unit continued to administer PRAMS, which includes questions on prenatal substance abuse. Information and materials continued to be distributed such as Baby and Me and the MCH Epidemiology Unit Data Books. Baby and Me includes information

revisions:	the MCH Epidemiology Unit Data Books. 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.
Analyses of effectiveness of current program activities:	The MIECHV and Healthy Start programs continued to provide services in the Municipality of Anchorage and Nome Census area. WCFH was awarded a competitive MIECHV grant which expanded services in Anchorage and also expanded services to the Mat-Su Borough. Alcohol use during pregnancy will continue to be assessed during home visits. As Baby and Me became outdated, WCFH created Healthy Pregnancy and Beyond wallet cards. The cards will be distributed at no cost to all clinical providers with preconception, prenatal and interconception clients in their caseloads. The cards hold URLs to prenatal and interconceptional health information from March of Dimes, HRSA's Office on Women's Health, Alaska211 resource line and the State Department of Health on Facebook. The MCH Epidemiology Unit will continue to administer PRAMS. The Epidemiology Unit continues to work on making the ABDR data collection process more efficient and improving the database used for storing data. The Healthy Start program manager, who is also leading the CoIIN workgroup on substance abuse, presented to Governor's Council on Disabilities and Special Education (GCDSE) work group on FAS regarding the CoIIN workgroup initiatives.
Plan 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. Alcohol use is

	discussed with clients in the program. 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 for home visitors.
Interpretation of data (FY14 & FY15):	There is no new PRAMS data since 2012 due to the mandatory data system change. 2012 PRAMS data showed no improvement in this measure between 2011 and 2012. In 2012, 82.8% of women who recently delivered a live-born infant reported on PRAMS that their prenatal health care provider had advised them not to drink alcohol during their pregnancy. This measure has also not changed in recent years. The number of clients receiving services from Healthy Start quadrupled during this time period. Healthy Start will terminate data reporting to HRSA in July 2016, but will continue to collect, track, evaluate and report their performance measures to their stakeholders going forward.
Strategies and initiation of new efforts (if adequate progress not achieved):	WCFH will coordinate training for home visitors on substance use during pregnancy in collaboration with the Division of Behavioral Health.

SPM #6:

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

Previous year's activities, accomplishments, challenges and revisions:	The Alaska Family Violence Prevention Project (AFVPP) continues to provide technical assistance and resources for teams of trainers statewide who participated in a series of train-the-trainers on adolescent brain development, substance abuse, dating violence and Adverse Childhood Experiences. The AFVPP clearinghouse continued to distribute resources throughout Alaska including safety cards on intimate partner violence and pregnancy and reproductive and sexual coercion as well as posters on intimate partner violence and implications for pregnancy.

Analyses of effectiveness of current program activities:	The AFVPP continues to distribute resources including safety cards on intimate partner violence, unhealthy relationships and reproductive and sexual coercion and the new teen safety card which has exceeded expectations in terms of demand. The AFVPP is working with the Alaska Native Tribal Health Consortium to develop on-line training on how to use the Alaska safety card on intimate partner violence that includes content on reproductive and sexual coercion. The AFVPP conducted a statewide, three part webinar series on trauma-informed schools that addresses the connection between early childhood adversities, teen pregnancy, dating violence and early initiation of sexual activity.
Plan for the coming year:	The AFVPP will continue to operate our clearinghouse and acquire up-to-date resources to share with communities. The AFVPP will conduct another webinar series on trauma-informed schools that addresses early childhood adversities and the connection to teen pregnancy, relationship violence and early initiation of sexual activity.
Interpretation of data (FY14 & FY15):	In 2012, 2.9% of women who recently had a live-born infant experienced either physical violence by their husband or partner OR were threatened or limited in activities against her will or made to feel unsafe by her husband or partner (a controlling partner) during pregnancy.

SPM # 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.

Previous year's activities, accomplishments, challenges and revisions:	Staff from WCFH authored an article in the Spring 2014 Northwest Bulletin, "Early identification of developmental delays and maternal depression." A panel presented on home visiting in Alaska at the Statewide Public Health Nursing Conference in April 2014. WCFH worked with the Alaska Native Tribal Health Consortium (ANTHC) to plan the September 2014 biennial Maternal Child Health (MCH) and Immunization conference, "Advancing Wellness Across the Lifespan." The

	planning committee invited Michele Curtis, M.D., MPH to present a plenary on pregnancy in the context of a woman's lifespan, and a breakout session on maternal mental health and depression. We continued to focus efforts related to perinatal depression on the two home visiting grants for Healthy Start and the Maternal, Infant & Early Childhood Home Visiting (MIECHV) programs. Healthy Start is located in Nome and administered by Norton Sound Health Corporation. Providence In-Home Services (PI-HS) provided the Nurse-Family Partnership (NFP) model of home visiting in the Municipality of Anchorage (MOA). Southcentral Foundation offers the NFP through the Nutaqsiivik home visitation program and served Alaska Native families in the MOA and the Mat-Su Borough. These home visitation programs provided screening and referral for depression. The MCH Epidemiology Unit in WCFH conducted the annual Pregnancy Risk Assessment Monitoring System (PRAMS) and Childhood Understanding Behaviors Survey (CUBS) surveys, which include questions related to maternal depression. WCFH published findings on the WCFH website, created data books, and distributed the information to stakeholders across the state.
Analyses of effectiveness of current program activities:	The biennial MCH and Immunization conference, "Advancing Wellness Across the Lifespan" commenced in Anchorage September 24-25, 2014. Michele Curtis, M.D., MPH gave a plenary, "Pregnancy as a Transgenerational Event" and a breakout session, "Depression, Anxiety, and Pregnancy: Who's Stressed Out?" A panel presented on home visitation programs in Alaska. A nurse consultant provided a two-part session on "Tools and Techniques for Using the Bright Futures Periodicity Schedule in Infancy and Early Childhood." The Bright Futures Periodicity Schedule recommends a psychosocial/behavioral assessment at every well child visit beginning with the newborn visit. Bright Futures resources address maternal depression and screening. WCFH distributed Bright Futures resources, including 35 Bright Futures Guidelines books, 62 pocket guides; 7 clinical handbooks, and 9 toolkits. WCFH released the Alaska Maternal and Child Health Data Book 2014: Life Course Edition in September 2014. Organization of the data book is according to themes, rather than chapters. Theme seven is mental health. In December 2014, WCFH released the 2013 CUBS Data Sheets, which include data on

	mental health, abuse, and stress among mothers of 3-year-olds. WCFH continues to administer Healthy Start and MIECHV grants, with plans to expand the PI-HS NFP in the MOA and will begin to serve families in the Mat-Su Borough by the summer 2015. The Nutaqsiivik NFP program continues to serve Alaska Native families in Anchorage and the Mat-Su Borough. These home visitation programs provide screening and referral for depression. The MCH Epi Unit continues to conduct the annual PRAMS and CUBS surveys, which include questions related to maternal depression. The interagency developmental screening workgroup developed a policy for EPSDT regarding the use of developmental screening tools, but it did not include tools to screen for maternal depression. The workgroup plans to continue to work toward adding maternal depression screening tools to the policy.
Plan for the coming year:	Healthy Start will continue to serve families in the Norton Sound region until the grant ends on June 30, 2016. Providence will expand NFP services to families in the MOA and Mat-Su Borough. The Nutaqsiivik NFP will continue to serve Alaska Native families in the MOA and Mat-Su Borough. These home visitation programs provide screening and referral for depression. The interagency developmental screening workgroup will continue to work toward adding maternal depression screening tools to the EPSDT policy. Planning for the next biennial MCH and Immunization Conference for the fall of 2016 will begin.
Interpretation of data (FY14 & FY15):	There is no new Pregnancy Risk Assessment Monitoring System (PRAMS) data since 2012 due to the mandatory data system change. The percentage of women reporting "yes" has been increasing since 2009 and was 84.5% in 2012. Alaska PRAMS data for 2009 – 2011 found the most frequent postpartum feeling reported by all women who recently delivered a live birth was often or always feeling slowed down (19.2%). This was more common among White women (22.8%) than among Alaska Native women (14.6%). Compared to

women (22.8%) than among Alaska Native women (14.6%). Compared to White women (8.1%), Alaska Native women (12.5%) were more likely to report that they often or always felt down, depressed, or sad after giving birth. More women reported that a health care provider talked with them about depression after giving birth (81.4%) than during pregnancy (75.4%). Talking with a provider was more common among White women than among Alaska Native women during both time periods.

Perinatal/Infant Health - Plan for the Application Year

The state's Title V program has focused a tremendous amount of time, resources and effort over the last 30 years to reverse the infant mortality rate. In the early 1980's the state was at the bottom in 49th place out of 50 with one of the highest infant mortality rates in the nation. Efforts such as perinatal regionalization, maternal and neonatal transport systems, the development of a Level III/B and level II neonatal units, the development of a high risk perinatal unit have led to the significant decrease in infant mortality with Alaska ranking at or near the top of the states with one of the lowest infant and neonatal mortality rates. The post neonatal mortality rate does not meet the HP 2020 performance objective and exceeds the national rates. To that end, Title V WCFH has chosen to focus on behaviors that impact overall infant mortality and thus prioritized parental tobacco, alcohol and drug use reduction strategies as their CoIIN strategy.

Perinatal and infant population objectives are:

1. Increase health care provider access to tools that support screening women of reproductive age for: a. use of alcohol, tobacco and drugs, and b. desire for conception in the coming year,
2. Increase the percentage of Alaskans who currently do not use tobacco to 83% by 2020,
3. Reduce the percentage of Alaskans who report binge drinking in the past 30 days (based on the following criteria: 5 or more alcoholic drinks for men; 4 or more alcoholic drinks for women on one occasion), and
4. After gathering baseline data, demonstrate that 50% of Alaska Medicaid providers caring for pregnant women and women of childbearing age, bill for screening for alcohol and /or substance use (other than tobacco).

Perinatal and infant population strategies are:

1. Promote use of Oregon's *One Key Question* clinical tool, which is used to screen women for immediate intention for pregnancy (among health care providers, especially those serving women of childbearing age covered by Medicaid,
2. Promote use of *AAR*: **Ask** at every visit, **Advise** patients to quit, and **Refer** to cessation services among health care providers, especially those serving women of childbearing age covered by Medicaid, and
3. Promote self and provider referral to the Alaska QUIT line (1-800-QUIT-NOW) http://alaskaquitline.com/

3. Promote self and provider referral to the Alaska QUIT line (1-800-QUIT-NOW) http://alaskaquitline.com/
4. Promote use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) among health care providers, especially those serving women of childbearing age who are covered by Medicaid.

Published literature notes that infants born at very low birth weight have a significantly increased risk for infant mortality, including Sudden Unexplained Infant Death. Causes of very low birth weight include prenatal smoking, substance and alcohol use. These risk behaviors may be co-occurring in the same individual. Reducing these risk behaviors in women of reproductive age prior to conception is an optimal strategy for reducing their negative impact upon infant health. Reducing these risk behaviors among pregnant women also reduces the potential for negative impact on infant health.

PRAMS data indicate that reported cigarette use during the last 3 months of pregnancy declined from 17.7% in 2002 to 13.2% in 2012 (similar to the 13.6% prenatal smoking reported in the National Vital Statistics System for Alaska in 2013). However, use of marijuana among pregnant women increased from 3.5% in 2002 to 7.8% in 2011; and prenatal use of alcohol increased from 5.3% to 6.1% in 2008, though this was not statistically significant. Marijuana use trends may shift with legalization of recreational use in February 2015.

Much of the planned for the coming year in the infant health domain is related to work on the national CoIIN to prevent infant mortality initiative. WCFH has established three focus areas for COIIN work: 1) infant safe sleep, 2) tobacco use, and 3) preconception and interconception health. The tobacco work group will focus not only on tobacco but alcohol and drugs. The following National Performance Measures will be used to evaluate the work: NPM #3 Percent of very low birth weight (VLBW) infants born in a hospital with a level III+ Neonatal Intensive Care Unit (NICU); NPM #5 Percent of infants placed to sleep on their backs; NPM#14 Percent of women who smoke during pregnancy and percent of children who live in households where someone smokes.

Preconception and interconception health, including tobacco and substance use, are highly associated with very low birth weight and SUIDs. In 2014, 76% of VLBW infants were born in a hospital with a level III+ NICU. In 2012, 13.2% of women reported smoking in the last three months of pregnancy on PRAMS. Impaired parents may fail to place their infant to sleep safely: alone, on their backs and with safe bedding. The percent of women who reported on PRAMS placing their infant to sleep on their backs has been slowly increasing since 2000, and over 70% of women reported placing their infant to sleep on their backs in 2012.

Currently, WCFH has no statewide activities focusing on these risk behaviors. The MIECHV and Healthy Start Programs provide case management and home based support services for pregnant women and mothers with babies up to two years of age for families living in Anchorage and the Nome census areas, respectively. The needs assessment identified these programs as providing some of the services most needed and beneficial; however families in most regions of the state do not have access to such services. The MIECHV program has applied for funds to expand its services into the Matanuska-Susitna region beginning in mid-2015. The Healthy Start program is scheduled to terminate services in mid-2016 due to lack of grant funding.

WCFH staff members have a long standing collaborative working relationship with health care providers statewide. WCFH will promote broad use of Oregon's *One Key Question*; *Screening, Brief Intervention and Referral to Treatment*; the state tobacco *QUIT* program, and *Ask/Advise/Refer* tools among health care providers as an effective strategy to address these issues. These clinical tools are widely available, but informal surveys of health care providers indicate they are not consistently used.

Perinatal/Infant Health - Annual Report

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

Annual Objectives

	2016	2017	2018	2019	2020
Annual Objective	79	81	83	85	87

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

Annual Objectives

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

NPM # 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.

Previous year's activities, accomplishments, challenges and revisions:	In 2014, the NBMS program welcomed a new co-manager. The 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 brochure was updated. The program created a training video on specimen collection, handling, and transport in collaboration with the public information team and a local birthing facility. The program also distributed a webinar on specimen collection. The NBMS advisory committee held three meetings which included presentations on 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 Critical Congenital Health Disease (CCHD) began 1/1/14. The NBMS staff updated regulations and reporting went into effect. The CCHD Steering Committee met and members continued to promote pulse oximetry screening. A CCHD toolkit for birthing facilities was created and distributed across the state. The 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.
Analyses of effectiveness of current program activities:	The NBMS Advisory Committee held three meetings which included program updates, a presentation from a local pediatric endocrinologist, and an immunologist on the SCID screening process planning for Alaska. The advisory committee is updating the retention policy for blood spots and seeking new members, including a parent member. QI efforts include promoting the NBMS training video, site visits to facilities in Bethel, Ketchikan and Fairbanks, and phone calls to birthing facilities with challenges meeting satisfactory QI metrics, particularly transit time. Other QI activities include the birth data match and practice profiles. A SCID workgroup met to plan implementation of screening for SCID which is targeted for FY16. This group developed the process and materials for post screening follow-up. As an outgrowth of the group, a local immunologist gave educational talks to a variety of groups including Pediatric Grand Rounds in Anchorage. Staff from the program presented at the Public Health Nursing Conference in September and will present at a Community Health Aide conference in April. CCHD enters the second year. Reports are being received from birthing facilities throughout the state. CPT-1A projects continue this year. There were presentations for PHNs, the

	CPT-1A projects continue this year. There were presentations for PHNs, the ANMC and Tanana Chiefs by the metabolic physician, the lead in the project. Alaska will continue to collaborate with the Oregon Public Health Lab on changing testing methodology for CPT-1A and will explore opportunities to learn more about this disorder and the possible effects on Alaskan children. As 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 Western States Genetic Services Collaborative (WSGSC) and the other partners in a new CPT-1A long term follow-up project continue to move forward. The NBMS program continues to be an active partner as this study progresses.
Plan for the coming year:	The Alaska 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 NBMS advisory committee will hold three meetings in the upcoming year that will include presentations of interest to the group, program updates, and discussion on new developments of interest to NBMS. SCID is projected to be added to Alaska's newborn screening panel in September 2015 which will require fee increases. The processes and materials developed by the SCID work group will guide the NBMS program, along with the local pediatric immunologists. CPT-1A projects will continue and the NBMS program will be an active partner. Continuing work from FY15, the program aims to use an integrated database for both the NBMS program and the hearing screening program for tracking and follow-up. The program 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 continue to collaborate with the WSGSC on efforts related to newborn metabolic screening and genetic services in Alaska. The Alaska State Public Health Laboratory and the program will create a MOU to ensure all needed space, supplies, and equipment are available in the event of a disaster.
Interpretation of data (FY14 & FY15):	We continue quality improvement efforts on our birth matching process using Bureau of Vital Statistics and Oregon Public Health Laboratory (OPHL) data to ensure full screening coverage and capture all refusals. In CY 2013, 98.5% of newborns were screened and 99.4% in CY 2014.
Strategies and initiation of new efforts (if adequate progress not achieved):	100% of children received timely follow-up. The NBMS program will continue site visits and quarterly practice reports to agencies
NPM #11 The percent of mothers who breastfeed their infants at 6 months	
Previous year's activities, accomplishments, challenges and revisions:	WIC agencies continue to provide Breastfeeding Peer Counselor (BFPC) services and operate the breast pump loan program. WIC and the University of Alaska collaborate to provide quarterly newsletters, teleconferences and a breastfeeding list serve. BFPC modules were placed on a new online platform. They offer relevant and updated materials. WCFH staff contributed to work on WIC breastfeeding promotion posters which were be distributed to clinics statewide. The lactation room for public health staff working in the Anchorage Frontier Building continues to serve that population. Mothers using the room have expressed their approval. WCFH convened a small workgroup to design a product to support breastfeeding mothers upon discharge from the hospital. Staff from WIC, home visiting programs, Healthy Start, the Alaska Breastfeeding Coalition and the Alaska Native Tribal Health Consortium participated. The wallet size cards provide URLs to comprehensive breastfeeding support services as well as basics about baby behaviors and appropriate parental responses. URLs included: American Academy of Pediatrics for Parents, WIC, Office on

	Women's Health, US Breastfeeding Committee, *ShotbyShot*, and Alaska 211 which provides connections to local community resources. The information has a heavy emphasis on infant behaviors, especially crying, and tips for appropriate parental responses to infant behavior. The group labeled the card *Healthy Alaskan Baby* card, as the information provided extends beyond breastfeeding. The MCH Epidemiology Unit continued to administer surveys to gather data on breastfeeding prevalence such as PRAMS and the Childhood Understanding Behaviors Survey (CUBS).
Analyses of effectiveness of current program activities:	PRAMS data on leading reasons mothers reported for stopping breastfeeding were reviewed by stakeholders who agreed that the four leading reasons reported for stopping are all highly amendable to improvement when evidence-based maternity practices, such as those taught in the Ten Steps classes, are adhered to. While Alaska breastfeeding initiation rates continue to improve overall, PRAMS data show continuation rates drop off by about 10% per month among mothers who discontinue in the first three months after delivery. Addressing the barriers identified and reported by mothers who stop breastfeeding during the first 3 months following birth is key to improving breastfeeding exclusivity and continuation rates. CDC 2007 Maternity Practices in Infant Nutrition and Care (mPINC) survey scores were reviewed and showed that hospital maternity staff training in evidence-based practices ranked well below the national average and lowest for all Alaska dimensions evaluated by mPINC. In November 2014, ABI applied for a $15,000 grant from the Association of Territorial and State Health Officers (ASTHO) in order to build leadership and skill among maternity care staff from 13 hospitals. The ASTHO project allowed 13 RNs from each of these hospitals to participate in intensive lactation training. With support of each hospital's clinical and administrative leadership, each RN is conducting trainings in evidence-based maternity practices for all clinical staff. As of March 6, 2015, those RNs have trained 193 of their clinical peers and practitioners. Additional trainings are scheduled throughout March, April and May. The RNs and their clinical leadership have begun drafting and reforming their current lactation policies based on the Ten Steps model policies. Evaluation will include assessment of mPINC scores, especially in the areas of staff training and model policy. The ASTHO project will transition to WIC during FY16.

	The Healthy Start and Maternal, Infant & Early Childhood Home Visiting programs continue to serve clients in Nome Census Borough and within the Municipality of Anchorage. The MIECHV program was awarded a competitive grant which allowed for the expansion of services in Anchorage and also in the Mat-Su Borough. The MIECHV program focuses CQI efforts on breastfeeding initiation and continuation. The percentage of mothers breastfeeding their infants at birth increased from 83% to 92%, and the percentage breastfeeding at six-months-old went from 20% to 45% (as of 2/15).
Plan for the coming year:	PRAMS staff will continue to collect, monitor, evaluate and report their data on reasons mothers give for stopping breastfeeding in the early weeks and months after birth. *Healthy Alaskan Baby* cards will be distributed to all facilities that deliver and/or care for infants. WCFH will continue to collaborate and coordinate efforts with WIC. The Healthy Start and MIECHV programs will continue to promote breastfeeding initiation and continuation as a part of health promotion. During infant safe sleep trainings, breastfeeding will continue to be presented as a protective factor in preventing sleep related deaths.
Interpretation of data (FY14 & FY15):	Published literature on the evidence-based maternity practices shown to improve breastfeeding exclusivity and duration rates, and the PRAMS data on reasons mothers reported for stopping breastfeeding, are a compelling basis for supporting efforts aimed at improving those maternity practices. 2013 mPINC scores for maternity staff training in evidence based practices in breastfeeding improved over 2007 but remain among the lowest ranking in the nation and the lowest scoring dimension evaluated by CDC. The 2013 mPINC score for model hospital policy is 12%, up from 5% in 2007. CQI efforts in the MIECHV program which included enhances training for nurses, the creation of a visual aid kit to use on home visits, the creation of a breastfeeding library for nurses, and also making clients aware of breastfeeding laws in the workplace.

NPM #12

Percent of children who have been screened for hearing prior to hospital discharge

Previous year's activities, accomplishments, challenges and revisions:	Alaska's Early Hearing Detection and Intervention (EHDI) Program is located in WCFH. The ongoing focus is to reduce the number of infants lost to follow-up after not passing their newborn hearing screening and to increase the screening rate for out of hospital (OOH) births. Screening reports are distributed quarterly to birthing hospitals and midwifery centers. The program continued to work with Alaska Native Medical Center (ANMC) on a protocol to administer diagnostic assessments before infants were discharged to remote regions. The program also worked with this facility and the next largest birthing facility to upload data electronically with the goal of improving timely follow-up. All parents of children requiring follow-up were notified by letter and the primary care provider (PCP) was notified by fax. The state early intervention/infant learning program (EI/ILP) had 3/5 staff positions vacant. A revision of the MOA between EHDI and EI/ILP was on hold until a program manager and staff was hired.
Analyses of effectiveness of current program activities:	In CY2013 and CY2014, the screening rate for infants born in hospitals was 99%. In CY 2013, the screening rate for OOH births improved to 71% from 53% in CY2012. In 2014, the screening rate for OOH births declined to 59%. Analysis of this data is reported below.
Plan for the coming year:	A new MOA between EHDI and EI/ILP is currently in draft. The EHDI Program is working with ANMC to import demographic and screening results electronically. A protocol for immediate diagnostics for infants returning to remote locations was drafted and the change in the rate of loss to follow-up for this population is being tracked. A tool to match data between the EHDI database and vital statistics is in process; as well as a plan to streamline follow-up between EHDI and newborn metabolic screening (NBMS).
Interpretation of data (FY14 & FY15):	The screening rate for OOH births increased in 2013 and then declined in 2014. However there were 100 additional OOH births reported in 2014. The screening rate for the four midwifery centers that are loaned screening equipment by the state is 92%. The 100 additional births were primarily assisted by a new midwifery that does not have screening equipment and has a low screening rate for their clients.
Strategies and initiation of new efforts	The EHDI Program will explore options for loaning equipment to midwifery centers with populations that have low screening rates. The Program will be

(if adequate progress not achieved):	tracking the loss to follow-up for populations that receive their care through the tribal health system. The EHDI Program will be working with one of the EI/ILP programs on a QI project for entering data in the EHDI database. The EHDI Program is reviewing its process for earlier notification to the PCPs and parents of infants requiring follow-up. The program will examine trends in loss to follow-up and employ quality improvement measures to improve the number of children successfully completing the National EHDI 1-3-6 Goals of screening by one month, diagnosis by 3 months, and intervention by 6 months.
NPM #17	
Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.	
Previous year's activities, accomplishments, challenges and revisions:	WCFH continued to utilize the perinatal listserv to disseminate information to stakeholders and healthcare providers. *Baby and Me* books were distributed as a prenatal/newborn resource for parents. It addresses low birth weight among other perinatal topics. 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 tracked data on low birth weight infants during monthly continuous quality improvement meetings with home visitors. The nurse home visitors utilized in-person and online training related to having a healthy pregnancy. Text4baby, which includes content related to preterm birth and low birth weight, is promoted on the State of Alaska websites. WCFH also held 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

	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.
Analyses of effectiveness of current program activities:	The MIECHV and Healthy Start programs continued to serve clients in the Municipality of Anchorage and Nome Census borough. The MIECHV program was awarded a competitive grant to expand the services in Anchorage along with expanding the service area to the Mat-Su Borough. Data on low birth weight infants continues to be monitored in monthly continuous quality improvement (CQI) meetings. Providence Maternity Center in Anchorage is the only Level III NICU in the state. Providence Nurse-Family Partnership continues to work with OB Triage on referrals to the program. The Healthy Start and MIECHV NFP programs continue to educate and support clients in having healthy pregnancies. Information and materials continued to be distributed such as *Baby and Me* and the MCH Epidemiology Unit Databooks. As *Baby and Me* became outdated, WCFH created *Healthy Pregnancy and Beyond* wallet cards. The cards will be distributed at no cost to all clinical providers with preconception, prenatal and interconception clients in their caseloads. The cards hold URLs to prenatal and interconceptional health information from March of Dimes, HRSA's Office on Women's Health, Alaska211 resource line and the State Department of Health on Facebook. Through technical assistance from MCHB, WCFH assembled a workgroup looking to improve the Medicaid application process for pregnant women. This group includes WCFH, Public Assistance, tribal health, and a perinatal case manager. The group will be doing a systems mapping exercise of the Medicaid application process for pregnant women and make recommendations to leadership on process changes. The goal is for women to have early access to prenatal care to ensure better birth outcomes.
Plan for the coming year:	The MIECHV Nurse-Family Partnership program will continue to work towards an effective expansion of the program in Anchorage and the Mat-Su Borough. They will continue to partner with the Providence OB Triage on referrals to the program. WCFH will continue to coordinate or provide trainings to the home visitors on having a healthy pregnancy. *Healthy Pregnancy and Beyond* wallet cards will be distributed at no cost to all clinical providers. They contain links to evidence-based resources on having

	all clinical providers. They contain links to evidence-based resources on having a healthy pregnancy. WCFH will continue the work group looking at the Medicaid application process for pregnant women and make recommendations to Public Assistance leadership. The WCFH MCH Epidemiology Unit will continue to provide reliable data on maternal and child health issues which are used in planning and evaluating programs, preventing poor health outcomes and guiding public health policy.
Interpretation of data (FY14 & FY15):	2011-2013 Bureau of Vital Statistics data demonstrated that 61.8% of VLBW infants were born at a Level III tertiary care facility. This is a decrease. The number of clients receiving services from Healthy Start quadrupled during this time period. Healthy Start will terminate data reporting to HRSA in July 2016, but will continue to collect, track, evaluate and report their performance measures to their stakeholders going forward.

SPM # 8

Percent 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.)

Previous year's activities, accomplishments, challenges and revisions:	On July 31, 2013 WCFH distributed an Alaska Infant Safe Sleep Toolkit to each birthing facility in the state. Follow up with hospitals found that many tribal facilities used Healthy Native Babies to promote safe sleep. Two large hospitals in Anchorage implemented the toolkits. In January 2014, the Section Chief presented on Alaska's Infant Safe Sleep project at an ASTHO meeting. ASTHO later interviewed Perinatal Nurse Consultants for an article regarding the project. At the Statewide Public Health Nursing conference in April, staff participated in a panel presentation on home visitation in Alaska, and the State of Alaska Maternal Child Health Programs. Our section worked with the Alaska Native Tribal Health Consortium to plan the biennial MCH and Immunization Conference, scheduled for September

	2014, and Healthy Native Babies post-conference training. WCFH continued to administer grants for Healthy Start and the Maternal, Infant, and Early Childhood (MIECHV) home visitation programs, which include infant safe sleep and continued to distribute infant safe sleep resources. A perinatal nurse consultant continued to attend Maternal and Infant Mortality Reviews (MIMR).
Analyses of effectiveness of current program activities:	During the summer of 2014, the Office of Children's Services (OCS) noticed an increase in sleep related deaths among their families. This prompted representatives from several agencies to pull together. Data analysis by our MCH Epi Unit found that 66 infants died a sleep environment from 2012 through 2014. All infant deaths occurred in families receiving public assistance. Sleep position was known for 47 infants, and 21 (45%) were placed in a position other than on their back. Bed-sharing occurred in 47 (67%) of the 66 deaths, and 26 (55%) of the caregivers were under the influence or probably under the influence of alcohol, tobacco, and/or other substances. Law enforcement SUID investigations of 50 infants found blankets, pillows, furs, or soft bedding among half. The case series analysis is available in an Epi Bulletin published in June 2015 (http://www.epi.hss.state.ak.us/bulletins/docs/b2015_13.pdf). ASTHO published the State Story about Alaska's Infant Safe Sleep Project in August. The biennial Maternal Child Health and Immunization conference occurred in Anchorage September 24-25, 2014. Staff presented on home visiting in Alaska; strategies for reducing fetal and infant mortality; and MCH leaders gave a plenary on State of the State. WCFH hosted an Infant Safe Sleep Task Force meeting and recognized hospitals that implemented the hospital safe sleep toolkits, and gave awards at the conference. WCFH supported a post-conference Healthy Native Babies training with 17 attendees. WCFH staff provided several presentations about infant safe sleep and sharing of data, including several interdepartmental meetings, the Child Maltreatment Conference, Neonatal Symposium, statewide webinars for public health nurses, and the Office of Children's Services; staff at hospitals in Ketchikan and Anchorage, as well as WIC staff.

	The MCH Epi Unit surveyed 115 mothers sampled for PRAMS with a supplemental question related to access and use of cribs. Nineteen percent said they don't have a crib. Of these, 55% said they can't afford one, 18% said they don't have space, and 27% had other reasons, such as the baby sleeps with them, or sleeps in another type of bed. The hospital in Ketchikan and a clinic in Fairbanks began baby box projects, which include education. Other facilities are discussing similar projects. WCFH continues to administer Healthy Start and MIECHV grants. The Nurse Family Partnership will expand services in Anchorage and will begin in the Mat-Su Borough by the summer of 2015. WCFH continues to distribute safe sleep resources, and Perinatal Nurse Consultants attend MIMR. Staff attended the annual AMCHP Conference and brought back examples of infant safe sleep approaches. The section worked with tribal MCH leadership to share Alaska sleep related infant mortality data and the Collaborative Improvement and Innovations Network (CoIIN) to Reduce Infant Mortality initiative at Pediatric Grand Rounds and the All Alaska Pediatric Partnership meeting in February. A group is participating in the CoIIN SIDS/SUID/Safe Sleep Learning Network and Online Community with a focus to improve safe sleep practices.
Plan for the coming year:	WCFH will continue work with the CoIIN SIDS/SUID/Safe Sleep Learning Network. Projects include the development of a state fact sheet, work with WIC, OCS, and quality improvement cycles to evaluate the Infant Safe Sleep toolkits. A MCH Epidemiology intern will also conduct evaluation activities related to safe sleep efforts. WCFH will continue with current activities, including participation in MIMR, the provision of trainings, and distribution of safe sleep materials. The Healthy Start grant ends June 30, 2016, while MIECHV will expand Nurse Family Partnership in Anchorage and the Mat-Su Borough.
Interpretation of data (FY14 & FY15):	There was an improvement in this data point from 66.1% in 2011 to 53.8% 2012. There were declines in the percent reporting usually putting their infant to sleep on his/her side or stomach, use of bumper pads, and use of blankets. There was no decline in the percent reporting that their baby usually sleeps with pillows or stuffed toys. The infant mortality in a sleep-environment case series analysis recently published in an Epidemiology Bulletin helped describe the characteristics of

	published in an Epidemiology Bulletin helped describe the characteristics of families that experienced sleep-related deaths. This will help WCFH better target the at-risk population with risk reduction messaging to decrease sleep-related deaths.
Strategies and initiation of new efforts (if adequate progress not achieved):	WCFH anticipates that work with CoIIN will help reduce infant deaths in a sleep environment.
SPM # 10 Percent of early term births at 37 completed weeks of gestation to 38 completed weeks of gestation	
Previous year's activities, accomplishments, challenges and revisions:	The Healthy Start and Maternal, Infant, & Early Childhood Home Visiting (MIECHV) programs provided client education around late preterm birth and near term birth for their clients in the Nome and Anchorage areas. Work on the 39 Weeks initiative remained stalled, for lack of a March Of Dimes (MOD) Director of Program Services. Finally, in late 2014 that position was filled. The largest birthing hospital in Alaska has not adopted a hard stop policy but other hospitals have adopted policies on early elective deliveries.
Analyses of effectiveness of current program activities:	WCFH welcomes the return of leadership from the MOD and will support those efforts. The Healthy Start and MIECHV programs are continuing to provide client education around late preterm birth and near term birth for their program clients in the Nome and Anchorage areas. To replace *Baby and Me*, WCFH staff researched and designed a wallet size Healthy Pregnancy and Beyond card which holds URLs to prenatal and interconceptional health information from March of Dimes, HRSA's Office on Women's Health, Alaska211 resource line and the State Department of Health on Facebook. Once printed, WCFH plans to distribute the cards at no cost to all clinical providers serving preconceptional, prenatal and interconceptional clients. *Healthy Pregnancy and Beyond* cards are being printed and will be distributed at no cost to all clinical providers with preconception, prenatal and interconception clients in their caseloads.

	interconception clients in their caseloads.
Plan for the coming year:	The MIECHV program will continue to provide client education around late preterm birth and near term birth for their program clients in the Anchorage and Mat-Su areas. In July 2016, HRSA Healthy Start funding will end and Healthy Start will continue operations under their sustainability plan. *Healthy Pregnancy and Beyond* cards will be distributed at no cost to all clinical providers with preconception, prenatal and interconception clients in their caseloads. The MCH Epidemiology Unit will continue to administer surveys such as PRAMS and the Childhood Understanding Behaviors Survey (CUBS) along with publishing data on maternal child health topics.
Interpretation of data (FY14 & FY15):	The percentage of early term births decreased in 2013 from the previous year. The Healthy Start and MIECHV programs each have their own performance measures. Data on preterm birth is collected, evaluated and reported to HRSA. Data will continue to be collected, tracked, evaluated and reported to HRSA regularly. The number of clients receiving services from Healthy Start quadrupled during this time period. Healthy Start will terminate data reporting to HRSA in July 2016, but will continue to collect, track, evaluate and report their performance measures to their stakeholders going forward. The MIECHV program in Anchorage reached capacity and then expanded by four home visitors. Pre-term birth data is monitored in monthly continuous quality improvement meeting with the MIECHV contractor, Providence Nurse-Family Partnership

Child Health - Plan for the Application Year

The WCFH leadership team identified the state priority for child health as the need to increase access and preventative health care services to Alaskans and their families. The needs assessment identified major issues for children, especially preschool and school age, including age appropriate physical growth, cognitive and socioemotional development and school readiness. The effects of poor health in childhood can last until adulthood. Screening for physical, developmental and behavioral health conditions is a foundational activity for all children and should occur according to the recommended periodicity schedule developed by the American Academy of Pediatrics in their Bright Futures document.

The three child health objectives are to 1) increase the percentage of children enrolled in Medicaid who receive a well child exam and developmental screen at 9, 18 and 30 months of age using the Bright Future Periodicity Schedule; 2) Increase the number of children ages 5-8 enrolled in Medicaid who receive an annual well child visit; 3) Increase the number of children 1-3 years of age who have an annual dental health visit. The related NPM is percent of children ages 9 through 71 months receiving a developmental screening using a parent-completed screening tool (NPM#6). During 2011-2012, 33% of Alaska parents reported that their child had received this screen, compared to 30.8% nationally (NSCH). However, only 77% of Alaska parents reported that their child had received a preventative health visit in the last year and 72% received a preventative dental health visit. This compares with the national data of 84.4% and 77% respectively. Finally, 37% of children were identified by their parents as needing mental health services, but they did not get them.

The child health strategies will be to educate all parents on the importance of regular preventative health screens and the inclusion of evidenced based developmental screens. WCFH will partner with the ECCS and Pediatric Medical Home program to promote the use of the online Ages and Stages Developmental Screening tool that is available statewide and linked with the Early Intervention/Infant learning program. Support of the Pediatric Medical Home Chapter Champion to promote medical home concepts and certification along with the use of Bright Futures will be an ongoing activity. Finally, WCFH will continue to promote and educate parents on the importance of oral health screens and prevention of dental decay.

Currently work to promote preventative health screens and developmental screening is occurring on a number of fronts. WCFH staff members are already working with the ECCS program manager to promote the use of the Ages and Stages on line tool. Upon completion of the tool in health care practices, the information about children who are delayed or of concern is transmitted to the central Early Intervention office and this information is then shared with the regional early intervention offices that are located throughout the state. This helps to link the local early intervention office with the local health care provider with the goal of streamlining the referral process if a child needs more in depth screening and assessment.

In addition, the D-70 program manager is working closely with the Pediatric chapter champion, Dr. Thad Woodard, and the Alaska Primary Care Association to assist other clinical practices to achieve their medical home certification. As a part of this process, Dr. Woodard speaks about the importance of developing systems to promote and track well child visits in a medical home practice. The D-70 grant is also working with other partners to develop a 'shared resource' that will be a comprehensive approach to support the delivery of services. Help Me Grow is the trademarked program that will be developed as a large pilot to serve in this capacity. The WCFH School Nurse Consultant works with schools across the state regardless if they have a school nurse or not, to promote the importance of well child visits on an annual basis for children who are in preschool or are school aged. Finally, the Oral Health program actively links interested Title One schools with dental health providers who are willing to perform dental sealants in the school, and continues to work with communities on water fluoridation and dental health access issues.

Child Health - Annual Report

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

Annual Objectives

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

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

Annual Objectives

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

NPM #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.

Previous year's activities, accomplishments, challenges and revisions:	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. WCFH promoted a Bright Futures prenatal visit with health care providers for the baby to promote infant immunizations through discussions, presentations and meetings. 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. 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 and monitor vaccine coverage data of infants in the program. WCFH surveyed health care providers regarding the prenatal pediatric preventive

	WCFH surveyed 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. Collective Impact sessions at the annual A2P2 pediatric conference resulted in the "First 1,000 Days" campaign to promote early childhood health. A Healthy Alaskans 2020 (HA2020) work group developed actions for the immunization indicator. Interagency and section work groups continue to address immunizations. The IZ Program provided professional development on IZ Updates (which included school nurse VacTrAK module) at the 2014 Alaska School Nurses Association conference. The State held focus groups with vaccine hesitant parents to test vaccine messaging. It was determined that best strategy would be to provide vaccine information about over internet sites. DPH is working with A2P2 to make short vignettes with pediatric providers that provide factual information about vaccines. Media campaigns such as such as radio PSAs, an annual Iditarod immunization campaign, and National Infant Immunization Week (NIIW) occurred. Social media campaigns targeted influenza vaccination for children, adolescents, and adults.
Analyses of effectiveness of <u>current</u> program activities:	WCFH screens the immunization status of children attending specialty clinics and informs parents and providers of needed vaccines. 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 statewide Alaska MCH and Immunization conference, "Advancing Wellness across the Lifespan," was held September 2014 in Anchorage. A subcommittee planned 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) held its annual membership meeting during the conference. Alaska has launched a year-long campaign to convey vaccine messaging. The State DPH works in collaboration with A2P2 to develop messaging and videos to post online. Nurse Consultants in WCFH and Epidemiology 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. The first birthing facility in Alaska has been named to the Immunization Action Coalition's Hep B Birth Dose Honor Roll Joint Base Elmendorf Richardson (JBER). WCFH surveyed health care providers regarding the prenatal pediatric preventive visit as indicated on the Bright Futures Periodicity Schedule; results were analyzed this year. Of the 7 providers that responded to the survey 100% were providing information about infant vaccines. Nurse consultants continue to educate PHN's about immunizations, immunization outreach, updating immunization medical directives, and updating immunization logic models. The WCFH School Health Nurse Consultant invited the Alaska Immunization Program Training and Education Manager to speak to the School Health Nurse Advisory Committee meeting in April on HPV immunizations. Materials from a HPV campaign through a CDC grant to the State of Alaska Immunization Program were promoted and information disseminated through this committee to school districts with school nursing services. The consultant also facilitated a speaker from the Immunization Program for a session on HPV immunizations at the Alaska School Nurses Association conference in April. Another session at the conference included a presentation on measles. A consultant arranged a webinar on skin rashes presented in March by an infection preventionist that was attended by over 30 school and public health nurses. The Back to School webpage was promoted statewide for school districts to link to in the registration information sections of their websites.
Plan for the <u>coming year</u>:	The A2P2 will continue the *First 1,000 Days Campaign* with work groups focusing on immunizations and the medical home. HA2020 will track progress related to identified actions and expected outcomes. Interagency immunization work groups will continue to meet. 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. WCFH will continue to integrate the importance of newborn and infant vaccines into our existing programs such as home visiting and the pediatric specialty clinics

	The WCFH MCH Epi Unit will conduct the annual CUBS survey, with revisions implemented in 2015 to the questions about immunizations to gather additional data on barriers to on-time vaccines. WCFH will continue to promote immunizations and well child visits within the context of the medical home, and with programs and groups serving children. DPH will continue work with A2P2 to make short "Ask Us" vignettes that provide factual information to parents about vaccines from a non- governmental, non- biased agency. The Alaska Immunization Program, (AIP), along with participants from WCFH, is participating in a workgroup for HPV campaign materials for the 2014 PPHF HPV Immunization Grant awarded to AIP. Part of the work involves "Alaskanizing" CDC materials for targeted populations and promoting the materials to school nurses.
Interpretation of data (FY14 & FY15):	The percentage of children who received this full schedule increased in CY13.
Strategies and initiation of new efforts (if adequate progress not achieved):	The MIECHV Nurse-Family Partnership program will continue to promote immunizations. New staff will receive training on immunizations and vaccine hesitancy. WCFH is working to allow home visitors access to VacTrAK. WCFH will implement new processes in the specialty clinics to ensure parents and providers are aware of the child's IZ status. The AIP is developing messaging, informational brochures, and posters to promote HPV vaccination in adolescents.
NPM #9 Percent of third grade children who have received protective sealants on at least one permanent molar tooth.	
Previous year's activities, accomplishments, challenges and revisions:	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 dental preventive and enhanced restorative services for enrolled adults (includes coverage for pregnant women). The OHP collaborated with three community health center dental programs on the dental sealant pilot programs at four elementary discussed in previous year reports (schools have more than 50% of

	children are eligible for the free and reduced school lunch program). 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 and clinical aspects (e.g., periodontics and denture construction).
Analyses of effectiveness of current program activities:	In FY15, 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 target low-income children. Dental workshops are to be conducted in May 2015 for CHC/Tribal dental staff. The OHP in collaboration with the oral health coalition continues to work on implementation of recommendations in the state oral health plan - priority recommendations include: 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 in dental office settings (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 Dental Clinic manager in Kotzebue in September 2014 with requests for information from the Tribal council and to the City Manager in Sitka in December 2014. Both of these fluoridation education efforts were in response to local official contacts by individuals opposed to community water fluoridation. The Dental Officer (DO) convened a dental advisory group for input on adopting the Medicaid EPSDT dental periodicity schedule and sent recommendations to the Medicaid staff in November 2014 – adoption of the dental periodicity schedule is anticipated by the end of this year. Adoption of the age one dental visit for EPSDT was included in a Medicaid regulation project and should also be adopted b the end of the year.
Plan for the coming year:	The OHP will continue working with Medicaid to address private dental issues with the program to encourage broader dental participation and will work with other department staff in implementing a Medicaid expansion under the Affordable Care Act if authorized by the legislature in the 2015 legislative session. The OHP and Medicaid will assess progress on the Medicaid Dental Action Plan aimed at increasing child utilization of preventive dental services and increased use of dental

	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 be working with CHC dental programs to encourage the Medicaid program to provide for Medicaid reimbursement for school-based dental services in order to transition the sealant pilot programs off grant funding and into billing Medicaid for the project sustainability. 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.
Interpretation of data (FY14 & FY15):	The sealant utilization for the 2010/2011 Basic Screening Survey (BSS) was 46.8% (down from 55.3% in the 2007 BSS and the 2004 BSS at 52.4%). 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.
NPM #10 The rate of deaths to children aged 14 years and younger caused by motor vehicle.	
Previous year's activities, accomplishments, challenges and revisions:	Alaska's Injury Prevention (IP) program, located in the Division of Public Health's Section of Chronic Disease Prevention and Health Promotion provided primary leadership on activities around the prevention of deaths to children caused by motor vehicle, while WCFH had a partnership role. For more discussion of these activities, see Other Programmatic Activities.
Analyses of effectiveness of current program	See Other Programmatic Activities for analysis of work conducted by the Injury Prevention program.

activities:	The MIMR-CDR program managed by WCFH continues to review all child deaths under age 14, including those caused by motor vehicles. An annual report describing reviews to infant deaths that occurred 2008-2012 was published in June 2015.
Plan for the coming year:	See Other Programmatic Activities for work conducted by the Injury Prevention program. MIMR-CDR plans to continue to review all child deaths under age 14, including those caused by motor vehicles, and will work on improving recommendations to prevent deaths so that they are more actionable and targeted towards appropriate audiences. An annual report describing findings of child death reviews for children ages 1-14 will be published in FY16.
Interpretation of data (FY14 & FY15):	The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children has significantly declined from 9.3 in 1993-1995 to 2.5 in 2011-2013. During this most recent 3 year time period, there were only 12 deaths in this category. According to the Children's Safety Network, child safety seat laws have reduced fatal injuries nationally to children by 35%. In 2009 the Alaska State legislature passed new legislation requiring the use of booster seats for young children and clarified the use of child passenger restraints based on the national standards. This law makes information provided to the public more easily understood and assists law enforcement with enforcing the laws. The challenge remains that there are many motor vehicle deaths in the rural parts of the state where child passenger safety seats are not used due to alternative methods of travel such as four wheelers and snow machines, which are used both for recreational and utilitarian purposes. There is no "recommended" method of securing or carrying young children on these types of vehicles, yet in some areas of the state these are the routine methods of transportation and it is commonplace for parents to allow young children to drive these types of vehicles. In 2011, CUBS data indicated that 25% of 3-year-olds rode on an ATV (four-wheeler) or snow mobile, including being pulled behind one in a sled or trailer, in the past week. (CUBS stopped asking this question in 2012.)

NPM #13

Percentage of children without insurance

Previous year's activities,	The Department received its fifth CHIPRA performance bonus payment in the amount of nearly $2,500,000, after adjustments, for meeting both enrollment targets

accomplishments, challenges and revisions	and streamlining and simplifying its eligibility policies. The Title V Care Coordination grant worked collaboratively with the Health Planning and Systems Development (HPSD) Section in DPH under their CHIPRA T-CHIC grant with OR and WV to address children's care coordination in AK primary care practices. In early FFY 14, the T-CHIC project coordinator and HPSD assisted in planning a session to address children's care coordination in AK primary care practices. The T-CHIC project coordinator and HPSD also assisted in planning a session related to navigating primary care practice redesign of the Alaska Rural Health Conference. WCFH worked with the University of Alaska Anchorage to establish a care coordination curriculum. The WCFH Care Coordination Program Manager also presented along with the Executive Director of the All Alaska Pediatric Partnership (AAPP) on new developments related to patient centered models of care. WCFH CSHCN staff coordinated with Medicaid/CHIP staff to assure both programs met requirements for outreach and education around EPSDT services and Medicaid coverage. Continued work was done on developmental screening policy under EPSDT to support reliable measurement of the developmental screening children's measure. The Medicaid Agency approved the developmental screening policy which helped the Department identify when a standardized developmental screening tool had been used and helped Medicaid improve its measurement processes and meaningful use of the data collected: however, in FFY 14 was not able to fully implement due to the implementation in first quarter FFY 14 of their new Enterprise Medicaid Management Information System (MMIS) and the system issues encountered/defects which are still ongoing. The developmental screening metric is a core CHIPRA children's quality metric to meet NQF standards and to support ABCD efforts. Title V, Medicaid/CHIP, and others continued work with the Oregon Pediatric Improvement Partnership (OPIP) at OHSU through our T-CHIC project to implement the policies and procedures to collect and measure data related to the CHIPRA core children's quality measures and to conduct process improvement activities and learning collaboratives with the WCFH care coordination grantees and the T-CHIC CHIPRA grantees.
Analyses of effectiveness of current program activities:	WCFH received another HRSA pediatric medical home care coordination grant in FFY 15 and the T-CHIC CHIPRA AK pilot projects have continued their collaborative work through a CMS no cost extension (NCE) through August 2015 on care coordination begun in 2012. We will be holding one or more learning collaborative meetings with pediatric practices, CHCs and a Tribal Health System to

collaborative meetings with pediatric practices, CHCs and a Tribal Health System to focus on Alaska Medical Homes: Delivering Patient Centered Care which will include an overview on understanding a learning collaborative, patient's experience of care, patient engagement, self-management, shared decision making, connecting communities, behavioral health integration and trauma informed care. We will be utilizing the results from the administration of the CAHPS PCMH C&G survey with these practices to begin to collaborate on QI using these survey results. The CAHPS is currently one of the children's core quality measures, and can be used in the NCQA PCMH recognition process. This learning collaborative is being done in collaboration with Title V, the Alaska Primary Care Association – PCMH Initiative and Medicaid/CHIP so we can begin to standardize the CAHPS PCMH work with CHCs across the state and pediatric practices. It is hoped that the lessons learned by the Title V care coordination grant funding and the continued T-CHIC work will be utilized especially with regard to identification of children and youth with special health care needs through the Child and Adolescent Health Measurement Initiative (CAHMI) screener which utilizes the MCH definition of children with special health care needs. The TCHIC staff made some headway by meeting with the section in the Medicaid Agency that is participating in a National Governors' Association (NGA)/National Academy of State Health Policy (NASHP) collaboration on work with super utilizers, called the Alaska Medicaid Coordinated Care Initiative (AMCCI) by informing them of the CAHMI screening tool used to identify C&YSHCNs; however, the Medicaid section overseeing this NGA project chose not to utilize this MCH recommended screener for identification of chronic conditions and special health care needs. TCHIC also encouraged the AMCCI to take part in the fall 2014 CAHPS PCMH survey with the Medicaid agency (CHIP portion of Medicaid is required to do the CAHPS and participated with the practices above as a "pseudo" practice to meet the CHIPRA state agency survey requirements related to CAHPS) to obtain baseline patient experience of care information for these high utilizers of Medicaid services; however, we were unable to obtain buy in from the AMCCI team.

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. In addition Title V, ILP, ECCS and Medicaid/CHIP will continue to work with CAHMI through our T-CHIC project to implement the policies and procedures necessary to effectively collect and measure the CHIPRA core children's quality measures, including the CAHPS PCMH survey

	and the child developmental screening measure, at both the state and practice levels. MCH Title V/CYSHCN will continue to do an additional distribution of Bright Future's guidebooks and ASQ tool kits to interested providers and ECCS and Department stakeholders continue to collaborate on enhancement and implementation of this statewide work. Title V dollars 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. Reproductive health services for young women and teens will be provided using Title V dollars. While some Medicaid reimbursement is available, it covers only part of the costs of these services.
Plan for the coming year:	Title V and Medicaid/CHIP/EPSDT section of the Medicaid Agency will continue to work on informing providers on the status of the backlog of applications and renewals as this relates to children and pregnant women enrolled in DenaliCare (Medicaid) and the children enrolled in Denali KidCare (CHIP) as the priority for this measure is to reduce the number of uninsured children. The Division of Health Care Services has encountered defects in its new Medicaid Management Information System (MMIS) which was implemented in October 2013 and is working to ensure timely provider payments for Medicaid and CHIP claims. In addition, the Division of Public Assistance (DPA) began to transition applicants and renewals to the new ARIES eligibility system in August. At the time of writing, the old Legacy system is still running alongside. The DPA hopes to connect to the Health Insurance Marketplace shortly to ensure electronic transmission of files between the HIM and ARIES. The difficulties experienced with both new systems has resulted in a decline and delays in Medicaid/CHIP eligibility and enrollment, so the collaboration between Title V, Medicaid and outside stakeholders is critical as we work toward reducing the eligibility backlog.
Interpretation of data (FY14 & FY15):	Children's enrollment data showed a 7% decline overall in enrollment between FFY 13 and 14. According to the Current Population Survey (CPS), the rate of uninsured children under age 19 below 200 percent of poverty as a percent of total children under age 19 was 3.8 in 2013, around a 20% decrease since 1996-1998.

NPM #14

Percentage of children, ages 2 to 5 years, receiving WIC services with Body Mass Index (BMI) at or

above the 85th percentile. (At or above the 95th percentile for Alaska.)	
Previous year's activities, accomplishments, challenges and revisions:	Alaska adopted 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. 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 "*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. Changes to the WIC food package continued to help WIC families eat more nutritious meals regularly while fostering a life-long consumption of healthy foods. In SFY 2014, WIC once again offered Farmers' Market coupons to purchase produce grown locally in various parts of the state. In FFY 14, the program served 5,965 participants. WIC Vendors across the state were monitored to assure a variety of healthy WIC foods and produce were made available in remote areas. 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. Breastfeeding posters were developed targeting duration rates of Alaska Native breastfeeding women. Posters are available to state partners and posted on a national web site for use in national breastfeeding campaigns.
Analyses of	WIC implemented changes to the food package to support goals of obesity

effectiveness of current program activities:	prevention and reduction. 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 BFPC online training is updated to provide a quality training mechanism for our BFPC program. The WIC program received targeted funds to implement three projects related to breastfeeding and nutrition education, including updates to a breastfeeding room to support expansion of breastfeeding services in the Bethel WIC office, additional breastfeeding training for staff in Southeast Alaska, and funds to develop nutrition education materials. The education materials will assist local agencies in discussing and promoting nutrient dense Alaskan foods such as salmon and other fish; moose; caribou; sea mammals; berries and greens. Breastfeeding posters in development are targeted at increasing initiation rates of Hmong women. Posters will be available to state partners and posted on a national web site for use in national campaigns.
Plan for the coming year:	The State WIC Breastfeeding Coordinator/IBCLC 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 WCFH staff. Alaska WIC local agency grantees will continue to infuse the goal of reducing the prevalence of overweight and obesity in their nutrition education and service plans. Participant-centered education will be used to engage participants in setting their own nutritional goals and encouraging them to incorporate WIC foods into daily meals. Local WIC agencies will continue efforts focusing on breastfeeding promotion and support. They will continue to support client's breastfeeding goals and empowering women to advocate for their right to have time and a private space to pump breastmilk in the workplace environment.
Interpretation of data (FY14 & FY15):	Alaska's WIC program rates for obese children increased from 21.5% in 2013 to 24% in 2014.

SPM #3 Percent of mothers who report tooth decay in their 3-year old children.	
Previous year's activities, accomplishments, challenges and revisions:	The 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 for Anchorage Assembly meetings – September 2013 the Anchorage Assembly voted to support continued fluoridation of that community's public water supply.
Analyses of effectiveness of current program 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). Education activities provided to community partners on water fluoridation in SFY2014 included: provision of educational information to the Tribal council in Kotzebue (September 2014) and city manager in Sitka (December 2014). Both of these communities have retained community water fluoridation. The OHP convened an advisory group in the fall of 2014 to develop a dental periodicity schedule and forwarded recommendation to Medicaid staff in November 2014. The periodicity schedule should be adopted before the end of this fiscal year. Additionally, regulations are in process to adopt the age one dental visit for children enrolled in Medicaid (EPSDT guidelines) with provisions for earlier dental visits as medically necessary. The OHP presents/discusses the need for early dental visits with pediatric dentists/Tribal dental programs to reduce the prevalence/severity of ECC in Alaska. The OHP, with HRSA funding support, 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

	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.
Plan 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 to other schools with high percentages of students from low-income families. The program will continue to assist in providing information for workshops for medical providers to address caries risk assessment and early childhood caries (ECC) prevention. 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 ECC caries in Alaskan children.
Interpretation of data (FY14 & FY15):	The indicator is from the Childhood Understanding Behaviors Survey (CUBS) for mothers reporting a health care provider has indicated their child has tooth decay or cavities (for 3-year old children). CUBS data from 2013 indicated 16.5% of mothers reported they had been told by a health care provider that their 3-year old had dental decay – as compared with 16.2% in 2012, 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/exam and/or the mother may not remember what the child's health care provider indicated with respect to dental decay. However, it is likely part of the increase seen with 2011-2013 CUBS data is related to reported increases in the percent of children receiving a dental check-up or teeth cleaning (57.0% in 2013, 55.2% in 2012 and 53.8% in 2011 as compared with 42.8% 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 caries experience (treated or untreated dental decay) in 2005; 41% had caries experience in the 2007 BSS; and 41% with the 2010/2011 BSS.

SPM#9	
Percentage of mothers who report their 3-year-old child had a BMI greater than the 85th percentile (overweight and obese).	
Previous year's activities, accomplishments, challenges and revisions:	See Other Programmatic Activities for activities conducted by the Obesity Prevention Program in the Section of Chronic Disease and Health Promotion. WCFH collaborates with and advises the Obesity Prevention program and provides data from CUBS to inform their work.
Analyses of effectiveness of current program activities:	See Other Programmatic Activities for analysis of work conducted by the Obesity Prevention program.
Plan for the coming year:	See Other Programmatic Activities for work conducted by the Obesity Prevention program.
Interpretation of data (FY14 & FY15):	This indicator has declined from 41.2% in 2008 to 36.6% in 2013. It is unknown what may have caused the increase in 2012 to 43.4% (the highest of all years of data available). During all years, overweight and obesity was more common among Alaska Native 3-year-olds compared to White 3-year-olds. The higher prevalence of obesity in Alaska Native children may be explained by differences in lifestyle patterns and food consumption in certain parts of the state, specifically the Northern/Southwest region, which has higher consumption of energy dense beverages (Wojcicki JM et al, *Risk Factors for Obesity at Age 3 in Alaskan Children, Including the Role of Beverage Consumption: Results from Alaska PRAMS 2005-2006 and Its Three-Year Follow-Up Survey, CUBS, 2008-2009*. PLos ONE March 2015).

Adolescent Health - Plan for the Application Year

The state priority need for adolescent health is to increase healthy relationships. The adolescent objectives are to 1) decrease the percentage of students who had been physically hurt on purpose by someone they were dating or going out with one or more times during the past 12 months, 2) decrease the percentage of students who report that they would not feel comfortable seeking help from at least one adult besides their parents if they had an important question affecting their life, and 3) decrease the percentage of students who had been bullied on school property during the past 12 months (2019 YRBS data). The adolescent strategies are to 1) promote and disseminate evidence-based healthy relationship programming, 2) increase program implementation that uses a positive youth development framework, and 3) provide expertise on healthy relationship risk and protective factors. These relate to the population's state priority needs by specifically addressing 1) unhealthy relationships, 2) issues related to reproductive health, such as reproductive coercion and intimate partner violence, 3) child maltreatment, including peer to peer maltreatment, and 4) behavioral and mental health problems, including alcohol and drug use, depression, self-harm, and suicide.

Currently the adolescent health program is addressing the priorities identified in the needs assessment summary (unhealthy relationships, child maltreatment, mental and behavioral health) by supporting evidence-based programing. Grant funds are being used to launch and support primary prevention of sexual assault interventions, specifically Green Dot and Bringing in the Bystander. Schools across Alaska have adopted the Fourth R for Healthy Youth Relationships strategies to teach sexual health, substance abuse prevention, suicide prevention, and bullying prevention. Alaska Promoting Health Among Teens, Positive Prevention, Healthy Relationships Plus are being implemented in and out of schools in communities across the State. Additionally, Alaska grown evidence-informed interventions, such as Talk Now Talk Often, Stand Up Speak Up, COMPASS: A Guide for Men, and patient safety cards and clinical screening tools are supported by the adolescent health program to offer tailored education to parents, clinicians, youth, and young men. The adolescent health program works with a positive youth development philosophy and supports the *Lead On! for Peace and Equality* a youth leadership conference. Likewise, the adolescent health program supports the Youth Alliance for Healthier Alaskans, a group of young adults from across the state who advise public health programming.

The current national performance measure is NPM#9, the percent of adolescents, ages 12-17 years, who are bullied is measured by the annual Alaska Youth Risk Behavior Survey (YRBS). The trend from 2009, when the bullying questions were added to the YRBS, has not changed and currently 27% of students report being bullied. In 2013 there was no statistically significant difference between alternative and traditional schools when looking at bullying on school property or electronic bullying in the past 12 months. As well, U.S. and Alaska students report equal risk of being bullied on school property. The adolescent health program plans to improve performance by including social and emotional learning aspects into our work. We will continue to provide the previously mentioned evidenced-based programing to improve healthy relationships. We will work closely with partners across the state including the Department of Education and Early Development, the Council on Domestic Violence and Sexual Assault (DVSA), and the Alaska Network on DVSA. In 2015, staff will present at the DVSA Prevention Summit on adolescent health and resiliency. Staff will attend Youth Mental Health First Aid instructor certification training with the intent to offer technical assistance to teachers implementing the Fourth R curriculum. Staff will serve on the Statewide Steering Committee for DVSA Prevention, the School Health Collaborative Workgroup, the Division of Public Health Marijuana Workgroup, the Alaska Health Education Library Project, the Alaska Committee to Prevent Underage Drinking, the HPV Vaccination Joint Initiative Workgroup, and plan the School Health and Wellness Conference and the Alaskan Public Health Association's annual Health Summit. Staff is working with other state prevention partners to draft an informative whitepaper on violence prevention efforts for stakeholders and legislators. Staff will continue to support the use of long acting reversible contraception for adolescents and work closely with school and public health nurses to identify and implement evidence-informed sexual health curriculum in schools across Alaska. In 2016, adolescent health staff will expand healthy relationship programming to high risk youth in the foster care system and juvenile justice detention centers.

Adolescent Health - Annual Report

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

Annual Objectives

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

NPM #8:

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

Previous year's activities, accomplishments, challenges and revisions:

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 FY14, 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 resources and trainings on long-acting reversible contraception.

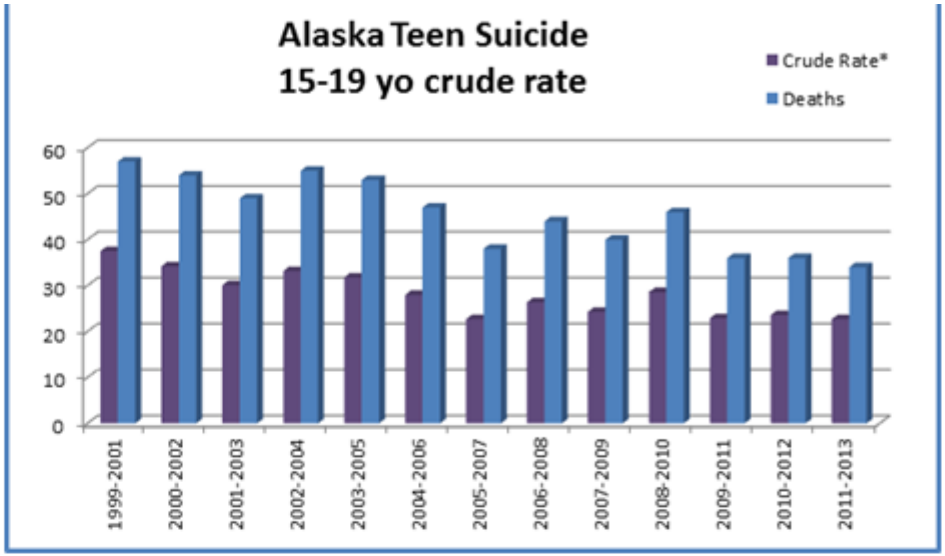
The Adolescent Health Program (AHP) targeted the issues of teen pregnancy and unhealthy relationships by promoting healthy relationships in Alaska's teens. The AHP provided administrative support for three grants to communities aimed at involving youth in the prevention of teen pregnancy and unhealthy relationships.

The AHP managed two federal teen pregnancy prevention grants, both 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. 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 contraception, 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. A limited supply of long-acting reversible contraceptives was provided to young women in 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.
Analyses of effectiveness of <u>current</u> program activities:	Most FY14 projects are continuing during FY15. 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 offer comprehensive sexuality education and counseling 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. The Healthy Start perinatal nurse consultant continues to collaborate with Norton

	Sound Health Corporation, Healthy Start staff and the Healthy Start perinatal nurse consultant continues to collaborate with Norton Sound Health Corporation, Healthy Start staff and Kawerak tribal leaders from the Nome Bering Straits area in order to address their concerns about teen pregnancy, especially rapid repeated teen pregnancy. Part of this effort included use of Healthy Start funds to support one practitioner to participate in skill-based clinical training in effective contraceptive care. Competing demands of the state's perinatal programs hampered the nurse consultant's efforts to further collaboration with the Nome regional Division of Public Assistance to address motivational interviewing facilitating referrals of young female clients at risk of rapid repeat pregnancy.
Plan for the coming year:	In FY16, Title V will continue to fund nurse practitioners to provide comprehensive reproductive health services, including comprehensive education and counseling, to women ≤ 21 years old being seen at the Kodiak Public Health Center (PHC) and the Juneau High School Teen Health Centers. The Women's Health nurse consultants also will continue to work with Public Health Nursing and the Community Health Centers in both communities to assure an adequate referral and follow-up system among all providers in meeting the reproductive health and primary care (medical home) needs of the young women served. 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 as a core part of their service delivery. The Perinatal nurse consultant will continue to work to further collaboration between the Nome regional Division of Public Assistance and the Norton Sound Healthy Start Program. Healthy Start has set aside funding to cover the cost of one practitioner to participate in skill-based clinical training in effective contraceptive care. Healthy Start is working to develop standardized care plans that include planning for contraceptive care in the immediate post-partum and desired 24 month interconception time frames. All Adolescent Health FY 15 projects will continue in FY16.
Interpretation of data (FY14 & FY15):	In 2013, Alaska had a teen birth rate of 29.7 births per 1,000 young women aged 15-19, which is slightly above the national teen birth rate of 26.6 births per 1,000 young women aged 15-19. In 2013 Alaska reported substantial geographic

	variation in adolescent childbearing with teen birth rates at 65.3 births per 1,000 young women aged 15-19 in the northern region and 59.9 births per 1,000 young women aged 15-19 in the southwest region. Overall, Alaska's teen birth rate is lower than the Healthy People 2020 target of 36.2 per 1,000. Alaska's teenage birth rate had declined since 2007. Teen birth rate declines are credited to widespread education campaigns, increased access to contraception, and delayed sexual début.
Strategies and initiation of new efforts (if adequate progress not achieved):	The AHP will continue to address disparities by applying for competitive funds issued by the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Health, Office of Adolescent Health (OAH), titled, "Replicating Evidence-Based Teen Pregnancy Prevention Programs to Scale in Communities with the Greatest Need." As well, the AHP will issue two new three-year competitive community grants to agencies in Alaska for teen and unintended pregnancy prevention activities.
NPM #16: The rate (per 100,000) of suicide deaths among youths ages 15 through 19	
Previous year's activities, accomplishments, challenges and revisions:	The Division of Behavioral Health's (DBH) Comprehensive Behavioral Health Prevention & Early Intervention Services (CBHPEIS) Program provided primary leadership on suicide prevention activities, while WCFH had a partnership role. For more discussion of these activities, see Other Programmatic Activities. The Adolescent Health Program in WCFH shared suicide prevention materials with their program participants.
Analyses of effectiveness of current program activities:	See Other Programmatic Activities.
Plan for the coming year:	See Other Programmatic Activities.
Interpretation of data (FY14 & FY15):	Teen suicide had slowed in 2010 but continues to be significantly lower than the previous decade at 22.7 per 100,000 between 2011-2013.



Crude rates are the number of deaths per 100,000. Bureau of Vital Statistics. Last updated 3/9/2015.

Strategies and initiation of new efforts (if adequate progress not achieved):	It is anticipated that in the Spring of 2015, SAMHSA will announce a new round of Garrett Lee Smith Youth Suicide Prevention cooperative agreements. The Division will be eligible to apply and will begin to reassess current strategies, goals and outcomes to determine how the Division can maximize its efforts in suicide prevention. In order to do this, it is expected that the Division will need to gather all of its partners to conduct a thorough analysis using data and other information gathered from a variety health sectors in which suicide prevention plays a key role. In addition to partnering on prevention work with the Adolescent Health Program in WCFH, DBH will partner with WCFH's Maternal Infant Mortality Review and Child Death Review Program (MIMR-CDR) and the Medical Examiner's Office on coordinating comprehensive reviews of all teen suicide deaths.

SPM #5:

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

Previous year's activities, accomplishments, challenges and revisions:	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 consistently collaborated and planned future work. The AHP helped plan and sponsor a statewide youth leadership event entitled, Lead On! For Peace and Equality. The event focused on teaching youth methods for community engagement to prevent dating violence. The AHP collaborated with non-profit and State agencies to continue funding the multi-media Stand Up, Speak Up campaign aimed at reducing unhealthy relationships in teens and increasing youth leadership throughout the state. AHP supported the development of a male healthy relationships curriculum and training called COMPASS. AHP supported the development and dissemination of parent conversation tools, called Talk Now Talk Often, designed to facilitate discussions around healthy relationships and violence reduction. The AHP is managing a federal PREP grant using The Fourth R curriculum, which focuses on establishing healthy relationships as a way to reduce substance abuse, violence and teen pregnancy. Training was held in October, where 27 teachers were to implement the Fourth R curriculum in their classrooms. 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.
Analyses of effectiveness of current program activities:	All AHP projects started in FY14 continued into FY15. The AHP manager served on various committees working to address intimate partner violence among young adults including the Council on Domestic Violence and Sexual Assault (DVSA) Data Committee, DVSA Training and Infrastructure Committee, K-5 Social Emotional Learning Curriculum Workgroup, and Statewide Agency DVSA Prevention Committee. The AHP team presented at the Statewide DVSA Prevention Conference in March 2015 regarding the teen dating violence

	and youth resiliency. In February 2014, the AHP received the Rape Prevention Education (RPE) Program grant from the Centers for Disease Prevention and Control for the primary prevention of sexual assault. The work of this grant addresses intimate partner violence among young adults and healthy relationships by implementing the Green Dot intervention in the Fairbanks community and at the University of Alaska Fairbanks. As well, 53 school counselors were trained in the Healthy Relationships Plus curriculum and funds supported the Statewide Domestic Violence and Sexual Assault Prevention Summit to support primary prevention of sexual assault prevention activities in rural communities.
Plan for the coming year:	Most projects from FY15 will continue through FY16. One noted change will be that RPE grant funds will move to support a sexual assault intervention called Bringing in the Bystander at the University of Alaska Anchorage.
Interpretation of data (FY14 & FY15):	The majority of Alaskan youth are in healthy relationships, but in 2013 14.7% of alternative high school students and 9.1% of traditional high school students reported being physically hurt on purpose by someone they were dating or going out with one or more times in the last 12 months (Alaska Youth Risk Behavior Survey). This data is similar to the national reported rate of teen dating violence and not statistically different from the 2009 Alaska data.
Strategies and initiation of new efforts (if adequate progress not achieved):	Additional efforts will be made at the university level to reduce teen dating violence.

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

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

This goal to increase the proportion of children (with and without special health care needs) receiving care in a medical home is consistent with identified priorities and goals in past needs assessments as well as current efforts related to systems integration and PCMH development led by Title V. Three primary strategies will be employed including, 1) Assess the CYSHCN systems of care to integrate families and create a state plan, 2) Develop a shared resource for families and primary care providers of CYSHCN using the "Help Me Grow" centralized system model, and 3) Expand provider access to medical home concepts and tools through education and statewide technical assistance. These strategies are consistent with current activities already underway and supported by HRSA "Systems Integration for CYSHCN" funding and ongoing state efforts.

Children with Special Health Care Needs - Annual Report

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

Annual Objectives

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

NPM #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.

Previous year's activities, accomplishments, challenges and revisions:	Family partnership is a cornerstone of Alaska's Title V CYSHCN programs. Each program with an advisory council strives to ensure accessibility and family involvement on all levels. Close partnership and contracted services with the state's Family to Family Health Information Center and Family Voices Chapter, Stone Soup Group (SSG) ensures ongoing representation and family

	involvement on the MCH policy level as well as individual family representation on committees and strategic planning teams, such as the Pediatric Medical Home and Systems Integration Program (HRSA "D70" Grant). The Statewide Family Advisory Committee (SFAC) was, upon mutual agreement of the hosting agencies, dissolved in FY14 due to difficulties convening families via teleconference. A parent navigator from SSG also worked on the Medicaid Eligibility workgroup (led by WCFH) looking to improve the Medicaid application process for pregnant women and CYSHCN.
Plan for the coming year:	To replace the state-wide reach of the disbanded SFAC and ensure a high level of diverse family representation in Title V programs, WCFH is engaged with the Stone Soup Group to recruit family members from a recent parent training program. This family advocacy training program was piloted in 2014-2015 in partnership with Stone Soup Group and the University of Alaska's Center for Human Development (Alaska's University Center for Excellence in Developmental Disabilities). Additional planned activities include the MIECHV program recruitment for family participation in a Medicaid eligibility workgroup, as well as development of a new Hands and Voices Alaska Chapter in collaboration with the state Early Hearing Detection and Intervention (EHDI) program and Stone Soup Group. The Newborn Metabolic Screening (NBMS) program will hold the annual PKU family event in August 2015. The new WCFH Family Delegate will continue to work with AMCHP.
Interpretation of data (FY14 & FY15):	There is no new data on this indicator to report. The most recent National Survey of Children with Special Healthcare Needs was in 2009-2010 when the prevalence for this indicator was 66.8%. In FY14, the CLP clinic reported that 92% of parent completed satisfaction surveys stated that they either strongly agree or agree that the clinic met their expectations. The percentage was 86% during FY15. FY15 reporting numbers are lower than FY14 due to staff turnover As a part of the Western States Genetics Services Collaborative (WSGSC) evaluation activities, the genetics and metabolic clinics began using a parent survey that required IRB approval. That process took time and decreased the clinic's capacity to collect parent/patient satisfaction data. Data for FY14 and 15 using the new survey is not yet available from WSGSC. It is anticipated the new survey will provide more useful parent feedback. The neurodevelopmental clinics had a difficult time collecting surveys back from

	The neurodevelopmental clinics had a difficult time collecting surveys back from parents in FY14 and formal parent satisfaction data is not available. The clinic welcomed a new clinic coordinator and physician in FY15.At that time it was determined that the satisfaction survey methodology needed to be revised and survey activities were suspended. The survey process is currently being revised and restructured to better accommodate the new flow of the clinic based on anecdotal feedback and the emerging needs of families.
Analyses of effectiveness of current program activities:	WCFH continues to have active advisory committees which include and support parent involvement such as: EHDI, NBMS, Youth Alliance for a Healthier Alaska, and the Alaska Health & Disabilities Committee. WCFH continued to use Title V money to support parent navigation in the neurodevelopmental outreach clinics and Cleft Lip & Palate (CLP) clinics. Policy level family participation has been sustained despite leadership changes and organizational challenges within the Stone Soup Group.
Strategies and initiation of new efforts (if adequate progress not achieved):	Family evaluation process of the pediatric neurodevelopmental clinics is being revisited due to the low historical rate of participation. The Stone Soup Group Parent Navigator for this program has offered ideas around more extensive pre and post surveying of the families to ensure their needs are being met.
NPM #3 The percentage of children with special health care needs age 0-18 who receives coordinated, ongoing, comprehensive care within a medical home.	
Previous year's activities, accomplishments, challenges and revisions:	Medical home infrastructure building has continued through collaborative efforts with the Title V HRSA funded Pediatric Medical Home Program, the Tri-State Children's Health Improvement Consortium (TCHIC) and numerous community partners. Primary care coordination service activities of the Pediatric Medical Home Program ended in June 2014 with the separation of the two care coordinators hired for clinical placement in partnering agencies. These positions were funded through the HRSA grant which formally ended in June 2014, and despite the clinical agency's desire to retain the positions full time, financial uncertainty within the clinical practices did not allow them to do so. The new distance-based Pediatric Care Coordination Training Program was developed in partnership with the All Alaska Pediatric Partnership and the University of Alaska Anchorage. This ten week course was designed as a distance-based continuing education course consisting of eight weekly modules

	and a two week final project. Focus group feedback was gathered from families and care coordinators to inform the content of the course which is loosely based on an existing curriculum framework developed by Boston Children's Hospital and the American Academy of Pediatrics. The Pediatric Medical Home Program Manager and WCFH continued to act as a central point of collaboration. The state's PCMH Physician Champions, Medicaid, Behavioral Health, Tribal Health, the All Alaska Pediatric Partnership and other central stakeholders convened regularly to continue promotion and further development of the PCMH model for Alaska's children. The PCMH standardized "CAHPS Patient Experience" survey was a collaborative activity which combined efforts and resources of the Pediatric Medical Home Program and TCHIC to include six clinics. The planned activity for the Family Voices Provider Survey has been tabled due to difficulty connecting with the national Family Voices agency.
Plan for the coming year:	Title V is working 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. This is the focus of the HRSA 2014-2017 "D70" funding which was awarded in late 2014. There is diverse stakeholder and family representation on the grant steering committee and a high level of interest in integration of primary care and behavioral health. Among state specific goals regarding medical home development, "strategy teams" have formed to identify common goals among the twelve funded states in the following areas: • Cross-systems care coordination • MCH 3.0 Alignment • Shared resource development (Help Me Grow in Alaska) Pediatric Medical Home program staff have worked on the new edition of CUBS (3 year old follow up survey to PRAMS) to include CAHMI CYSHCN screener elements for additional state level data on the prevalence of CYSHCN. Medical home focused activities will be infused into FY16 parent navigation performance measures. The EHDI and medical home program managers work closely to align efforts. The first cohort completed the university-based Pediatric Care Coordination course in Fall 2014. Evaluation and revisions are underway with plans to offer

	course in Fall 2014. Evaluation and revisions are underway with plans to offer the second cohort in Fall 2015. A new long-term instructor has been hired by the university and will be working with the program manager and the UAA Vice Provost to ensure a high quality and sustainable training program. WCFH will leverage partnerships and funding to lead planning and implementation of a new "Help Me Grow Alaska" program by FY17. Help Me Grow will be a centralized pediatric resource for families and providers statewide.
Interpretation of data (FY14 & FY15):	There is no new data on this indicator to report. The most recent National Survey of Children with Special Healthcare Needs was in 2009-2010 when the prevalence for this indicator was 42.8%. The care coordination pilot within the 2011-2014 Pediatric Medical Home Program (HRSA grant) reported 901 care coordination encounters FY14 between the two clinic sites. This number is up from the previous year's 813 encounters. These encounters focused primarily on the family/patients' medical or social needs, but included education and legal needs. FY15 data was not collected due to the pilot project ending.
Analyses of effectiveness of current program activities:	Current program activities are primarily associated with the 2014-2017 HRSA funded "D70" grant focusing on systems integration for CYSHCN and medical home development. The primary strategies of this work for all twelve states funded revolve around three areas of focus; Cross-Systems Care Coordination, MCH 3.0 Alignment, and development of a "Shared Resource" (Help Me Grow for Alaska). It is difficult to analyze the effectiveness as the HRSA technical assistance is in the process of defining these strategies and drafting aim statements for each that can be agreed upon by all twelve states. The high level of interest and support from other state agencies and community-based partners indicates the potential for this program to be effective on both the primary care practice level as well as policy. The CAHPS Patient Experience Survey partnership has resulted in a PCMH Learning Collaborative that will extend into FY15-FY16 to focus on practice level quality improvement and be offered to additional clinics statewide.
Strategies and initiation of new efforts (if adequate progress not achieved):	The PCMH/Integration Steering Committee has expressed interest in increasing educational opportunities for policy makers to observe and experience a high functioning PCMH practice. Opportunities will be explored with practices and committee members in FY16.
NPM #4	

NPM #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.

Previous year's activities, accomplishments, challenges and revisions:	Title V collected and tracked insurance payments for children accessing the MCH Block Grant supported and state-sponsored specialty clinics for CYSHCN. Staff documented billings and families who either self-pay, do not have insurance, or are unable to pay for services. 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 state general and MCH Block Grant funds. The largest percentages of unpaid fees (across all clinics) were for those who were self-pay. Insurance coverage for autism services was increased in the past year due to the passage and enactment of SB74 (private insurers) as well as an expansion of behavioral support services under State of Alaska employee benefits. The latter was due, in part, to a collaborative Title V effort with the Division of Behavioral Health which increased the awareness of issues surrounding insurance coverage for behavioral support services for children with autism. Alaska continued to have a contract with tribal health to provide Indian Health Services funds as a payer of last resort for children seen in the pediatric specialty clinics. WCFH continued to fund parent navigations services including health insurance enrollment and other supportive services.
Plan for the coming year:	Title V is partnering with other state and community based agencies as part of the National MCH Workforce Development Cohort 2 to improve access to Medicaid for pregnant women and CYSHCN. Primary partner agencies include the Division of Public Assistance and the Providence Family Medicine Residency Program. Title V staff is also involved with the Governor's Council on Disabilities and Special Education's Autism Ad Hoc Committee. This committee is currently drafting a new Five Year Autism Plan for the state which includes a focus on improving health coverage and services for children who experience autism.
Interpretation of data (FY14 & FY15):	There is no new data on this indicator to report. The most recent National Survey of Children with Special Healthcare Needs was in 2009-2010 when the prevalence for this indicator was 56.7%.

	Title V clinical billing information is available from FY14 and the first quarter of FY15 (see insurance billing table for details). Data reported is consistent with previous years. The appearance of a drop in Medicaid payments (9%) in the first quarter of FY15 could be due to Medicaid processing delays impacting all providers statewide. Medicaid systems issues are affecting both payment and eligibility processes and delaying care for many thousands of eligible Alaskans.
Analyses of effectiveness of current program activities:	Title V program activities around this NPM are currently limited due to the political climate and limited resources within the agency to perform outreach. It may be possible to analyze effectiveness of new outreach efforts beginning in FY16.
Strategies and initiation of new efforts (if adequate progress not achieved):	The previous administration (through Nov 2014) denied Medicaid Expansion. The current administration is a proponent of Medicaid Expansion and reform although at this time the governor's bill has not passed the legislature. Title V continues to monitor and remains active in discussions and planning relevant to the MCH population. Beginning in FY15, Alaska's Department of Health and Social Services initiated a department-wide effort around Medicaid Expansion and reform. Title V leadership has been involved in discussions around reform and will likely be involved with outreach efforts to increase enrollment should that change occur. Title V is also currently involved in a Medicaid eligibility project led by the National Center for MCH Workforce Development to improve processes and eliminate the backlog of applications for pregnant women and CYSHCN. This project involves multiple partnerships including the Division of Public Assistance, Providence Family Practice Residency Program, and the Stone Soup Group.
NPM #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.	
Previous year's activities, accomplishments, challenges and revisions:	WCFH program work continued to align with the Governor's Council on Disabilities and Special Education (GCDSE) 5-year plan that places a high priority on community-based access to services, early intervention, transitions and healthcare in rural Alaska. WCFH continued to sponsor pediatric outreach clinics for neurodevelopmental, genetics, metabolic, and cleft lip and palate disorders. WCFH continued to

	partner with the Center for Human Development (CHD) to have Leadership Education in Neurodevelopmental and Related Disabilities (LEND) fellows placed in outreach clinics. WCFH, the All Alaska Pediatric Partnership, and the University of Alaska partnered to provide the care coordination continuing education course to the first cohort of students. Care coordinators from throughout Alaska participated with the hopes of promoting patient-centered care in communities. The Genetics Clinic began an evaluation project with the Western States Genetics Services Collaborative regarding parent experiences and beliefs of the services provided in the clinic. After IRB approval, the survey was implemented with parents of children seen in the clinic. It is anticipated the first survey results will be available in FY16. The School Nursing and MCH Disabilities Preparedness programs continued. WCFH continued to use Block Grant funds to support parent navigation at the outreach clinics.
Plan for the coming year:	WCFH will continue to work on community-based workforce development projects which will improve local access to care. WCFH will continue to offer and coordinate pediatric outreach clinics for neurodevelopmental, genetics, metabolic, and cleft lip and palate disorders. These clinics will continue to foster early identification and referral and decrease the burden on families to either travel outside of Alaska for diagnoses. WCFH will continue to partner with CHD to have LEND fellow placed in outreach clinics. The Care Coordination curriculum will continue to serve a new cohort of students in FY16. WCFH will continue to partner with the Alaska Native Tribal Health Consortium (ANTHC) to support the attendance of a genetic counselor in the genetics outreach clinics in Anchorage, Fairbanks, and southeast Alaska. To support community-based services, the outreach clinics will continue to provide interpreter services, along with culturally appropriate materials. WCFH will continue partnering with the local parent leadership group at Stone Soup Group to strengthen parent support and navigation in rural and urban communities. WCFH will continue to participate in the GCDSE's autism ad hoc committee.

	This is committee reconvened in FY15 to revise the state plan for autism and includes diagnosis, systems integration, and early intervention. The WCFH D70 Medical Home program will also create a state plan for CYSHCN based on the National Standards created by AMCHP.
Interpretation of data (FY14 & FY15):	There is no new data on this indicator to report. The most recent National Survey of Children with Special Healthcare Needs was in 2009-2010 when the prevalence for this indicator was 55.2%.
Analyses of effectiveness of current program activities:	The outreach clinics continue to provide gap filling services as Alaska experiences a shortage of pediatric specialty care providers, particularly in rural Alaska. There is one pediatric neurodevelopmental physician in the state providing diagnoses for Autism. It is expected this physician will retire at the end of 2015. During FY15, WCFH partnered with the Providence Autism Diagnostic Network (PADN) and Providence Behavioral Health programs to transition the current model of diagnosis into a multidisciplinary approach. Providence Behavioral Health noted they no longer have the capacity to take on the PADN program and transition it to the behavioral health model. WCFH used general funds to help support PADN to begin strategic planning on a future model for diagnosis in Alaska. WCFH convened a workgroup comprising of Public Health, Public Assistance, tribal health, the private sector, and a parent of a child with special health care needs to partner in a systems mapping exercise of the Medicaid application process for pregnant women and TEFRA. The goal is to make recommendations to Public Assistance leadership on strategies to improve this process for families. As this project continues, the group is looking at facilitating training for parents and providers on the application process. WCFH met with the local Stone Soup Group parent leadership group to include their voice in this process.
Strategies and initiation of new efforts (if adequate progress not achieved):	Because of the transition in clinic coordination staff and medical provider in the neurodevelopmental screening clinics, fewer community presentations occurred this year in rural communities. This will be reintroduced in collaboration with Stone Soup Group, CHD, and the Special Education Service Agency (SESA). Potential training opportunities include: improving communication between families and providers, behavioral management of children and adults, autism resources and outreach, care coordination techniques, early identification and intervention, etc. This will help to better understand each community's unique needs and help to tailor the outreach clinics.

	WCFH's partnership with PADN will continue as they reevaluate their program and make plans for the future. This partnership will help inform the system of services for children with autism and also provide a more streamlined approach to diagnosis.
NPM #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.	
Previous year's activities, accomplishments, challenges and revisions:	Women's Children and Family Health (WCFH) staff continued efforts to build a system of care that successfully transitions 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 continued leadership on MCH issues; Stone Soup Group (SSG) offered the consumer voice; the Center for Human Development (CHD) offered innovative programs; and the Alaska Mental Health Trust Authority served as a financial provider for CYSHCN programs. State 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 (AMHTA).
Plan for the coming year:	Agencies will continue to address transition issues based on the Governor's Council on Disabilities and Special Education (GCDSE) 2011-2016 Statewide plan. WCFH will continue to partner with such key stakeholders as the GCDSE, SSG, CHD, DPA, the AMHTA, SESE, and DEED to ensure coordination around transition issues. Although transition did not score as the top priority for this population, the Needs Assessment contained several comments which highlighted how big of an issue this is for families.
Interpretation of data (FY14 & FY15):	There is no new data on this indicator to report. The most recent National Survey of Children with Special Healthcare Needs was in 2009-2010 when the

(FY14 & FY15):	Survey of Children with Special Healthcare Needs was in 2009-2010 when the prevalence for this indicator was 45%.
Analyses of effectiveness of current program activities:	The CHD offers a program called "Transition to Postsecondary Education for Students with Intellectual and Developmental Disabilities (I/DD). This program provides a post-secondary college experience at the University of Alaska to develop self-advocacy skills, engage in career exploration, and develop social skills that lead to employment in a career field or enrollment in a post-secondary educational program. This involves a partnership with the DVR and the Anchorage School District. In partnership with the GCDSE, CHD also provides training on employment-related issues to providers, family members, and teachers to increase the number of youth with I/DD to transition to employment. SSG, the local Family to Family Information Center, also provides services for this population. They provide information, resources and referrals for adult health care providers, guardianship, estate planning, social security, waivers, education (higher education, public schools, vocational programs, and DVR), housing employment, recreation, and social skills support. Parent Navigators continue to accompany families to IEP meetings when transition plans are being formulated. Transition-aged youth are invited to attend SSG's "Moving Up, Moving On" program, which is a ten-week program focused on teen friendships, dating, safety, and independent living skills. They also facilitate a support group for parents of transition-aged youth along with hosting trainings with guest facilitators that focus on topics such as estate planning, guardianship, social security, and Medicaid waivers. WCFH remains in a contractual relationship with both CHD and SSG. Project SEARCH, which is a national program that helps young adults with disabilities as they transition from high school to the general workforce, continues to operate in four locations in Alaska. Project locations include the Providence Alaska Medical Center in Anchorage, Mat-Su Regional Medical Center in Palmer, Fairbanks Memorial Hospital, and Central Peninsula Hospital in Soldotna. This program involves pairing students that have significant disabilities, such as hearing loss, autism, or physical impairments, with job rotations that allow them to gain experience in the workforce. This program involves these agencies partnering with their local school districts.

The DVR continues to work with high school students on transitioning to the workforce as well. The CHD's Partners in Policymaking continued to coordinate the "I Vote, I Count!" campaign which aims to empower Alaskans with disabilities and other beneficiaries of the Alaska Mental Health Trust to become active voters and a part of the political process.

The Alaska DOL continues to operate the "Ticket to Work" program which provides work incentives and employment support to people ages 18 to 64 who receive social security disability insurance or supplemental security income benefits who also have interest in entering the workforce.

Despite the various services, transition planning continues to remain a challenging issue for Alaska families of CSHCN.

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

The needs assessment identified both child maltreatment (CM) and behavioral/mental health problems (BMH) as priority areas that have extensive life course implications. These two priority areas both have cross-cutting health implications for each of the five population domains and therefore deserve a more collaborative and comprehensive focus. Alaska's five-year-state action plan identifies the two priority needs for these life-course domains specifically as 1) Reduce the rate of child maltreatment and 2) Increase evidence based screening for all MCH populations for behavioral and mental health problems.

These two priority needs were strategically selected to ensure that resources and efforts are considered among all population domains resulting in a collaborative collective impact. Each specific objective selected is a "winnable" measure supported by actionable and feasible activities that can be accomplished over the duration of this grant cycle.

For each of the life course priority measures further details regarding the strategies, challenges, and approach will be discussed below.

Reduce the rate of child maltreatment:

Alaska continues to have documented rates childhood victimization above that of the national average (during 2008-2012 the rate (per 1,000 children) of unique child victims in Alaska was 15.6 vs 9.2 nationally). Reducing CM requires a unified effort from multiple sectors. One major challenge that has impeded success in preventing CM in Alaska is a lack of knowledge about the individual prevention efforts being implemented and delivered across the state. While Alaska has a small population, the geographic expanse can lead to isolated efforts and poor collaboration. The initial activities will focus on quantifying current primary prevention activities across the state and move towards a collective impact model. Prevention activities will be classified by focus (broad injury prevention, child maltreatment, strengthening families…) and intent. Furthermore, each of the identified efforts will be assessed to determine if they are evidence-based and true to the models. This activity will be accomplished by working in partnership with the Alaska Children's Trust, with results disseminated broadly to increase awareness and

communication and used to establish a statewide multi-sector CM prevention workgroup.

Second, the Alaska Surveillance of Child Abuse and Neglect (SCAN) program within WCFH will continue to develop a centralized data cube for cross-jurisdictional data. This program has had multiple setbacks that have impacted the release of timely data and include, staff changes, administrative changes, data sharing restrictions, and resource limitations. Over the past year, each of these challenges has been mitigated. The SCAN program as three components 1) timely trend analysis, 2) comprehensive magnitude assessments, and 3) longitudinal risk factor and outcome assessment. The SCAN program will utilize predictive analytics to identify modifiable risk factors and population characteristics at each level of the ecologic model. This information will be used to inform decision makers and focus resources

Third, building upon the information obtained from the first two activities efforts to expand and support proven evidence based efforts will be made. Support will primarily occur within the context of data analysis, evaluation, and technical support. Other efforts will be on identifying communities ready to implement changes and supporting them on identifying resources to implement the prevention efforts. This systems support will ensure that both the prior activities have actionable focus on increasing collaborative prevention efforts.

The specific NPM related to this priority is "the rate of injury-related hospital admissions per population ages 0 through 19 years" (NPM #7), which was 195.6 per 1,000 children ages 0 through 9 and 215.3 per 1,000 children ages 10 through 19 in 2012. Because greater than 65% of all allegations of CM received by CPS are neglect related and the preponderance of post-neonatal mortality and morbidity is associated with poor parental supervision, focusing on hospitalizations allows for "upstream" prevention efforts to be initiated that address parental supervision and overall parenting.

Increase evidence based behavioral and mental health screening:

Early identification and referral of BMH problems is essential for improving the overall health and wellbeing of all cross-cutting populations. Childhood behavioral screening if completed early can improve health outcomes by recognizing and addressing behaviors in context and applying the appropriate resources. Furthermore, assessing maternal mental health and referring for treatment can improve personal health as well as that of their children and families.

As this is a new priority for WCFH, the key activities within the action plan are on systems improvement, partnering, and providing technical support. The primary activity specified is to improve the partnership with the Division of Behavioral Health (DBH). This has already been initiated in the form of increased data sharing. Further efforts will focus on working with DBH to identify and create a resource list of evidence based screening tools. This list will be made available to providers and educators and encouraged to adopt the use of the identified tools.

In conjunction with DBH, WCFH will provide technical support to providers and educators implementing the use of the screening tools to ensure that the use is standardize across agencies.

Finally, increased efforts will be made to support the utilization of screening tools within the education system to identify both victims and perpetrators of bullying.

While screening is a useful without services to address the issues identified the utility is lost. A resource list of service providers and agency contacts will also be developed to support the development of comprehensive statewide screening. Alaska is challenged by limited resources in many rural communities thus ensuring that these communities have available options is important

that these communities have available options is important.

All of the strategies aimed at improving the system to increases the use of standardized screening directly relate to both NPM's specified for this cross-cutting domain state priority need. The NPMs chosen were "percent of children ages 10-71 months receiving a developmental screening using a parent complete screening tool" (NPM #6); and "percent of adolescents ages 12 through 17 years who are bullied" (NPM #9). NPM #6 is shared with the child health domain, while NPM #9 is shared with the adolescent health domain.

Cross-Cutting/Life Course - Annual Report

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

Annual Objectives

	2016	2017	2018	2019	2020
Annual Objective	12.9	12.3	11.7	11.1	10.5
Annual Objective	28	26.6	25.3	24	22.8

SPM # 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

Previous year's activities, accomplishments, challenges and revisions:	Staff from WCFH authored an article in the Spring 2014 Northwest Bulletin, "Early identification of developmental delays and maternal depression." A panel presented on home visiting in Alaska at the Statewide Public Health Nursing Conference in April 2014. The Section of WCFH worked with the Alaska Native Tribal Health Consortium (ANTHC) to plan the September 2014 biennial Maternal Child Health (MCH) and Immunization conference, "Advancing Wellness Across the Lifespan." The planning committee invited Michele Curtis, M.D., MPH to present a plenary on pregnancy in the context of a woman's lifespan, and a breakout session on maternal mental health and depression. We continued to focus efforts related to perinatal depression on the two home visiting grants forHealthy Start and the Maternal, Infant & Early Childhood Home Visiting (MIECHV) programs. Healthy Start is located in Nome and

	Home Visiting (MIECHV) programs. Healthy Start is located in Nome and administered by Norton Sound Health Corporation. Providence In-Home Services (PI-HS) provided the Nurse-Family Partnership (NFP) model of home visiting in the Municipality of Anchorage (MOA). Southcentral Foundation offers the NFP through the Nutaqsiivik home visitation program and served Alaska Native families in the MOA and the Mat-Su Borough. These home visitation programs provided screening and referral for depression. The MCH Epidemiology Unit in WCFH conducted the annual Pregnancy Risk Assessment Monitoring System (PRAMS) and Childhood Understanding Behaviors Survey (CUBS) surveys, which include questions related to maternal depression. WCFH published findings on the WCFH website, created data books, and distributed the information to stakeholders across the state.
Analyses of effectiveness of current program activities:	The biennial MCH and Immunization conference, "Advancing Wellness Across the Lifespan" commenced in Anchorage September 24-25, 2014. Michele Curtis, M.D., MPH gave a plenary, "Pregnancy as a Transgenerational Event" and a breakout session, "Depression, Anxiety, and Pregnancy: Who's Stressed Out?" A panel presented on home visitation programs in Alaska. A nurse consultant provided a two-part session on "Tools and Techniques for Using the Bright Futures Periodicity Schedule in Infancy and Early Childhood." The*Bright Futures Periodicity Schedule*recommends a psychosocial/behavioral assessment at every well child visit beginning with the newborn visit. Bright Futures resources address maternal depression and screening. WCFH distributed Bright Futures resources, including 35*Bright Futures Guidelines*books,62 pocket guides; 7 clinical handbooks, and 9 toolkits. WCFH released the*Alaska Maternal and Child Health Data Book 2014: Life Course Edition.*Organization of the data book is according to themes, rather than chapters.Theme seven is mental health. Alaska PRAMS data for 2009 – 2011 found the most frequent postpartum feeling reported by all women who recently delivered a live birth was often or always feeling down (19.2%). The majority of women who recently delivered a live birth reported that a health care provider talked with them about depression during pregnancy (75.4%) and after giving birth (81.4%) (p. 42). In December 2014, WCFH released the 2013 CUBS Data Sheets, which include mental health, abuse, and stress. WCFH continues to administer Healthy Start and MIECHV grants, with plans to expand the PI-HS NFP in the MOA and will begin to serve families in the

	Mat-Su Borough by the summer2015. The Nutaqsiivik NFP program continues to serve Alaska Native families in Anchorage and the Mat-Su Borough. These home visitation programs provide screening and referral for depression. The MCH Epi Unit continues to conduct the annual PRAMS and CUBS surveys, which include questions related to maternal depression. The interagency developmental screening workgroup developed a policy for EPSDT regarding the use of developmental screening tools, but it did not include tools to screen for maternal depression. The workgroup plans to continue to work toward adding maternal depression screening tools to the policy.
Plan for the coming year:	Healthy Start will continue to serve families in the Norton Sound region until the grant ends on June 30, 2016. Providence will expand NFP services to families in the MOA and Mat-Su Borough. The Nutaqsiivik NFP will continue to serve Alaska Native families in the MOA and Mat-Su Borough. These home visitation programs provide screening and referral for depression. The interagency developmental screening workgroup will continue to work toward adding maternal depression screening tools to the EPSDT policy. Planning for the next biennial MCH and Immunization Conference for the fall of 2016 will begin.
Interpretation of data (FY14 & FY15):	There is no new Pregnancy Risk Assessment Monitoring System (PRAMS) data since 2012 due to the mandatory data system change. The percentage of women reporting "yes" increased from 2011 to 2012.
SPM # 2 Rate of reports of maltreatment per thousand children 0-9 years of age	
Previous year's activities, accomplishments, challenges and revisions:	The primary activities focused on continued development of the SCAN program and ensuring data collection. The primary accomplishments with respect to data collection were newly signed data sharing agreements with the Division of Behavioral Health, Juvenile Justice, and nearly all of the Child Advocacy Centers. Additional accomplishments included online real-time direct access to child protection data, child advocacy data, and many hospital eHealth records.

	The primary challenges remaining with data sharing are largely technical and require a more permanent solution with IT to improve the secure data transfers. Additional challenges are poor data quality and completeness of information from some sources. Further efforts are underway to obtain local law enforcement data from each sentinel site. We competed the statewide Abusive Head Trauma assessment and will continue to update this information bi-annually due to small numbers. We also completed a study looking at the association between maternal self-reporting history of intimate partner violence and subsequent offspring maltreatment reports to identify pre-birth intervention/prevention points. Due to resource limitations we were unable to implement a near-death review, but have been working diligently to establish sentinel surveillance activities for maltreatment and the longitudinal cohort. The longitudinal birth cohort uses a PRAMS base sample, and has been constructed through linkages with the Alaska Permanent Fund Dividend and should be completed with all other sources during the next year. The SCAN program will continue to work the Alaska Children's Trust, the Children's Justice Act Task Force, and the Mat-Su Health Foundation to develop a collective impact framework, establish common measurement goals, and work to promote evidence based primary prevention efforts. SCAN will also provide technical data assistance to these partners and Home Visiting efforts.
Analyses of effectiveness of current program activities:	The current data development for compiling cross-jurisdictional maltreatment estimates is challenging but extremely effective at both developing public health relevant data, and bringing agencies together. The data linkage process has been improved to streamline the probabilistic matches and reduce manual reviews. Attempts to improve data quality, timeliness, and consistency have largely been successful. Both the quality and consistency have exceeded expectations, while timeliness is still yet to be realized. The SCAN data has been utilized by multiple partners and continues to be requested by various agencies across the state.

	The current data sharing agreement development process is effective for the most part, but new challenges have been identified with some Alaska Native Corporations that are not HIPAA covered entities.
Plan for the coming year:	We will work to continue to build the SCAN program through data linkages and information sharing. Key focus will be on obtaining all CAC data, Alaska State Trooper Information, and local police department data for each sentinel site across the state. We will work with legal to ensure that all partners have the protections they need to share PHI with the SCAN program. The SCAN program will publish the "Anchorage Incidence Study" which uses the largest sentinel site to demonstrate the utility of the multi-source data linkages to quantify the magnitude of maltreatment. Other data projects include assessing the association between maternal marijuana use and subsequent CPS referrals of offspring, the impact of censoring due to emigration on population based measure of frequency and effect, the consistency of child death review classification of maltreatment, and the development of a predictive analytic model of maltreatment that uses a cumulative risk theory approach based on time-varying scores by ecological domain.
Interpretation of data (FY14 & FY15):	The rate of unique children with at least one report of maltreatment has remained flat at approximately 93.0 per 1,000 children 0-9 years of age in Alaska during the two review periods. Reporting of suspected child abuse is a strong indicator for public health purposes as it provides an indication of the impact primary prevention efforts are having on not only experienced maltreatment but at preventing experiences from rising to the level of suspicion. Increased awareness of ACEs and state specific data as well as more attention to this topic may actually increase this indicator temporally, but with successful primary prevention efforts should ultimately see a drop.
Strategies and initiation of new efforts (if adequate progress not achieved):	If adequate progress on data collection is not made we will engage the division director and medical director at communicating our needs and efforts. Currently, the processes developed have successfully addressed all issues. If analytic activities are delayed we will work with the section chief and unit manager to ensure that staff time is allocated to this project due to its priority specification.

Other Programmatic Activities

IV F 1 b ii. Other Programmatic Activities (optional)

WCFH plans to continue using Title V funds to co-sponsor with the Alaska Native Tribal Health Consortium the Alaska Maternal Child Health & Immunization Conference. The fifth biennial conference will be held in Anchorage in September 2016. The conference provides an opportunity for rural and urban Alaskan health professionals to come together to learn about best practices, tools, and surveillance data related to the prevention, diagnosis, and treatment of women's, children's, and adolescent health issues in Alaska. Presentations typically cover a wide range of topics important to maternal and child health in the state. Past presentations and more information about the conference can be found online here: http://www.alaskamchconference.org/index.html.

Investment in the state's MCH data infrastructure, including surveillance projects within the MCH Epidemiology Unit such as the Childhood Understanding Behaviors Survey, the Maternal Infant Mortality and Child Death Review, and the Alaska Birth Defects Registry, is a priority that impacts work in all of the population domains. WCFH programs rely on the MCH Epidemiology Unit epidemiologists to provide analysis and presentation of data from the Unit's surveillance programs as well as other sources, such as the Alaska Bureau of Vital Statistics, to inform prevention programming and to address the identified state priority needs. A critical partner for supporting the MCH Epidemiology Unit is MCHB's State Systems Development Initiative grant program for building data capacity in Alaska.

Maternal/Women's Health

The two cross-cutting issues for the Women's/Maternal Health population that were identified in the Title V 5-year Needs Assessment are 1) access to behavioral/mental health screening services, and 2) addressing unhealthy relationships/intimate partner violence. The Primary Care Needs Assessment being developed with the input of the Adolescent Health/Family Planning Program (AH/FPP) staff includes assessment of current service delivery and shortages in these two areas of need. Provision of comprehensive women's and reproductive health services necessarily includes addressing the behavioral health and safety needs of women through preventive and behavioral health screenings; this will be an integral part of the follow-up to be performed by the AH/FPP staff in the next 5-year period. Additionally, AH/FPP staff will begin work on the CoIIN initiative around preconception/ interconception health. The actual objectives and strategies for this initiative are under development during summer of 2015. Progress on which will be reported in future funding periods for the Title V grant.

Most of the activities described in the Plan for the Application Year and the Annual Report for the maternal/women's health domain have been the result of leadership through other federal grant programs (Title X, Healthy Start, Adolescent Health programs, etc.).

Perinatal/Infant's Health

Since 2014, Alaska has participated in the national Collaborative Improvement and Innovation Network (CoIIN) to reduce infant mortality. WCFH has assembled a diverse team of MCH leaders to participate in this Collaborative, including State Title V leadership and staff, representatives from the Alaska Native Tribal Health Consortium Epi Center and the Alaska Native Medical Center, physicians and nurses from the private and public sector, child protection staff, associations members from AAP-Alaska Chapter and the Primary Care Association as well as other local stakeholders in the field of Maternal and Child Health. The Alaska CoIIN team developed an Alaska Infant Mortality Action Plan which encourages leadership to share innovations, build quality improvement capacity, promote evidence based strategies to improve birth outcomes and reduce disparities through policy and practice changes. Currently Alaska has chosen to focus on the following 3 strategic areas to reduce infant mortality in the state:

following 3 strategic areas to reduce infant mortality in the state:

1. SIDS/SUID/Safe Sleep – to improve safe sleep practices

2. Smoking Cessation – to reduce smoking before, during, and/or after pregnancy

3. Preconception/Interconception Health – to promote optimal women's health before, after, and in between pregnancies and promote the use of long-acting contraceptive methods.

Alaska's Title V program has also chosen to develop a 4th strategic area of its own using the same QI principles focused on reducing the use and abuse of illegal substances and alcohol. As many infant fatalities in Alaska occur in environment with poor parental supervision due to substance use and history of CPS involvement, working with CoIIN to improve parenting and sleep practices will likely contribute to reducing child maltreatment.

WCFH continues to receive HRSA funding for the Maternal, Infant & Early Childhood Home Visiting (MIECHV) and Healthy Start grants. WCFH continues to partner with Providence In-Home Services to implement the Nurse-Family Partnership (NFP) model of home visiting. The program became fully staffed and reached service capacity in September 2014. In February 2015, WCFH was awarded a competitive grant to expand the current NFP program by four nurse home visitors. Two of those four new nurse home visitors serve clients in the Mat-Su Borough north of Anchorage, the state's largest city. This funding has allowed for WCFH to expand the service delivery area for the program and offer services in a large geographic area that experiences some of the highest rates of teen pregnancy, poverty, child maltreatment and unemployment. The NFP program focuses on improving such outcomes as breastfeeding initiation and continuation, assuring early and continuous prenatal and well-child visits, decreasing repeat pregnancies, screening for maternal depression and intimate partner violence, developmental screening of children, decreasing tobacco use during pregnancy, among many others. The first 20 months of program implementation demonstrated that Providence improved outcomes in five out of the six reporting domains. This federal funding has allowed the Title V program to provide health promotion services to at-risk populations in our state. Funding by the Title V MCH block grant is used to support other data sources as benchmarks and is blended and braided with other sources of funds to enhanced capacity in priority areas.

Norton Health Sound Corporation (NHSC) continues to be Alaska's Healthy Start grantee. NSHC serves clients in Nome and the surrounding census area, including remote villages. Healthy Start clients continue to receive important health promotion and prevention education on such topics as having a healthy pregnancy, tobacco cessation, breastfeeding, decreasing repeat pregnancies, among others. WCFH has worked with NSHC to develop and implement a case management system to improve overall case management services for these clients along with increasing the capacity to bill for Medicaid. Alaska will no longer be eligible to receive the Healthy Start grant as of May 2016. The WCFH Program Manager/Nurse Consultant continues to work with the grantee on program evaluation, developing case management capabilities, and other program sustainability efforts.

Title V MCH –Perinatal and Early Childhood program was awarded technical assistance by the MCH Workforce development center to work with the Division of Public Assistance and other state and community stakeholders to reduce the backlog of Medicaid applications. Delays in processing applications for pregnant women and children with disabilities are leading to delayed prenatal care and intervention services for these vulnerable populations. Technical assistance will include "value stream" mapping and elements of the National Academy of State Health Policy's "Maximizing Enrollment Project." These activities support the identified priority of systems integration for CYSHCN while simultaneously addressing issues around access to primary care and prevention for pregnant women and CYSHCN.

Adolescent Health

Youth suicide prevention activities (NPM#16 for reporting years FY2014-2015 and the new National Outcome Measure 16.3) are primarily accomplished through a partnership with the Division of Behavioral Health's (DBH) Comprehensive Behavioral Health Prevention & Early Intervention Services (CBHPEIS) Program. The CBHPEIS is the state's largest prevention program that serves Alaskan communities addressing a variety of behavioral health problems and conditions such as substance abuse, mental health and suicide. In FY14, seven grantees prioritized suicide as their leading prevention focus and employed strategies that were designed to create both short-term and long-term outcomes in reducing suicide. In addition, many of these grantees are working to increase protective factors, promote resiliency and community wellness. New peer leadership programs were also introduced in order to expand universally driven approaches that help to guide social norms and increase help-seeking behaviors especially among youth who may be at risk of suicide.

It is anticipated that in the Spring of 2015, SAMHSA will announce a new round of Garrett Lee Smith Youth Suicide Prevention cooperative agreements. The Division will be eligible to apply and will begin to reassess current strategies, goals and outcomes to determine how the Division can maximize its efforts in suicide prevention. Currently under this grant, the Alaska Youth Suicide Prevention Project has refocused its efforts to enhance and expand the Alaska Gatekeeper Training statewide by incorporating QPR (Question, Persuade, Refer) component as a nationally recognized best practice. Additional progress has been made on implementing the Alaska Careline "Text 4help to 839863" service. There has been incremental growth targeting youth populations who are more likely to text than use the Alaska Careline call center phone number or the national Lifeline.

As a result of the Alaska Gatekeeper QPR Training, DBH has trained and certified over 130 trainers, completed over 60 trainings and trained over 1,200 participants in the model. Trainings were held primarily in education and other community settings. Outcomes of the training that include knowledge and skills gained are:

- 70% report using their training to have informal conversations about suicide and suicide prevention with youth and others.
- 52% report using their training to identify youth who might be at risk of suicide.
- 38% report using their training to make referrals to mental health services for at-risk youth.

In FY16, the CBHPEIS community coalitions will develop strategic plans many of which will target several variables related to suicide prevention. These strategies may include trainings, 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. In addition, all grantees are expected to enter into Memorandum of Agreements (MOA) to promote Careline, Alaska's statewide crisis call center.

DBH also continues to disseminate and deliver postvention resources to grantees, groups and communities who are seeking technical assistance, support and guidance in responding to completed suicides. The Division is also working on completion of a DVD, "Preparing to Heal" (a companion to our Alaska Postvention Resource Guide) which will be directed to outreach and care providers in order to support community postvention planning and response teams. DBH will continue media and information campaigns that increase awareness, reduce stigma associated with depression and suicide, and promote help-seeking behaviors. This will also include continuation of the "Text 4help" campaign.

Child Health

Activities around the prevention of deaths to children aged 14 years and younger caused by motor vehicle (NPM #10 for reporting years FY2014-2015) are primarily accomplished through a partnership with Alaska's Injury Prevention (IP) program, located in the Division of Public Health's Section of Chronic Disease Prevention and Health Promotion. The IP program continues its supporting role with the Alaska Child Passenger Safety Coalition (CPSC). Previously "Be Safe Be Seen," the project now known as "Bike-N-Walk Safely Alaska!" developed an educational poster, which has been included in a resource kit that was distributed to schools and organizations focusing on pedestrian safety. Fifteen kits were distributed and the tools were implemented throughout the state reaching over 300 children. The Bike-n-Walk Safely Alaska! Program will likely continue throughout FY16 to provide technical assistance and resources to communities engaged in safe biking and/or walking projects for 0-14 year old children.

WCFH continues to partner with and advise the obesity prevention program in the Section of Chronic Disease Prevention and Health Promotion on activities around reducing childhood obesity (SPM #9 for reporting years FY2014-2015). The Play Every Day campaign was launched in 2012 to raise awareness statewide about the health concerns associated with childhood obesity and to motivate Alaska families and children to be physically active, 60 minutes a day, for the best health and for maintaining a healthy weight. Play Every Day uses CUBS data around child BMI and consumption of sugar sweetened beverages to inform its efforts.

The Obesity Prevention School Grants program includes 9 Alaskan school district grantees working to improve their school nutrition and physical activity environments by increasing opportunities for before, during and after school physical activity and improving the nutritional content of foods available for consumption at schools. Outcomes of this grant program will be evaluated through collecting and analyzing student height and weight.

OPCP Community Nutrition (CN) works to improve access to and availability of affordable, healthy foods for all Alaskans. Community Nutrition initiated and continues to support the Alaska Farmers' Market-Quest Program, allowing low income Alaskans the chance to use their SNAP benefits at farmers' markets. CN supports schools, ECEs, and community partners' food and nutrition initiatives and events, such as salad bars in schools, Farm-to-School and fish to school. CN provides leadership and support to the Alaska Food Policy Council, which serves as a resource for information on local and state food systems, and works to identify and propose policy and environmental changes that can improve the production, processing, distribution, health, security and safety of our food.

The Play Every Day campaign ran a TV PSA featuring an Anchorage family who was motivated by the Healthy Futures Challenge. You can watch the PSAs here: http://www.youtube.com/playeverydayAK. The same family was featured in a PSA that is running statewide, carrying the Play Every Day message of 60 minutes of physical activity every day for the best health. The campaign also launched a new Facebook page. Play Every Day's partner in physical activity – the Healthy Futures Program – finished the Spring Healthy Futures Challenge in a record 165 schools across Alaska in more than 30 school districts.

The Play Every Day campaign will be redesigning its website (playeveryday.alaska.gov) during the remainder of this fiscal year. The campaign also will be creating a TV PSA and complementary communication materials focused on helping Alaska parents better under the problem and the consequences of childhood obesity. It also will start creating communication materials for a brand new arm of the campaign – motivating Alaska parents to reduce the amount of sugary drinks they are serving their children. All districts are working with their school boards to strengthen and pass a gold standard school wellness policy to create supportive environments for good nutrition and physical activity.

Children with Special Health Care Needs

Children with Special Health Care Needs

In 2014, WCFH was awarded another 3-year grant from HRSA for the D70 Medical Home Program. The goal of this program is to increase the proportion of children and youth with special health care needs (CYSHCN) who receive integrated care through a patient/family-centered medical/health home approach by 20% over 2009/2010 levels by 2017. Activities of this grant include developing a state plan for CYSHCN, developing and implementing the Help Me Grow shared resource center, and promoting medical home initiatives in the state. This federal funding has helped to enhance the CYSHCN program in Alaska.

II.F.2 MCH Workforce Development and Capacity

Overview of the MCH Workforce and WCFH capacity

MCH workforce development and capacity was discussed in detail in Section 2.B.II.b.iii of the Needs Assessment. Maternal Child Health related programs are currently implemented by four divisions within the Department of Health and Social Services: the Division of Public Health, the Office of Children's Services, the Division of Public Assistance, and the Division of Health Care Services. In the most recent reorganization in 2005, several MCH programs were returned to the Division of Public Health to create a new section, Women's, Children's and Family Health (WCFH). WCFH started with 15 FTE's and has expanded its staff to support expanded programs to nearly 50 FTE's as of SFY15. Funding cuts to state GF will result in a reduction of 3.0 FTE's in SFY16.

WCFH staff members are well qualified to deliver services and programs required by Title V MCH, children and youth with special health care needs, and other grant and special funding streams. Over 13 staff members have a master's in public health and four have graduate degrees in public administration, education, biostatics, planning or nursing. Seven staff members have double master's degrees and one is completing his PhD. There are also several health care professionals on staff including two family nurse practitioners, 5 registered nurses, and a dentist.

The WCFH program staff has impressively diverse experiences including executive leadership of a Children's Hospital, Peace Corps, Vista, public health nursing in rural Alaska, public health internships in third world countries, community planning, early intervention programs, parent navigation and family service delivery in the tertiary hospital, disability service delivery, laboratory supervision, school nursing, genetic counseling and community health education. Ongoing training plans are a part of the annual evaluation process and staff are encouraged and supported to gain new skills and try new programs as opportunities present themselves. All staff members regardless of their position or degree are offered training stipends for public health conferences or education related to their program.

In 2009, the MCH Epidemiology Unit was nationally recognized as a leader in improving public health practice through effective use of data, epidemiology and applied research. An updated list of publications for SFY 2015 written by the Title V MCH staff is attached.

Cuts to funding continue to affect workforce capacity. Funding cuts to state GF will result in a reduction of 3.0 FTE's in WCFH during SFY16. Important programs such as the Pregnancy Risk Assessment and Monitoring System are key to collecting the data needed for the MCH Title V Block grant application. Activities sponsored by the Title V Block grant are managed carefully in order to maximize outcomes. Underfunding many of the surveillance programs can have a significant impact as many rely on the data for their federal grant applications.

In Alaska, there is a chronic shortage of pediatric subspecialists. While the state's only children's hospital has been successful in recruiting a number of subspecialists to the state, many are represented by only one clinician in that specialty making for long work hours and difficulty covering for vacations. One critical shortage is Pediatric Neurodevelopmental care. The state's only PND works only part time and will be retiring as of December 31st. Without this specialty in Alaska, children needing diagnoses could face long flights to Seattle or Portland and face a 6-9 month waiting list. In addition, many of the existing resources are concentrated in Anchorage and states 75 or so pediatricians are concentrated to the three largest cities (Anchorage, Fairbanks and Juneau) Access to these resources from outside the southcentral region entails high transportation costs many times borne by the Medication program. The use of telemedicine is limited due to narrow band with in most of Alaska

narrow band with in most of Alaska.

Actions taken to improve the capacity of the MCH workforce in the state

- WCFH sponsors the biennial Alaska MCH and Immunization Conference, which serves as an opportunity for rural and urban Alaskan health professionals to come together to learn about best practices, tools, and surveillance data related to the prevention, diagnosis, and treatment of women's, children's, and adolescent health issues in Alaska. The 2014 conference was approved for up to 14.5 continuing education credits for physicians and nurses and up to 12.5 CE credits for tribal community health aides. In 2014, 256 people attended the conference with over 100 of the attendees being nurses. Others included MCH program managers, researchers, physicians, and other health care providers in MCH.
- The new CYSHCN Director has been participating in AMCHP's Leadership Institute for new CYSHCN Directors and the New Director Mentor Program (NDMP). The Leadership Institute provides training and technical assistance to new Directors on leadership strategies along with developing knowledge, skills, and abilities related to CYSHCN.
- Two MCH Epidemiology senior staff members attended the national CityMatCH Leadership and Epidemiology Conference in September 2014. At the conference they each attended pre-conference trainings sponsored by AMCHP in addition to presenting posters and attending the regular conference sessions to learn about national activities and resources available for MCH Epidemiologists.
- Two WCFH staff (the Title V Block Grant and MCH Needs Assessment coordinator and the CYSHCN Director) attended the Association of Maternal and Child Health Programs (AMCHP) 2015 Annual Conference in January 2015 along with the Title V and CYSHCN directors. At the conference they received hands on training to finalize the required Five Year Needs Assessment process, update outcome, structure and process measures and learned about plans for future annual reporting for the MCH Block Grant.
- Title V MCH funds are used annually to sponsor the All Alaska Pediatric Partnership Conference. This statewide conference attracts pediatricians, sub specialists and nurses from hospitals, schools and public health agencies and addresses "just in time topics" pertinent to improving health outcomes for Alaska's children and teen population.

Changes to the workforce funded by Title V:

- In June 2015 a senior epidemiologist with a nursing background and PhD in epidemiology retired to move closer to family in Georgia. It is unlikely we will be able to easily replace her substantial experience and skills. This position will be posted for recruitment in July/August 2015, with a focus on working with surveillance of child abuse and neglect data as well as assisting with CollN work and supporting data needs for the nurse home visiting program.
- In June 2015, the manager of the Maternal Infant Mortality Review and Child Death Review program for roughly the past 8 years retired. While this is a loss of much institutional knowledge about the program and how it runs, it provided an opportunity institutes program efficiencies aligning skill sets. The position will be recruited as a Epidemiology Specialist I to bring more epidemiology support to the program and other duties have been reassigned to existing staff.
- In June 2014, an epidemiology specialist position within the MCH Epidemiology Unit was reclassed to be a Public Health Scientist with the current incumbent completing his PhD in 2016.
- The manager of the MCH Epidemiology Unit retired in May 2014. After serving as unit manager for two months, the former Epidemiology Specialist II and Coordinator for the CUBS program was permanently hired in July 2014. Due to budget cut-backs, there are no current plans to fill her vacated position. She continues to support CUBS as part of her Unit Manager duties.

Critical workforce development and training needs of state Title V staff

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

II.F.3. Family Consumer Partnership

The Adolescent Health program has an established family/consumer partnership through the Youth Alliance of Healthier Alaska (YAHA), which has diverse membership of youth from across the state. YAHA contributes to Title V activities as an advisory committee and also assists with strategic and program planning and materials development. The group provided feedback to the development of the 2015 Needs Assessment survey, and also responded to and forwarded the survey to their peers. There were eight members engaged in this partnership during the 2014-2015 school year. Each member engaged for a full day of orientation in September 2014 and then for three hours per month, as well as additional individual work. Youth are trained in MCH core competencies; specifically they were trained in the public health model and are introduced to life course theory. The mission of the YAHA is to advise the adolescent health program and other health programs in Alaska and to create interventions designed to improve the lives of adolescents in Alaska. In 2014-2015, youth made decisions and provided insight and advice on a wide spectrum of topics. They served as a review committee before materials created for teens by various health programs were designed or distributed. They partnered with community organizations to create community action plans to address youth-related challenges. They advised DPH on issues such as substance abuse, violence, suicide, injury, teen pregnancy, nutrition, and fitness, which positively impacts programs and policies.

The family/consumer voice is also present in the newborn hearing screening advisory committee where parents inform the program and provide their story to the group. The Newborn Metabolic Screening Advisory (NBMS) advisory committee tried to recruit a parent representative this fiscal year as previous parent representatives have moved out of state. The program will continue to recruit a family member of a child with a disorder detected through the NBMS screening process in order to maintain the family voice. The CYSHCN Director and D70 Medical Home Program Manager also presented to a local parent leadership group about how their voice can benefit CYSHCN programs in Alaska.

The Alaska Health and Disabilities Committee (AHDC) continually reaches out to Alaskans with disabilities and family members of Alaskans with disabilities to request participation on the committee. Currently, 27 of the 45 members are Alaskans with disabilities or family members of Alaskans with disabilities. In addition, work groups working on focused areas include people with disabilities.

The Early Hearing Detection and Intervention (EHDI) program advisory committee currently has 5 family/consumer members. These families/consumers collaborate with program staff and partner on program activities and quality improvement efforts. Families are offered an honorarium when participation falls outside of their paid professional role.

During FY16 as has been the case for FY 2010-2014, the Neurodevelopmental Outreach Clinics will offer community presentations by the clinic coordinator, parent navigators, LEND fellows, or other stakeholders regarding autism and other neurodevelopmental disorders. Families will be recruited to attend these presentations and participate in community conversations.

Alaska continues to sponsor pediatric outreach clinics for autism and neurodevelopmental disorders, genetics, metabolic, and cleft lip and palate disorders. All specialty clinics collect client satisfaction surveys during or after the clinics. As a part of WCFH's grant with the Western States Genetic Services Collaborative (WSGSC), the Genetics and Metabolic clinic participate in a project in which parent surveys collect data on parent thoughts and attitudes related to the services provided in the clinic. The IRB approval was obtained in 2013 and continues to be utilized in the clinics. It is anticipated that analysis of these findings will be available in 2015. The responses from parents will help to better understand the quality of services provided and if the clinics are providing parent with the information they need.

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

In the Maternal, Infant, & Early Childhood Home Visiting program, parent/consumer involvement is valued. The nurse home visitors in the Providence Nurse-Family Partnership program complete client satisfaction surveys through the client's course of the program. The survey results are used for quality improvement and program planning activities. Parents, along with other family members or close friends, are invited to attend client events. Since the January 2013 start of the program, parents have been asked to participate in holiday parties, baby clothing exchanges, client graduation parties, and summer picnics. As a part of promoting the program to the community, Providence has identified a client leader who has spoken about the program in public venues and has served as an advocate for other families.

II.F.4. Health Reform

Alaska's newly elected Governor has made Medicaid expansion a number one priority. His new administration includes a new Commissioner, Val Davidson, a longtime Alaska Native leader, for the Department of Health and Social Services. She has over 15 years of experience working at the state and federal level on Medicaid and wholly supports Medicaid expansion as a catalyst for Medicaid reform. Expanding Medicaid will give over 40,000 Alaskans access to affordable health care and help reduce over-utilization of emergency services. Currently, adult Medicaid is limited to residents who must not only be low-income (≤78% FPL), but also be in a certain category such as disabled, pregnant or caretakers of dependent children. Those in the expansion population include individuals who are not currently offered affordable health insurance coverage by their employer, or may not be eligible for subsidized plans on the Health Insurance Marketplace and cannot afford to purchase an individual health insurance plan on their

Health Insurance Marketplace and cannot afford to purchase an individual health insurance plan on their own. This "newly eligible" population would include all childless adults between 100% and 133% FPL.

During the first regular session (2015) of the 29th Alaska Legislature, the Governor proposed both Medicaid expansion and Medicaid reform bills as a means of achieving cost savings to assist in financing any expansion efforts that are approved. Neither of these bills passed through the Alaska legislature in the 2015 session. At this time, it is unknown if the Governor will call an additional special session just to address Medicaid expansion and reform.

During the 2015 legislative session, a public health work group, co-led by the Title V Director, convened to provide the public health voice in Medicaid expansion. The Commissioner's new health care policy leader collaborated with public health representatives in the work group. Programs from within WCFH, as well as the division and department as a whole, critically reviewed their programs for any cost-savings measures that might apply, such as working with the Division of Medical Assistance (AK Medicaid) to more closely align their payment processes with national best practice standards of care and primary prevention efforts. This process improvement work with Medicaid will move forward regardless of the outcome of the proposed legislation.

In the Title X program, clinical service sites are required to collect and report on ACA Outreach and Enrollment activities on a quarterly basis to the federal agency. One of Alaska's Title X sites has a special Outreach and Enrollment grant through the National Family Planning and Reproductive Health Association (NFPRHA) to enhance their O&E activities and increase enrollment in Alaska's Exchange. This agency also works collaboratively with the local Community Health Center to assure coordination of their shared clients' primary care needs.

In an effort to assure the provision of culturally and linguistically appropriate services and coordination of health care for vulnerable populations in Alaska, a draft policy has been proposed to require that all grants and contracts issued by Alaska's Division of Public Health contain language requiring sub-recipients to assure that 1) services rendered are sensitive to the unique cultural aspects of the population served under these agreements; all agreements must include the official definition of cultural competency, as well as the hyperlink to training resources, guides, etc., found on the Office of Minority Health website; and 2) translation services are available for clients with Limited English Proficiency (LEP), and must be appropriate for the services rendered under that grant or contract, e.g., if medical services are being provided under the grant or contract, a medical translation service must be obtained. Since program inception, all Title X sites under the State of Alaska's grant program meet or exceed these proposed requirements per national best practice standards and as required by federal law, and WCFH staff will continue to work with the DPH Director's office to pursue adoption of this policy for all Division grants and contracts.

The Alaska Title V program is working in collaboration with the state's 211 system that received federal funding to provide client navigation support for those looking to enroll in plans available on the Marketplace. Inquiries from callers to the 1-800 Title V line have been directed to 211 for assistance. This service plays a large support role during the fall enrollment period. Other efforts to improve enrollment in the current Medicaid system include more recent work with the Division of Public Assistance and the Division of Health Care Services on the enrollment processing system. Technical Assistance from the MCH Workforce Development Center at Chapel Hill is helping to map out current processes and use QI tools to improve efficiency and accuracy with the goal of decreasing the length of time it takes to process an enrollment application for Medicaid coverage.

There has been no word from the Governor's office or the Commissioner's office on plans or strategies that will be implemented to continue the legislative push to allow for Medicaid expansion during the second year of the legislature beginning in January 2016. The related bills do stay "live" during the next session and thus it is expected that work will continue on legislation proposed during 2015.

II.F.5. Emerging Issues

There are numerous emerging issues that are significant for understanding current or projected strengths and needs of the Alaska MCH population. These include:

- Health Care Provider Shortages: Alaska continues to have challenges related to provider shortages, particularly in rural Alaska and in pediatric specialty fields. There continue to be challenges in recruiting both primary care and specialty providers to the state. It is anticipated that the only pediatric neurodevelopmental physician in the state will retire at the end of CY2015. Because of this impending retirement, WCFH is partnering with Providence Alaska Medical Center and the Mental Health Trust Authority (MHTAAR) to identify other models for diagnosing children with autism and other neurodevelopmental disorders. The Title V Director and the CYSHCN Director have been in conversation with the Universities of Massachusetts, Utah and Washington as well as Alaska's LEND program to identify a training curriculum and process for training pediatricians, family practitioners and nurse practitioners in limited diagnostic techniques using a defined process. Technical Assistance from MCHB will be sought to help support a planning meeting to develop a plan and draft a training curriculum. MHTAAR is also sponsoring community meetings to develop Phase II of statewide Autism planning.
- Budget cuts: Cuts to the state general funds related to MCH will continue to be a barrier to overcome. This requires strategic planning and program prioritization to ensure WCFH is utilizing resources in the most effective manner. Difficult decisions will need to be made in the next year that will affect service delivery to the state's MCH and CYSCHN population.
- Medicaid Expansion: It is still to be determined if and how Medicaid Expansion will occur in the Alaska. Medicaid expansion has not been implemented in Alaska and was not passed by the 2015 legislature, despite support from Governor Walker and the majority of the state's population. The Governor was elected due to his support of expansion. The Adolescent Health Program is working on projects to reach youth without medical coverage and/or homeless youth without identification to help them access preventative medical visits.
- Immunizations: There continues to be a growing distrust in the government within Alaska. This could impact vaccine coverage rates along with survey response rates which impact the quality of data collected by PRAMS and CUBS. Vaccination rates among Alaskan children have been decreasing. The 2016-2020 Strategic Plan for the Division of Public Health identified increasing the percent of children with on-time immunizations as a winnable battle. Among children aged 19-35 months for the combined series, coverage was 63.9% according to the 2013 National Immunization Survey. The most frequently reported reasons given for delaying or not getting shots were that the mother thought too many shots are given at once (61%) and that some shots are given too early (48%) (CUBS 2013). Although vaccine hesitancy due to personal beliefs is higher among more educated and higher income mothers, data from the Section of Epidemiology indicate that children from families with lower socioeconomic status are less likely to be up-to-date on shots such as DTaP. In recent years, rising vaccine costs and decreased federal funding have hindered DHSS's ability to supply vaccines for Alaskans. In June 2014, Senate Bill 169 was signed into law, authorizing the formation of a vaccine assessment account, from which the Immunization Program will be able to purchase pediatric and adult vaccines at discounted rates for distribution to health care providers. This long-term vaccine financing solution will be funded by private and public health care insurers, health benefit plans, Employee Retirement Income Security Act plans, third-party administrators, and other payers, who will be assessed based on their proportionate share of the overall vaccine costs. An independent vaccine assessment council, appointed by the DHSS Commissioner, will determine assessments and oversee programmatic activities.
- Chronic conditions in children: While there is no state-wide surveillance of child weight, one-third of children entering kindergarten and first grade in the Anchorage School District were overweight or at-risk for becoming overweight. The 2016-2020 Strategic Plan for the Division of Public Health identified increasing the proportion of children who are at a healthy weight as a winnable battle. Tooth decay and obesity are currently the most prevalent chronic health issues among children.
- Early intervention: Alaska is increasingly turning its focus on early intervention. Current laws and regulations that support early intervention include universal newborn metabolic screening, newborn hearing screening and critical congenital cardiac screening. Early screening for autism and other neurodevelopmental disorders is also a priority. Early intervention can significantly improve a child's outcome for school readiness and general health. Lack of funding continues to be a barrier to effectively implementing all aspects of early intervention, data collection and surveillance, evaluation of the program and reporting.
- Newborn Metabolic Conditions: The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children (SACHDNC) continues to expand the number of conditions on the recommended uniform screening panel (RUSP). As conditions such as severe combined immunodeficiency disorder (SCID) and Pompe Disease are added, additional costs are incurred to

immunodeficiency disorder (SCID) and Pompe Disease are added, additional costs are incurred to state NBMS programs and state public health laboratories. These new conditions carry additional costs related to the technology associate with the testing. As the conditions are added, the corresponding fees to birthing facilities, and ultimately families, will become costly. Challenges exist for state programs on how best to support families who may have a child with this condition as oftentimes there is no cure for the condition diagnosed.

- School health: The increase of chronic conditions among school age children, such as asthma, autism, or diabetes, will require school districts to develop capacity to meet the medical needs of children during the school day. Currently, the capacity does not exist in the smaller school districts.
- Sexual violence: The Adolescent Health Program is working with college campuses across the state to implement sexual violence prevention activities and address sexual violence on campuses using strategies at multiple levels of the social ecological model.
- Marijuana: In November 2014, Alaska voters approved an initiative legalizing recreational marijuana use. Medical marijuana has been legal in Alaska since 1998. Even prior to legalization, prenatal marijuana use in some Alaska populations was almost as high as prenatal cigarette use (PRAMS). A recent study of Alaska PRAMS data found that at 7.1%, the overall prevalence of prenatal marijuana use in Alaska during 2009-2011 was nearly three times as high as reported in Hawaii in a similar study. Marijuana use before and during pregnancy was more common among younger women. Prenatal use among Alaska Native women and residents of the Northern and Southeast regions was nearly twice that of their comparison groups. The active compound of cannabis, THC, passes freely through the placental barrier. Current studies indicate that prenatal cannabis exposure is associated with an increased risk of neurobehavioral problems in offspring, including issues with attention, memory, and problem solving. Additional studies are needed to determine the health impacts associated with marijuana use around the time of pregnancy. In addition to utilizing PRAMS to examine trends in marijuana use during pregnancy, the CUBS survey is adding a question to examine the behavior among mothers of 3-year-olds. During SFY16, the adolescent health program in WCFH is also planning work around educating parents/caregivers through websites, fact sheets, and a parent/caregiver guide about legalized recreational marijuana in Alaska and the potential consequences for young adults.
- Alaska has assembled a diverse team of MCH leaders to participate in the Collaborative Improvement and Innovation Network (CoIIN) to Reduce Infant Mortality. In addition, Title V staff, Alaska's team includes an ANTHC MCH Director, an ACOG-Alaska chapter past chairperson, community OB/GYNs, a neonatologist from the private sector, and other local health care clinical and nursing leaders in the field of MCH. The Alaska CoIIN team developed an Alaska Infant Mortality Action Plan which encourages leadership to share innovations, build quality improvement capacity, promote evidence based strategies to improve birth outcomes and reduce disparities through policy and practice changes. Currently, Alaska has chosen to focus on the following 4 strategic areas to reduce infant mortality in the state: 1) to improve safe sleep practices; 2) to reduce smoking before, during, and/or after pregnancy; 3) to reduce substance use before, during, and/or after pregnancy; and 4) to promote optimal women's health before, after, and in between pregnancies.
- Prenatal Care: Late entry into prenatal care has been identified as an emerging issue. In 2015, WCFH members are collaborating with the Division of Public Assistance (DPA) on a CoIIN project to improve preconception and interconception care for low income women of all ages. The belief is that by improving outcomes during the preconception period and in between pregnancies with the ultimate goal of reducing infant mortality rates in Alaska. Using the Quality Improvement model, project staffs will test presumptive eligibility for Medicaid benefits at one federally-qualified Community Health Center (CHC) (pilot site) for low income clients who have a positive pregnancy test and want to apply for Medicaid for prenatal care. The theory to be tested is that receiving Medicaid benefits at the earliest possible point in pregnancy will allow the CHC staff to better coordinate early and adequate prenatal care visits, dispense prenatal vitamins, and identify and address potential health risks in the pregnant woman to ameliorate maternal and infant health outcomes.
- Related to the COIIN efforts surrounding pre-/interconception care: Through a work force development opportunity provided by MCHB funding via the MCH Workforce Development Center at the University of Chapel Hill, WCFH assembled a work group to develop strategies to reduce the current 10,000 application backlog at the DPA. The work group includes participation of the CYSHCN Director/MIECHV Coordinator, the D70 Program Manager, DPA, a care coordinator, and a consumer. This group will be completing a systems mapping exercise of the application process to make recommendations to leadership on streamlining this process. The goal is to improve early access to prenatal care. This project also involves outreach and education to consumers and health care agencies on the application process.

agencies on the application process.

- Alcohol use: Alaska's Division of Behavioral Health (DBH) promotes use among all providers of a tool for standardized screening, brief intervention, and referral to treatment (SBIRT) for alcohol use among women of childbearing age to reduce alcohol-exposed pregnancies, FASD, and other health concerns related to alcohol abuse (incl. maternal depression and intimate partner violence). When combined with screening for other risk behaviors, such as lack of contraceptive use, the SBIRT tool has been effective in many settings for primary prevention, risk reduction, and FASD-informed care coordination. Many practice settings such as those in the tribal health clinic or private offices have not yet adopted these strategies, so promoting the use of these tools is a focus of work by WCFH, Public health nursing and other professional associations.
- Contraception: Another effort to be made by WCFH staff is the active promotion of long-acting reversible contraceptives (LARCs) to public and private providers, as well as working with the Medicaid program to assure removal of any logistical or cost barriers to access to LARCs for Medicaid-eligible women. Lack of an expansion of Medicaid for family planning or otherwise is a barrier to reaching poor working families and single adults who would greatly benefit from access to LARCS.
- Cervical Cancer: During 2000-2012, the percentage of Alaskan women aged 18 years or older who reported on the BRFSS that they received a Pap test within the last 3 years decreased from 91.5% in 2000 to 87.0% in 2012. Decreasing colorectal and cervical cancer was identified in the 2016-2020 Strategic Plan for the Division of Public Health as a winnable battle. Screening, through the Pap test and the human papillomavirus (HPV) test, significantly reduces mortality from cervical cancer through early detection and treatment. The State of Alaska's Breast and Cervical Cancer Early Detection Program (BCHC) is housed in WCFH and provides funding for breast and cervical cancer screening and diagnosis for women aged 18-64 years with limited incomes who have little or no health insurance. Over the next couple of years, the BCHC program will focus their efforts on novel ways to identify late or never screened women across the state. Using new technology, the BCHC program can target villages and specific parts of the state where there are high rates of cancer and low numbers of screening personnel. The BCHC program continues to link with the Cancer program in Chronic Disease to look at ways to reach our multicultural population and educate them on screening standards.

II.F.6. Public Input

Since the FY 2016 Block Grant coincides with the 2015 Needs Assessment, a full description of the Title V public participation program can be found in the 2015 Needs Assessment Summary submitted with this application. A brief description will be presented here.

WCFH, the Title V agency, relies on on-going, continuous engagement with stakeholders for meaningful public participation. WCFH works with and sponsors numerous advisory committees composed of health care providers, parents, consumers, coalition members, and public health staff from across Alaska. They meet on a regular basis, usually once per quarter, to provide input on program's needs, assess quality, and provide ideas for future directions. In addition, all the agencies within the Department of Health and Social Services who offer MCH services, including WCFH, maintain web pages of their programs. The web sites include contact information so that anyone reviewing the site can provide input on the work described.

For the 2015 Needs Assessment, focus groups were conducted with selected WCFH advisory committees including the School Nurse Advisory Committee, Newborn Metabolic Screening Committee and Patient Centered Medical Home Committee. In addition, an online survey was implemented through Survey Monkey from October through December of 2014. The online survey yielded 1,065 individual responses and over 3,500 total comments. A full description of the public input process for the Needs Assessment is in Chapter II. B. Needs Assessment Summary.

For the FY 2016 Block Grant Application, WCFH relied on its Title V web page to disseminate information (http://dhss.alaska.gov/dph/wcfh/Pages/titlev/default.aspx). An Executive Summary describing the Title V program, priorities, and activities was posted at the top of the page. The web page also contained links to prior applications and state and national performance measure narratives. An explanation and link to the Executive Summary was distributed through postings on the DHSS Facebook page and Twitter account, along with WCFH contact information to enable feedback on the use of Title V funds. In addition, the summary was distributed to an extensive email list of pediatricians and other children's health practitioners around the state in a weekly newsletter compiled by Anchorage physician Dr. Bruce Chandler. The DPH Alaska Public Health GovDelivery listserve was used to distribute the summary to approximately 2000 subscribers, and then DPH Alaska Perinatal News GovDelivery listserv was used to distribute the summary to 797 subscribers. Within the first four hours of the Perinatal News GovDelivery notice, there were 63 unique opens of the email and 16 unique clicks on either the attached Executive Summary or the Title V website link embedded in the email.

The executive summary was also distributed by WCFH staff to members of the following advisory committees:

- Alaska Home Visiting Steering Committee
- Pediatric Medical Home Steering Committee
- Newborn Metabolic Screening Advisory Committee
- PRAMS Steering Committee
- CUBS Steering Committee
- EHDI Steering Committee

The executive summary was also distributed via a Pediatric community listserve to over 700 participants and to a variety of other list serves that Title V participate in including those with Stone Soup Group, the PTI HRSA grantee and the Governor's Council on Special Education and Disabilities.

A copy of the Executive Summary is attached in Chapter III. C. Executive Summary.

As of this posting date, three non-Title V entities responded to the announcement and requests for feedback. The Alaska Mental Health Board expressed an interest in collaborating on substance cessation and child maltreatment work. The March of Dimes supported the life course approach to our seven chosen priorities and is particularly enthusiastic about the decision to include child maltreatment and behavioral/mental health problems as cross-cutting priorities. However, they suggest that infant mortality should be explicitly stated as a priority as well. A representative of the Yukon-Kuskokwim Health Corporation made a number of suggestions about how Title V funds could be spent; including parenting classes for young mothers, funds for young mothers to travel to women's shelters (or available shelters in every village), and increased focus on young mothers with a history of DV – for both parenting classes and helping their children access well-child exams. The Title V program will continue to collect feedback over the next month and collate the information for consideration of inclusion by the Title V leadership team in the strategic activities.

II.F.7. Technical Assistance

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

- Training in understanding and becoming proficient in alternative communication platforms to receive and transmit information to younger audiences and staff (blogs, webcasts, webinars, social media, conference calls, and emails.) This would assist with work around promoting healthy relationships and protective factors among youth, as well as disseminating a population based campaign for the primary prevention of child maltreatment.
- Training in program evaluation and advanced analysis skills for epidemiologists to support the volume of MCH and CYSHCN data needed by WCFH program staff and to support the CollN activities. Examples of analysis training that would be useful include training on small number analysis, propensity scores, structural equation modeling, and inverse probability weighting. The most effective use of funds would be to hire a consultant to come to Alaska who could conduct a training for multiple staff here, rather than sending Alaska MCH Epi Unit staff to training courses elsewhere.
- Leadership development is a consistent need. Assuring that leaders are proficient coaches for employees is important, in particular as more millennials are hired on as junior professional-level staff. Millennials want their work to make an impact, they are tech savvy, racially diverse, educated, like to collaborate, and expect constant coaching and feedback. In order to retain young staff and develop future leaders, current WCFH leadership could use additional training in coaching this next generation and inspiring others with a shared vision.
- Training and resources for Title V and state partners in expanding trauma-informed service delivery for state-based services.
- Technical Assistance to support a project to expand the network of providers who can diagnose children suspected of experiencing autism. Conceptually, this project involves the creation of a process to triage developmentally atypical children into two groups to determine the level of clinician capable of making a diagnosis, and allowing children with clearer developmental patterns to be diagnosed at the local level by trained pediatricians or nurse practitioners, while reserving more scarce developmental pediatric time for those children whose developmental pattern appears to be more complex in nature. Specific needs for this would be financial support and TA to do the following:

  - Create a triage tool that distinguishes children who could be evaluated and diagnosed by a trained pediatrician or nurse practitioner from children who require evaluation by a developmental pediatrician.
  - Identification and organization of a standard battery of assessment instruments and checklists to collect developmental and behavioral information about each child.
  - Develop an evaluation template including the key features required for diagnosis of developmental disorders for use by the pediatrician or nurse practitioner.
  - Develop a training curriculum to support each element of the evaluation process.

III. Budget Narrative

	2012		2013		2014	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,102,057	$1,103,380	$1,091,900	$1,009,552	$1,008,498	$1,050,528
Unobligated Balance	$0	$41,227	$0	$0	$0	$0
State Funds	$16,744,140	$14,766,425	$17,372,096	$16,294,188	$14,766,425	$18,298,931
Local Funds	$0	$0	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0	$0	$0
Program Funds	$75,000	$78,100	$100,000	$100,000	$90,000	$113,148
SubTotal	$17,921,197	$6,154,100	$18,563,996	$6,711,300	$15,864,923	$19,462,607
Other Federal Funds	$6,154,100	$15,989,132	$6,711,300	$17,403,740	$6,441,474	
Total	$24,075,297	$22,143,232	$25,275,296	$24,115,040	$22,306,397	$19,462,607

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,043,564		$1,050,528	
Unobligated Balance	$0		$0	
State Funds	$14,504,339		$4,471,700	
Local Funds	$0		$0	
Other Funds	$0		$0	
Program Funds	$140,000		$100,000	
SubTotal	$15,687,903		$5,622,228	
Other Federal Funds	$6,765,745		$5,922,338	
Total	$22,453,648		$11,544,566	

III.A. Expenditures

The Alaska Title V program experienced flat funding in SFY14 for the state general fund dollars. The Title V Block grant totally slightly over 1 million dollars continues to be significantly relied upon for infrastructure dollars focused on the state priorities identified in the MCH 5 year needs assessment. State general fund maintenance of effort dollars come in large part from the appropriation for the infant learning program and additional state dollars for the WIC program. Other state dollars include those from the Mental Health Trust authority, interagency receipts from the Division of Public Assistance and a portion of state general fund dollars applied to child protection.

Ongoing fee collection for the specialty clinics is important to the MCH Title V program and provides about 110-113K per year, however this covers only about 20% of the cost of providing these clinics across the state of Alaska. Fees are limited by regulation to the Medicaid rate and do not reflect the actual cost of supporting these clinics. Gap filling services such as these are supported through a combination of state general fund dollars, fees, Medicaid receipts and MCH Title V funds. Title V dollars are used to pay for staff to coordinate the clinic, travel staff and contracted physicians to the sites and for contracts for medical and other specialty providers. Title V funds are not used to pay for Direct services as listed on 3b of the financial expenditures page. The state FY 16 budget will pose challenges for state programs to maintain their programmatic missions and still affect outcomes in a positive manner.

Federal grants are critical to providing the infrastructure to carry forward the state's priorities. Alaska moved away from direct services nearly 15 years ago and has provided dollars for linking services, technical assistance and infrastructure support in the way of data surveillance, program evaluation and data analysis to support the services delivered oftentimes by other agencies outside of DHSS. For example, partnerships such as Alaska Primary Care Association provide a critical venue to distribute information and link interested medical practices with our D-70 grant focused on promoting and implementing pediatric medical homes. Work with the University of Alaska-Anchorage's Center for Human Development have been an important partner in developing the workforce to deliver intensive early intervention applied behavioral analysis services to children diagnosed with autism. The structure implemented by the CoIIN initiative has been critical to evaluating our Alaska Infant Safe Sleep program and supporting the data and Quality Improvement work.

Alaska's program also received funds from other agencies such as the Division of Public Assistance through a reimbursable service agreement (RSA). The funding supports the Division of PA on meeting their Temporary Aid to Need Families (TANF) requirements for teen and out of wedlock pregnancy prevention requirements. Funding from the Mental Health trust Authority also supplement work on autism systems building efforts. Finally, funds are received via an RSA's from Emergency and Disaster Planning to help build improved programs and systems for people with disabilities. We have particularly focused on pregnant women, infant and children/adolescents with special conditions in the planning and sheltering in times of a disaster.

III.B. Budget

Budget in FY 16

With the dramatic drop in the price of oil prior to the new legislative session which started in January of 2015, our newly elected governor announced a 25% reduction in the budget over the next two to three years. The MCH Title V program was cut 13% in state general funds for SFY16 and will experience an anticipated additional 10-15% cut in SFY17. This will result in the termination of some programs, consolidation of programs and layoffs or keeping position vacant for a lengthy period of time. Likely the Division of Public Health will experience consolidation of Sections if deep cuts continue or those expected in SFY17 are realized or are greater.

Two federal grants were applied for but not awarded for this coming state fiscal year; one was approved by not funded. An additional grant was awarded but has not been announced as of the time of this submission. Programs that are in a precarious place in the near future include the Oral Health program as it will be without federal funding after September 1st with the exception of some carry forward. Long term financing for this program is unknown. The state will full expend the MCH Title V grant which expires September 30, 2015 and will fully expend the next years grant due to expire September 30, 2016 as well as one half of the grant award anticipated to be awarded October 1, 2015.

It is anticipated that two long term staff will retire during or at the end of the state fiscal year. Filling these vacancies will take time due to their specialization.

The budget for next reporting year was kept constant anticipating flat funding for the block grant. State general funds used for maintenance of effort were reduced by approximately 10%. A new accounting system will be implemented starting at the end of July of 2015. This will hopefully make tracking expenditures less time consuming.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - MOA with Medicaid-not signed.pdf

V. Supporting Documents

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

Supporting Document #01 - Combined_OrgCharts.pdf

Supporting Document #02 - MCH Epi publications_June 2015.pdf

Supporting Document #03 - WCFH.ProgramDescriptions.pdf

Supporting Document #04 - 2015NeedsAssessmentSurveyResultsCombined.pdf

Form 2

MCH Budget/Expenditure Details
State: Alaska

	FY16 Application Budgeted	FY14 Annual Report Expended
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$1,050,528	$1,050,528
Of the Federal Allocation, the amount earmarked for:		
A. Preventive and Primary Care for Children	$325,663 (31%)	$325,663 (31%)
B. Children with Special Health Care Needs	$346,674 (33%)	$346,674 (33%)
C. Title V Administrative Costs	$105,052 (10%)	$105,052 (10%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$0	$0
3. STATE MCH FUNDS (Item 18c of SF-424)	$4,471,700	$18,298,931
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$0	$0
5. OTHER FUNDS (Item 18e of SF-424)	$0	$0
6. PROGRAM INCOME (Item 18f of SF-424)	$100,000	$113,148
7. TOTAL STATE MATCH (Lines 3 through 6)	$4,571,700	$18,412,079
A. Your State's FY 1989 Maintenance of Effort Amount	$4,471,700	
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$5,622,228	$19,462,607
9. OTHER FEDERAL FUNDS		
Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$5,922,338	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$11,544,566	$19,462,607

9. OTHER FEDERAL FUNDS

Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$250,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$159,600
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$145,300
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$193,600
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$1,000,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health	$220,164
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$95,374
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$250,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$532,300
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Breast and Cervical	$2,076,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	$400,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > D-70 grant for CYSHC	$300,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Disabilities & Healt	$300,000

	FY14 Annual Report Budgeted
1. FEDERAL ALLOCATION	$1,008,498
A. Preventive and Primary Care for Children	$326,549
B. Children with Special Health Care Needs	$326,550
C. Title V Administrative Costs	$100,000
2. UNOBLIGATED BALANCE	$0
3. STATE MCH FUNDS	$14,766,425
4. LOCAL MCH FUNDS	$0
5. OTHER FUNDS	$0
6. PROGRAM INCOME	$90,000
7. TOTAL STATE MATCH	$14,856,425

Form Notes For Form 2:

None

Field Level Notes for Form 2:

1 . **Field Name :** 3. STATE MCH FUNDS

Fiscal Year : 2014

Column Name : Annual Report Expended

Field Note :

Additional state general fund dollars came from sources such as the Early Intervention match requirements, state GF to the WIC program, and state match dollars from Medicaid

2 . **Field Name :** 6. PROGRAM INCOME

Fiscal Year : 2014

Column Name : Annual Report Expended

Field Note :

More program income was collected than anticipated

Data Alerts for Form 2:

None

Form 3a

Budget and Expenditure Details by Types of Individuals Served
State: Alaska

I. TYPES OF INDIVIDUALS SERVED	FY16 Application Budgeted	FY14 Annual Report Expended
IA. Federal MCH Block Grant		
1. Pregnant Women	$134,729	$134,729
2. Infants < 1 year	$118,444	$118,444
3. Children 1-22 years	$325,663	$325,663
4. CSHCN	$346,674	$346,674
5. All Others	$125,017	$125,017
Federal Total of Individuals Served	$1,050,527	$1,050,527
IB. Non Federal MCH Block Grant		
1. Pregnant Women	$1,696,270	$1,884,744
2. Infants < 1 year	$1,870,338	$2,078,153
3. Children 1-22 years	$999,459	$1,129,268
4. CSHCN	$10,823,391	$12,225,990
5. All Others	$882,699	$980,776
Non Federal Total of Individuals Served	$16,272,157	$18,298,931
Federal State MCH Block Grant Partnership Total	$17,322,684	$19,349,458

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1. **Field Name :** IA. Federal MCH Block Grant, 3. Children 1-22 years

   Fiscal Year : 2016

   Column Name : Application Budgeted

   Field Note :

   We anticipate for FY 2016 a reduction of 10-percent reduction in GF, thus then number of children served and the state match will be reduced

2. **Field Name :** IA. Federal MCH Block Grant, 4. CSHCN

   Fiscal Year : 2016

   Column Name : Application Budgeted

   Field Note :

   More dollars have been added to support children with autism and thus a slight increase in the dollars for CYSHCN

Data Alert for Form 3a:

None

Form 3b

Budget and Expenditure Details by Types of Services
State: Alaska

	FY16 Application Budgeted	FY14 Annual Report Expended
I. TYPES OF SERVICES		
IIA. Federal MCH Block Grant		
1. Direct Services	$0	$0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$0	$0
B. Preventive and Primary Care Services for Children	$0	$0
C. Services for CSHCN	$0	$0
2. Enabling Services	$420,211	$475,553
3. Public Health Services and Systems	$630,317	$574,975
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$0
Physician/Office Services		$0
Hospital Charges (Includes Inpatient and Outpatient Services)		$0
Dental Care (Does Not Include Orthodontic Services)		$0
Durable Medical Equipment and Supplies		$0
Laboratory Services		$0
Direct Services Total		$0
Federal Total	**$1,050,528**	**$1,050,528**

	FY16 Application Budgeted	FY14 Annual Report Expended

IIB. Non-Federal MCH Block Grant

1. Direct Services	$0	$0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$0	$0
B. Preventive and Primary Care Services for Children	$0	$0
C. Services for CSHCN	$0	$0
2. Enabling Services	$1,142,925	$7,271,000
3. Public Health Services and Systems	$3,428,775	$11,141,079
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$0
Physician/Office Services		$0
Hospital Charges (Includes Inpatient and Outpatient Services)		$0
Dental Care (Does Not Include Orthodontic Services)		$0
Durable Medical Equipment and Supplies		$0
Laboratory Services		$0
Direct Services Total		$0
Non-Federal Total	**$4,571,700**	**$18,412,079**

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

Form 4

Number and Percentage of Newborns and Others Screened, Cases Confirmed and Treated
State: Alaska

Total Births by Occurrence **11,203**

1a. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Classic phenylketonuria	11,137	2	2	2
Primary congenital hypothyroidism	11,137	122	3	3
Classic galactosemia	11,137	22	0	0
S,S disease (Sickle cell anemia)	11,137	0	0	0
Propionic acidemia	11,137	1	1	1
Biotinidase deficiency	11,137	1	0	0
Congenital adrenal hyperplasia	11,137	14	0	0
Medium-chain acyl-CoA dehydrogenase deficiency	11,137	0	0	0
Very long-chain acyl-CoA dehydrogenase deficiency	11,137	0	0	0
Cystic fibrosis	11,137	1	1	1

1b. Secondary RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Carnitine palmitoyltransferase type I deficiency	11,137	173	173	173

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Newborn Hearing	10,969	148	20	13

3. Screening Programs for Older Children & Women

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment

4. Long-Term Follow-Up

The state of Alaska NBMS program follows infants from screening, to diagnosis, and then referral to treatment. The program captures a treatment start date if applicable for certain disorders. The program does not have the resources or staff to do any long term follow-up of outcomes past that point in time.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1. **Field Name :** Classic phenylketonuria - Receiving At Lease One Screen

   Fiscal Year : 2016

   Column Name : Core RUSP Conditions - Newborn

   Field Note :

   Column A, in CY 2014 there were 39 refusals, and no missed screens.

2. **Field Name :** Classic phenylketonuria - Positive Screen

   Fiscal Year : 2016

   Column Name : Core RUSP Conditions - Newborn

   Field Note :

   Column B, the # of presumptive positive screens reflects all unduplicated children who had an abnormal result on either the first, second, or repeat metabolic screen. It reflects both children who had just an abnormal blood spot result and children who needed diagnostic testing.

3. **Field Name :** Primary congenital hypothyroidism - Receiving At Lease One Screen

   Fiscal Year : 2016

   Column Name : Core RUSP Conditions - Newborn

   Field Note :

   Column A, in CY 2014 there were 39 refusals, and no missed screens.

4. **Field Name :** Primary congenital hypothyroidism - Positive Screen

   Fiscal Year : 2016

   Column Name : Core RUSP Conditions - Newborn

   Field Note :

   Column B, the # of presumptive positive screens reflects all unduplicated children who had an abnormal result on either the first, second, or repeat metabolic screen. It reflects both children who had just an abnormal blood spot result and children who needed diagnostic testing.

5. **Field Name :** Classic galactosemia - Receiving At Lease One Screen

   Fiscal Year : 2016

   Column Name : Core RUSP Conditions - Newborn

   Field Note :

   Column A, in CY 2014 there were 39 refusals, and no missed screens.

6. **Field Name :** Classic galactosemia - Positive Screen

   Fiscal Year : 2016

   Column Name : Core RUSP Conditions - Newborn

   Field Note :

   Column B, the # of presumptive positive screens reflects all unduplicated children who had an abnormal result on either the first, second, or repeat metabolic screen. It reflects both children who had just an abnormal blood spot result and children who needed diagnostic testing.

7. **Field Name :** S,S disease (Sickle cell anemia) - Receiving At Lease One Screen

Fiscal Year : 2016

Column Name : Core RUSP Conditions - Newborn

Field Note :

Column A, in CY 2014 there were 39 refusals, and no missed screens.

8. **Field Name :** Propionic acidemia - Receiving At Lease One Screen

Fiscal Year : 2016

Column Name : Core RUSP Conditions - Newborn

Field Note :

Column A, in CY 2014 there were 39 refusals, and no missed screens.

9. **Field Name :** Propionic acidemia - Positive Screen

Fiscal Year : 2016

Column Name : Core RUSP Conditions - Newborn

Field Note :

Column B, the # of presumptive positive screens reflects all unduplicated children who had an abnormal result on either the first, second, or repeat metabolic screen. It reflects both children who had just an abnormal blood spot result and children who needed diagnostic testing.

10. **Field Name :** Biotinidase deficiency - Receiving At Lease One Screen

Fiscal Year : 2016

Column Name : Core RUSP Conditions - Newborn

Field Note :

Column A, in CY 2014 there were 39 refusals, and no missed screens.

11. **Field Name :** Biotinidase deficiency - Positive Screen

Fiscal Year : 2016

Column Name : Core RUSP Conditions - Newborn

Field Note :

Column B, the # of presumptive positive screens reflects all unduplicated children who had an abnormal result on either the first, second, or repeat metabolic screen. It reflects both children who had just an abnormal blood spot result and children who needed diagnostic testing.

12. **Field Name :** Congenital adrenal hyperplasia - Receiving At Lease One Screen

Fiscal Year : 2016

Column Name : Core RUSP Conditions - Newborn

Field Note :

Column A, in CY 2014 there were 39 refusals, and no missed screens.

13. **Field Name :** Congenital adrenal hyperplasia - Positive Screen

Fiscal Year : 2016

Column Name : Core RUSP Conditions - Newborn

Field Note :

Column B, the # of presumptive positive screens reflects all unduplicated children who had an abnormal result on either the first, second, or repeat metabolic screen. It reflects both children who had just an abnormal blood spot result and children who needed diagnostic testing.

14. Field Name : Medium-chain acyl-CoA dehydrogenase deficiency - Receiving At Lease One Screen

Fiscal Year : 2016

Column Name : Core RUSP Conditions - Newborn

Field Note :

Column A, in CY 2014 there were 39 refusals, and no missed screens.

15. Field Name : Very long-chain acyl-CoA dehydrogenase deficiency - Receiving At Lease One Screen

Fiscal Year : 2016

Column Name : Core RUSP Conditions - Newborn

Field Note :

Column A, in CY 2014 there were 39 refusals, and no missed screens.

16. Field Name : Cystic fibrosis - Receiving At Lease One Screen

Fiscal Year : 2016

Column Name : Core RUSP Conditions - Newborn

Field Note :

Column A, in CY 2014 there were 39 refusals, and no missed screens.

17. Field Name : Cystic fibrosis - Positive Screen

Fiscal Year : 2016

Column Name : Core RUSP Conditions - Newborn

Field Note :

Column B, the # of presumptive positive screens reflects all unduplicated children who had an abnormal result on either the first, second, or repeat metabolic screen. It reflects both children who had just an abnormal blood spot result and children who needed diagnostic testing.

18. Field Name : Newborn Hearing - Receiving At Lease One Screen

Fiscal Year : 2016

Column Name : Other Newborn

Field Note :

Data available for CY 2013 only.

19. Field Name : Newborn Hearing - Positive Screen

Fiscal Year : 2016

Column Name : Other Newborn

Field Note :

148 did not pass final screening. \r\n36 diagnosed with no hearing loss. \r\n20 diagnosed with hearing loss.

20. Field Name : Newborn Hearing - Confirmed Cases

Fiscal Year : 2016

Column Name : Other Newborn

Field Note :

Of the 20 diagnosed with hearing loss:\r\n13 referrals for treatment; 12 eligible and 1 eligibility unknown. \r\n\r\n3 declines, 2 moved out of jurisdiction, 2 unknown/unresponsive.

21. Field Name : Newborn Hearing - Referred For Treatment

Fiscal Year : 2016

Column Name : Other Newborn

Field Note :

12 referred and eligible. 1 referred but eligibility unknown.

Form 5a

Unduplicated Count of Individuals Served under Title V
State: Alaska

Reporting Year 2014

		Primary Source of Coverage				
Types of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private/Other %	(E) None %	(F) Unknown %
1. Pregnant Women	12,795	47	0	27	25	1
2. Infants <1 year of Age	10,590	31	0	51	13	5
3. Children 1 to 22 Years of Age	230,329	31	0	51	13	5
4. Children with Special Health Care Needs	2,354	26.3	0	69.7	4	0
5. Others	0	0	0	0	0	100
Total	256,068					

Form Notes for Form 5a:

None

Field Level Notes for Form 5a:

1. **Field Name :** Pregnant Women Total Served

Fiscal Year : 2014

Column Name :

Field Note :

All pregnant women receive Title V Service.

1A. Data Source: Alaska BVS. Reported for 2013. 2014 data available in late 2015.All term pregnancies + ITOPS + fetal deaths counted.

1B - 1F. Data Source: Alaska PRAMS. Insurance coverage reported for 2012, most recent year available.

2. **Field Name :** Infants Less Than One Year Total Served

Fiscal Year : 2014

Column Name :

Field Note :

All infants receive Title V services through infrastructure building and population-based services such as education/outreach programs. A smaller proportion receive direct care and enabling services.

2A. Data Source: Alaska Department of Labor Population Estimates as of July, 2013. Estimates for 2014 are not available yet.

2B - 2F: Estimates for health insurance coverage from Kaiser Family Health Foundation. Health Insurance Coverage of Children 0-18. 2013. http://kff.org/other/state-indicator/children-0-18/

2C. CHIP and Medicaid coverage are combined and reported under column 2B.

3. **Field Name :** Child1To22Years_TotalServed

Fiscal Year : 2014

Column Name :

Field Note :

All children receive Title V services through infrastructure building and population-based services such as education/outreach programs. A smaller proportion receive direct care and enabling services.

All infants receive Title V services through infrastructure building and population-based services such as education/outreach programs. A smaller proportion receive direct care and enabling services.

3A. Data Source: Alaska Department of Labor Population Estimates as of July, 2013. Estimates for 2014 are not available yet.

3B - 3F: Estimates for health insurance coverage from Kaiser Family Health Foundation. Health Insurance Coverage of Children 0-18. 2013. http://kff.org/other/state-indicator/children-0-18/

3C. CHIP and Medicaid coverage are combined and reported under column 2B.

4. **Field Name :** ChildrenWithSpecialHealthcareNeeds_TotalServed

Fiscal Year : 2014

Column Name :

Field Note :

4A. Data reported for 2013, 2014 is not available yet. This is an unduplicated count of clients diagnosed or referred from: cleft lip & palate clinics, EHDI clients diagnosed & referred for services, ILP part C and not part C, autism outreach, genetics & metabolic clinics, and neurodevelopmental outreach.

4B - 4F. Data Source: National Survey of CSHCN. 2009/10. 55.2% had private insurance only, 14.5% had both public and private insurance.

Form 5b

Total Recipient Count of Individuals Served by Title V
State: Alaska

Reporting Year 2014

Types Of Individuals Served	Total Served
1. Pregnant Women	12,795
2. Infants < 1 Year of Age	10,590
3. Children 1 to 22 Years of Age	230,329
4. Children with Special Health Care Needs	2,354
5. Others	0
Total	256,068

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

1. Field Name : Pregnant Women

Fiscal Year : 2014

Column Name :

Field Note :

All pregnant women receive Title V Service.

Data Source: Alaska BVS. Reported for 2013. 2014 data available in late 2015.All term pregnancies + ITOPS + fetal deaths counted.

2. Field Name : Infants Less Than One Year

Fiscal Year : 2014

Column Name :

Field Note :

All infants receive Title V services through infrastructure building and population-based services such as education/outreach programs. A smaller proportion receive direct care and enabling services.

Data Source: Alaska Department of Labor Population Estimates as of July, 2013. Estimates for 2014 are not available yet.

3. Field Name : Children 1 to 22 Year of Age

Fiscal Year : 2014

Column Name :

Field Note :

All children receive Title V services through infrastructure building and population-based services such as education/outreach programs. A smaller proportion receive direct care and enabling services.

Data Source: Alaska Department of Labor Population Estimates as of July, 2013. Estimates for 2014 are not available yet.

4. Field Name : Children With Special Health Care Needs

Fiscal Year : 2014

Column Name :

Field Note :

Data reported for 2013, 2014 is not available yet. This is an unduplicated count of clients diagnosed or referred from: cleft lip & palate clinics, EHDI clients diagnosed & referred for services, ILP part C and not part C, autism outreach, genetics & metabolic clinics, and neurodevelopmental outreach.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX
State: Alaska

Reporting Year 2014

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	11,216	6,263	353	2,060	712	279	1,026	523
Title V Served	11,216	6,263	353	2,060	712	279	1,026	523
Eligible for Title XIX	5,469	2,199	162	1,631	389	225	606	257
2. Total Infants in State	10,590	5,869	438	1,816	467	149	1,851	0
Title V Served	10,590	5,869	438	1,816	467	149	1,851	0
Eligible for Title XIX	6,251	2,102	214	1,910	289	394	981	361

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	10,216	828	172	11,216
Title V Served	10,216	828	172	11,216
Eligible for Title XIX	4,998	367	104	5,469
2. Total Infants in State	9,692	898	0	10,590
Title V Served	9,692	898	0	10,590
Eligible for Title XIX	5,794	324	133	6,251

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1. **Field Name :** 1. Total Deliveries in State

   Fiscal Year : 2016

   Column Name : Total All Races

   Field Note :

   Data Source: Bureau of Vital Statistics

2. **Field Name :** 1. Title V Served

   Fiscal Year : 2016

   Column Name : Total All Races

   Field Note :

   Data Source: Alaska Bureau of Vital Statistics

   All pregnant women and infants receive Title V services.

3. **Field Name :** 1. Eligible for Title XIX

   Fiscal Year : 2016

   Column Name : Total All Races

   Field Note :

   Data Source: Bureau of Vital Statistics

4. **Field Name :** 2. Total Infants in State

   Fiscal Year : 2016

   Column Name : Total All Races

   Field Note :

   Provisional Data.

   Data Source: Alaska Department of Labor Population Estimates as of July, 2013. Estimates for 2014 are not available yet.

5. **Field Name :** 2. Title V Served

   Fiscal Year : 2016

   Column Name : Total All Races

   Field Note :

   Provisional Data

   Data Source: Alaska Department of Labor Population Estimates as of July, 2013. Estimates for 2014 are not available yet.

   All infants receive Title V services through infrastructure building and population-based services such as Newborn Hearing and Metabolic Screening, and educational / outreach programs. A smaller proportion receive direct care services and enabling services.

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

   Fiscal Year : 2016

   Column Name : Total All Races

   Field Note :

   Data Source: Alaska Medicaid

   Infant Medicaid data for CY 2014. Infants are defined as 1 year or older on Jan. 1, 2014 and eligible for Medicaid in CY14.

Form 7

State MCH Toll-Free Telephone Line and Other Appropriate Methods Data
State: Alaska

	Application Year 2016	Reporting Year 2014
A. State MCH Toll-Free Telephone Lines		
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 799-7570	(800) 799-7570
2. State MCH Toll-Free "Hotline" Name	Women's Children's and Family Health	Women's Children's and Family Health
3. Name of Contact Person for State MCH "Hotline"	Veronica Holmquist	Veronica Holmquist
4. Contact Person's Telephone Number	(907) 269-3462	(907) 269-3462
5. Number of Calls Received on the State MCH "Hotline"		200
B. Other Appropriate Methods		
1. Other Toll-Free "Hotline" Names	NA	NA
2. Number of Calls on Other Toll-Free "Hotlines"		0
3. State Title V Program Website Address	http://dhss.alaska.gov/dph/wcfh/Pages/default.aspx	http://dhss.alaska.gov/dph/wcfh/Pages/default.aspx
4. Number of Hits to the State Title V Program Website		7,364
5. State Title V Social Media Websites	NA	NA
6. Number of Hits to the State Title V Program Social Media Websites		0

Form Notes for Form 7:

None

Form 8

State MCH and CSHCN Directors Contact Information
State: Alaska

Application Year 2016

1. Title V Maternal and Child Health (MCH) Director

Name	Stephanie Wrightsman-Birch
Title	MCH Title V Director
Address 1	3601 C Street Suite 322
Address 2	
City / State / Zip Code	Anchorage AK 99503
Telephone	(907) 334-2424
Email	stephanie.wrightsman-birch@alaska.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director

Name	Rebekah Morisse
Title	CYSHCN Director
Address 1	3601 C Street, Suite 322
Address 2	
City / State / Zip Code	Anchorage AK 99503
Telephone	(907) 269-4762
Email	rebekah.morisse@alaska.gov

3. State Family or Youth Leader (Optional)

Name	
Title	
Address 1	
Address 2	
City / State / Zip Code	
Telephone	
Email	

Form Notes for Form 8:
None

Form 9

List of MCH Priority Needs
State: Alaska

Application Year 2016

	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1 .	Reduce substance abuse among families, including alcohol, tobacco and drugs.	Continued	
2 .	Increase access and preventative health care services to Alaskans and their families.	New	
3 .	Increase healthy relationships.	New	
4 .	Increase access to reproductive health services that adhere to national best practice guidelines.	New	
5 .	Improve system of care for families with children and youth with special health care needs	Continued	
6 .	Reduce the rate of child maltreatment	Continued	
7 .	Increase evidence based screening for all MCH populations for behavioral and mental health problems	New	

Form Notes for Form 9:

None

Form 10a

National Outcome Measures
State: Alaska

Form Note for Form 10a NPMs and NOMs:

NPM #1. Calculated as an approximate 2.5% increase per year, beginning with a 2.5% increase over the average of the past couple years.

NPM #3. Healthy People 2020 Target is 83.7%. Recent decrease due to the lack of perinatologists in the state; a new contract was recently signed so we feel a return to 79% is an achievable goal in 2016.

NPM #5. Healthy People 2020 Target is 75.9%. In 2012 approximately 75% of infants in Alaska were placed to sleep on their backs (PRAMS).

NPM #6. Calculated as an approximate 2.5% increase per year.

NPM #7. Calculated as an approximate 2.5% decrease per year. Objectives reported in worksheet are for children ages 0 through 9. Annual Objectives for adolescents ages 10 through 19 are:
(2016) 252, (2017) 246, (2018) 240, (2019) 234, (2020) 228

NPM #9. Estimates based off of YRBS data. Calculated as an approximate 2.5% decrease per year.

NPM #11. Healthy People 2020 Target is 63.3%. Calculated as an approximate 5% increase per year. Objectives reported in worksheet are for CSHCN. Objectives for non-CSHCN are:
(2016) 57%, (2017) 58%, (2018) 59%, (2019) 61%, (2020) 63%

NPM #14A and #14B. NPM #6. Calculated as an approximate 5% decrease per year.

NOM-1 Percent of pregnant women who receive prenatal care beginning in the first trimester

State Provided Data	
	2014
Annual Indicator	78.2
Numerator	8,344
Denominator	10,668
Data Source	Alaska Bureau of Vital Statistics
Data Source Year	2015

NOM-1 Notes:

None

Data Alerts :

None

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

NOM-2 Notes:
None

Data Alerts :

None

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

State Provided Data	
	2014
Annual Indicator	10.0
Numerator	
Denominator	
Data Source	Alaska Maternal and Infant Mortality Review
Data Source Year	2000-2011

NOM-3 Notes:
This is the average rate for 2000-2011; the most recent data available from within the State.

No Federally Available Data was provided by HRSA for this measure.

Data Alerts :

None

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

State Provided Data	
	2014
Annual Indicator	3.0
Numerator	673
Denominator	22,780
Data Source	Alaska Bureau of Vital Statistics
Data Source Year	2015

NOM-4.1 Notes:
None

Data Alerts :

None

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

State Provided Data	
	2014
Annual Indicator	0.9
Numerator	102
Denominator	11,390
Data Source	Alaska Bureau of Vital Statistics
Data Source Year	2015

NOM-4.2 Notes:
None

Data Alerts :

None

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

State Provided Data	
	2014
Annual Indicator	5.0
Numerator	571
Denominator	11,390
Data Source	Alaska Bureau of Vital Statistics
Data Source Year	2015

NOM-4.3 Notes:
None

Data Alerts :

None

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

State Provided Data	
	2014
Annual Indicator	1.0
Numerator	116
Denominator	11,369
Data Source	Alaska Bureau of Vital Statistics
Data Source Year	2015

NOM-5.1 Notes:
None

Data Alerts :

None

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

NOM-5.2 Notes:
None

Data Alerts :

None

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

NOM-5.3 Notes:
None

Data Alerts :

None

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

NOM-6 Notes:
None

Data Alerts :

None

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

NOM-7 Notes:
None

Data Alerts :

None

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

NOM-8 Notes:
None

Data Alerts :

None

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

State Provided Data	
	2014
Annual Indicator	6.5
Numerator	
Denominator	
Data Source	Alaska Bureau of Vital Statistics
Data Source Year	2014

NOM-9.1 Notes:
None

Data Alerts :

None

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

State Provided Data	
	2014
Annual Indicator	2.9
Numerator	
Denominator	
Data Source	Alaska Bureau of Vital Statistics
Data Source Year	2014

NOM-9.2 Notes:
None

Data Alerts :

None

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

State Provided Data	
	2014
Annual Indicator	3.6
Numerator	
Denominator	
Data Source	Alaska Bureau of Vital Statistics
Data Source Year	2014

NOM-9.3 Notes:
None

Data Alerts :

None

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

NOM-9.4 Notes:
None

Data Alerts :

None

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

NOM-9.5 Notes:
None

Data Alerts :

None

NOM-10 The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

NOM-10 Notes:
None

Data Alerts :

None

NOM-11 The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations

NOM-11 Notes:
None

Data Alerts :

None

NOM-12 Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Data Alerts :

None

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

Data Alerts :

None

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

NOM-14 Notes:
None

Data Alerts :

None

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

NOM-15 Notes:
None

Data Alerts :

None

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

NOM-16.1 Notes:
None

Data Alerts :

None

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

NOM-16.2 Notes:
None

Data Alerts :

None

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

NOM-16.3 Notes:
None

Data Alerts :

None

NOM-17.1 Percent of children with special health care needs

NOM-17.1 Notes:
None

Data Alerts :

None

NOM-17.2 Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM-17.2 Notes:
None

Data Alerts :

None

NOM-17.3 Percent of children diagnosed with an autism spectrum disorder

NOM-17.3 Notes:
None

Data Alerts :

None

NOM-17.4 Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

NOM-17.4 Notes:

None

Data Alerts :

None

NOM-18 Percent of children with a mental/behavioral condition who receive treatment or counseling

NOM-18 Notes:

None

Data Alerts :

None

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

NOM-19 Notes:

None

Data Alerts :

None

NOM-20 Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

NOM-20 Notes:

None

Data Alerts :

None

NOM-21 Percent of children without health insurance

NOM-21 Notes:

None

Data Alerts :

None

NOM-22.1 Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations

NOM-22.1 Notes:

None

Data Alerts :

None

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

NOM-22.2 Notes:

None

Data Alerts :

None

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

NOM-22.3 Notes:

None

Data Alerts :

None

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

NOM-22.4 Notes:

None

Data Alerts :

None

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

NOM-22.5 Notes:

None

Data Alerts :

None

Form 10a
National Performance Measures
State: Alaska

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

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

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

	2016	2017	2018	2019	2020
Annual Objective	79	81	83	85	87

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

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

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

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

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

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

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

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

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

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

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

	2016	2017	2018	2019	2020
Annual Objective	12.9	12.3	11.7	11.1	10.5
Annual Objective	28	26.6	25.3	24	22.8

Form 10b

State Performance/Outcome Measure Detail Sheet
State: Alaska

States are not required to create SOMs/SPMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10c

Evidence-Based or Informed Strategy Measure Detail Sheet
State: Alaska

States are not required to create ESMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10d

National Performance Measures (Reporting Year 2014 & 2015)
State: Alaska

Form Notes for Form 10d:

None

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

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

Data Alerts:

None

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

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

Field Level Notes for Form 10d NPMs:

1 . Field Name : 2014

Field Note :

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

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

2 . Field Name : 2013

Field Note :

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

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

3 . Field Name : 2012

Field Note :

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

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

4 . Field Name : 2011

Field Note :

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

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

Data Alerts:

None

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

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

Field Level Notes for Form 10d NPMs:

1 . Field Name : 2014

Field Note :

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

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

2 . Field Name : 2013

Field Note :

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

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

3 . Field Name : 2012

Field Note :

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

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

4 . Field Name : 2011

Field Note :

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

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

Data Alerts:

None

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

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

Field Level Notes for Form 10d NPMs:

1 . Field Name : 2014

Field Note :

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generatethe NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

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

2 . Field Name : 2013

Field Note :

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generatethe NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

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

3 . Field Name : 2012

Field Note :

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

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

4 . Field Name : 2011

Field Note :

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

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

Data Alerts:

None

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

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

Field Level Notes for Form 10d NPMs:

1 . Field Name : 2014

Field Note :

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

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

2 . Field Name : 2013

Field Note :

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

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

3 . Field Name : 2012

Field Note :

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

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

4 . Field Name : 2011

Field Note :

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

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

Data Alerts:

None

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

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

Field Level Notes for Form 10d NPMs:

1 . Field Name : 2014

Field Note :

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

2 . Field Name : 2013

Field Note :

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

3 . Field Name : 2012

Field Note :

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

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

4 . Field Name : 2011

Field Note :

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

Data Alerts:

None

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

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

Field Level Notes for Form 10d NPMs:

1 . Field Name : 2014

Field Note :

Data reported for 2013, most recent year available.

Note:

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

2 . Field Name : 2013

Field Note :

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

Note:

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

3 . Field Name : 2012

Field Note :

2011 is the latest data available.

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

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

4 . Field Name : 2011

Field Note :

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

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

Data Alerts:

None

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

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

Field Level Notes for Form 10d NPMs:

1 . Field Name : 2014

Field Note :

2013 data is most recent available for age-specific birth rates.

2014 data will be reported in late 2015.

2 . Field Name : 2013

Field Note :

Updated with 2013 data.

3 . Field Name : 2012

Field Note :

Source: Alaska Bureau of Vital Statistics.

4 . Field Name : 2011

Field Note :

Source: Alaska Bureau of Vital Statistics. 2011 is the latest available data

Data Alerts:

None

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

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

Field Level Notes for Form 10d NPMs:

1 . Field Name : 2014

Field Note :

2010/2011 BSS dental assessments

2 . Field Name : 2013

Field Note :

2010/2011 BSS dental assessments

3 . Field Name : 2012

Field Note :

2010/2011 BSS dental assessments

4 . Field Name : 2011

Field Note :

Data source: AK Oral Health Program, 2007 Oral Health Survey. Available at http://www.hss.state.ak.us/dph/wcfh/Oralhealth/docs/ 2007_OralHealth_Children.pdf. The next survey is awaiting funding.

Data Alerts:

None

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

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

Field Level Notes for Form 10d NPMs:

1 . Field Name : 2014

Field Note :

2013 is most recent year available.
Due to small numbers this rate is reported as a 3 year average, 2011-2013.

2 . Field Name : 2013

Field Note :

Due to small numbers this rate is reported as a 3 year average, 2011-2013.

3 . Field Name : 2012

Field Note :

Due to small numbers this rate is reported as a 3 year average, 2010-2012.

4 . Field Name : 2011

Field Note :

Due to small numbers this rate is reported as a 3 year average, 2009-2011.

Data Alerts:

None

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

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

Field Level Notes for Form 10d NPMs:

1 . Field Name : 2014

Field Note :

Data from 2011, most recent year available.

Data obtained through the National Immunization Survey.
http://www.cdc.gov/breastfeeding/data/nis_data/

2 . Field Name : 2013

Field Note :

Updated to reflect most recent data available, 2011.

Data obtained through the National Immunization Survey.
http://www.cdc.gov/breastfeeding/data/nis_data/

3 . Field Name : 2012

Field Note :

Note: Indicator is now inaccurate. Final 2011 number is 64.3.
Source: http://www.cdc.gov/breastfeeding/data/nis_data/

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

4 . Field Name : 2011

Field Note :

Note: Indicator is now inaccurate. Final 2011 number is 64.3.
Source: http://www.cdc.gov/breastfeeding/data/nis_data/

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

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	97.6	97.9	99.0	99.3	
Numerator	10,413	10,168	10,447	10,336	
Denominator	10,673	10,387	10,555	10,408	
Data Source	AK Newborn Hearing Screening Program	AK Newborn Hearing Screening Program	AK Newborn Hearing Screening Program	AK Newborn Hearing Screening Program	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1 . Field Name : 2014

Field Note :

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

2 . Field Name : 2013

Field Note :

Updated with final numbers for 2013.

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

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

3 . Field Name : 2012

Field Note :

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

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

Data Alerts:

None

NPM 13 - Percent of children without health insurance.

	2011	2012	2013	2014	2015
Annual Objective	10.5	10.5	10.5	12.0	11.5
Annual Indicator	13.0	14.0	13.0	13.0	
Numerator					
Denominator					
Data Source	Kaiser Family Foundation	Kaiser Family Foundation	Kaiser Family Foundation	Kaiser Family Foundation	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1 . Field Name : 2014

Field Note :

2013 is most recent data available. 2014 will be available in late 2015.

Data Source: Kaiser Family Foundation
http://kff.org/other/state-indicator/children-0-18/

2 . Field Name : 2013

Field Note :

Updated with 2013 data.

Data Source: Kaiser Family Foundation
http://kff.org/other/state-indicator/children-0-18/

3 . Field Name : 2012

Field Note :

/2015/ Source: Henry Kaiser Family Foundation, State Health Facts online, Alaska: Health Insurance Coverage of Children 0 - 18, states (2011-2012). Based on American Community Survey. Numerators and denominators were not reported. Retrieved 3/19/2014 from http://www.statehealthfacts.org/profileglance.jsp?rgn=3.

4 . Field Name : 2011

Field Note :

/2014/ Source: Henry Kaiser Family Foundation, State Health Facts online, Alaska: Health Insurance Coverage of Children 0 - 18, states (2010-2011). Based on American Community Survey. Numerators and denominators were not reported. Retrieved 7/1/2013 from http://www.statehealthfacts.org/profileglance.jsp?rgn=3.

Data Alerts:

None

NPM 14 - Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

	2011	2012	2013	2014	2015
Annual Objective	20.0	20.0	20.0	20.0	20.0
Annual Indicator	21.4	22.0	21.5	24.1	
Numerator	3,469	3,635	3,308	702	
Denominator	16,192	16,525	15,382	2,917	
Data Source	WIC program, Report #340.	WIC program	WIC program	WIC program	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1 . Field Name : 2014

Field Note :

Date: 2014 Source: WIC program

This year's data is a smaller subset of the SFY's data. WIC adopted a new data system (SPIRIT) during SFY 2014. The data reported here is April 2014-June 2014. Data can no longer be retrieved from the old system.

2 . Field Name : 2013

Field Note :

Date: 2013 Source: WIC program, Report #340. Data covers children 2-4 years, 5 year olds are not included because they are not part of the WIC program. The indicator measures children with a BMI at or above the 95th percentile. AK does not collect data on 85th %-ile. Note that growth curves for Alaska Native children may not be the same as for non-Native children.

3 . Field Name : 2012

Field Note :

Date: 2013 Source: WIC program, Report #340. Data covers children 2-4 years, 5 year olds are not included because they are not part of the WIC program. The indicator measures children with a BMI at or above the 95th percentile. AK does not collect data on 85th %-ile. Note that growth curves for Alaska Native children may not be the same as for non-Native children.

Data Alerts:

None

NPM 15 - Percentage of women who smoke in the last three months of pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	14.5	14.5	13.0	12.0	12.0
Annual Indicator	13.8		13.2	13.2	
Numerator	1,517				
Denominator	10,957				
Data Source	PRAMS		AK PRAMS	AK PRAMS	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1 . Field Name : 2014

Field Note :

Source: AK PRAMS, Phase VI Q 31.

2012 reported, most recent data available.

2 . Field Name : 2013

Field Note :

Source: AK PRAMS, Phase VI Q 31.

2012 reported, most recent data available.

3 . Field Name : 2012

Field Note :

Source: AK PRAMS, Phase VI Q 31.
2012 data not available.

Data Alerts:

None

NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

	2011	2012	2013	2014	2015
Annual Objective	22.0	22.0	22.0	21.0	21.0
Annual Indicator	23.0	23.6	22.7	22.7	
Numerator	36	36	34	34	
Denominator	156,509	152,631	149,510	149,510	
Data Source	Alaska Bureau of Vital Statistics Vital Statistics	Alaska Bureau of Vital Statistics Vital Statistics	Alaska Bureau of Vital Statistics	Alaska Bureau of Vital Statistics	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1 . Field Name : 2014

Field Note :

Due to small numbers, this indicator is reported by 3-year moving averages.

Most recent data available is 2011-2013; 2012-2014 will be reported in late 2015.

2 . Field Name : 2013

Field Note :

Due to small numbers, this indicator is reported by 3-year moving averages. (2011-2013)

3 . Field Name : 2012

Field Note :

Source: Alaska Bureau of Vital Statistics. The most recent data available is 2009 - 2011. This indicator is reported by 3-year moving averages.

4 . Field Name : 2011

Field Note :

Source: Alaska Bureau of Vital Statistics. The most recent data available is 2009 - 2011. This indicator is reported by 3-year moving averages.

Data Alerts:

None

NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

	2011	2012	2013	2014	2015
Annual Objective	86.0	90.0	90.0	90.0	90.0
Annual Indicator	76.9	71.1	61.8	74.5	
Numerator	83	69	68	76	
Denominator	108	97	110	102	
Data Source	Alaska Bureau of Vital Statistics	AK Bureau of Vital Statistics	Alaska Bureau of Vital Statistics	Alaska Bureau of Vital Statistics	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1 . Field Name : 2012

Field Note :

Source: AK Bureau of Vital Statistics.

2 . Field Name : 2011

Field Note :

Source: AK Bureau of Vital Statistics. CY 2011 is most recent data available.

Data Alerts:

None

NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

	2011	2012	2013	2014	2015
Annual Objective	85.0	85.0	85.0	85.0	85.0
Annual Indicator	78.0	76.9	79.4	78.1	
Numerator	8,432	8,088	8,563	8,344	
Denominator	10,812	10,514	10,778	10,688	
Data Source	Source: AK Bureau of Vital Statistics.	AK Bureau of Vital Statistics	Alaska Bureau of Vital Statistics	Alaska Bureau of Vital Statistics	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1 . Field Name : 2013

Field Note :

Updated with 2013 data.

2 . Field Name : 2012

Field Note :

Source: AK Bureau of Vital Statistics.

3 . Field Name : 2011

Field Note :

Source: AK Bureau of Vital Statistics. CY 2011 is most recent data available

Data Alerts:

None

Form 10d

State Performance Measures (Reporting Year 2014 & 2015)
State: Alaska

SPM 1 - Percent of women women who recently delivered a live-born infant and reported having one or more alcoholic drinks in an average week during the last 3 months of pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	1.5	1.5	1.5	1.4	1.4
Annual Indicator	1.8		1.0	1.0	
Numerator	198		107	107	
Denominator	10,879		10,688	10,688	
Data Source	PRAMS		Alaska PRAMS	Alaska PRAMS	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1 . Field Name : 2014

Field Note :

2012 data most recent available.

Source: AK PRAMS, Phase VI Q 36a.

2 . Field Name : 2013

Field Note :

2012 data most recent available.

Source: AK PRAMS, Phase VI Q 36a.

3 . Field Name : 2012

Field Note :

2012 data not available

Source: AK PRAMS, Phase VI Q 36a.

4 . Field Name : 2011

Field Note :

Data for 2011 is not yet available.

Data Alerts:

None

SPM 2 - Rate of reports of maltreatment per thousand children 0 - 9 years of age.

	2011	2012	2013	2014	2015
Annual Objective	65.0	65.0	90.0	92.0	91.0
Annual Indicator	94.2	94.2	93.0	73.8	
Numerator	10,037	10,037	9,989	7,970	
Denominator	106,519	106,519	107,380	108,043	
Data Source	Alaska Surveillance of Child Abuse and Neglect.	Alaska Surveillance of Child Abuse and Neglect.	Alaska Surveillance of Child Abuse and Neglect.	Alaska Surveillance of Child Abuse and Neglect	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1 . Field Name : 2014

Field Note :

The data are still provisional as the program continues to progress.

2 . Field Name : 2013

Field Note :

The data are still provisional as the program continues to progress.

3 . Field Name : 2012

Field Note :

Provisional. Accuracy of the indicator will be improved when more AK State Trooper and Child Advocacy Center data is included.

4 . Field Name : 2011

Field Note :

The definition of this performance measure was changed in the FY 2014 application to cover children 0-9 years. Data for 2010 was revised.

Source: Alaska Surveillance of Child Abuse and Neglect. This number includes any “valid” report – validity as determined by the agency and or meets the SCAN criteria of having a valid name and date of birth. Duplicates were excluded. The indicator represents the number of children ages 0-9 with at least one valid report of maltreatment (physical, mental, sexual, or neglect).

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	10.0	10.0	15.0	15.0	14.0
Annual Indicator	17.3	16.2	16.5	16.5	
Numerator	1,850	1,706	1,784	1,784	
Denominator	10,705	10,546	10,827	10,827	
Data Source	Alaska Childhood Understanding Behaviors Survey	Alaska Childhood Understanding Behaviors Survey	Alaska Childhood Understanding Behaviors Survey	Alaska Childhood Understanding Behaviors Survey	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1 . Field Name : 2014

Field Note :

The latest data available are 2013. 2014 will be available in late 2015.

2 . Field Name : 2013

Field Note :

Updated with 2013 data.

3 . Field Name : 2012

Field Note :

Latest data is for 2011

4 . Field Name : 2011

Field Note :

Latest data is for 2011

Data Alerts:

None

SPM 4 - Percent of women who recently delivered a live-born infant and are not doing anything now to keep from getting pregnant.

	2011	2012	2013	2014	2015
Annual Objective	16.0	15.0	15.0	15.0	15.0
Annual Indicator	18.2		20.7	20.7	
Numerator	1,986		2,191	2,191	
Denominator	10,893		10,576	10,576	
Data Source	PRAMS		Alaska PRAMS	Alaska PRAMS	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1 . Field Name : 2014

Field Note :

Source: AK PRAMS, Phase V Q 58, Phase VI, Q 61.

2012 data most recent available.

2 . Field Name : 2013

Field Note :

Source: AK PRAMS, Phase V Q 58, Phase VI, Q 61.

2012 data most recent available.

3 . Field Name : 2012

Field Note :

Source: AK PRAMS, Phase V Q 58, Phase VI, Q 61.

2012 data not available

Data Alerts:

None

SPM 5 - Percent of high school students who were hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend during the previous 12 months.

	2011	2012	2013	2014	2015
Annual Objective	8.0	8.0	12.0	12.0	10.0
Annual Indicator	12.0	12.0	9.1	9.1	
Numerator					
Denominator					
Data Source	AK Youth Risk Behavior Surveillance System	AK Youth Risk Behavior Surveillance System	AK Youth Risk Behavior Surveillance System	AK Youth Risk Behavior Surveillance System	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1 . Field Name : 2014

Field Note :

/2016/ AK Youth Risk Behavior Surveillance System. The YRBS is a biennial survey that is conducted only in odd years.

Data reported for 2013.

2 . Field Name : 2013

Field Note :

/2014/Source: AK Youth Risk Behavior Surveillance System. Question changed to "among students who dated or went out with someone during the past 12 months who had been physically hurt on purpose by someone they were dating or going out with one or more times"

3 . Field Name : 2012

Field Note :

Source: AK Youth Risk Behavior Surveillance System. Available at Youth Online, http://apps.nccd.cdc.gov/youthonline/App/Default.aspx. Numerators and denominators are not reported. The measure applies to traditional high school students. The latest available data is for 2011. Accessed 5/3/2013. ywg

4 . Field Name : 2011

Field Note :

Numerators and denominators for the YRBSS are not reported.

Source: AK Youth Risk Behavior Surveillance System. Available at Youth Online, http://apps.nccd.cdc.gov/youthonline/App/Default.aspx. Numerators and denominators are not reported. The measure applies to traditional high school students. The latest available data is for 2011. Accessed 5/3/2013. ywg

Data Alerts:

None

SPM 6 - Percent of women who recently had a live-born infant and experienced intimate partner violence during pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	4.1	4.1	4.1	4.1	3.9
Annual Indicator	4.4		2.9	2.9	
Numerator	468		304	304	
Denominator	10,618		10,527	10,527	
Data Source	PRAMS		Alaska PRAMS	Alaska PRAMS	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1 . Field Name : 2014

Field Note :

Source: AK PRAMS, Phase VI Q. 39 & 71b

2012 data most recent available.

2 . Field Name : 2013

Field Note :

Source: AK PRAMS, Phase VI Q. 39 & 71b

2012 data most recent available.

3 . Field Name : 2012

Field Note :

Source: AK PRAMS, Phase VI Q. 39 & 71b

2012 data available now, but unable to update at this point.

Data Alerts:

None

SPM 7 - Percent of women who delivered a live birth and had a provider talk to them about post partum depression since their new baby was born.

	2011	2012	2013	2014	2015
Annual Objective	88.0	88.0	88.0	88.0	90.0
Annual Indicator	82.8		84.5	84.5	
Numerator	8,797		8,668	8,668	
Denominator	10,623		10,261	10,261	
Data Source	PRAMS		Alaska PRAMS	Alaska PRAMS	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1 . Field Name : 2014

Field Note :

Data Source: AK PRAMS, Q 74d, Phase VI

2012 data most recent available.

2 . Field Name : 2013

Field Note :

Data Source: AK PRAMS, Q 74d, Phase VI

2012 data most recent available.

3 . Field Name : 2012

Field Note :

Data Source: AK PRAMS, Q 74d, Phase VI
2012 data now available but not able to update.

Data Alerts:

None

SPM 8 - Percent of women who recently had a live-born infant and reported having one or more environmental factors in the home that are associated with SIDS/unexplained asphyxia.

	2011	2012	2013	2014	2015
Annual Objective	60.0	60.0	64.0	64.0	62.0
Annual Indicator	66.1		53.8	53.8	
Numerator	7,051		5,607	5,607	
Denominator	10,664		10,413	10,413	
Data Source	PRAMS		Alaska PRAMS	Alaska PRAMS	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1 . Field Name : 2014

Field Note :

Data Source: AK PRAMS, Q 74d, Phase VI

2012 data most recent available.

HP 2020 Obj: Reduce infant deaths from sudden unexpected infant deaths (including SIDS, unknown cause, accidental suffocation and strangulation in bed) to 0.84 per 1,000 live births. 2006 US baseline: 0.93

2 . Field Name : 2013

Field Note :

Source: AK PRAMS, Phase VI Q. 58, 59 c-f.

2012 data most recent available.

HP 2020 Obj: Reduce infant deaths from sudden unexpected infant deaths (including SIDS, unknown cause, accidental suffocation and strangulation in bed) to 0.84 per 1,000 live births. 2006 US baseline: 0.93

3 . Field Name : 2012

Field Note :

Source: AK PRAMS, Phase VI Q. 58, 59 c-f.
2012 data now available but unable to update.

HP 2020 Obj: Reduce infant deaths from sudden unexpected infant deaths (including SIDS, unknown cause, accidental suffocation and strangulation in bed) to 0.84 per 1,000 live births. 2006 US baseline: 0.93

Data Alerts:

None

SPM 9 - Percent of mothers who report their 3-year-old child had a BMI greater than the 85th percentile (overweight and obese).

	2011	2012	2013	2014	2015
Annual Objective	25.0	25.0	36.0	36.0	35.0
Annual Indicator	39.0	43.4	36.6	36.6	
Numerator	3,241	3,462	2,942	2,942	
Denominator	8,317	7,979	8,029	8,029	
Data Source	Alaska Childhood Understanding Behaviors Survey	Alaska Childhood Understanding Behaviors Survey	Alaska Childhood Understanding Behaviors Survey	Alaska Childhood Understanding Behaviors Survey	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1 . Field Name : 2014

Field Note :

Latest data available for 2013. 2014 will be available in late 2015.

2 . Field Name : 2013

Field Note :

Updated with 2013 data.

3 . Field Name : 2012

Field Note :

Updated with 2012 data.

4 . Field Name : 2011

Field Note :

Latest data is for 2011.

Data Alerts:

None

SPM 10 - Percent of preterm births at 34-36 weeks completed gestation.

	2011	2012	2013	2014	2015
Annual Objective	5.0	5.0	5.0	25.0	24.5
Annual Indicator	6.7	25.3	24.9	25.2	
Numerator	771	2,820	2,853	2,872	
Denominator	11,436	11,148	11,451	11,396	
Data Source	AK Bureau of Vital Statistics.	AK Bureau of Vital Statistics	Alaska Bureau of Vital Statistics	Alaska Bureau of Vital Statistics	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1 . Field Name : 2014

Field Note :

In 2012 this indicator was changed to measure 37-38 completed gestation weeks which we felt was more meaningful. This measure was used to support the March of Dimes '39 Week' campaign. For 2005 the percent was 24.6%, for 2006 it was 24.9%, for 2007 it was 26.2%, for 2008 it was 26.3, for 2009 it was 25.1%, for 2010 it was 24.5%, for 2011 it was 25.1%.

2 . Field Name : 2013

Field Note :

Updated with 2013 data.

In 2012 this indicator was changed to measure 37-38 completed gestation weeks which we felt was more meaningful. This measure was used to support the March of Dimes '39 Week' campaign. For 2005 the percent was 24.6%, for 2006 it was 24.9%, for 2007 it was 26.2%, for 2008 it was 26.3, for 2009 it was 25.1%, for 2010 it was 24.5%, for 2011 it was 25.1%.

3 . Field Name : 2012

Field Note :

In 2012 this indicator was changed to measure 37-38 completed gestation weeks which we felt was more meaningful. This measure was used to support the March of Dimes '39 Week' campaign. For 2005 the percent was 24.6%, for 2006 it was 24.9%, for 2007 it was 26.2%, for 2008 it was 26.3, for 2009 it was 25.1%, for 2010 it was 24.5%, for 2011 it was 25.1%.

4 . Field Name : 2011

Field Note :

The latest available data is for 2011.

Data Alerts:

None

Form 11
Other State Data
State: Alaska

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the FY 2016 application and FY 2014 annual report.

State Action Plan Table

State: Alaska

Please click the link below to download a PDF of the State Action Plan Table.

State Action Plan Table