Maternal and Child Health Services Title V Block Grant

Alaska

FY 2020 Application/ FY 2018 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

THE STATE of ALASKA
GOVERNOR MICHAEL J. DUNLEAVY

Department of
Health and Social Services

DIVISION OF PUBLIC HEALTH
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June 6, 2019

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 FY20 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 30% for preventative and primary care for children, and 30% for CYSHCN. We look forward to our application review scheduled in Anchorage August 21-22, 2019.

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

Thank you for this opportunity to apply.

Sincerely,

Rebekah Morisse, RN, BSN, MPH
MCH Title V Director
Section Chief, WCFH

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 F of the 2018 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: December 31, 2020.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: December 31, 2020.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

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. Alaska's 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 mission of WCFH is to promote the best health outcomes for all Alaska women, children, young adults and their families of all abilities across the lifespan. WCFH programs 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. Our target populations include pregnant women and their 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.

ALASKA'S MCH POPULATION

Alaska's 2018 resident population was estimated at 736,239; 21% of the total population were children less than 15 years of age and 20% were women of childbearing age (15-44 years). Alaska had 10,090 births in 2018.

Health disparities and health equity have large implications for the health status of Alaska's MCH populations. Differences in health outcomes exist 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. The causes of these disparities are multifactorial and include a long history of discrimination and the loss of traditional lifestyles. As the Alaska Native population becomes increasingly urban or adopts western lifestyles and diet, whether by choice or not, chronic diseases such as diabetes and heart disease are of increasing concern. Significant improvements in the health of Alaska Native people have been made since the 1970s. Large investments in infrastructure including housing, safe water and sanitation facilities, community health aide-staffed tribal village clinics, and regional hospitals contributed to significant improvements in life expectancy, infant mortality and infectious disease. However, continuing disparities remain, including in key MCH outcomes such as postneonatal mortality; child, adolescent, teen (especially teen suicide), and maternal mortality; and oral health. Behavioral and mental health conditions are a major concern for all Alaskan MCH populations.

TITLE V MCH STATE PRIORITIES FOR 2015 – 2020:

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

ALASKA'S FRAMEWORK FOR NEEDS ASSESSMENT, PROGRAM PLANNING, AND PERFORMANCE REPORTING

Alaska's maternal child health (MCH) priorities for 2015-2020 were identified in a statewide needs assessment conducted in 2015 and are re-examined on an annual basis. Our ongoing assessment activities revolve around four functions: meeting with advisory committees; participating in other organizations' committees; partnering with other agencies on program implementation; and surveillance and research.

The MCH Title V and CSHCN Directors along with WCFH leadership and MCH Epidemiology staff selected National Performance Measures (NPMs) to track and demonstrate impact of our efforts. NPMs are linked to the identified priorities and informed by indicator data available from the MCH Epidemiology Unit's surveillance programs. The group considered the availability of data for the proposed measures, the likelihood a change in the measure would be seen during the five year grant period, and how closely linked the measure was to actual work being done by the Title V program. Additional State Performance Measures (SPMs) were developed to address population needs that were identified but were not adequately addressed by the NPMs.

Alignment of the work of Title V programs with other work focused on improving outcomes for women, all children and their families is critical for us as we assure transparency, reduce duplication and breakdown silos. As we reviewed potential performance measures, we referred to the Division of Public Health 2016-2020 Strategic Plan to guide our work.

In 2017, WCFH adopted a Strategic Plan reflective of the priorities outlined in the MCH Title V Needs Assessment as well as current State priorities. The 2017-2020 Plan lays out the framework that Section programs follow to achieve our mission. Our work falls into four categories:

STRATEGIES	**Serve as Alaska's chief strategists for existing and emerging public health issues** • Increase access to family-centered and culturally appropriate health services • Provide leadership to identify upstream and emerging opportunities to guide state and national health policy, improve health outcomes and contain costs.
SERVICES	**Protect life, health, and safety through core public health functions** • Support and enable preventative services to increase early identification and intervention for individual and population-level health issues.
SCIENCE	**Serve as the trusted source of health information** • Collect, analyze and disseminate meaningful data to plan, implement and evaluate programs that realize the vision of healthy Alaskans today and tomorrow. • Build trust as a reliable and accessible resource to partners and the public.
SYSTEMS	**Strengthen essential public health infrastructure, services, and partnerships** • Partner with families and consumers, keeping their voice and leadership central: "nothing about us, without us." • Collaborate broadly to grow networks and systems. • Build capacity through education, securing funding and sharing quality data.

TITLE V'S ROLE IN ASSURING COMPREHENSIVE, COORDINATED, FAMILY CENTERED SERVICES

WCFH actively recruits Alaska parents, providers, and communities to help set priorities and initiate activities on all levels of decision making, keeping the family and consumer voice and leadership central. As a standard, all WCFH advisory committees include at least one parent. Their participation is a valuable addition to assuring the voice of parents is included in policies, educational materials, and outreach. In 2017, WCFH instituted an honoraria process to recognize the professional support parents provide our programs. All specialty clinics conduct client satisfaction surveys during or after the clinics. Family engagement on the statewide and local community levels has been critical to the launch of Help Me Grow Alaska, a system that connects children and families with services through centralized outreach, screening, referral and care coordination services. The Children and Youth with Special Health Care Needs (CYSHCN) Systems Integration Grant and subsequent Early Childhood Comprehensive Systems project focus on family engagement through committee participation and quality improvement efforts using the Strengthening Families framework and with active participation with the state's primary family representation agency, Stone Soup

Group. WCFH is especially proud of efforts to incorporate the voice of youth through the Youth Alliance for a Healthier Alaska.

WCFH partnered with Alaska's University Center for Excellence (USED) to develop and administer a Family Navigation Training to provide staff in clinical and support settings the person-centered skills they need to help families access the services they need. The training builds on principals of care coordination and introduces skills such as shared decision making, active listening, asset mapping and professional collaboration.

TITLE V PARTNERSHIPS

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.

OTHER FEDERAL INVESTMENTS: In addition to the Title V Block Grant, other Maternal Child Health Bureau programs administered by WCFH include the State Systems Development Initiative, Maternal Infant Early Childhood Home Visiting (MIECHV), Early Childhood Comprehensive Systems (ECCS), and Universal Newborn Hearing Screening. WCFH also administers CDC's Early Hearing Detection & Intervention (EHDI), Personal Responsibility Education Program, Teen Pregnancy Prevention, Title X Family Planning, and Breast and Cervical Health Check. WCFH collaborates with federally qualified health centers throughout Alaska.

STATE AND LOCAL MCH PROGRAMS: There are only three local governmental agencies in Alaska; all have interpreted their health powers very narrowly. Using Title V dollars, WCFH collaborates with the Borough of Juneau to fund nurse practitioners to offer reproductive health and well child visits in high schools in one community.

OTHER PROGRAMS WITHIN ALASKA DHSS: Key examples are listed briefly below:

Contraceptives and nurse practitioner contracts are funded through Title V to support reproductive health services provided by public health centers and other private providers. WCFH has data use agreements with the DPH Section of Health Analytics and Vital Records, Office of Children's Services (OCS), and Division of Behavioral Health, and regularly accesses data from Medicaid, WIC, and the Division of Juvenile Justice. WCFH and the Division of Senior and Disability Services have an agreement to link EHDI program data with Early Intervention/Infant Learning Program (EI/ILP).

The CYSHCN Director serves on the Strengthening Families Leadership Team in OCS. WCFH has partnered with OCS, the Governor's Council on Disabilities & Special Education, and EI/ILP on improving the use of evidence-based developmental screening tools and launching Help Me Grow in Alaska. Title V partners with the Section of Chronic Disease Prevention and Health Promotion on initiatives related to childhood obesity and oral health.

OTHER GOVERNMENT AGENCIES: WCFH has data sharing agreements with the Department of Revenue, the Department of Public Safety, and the court system. The School Nurse/School Health consultant is a member on the steering committee charged with developing the school health track for the Department of Education and Early Development's (DEED) statewide education plan. WCFH also collaborates with DEED on the administration and evaluation of the Parents as Teachers home visiting program.

VII. TRIBES, TRIBAL ORGANIZATIONS: Collaboration with the Alaska Native Tribal Health Corporation (ANTHC) includes:

- Co-sponsoring the biennial Alaska MCH and Immunization Conference
- Participating on the ANTHC EpiCenter Scientific Advisory Committee
- ANTHC providers participate on many WCFH advisory committees and collaborate in multiple areas such as newborns screening, CYSHCN, safe sleep, maternal child death reviews, among others.

PUBLIC HEALTH AND HEALTH PROFESSIONAL EDUCATIONAL PROGRAMS AND UNIVERSITIES: WCFH collaborates with the University of Alaska Anchorage (UAA) to sponsor statewide clinics for screening and diagnosis of autism/neurodevelopmental disorders, along with other initiatives such as Project ECHO, family navigation, and professional development and training opportunities related to autism. The MCH Epidemiology Unit Manager serves on the community advisory committee for UAA's MPH program and the Title V Director serves on the community advisory committee for the Nursing program. UAA's Center for Human Development is a close collaborator in developing programs for CYSHCN and conducts phone interviews for PRAMS and CUBS.

OTHER ORGANIZATIONS THAT SERVE THE MCH POPULATION: WCFH actively participates and is a leader in the All Alaska Pediatric Partnership. WCFH invites coalitions and non-profit agencies to participate in advisory committees and stakeholder meetings such as 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 reproductive health initiatives. Community level grantees deliver direct services for WIC, EI/ILP, and breast and cervical cancer screening and outreach. WCFH funds parent navigation services for the autism/neurodevelopmental screening and diagnostic clinics, EHDI, and families of children with cleft lip and palate conditions.

HOW FEDERAL AND NON-FEDERAL FUNDS SUPPORT MCH SERVICES

It cannot be understated how important federal grants are to providing the infrastructure to carry forward the state's MCH priorities. The Alaska MCH/CYSCHN programs transitioned from direct service nearly 15 years ago and have since provided dollars for linking services, technical assistance and infrastructure support for data surveillance and analysis, and program evaluation. Gap filling services in the form of support and coordination have been offered in the areas of Cleft Lip and Palate clinics, metabolic, neurodevelopmental and genetic services. Our epidemiological infrastructure is crucial to measuring the effectiveness of service delivery not only in the programs delivered by WCFH, but also outside of DPH and DHSS. Partnerships such as Alaska Primary Care Association provide a critical venue to distribute information and link interested medical practices with our HRSA/MCHB grant focused on promoting and implementing pediatric medical homes. Work with the UAA's Center for Human Development has been an important partner in developing the workforce to deliver intensive early intervention applied behavioral analysis services to children diagnosed with autism.

III.A.2. How Federal Title V Funds Support State MCH Efforts

The majority of Title V dollars support the work of the Maternal Child Health (MCH) Epidemiology Unit. The surveillance, data analysis, and evaluation provided by the Unit is an important part of the MCH infrastructure for Alaska. This data is used to support needs assessments, create recommendations for policy, determine health priorities, identify gaps in services and disparities, and ensure successful implementation and evaluation of programs. Title V funds support the work of such programs as the Maternal Child Death Review, the Alaska Birth Defects Registry, the Alaska Longitudinal Child Abuse and Neglect Linkage project (ALCANLink), Childhood Understanding Behaviors Survey (CUBS), among others. Title V dollars were also used to support the implementation of a perinatal quality collaborative, provide technical assistance to school nurses in Alaska, provide education to child welfare workers and health care providers on safe sleep practices, update the Alaska safe sleep curriculum and educational materials and conduct other work related to systems of care for children and youth with special health care needs (CYSHCN). Title V dollars also supported CYSHCN by funding family navigation services, pediatric specialty clinics, and genetic counseling services. Title V dollars were also used to continually update the Alaska State Plan for CYSHCN with our partners to ensure a coordinated effort in Alaska.

III.A.3. MCH Success Story

The Alaska Perinatal Quality Collaborative (AKPQC) launched in January 2019, the culmination of a year of planning coordinated by the Section of Women's, Children's, and Family Health (WCFH) in collaboration with the AKPQC Steering Committee. The launch event drew a multidisciplinary group of 75 participants from around Alaska. Three nationally recognized experts in maternal and neonatal health presented on collaborative quality improvement (QI) methods and successful initiatives. Title V funds supported meeting coordination for the event as well as some personnel costs for WCFH staff who worked on it. Title V TA funds supported travel for one of the out-of-state speakers.

During the event, we facilitated a group discussion and interactive voting activity on perinatal health issues and potential focus areas of the AKPQC. Based on this feedback and a review of Alaska severe maternal morbidity (SMM) data, the AKPQC Steering Committee chose severe maternal hypertension as an initial focus area. To date, seven hospitals representing almost 70% of births in Alaska are enrolling in the initiative. WCFH will continue to coordinate this initiative and will launch a neonatal branch of the AKPQC in Fall 2019. Launching a PQC has been a goal for WCFH for a few years, and it is exciting to see it come to reality. There is a very engaged steering committee that includes multiple hospitals, the State Hospital Association, and Alaska chapters of ACOG, AAP, and AWOHN, among others.

III.B. Overview of the State

Alaska is a large, sparsely populated state. The land mass of the state encompasses 570,641 square miles, averaging a population density of just 1.3 persons per square mile. This is the lowest population density of any state. The July 2018 Alaska resident population was estimated at 736,239 by the Alaska Department of Labor and Workforce Development. This represented a decrease of 1,608 people compared to 2017 and was the second year of annual population decrease in Alaska since the oil crisis in the mid-1980s. The decrease was primarily driven by negative migration, however the state also had 358 fewer births compared to 2017. There were 10,090 resident births in 2018. Alaska had 157,376 children less than 15 years of age (21.4% of the total population) and 145,386 women of childbearing age (15-44 years) in 2018 (19.7% of the total population).

In 2018, 80% of people in Alaska lived in cities or places with populations of 2,500 or more. Cities with more than 20,000 people included the Municipality of Anchorage (295,365), the City and Borough of Juneau (32,247), and the City of Fairbanks (31,668). These three areas were home to 49% of Alaska's population. Alaska has a trend of migration from rural to urban areas that has remained fairly stable over the past 20 years. Of those who dwell in rural areas, the majority are Alaska Native people.

The industries with the greatest number of employees in Alaska include government, health care, retail trade, leisure and hospitality. Alaska was home to 17,302 active duty, reserve, and civilian military personnel in 2017, representing 2% of the state's population. Anchorage, Fairbanks, and Kodiak Island all have large active duty military and dependent populations.

According to the Department of Labor statewide projections, Alaska's statewide population is projected to increase from 737,080 in 2017 to 837,806 in 2045. As Alaska's population ages in the coming years, annual growth is expected to slow. Alaska's population aged 65+ is expected to grow at the fastest rate over the projection period, followed by the population aged 0-19. The population aged 20-64 is projected to increase at the slowest rate.

In 2017, 67% of Alaska's population was reported to be White, 19% Alaska Native/American Indian, 10% Asian or Pacific Islander, and 5% African American (all percentages are for the race alone or in combination). Alaskans of Hispanic origin made up 6%. Cultural diversity among the non-Native population is increasing. The 2013-2017 American Community Survey (ACS) indicates 8% of Alaskans were foreign-born. Pacific Islanders are the fastest-growing racial group in Alaska, largely due to immigration, and the largest immigrant group in Alaska are Filipinos (documented and undocumented) (Anchorage Daily News, 2019). More than half of the students in the Anchorage School District are ethnic minorities, speaking 110 different languages. In the 2018-2019 school year, 16 of the top 30 highest diversity public schools in the United States were in Anchorage. The Asian and Pacific Islander population in particular has been increasing, overall as well as among the birth population, growing from 6% of births in 2000 to 11% in 2017. In Alaska, Filipinos compose half of the Asian American community, and the Pacific Islander population (2%) is five times higher than the national average (ADN 2019).

Strengths and Challenges that Impact Health Status

Health disparities and health equity have large implications for the health status of Alaska's MCH population. The most well documented and commonly studied differences in health 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. The causes of these disparities are multifactorial and include a long history of discrimination and the loss of traditional lifestyles. As the Alaska Native population becomes increasingly urban or adopts western lifestyles and diet, whether by choice or not, chronic diseases such as diabetes and heart disease are of increasing concern. Living in remote communities with high unemployment rates, low income and significantly higher costs for food, fuel, and supplies, as well as barriers to accessing health care services are also contributing factors.

Significant improvements in the health of Alaska Native people have been made since the 1970s. Large investments in infrastructure including housing, safe water and sanitation facilities, community health aide-staffed tribal village clinics, and regional hospitals contributed to significant improvements in life expectancy, infant mortality and infectious disease. However, research documents that continuing and significant disparities remain, including in key MCH outcomes such as postneonatal mortality; child, adolescent, teen (especially teen suicide), and maternal mortality; and oral health.

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 2017, 57% of Alaskan adults aged 19-64 years were covered by employer or other private health insurance; 24% were covered by Medicaid or other public insurance (Kaiser Foundation). According to the 2019 Scorecard on State Health System Performance by the Commonwealth Fund, Alaska ranks 46th in the nation for uninsured adults and 47th for uninsured children. In 2017, 10% of Alaska children under age 19 were not covered by any health insurance, compared to 5% for the U.S. (ACS data published by Kids Count). In the same year, 13% of Alaska parents (defined as adults who live with at least one of their own children under age 18) were not covered by any health insurance. A limitation of many of these data sources on health insurance is that they don't count tribal coverage or Indian Health Service as insurance, which may inflate Alaska's percentage who are uninsured.

Poverty affects health both through decreased access to material resources, like health care and nutritious 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. According to the Kids Count Alaska Economic Well-Being report, there are significant disparities in family income by race/ethnicity in Alaska. While median family income was $75,500 in 2015, only White families earned more than the median ($91,300) while all other race/ethnicities earned less (non-White median family income was $48,700).

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. The FBI's 2017 Uniform Crime Report found that Alaska has the highest rate of violent crime in the US, based on rates of aggravated assault, robbery, rape, and homicide. In 2017, Alaska's homicide rate per 100,000 individuals was 10.6, compared to 6.2 for the US. The 2015 Alaska Victimization Survey results show a decline in intimate partner violence and sexual assault since 2010, although data support that fully 50% of adult women in the state have experienced violence in their lifetime, compared to 37.3% nationwide. In 2016-2017, 59% of Alaskan children lived in a safe neighborhood (based on parental opinion, NSCH). Adverse Childhood Experiences (ACEs) are major risk factors for leading causes of illness and death as well as poor quality of life. The higher the number of ACEs a person has, the more likely they are to experience poor health. The 2013-2015 Alaska BRFSS found that 65.7% of Alaskans had one or more ACEs, while 19.5% reported four or more.

Health care delivery in Alaska consists of four distinct systems; tribal, military, public and private. The Alaska Native Tribal Health Consortium (ANTHC) is a consortium of tribal entities that provides several levels of medical care: primary care at village clinics, primary and secondary care at regional hospitals, and tertiary care at the Alaska Native Medical Center hospital in Anchorage. ANMC receives some funding from the Indian Health Service but is supported to a greater extent by the various regional corporations. Publicly-funded health care agencies serve the largest portion of low income, uninsured individuals and families in Alaska. To date, there are a total of 27 organizations (including tribal corporations) that provide primary care and preventive health services at 169 community health centers (CHCs) statewide. In addition to CHCs, the state government operates 16 Public Health Centers that provide population-based health services, disease screening and referral, and extensive collaboration with other community providers to assure coordinated care and access to services for vulnerable populations. On the private side, there are private non-profit and for-profit secondary and tertiary care hospitals, as well as self-employed and private practice health care providers. The military system is fairly expansive with clinics and hospitals in some of the larger population areas of the state as well as a relationship with the Veteran's Administration supporting the active duty and retired armed forces.

Geographic isolation means significant challenges in assuring all MCH populations have access to routine preventive care, and acute medical and specialty care. Approximately 75% of Alaskan communities, including the capital city of Juneau, are not connected to a road system. Accessing "nearby health services" or specialized health care means travel by commercial jet, small plane, the marine ferry system, all-terrain vehicles, small boats or snow machines. Some residents may travel distances equivalent to Washington, D.C. to New Orleans for even routine medical care. Severe weather can render travel impossible, creating especially critical situations in medical emergencies.

Specialty care, even in urban areas of the state, is limited. Many communities have no facilities equipped for childbirth, so pregnant women must leave their homes four weeks before their due date and travel to a larger community with a hospital that performs births. Even well-child check-ups, prenatal exams and regular dental exams are difficult to provide. Recruiting and retaining physicians and primary health care providers for non-urban practices

is an ongoing barrier to providing health care services.

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 550 Community Health Aides/Practitioners (CHAPs) who work in over 170 rural Alaska villages to provide basic health care services and referrals. The CHAP program is a vital link in the Alaska Tribal Health System. The Alaska Dental Health Aide Therapist Initiative, another ANTHC program, is conducted in collaboration with the University of Alaska-Barrow and various established sites in Bethel and Anchorage to train Alaska Native dental health aides for community-level dental disease prevention in underserved Alaska Native populations. The Behavioral Health Aide Project aims to develop village-based behavioral health service capacity, focusing on prevention, early intervention and case management.

Title V in the Context of the State Health Agency

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. WCFH programs are described in the WCFH Program Descriptions (attached as a supporting document, in addition to the WCFH organizational chart). The Section of Chronic Disease Prevention and Health Promotion (CDPHP) manages the following programs that touch the MCH population: Obesity Prevention and Control; School Health; Youth Risk Behavior Survey (YRBS); Tobacco Prevention and Control; and Injury Prevention: Child Passenger Safety, Bike-n-Walk Safely Alaska!, and Kids Don't Float!. The Section of Epidemiology (SOE) manages the Alaska Immunization Program.

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

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

Three local governments, the Municipality of Anchorage, North Slope Borough, and Maniilaq Association, operate local health departments as grantees of the State Public Health Nursing section. As noted above, Alaska DHSS offers a wide range of health assessment and disease prevention services through 16 Public Health Centers (PHC) and itinerant nursing services that reach approximately 280 communities statewide. However, since 2015, around 45 public health nursing positions have been cut in addition to closure of six community PHC's across the state. Specific services that are no longer provided due to budget cuts in the past few years include well child exams for children over 7 years of age, and immunizations, reproductive health services, and sexually transmitted infection screening and treatment for adults 30 and over. Public Health Nursing is facing additional significant cuts in the FY20 budget (over 2 million dollars) currently being considered by the legislature. These types of cuts will mean less staffing and possibly less health centers.

State priorities

The mission of the Alaska DHSS is to promote and protect the health and well-being of Alaskans. The Department's 2016 priorities – Health and wellness across the life span; Health care access, delivery and value; and Safe and responsible individuals, families and communities – span the breadth of the department and encompass the unique service-areas represented within.

DHSS, in partnership with ANTHC, developed Healthy Alaskans 2020 (HA2020) health priorities during a series of

expert workgroup meetings and public input surveys during 2012 and 2013. The process to update these priorities and create Healthy Alaskans 2030 indicators was begun during 2019. The 25 health priorities identified for HA2020 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. Some WCFH staff members are participating in HA2030 workgroups.

The Alaska DPH mission is to protect and promote the health of Alaskans; with a vision of healthy Alaskans today and tomorrow. In 2019, DPH began a strategic planning process to update the 2016-2020 Strategic Plan. The Title V Director and Block Grant Coordinator are part of this effort. The current plan identifies 13 "Winnable Battles." Seven of these related to MCH priorities, including:

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

In 2017, the WCFH established our own strategic plan (attached as a supporting document) reflective of the priorities outlined in the MCH Title V needs assessment as well as state priorities.

DPH is actively pursuing accreditation status with the national Public Health Accreditation Board (PHAB). The process of obtaining initial accreditation status will give DPH the opportunity to assess its performance against a set of nationally recognized standards and measures based on the 10 Essential Public Health Services. WCFH staff are represented on the core team leading this effort as well as domain-specific teams.

Components of Alaska's system of care for meeting the needs of underserved and vulnerable populations

Alaska ranked 34th in the nation on the Commonwealth Fund's 2018 Scorecard on State Health System Performance, which was based on more than 40 measures of health care access, quality, efficiency, health outcomes and disparities. Alaska was below the national average in four of the main categories (access and affordability, prevention and treatment, healthy lives, and disparity) and above average on avoidable hospital use and cost.

The only children's hospital in Alaska is the Children's Hospital at Providence (TCHAP), located in Anchorage. The state's only Level III NICU is at TCHAP, while Alaska Native Medical Center and Alaska Regional Hospital in Anchorage and Fairbanks Memorial Hospital have Level II NICUs. Increasing NICU services has been discussed at some hospitals. WCFH is monitoring this in terms of any effects to regionalization of care. In an effort to reduce costs, as of May 2018 the military hospital at Joint Base Elmendorf-Richardson (JBER) is transferring infants born between 32-36 weeks and/or their laboring mothers to ANMC instead of Providence, as was previously done. Since both JBER and ANMC are federal entities, this new agreement will allow JBER to save money over transferring the patients to a private facility, and also helps to increase the census at ANMC.

There is a chronic shortage of pediatric subspecialists in the state. While TCHAP and ANTHC have been successful in recruiting a number of subspecialists to the state, many are represented by only one clinician in that specialty. The past two years have seen the addition of two pediatric neurodevelopmental physicians to Alaska, which has been a great success for our MCH system. There had been longstanding efforts to recruit 2-3 physicians to the state.

While tribal health has been increasing their number of pediatric specialties, TCHAP is noting a reduction as the health system has seen positions cut across a number of disciplines in Anchorage. This includes sub-specialty providers, the Medical Director of TCHAP, among other positions. This is an area of concern for Title V, and we are looking to partner as a community to discuss the status of pediatrics in Alaska and what we must do next. We plan to

co-host a community forum in the fall of 2019 to discuss next steps in regards to workforce development and services in Alaska. As of 6/30/19, there will no longer be a Genetics Clinic in the state of Alaska. The contractors providing these services (Oregon Health & Science University) no longer have the capacity to travel to Alaska. Tribal health and TCHAP have been in discussions with other universities to establish a new contract to continue diagnostic genetics services in Alaska. There will likely be a gap in service while a transition to a contractor occurs. In the interim, families will need to travel outside of Alaska.

Many of the existing resources for specialty care continue to be concentrated in the large population centers. The state's 128 pediatricians (2017 State Physician Workforce Data Book) and neonatal and maternal specialists are primarily based in Anchorage, Fairbanks and Juneau. Access to these resources from other areas often entails high transportation costs, many times borne by the Medicaid program. While telemedicine is being used increasingly in rural and frontier Alaska, it is limited to tribal health care centers where the mix of patients is predominantly tribal health beneficiaries. Infrastructure availability and use in the private sector is limited and tends to be within the corporation and service area. One exception to this is the E-ICU, Providence provides coverage from their tertiary medical center to secondary hospitals outside of Anchorage. Billing on a fee for service model with no managed care, lengthy waits for licensure, and siloed telecommunication systems and practice models are three significant impediments to expansion of this technology.

Medicaid and Denali KidCare (CHIP) serve a large share of Alaska's at-risk and vulnerable child population, including approximately 71% of children living in or near poverty, 46% of children with disabilities or other special health care needs, and 100% of children in foster care (Georgetown University Health Policy Institute Alaska Snapshot 2018). Medicaid coverage for pregnant women and children was broadened in the 1980s with an expansion of eligibility based on higher income standards and the addition of EPSDT, which broadened specific services that the state was required to provide children. Alaska implemented Medicaid expansion under the Affordable Care Act in September 2015 that extended coverage to childless adults up to 138% FPL and afforded many additional residents coverage of their health care costs. The number of children ever enrolled in Title XXI-CHIP during the fiscal year increased from 18,704 in FFY17 to 19,747 in FFY18 and in Title XIX from 100,161 in FFY17 to 102,629 in FFY18 (CMS FY18 Children's Enrollment Report).

Alaska is one of two states whose Medicaid payments are based on fee for service. Because of this, CYSHCN and their families are only able to access care coordination at two points within our system of care. The first is if they are eligible for Part C Early Intervention services, where the child must be under 36 months of age and have a documented 50% developmental delay. The second is if they are eligible for either a Children with Complex Medical Needs or Intellectual or Developmental Disability waiver. To contain costs, Senior and Disability Services is only selecting 50 new waivers a year limiting families' access to care coordination.

Specific state statutes and other regulations that have relevance to Title V

Alaska state law directs DHSS to promulgate regulations for the control of conditions or diseases of public health importance. Alaska statutes authorize the Department to (among other activities) collect, analyze, and maintain databases of confidential information related to conditions of public health importance and any data needed to provide essential public health services and functions. Alaska regulations mandate reporting of certain conditions of public health importance to the Division of Public Health, including birth defects, which are reported to WCFH. Additionally, the Department may identify, assess, prevent, and ameliorate conditions of public health importance through:

1. Surveillance—WCFH surveillance programs include the Pregnancy Risk Assessment Monitoring System (PRAMS), Childhood Understanding Behaviors Survey (CUBS), Alaska Birth Defects Registry (ABDR), and Maternal Child Death Review (MCDR);
2. Epidemiological tracking, program evaluation, and monitoring—in WCFH this includes the Title V Maternal-Child Health Indicators Program;
3. Testing and screening programs—in WCFH these programs include Breast and Cervical Health Check (BCHC); autism, Pediatric subspecialty clinics; and newborn bloodspot and hearing screening;
4. Treatment;
5. Administrative inspections; or other techniques.

During 2018 regulations that affect the newborn bloodspot screening and Alaska Birth Defects Registry programs were revised. On July 1, 2018, Alaska became a one-screen state for bloodspot screening and also funds and coordinates a courier system for transport. The updated birth defects registry regulations expand the list of

organizations required to report and includes private or public health insurance organizations and diagnostic laboratories operating in Alaska, and requires infant/child and maternal identifiers to be reported.

The following is a full list of Alaska state statutes (AS) and Alaska administrative code (AAC) regulations of relevance to Title V. Items that are bolded have direct relevance to programs in WCFH.

AS 08.65	Direct-Entry Midwives
AS 08.68	Board of Nursing
AS 11.41.434-440	Sexual Abuse of a Minor
AS 14.07.020	Duties of the Department of Education and Early Development
AS 14.12.115	Indemnity to School Staff
AS 14.20.680	Required Alcohol and Drug Related Disabilities Training
AS 14.30.045	Tuberculosis screening
AS 14.30.065-127	Physical Examinations and Screening Examinations
AS 14.30.141	Self-administered Medication in School
AS 14.30.231	Assure appropriate programs & services for children with disabilities
AS 14.30.355-356	Sexual Abuse and Sexual Assault Awareness and Prevention
AS 14.30.362	Suicide Awareness and Prevention Training
AS 14.33.100	School Crisis Response Plan
AS 14.33.200	Harassment, Intimidation, or Bullying Prohibition Policy
AS 18.05	Administration of Public Health and Related Laws
AS 18.15.010-900	Disease Control & Threats to Public Health
AS 18.15.200	**Screening for Metabolic Disorders**
AS 18.16.010	Regulation of Abortions
AS 18.50.010-040	Vital Statistics Act
AS 18.66.310	Continuing Education for Public Employees
AS 25.20.010	Age of majority
AS 25.20.025	Examination and Treatment of Minors
AS 40.25.125	Public Record Disclosures
AS 44.29.020	Duties of the Department of Health & Social Services
AS 47.07.030	Medical Services to be Provided for Pregnant Women
AS 47.07.067	Payment for adult dental services
AS 47.17.010-290	Child Protection
AS 47.20	Services for Developmentally Delayed or Disabled Children
AS 47.20.300-390	Newborn and Infant Hearing Screening, Tracking and Intervention Program
04 AAC 06.055	Immunizations required for school entry
04 AAC 52.250	Special Education Aides
07 AAC 12.401-.449	Free Standing Birth Centers
07 AAC 23.010-.900	Programs for Children with Disabilities
07 AAC 27.007	Reporting by laboratories
07 AAC 27.012	**Birth Defects Registry**
07 AAC 27.110-.111	Prophylactic treatment of newborn's eyes
07 AAC 27.510-590	**Screening of newborn children for metabolic disorders**
07 AAC 27.600-650	**Newborn Hearing Screening**
07 AAC 27.890-.900	**Confidentiality, authorized users, and security standards; definitions**
07 AAC 78	Grant Programs
07 AAC 80	Fees for Department Services
12 AAC 02.280-282	Board of Nursing - licensing fees
12 AAC 44	Board of Nursing, including Advanced Nurse Practitioner
14 AAC 12-14	Renewal & Continuing Competency Requirements for Certified Direct-Entry Midwives
CH. 56 SLA 13	**Critical Congenital Cardiac Screening**

III.C. Needs Assessment

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The MCH Epidemiology Unit supports a variety of ongoing needs assessment activities, including coordinating the PRAMS and CUBS surveys, the Birth Defects Registry, the Alaska Longitudinal Child Abuse and Neglect Linkage project, and the Maternal Child Death Review. Epidemiologists analyze data from these systems and produce reports and disseminate data online so that it is easily accessible to program staff for needs assessments and program evaluation purposes. As well, the Unit regularly analyzes data from external sources, including Medicaid and the Health Facilities Data Reporting System. In the past year, we conducted focused analyses to examine outcomes related to Title V priorities including severe maternal morbidity, maternal mortality, child maltreatment, and early childhood dental visits, and produced a comprehensive data book of perinatal health indicators. We seek stakeholder input before finalizing relevant formal publications.

Within each population domain a number of WCFH program advisory committees meet throughout the year to provide input on program strategies and objectives. Many of these committees have at least one family member or self-advocate.

Staff turnover and long-term vacancies, combined with other critical non-Title V-funded vacancies, had notable impacts on Alaska's Title V program capacity. Two partially Title V-funded positions (Perinatal/Reproductive Health Nurse Consultant and PRAMS and CUBS Survey Operations Manager) were vacated, with both positions unfilled for several months due to hiring freezes and difficulties recruiting qualified applicants. As of July 2019, there is still not a Dental Consultant contractor for the State of Alaska. Alaska named a new CYSHCN Director in January 2019.

The Division of Public Health (DPH) also had several critical staff changes over the past year, along with the new administration which came in December 2018. Changes of key Title V collaborators in DPH included Public Health Director, Chief Medical Officer, Medicaid Director, CHIP Director, and State Medical Examiner.

Emerging issues during the past year include emergency preparedness following the November 2018 7.2 magnitude earthquake that hit the Anchorage area, vaccine hesitancy in light of the ongoing national measles epidemic, legislation requiring able-bodied recipients of Medicaid to pursue employment, and new State funding for marijuana prevention and education work. Sexually transmitted infections continue to increase; Alaska had the highest Chlamydia infection rate in the nation during 2010-2018, and in 2018 experienced the largest syphilis outbreak in Alaska in at least 4 decades. Opioid and other substance use continue to impact overall population health. Another emerging issue is the possibility of Medicaid transformation in the form of Block Grant funding to Alaska.

Women's/Maternal Health

Alaska's priority needs for the women's health domain are: 1) to increase access to reproductive health services that adhere to national best practices, and 2) to increase evidence-based screening for all MCH populations for behavioral and mental health problems. In 2017, 46.7% of Alaska women ages 18-44 years of age reported having had a past-year preventive health visit (a routine check-up that was not for injury, illness or a condition) (BRFSS). This percentage declined from 55.4% in 2016, likely due to changes in breast and cervical screening intervals that are a large driver for women to go in for preventive health visits. According to PRAMS, 67% of women who delivered in 2017 had a some type of health care visit in the 12 months before they got pregnant. Of those, 48% had a regular checkup at their family doctor's office and 45% had a regular checkup with an OB/GYN.

Behavioral and mental health conditions remain a major concern for all Alaskan MCH populations. In 2017, 27.2% of women ages 18-44 years reported ever having a depressive disorder (BRFSS), and symptoms of postpartum depression were reported by 13% of women who delivered a live birth in 2017 (PRAMS). Mental health conditions contributed to 30% of the pregnancy-associated deaths that occurred 2012-2017, and drug or alcohol overdose was the mechanism of death for 27% of all pregnancy-associated deaths during that time period. Alaska's five-year rolling average pregnancy-related mortality rate declined to 7.2 per 100,000 live births in 2013-2017. Teen births continued to decline; the teen birth rate was 21.4 per 1,000 in 2017, compared to 43.2 per 1,000 in 2009.

There were no notable changes in partnerships/collaborations or changes in systems of care in the past year relevant to the women's health domain.

Perinatal/Infant Health

Alaska's priority need for the perinatal and infant health domain is to reduce substance use among families.

Neonatal Abstinence Syndrome continued to increase among Alaskan Medicaid-enrolled births from 2.7 per 1,000 live births in 2004 to 23.3 in 2017. Among 770 women who were screened before delivery at Alaska facilities participating in the Alaska Prenatal Screening Program 2017-2018, 23% used some type of harmful substance during the last month of pregnancy, including tobacco, alcohol, marijuana, prescription medications and other drugs, with 3% reporting heroin, amphetamines, cocaine, crack, or methamphetamines. Among all women who delivered in 2017, 8.6% used marijuana during their pregnancy and 11.8% used it since their baby was born (PRAMS).

Alaska's infant mortality rate (IMR) in 2018 was 5.7 per 1,000 live births, similar to the rate of 5.6 in 2017. Alaska Native and Black infant mortality rates are more than twice the rates for White and Asian/Pacific Islander infants. Disparities persist by region of residence as well, with residents of the Northern and Soutwest regions having significantly higher rates compared to residents of all other regions. Among the 22 out-of-hospital infant deaths that were reviewed by the MCDR committee in 2018, 68% were related to an unsafe sleep environment, and in 50% the adult caring for the infant had a history of substance-abuse or was impaired at the time of death. Of note, the percent of infants placed to sleep on their backs has been steadily increasing, from 71% reported by mothers who delivered in 2013 to 80% in 2017 (PRAMS).

In October 2018, Title V staff partnered with the ASTHO, the DHSS Chief Medical Officer, Division of Behavioral Health, Alaska Medicaid Program, State Opioid Treatment Authority, Office of Children's Services (OCS), Office of Substance Misuse and Addiction Prevention and clinical providers to continue work to address policy and systems barriers and comprehensive needs of women of reproductive age who use opioids and other harmful substances, especially those who are pregnant or have infants and young children. Alaska has centered its efforts around Plans of Safe Care as outlined under the Child Abuse Prevention and Treatment Act. Some first steps include launch of a pilot project in Palmer in conjunction with the Palmer Families, Infants and Toddlers Court. Alaska Court System officials, including two Assistant Attorneys General are participating. Data from the Alaska Prenatal Screening Program is being used to guide the groups' work plans.

WCFH continues to work with partners to create Alaska-specific infant safe sleep educational materials and trainings and update the state's safe sleep website. We partnered with Cribs for Kids to support Alaska's hospitals in attaining national Safe Sleep Hospital certification, and worked with tribal health partners to develop Alaska-specific safe sleep materials for families and caregivers of infants focused on harm reduction. In the past year we partnered with OCS to conduct safe sleep training for child welfare workers.

During 2018, WCFH facilitated the launch of the Alaska Perinatal Quality Collaborative (PQC). Prior to the launch, we conducted an online survey of over 200 health professionals and a few parents that asked respondents to rank OB and pediatric topic areas which the fledgling PQC should consider focusing on for initial activities. The PQC Steering Committee has two parent representatives. The MCDR program also expanded committee membership to reach new partners.

Child Health

One of Alaska's priority needs for child health is to reduce child maltreatment. The rate of unique substantiated child maltreatment victims per 1,000 children aged 0-17 years was 15.0 per 1,000 children in 2017 (NCANDS). While approximately 10% of Alaskan children ages 0-17 are reported to child welfare for a suspicion of maltreatment during an average year, cumulative estimates show that 32% of children born in Alaska are reported before age 8 (ALCANLink, data from the 2009-2011 birth cohort).

A second priority need for children is increasing access to preventive health services. Data collected from school nurses in 2018 show 18% of Alaska's children have chronic diseases. The percent of 3-year-olds who have seen a health care provider for routine medical care in the past 12 months has not significantly changed in the past five years and was 89.5% in 2017 (CUBS). Data on developmental screening varies by source. In 2017, 75% of mothers of 3-year-olds indicated that they had completed a questionnaire or a health care provider went through a checklist of questions with her about her child's development in the past 12 months (CUBS). However, the 2016-17 NSCH indicated that 42.3% of children ages 9 through 35 months received a developmental screening using a parent-completed screening tool. Many children are entering kindergarten unprepared; only 19% of children demonstrated all 13 goals within 5 domains in the 2018 Alaska Developmental Profile, and 32% demonstrated 11 or more goals.

Under the HRSA/MCHB ECCS grant, WCFH continued to partner with state and community-based programs to promote the use of the online ASQ developmental screening tool. Leveraging ECCS and Title V funding, WCFH also continues to support the implementation of Help Me Grow (HMG) Alaska, which launched at the beginning of 2018 and is coordinated by the All Alaska Pediatric Partnership (AAPP).

In December 2018, a partnership with the Alaska Allergy and Immunology Foundation began with funding from 1801 CDC Grant from DEED to train lay people to give Epinephrine to children with undiagnosed anaphylaxic allergies. This included training for school nurses and school personel on chronic disease management for children in school.

The MCH Epidemiology Unit increased its collaborations to support work to improve child maltreatment data and ALCANLink surveillance. New non-federal national partners include Mathematica Policy Research, Inc., the Doris Duke Foundation, the National Center for Fatality Review and Prevention and the Casey Foundation. The Unit was also invited to participate in a NIH consortium grant application with Washington University in St. Louis. This grant funding is currently supporting a Child Welfare Data SMART collaborative project between three universities and WCFH. Finally, the Alaska Mental Health Board is helping to pay for a 12 month Research Analyst position to support ALCANLink.

Adolescent Health

Increasing healthy relationships remains an adolescent population priority, as well as increasing access to preventive health services for Alaskans and their families. In 2017, 82% of students reported that they would feel comfortable seeking help from at least one adult besides their parents if they had an important question affecting their life (YRBS). Overall health status for children ages 12-17 years is good, with 88.8% in excellent or very good health in 2016-2017 (NSCH). However, 32% of high school students in 2017 had serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional problem (YRBS). Among 12-17 year olds, 83.3% had a preventive dental visit in the past year, and 69.1% had a preventive medical visit (2016-2017 NSCH).

With CDC Rape Prevention Education Program funding, WCFH is supporting a statewide train the trainer implementation of Coaching Boys into Men in partnership with the Alaska School Activities Association. In 2018, WCFH was awarded a HRSA grant and will partner with Christian Health Associates to provide dental care to underserved citizens. In 2019, the Adolescent Health Program began partnering with the Michigan Medicine's Adoelscent Health Initiative to pilot the Alaska Youth Friendly Clinics Project: Adolescent Centered Environment-Assessment Process with three sites. The pilot has completed initial data collection, implementation planning and current action steps with a pediatric clinic, a school-based health center and a reproductive health clinic.

Children and Youth with Special Health Care Needs

Our priority for the CYSHCN domain is to improve systems of care. The 2016-2017 NSCH estimated that 17% of Alaskan children ages 0-17, or 31,621, have special health care needs. Only 19.1% of Alaskan CYSHCN received care in a well-functioning system, 47.3% had a medical home, and 4% of children ages 0-17 were not able to obtain needed health care in the past year (2016-2017 NSCH). Alaska CUBS asks mothers of 3-year-olds about problems that kept her from getting heath care for her child when he or she was sick. In 2017, the most common responses were that she couldn't get an appointment when she wanted one (8.4%), she didn't have enough money or insurance to pay for it (7.4%), and she couldn't take time off from work (6.7%).

Only 23% of the 13,922 Alaskan CYSHCN aged 12-17 received transition services to adult health care in 2016-2017. In an effort to improve existing systems of care Title V funds are being used to collaborate with a variety of agencies and service providers throughout the State to improve access to healthcare services and knowledge of resources for CYSHCN.

In 2019, DEED and WCFH began partnering to offer Family Engagement training, using funds from the Preschool Development Grant. The WCFH Family Engagement Lead is developing the training and will recruit family members and caregivers to participate.

Finally, WCFH is participating in advisory meetings with the Mental Health Trust, AAPP, and the Division of Behavioral Health (DBH) regarding the Alaska Partnership Access Line - Pediatric Alaska (PAL-PAK). This is a new partnership between DBH and Seattle Children's Hospital PAL line, and offers prescribing pediatric care providers in Alaska support when they have questions about child and adolescent mental healthcare, including diagnostic clarification, medication adjustment and treatment planning. This initiative is in direct response to the lack of psychiatrists available in Alaska to treat pediatric patients with mental health needs.

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The Maternal Child Health Epidemiology Unit within WCFH uses Title V funding to support a variety of ongoing needs assessment activities, including managing and coordinating two surveys of mothers in Alaska (PRAMS and CUBS), the Birth Defects Registry, and the Maternal Child Death Review. Epidemiologists analyze the data from these systems throughout the year and produce reports and disseminate data online so that it is easily accessible to program staff for needs assessments and program evaluation purposes. The Unit continues to regularly analyze data from outside sources and has increased its capacity to analyze Medicaid and the Health Facilities Data Reporting System data. In the past year, we have used these datasets to examine outcomes related to Title V priorities including Neonatal Abstinence Syndrome, dental visits, and developmental screening.

A variety of WCFH program advisory committees meet throughout the year to provide input on program strategies and objectives. All of the advisory committees for Children and Youth with Special Health Care Needs (CYSHCN) include at least one family member or self advocate.

During the reporting year, there was a considerable amount of turnover in WCFH. Alaska's longtime Title V Director/Section Chief retired and a new Director was hired. The 100% Title V-funded School Nurse Consultant position and two partially Title V-funded positions (Perinatal/Reproductive Health Nurse Consultant and PRAMS and CUBS Survey Operations Manager) were vacated. The Survey Operations Manager position was filled immediately, however both nurse positions remained vacant for several months due to difficulties recruiting qualified applicants. Additionally, the incoming Title V Director continued covering her former position as Perinatal and Early Childhood Unit Manager until that position was filled over six months later, along with the work of other vacant positions. The staff turnover and long-term vacancies, combined with other critical non-Title V-funded vacancies, particularly in Children and Youth with Special Healthcare Needs (CYSHCN), had notable impacts on Alaska's Title V program capacity. Alaska's Dental Director retired during the reporting year and this position was not able to be filled due to decreases in State general funds. This time of vacancies and transition delayed such projects as the implementation of a perinatal quality collaborative and oral health work. WCFH also took on new programs such as Parents as Teachers and the Early Childhood Comprehensive Systems (ECCS) program during this time.

Emerging issues during the past year include the impacts of climate change on public health, legislation requiring able-bodied recipients of Medicaid to pursue employment, and new State funding for marijuana prevention and education work. Sexually transmitted infections have been increasing, with a gonorrhea outbreak in 2016 and 2017, and an increase in syphilis cases during the first quarter of 2018. Opioid and other substance use continue to impact overall population health, with recent increases noted in deaths due to fentanyl as well as methamphetamine use. In 2018, the Alaska legislature passed comprehensive legislation to improve Alaska's welfare system, establishing new training and workload standards for caseworkers. The OCS system has been extremely overburdened in recent years due to a number of issues, including increases in referrals related to parental opioid use.

Women's/Maternal Health

Alaska's two priority needs for the women's health domain are: 1) to increase access to reproductive health services that adhere to national best practices, and 2) to increase evidence-based screening for all MCH populations for behavioral and mental health problems.

In 2016, 56.1% of Alaska women ages 18-44 years of age reported having had a past-year preventive health visit (a routine check-up that was not for injury, illness or a condition) (BRFSS). This percentage has been relatively stable since 2013. Other indicators of women's health have also shown no significant trends in recent years, for example severe maternal morbidity (155.9 per 10,000 hospital deliveries for the first three quarters of 2015), and pregnancy-related mortality (five deaths identified during 2012-2016). One key measure, teen pregnancy, continued to decline and was 25.8 per 1,000 in 2016, compared to 43.2 per 1,000 in 2009. Additionally, Alaska's preterm birth rates very slightly decreased from 8.98 in 2015 to 8.92 in 2016, a small but notable decrease as the US rate and rates for most states increased during that time.

In 2016, 85.9% of Alaska women aged 21-65 received recommended cervical cancer screening. That same year, 67.6% of Alaska women aged 50-74 reported that they had received breast cancer screening (mammogram) within the past 2 years, compared to the HP2020 target of 81.1%.

Behavioral and mental health conditions remain a major concern for all Alaskan MCH populations. In 2016, 25.7% of women ages 18-44 years reported ever having a depressive disorder (BRFSS), and symptoms of postpartum depression were reported by 12.7% of women who delivered a live birth in 2015 (PRAMS). Discussions with a health care provider about postpartum depression is increasing, from 80.4% in 2009 to 88.2% in 2015 (PRAMS). Additionally, in 2015, 77.3% of Alaska women delivering a live birth reported that a health care worker talked with her during a prenatal care visit about what to do if she feels depressed during pregnancy or after her baby was born (PRAMS).

In support of the findings of the 5-year NA, WCFH Adult Health Unit staff continue to collaborate with other DPH sections and statewide coalitions in efforts to establish baselines and improve the quality of and access to preventive health services for Alaska women in their childbearing years. Alaska's Medicaid expansion in September 2015 and ongoing improvements to Alaska's health insurance systems continue to provide promising opportunities for Alaska women to have increased access to low-cost and subsidized health care insurance options that, hopefully, will stem the tide of decline in seeking critical preventive health services in coming years.

Perinatal/Infant Health

Alaska priority need for the perinatal and infant health domain continues to be to reduce substance use among families, including alcohol, tobacco and drugs. Although Alaska's total infant mortality rate has declined in the past two years, with a preliminary IMR of 2017 of 4.9 per 1,000 live births, the Alaska Native and White disparity persists, particularly in rural areas. Substance use and unsafe sleep practices continue to be leading contributing factors for infant mortality and help to drive this disparity.

Neonatal Abstinence Syndrome from maternal opioid use during pregnancy increased among Alaskan Medicaid-enrolled births from 2.7 per 1,000 in 2004 to 16.9 per 1,000 live births in 2016. The increasing trend has plateaued since 2014. As the incidence of NAS has increased, reports to child protective services for NAS have also increased; during 2007-2016, 28% of Medicaid enrolled infants diagnosed with NAS were temporarily or permanently placed in protective custody within one month of birth. The prevalence of Fetal Alcohol Syndrome among Alaskan births 2007-2013 was 1.7 per 1,000 live births (ABDR).

In January 2018, Title V staff successfully partnered with the Governor's office, Medicaid Behavioral Health Services, the State Opioid Treatment Authority, and the Office of Children's Services to apply for a National Governors Association technical assistance project aimed at addressing policy barriers to the prevention and treatment of NAS. The Title V funded Alaska Birth Defects Registry submitted proposed regulations changes for reportable birth defects to make it easier for the state to track NAS and its related risk factors and exposures. Concerns about NAS have also opened a window for renewed efforts around improving access to immediate post-partum Long Acting Reversable Contraception (LARCs) with a special focus on women who report use of alcohol, marijuana and/or opioids or other illicit substances during their pregnancy.

The Title V program adapted the Healthy Native Babies curriculum to reflect the updated AAP Safe Sleep guidelines and the needs of Alaska's families, called Healthy Alaska Babies. The program is a partner of Cribs for Kids, supporting Alaska's hospitals in attaining national Safe Sleep Hospital certification. Alaska's program worked with tribal health partners to develop new safe sleep materials for families and caregivers of infants, including conducting informal focus groups with non-clincal staff on language and messaging, , focused on harm reduction. WCFH will continue to work with partners to create more Alaska-specific educational materials and to update the state's safe sleep website.

Alaska's MCDR committee continues to conduct activities to improve timeliness of reviews and the dissemination of findings related to primary prevention. The program re-applied in 2018 for funding to participate in the national SUID case registry system.

Child Health

Reducing the rate of child maltreatment and increasing access to preventive health services for Alaskans and their families are the priority needs for the child health domain. The rate of unique substantiated child maltreatment victims per 1,000 children aged 0-17 years was 16.8 per 1,000 children in 2016 (NCANDS). While approximately 10% of Alaskan children ages 0-17 are reported to child welfare for a suspicion of maltreatment during an average year, recently calculated cumulative estimates show that 32% of children born in Alaska are reported before age 8 (ALCANLink, data from the 2009-2011 birth cohort).

In 2016, 93.5% of Alaska children ages 0-17 were in excellent or very good health according to parental report. This was the second highest prevalence in the nation. Alaska also ranked high (5th in the nation) on the percent of children ages 9 through 35 months who received a developmental screening using a parent-completed screening tool (NSCH), at 46.8%. According to Alaska CUBS, the percent of 3-year-olds who have seen a health care provider for routine medical care, such as a well-child check-up or physical exam, has not significantly changed in the past five years, and was 88.1% in 2016.

In July 2017, WCFH began managing the HRSA/MCHB ECCSgrant, and through this project is partnering with other state and community-based programs to promote the use of the online ASQ developmental screening tool available statewide. WCFH and the Title V program continues to support the implementation of Help Me Grow (HMG) Alaska , now coordinated by the All Alaska Pediatric Partnership (AAPP). Leveraging the ECCS grant and Title V funding, HMG launched in the beginning of 2018.

Due to staff vacancies, Title V held off on exploring a proposed Medicaid CHIP Health Services Initiative related to universal developmental screening promotion, however we plan to reassess this in the upcoming year now that positions are filled.

Adolescent Health

Increasing healthy relationships remains an adolescent population priority, while this year the priority of increasing access to preventive health services for Alaskans and their families falls within this domain as well. Healthy relationships are evaluated by the percentage of students who report that they would feel comfortable seeking help from at least one adult besides their parents if they had an important question affecting their life. This indicator decreased from 86% in 2015 to 82% in 2017, although the trend has not been consistent since 2007 (YRBS).

Overall health status for children ages 12-17 years is good, with 92.7% in excellent or very good health in 2016 (NSCH). Among this age group, 81.3% had a preventive dental visit in the past year (NSCH). However, mental health is an area of concern. The percentage of high school students feeling sad or hopeless continued to increase and was 36.1% in 2017. Also increasing in 2017 was the percentage of students who made a suicide plan in the past year (20.7%), and the percentage who made at least one suicide attempt during the past year (12.1%). However, among students who have considered, planned, or attempted suicide during the past year, 46.8% have talked to someone about suicide.

Changes in Title V program capacity and established program collaborations and partnerships included continued collaboration with the Association of State and Territorial Health Officials (ASTHO) and the CDC Division of Violence Prevention, National Center for Injury Prevention and Control to strengthen the State's ability to prevent sexual violence. A new collaboration/partnership was established with the Alaska Section of Chronic Disease and Health Promotion to assist with implementation of a small portion of the CDC Preventive Health and Health Services Block Grant, specifically in the prevention of sexual violence among child and youth in Alaska and the dissemination of and training dedicated to the Alaska Safe Children's Act Tool Kit/Resource Guide for Schools. In addition, the Alaska Dental Action Coalition has reassessed its priorities after losing the state Dental Director. The coalition is choosing to have more direct priorities such as fluoride, perinatal oral health, school aged, and oral health and aging. In early 2018, WCFH co-authored a HRSA grant with the Alaska Native Tribal Health Consortium to contract with a Dental Director and hire dental specialists to provide care in underserved communities.

Children and Youth with Special Health Care Needs

Our priority for the CYSHCN domain is to improve systems of care. Approximately 16% of Alaskan children ages 0-17, or 29,864, have special health care needs according to the 2016 National Survey of Children's Health (NSCH). In addition, 24% of Alaskan families with CYSHCN experienced financial problems due to providing for the special needs of the child with 27% reporting family members had to cut back or stop work because of their child's needs. In Alaska, 28% of CYSHCN had at least one unmet healthcare need and familes reported spending 11 or more hours a week either providing or trying to coordinate care .In 2016, 9.5% of Alaskan mothers of 3-year-olds said their child needs or uses more medical care, mental health, or educational services than is usual for most children of the same age, and 7.4% said that their child is limited in his or her ability to do things most children of the same age can do (CUBS). HRSA has designated most of Alaska's geographic area as Health Professional Shortage areas (HPSA's) based on the lack of primary care physicians, dentists and psychiatrists. Less than 20% (19.2%) of Alaskan CYSHCN received care in a well-functioning system while 50.5% had a medical home (2016 NSCH). Among Alaska CYSHCN, 76.7% had excellent or very good health in 2016 compared to 96.8%

of non-CYSHCN (2016 NSCH).

II.B MCH Population Needs

Women's/Maternal Health

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

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

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

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

Perinatal/Infant Health

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

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

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

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

Alaska's MCDR committee continues to conduct activities to improve timeliness of reviews and the dissemination of findings

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

Child Health

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

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

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

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

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

Adolescent Health

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

Changes in Title V program capacity and established program collaborations and partnerships included continued collaboration with the Association of State and Territorial Health Officials (ASTHO) and the CDC Division of Violence Prevention, National Center for Injury Prevention and Control to strengthen the State's ability to prevent sexual violence. In addition, the Adolescent Health Program received a supplementry Rape Prevention Education Program grant to assist with evaluation efforts. A new collaboration/partnership was established with the Alaska Section of Chronic Disease and Health Promotion to assist with implementation of a small portion of the CDC Preventive Health and Health Services Block Grant, specifically in the prevention of sexual violence among child and youth in Alaska and the dissemination of and training dedicated to the Alaska Safe Children's Act Tool Kit/Resource Guide for Schools.

Activities to operationalize the three major adolescent health needs identified in the NA process included hosting a statewide youth leadership summit focused on healthy relationships called Lead On! The Adolescent Health Program implemented an evidence-based intervention, *Bringing in the Bystander,* at the University of Alaska Anchorage that reached over 1000 students from August 2016 – May 2017 and multiple teen pregnancy prevention/sexual health education curriculas. The Adolescent Health Program staff worked extensively with the Alaska Safe Children's Act Taskforce, which is providing recommendations to the Department of Education and Early Development on new legislation that stipulate that school districts in Alaska must train employees and students on sexual abuse prevention (K-12) and dating violence and abuse

prevention (grades 7-12). The *Alaska Fourth R Healthy Relationship Program* for grades 7-9 that teaches healthy relationship skills and empowers adolescents to make healthier decisions about relationships, sexual behavior, and substance use continued to expand. Over 300 school staff and community partners throughout Alaska are trained to teach the *"Fourth R'* and 81 schools have received the curricula and training materials.

Children and Youth with Special Health Care Needs

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

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

Life Course

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

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

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

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

The bacteria associated with caries are usually passed mother to child so managing dental caries in pregnant women is crucial to targeting at risk children for early dental care. PRAMS data indicate some small increases in oral health indicators

among women who recently delivered a live birth in Alaska. The percent of women who had insurance to cover dental care during their pregnancy decreased 79.3% in 2013 to 78.5% in 2014. The prevalence of women who reported getting their teeth cleaned in the 12 months before getting pregnant increased from 60.4% in 2013 to 62.5% in 2014.

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

FY 2017 Application/FY 2015 Annual Report Update

Women's/Maternal Health

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

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

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

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

Perinatal/Infant Health

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

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

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

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

Finding of the five year needs assessment were operationalized into the Infant Mortality CoIIN, and include activities around

substance use, smoking cessation, safe sleep practices, and pre and interconception health. These efforts are described throughout the Plan for the Application Year and Annual Report.

Child Health

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

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

Adolescent Health

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

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

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

Children and Youth with Special Health Care Needs

Alaska selected NPM 11 for the CYSHCN domain (percent of children with and without a special health care need having a medical home). The National Survey of Children's Health (2011/2012) reports that 51.9% of all Alaska's children have a medical home compared to 42.8% of CYSHCN according to the National Survey of Children and Youth with Special Healthcare Needs (2009/2010). Although no new national data is available on the CYSHCN population in Alaska, statewide activities continue to assess needs and response to activities using Title V Block Grant Needs Assessment, program

evaluation and quality improvement methodology. Additional primary care practice and statewide Medicaid data were gathered in the past year through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. CAHPS data has been aggregated and will be analyzed for further insight into Alaska's CYSHCN population by the WCFH MCH Epidemiology Unit staff who are heavily supported by Title V block grant funding.

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

Life Course

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

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

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

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

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

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

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

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

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

II.B.1. Process

Goals and Framework

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

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

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

Stakeholder Involvement

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

Quantitative and Qualitative Methods

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

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

Data Sources

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

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

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

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

Finalization

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

II.B.2. Findings

II.B.2.a. MCH Population Needs

Women's/Maternal Health

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

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

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

childbearing years.

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

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

Perinatal/Infant Health

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

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

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

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

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

persists, particularly in rural areas.

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

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

Child Health

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

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

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

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

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

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

Adolescent Health

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

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

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

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

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

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

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

adolescents and the unique role of the AHP.

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

Children and Youth with Special Health Care Needs

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

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

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

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

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

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

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

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

Life Course

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

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

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

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

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

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

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

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

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

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

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

II.B.2.b Title V Program Capacity

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

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

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

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

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

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

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

(a)

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

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

Women/Maternal Health

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

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

Perinatal/Infant Health

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

Children and Youth with Special Health Care Needs

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

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

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

Child Health

Access to a pediatric medical home has been a key area of focus. Title V collaborates with ECCS to implement online use of the Ages and Stages screening tool, and with the Section of Public Health Nursing (SOPHN) trains nurses to offer comprehensive well child screens in remote communities. Frequent turnover of health aides in many villages presents

challenges in maintaining trained staff and thus preventive health visits are of lower priority. Capacity for the Title V program has been enhanced with the HRSA D70 grant award.

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

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

Adolescent Health

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

Cross-cutting/Life Course Health

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

(b)

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

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

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

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

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

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

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

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

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

(a)

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

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

MCH Epidemiology Unit: **14.0 FTEs**

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

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

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

School Age and Adolescent Health Unit: 9.0 FTEs

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

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

Early Childhood and Perinatal Health Unit: 13.0 FTEs

Section Operations Support: 3.0 FTEs

(b)

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

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

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

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

MIECHV home visitors receive cultural diversity training.

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

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

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

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

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

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

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

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

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

vi. Other government agencies:

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

vii. Tribes, Tribal Organizations:

Collaboration with ANTHC includes:

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

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

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

ix. Family and consumer partnership and leadership programs:

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

x. Other organizations that serve the MCH population:

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

III.D. Financial Narrative

	2016		2017	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,050,528	$1,051,991	$1,050,524	$1,051,991
State Funds	$14,471,700	$11,754,544	$14,169,000	$11,378,435
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$100,000	$30,000	$30,000	$18,353
SubTotal	$15,622,228	$12,836,535	$15,249,524	$12,448,779
Other Federal Funds	$5,922,338	$6,667,176	$6,091,206	$6,044,206
Total	$21,544,566	$19,503,711	$21,340,730	$18,492,985

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,051,157	$1,051,157	$1,057,450	
State Funds	$11,490,000	$10,080,107	$11,300,000	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$0	$25,965	$18,400	
SubTotal	$12,541,157	$11,157,229	$12,375,850	
Other Federal Funds	$6,240,749	$6,240,749	$6,281,723	
Total	$18,781,906	$17,397,978	$18,657,573	

	2020	
	Budgeted	Expended
Federal Allocation	$1,078,526	
State Funds	$9,500,000	
Local Funds	$0	
Other Funds	$0	
Program Funds	$26,000	
SubTotal	$10,604,526	
Other Federal Funds	$6,745,094	
Total	$17,349,620	

III.D.1. Expenditures

Expenditures (2019 Narrative for FFY 2018)

In State FY19, the Section of Women's, Children's and Family Health (WCFH) did not experience additional cuts to general fund dollars. The Alaska Title V Block grant totaled slightly over 1 million dollars and continues to be relied upon heavily for enabling services and public health systems/infrastructure dollars. The Title V federal program dollars were budgeted in SFY19 to support the state priorities identified in the MCH 5-year needs assessment, program priorities and accompanying national outcome measures. State general fund maintenance of effort (MOE) dollars come in large part from the state appropriation for the State's Infant Learning Program (Early Intervention), Women, Infants and Children (WIC), and Immunization programs, as well as general funds for the childhood obesity prevention program. Also included in the MOE reporting are dollars from a designated general fund/mental health appropriation for the Section of WCFH, and a percentage of designated general fund appropriation for child protection.

Ongoing fee collections for the pediatric sub-specialty clinics continue to be less significant of a revenue source given that WCFH currently only now sponsors two clinics (Metabolic Genetics and Autism/Neurodevelopmental). WCFH previously administered Genetics and Cleft Lip & Palate Clinics and thus collected more revenue from private insurance, Medicaid, Indian Health Services, and private pay. The fees collected from the clinics cover less than less 10% of the cost of providing these clinics across the state of Alaska. Fees charged are limited by state regulation to the Medicaid rate and do not reflect the actual cost of supporting these clinics or charges in the private health care sector. The Title V Block grant continues to be used to support the costs of the clinics, including contracts for the medical specialists, genetic counselors, and dietician. They also support other costs such as travel and dictation services. In addition, gap filling services such as these are supported through a combination of State general fund dollars, program fees, and Medicaid administrative claim dollars. Title V federal funds are not used to pay for Direct services as defined on Form 3b of the financial expenditures page.

WCFH continues to rely heavily on discretionary federal funding to support MCH and CYSCHN programs and initiatives. This includes: Early Hearing Detection & Intervention, Universal Newborn Hearing Screening, Maternal, Infant & Early Childhood Home Visiting, Early Childhood Comprehensive Systems, Teen PREP, PRAMS, Improving SUID Reviews, SSDI, Title X Family Planning, Breast and Cervical Health Check, and Rape Prevention Education grants.

WCFH transitioned from direct service nearly 17 years ago and has since utilized federal Block Grant dollars for linking services, technical assistance and infrastructure support for data surveillance and analysis, and program evaluation. The Block Grant heavily funds the data and surveillance programs located within the MCH Epidemiology Unit, in particular the CUBS survey of mothers of 3-year-olds, the birth defects registry, and the Maternal Child Death Review. The Title V Block Grant also supported program staffing for such areas as infant safe sleep, school nursing, oral health, maternal depression, and the implementation of the Alaska Perinatal Quality Collaborative.

Our epidemiological infrastructure is crucial to measuring the effectiveness of service delivery not only in the programs delivered by WCFH, but also outside of the Division of Public Health and the Department.

Alaska's programs also received funds from other agencies such as the Division of Public Assistance and the Office of Substance Misuse and Addiction Prevention through a reimbursable service agreement (RSA). The DPA funding supports that Division in meeting their Temporary Aid to Need Families (TANF) requirements for teen and out of wedlock pregnancy prevention work. Small grants from the Association of State and Territorial Health Officials (ASTHO) provided funds for start-up or pilot programs to "test interventions" on a smaller scale and entice smaller agencies to implement new and evidence based interventions on a smaller scale.

In the past year, WCFH has done an effective job of securing additional revenue sources during times of decreased federal and state dollars. The Section receives money from the Division of Behavioral Health to support the work of the perinatal/infant domain priority of reducing substance use. These dollars are supporting a Nurse Consultant to implement the Alaska Prenatal Screening Program. This project involves screening all pregnant women at hospital admission using the 4P's Plus screening tool along with Screening, Brief Intervention and Referral to Treatment (SBIRT) and the evidence-informed One Key Question (OKQ) tool to screen for desire for pregnancy in the upcoming year.

WCFH also received additional revenue support through contracts with the State of Washington (MIECHV Home Visiting Innovation), The University of Colorado (quality improvement for newborn bloodspot screening), the Alaska Children's Trust (KidsCount data analysis), Department of Education & Early Development (Parents as Teachers), Western States Regional Genetics Network, and other funding to support the ALCANLink project. During State FY19, Alaska also applied for a small amount of funding to support AIM activities through the Association of Obstetricians & Gynecologists.

The Section did receive a cut to our budget authority for FY20, including a 50% reduction in travel costs. There was also a reduction to state general funds and designated state general fund-mental health dollars.

WCFH meets the 30% requirement for CYSHCN by allocating dollars to pediatric specialty clinics, genetic counseling services, parent navigation services for CYSHCN. There is also staffing time to support the Alaska Birth Defects Registry and systems work related to improving transitions to health care for CYSHCN. WCFH is meeting the 30% requirement for children by funding for the School Nurse Consultant to work on health promotion and screening also for data infrastructure for the MCH Epidemiology Unit.

III.D.2. Budget

Budget (2019 Narrative for the FFY 20 application)

Budget in FY20

With the continued decrease in revenue generated by oil, the state continues to be at a crossroads in decision making on how the state government will continue to function and what programs will continue. The FY20 Governor's proposed budget included a decrement to WCFH in general fund dollars. That money however was put back into the budget by the legislature and is awaiting approval from the Governor. The Governor has the ability to do line items vetoes. As of June 2019, we are awaiting approval of the operating budget by the Governor. WCFH did not experience any layoffs in SFY19, and we do not expect any in SFY20.

State programs continue to be under pressure to reduce their expenses. Many state agencies, including the Department of Health & Social Services and the Department of Education and Early Development as well as the University system, will be taking significant cuts in FY20.The current operating budget, which is waiting for signature by the Governor as of June 2019, has over a 2 million dollar general fund decrement to the Section of Public Health Nursing. It is still to be determined how this cut will be implemented and any resulting impact to staffing and services in Alaska. The impact of the prior reductions has been felt especially in rural Alaska where there is heavy reliance on public health nurses to deliver public health services such as disease outbreak investigation, immunizations, emergency preparedness and gap filling services especially for children and pregnant women.

Leadership in the Section of Women's, Children's and Family Health prepared for cuts starting back in SFY16 by combining programs, transitioning clinics outside of state sponsorship, eliminating positions, focusing on work that is a core function of public health and that addresses selected maternal and child health performance and outcome measures.

A hiring and travel freeze were implemented in February 2019. While WCFH has been successful in obtaining approvals to recruit and hire, it has been a very time consuming process with many delays. Our Human Resources Department continues to be very short-staffed with long turnaround times. WCFH also must obtain approval from the Governor's Office to post any positions for hire. WCFH has been very thoughtful in preparing for budget cuts and will continue to look for additional revenue to support our work.

During FY19, WCFH began implementing a federal HRSA grant related to oral health workforce development. This federal grant will support the addition of a Dental Consultant in FY20. There have been delays in implementing this project due to the loss of the required in-kind match, but this should be on track for SFY20. WCFH also receives CDC funding to work on breastfeeding promotion in hospitals through partnership with our Section of Chronic Disease & Health Promotion. WCFH will also receive a small amount funding from the Department of Education & Early Development as part of Alaska's new preschool development grant. This money will focus on parent training. Lastly, WCFH will receive a small amount of funding from the American College of Obstetricians and Gynecologists to support work on the Alliance for Innovation in Maternal Health.

WCFH also applied for CDC Maternal Mortality funding in SFY19 and we are working on a joint application with the State of Washington related to the HRSA State Maternal Health Innovation Program Grant.

Block Grant dollars for the upcoming year will focus on infrastructure and enabling services, as in years past. This funding will support staff time to work on priority areas such as safe sleep, medical transition to adulthood, the perinatal quality collaborative, school nurse consulting, oral health, and the various programs within the MCH Epidemiology Unit such as the Maternal Child Death Review Committee, Alaska Birth Defects Registry, Pregnancy Risk Assessment Monitoring System, and the Childhood Understanding Behaviors Survey, along with support of ALCANLink.

The non-federal budget for next reporting year was reduced slightly in anticipation of further reductions in State general funds. More details will be shared in further reports in the next Title V Block grant submission.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Alaska

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

Alaska's 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). WCFH programs 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. 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.

In 2017, WCFH adopted a Strategic Plan reflective of the priorities outlined in the MCH Title V Needs Assessment. The Strategic Plan 2017-2020 lays out the framework that guides the work of all programs in the Section.

STRATEGIES	**Serve as Alaska's chief strategists for existing and emerging public health issues** • Increase access to family-centered and culturally appropriate health services. • Provide leadership to identify upstream and emerging opportunities to guide state and national health policy, improve health outcomes and contain costs.
SERVICES	**Protect life, health, and safety through core public health functions** • Support and enable preventative services to increase early identification and intervention for individual and population-level health issues.
SCIENCE	**Serve as the trusted source of health information** • Collect, analyze and disseminate meaningful data to plan, implement and evaluate programs that realize the vision of healthy Alaskans today and tomorrow. • Build trust as a reliable and accessible resource to partners and the public.
SYSTEMS	**Strengthen essential public health infrastructure, services, and partnerships** • Partner with families and consumers, keeping their voice and leadership central: "nothing about us, without us." • Collaborate broadly to grow networks and systems. • Build capacity through education, securing funding and sharing quality data.

Title V is co-located in WCFH with many state and federal programs that serve the maternal and child population such as the Early Childhood Comprehensive Systems, Maternal, Infant & Early Childhood Home Visiting, newborn screening, Title X, among others. The Title V umbrella and framework guides the work of these programs as well as the uniquely Title V efforts, and funding is often braided together to accomplish mutual goals. The Section staff and programs are organized according to the life course framework with the understanding that what happens early in life

affects a person into adulthood. Some other key MCH programs are located elsewhere in the Division or Department, but partner closely with Title V to share data and staff expertise, establish priorities, and align strategies.

WCFH functions as a convener and leader that brings together stakeholders, both clinical and non-clinical, to the table to improve MCH health issues in Alaska. Some examples of this include work around increasing access to long-acting reversible contraceptives and implementing Alaska's first perinatal quality collaborative. The strong partnerships we have with the private sector, tribal health, educational institutions, and other non-profits serve as a major strength of the Title V program. We see parents and families as professional partners and serve as public health's leader in ensuring the voice of families and consumers is heard.

III.E.2.b. Supportive Administrative Systems and Processes

III.E.2.b.i. MCH Workforce Development

Recruitment and retention of a qualified Title V program staff:

During the past year, several new people joined the Section in the areas of school nurse consultation, children and youth with special healthcare needs, early childhood, perinatal nursing, and MCH Epidemiology. Rebekah Morisse continues in the roll of Title V MCH Director. In January 2019, she officially transitioned the role of CYSHCN Director to Christie Reinhardt, Perinatal & Early Childhood Unit Manager.

The Section continues to have 41.0 FTE of staff including program managers, nurses, epidemiologists and administrative stuff. No positions were eliminated in the Governor's proposed FY20 state budget. In FY17, there were 50.0 FTEs of positions located with the Section. In February 2019, the new administration implemented a hiring freeze on all positions. This caused delays in posting positions and conducting recruitments. Vacancies included oral health, early childhood comprehensive systems, adolescent health, survey operations management, and administrative support. As of June 2019, positions have started to move ahead for recruitment. The Public Health Director's Office had to designate a position to assist the HR department due to staffing shortages.

Despite recruitment challenges, current WCFH staff members are highly qualified to deliver services and programs required by Title V as well as our other grant and special funding streams. During the past year, WCFH hired very qualified and enthusiastic people to fill vacated positions. Staff members have master's degrees in such areas as public health, public administration, education, nursing, biostatistics, planning, business, social work, organizational leadership, and one has a PhD in Epidemiology. There are several health care professionals on staff including five registered nurses. Staff professional experience prior to coming to WCFH is impressively diverse, including Peace Corps, public health nursing in rural Alaska, public health internships in developing countries, CDC fellowships, community planning, disability services, parent navigation, advocacy, social work, school nursing, and community health education. The staff collectively bring together their diverse backgrounds, education and work experiences.

The Section envisions an ongoing need for masters-level trained staff to serve as program managers and leaders and makes an effort to work with the local university, as well as strengthening our network with universities outside Alaska. The Section has maintained membership on the Advisory Committees for the University of Alaska-Anchorage (UAA) MPH program and School of Nursing. One staff member serves on the Alaska Public Health Association Board, which has a complementary goal of improving overall public health workforce capacity in the state. WCFH staff have continued to host students to encourage professional development and to develop the MCH workforce in Alaska. During the past year, the Section hosted nursing students and other interns.

Training and growth opportunities for Title V program staff and family leaders

Ongoing professional and leadership development is a part of the annual evaluation process and staff are encouraged and supported to gain new skills as opportunities present themselves. We support staff taking full advantage of AMCHP's MCH Leadership Competencies and Workforce trainings and other leadership development opportunities. WCFH staff readily access the online Innovation Station and MCH Navigator for additional training. Multiple staff members have participated in AMCHP's Next Generation Leaders Cohort, Family Leaders Cohort, MCH Epi Peer-to-peer Cohort, or the Leadership Institute for CYSHCN Directors. The Title V Coordinator completed the Next Generation Leaders Cohort in October 2018. The Program Coordinator for the EHDI program, who is Alaska's Title V Family Delegate currently participates on the LEND Family Advisory Council, as a core member of the Family ECHO Team and also serves on the Strengthening Families Leadership Team. Multiple staff have attended the Alaska Strengthening Families protective factors framework training. This professional development opportunity is encouraged for all new Section employees. Finally, all staff participate in the Alaska Division of Personnel and Labor Relations professional development trainings. As the State continues to experience a travel freeze, trainings provided by AMCHP and third party funding for conference attendance continue to be a very valuable resource to ensure continued professional development.

WCFH uses Title V funds to organize and co-sponsor with the Alaska Native Tribal Health Consortium (ANTHC) the biennial Alaska MCH and Immunization Conference, which many staff attend. The conference brings rural and urban health professionals together to learn about best practices and tools for the prevention of key and emerging MCH and family health issues. The sixth biannual conference was held in September 2018 and offered continuing education credits for physicians, nurses, public health professionals and tribal community health and behavioral

health aides. There were an average number of 230 attendees on each of the three days with 174 post conference evaluation respondents scoring the conference as 3.5 out of 4. In addition, through partnership with ANTHC, 28 travel scholarships were awarded for rural participants to participate in the conference. It is anticipated the next conference will be held in February 2021.

Title V staff continue to attend the All Alaska Pedatric Partnership's annual pediatric symposium. This statewide conference attracts pediatricians, sub specialists and nurses from hospitals, schools and public health agencies and addresses "just in time topics" pertinent to improving health outcomes for Alaska's children and teen population. The November 2018 symposium had an emphasis on early childhood but included presentations on oral health, traumatic brain injury, school-based health centers, and HPV vaccine. The next symposium will be held in October 2019, and the Title V Director is serving on the planning committee.

The School Nurse Consultant serves on the planning committees of the School Health & Wellness Institute and the Alaska School Nurses Association (ASNA) annual meeting, both of which provide Continuing Nursing Education contact hours. The annual ASNA meeting addressed current issues in school health, chronic diseases, childhood trauma and mental health for school nurses statewide.

WCFH has also supported workforce development for over 11 years through the Youth Alliance for Healthy Alaska (YAHA). Youth participants learn about public health, the socioecological framework, and the effectiveness of prevention and gain experiences working with people from diverse backgrounds, locations and ages. They learn hard skills such as professional writing, developing presentations and video making, as well as soft skills including coordinating group work, time management and navigating differing opinions effectively. Many previous members have pursued academic and career paths related to public health; most recently, a former YAHA member applied for a position in the section while pursuing her MPH.

Innovations in staffing structures and workforce financing

WCFH has been strategic and innovative when exploring funding opportunities. We have stayed in close communication with partners and those in other states to look at shared funding to support programs and positions. Alaska collaborated with other Region X MIECHV programs to apply for a workforce development grant for home visitors. Our Section has also continued to leverage funding from the Division of Behavioral Health, the Office of Substance Misuse and Prevention, the Department of Education and Early Development, and the Office of Children's Services. During the past year, WCFH was also able to leverage funding from Alaska's new preschool development grant.

Over the past few years, the MCH Epidemiology Unit has sought and received funds from a variety of new partners that have enabled the Unit to diversify its sources of workforce financing. The Alaska Children's Trust (ACT) pays for personnel time for the MCH Indicators Research Analyst to update Alaska data on the national Kids Count Data Center. Most of the indicators are relevant to Title V and SSDI and are measures that the Unit is already calculating and tracking, and the work has enabled the Unit to gain expertise in another widely used national data center. In addition, the Unit has received funding to support the ALCANLink surveillance program and work related to child maltreatment data. Through a project with Mathematica Policy Research, Inc., Alaska is serving as a feasibility site to study the practicability of linking administrative data to better understand child maltreatment incidence. As a sub-recipient of an NIH grant to Washington University in St. Louis, Alaska's senior MCH Epidemiolgoist is supporting a Child Welfare Data SMART collaborative project with three universities. Other funding that the MCH Epi Unit has leveraged with Title V to support child maltreatment work comes from the Doris Duke Foundation, the Alaska Mental Health Board, the National Center for Fatality Review and Prevention and the Casey Foundation.

In September 2018, Alaska was awarded a HRSA Grant to Support Oral Health Workforce Activities, specifically to develop and implement innovative programs to address the dental workforce needs of designated dental health professional shortage areas (Dental HPSAs). Alaska will increase the accessibility and quality of oral health services within a major Dental HPSAs area, Anchorage, by contracting with a Dental Consultant to provide clinical consultation and strategic oversight and providing dental services to underserved residents. There have been some challenges with this project as the in-kind funder and major partner for this project, ANTHC, withdrew their support and funding due to concerns about cuts to their Medicaid reimbursement. Christian Health Associates will be the new in-kind funder and major contractor. While there were also difficulties in recruiting for a Dental Consultant, the new request for proposal document is clearer and will be more able to attract a dentist to assist the Alaska program.

The Adolescent Health Program is currently strategizing the potential for a long term, non-permanent student intern postion for first year college students in the MPH, Adolescent Health, Social Work and Youth Development fields.

III.E.2.b.ii. Family Partnership

The Section of WCFH seeks and values parent and consumer feedback on all of our programs and recruits Alaska parents, providers, and communities to help set priorities and initiate activities at all levels. Parent feedback was particularly helpful during the 2015 Title V Five-Year Needs Assessment, and we anticipate and will be seeking an even broader reach when the next Needs Assessment takes place. WCFH staff identified strong family and support systems as a Section value on the 2017-2020 Strategic Plan, with the specific goal of ensuring that the family/consumer voice is represented within Section programs and services. To operationalize this value, WCFH has a position with the formal role of Family Engagement Lead, currently held by John Cartwright. John is a former Alaska LEND Fellow who also serves as the Program Coordinator for the Newborn Hearing Screening program. He is the parent of a child with special health care needs and a self-advocate who experiences hearing loss.

A strong component of family partnership is through membership on the Section's various program Advisory Committees. Parent participation is valuable for assuring the voice of families is included in policies, educational materials, and outreach. We actively work to identify new channels to engage and retain families on these committees. All of the advisory committees for CYSCHN include at least one parent. To recognize the professional contributions of family members who participate in these types of activities, the Perinatal & Early Childhood Health Unit implemented an honoraria process in 2017. This effort was built upon a partnership with Stone Soup Group, Alaska's Parent Training and Information (PTI) and Family to Family grantee, who oversees the issuance and tracking of the honoraria funds to family members.

The EHDI Advisory Committee currently has 8 active family/consumer members. These members collaborate with program staff and other committee participants to take part in design, planning, implementation and evaluation of the newborn hearing screening program protocol, policy and quality improvement efforts. EHDI also provides funds for family navigation services to parents of children with hearing loss.

With additional funding from year one of the Alaska 0-5 Preschool Development Grant (PDG), in 2019, parent engagement training housed at the Section will be expanded to develop 20 short, 15-minute, self-paced online learning modules based on relevant curricula developed to promote parent engagement, expand parent confidence, choice, systems change and individual advocacy for their children. The Family Engagement Leader will work with the University of Alaska-Anchorage Center for Human Development (UAA-CHD) to turn the curriculum into an asynchronous online training that will be a sustainable tool for future use. The objective is to fully engage parents, especially those in low-income and rural communities, in the development and education of young children and in the successful transition to elementary school. The Department of Education & Early Development (DEED) recognizes the Alaska Title V program as a content expert in family engagement. This is what led to the current opportunity for collaboration.

The Adolescent Health program established family/consumer partnership in 2008 through the Youth Alliance of Healthier Alaska (YAHA), which has diverse membership of youth from across the state. This group contributes to Title V priorities as an advisory committee and also assists with strategic and program planning and materials development. YAHA's mission is to interweave youth voice into health programs in Alaska and create interventions designed to improve the lives of adolescents. This work is funded through the Division of Public Assistance TANF federal pass through funds.

In 2018-2019, YAHA supported students in Unalaska, Palmer, Chefornak, Ketchikan, Juneau and Anchorage in developing projects that addressed: e-cigarette use among teens, substance abuse prevention and mental health promotion, healthy relationships, sexual health, and violence prevention. In addition, YAHA members reviewed the Municipality of Anchorage's H.E.A.R.T. sexual health and healthy relationships curriculum, provided feedback to the Alaska Network on Domestic Violence and Sexual Assault related to the creation of a School Climate guidebook for teachers and administrators and YAHA provided feedback on the content and event branding for Anchorage's inaugural, The Youth Empowerment Party.

In the Maternal, Infant, & Early Childhood Home Visiting (MIECHV) program, the nurse home visitors in the Providence Nurse-Family Partnership (NFP) program have been using smartphones to complete client satisfaction surveys during pregnancy and when the child turns one year of age. They engage parents, along with other family members or close friends, to participate in client events and graduations. The Providence NFP program continues to have a parent who participates on their Community Advisory Board. She provides input on client recruitment and retention and other program activities and materials.

Family engagement on the statewide and local community levels has been critical to the launch of Help Me Grow Alaska, a system that connects children and families with services through centralized outreach, screening, referral and care coordination services. The CYSHCN Advisory Committee also has parent representatives that provide input to WCFH and other stakeholder programs. WCFH continues to administer the federal Early Childhood Comprehensive Systems (ECCS) grant. Family engagement continues to be a priority in the three place-based communities of Kodiak, Mat-Su, and Nome. Each community has identified a family leader.

WCFH continues to provide general fund support for the Center for Human Development to lead the LEND Family Advisory Council (LFAC), a parent driven council advocating for positive change through a unified voice. The mission of LFAC is to cultivate parents as professionals providing expertise about individuals who experience disabilities through collaboration, mentorship, leadership and education throughout our communities. Feedback from this council is critical to making systems changes in the care of CYSHCN and was used to shape the development of the online curriculum for family navigation training. Alaska's CYSHCN Director is a founding member of the LFAC and a LEND Family Mentor.

All WCFH staff who interact with families at any level have the opportunity to participate in a two-day Strengthening Families training. The Strengthening Families Protective Factors Framework is an international initiative that aims to develop and enhance five protective factors that help keep families strong and children safe from abuse and neglect. A training on the framework was designed to help professionals who work with children and families in promoting the optimal development of all children by teaching strategies and everyday actions to build these protective factors. Almost all WCFH staff have taken the training over the past two years.

III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts

Alaska's State Systems Development Initiative (SSDI) grant funding supports the work of the MCH Epidemiology Unit. Our three goals for the current SSDI funding cycle are:

1. Build and expand Alaska's MCH data capacity to support Title V program efforts and contribute to data driven decision making.
2. Advance the development and utilization of linked information systems between key MCH datasets.
3. Provide data support for the Early Childhood Comprehensive Systems (ECCS) Collaborative Improvement Innovation Network (CoIIN).

Supported by SSDI, Alaska's MCH epidemiology capacity has grown from a single pediatric epidemiologist in the mid-1990s to a 12 person MCH Epidemiology Unit. The Unit's purpose is to provide reliable data on MCH issues for use in planning and evaluating programs, preventing poor health outcomes, and guiding public health policy. The Unit has several core data collection efforts that are supported by Title V and SSDI in addition to other funds, including the Pregnancy Risk Assessment Monitoring System (PRAMS), a 3-year follow-up to PRAMS called the Childhood Understanding Behaviors Survey (CUBS), the Alaska Birth Defects Registry (ABDR), the Maternal Child Death Review (MCDR), and the Alaska MCH Indicators Project. The bulk of SSDI funding pays for personnel costs for the Research Analyst who leads the MCH Indicators Project. The primary function of the RA is to collect and disseminate data for the Title V Block Grant, as well as to provide technical assistance for continuous quality improvement work for ECCS. The Alaska Longitudinal Child Abuse and Neglect Linkage project (ALCANLink), described elsewhere in this application, is also largely supported by Title V and is a key data linkage project of the state that is used to inform programs, especially around our Title V priority of reducing child maltreatment.

The MCH Epidemiology Unit has a longstanding relationship and formal data sharing agreements with the Section of Health Analytics and Vital Records (HAVRS). HAVRS provides preliminary and annual birth, death, and fetal certificate research datasets to WCFH. The Unit also has direct access to the Alaska Medicaid claims database (Cognos) and can create queries and extract data on an as needed basis. Other MCH datasets accessed for analysis of MCH Indicators include the newborn hearing screening and health facilities discharge data. We regularly analyze these dataset to inform and support Title V and Section programming, assessment and monitoring, to conduct ongoing monitoring of NPMs and SPMs, and to respond to emergent needs, such as work on Neonatal Abstinence Syndrome and Long-Acting Reversible Contraception.

To increase public and program access for data driven decision making, the Unit has focused on putting MCH data online in the Alaska Indicator-Based Information System (IBIS) and the Kids Count Alaska DataCenter. SSDI indicators currently available on Alaska IBIS as full reports include infant mortality, low birth weight, very low birthweight, preterm birth, immunization of 19-35 month olds, teen births, adequate prenatal care, cigarette smoking during pregnancy, and cesarean section among women with low-risk pregnancies. PRAMS and CUBS data are also available in the IBIS Custom Query Module for users to manipulate. The MCH Indicators Project Research Analyst has been working with Kids Count Alaska since early 2017 to update indicator data on the national DataCenter and incorporate Alaska-specific indicators.

With support from SSDI, the Alaska ECCS CoIIN collects indicators related to measuring impact of programmatic efforts. The ECCS CoIIN goal is to promote healthy development in young children through a 25% relative increase in children ages 0-3 that are achieving age appropriate developmental health. The MCH Indicators Research Analyst provides technical assistance to three communities on collecting data to measure progress. This ECCS work directly aligns with our Title V efforts to increase developmental screening.

For over a decade, Alaska has used Title V funding to increase and enhance the availability of early childhood population-based data through implementation of the CUBS program. CUBS is a mail and phone follow-up survey to PRAMS that interviews mothers of three-year-old children. Since ongoing data collection began in 2008 through 2018, 10,151 women have been included in the "sample" and 6,244 women have responded to CUBS. CUBS data are weighted annually to represent the total population of women who delivered a baby in the state three years earlier.

CUBS data continue to be used by a variety of programs within DPH as well as outside agencies to help target public health programs. The Section of Chronic Disease Prevention and Health Promotion Obesity program is a consistent and heavy user of CUBS data. This program leaned heavily on CUBS for the 2019 launch of a new media campaign targeting parents of pre-school age children with education about sugar-sweetened beverages, and they plan to use a supplemental question on CUBS as well as survey questions to evaluate this campaign in 2020. CUBS

data have informed programs around disparities in childhood obesity, vaccine hesitancy, oral health care, and school readiness; have been used to obtain funding for home visiting and projects to increase breastfeeding duration, and to advocate for improved early childhood education. In 2019, we published a CUBS Epidemiology *Bulletin* on Increases in Early Dental Visits as well as a report on Childcare-related Concerns of Alaskan Mothers.

III.E.2.b.iv. Health Care Delivery System

Alignment of the work of Title V programs with other work focused on improving outcomes for Alaskan women, children and their families is critical as we assure transparency, reduce duplication and breakdown silos. In the 2017-2020 WCFH Strategic Plan, we identified that strengthening essential public health infrastructure, services, and partnerships is one of the four strategies our section uses to achieve our mission and vision. This strategy is achieved through partnering with families and consumers, collaborating broadly to grow networks and systems, and building capacity through education, securing funding, and sharing quality data.

All of the programs and services within WCFH are delivered in collaboration and partnership with others. In addition to the Title V Block Grant, other key federal programs administered by WCFH include the Maternal Infant Early Childhood Home Visiting (MIECHV) program, Early Childhood Comprehensive Systems (ECCS), and Universal Newborn Hearing Screening/Early Hearing Detection & Intervention (EHDI), Personal Responsibility Education Program, CDC Rape Prevention Education Program, HRSA Oral Health Workforce Development, Title X Family Planning, and breast and cervical cancer screening. WCFH also collaborates with federally qualified health centers throughout Alaska to ensure access to quality health care and needed services for the MCH population. Title V funds are braided with TANF funds to support unintended teen pregnancy prevention work and improving clinics to be teen-friendly.

The past year has shown growth in collaboration between WCFH and the Department of Education and Early Development (DEED). Staff partner with DEED on a funding initiative titled, “Improving Student Health and Academic Achievement through Nutrition, Physical Activity and the Management of Chronic Conditions in Schools.” WCFH and DEED also partner to coordinate Alaska’s Early Childhood Coordinating Council. In 2019, WCFH began partnering with DEED on the implementation of Alaska’s Preschool Development Grant.

WCFH continues to partner with other state government partners including child welfare, the Governor’s Council on Disabilities & Special Education, and early intervention on improving the use of evidence-based developmental screening tools and launching Help Me Grow Alaska. Title V partners with the DPH Section of Chronic Disease Prevention and Health Promotion on initiatives related to childhood obesity, violence prevention, oral health, and cancer prevention leadership activities.

We frequently partner with tribal organizations, including co-sponsoring the biennial Alaska MCH and Immunization Conference with the Alaska Native Tribal Health Consortium. Finally, Title V staff participate on advisory committees or other coalitions led by non-governmental partners that serve the MCH population such as Stone Soup Group, YWCA, and community level grantees.

Coordination with Medicaid

Medicaid expansion began in Alaska in September 2015 by executive authority. By May 2019, 50,426 Alaskans were covered by Medicaid under expansion. This “newly eligible” population includes all childless adults between 100% and 133% FPL. An updated dashboard on the redesign can be found online.

Children represent almost half (47%) of Medicaid/CHIP enrollment, and Title V involvement in promoting well child visits and outreach as outlined in Section 504 of the Social Security Administration Act is critical to work by the Division of Public Assistance (DPA) and the Division of Healthcare Services to reduce the eligibility backlog. There are 94,066 Alaska children ages 18 or less who rely on Medicaid and Denali KidCare (CHIP) to access the care they need to be healthy. DPA connected the Health Insurance Marketplace for successful data transmission between the Marketplace and the AK DHSS, and began allowing the marketplace to make application determinations for the Alaska Medicaid expansion. Difficulties experienced with new data systems resulted in a decline and delay in child eligibility and enrollment, which the Department continued and will continue to work on and improve. However, Alaska has implemented Presumptive Eligibility options for hospitals to determine eligibility in ‘real time’ by giving uninsured people immediate temporary Medicaid if they appear to be eligible based on income, in an effort to streamline Medicaid and CHIP enrollment.

The 2016 legislative session saw several bills aimed at Medicaid reform, including some which impact the MCH population. The provisions of these bills were ultimately consolidated in Senate Bill (SB) 74 which was signed by Governor Walker in June 2016 and continued to be implemented into 2019. Highlights of the legislation, SB 74, included provisions for:

- 1115 demonstration waivers to receive federal authority to fund models of primary care case management and/or managed care/coordinated care organization delivery models, as well as a redesign of the Medicaid behavioral health system to provide specialized services to targeted populations. The substance use component of the waiver was approved in November 2018; the rest is still under review by CMS but is nearing approval. One of the arguments made for the waiver was supported by Title V data from the ALCANLink project, which indicated the importance of being able to secure services based on social determinants of health, which is beyond the scope of traditional Medicaid eligibility criteria.;
- Direction to the department to provide reimbursement and increase capability for telehealth including expanding use for primary care, behavioral health services and urgent care; and
- Develop coordinated care demonstration projects with one or more third parties with respect to improving efficacy of the health care delivery model, improving access to services and/or improving the quality of care for Medicaid recipients (RFPs in process).The pilot projects for this have begun.

In December 2018, a new Governor was elected in Alaska, with potentially large implications for how Medicaid is implemented in our state. At this time, it is to be determined what will happen with Medicaid Expansion in Alaska. The Governor's proposed FY20 state budget included a $249 million dollar cut to Medicaid. This proposed cut was met with concern from Alaska's providers, hospitals, and the hospital and nursing home association. The budget is still going through the legislative process, and it is to be determined what the final cut to Medicaid will be and what it will do to this program and its capacity to partner with public health. Already, it is difficult to bring new opportunities to Medicaid for consideration, given the potential cuts. The Medicaid program did not have the capacity to partner on the Integrated Care for Kids initiative. Alaska also has a new Medicaid Director as of May 2019, and the long-time CHIP Director retired in April 2019; the position has not been filled. The Governor has also expressed interest in piloting the use of Medicaid Block Grants.

Despite these challenges, WCFH was able to partner more with Medicaid in the past year. Both the Title V Director and MCH Epidemiology Unit Manager assisted Medicaid with their work to improve Alaska's core set of health quality measures. We assisted them in data gathering and provided education resources created by our Section. They have since distributed WCFH materials through their communication with providers. In 2019, Title V updated our MOU with Medicaid to better describe the partnership. This MOU will need additional work and clarification.

As mentioned in our 2018 report, in spring 2018, Alaska Title V and Medicaid partnered to host a statewide convening on improving access to long-acting reversible contraception (LARC). In late 2018, WCFH collaborated with Medicaid staff while they worked to create a document seeking to provide clarification regarding billing for LARC devices and LARC insertion. There continues to be discussion surrounding a carve-out for immediate postpartum LARC insertion. Currently, the Medicaid program does not have capacity to address this issue and is not prioritizing a carve-out for incentivizing the use of LARC. More information and discussion is needed here to better understand the issue.

The opioid epidemic has provided an opportunity for WCFH to partner with the Division of Behavioral Health and Medicaid on improving treatment services for pregnant women. The focus of our work related to substance use has been primarily on prevention and screening. The Title V Nurse Consultant led a National Governor's Association technical assistance project that brought together Title V, child welfare, Behavioral Health, Medicaid, and tribal health to improve the system of care for women needing treatment services in Alaska. The goal of the project was to explore the use of the Maternal Opiate Medical Support (MOMS) model from Ohio. It was determined that this model did not fit well with our current Medicaid structure but it has opened the door to additional partnership with these stakeholders.

III.E.2.c State Action Plan Narrative by Domain

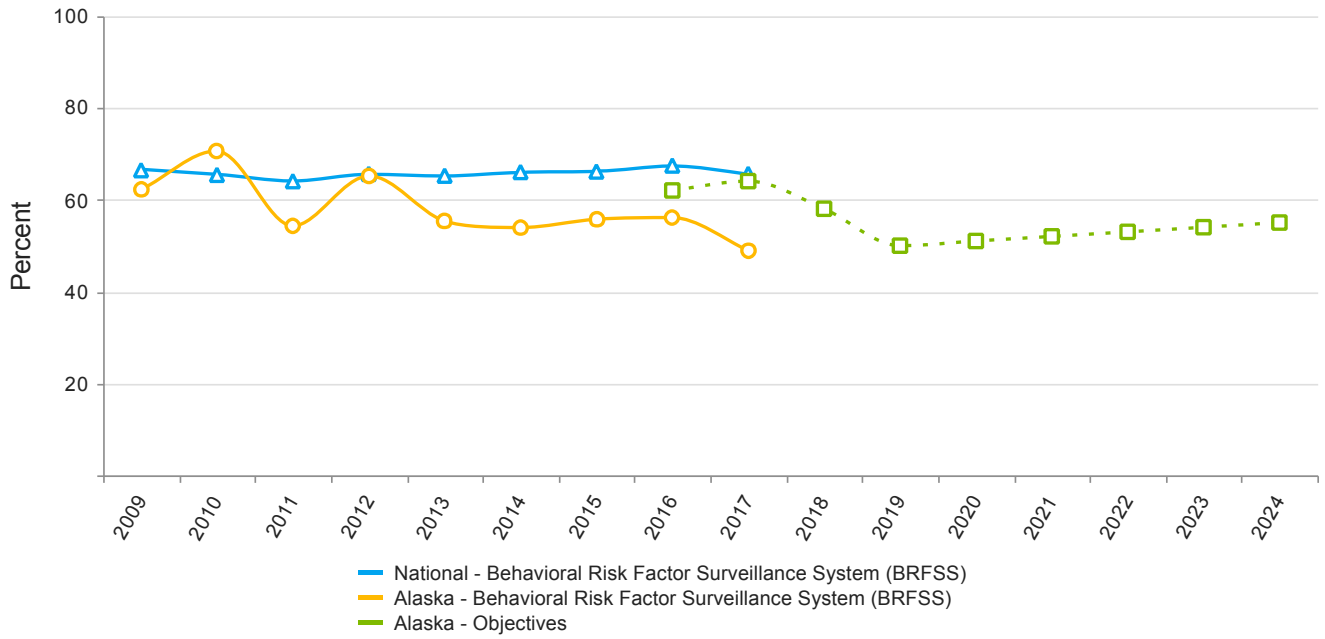
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2015	155.9	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2017	6.2 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2017	9.0 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2017	26.1 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2016	6.5	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2016	5.2	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2016	2.8	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2016	2.4	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2016	107.1	NPM 1
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	PRAMS-2017	6.3 %	NPM 1
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births	SID-2016	9.4	NPM 1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2017	22.0	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2017	13.4 %	NPM 1

National Performance Measures

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



Federally Available Data			
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)			
	2016	**2017**	**2018**
Annual Objective	62	64	58
Annual Indicator	55.6	56.1	49.0
Numerator	71,071	73,578	64,062
Denominator	127,889	131,127	130,730
Data Source	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	50.0	51.0	52.0	53.0	54.0	55.0

Evidence-Based or –Informed Strategy Measures

ESM 1.3 - Percent of rarely or never screened women who receive a Pap smear paid for by the Ladies First program.

Measure Status:	Active	
State Provided Data		
	2017	**2018**
Annual Objective		
Annual Indicator	14.7	14.2
Numerator	394	350
Denominator	2,672	2,460
Data Source	Ladies First Database	Ladies First Database
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	20.0	20.0	20.0	20.0	20.0	20.0

ESM 1.4 - Percent of women with persistent new-onset severe hypertension treated with first line medications within 60 minutes.

Measure Status:	Active				
Annual Objectives					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	60.0	70.0	80.0	90.0	93.0

State Action Plan Table

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

Priority Need

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

NPM

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

Objectives

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

Strategies

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

NPM 1.2 Retired (please see 5 Year Action Plan report narratives)

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

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

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

NPM 1.7 Retired (please see 5 Year Action Plan report narratives)

NPM 1.8 (New) Engage hospitals and birthing facilities in data-driven, collaborative quality improvement focused on reducing severe maternal morbidity due to severe hypertension in pregnancy in partnership with the Alliance for Innovation on Maternal Health (AIM) and Alaska Perinatal Quality Collaborative (PQC).

ESMs	Status
ESM 1.1 - Ratio of rarely or never screened women who are newly enrolled in the BCHC program.	Inactive
ESM 1.2 - Percent of all WIC clients referred to agency reproductive health or primary care providers who receive services.	Inactive
ESM 1.3 - Percent of rarely or never screened women who receive a Pap smear paid for by the Ladies First program.	Active
ESM 1.4 - Percent of women with persistent new-onset severe hypertension treated with first line medications within 60 minutes.	Active

NOMs
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations
NOM 3 - Maternal mortality rate per 100,000 live births
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)
NOM 5 - Percent of preterm births (<37 weeks)
NOM 6 - Percent of early term births (37, 38 weeks)
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.2 - Neonatal mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.4 - Preterm-related mortality rate per 100,000 live births
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

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

Priority Need

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

NPM

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

Objectives

By 2021, increase to 20% the percent of pregnant women screened for depression by the Alaska Prenatal Screening Program.

Strategies

NPM 1.6 (Revised) Support continued collaboration between the Alaska Prenatal Screening Program (APSP), Alaska Division of Behavioral Health, and partners across Alaska to increase the documented number of pregnant women screened with PHQ-2 and receiving appropriate referral and treatment of perinatal mood and anxiety disorders (PMAD).

ESMs	Status
ESM 1.1 - Ratio of rarely or never screened women who are newly enrolled in the BCHC program.	Inactive
ESM 1.2 - Percent of all WIC clients referred to agency reproductive health or primary care providers who receive services.	Inactive
ESM 1.3 - Percent of rarely or never screened women who receive a Pap smear paid for by the Ladies First program.	Active
ESM 1.4 - Percent of women with persistent new-onset severe hypertension treated with first line medications within 60 minutes.	Active

NOMs

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

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

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

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

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

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

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

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

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

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

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

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

WOMEN/MATERNAL HEALTH

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

NPM Strategy 1.1: Partner with community-based partners to provide patient navigation and health education information to disparate populations to increase the number of women who are rarely or never screened for cervical cancer through the Ladies First (formerly known as BCHC) program.

Ladies First addressed this objective through increased outreach to regions with poor health outcomes. Our Anchorage based outreach contractor has been averaging 30 – 40 community events per month and our lower Kenai Peninsula outreach contractor has been actively going door-to-door to engage with hard-to-reach people. Ladies First also partners with State Public Health Nursing to provide outreach to hard-to-reach areas of the state. The State of Alaska's Ladies First Program utilized ArcGIS mapping technology to identify communities in the state with low cervical cancer screening rates. The Ladies First Program, funded by the Centers for Disease Control and Prevention (CDC), pays for these cancer screening and diagnostic services for women ages 21-64 with incomes ≤ 250% FPL. During this reporting period, Ladies First outreach contractors provided health information to hundreds of people, and 14% of the patients receiving cervical cancer screening during this period were rarely or previously never screened (ESM 1.3).

Ladies First is in the second year of health systems interventions to increase clinic-level screening rates. They have contracted with the Alaska Primary Care Association (APCA) to conduct evidence-based strategies to increase cervical cancer screening at six Federally Qualified Health Centers (FQHC) across the state. They have also contracted with an Anchorage-based Clinically Integrated Network (Pinnacle Integrated Medicine) to conduct parallel activities at two large primary care and gynecology practices in the city. The two clinics participating in the Clinically Integrated Network project have shown a 3% and 6% respective increase in screening rates over the past year. The program has Intervention Implementation Plans with each group and has actively monitored rates and activities on a quarterly basis.

NPM Strategy 1:2: Strategy retired in 2018

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

The Family Planning Program concluded their 2-year participation in a national "Increasing Access to Contraception" Learning Community, sponsored by the Association of State and Territorial Health Officials (ASTHO). Participation in this learning community afforded WCFH access to evidence-based best practices successfully implemented by other states across the country to increase access to comprehensive women's health services. This included learning about innovative, state-based strategies for achieving this goal such as engaging with large foundations for funding (the most successful and well-known to-date is Colorado's efforts). Lessons learned from the Learning Community also facilitated the creation of the Alaska Long-Acting Reversible Contraception (LARC) Project, a public-private health care partnership coordinated by the Alaska Children's Trust with the goal of improving birth outcomes through increased access to LARC methods. Through this work, WCFH continued to explore opportunities to partner more closely with FQHCs to improve and expand their women's and reproductive health services using the Quality Improvement model, which in turn, will provide increased opportunities for the provision of all preventive health services.

NPM Strategy 1.4: Review all pregnancy-associated deaths through the Maternal and Child Death Review.

Over a recent 10 year period (2008–2017), the MCDR program identified 91 pregnancy-associated deaths to Alaska residents (80.8 per 100,000 live births), ranging from 5–12 deaths per year. The Committee classified 16 deaths during this time period as pregnancy-related, corresponding to a mortality rate of 14.2 per 100,000 live births. The number of pregnancy-related deaths per year ranged from 0–4 deaths during this same 10 year time period. Among more recent deaths, occurring between 2012-2017, causes of death identified by the MCDR Committee for

the 7 pregnancy-related deaths were hypertensive diseases of pregnancy (3 deaths), infection (2 deaths), cardiac failure secondary to a congenital heart defect, and pulmonary embolism. During this six-year period, substance use disorders contributed to over half of all pregnancy-associated deaths (52%), with 27% overall being directly caused by a drug or alcohol overdose. Likewise, mental health conditions contributed to 30% of the deaths. The MCDR Committee determined that 85% of the pregnancy-associated deaths during 2012-2017 were potentially preventable.

Over the past year, MCDR has increased its efforts to improve surveillance and collaboration to prevent maternal mortality. In September 2018, MCDR held a case review solely focused on maternal deaths and followed that meeting by hosting the annual summit where 80 attendees participated in round table discussions that focused on increasing collaboration and moving data to action. In addition, the MCH Epidemiology Unit published an Epidemiology Bulletin entitled “Pregnancy-Related Mortality in Alaska, 2012-2016” followed by a one page fact sheet on pregnancy associated mortality in Alaska. Both publications are posted online and were distributed via email to the MCDR listserv.

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

The Alaska PRAMS program continued to collect data on receipt of health care visits by women in the 12 months before getting pregnant, including “regular check-ups at their family doctor’s office or their OB/GYN’s office,” or “visits for family planning or birth control.” Results from 2016 and 2017 are currently available upon request to the PRAMS Coordinator. The results provide population-based and weighted data that directly and specifically measures utilization of preventive health visits by women prior to becoming pregnant. The data are monitored by the PRAMS Coordinator and reported in the annual Title V Needs Assessment update.

NPM Strategy 1.6: Support continued collaboration between the Alaska Prenatal Screening Program (APSP), Alaska Division of Behavioral Health, and partners across Alaska to increase the documented number of pregnant women screened with PHQ-2 and receiving appropriate referral and treatment of perinatal mood and anxiety disorders (PMAD).

APSP staff work with clinical care providers in Anchorage, Fairbanks, Juneau and the Mat-Su region, to promote, support and track universal screening of all pregnant women in order to identify those in need of treatment. During this reporting period, APSP screened 770 pregnant women (about 10% of all mothers giving birth during the time period) for depression using the PHQ-2 tool. Among those women, 9.4% reported ever feeling out of control or helpless, 10.9% reported loss of interest in doing things that used to be fun, and 27.8% reported feeling down, depressed or hopeless. APSP is currently evaluating its reporting mechanisms with an aim of improving the quality of its data, including capturing referral to treatment. APSP collects data on co-factors commonly associated with PMAD, including domestic violence, substance use and parity. The APSP is fully funded by DBH under their larger federal grant funding from the Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration of the US Department of Health and Human Services. DBH is the lead agency with oversight and planning responsibility for Alaska’s behavioral health treatment system, including Alaska’s Medicaid coverage system for diagnosis and treatment of PMAD.

NPM Strategy 1.7: Partner with the Alaska Dental Action Coalition to educate and increase awareness on the importance of perinatal oral health screenings, preventative dental visits, and good oral hygiene by creating a perinatal oral health issue brief, via the AMCHP E-Leaning Collaborative, for clients and providers using PRAMS data; surveying providers on capacity to care for pregnant women and referral process; facilitating coordination of perinatal oral health services and partnerships; and providing clinicians and program staff with trainings, resources, and tools to care for pregnant women. –Strategy retired

During this report period, the WCFH Perinatal and Reproductive Health Nurse Consultant participated on the AK Dental Action Coalition to draw awareness and create strategies related to oral health during the perinatal time period. Through the AMCHP E-Learning Collaborative, WCFH created Alaska’s first issue brief to raise awareness among Alaska health care providers of the importance of screening their prenatal patients for oral health status. The final 1-page document includes data from PRAMS and narrative information on poor birth outcomes associated with untreated periodontal disease, safe dental procedures during pregnancy, what Alaska Medicaid pays for, tips for brief patient screening about their oral health, and contact information for further questions. Additionally, the group

created a 1-page handout for pregnant women with information on safe practices for routine oral health care and the importance of seeing a dentist during their pregnancy. These materials have begun to be distributed. The Medicaid program is now sending them to Medicaid beneficiaries.

Although a draft survey of provider knowledge, attitudes and current practices around oral health for their pregnant patients was created, the WCFH Perinatal and Reproductive Health Nurse Consultant position was vacated in August 2018, so this work was put on hold pending a new hire and continued prioritization of this work. The Nurse Consultant position has been heavily focused on the PQC in 2019, and therefore this strategy will be retired until it is determined how much capacity WCFH will have in the upcoming year to work on perinatal oral health.

WOMEN/MATERNAL HEALTH

PLAN FOR THE APPLICATION YEAR: OCT 2019- SEPT 2020

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

NPM Strategy 1.1: Partner with community-based partners to provide patient navigation and health education information to disparate populations to increase the number of women who are rarely or never screened for cervical cancer through the Ladies First (formerly known as BCHC) program.

The State of Alaska's Ladies First Program is working to increase the number of patients receiving services through the program who are rarely or never screened for cervical cancer. Patients who have not had cervical cancer screening in over 5 years are 60% more likely to be diagnosed with cervical cancer, and low-income women are more likely to not have received a Pap test in over 5 years.

Similar to previous years, Ladies First will develop ArcGIS maps to visualize the cervical cancer screening rates by community with the goal of engaging partners in outreach and intervention work to increase those rates. The maps will include predictive analysis in order to show the potential number of women needing screening in communities based on available data. Prior work was very successful in creating focused partnerships in which non-profits, health centers, and community partners worked together to identify and prioritize patients who are rarely or never screened. Ladies First has added a third outreach contractor and now has full coverage in the Kenai Peninsula, an area with historically low screening rates.

This phase of the project will expand the development of ArcGIS neighborhood maps to urban areas such as Fairbanks and Juneau. This will allow the program to tailor outreach efforts and materials on neighborhoods with high proportions of patients with low-income and low screening rates. Materials will inform and guide patients to nearby clinics that participate in the Ladies First program and can provide screenings at no cost.

Ladies First will also continue quality improvement efforts through contracts with Alaska Primary Care Association (APCA) and a new contractor in the private sector, Mountain Pacific Quality Health, for health systems interventions to increase clinic-level screening rates. APCA will focus on working with Federally Qualified Health Centers (FQHC) across the state, and Mountain Pacific will focus on providers statewide including Ladies First contracted providers. The program has Intervention Implementation Plans with each group and will be actively monitoring rates and activities on a quarterly basis.

The current ESM is a good measure of these efforts as the program anticipates maintaining or increasing the proportion of women receiving Pap tests through the program who had never been screened before and were reached through our targeted efforts.

NPM Strategy 1:2: Retired in 2018

NPM Strategy 1.3: (Revised) Identify and partner with public and private providers statewide to improve and expand their preventive health services through health systems interventions that identify best practices and measure improvements (QI model).

As described above, Ladies First will continue QI activities within their health systems interventions to increase clinic-level screening rates. They have contracted with the Alaska Primary Care Association (APCA) to implement evidence-based strategies to increase cervical cancer screening at six Federally Qualified Health Centers (FQHC) across the state. Ladies First is also entering into a new contract with Mountain Pacific to engage in eCQI activities with health care providers statewide, including a focus on Ladies First contracted providers. Implementation Plans with each group will be actively monitoring rates and activities on a quarterly basis.

Through the work of the Alaska LARC Project, WCFH will continue to look for partnerships and funding opportunities to increase collaboration with FQHCs, private sector and tribal health care providers, and other agencies across the state to improve and expand their women's and reproductive health services, including provision of contraceptive methods and services, with the goal of reducing unintended pregnancies, improving birth outcomes, and increasing women's preventive health services. WCFH will continue to participate in the LARC committee that includes members from Medicaid, the Chief Medical Officer, tribal health, and the Alaska Children's Trust to further the goals and objectives of the 2018-2021 work plan to increase access to LARC.

NPM Strategy 1.4: (Revised) Review all pregnancy-associated deaths through the Maternal Child Death Review (MCDR) and increase awareness of recommendations.

Over the past year, the MCDR program increased its efforts to share program data in the hopes of prevention partners translating data to action. In January 2019, the MCDR program began publishing quarterly reports summarizing the prevention recommendations generated from the monthly death reviews. These reports are shared broadly via email and webpage through our MCDR listserv of partners, committee members and other stakeholders. MCDR will continue generating these quarterly reports of prevention recommendations, especially as they relate to reducing maternal mortality.

Although Alaska continues to record crude rates below the national average for pregnancy-related mortality, extensive disparities persist. Long term efforts to increase services and regionalize care have reduced some perinatal disparities among Alaska Native and rural populations, yet others still exist. Recently, MCDR has begun to focus on other minority populations, particularly the growing population of Asian/Pacific Islander women, who also experience substantial disparate maternal health outcomes. By standardizing the collection of high quality data through the use of MMRIA, MCDR can be more intentional about analyzing and sharing information on system and community factors that influence mortality, and help our partners understand and address the multifactorial issues that are causing health disparities. To continue moving these efforts forward, our Section recently applied for a federal CDC grant supporting maternal mortality review committee quality and prevention work and will be notified of award in August 2019.

In addition, MCDR will host its annual one day summit in January 2020, in conjunction with the statewide public health conference to increase engagement with our multi-disciplinary committee, present up to date surveillance data, and promote key prevention recommendations to reduce maternal and child mortality.

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

Starting with 2016 births, the Alaska PRAMS Phase 8 survey has collected data on receipt of health care visits by adult women in the 12 months before getting pregnant, including “regular check-ups at their family doctor’s office or their OB/GYN’s office,” or “visits for family planning or birth control.” The Phase 8 survey will continue to be used by PRAMS through 2021 births, covering a total of 6 years. Since these two questions are among the core questions on the Phase 8 survey, comparison data from other states are also available. Alaska PRAMS and Title V epidemiologists will continue to monitor the results of these survey questions as part of the annual Title V Needs Assessment update process. The data and associated public health recommendations for women may also be disseminated more broadly through a topic-specific Epidemiology Bulletin or other data brief published by the MCH Epidemiology Unit. In the upcoming year, the PRAMS Coordinator plans to add results from these questions and others that were new in Phase 8 to the online Indicator Based Information System PRAMS Custom Query module, which will enable web users to view the frequency of the indicators by a variety of demographic sub-populations.

NPM Strategy 1.6: (Revised) Collaborate with the Alaska Division of Behavioral Health (DBH), the Alaska Prenatal Screening Program (APSP) and clinical partners across Alaska to increase screening, referral, and treatment of perinatal mood and anxiety disorders (PMAD).

APSP will continue to support provider assessment, referral, and treatment of perinatal mood disorders during and after pregnancy. APSP will expand screening and assessment, which incorporates PHQ-2, to increase the number of birth facilities and outpatient prenatal care settings screening for PMAD. APSP will report on the number of pregnant women screened with an aim of increasing from the prior year’s rate of 10% to 15% of all women giving birth during the next reporting period. WCFH will use data from APSP to evaluate co-factors, such as domestic violence, substance use and the woman’s expressed desire to avoid pregnancy in the coming year, to develop Alaska-specific PSAs and outreach materials, co-sponsoring provider training; and creating a centralized repository for statewide PMAD resources, including an updated provider list.

NPM Strategy 1.7: Strategy retired – please see 5YAP Report

NPM Strategy 1.8: (NEW) Engage hospitals and birthing facilities in data-driven, collaborative quality improvement focused on reducing severe maternal morbidity due to severe hypertension in pregnancy in partnership with the Alliance for Innovation on Maternal Health (AIM) and Alaska Perinatal Quality

Collaborative (PQC).

WCFH recently partnered with multiple health care facilities and professional organizations to launch the Alaska Perinatal Quality Collaborative (AKPQC) and join the Alliance for Innovation for Maternal Health (AIM). Attendees at the PQC launch event in January 2019 came from a variety of perinatal health disciplines and represented a diversity of stakeholders. Participates were highly engaged and enthusiastic about the initiative. With support from Title V funds, WCFH coordinates both the AKPQC and AIM partnership in Alaska. Following the successful launch event, the AKPQC Steering Committee chose maternal hypertension as an initial priority focus area based on feedback from AKPQC membership, Alaska severe maternal morbidity (SMM) data, and successful hypertension initiatives in other states.

The AIM maternal hypertension initiative will follow a data-driven, collaborative quality improvement (QI) model focused on health care systems improvements to reduce severe maternal morbidity (SMM) related to severe hypertension in pregnancy. Participating facilities will implement evidence-based practices included in the AIM-supported hypertension safety bundle with a focus on responding quickly and appropriately during a hypertensive emergency with adequate systems in place to support this response. Participating facilities will be supported by WCFH through as-needed technical assistance, individual monthly coaching calls, and combined quarterly learning sessions. These sessions will focus on mentoring and learning among facilities through facilitated discussion and sharing of QI successes and challenges.

WCFH will analyze and submit quarterly outcome measures derived from hospital discharge data. Process and structure measures will be submitted directly to the AIM Data Center by participating facilities. State-level data will be used to monitor progress towards achieving goals related to timely treatment and reduced hypertension-related SMM. Facility-level data will be reviewed and discussed during monthly coaching calls to promote continuous QI through state and national benchmarking.

The AKPQC will also coordinate and host an annual face-to-face meeting in January 2020. This meeting will convene AKPQC members from around the state to learn from national experts, discuss state-level data, and share hypertension initiative success stories. During this event, the AKPQC Steering Committee will seek feedback from participants on a neonatal-focused initiative that will be expected to launch in 2020.

Perinatal/Infant Health

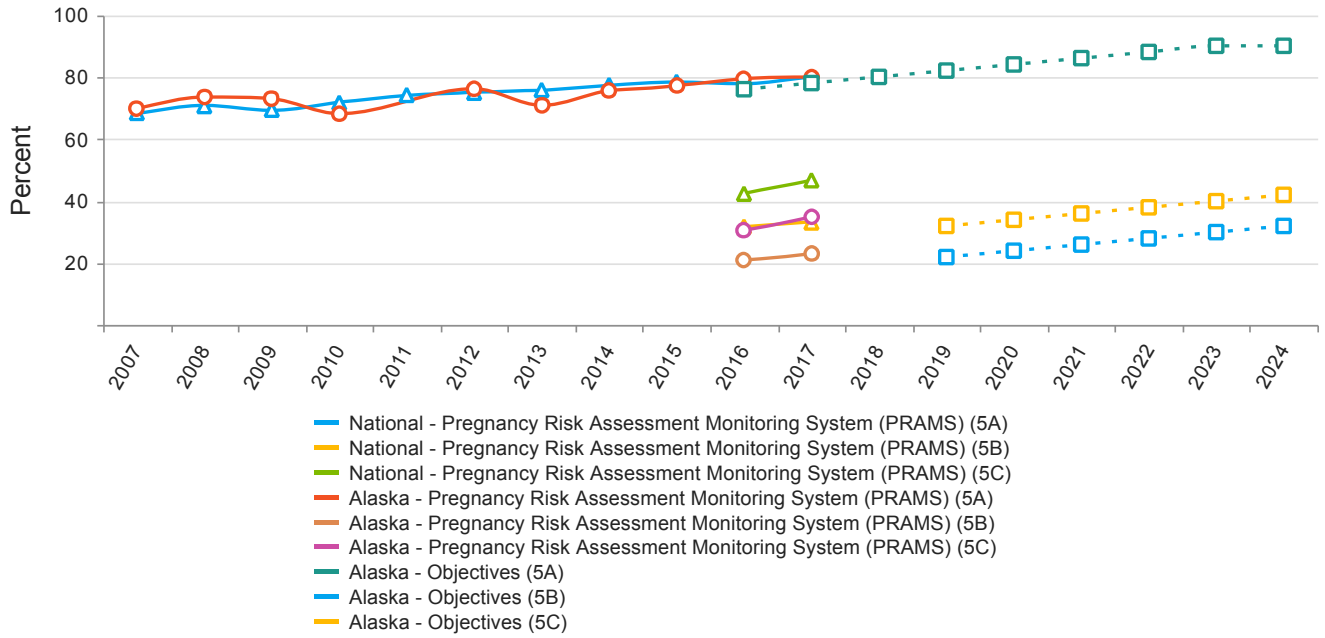
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2016	5.2	NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2016	2.4	NPM 5
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2016	116.0	NPM 5

National Performance Measures

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Indicators and Annual Objectives



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

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2016	**2017**	**2018**
Annual Objective	76	78	80
Annual Indicator	75.4	77.0	80.0
Numerator	7,980	8,028	7,777
Denominator	10,583	10,427	9,722
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2017

State Provided Data			
	2016	2017	2018
Annual Objective	76	78	80
Annual Indicator	79.4	80	
Numerator	8,198	7,777	
Denominator	10,320	9,722	
Data Source	PRAMS	PRAMS	
Data Source Year	2016	2017	
Provisional or Final ?	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	82.0	84.0	86.0	88.0	90.0	90.0

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2018
Annual Objective	
Annual Indicator	22.9
Numerator	2,158
Denominator	9,416
Data Source	PRAMS
Data Source Year	2017

State Provided Data		
	2017	**2018**
Annual Objective		
Annual Indicator	20.3	22.9
Numerator	2,078	2,158
Denominator	10,213	9,416
Data Source	PRAMS	PRAMS
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	22.0	24.0	26.0	28.0	30.0	32.0

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2018
Annual Objective	
Annual Indicator	34.8
Numerator	3,252
Denominator	9,351
Data Source	PRAMS
Data Source Year	2017

State Provided Data		
	2017	**2018**
Annual Objective		
Annual Indicator	30	34.8
Numerator	3,034	3,252
Denominator	10,128	9,351
Data Source	PRAMS	PRAMS
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	32.0	34.0	36.0	38.0	40.0	42.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		80	80
Annual Indicator	80	100	94.4
Numerator	20	26	17
Denominator	25	26	18
Data Source	Maternal Child Death Review (MCDR) Database	Maternal Child Death Review Committee Database	Maternal Child Death Review Committe Database
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	90.0	90.0	90.0	90.0	90.0	90.0

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

Measure Status:	Inactive - Birth facilities have expressed initial enthusiasm about pursuing certification, but have been unable to maintain that momentum. Because their window	
State Provided Data		
	2017	**2018**
Annual Objective	1	1
Annual Indicator	1	0
Numerator		
Denominator		
Data Source	List of birthing hospitals (20)	List of birthing hospitals (20)
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

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

Measure Status:	Inactive - Data is based on total births in 2018 (using vital statistics data) as denominator with numerator of facilities with active safe sleep policies/work:	
State Provided Data		
	2017	**2018**
Annual Objective	53	59
Annual Indicator	57.1	60.7
Numerator	6,030	5,999
Denominator	10,564	9,890
Data Source	Infant Safe Sleep Program and Vital Statistics	Infant Safe Sleep Program
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

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

Measure Status:	Active	
State Provided Data		
	2017	**2018**
Annual Objective	50	60
Annual Indicator	47.8	83.3
Numerator	11	15
Denominator	23	18
Data Source	Maternal Child Death Review Committe	Maternal Child Death Review Committee
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	85.0	85.0	90.0	95.0	95.0	95.0

ESM 5.8 - The number of maternity care providers participating in Alaska Breastfeeding Initiative trainings with integrated sharing of PRAMS data and information about safer sleep

Measure Status:	Active				
Annual Objectives					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	70.0	70.0	70.0	70.0	70.0

State Performance Measures

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

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		26	25
Annual Indicator	31.9	32.2	32.9
Numerator	1,749	1,998	1,812
Denominator	5,489	6,202	5,500
Data Source	AK PRAMS Phase 7 Q38. 2014 data most recent avail	AK PRAMS Phase 8 Q40	AK PRAMS Phase 8 Q40
Data Source Year	2015	2016	2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	30.0	29.0	28.0	27.0	26.0	25.0

State Action Plan Table

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

Priority Need

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

NPM

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Objectives

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

Strategies

NPM 5.1. Strategy retired in 2018

NPM 5.2 Review SUID cases using the CDC SUID Investigation Reporting Form algorithm to make consistent and accurate classifications and prevention recommendations.

NPM 5.3 Strategy retired in 2018

NPM 5.4 Partner with programs serving high risk families to provide evidence based infant safe sleep education.

NPM 5.5 Continue partnership with tribal health organizations to disseminate outreach materials and training programs for Alaska Native communities, providers and families that reflect current AAP guidelines and are culturally appropriate.

NPM 5.6 Strategy retired in 2019

NPM 5.7 (New) Increase safety of newborns, infants and toddlers by developing Plans of Safe Care and early identification of families with newborns with mother's reporting use of substances during the last month of pregnancy.

ESMs	Status
ESM 5.1 - Number of hospitals/birthing facilities using the Alaska Infant Safe Sleep Toolkit.	Inactive
ESM 5.2 - Percent of Alaska births that occur at a hospital that has implemented at least one component of the Alaska Infant Safe Sleep Toolkit.	Inactive
ESM 5.3 - Percent of SUID cases reviewed in prior year with complete SUID Investigation Reporting Forms	Active
ESM 5.4 - Percent of SUID cases reviewed in prior year classified using CDC categories	Inactive
ESM 5.5 - Number of birthing facilities with a Safe Sleep Certification from Cribs for Kids in Alaska.	Inactive
ESM 5.6 - Percent of infants born at a facility with Cribs for Kids Safe Sleep Certification or a safe sleep policy in place and has initiated the certification process.	Inactive
ESM 5.7 - Percent of SUID cases reviewed in prior year and classified using CDC categories that agree with CDC post-hoc classification.	Active
ESM 5.8 - The number of maternity care providers participating in Alaska Breastfeeding Initiative trainings with integrated sharing of PRAMS data and information about safer sleep	Active

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

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

Priority Need

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

SPM

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

Objectives

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

Strategies

SPM 1.1 Promote provider use of (Screening, Brief Intervention and Referral to Treatment) SBIRT for all harmful substances among all women of childbearing age, especially those who are pregnant.

SPM 1.2 Promote provider use of One Key Question tool among women of childbearing age, including those who are pregnant.

INFANTS/PERINATAL HEALTH

REPORT FOR THE APPLICATION YEAR: OCT 2017- SEPT 2018

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

NPM Strategy 5.1: Strategy retired in 2018

NPM Strategy 5.2: Review SUID cases using the CDC SUID Investigation Reporting Form algorithm to make consistent and accurate classifications and prevention recommendations.

During the past year, 94% of the cases of Sudden Unexplained Infant Death (SUID) reviewed by the MCDR Committee included the SUID Investigation Reporting Form. The SUID Investigation Reporting Form guides law enforcement personnel to collect data that are relevant and necessary to understand the cause, manner and circumstances of each death. By increasing the percentage of SUID deaths that have a completed the SUID Reporting Form, we can better understand the causes of such deaths and work to prevent them.

This is the second consecutive year the program achieved its ESM 5.3 annual objective (90% of the SUID deaths reviewed included a SUID Form). This was achieved through improved communication and partnerships with multiple law enforcement agencies and with the State Medical Examiner's Office (SMEO). The MCDR program has played a key role in advocating the need for accurate and complete SUID Investigation Forms during annual summit meetings and monthly meetings at the Medical Examiner's office. The SMEO continues to offer SUID training to law enforcement agencies on the importance of using these forms during their investigation. Although this coordination of efforts conducted across the state reflects a successful 94% collection of the SUID investigation form last year, there are still training efforts to be made, especially in areas outside of Anchorage.

Due to the Epidemiologist vacancy in the MCDR program for most of 2018, the program was unable to complete the quality assurance project to create an automated report that inspects the SUID Investigation reporting forms for completeness and aggregates the information to be shared back with the Medical Examiner's office to support and direct their trainings. This project remains a goal for the newly on-boarded MCDR Epidemiologist and MCDR Program Manager, both of whom are partially supported by Title V dollars.

In addition, the MCDR program was able to maintain ESM 5.7 accuracy of the SUID classification among cases reviewed by the MCDR committee at 83.3% agreement with the CDC post-hoc classifications. During our quarterly calls with CDC, we discuss the SUID classifications and why there might be a discrepancy between how our review committee classifies a SUID versus CDC experts. The CDC categorization matrix for SUID deaths allows the MCDR to track how consistent SUID deaths are being classified and how factors such as unsafe sleeping conditions contribute to such deaths. By increasing the number of SUID cases that are accurately and consistently classified using the CDC categories, we will be able to identify gaps in our data.

NPM Strategy 5.3: Strategy retired in 2018

NPM Strategy 5.4: Partner with programs serving low socioeconomic families to provide infant safe sleep education.

Alaska developed Healthy Alaska Babies (HAB), a 3 hour workshop on harm reduction safe sleep strategies based on Healthy Native Babies. HAB focuses on areas of greatest risk in Alaska, such as bed sharing and intoxicated caregivers. We held a photo shoot in partnership with the Alaska Native Tribal Health Consortium so that all images used in workshop materials are of Alaska Native families and infants and demonstrate both best practices and safer alternatives. Workshops have been held in 13 communities around the state, with 338 attendees. Most (280) were child protection workers; 28 work for tribal non-profits, 6 in public health nursing, 12 are child care providers, 9 work in hospitals, 2 are NFP nurses, and one is a Guardian Ad Litem.

Pre and post surveys were conducted with 135 attendees, which showed improved knowledge and behavioral intent:

- Breastfeeding helps reduce the risk of sleep related infant death:
  Pre: 66% true; Post: 92% true

- Pacifier use decreases risk of SUID:

Pre: 69% false; Post: 78% true

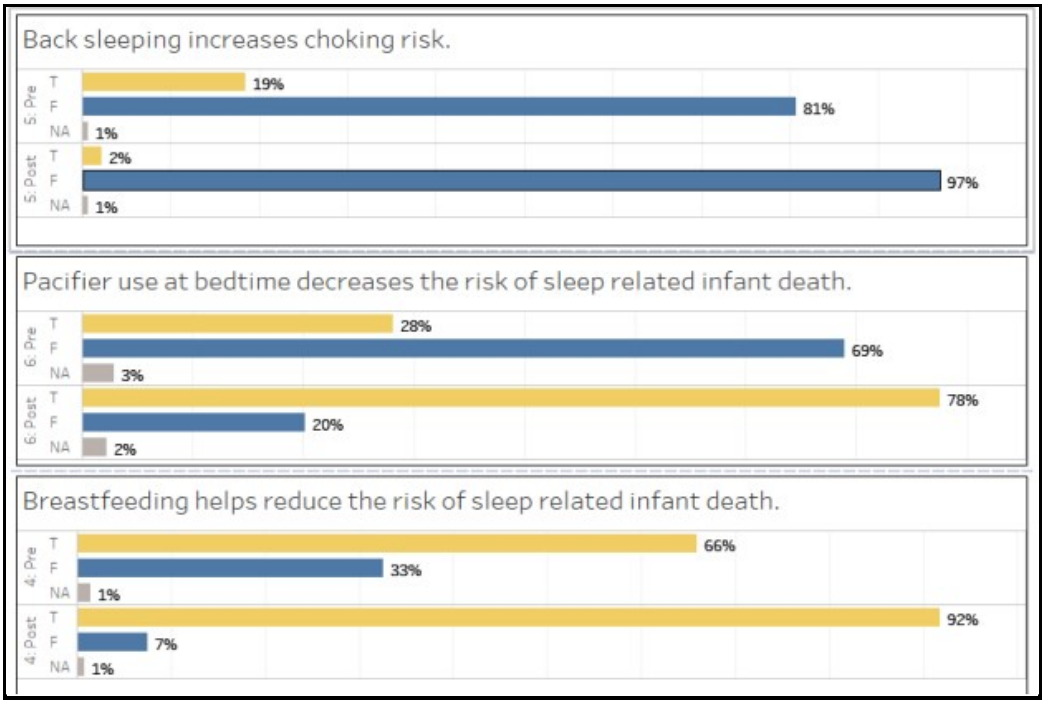
- "I feel comfortable discussing risk reduction for infant safe sleep:"
  Pre: 93% agree/strongly agree (42% strongly); Post: 100% agree/strongly agree (49% strongly)

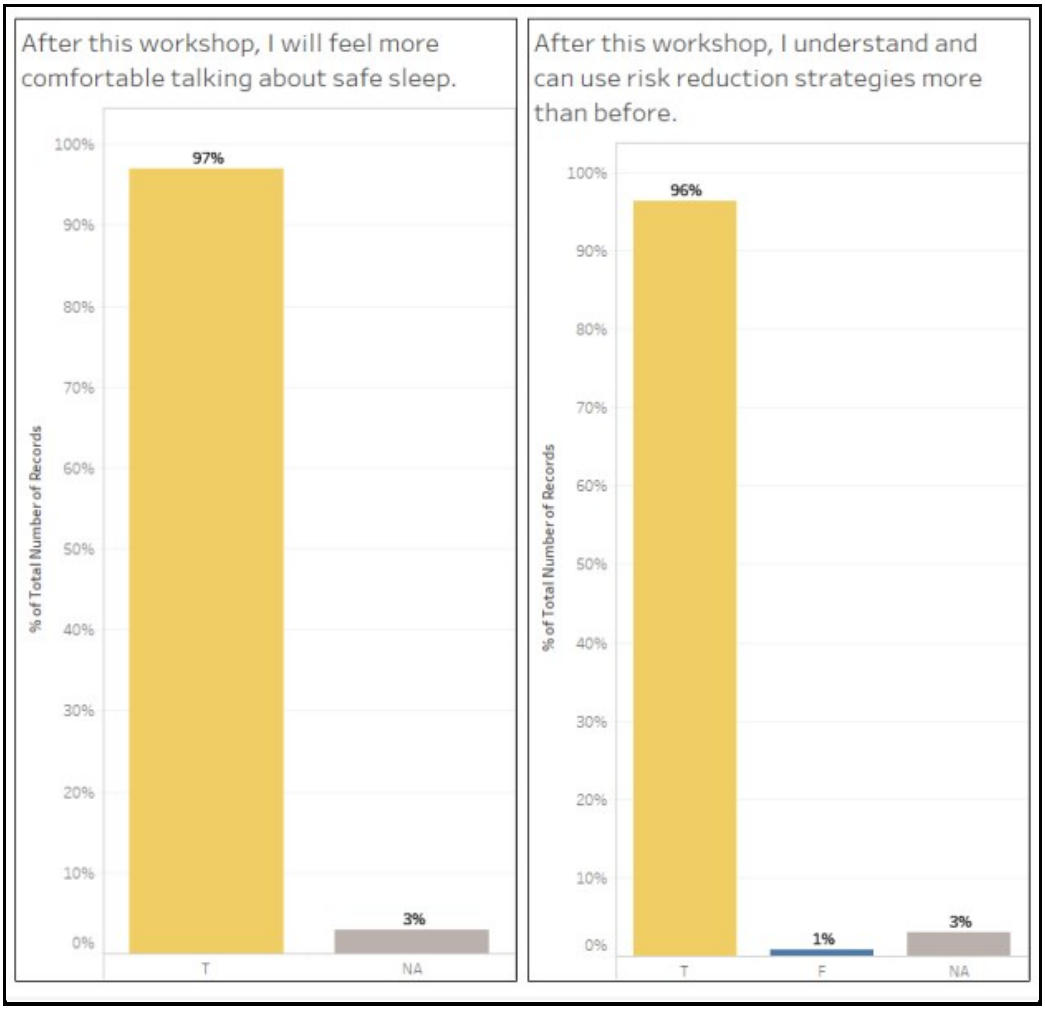
- "I feel confident I can educate caregivers about infant death and prevention:"
  Pre: 77% agree/strongly agree; Post: 100% agree/strongly agree

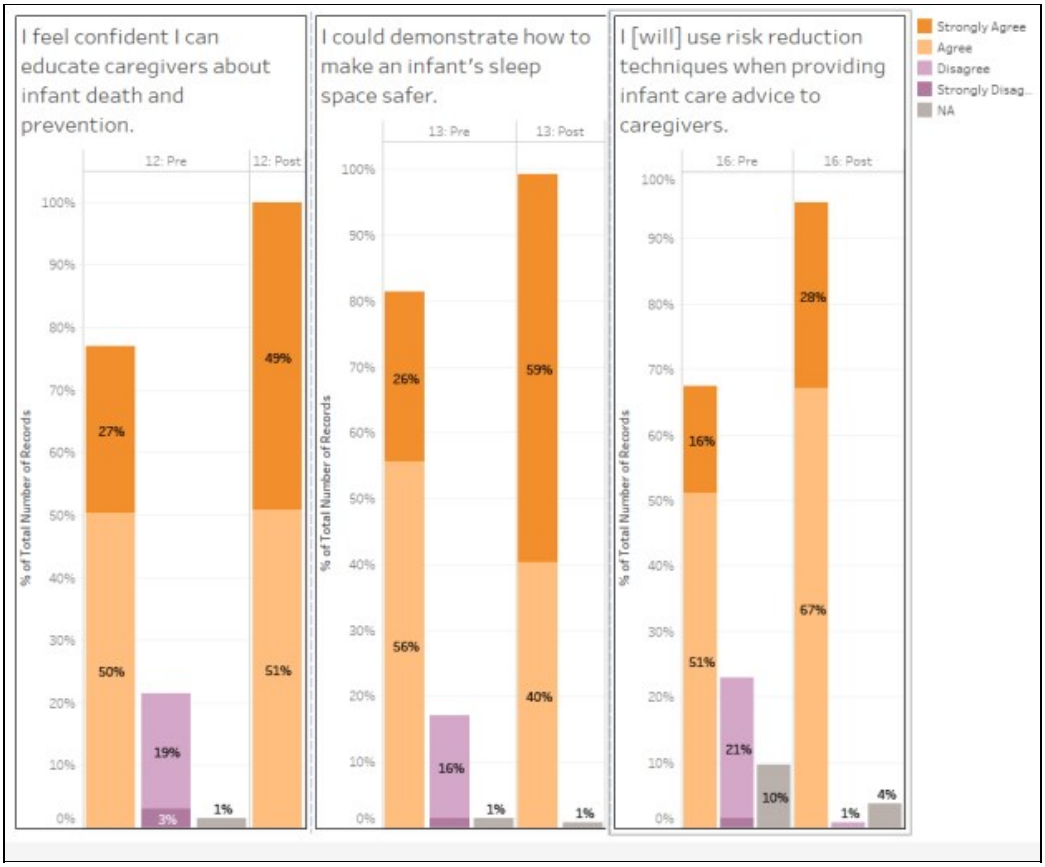
- "I could demonstrate how to make an infant's sleep space safer:"
  Pre: 82% agree/strongly agree; Post: 99% agree/strongly agree

- "I [will] use risk reduction techniques when providing infant care advice to caregivers."
  Pre: 67% agree/strongly agree; Post: 95% agree/strongly agree

Additional results from the Pre and Post tests are shown in the graphics below:




After this workshop, I will feel more comfortable talking about safe sleep.
% of Total Number of Records
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
97%
3%
T
NA
After this workshop, I understand and can use risk reduction strategies more than before.
% of Total Number of Records
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
96%
1%
3%
T
F
NA



NPM Strategy 5.5: Partner with tribal health organizations and Healthy Native Babies to update existing and develop new outreach materials and training programs for Alaska Native communities, providers and families that reflect current AAP guidelines and are culturally appropriate.

Alaska and the Alaska Native Tribal Health Consortium partnered to develop a rack card for families with images of Alaska Native families that is now in use across all facilities and agencies in the state. There are no longer separate tribal and non-tribal materials in use. Alaska distributed rack cards to every pediatric primary care provider, birth provider (hospital and midwifery), public health nursing office, and child protection office in the state, as well as any other partner agency that requested them. Goals include developing a comprehensive safe sleep website for families in partnership with tribal health**.** The materials and curriculum reflect the updated AAP guidelines and take a risk reduction approach.

NPM Strategy 5.6: Promote Cribs for Kids' National Safe Sleep Hospital Certification Program among birthing facilities statewide; support facilities in obtaining certification through training and technical assistance. – Strategy retired

While several facilities expressed interest in obtaining this certification, none were able to maintain the momentum to complete it, therefore this strategy and associated ESM's 5.5 and 5.6 are being retired. While still offering support and encouragement in expanding safe sleep efforts at birth facilities, Alaska will focus efforts on non-hospital partners in promoting safe sleep for Alaska's families, with special attention to those at highest risk, especially those with prior involvement with child protection. A new NPM 5.7 has been created to capture this work and is described in the Five Year Action Plan Narrative.

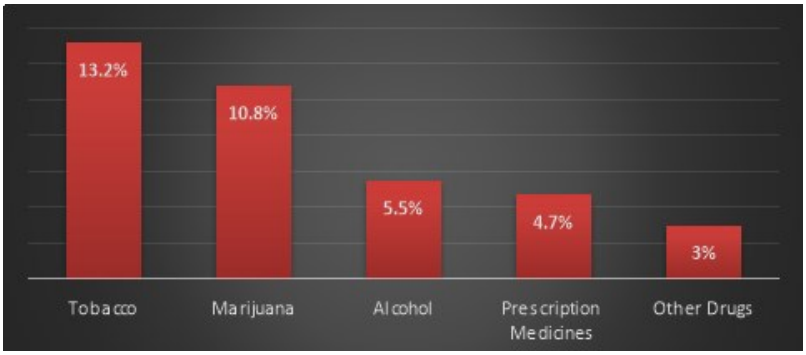
SPM 1: Percent of women who had one or more alcoholic drinks in an average week during the 3 months before pregnancy.

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

From July 1, 2017-April 31, 2018, the Alaska Prenatal Screening Program (APSP), formerly the Alaska 4P's Plus

project, screened 770 pregnant women for use of both prescribed and illicit substances potentially harmful for use during pregnancy using the screening, brief intervention and referral to treatment (SBIRT) process. The following chart describes those women's report of substance use during the month prior to delivery.

Percent of Women Reporting Use of Harmful Substances during Last Month of Pregnancy, July 1, 2017-April 2018, APSP (N=770)

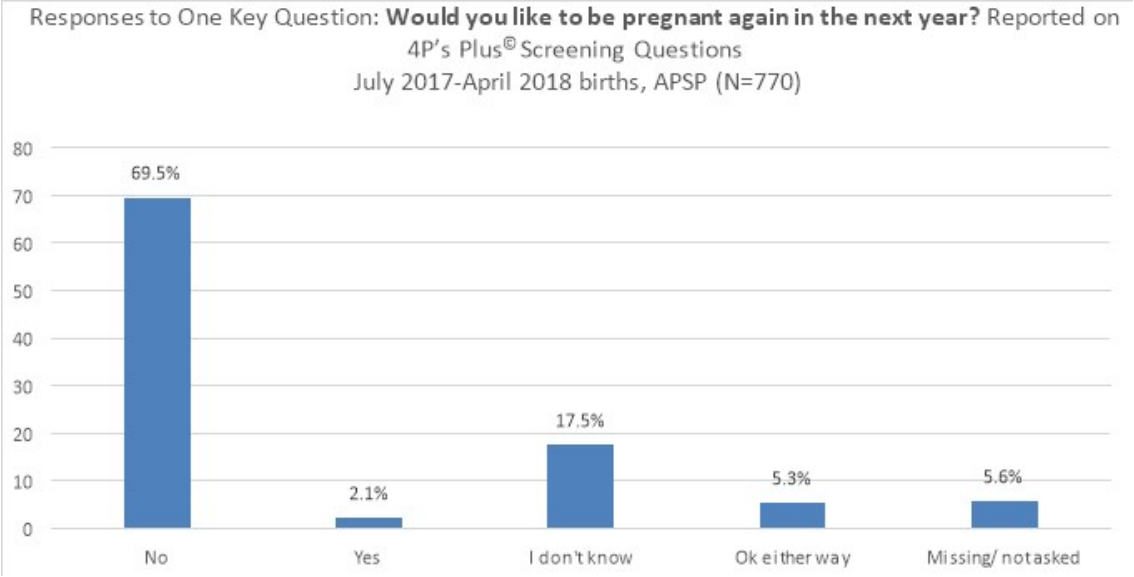


APSP promotes universal use of the SBIRT process and the APSP screening form which incorporates the validated 4P's Plus screening tool, among all providers of care for pregnant women. Regional hospitals in Anchorage, Fairbanks, Juneau and the Matanuska-Susitna Valley screened and reported data on 770 pregnant women during this period. About half of all births in Alaska are covered by Medicaid; APSP does not collect payer coverage information as part of its data set. The combined screening rate for these facilities was 42%. While not representative of all regions of the state, about 10% of all mothers giving birth during this time period were screened. In addition, two prenatal outpatient care providers screen their pregnant clients with the APSP screening tool. These clinics do not report data. Following any positive screening and assessment, a brief intervention is offered. Brief intervention is a non-judgmental approach to the complex and stigmatized circumstances surrounding families experiencing harms from substance use. Brief intervention is designed to engage the woman in a non-judgmental conversation about the risks harmful substances pose both to her and her baby. It is critical that care providers skilled in the process of brief intervention support each mother to have barrier-free access to needed care services. This helps assure the health and safety of both the mother and her baby. Special training to strengthen care provider skill in conducting brief intervention is usually necessary. Low levels for both care provider offering of the brief intervention and women's acceptance of the intervention when offered may be a sign that such training is needed. Among the pregnant women described above and having a positive screening and assessment, 64.8% accepted the brief intervention. APSP has not had capacity to conduct training in SBIRT skills during this reporting year.

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

Estimates of rates of unintended pregnancy in opioid-using women have been reported to be higher than 85%. (Pediatrics. Volume 139, Number 3, March 2017. *A Public Health Response to Opioid Use in Pregnancy.* Stephen W. Patrick, MD, MPH, MS, FAAP, Davida M. Schiff, MD, FAAP, *Committee on Substance Use and Prevention.)* During 2007-2016, over 69% of Medicaid-covered Alaskan mothers delivering a baby diagnosed with NAS had previously had at least one live birth. Use of harmful substances is often a chronic health problem, and for women of childbearing age, presents risk of exposing an unrecognized pregnancy to harmful substances. Supporting women of childbearing age to have healthy pregnancies can begin with caring conversations about their plans for childbearing. In support of this need, One Key Question is included as part of the APSP screening. The One Key Question tool asks the woman about her plans and desires for subsequent pregnancy so that care providers may support those needs. One Key Question enables client/patient-centered counseling and information that can help promote healthy birth outcomes with pregnancies spaced at healthy intervals and planned so that harmful substance use is avoided. The One Key Question is: "Would you like to become pregnant again in the next year?"

Screening pregnant women for substance use at the time of the first prenatal visit is ideal; however, as many as half of all pregnant women covered by Medicaid and reporting use of substances do not access regular prenatal care. For this reason, intervention and care at birthing facilities is critical. The chart below shows pregnant women's responses to One Key Question during APSP's first reporting period.


Responses to One Key Question: Would you like to be pregnant again in the next year? Reported on 4P's Plus© Screening Questions
July 2017-April 2018 births, APSP (N=770)
80
70
60
50
40
30
20
10
0
69.5%
2.1%
17.5%
5.3%
5.6%
No
Yes
I don't know
Ok either way
Missing/ not asked

PERINATAL/INFANT HEALTH

PLAN FOR THE APPLICATION YEAR: OCT 2019- SEPT 2020

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

NPM Strategy 5.1: Strategy retired 2018

NPM Strategy 5.2: (Revised) Review SUID cases using the CDC SUID Investigation Reporting Form algorithm to make consistent and accurate classifications and prevention recommendations.

Sudden Unexpected Infant Death (SUID) continues to be a primary contributor to Alaska's post-neonatal mortality as well as overall infant mortality. The MCDR program will continue to utilize the SUID classification decision making algorithm and focus on ensuring that we have the most consistent and reliable classification of these fatalities. Our accuracy is in large part predicated on the accuracy and completion of the SUID investigation reporting form completed by law enforcement agencies and doll reenactments. We are focusing on ensuring the completeness of the reporting forms, and making sure we have them for our reviews. As such we're measuring the proportion of SUID deaths that are reviewed where these forms are included.

We will continue to maintain relationships and encourage use of these forms by working with the State Medical Examiner's office and multiple law enforcement agencies across the state. This year, we plan to focus on completeness of the investigation form, including doll reenactments. We will seek out additional funding to support SUID Investigation trainings for agencies where inconsistencies are noted, especially in areas outside of Anchorage. Additionally, we will create an automated report that inspects the SUID Investigation reporting forms and aggregates the information that can be shared back with the Medical Examiner's office to support and direct their trainings.

We will also continue publishing quarterly reports that include review committee prevention recommendations related to SUIDs for the public and partners to review and hopefully include in their efforts to reduce infant mortality. The work of MCDR is largely funded by Title V dollars.

NPM Strategy 5.3: Strategy retired 2018

NPM Strategy 5.4: (Revised) Partner with programs serving high risk families to provide evidence based infant safe sleep education.

In June 2019, the current Nurse Consultant who has been leading Alaska's work around safe sleep will be leaving her position. While the position has been posted for recruitment, there will be a vacancy. While the past year has focused on training and outreach to child welfare workers, next directions for training and technical assistance are yet to be determined. Once the position is filled, this will be re-assessed to determine the best direction. In the interim, education materials will continue to be available for distribution.

In collaboration with the Alaska Section of Chronic Disease Prevention and Health Promotion, WCFH is partnering on a five-year CDC grant that is being used to conduct training for clinical providers in evidence-based maternity care practices for breastfeeding. Trainings are conducted at birthing facilities. Funding allows for up to eight facilities to have on-site training annually. The breastfeeding training curricula will include the addition of PRAMS data on infant safe sleep practices for each region where trainings are being conducted. AAP guidance regarding evidence-based safe sleep will be incorporated into each two-day training. Sign-in sheets from each training will be used to determine the number of maternity care providers participating. Regional WIC staff will also participate and be included in the counts. During the coming reporting period, trainings will be conducted at hospitals in the Yukon-Kuskokwim Delta, Fairbanks, Ketchikan, the Matanuska-Susitna region and, if funding allows, Kenai/Soldotna. All of these facilities serve Alaska Native peoples and families covered by Medicaid.

NPM Strategy 5.5: (Revised) Continue partnership with tribal health organizations to disseminate outreach materials and training programs for Alaska Native communities, providers and families that reflect current AAP guidelines and are culturally appropriate.

The Alaska DHSS Safe Sleep program and the Alaska Native Tribal Health Consortium will continue to partner to continue to disseminate the safe sleep rack card. All safe sleep materials will be collaboratively reviewed, edited, designed and shared by these two partners; no separate tribal and non-tribal materials will be developed or used.

During this coming year, these two partners will work together to develop a comprehensive safe sleep website that may be used by all Alaskan families and health and social service organizations.

NPM Strategy 5.6: Strategy retired in 2019, please see Report section.

NPM Strategy 5.7: (NEW) Increase safety of newborns, infants and toddlers by developing Plans of Safe Care and early identification of families with newborns with mother's reporting use of substances during the last month of pregnancy.

Consistent universal and evidence-based screening for all harmful substances, including tobacco, alcohol, marijuana, methamphetamines and opioids, among all pregnant women admitted to birth centers optimizes opportunity for identification and early and effective intervention for families with newborns at risk of harm. The Alaska Office of Children's Services (OCS) reports that children at greatest risk of harm are infants and toddlers. Adverse Childhood Experiences (ACEs) informs us that in families where substances are being used, there is increased risk of ACEs for the children living there. Early identification of families with newborns with mother's reporting use of substances during the last month of pregnancy will improve opportunities for meaningful early interventions, including Plans of Safe Care (as described under the federal Child Abuse Prevention and Treatment Act) that are most likely to be effective in reducing risk of harm for the newborn and their siblings

During 2018, the APSP screening rate among the four participating facilities was 42%; the total number of women screened was about 10% of all mothers giving birth in the state for that year. While the total number screened is significant, universal screening is the goal and 42% is far lower than desired. The low screening rate indicates a need for training, especially for training in effective brief intervention. Funding for this is not yet available and the APSP Nurse Consultant will address that problem as is possible. During the upcoming reporting period, APSP will support birth facilities in Anchorage, Fairbanks, Juneau and Palmer to improve screening rates among pregnant women admitted for delivery for all harmful substances, including tobacco, alcohol, marijuana, methamphetamines and opioids. APSP screeners will use the APSP screening form which incorporated the evidence-based 4P's Plus screening tool, followed by brief intervention for those with a positive assessment. Early identification of families with newborns with mother's report of use of substances during the last month of pregnancy, will be used to guide a therapeutic brief intervention and appropriate referral to treatment for both the mother and her newborn. In collaboration with the OCS, the Division of Behavioral Health, the DHSS Chief Medical Officer (a neonatologist), the Alaska Office of Substance Misuse and Addiction Prevention, Palmer Family, Infant and Toddler Court officials, the APSP Nurse Consultant, and regional health and social services providers, a pilot project to operationalize Plans of Safe Care in the Palmer/Mat-Su region will establish systems most likely to be effective in reducing risk of harm for the newborn and their siblings. APSP will support birth facility screeners to conduct effective screening and identify families with greatest need for a Plan of Safe Care. This work is funded by federal opioid dollars coming to WCFH from the Division of Behavioral Health.

SPM 1: Percent of women who had one or more alcoholic drinks in an average week during the 3 months before pregnancy.

SPM Strategy 1.1: Promote provider use of (Screening, Brief Intervention and Referral to Treatment) SBIRT for all harmful substances among all women of childbearing age, especially those who are pregnant.

During 2018, the APSP screening rate among the four participating facilities was 42%; while the total number of women screened was about 10% of all births in the state for that year. While the total number screened is significant, universal screening is the goal and 42% is far lower than desired. The low screening rate indicates a need for training, especially for training in effective brief intervention. Funding for this is not yet available, and the APSP Nurse Consultant will address that problem as is possible. During the coming reporting period, APSP will continue to support birth facilities in Anchorage, Fairbanks, Juneau and Palmer to improve screening rates among pregnant women admitted for delivery, for all harmful substances, including tobacco, alcohol, marijuana, methamphetamines and opioids. APSP screeners will use the APSP screening form, which incorporated the evidence-based 4P's Plus screening tool, followed by brief intervention for those with a positive assessment. In addition, ASPS will aim to bring on at least one additional birthing center agreeing to conduct all ASPS activities, including SBIRT. ASPS will work with Alaska Division of Behavioral Health (DBH) treatment staff to help strengthen referral processes for newly delivered mothers in need of substance use treatment care.

SPM Strategy 1.2: Promote provider use of One Key Question tool among women of childbearing age, including those who are pregnant.

During this reporting period, APSP will continue to support screeners from regional birth facilities in Anchorage, Fairbanks, Juneau and the Mat-Su/Palmer to effectively screen pregnant women for their desire for subsequent pregnancy and to provide evidence-based information about the value of pregnancy spacing as a factor in both maternal and child health. The number of women screened with the One Key Question will continue to be tracked and reported as an evaluation measure. APSP will also track and report on the number of APSP participating hospitals able to offer voluntary long acting reversible contraceptives (LARCs) to Medicaid covered women. APSP will work with the Alaska Medicaid Program and care providers to try to reduce barriers for women wanting LARCs, including the Alaska Governor's Council on Fetal Alcohol Spectrum Disorders (FASDs) Primary Prevention working group where the APSP serves as co-lead, to forward that group's goal of preventing FASDs by using the tandem strategy of screening women of childbearing age for use of alcohol and desire for immediate pregnancy followed by appropriate referral.

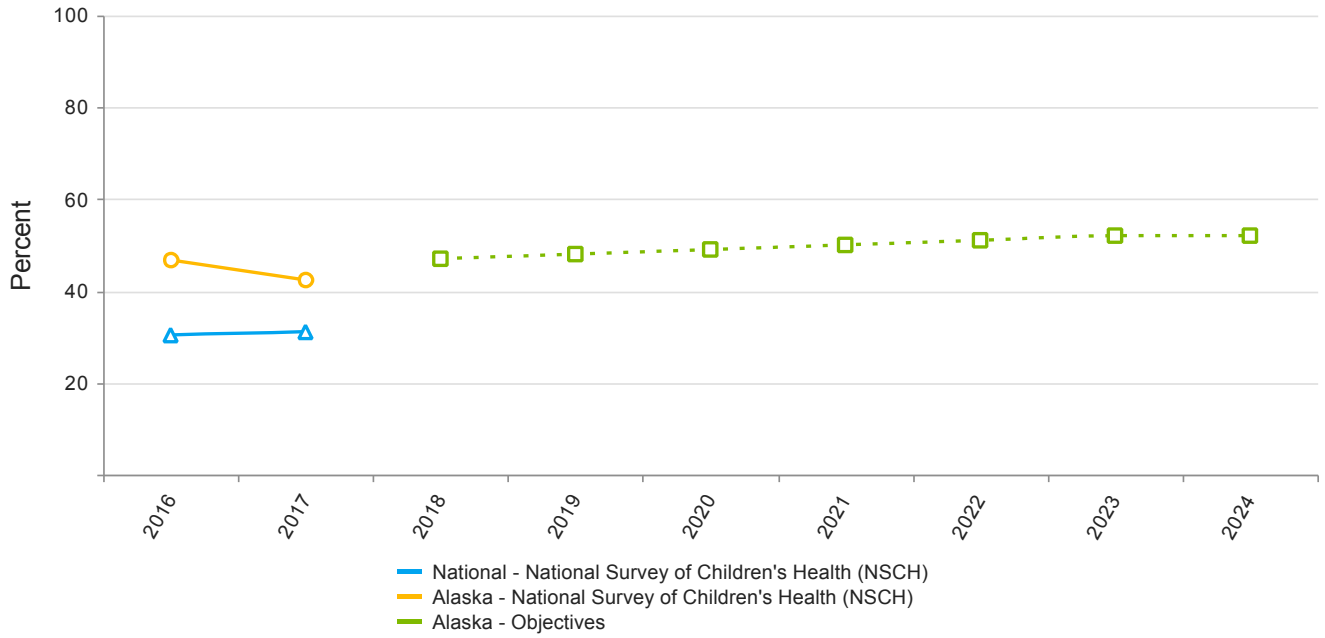
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	92.1 %	NPM 6

National Performance Measures

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
Indicators and Annual Objectives



Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	**2017**	**2018**
Annual Objective			47
Annual Indicator		46.8	42.3
Numerator		12,033	9,801
Denominator		25,736	23,177
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	48.0	49.0	50.0	51.0	52.0	52.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		94	94.5
Annual Indicator	93.4	89.9	76.1
Numerator	114	107	67
Denominator	122	119	88
Data Source	Nurse Family Partnership Program Data	Nurse Family Partnership Program Data	Nurse Family Partnership Program Data
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	75.0	75.0	75.0	75.0	75.0	75.0

State Performance Measures

SPM 5 - Percent of deaths among children ages 0-17 years classified as maltreatment-related by the Maternal Child Death Review (MCDR) committee.

Measure Status:	Active

State Provided Data		
	2017	2018
Annual Objective		
Annual Indicator	22.4	15.5
Numerator	26	18
Denominator	116	116
Data Source	Maternal Child Death Review Program	Maternal Child Death Review Program
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	16.0	15.5	15.0	14.5	14.0	13.5

State Action Plan Table

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

Priority Need

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

NPM

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Objectives

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

Strategies

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

NPM 6.2. Partner with Medicaid and participate in the ECCS CoIIN to promote the use of the online Ages and Stages Questionnaire developmental screening tools with health care providers and partners

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

NPM 6.4 (NEW) Participate on Medicaid Children's Core Workgroup to increase the number of children receiving developmental screening in the first three years of life, a Child Core Set measurement for CMS, and improve reporting of data.

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

NOMs

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

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

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

Priority Need

Reduce the rate of child maltreatment

SPM

SPM 5 - Percent of deaths among children ages 0-17 years classified as maltreatment-related by the Maternal Child Death Review (MCDR) committee.

Objectives

SPM 5 Reduce the percentage of child maltreatment related deaths (as specified by the MCDR program) occurring in Alaska among children ages 0-17 to 15% by 2021.

Strategies

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

SPM 5.2. Improve the reliability of maltreatment-related mortality classifications (particularly those related to child neglect and negligence) through a pilot study.

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

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

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

SPM 5.6 Support local/state based initiatives working to prevent maltreatment by providing and interpreting data.

SPM 5.7 Improve public access to child welfare data by updating the IBIS application with current data and expand the Rshiny online ALCANLink application.

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

CHILDREN'S HEALTH

REPORT FOR THE APPLICATION YEAR: OCT 2017- SEPT 2018

NPM 6: Percent of children ages 9 through 71 months, receiving a developmental screening using a parent completed screening tool.

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

The MIECHV program continues to partner with Providence In-Home Services to implement the evidence-based Nurse-Family Partnership (NFP) model of home visiting in the communities of Anchorage and Mat-Su. This program utilizes registered nurses, and families are served prenatally and until the child reaches two years of age. A core component of the model is developmental screening, and the Ages and Stages Questionnaire (ASQ) is the tool used by NFP. Home visitors continue to refer to early intervention grantees when necessary. In FY18 the program had a 76% screening rate of children enrolled in home visiting with at least one screening within the Bright Futures age groups during the reporting period, placing our program within the top 1/3 of MIECHV programs within the country for developmental screening.

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

The Early Childhood Comprehensive Systems (ECCS) team, including the program manager, evaluator, data leads, contractors and Community Leads are focusing their work on the overarching Alaska ECCS Project goal of a twenty-five percent increase in age appropriate developmental skills among three-year-olds in each place-based community. The three community organizations, Kodiak Area Native Association (KANA), Norton Sound Health Corporation (NSHC) and Matanuska-Susitna (Mat-Su) Raising Our Children with Kindness (R.O.C.K), are collaborating with parents, providers and community organizations to increase awareness around the importance of the Ages and Stages Questionnaire (ASQ) as a standardized, parent completed developmental-behavioral screening tool. Using state general funds from the Office of Children's Services, WCFHcontracted with Prentice Consulting and Alaska Center for Pediatrics to provide developmental screening stipends and technical support to increase the utilization of the ASQ Online System in multiple practices across the communities. The ECCS teams have been meeting with staff from hospitals and clinics, Early Intervention and Office of Children's Services Child Protection Workers in each community, and holding community events that feature developmental screening such as Baby Showers, Health Fairs, Dance Parties and screenings at Family Movie Nights.

These initiatives are beginning to show real results. This past year, there was a significant jump in developmental screenings in Alaska, primarily in the three ECCS communities. The statewide number had been hovering around 2,600 ASQ screenings per year, and this past year the number jumped to 4,542. Ideally, we want to see programs, partners and providers use the online version of the ASQ as this makes it potentially easier to incorporate the results into a child's health record, and to centralize data on the developmental health of Alaska's children. The number of ASQs done by families through an online portal was around 56% for several years, and this year it rose to 70%.

There has also been a change within Medicaid and the modifier and billing code for developmental screening. We have been working with Help Me Grow, the Early Intervention, and the Governor's Council on Disabilities and Special Education's Developmental Screening Task Force to create a centralized data system that will better track use of the ASQ screening tool.

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

Help Me Grow (HMG) Alaska was launched in January 2018 and implemented all four components of the HMG National Model: Child Health Provider Outreach, Family and Community Outreach, a Centralized Access Point, and Ongoing Data Collection and Analysis. The call center is staffed by thread, Alaska's Child Care Resource and

Referral Network. Initially starting in the three ECCS place-based communities, HMG has now expanded statewide as of 2019. The call center is staffed by thread, Alaska's Child Care Resource and Referral Network. The thread staff/care coordinators are trained in Strengthening Families, Family Navigation, Motivational Interviewing and other relevant topics. Care coordinators provide families with informational resources, opportunities to complete ASQs, and referrals to services using a warm handoff model. This year, HMG created a Child Health Provider Outreach training to educate providers and support staff on how to use HMG, how to implement developmental screening in their clinic and make referrals, and how to use developmental monitoring tools for parent education. HMG created and did initial testing of data collection tools, and hired a third party evaluator. They launched their website that includes a portal to an online ASQ in both English and Spanish, and started data collection and analysis on the landscape of standardized developmental screening across the state. HMG also partnered with the Alaska LEND (Leadership Education in Neurodevelopmental and related Disabilities) program at UAA CHD, on resource vetting, natural support identification and developmental ambassador projects.

This past year, WCFH was able to establish a baseline measure of awareness of HMG among parents of young children across Alaska. The baseline was established by adding a supplemental question to two surveillance surveys for mothers of young children: the Alaska Pregnancy Risk Assessment Monitoring System (PRAMS) survey, sent to women who had a baby within the past 30 days; and the Alaska Childhood Understanding Behaviors Survey (CUBS), sent out to the same mothers when the child is three years of age. Survey responses are collected by phone and mail. The supplemental question asked, "Before today, had you ever heard about Help Me Grow Alaska?" Mothers who responded to CUBS were more likely to have heard of HMG-AK than mothers who responded to PRAMS, with 11% of PRAMS respondents saying they were aware of HMG, and 14% of the CUBS mothers having heard of HMG. Mothers in the Mat-Su, Northern, and Gulf Coast regions were most likely to know of HMG-AK. In fact, in the Mat-Su Borough, almost one-fifth of surveyed mothers said they had previously heard of HMG-AK. The three ECCS pilot communities for HMG are located within these three regions. The question will be asked again in 2020 to measure changes in awareness.

During 2018, HMG provided services to almost 200 families in Alaska. Care coordinators provided families with resources on parenting skills, child development, and community services and programs. Families were also given opportunities to complete developmental screening for their child, and referrals for services were provided when needed. Over 400 resources were provided to families and 72 children completed an ASQ and received resources to promote healthy development, with 20 children referred to additional services. A short survey was sent out to families that were provided resources and/or referrals and had received follow-up from care coordinators to gauge satisfaction. Families rated HMG care coordinators highly in terms of professionalism, politeness, communication, knowledge of the area of concern or question presented, ability to help with the concern or question, and follow-up. Families also rated the resources and referrals they received from HMG as helpful, with the majority stating they were very helpful. Almost all families reported that their needs had been met by HMG.

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

The proportional distribution of the types of deaths among children in Alaska has remained fairly constant over the past decade. Due to both the priority and preventability of these specific deaths, we chose to focus our understanding on reducing deaths related to this cause. In prior years when we've detected a significant drop or increase in a cause specific mortality, we've observed parallels with total mortality. Because these sentinel events result in often more timely tracking they are conducive to informing policy and practice. During the past year, the MCDR program had difficulty filling an epidemiologist vacancy which resulted in reduced assessments and analysis, however, during this year the MCDR program has worked to improve the consistency in how teams classify these deaths by developing a new tool that will be implemented during the next year.

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

The ALCANLink program is partnering with the Alaska Children's Trust (ACT) to begin developing these graphics. During the recent budget cycle, ALCANLink was branded, the data system was systematically improved, and multiple presentations were given across the state to various stakeholders, including Commissioners and legislators. Now that the foundation work is completed, these informative info graphics can be created.

SPM Strategy 5.2: Improve the reliability of maltreatment-related mortality classifications (particularly those related to child neglect and negligence) through a pilot study.

The MCDR program, in partnership with Alliance 1, obtained funding from the Travis Fund and the Rasmuson Foundation to develop a tool to improve the consistency of maltreatment classification. Three in-person visits convening national experts occurred and a tool developed. The tool operationalizes a public health approach to classification establishing guidelines for teams on how to consider parent/caregiver and hazards to reduce individual bias. This tool will be implemented during subsequent years, piloted in other jurisdictions, and tested.

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

The MCDR and ALCANLink programs have partnered closely with the Office of Children's Services (child welfare) to establish definitions. The vital records classification and public health classifications have been developed. A task force has been convened to establish CAPTA defined maltreatment deaths. This has been problematic in the past due to our state not investigating child deaths. The foundational components to enable improved tracking are in place and will be centered with the MCDR program, with data being made available annually.

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

The ALCANLink project focused efforts on obtaining educational records. This resulted in an official request from the Commissioner of Education to link education records to ALCANLink to improve and understand the factors that predict poor developmental profiles assessed at Kindergarten and lower reading scores measured in 3rd and 4th grade. A MOU is being developed to enable data transfers and analysis.

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

The Doris Duke Charitable foundation provided funding to support the development of ALCANLink. A contractor was hired and a system was developed using PENTAHO to normalize extract, transformation, and loading of the core ALCANLink datasets. A SQL database was also created to house these data and partition identifiers from the data. This has improved functionality and consistency of information when conducting annual imports of administrative data. Additional support from Mathematica was obtained to support replication of these methods in Oregon. The data infrastructure built has enabled us to more readily replicate and ensure that our methods are consistent.

SPM Strategy 5.6: Support local/state based initiatives working to prevent maltreatment by providing and interpreting data.

ALCANLink data was used to support multiple initiatives, legislative presentations, scientific, and programmatic. Recent examples include working with a home visiting program to help them identify ways based on the data to improve services, meeting with the ACT to help them formulate their strategic plan and focus, and establish a justification for the 1115 Medicaid waiver demonstration project.

SPM Strategy 5.7: Improve public access to child welfare data by updating the IBIS application with current data and expand the Rshiny online ALCANLink application.

The IBIS application has been updated but being refined for the next year to better describe the differences of National Child Abuse and Neglect Data System (NCANDS) data. The analyst who was doing this work left in 2018 leaving a vacancy that has now been replaced. Efforts to coordinate with the Office of Children's Services to ensure alignment are underway. The Rshiny application for ALCANLink has been updated from a beta version to 1.0, with additional information and expanded capabilities.

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

This effort was set back while other SPM strategies are accomplished. The ALCANLink project put up a website and is now working at expanding information on the site as a temporary holding place for the variety of data on this topic.

CHILDREN'S HEALTH

PLAN FOR THE APPLICATION YEAR: OCT 2019- SEPT 2020

NPM 6: Percent of children ages 9 through 71 months, receiving a developmental screening using a parent completed screening too

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

WCFH will continue to contract with the Providence Nurse-Family Partnership program for them to provide evidence-based maternal child health home visiting services. This includes the use of the Ages and Stages Questionnaire (ASQ) according to the Bright Futures schedule. WCFH will continue to be available for training related to developmental screening and for evaluation of developmental screening and referrals. Providence is also interested in exploring the use of the ASQ online system for providers.

NPM Strategy 6.2: (Revised) Partner with Medicaid and participate in the ECCS CoIIN to promote the use of the online Ages and Stages Questionnaire developmental screening tools with health care providers and partners

The Early Childhood Comprehensive Systems (ECCS) federal grant program has a five-year goal of a 25% increase in age-appropriate developmental skills among three-year-olds in each place-based community. We will continue to collaborate with parents, providers, community organizations and Medicaid to increase awareness and use of the ASQ as a standardized, parent-completed developmental-behavioral screening tool. We have seen improvements in ASQ online screening in Alaska, and the ECCS Grant will continue to contract with Prentice Consulting and Alaska Center for Pediatrics to provide developmental screening stipends and technical support to continue increasing the utilization of the ASQ Online System in multiple practices across the communities. The ECCS Data Lead will continue to collect, analyze and share developmental screening data with the communities, providers and partners. ECCS Community Leads will continue their work promoting Help Me Grow Alaska as a resource to assist programs and parents in completing ASQs and finding resources for any areas of concern. Working with the ECCS team, WCFH will continue to look for innovative ways to promote developmental screenings throughout Alaska.

WCFH will continue to participate in the Governor's Council on Disabilities and Special Education's Developmental Screening Taskforce. This multidisciplinary group includes participation from ECCS, Medicaid, Early Intervention, Help Me Grow (HMG), Title V, MIECHV, home visitors, tribal health, pediatric providers, and the Alaska Mental Health Trust Authority, among many others. This group continues to focus on online ASQs and centralized statewide data collection.

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

The HMG Alaska program, under the umbrella of the All Alaska Pediatric Partnership (AAPP), has a goal of connecting children and families with the services they need, and they will continue to expand their reach and scope. The WCFH Section Chief is a board member of AAPP. HMG is now accepting calls statewide. Because of increased funding, they will be adding a full-time Outreach Coordinator to adapt their marketing to reach families and providers, with an emphasis on provider education and referrals driven by provider interactions. The secondary strategy will be to direct family and community outreach. Because of new partnerships with the Division of Behavioral Health and Seattle Children's Hospital, they will be adding specialized pediatric mental health information, referrals and case management. As part of this work, they will also be doing provider education and outreach on this new service. HMG also has new funding for an environmental scan of early childhood programs that will assist in collaboration, coordination of services, gap identification, information sharing and needs assessments. They are continuing to develop their data base and a statewide shared resource list.

HMG is also involved in ongoing discussions about how ASQ data is used and current relationships and data sharing look, and are exploring what other possible data structures might look like for Alaska. They are partnering to

create opportunities for the use of the ASQ in the large Community Health Aide program and increasing training opportunities for other for potential large groups of new screeners, including child care providers as part of the Learn and Grow quality improvement strategies.

The first HMG evaluation noted many successes during their first year of being open for business statewide, but noted a need for more leadership from their advisory committee. HMG is restructuring this committee, and WCFH will be part of this leadership board. Facilitated strategic planning for the HMG Leadership Committee is slated to take place in the summer of 2019.

NPM Strategy 6.4: (NEW) Participate on Medicaid Children's Core Workgroup to increase the number of children receiving developmental screening in the first three years of life, a Child Core Set measurement for CMS, and improve reporting of data.

The Title V Director and MCH Epidemiology Unit Manager will continue to participate on a Children's Core Set Workgroup with the EPSDT Coordinator and Medicaid Medical Director. This group meets on an ad hoc basis. The goals of the workgroup are to increase the number of children receiving the measured services and improve the reporting of data to CMS related to Core Set standards. Developmental screening in the first three years of life was identified by the Medicaid program as one of the priority core measures that need to be improved.

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

The senior MCH Epidemiologist secured funding to develop a standardized method to assist the Alaska Child Death Review team with classifying maltreatment fatalities. This project has enlisted the help of national experts for developing the classification tool and will be pilot tested in May of 2019, with additional follow-up tests into the third quarter of 2019. Full deployment will occur after initial refinements are made. This tool operationalizes a public health definition by expanding case classification beyond those classified by child welfare and vital records to incorporate caregiver willful behavior. In partnership with child welfare these data will be used to better understand the extent of fatalities where the caregiver failed to protect a child from a documented hazard. Nationally and in Alaska, the consistent and comprehensive classification of maltreatment deaths has been problematic. This effort will ensure we have a reliable numerator that is clearly defined and reportable. Initiating and measuring prevention efforts is impossible without accurate information.

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

Now that ALCANLink is branded and templates have been created for data to be presented consistently, at least one and potentially a series of infographics will be developed. This work will be done in conjunction with the Alaska Children's Trust. The initial graphic will be centered on familial stressors and the relationship with child welfare involvement.

SPM Strategy 5.2: Improve the reliability of maltreatment-related mortality classifications (particularly those related to child neglect and negligence) through a pilot study.

Now that a tool for classifying maltreatment during mortality case reviews has been developed, over the course of the next year, other jurisdictions around the country will test the tool and provide feedback. Once refined, it will be fully implemented and tested. We are developing the research methodology that will enable us to test if this new tool improves the consistency and reliability of classification of maltreatment deaths, particularly neglect and negligence fatalities. To test this, a rural jurisdiction to ensure compatibility and interoperability will also be initiated.

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

The established task force to address this problem will create the CAPTA defined deaths and outline the process for data management and dissemination. This team will meet at least monthly until the system has been created and these data are made available. The improved access and description of definitions used to quantify these fatalities will enable clearer communication of these important events. The MCDR program will work at establishing a process for identification and quantification of deaths meeting the vital records, CAPTA, and public health definitions.

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

This ongoing effort will continue to focus on obtaining education data. In partnership with the Alaska Mental Health Board, funds form the Alaska Mental Health Trust Authority were acquired to fund a temporary Research Analyst to assist with the ALCANLink project. This researcher will work closely with the Department of Education & Early Development to establish the MOU to allow data sharing, link in these data using the developed linkage methodology, and conduct analyses using these data. Other linkages will be pursued as time and interest allow.

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

This strategy related to ALCANLink has been accomplished. We are now replicating in Oregon. All MOU's have been established, and the project is currently under IRB. We will work with our partners to establish and evaluate data linkages, compare estimates, and work to validate these methods. Upon validation, we will imitate replication in other states that have expressed interest.

SPM Strategy 5.6: Support local/state based initiatives working to prevent maltreatment by providing and interpreting data.

ALCANLink data are in high demand and the added support of the Research Analyst will enable additional analyses during the upcoming year. ALCANLink has also partnered with academics, including the University of North Carolina-Chapel Hill, Berkeley, The University of Alaska-Anchorage, and Tulane to conduct research using these data. Findings will be translated to lay communication pieces to ensure these data support local efforts and the public. We plan on presenting these data to multiple audiences and developing at least two new research manuscripts.

SPM Strategy 5.7: Improve public access to child welfare data by updating the IBIS application with current data and expand the Rshiny online ALCANLink application.

In partnership with OCS, we will work to update the code used to create the IBIS query modules. This will ensure better alignment of data and reduce confusion among our many partners. The ALCANLink application will be further developed by including more comprehensive descriptions, additional data points, and functionality.

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

This effort will be advocated during the development of a statewide strategic plan on child maltreatment prevention being directly by ACT. The Research Analyst supporting ALCANLink will be leveraged to work on collecting and compiling key data points. We will seek additional funds and resources to identify the best place to host and maintain this site.

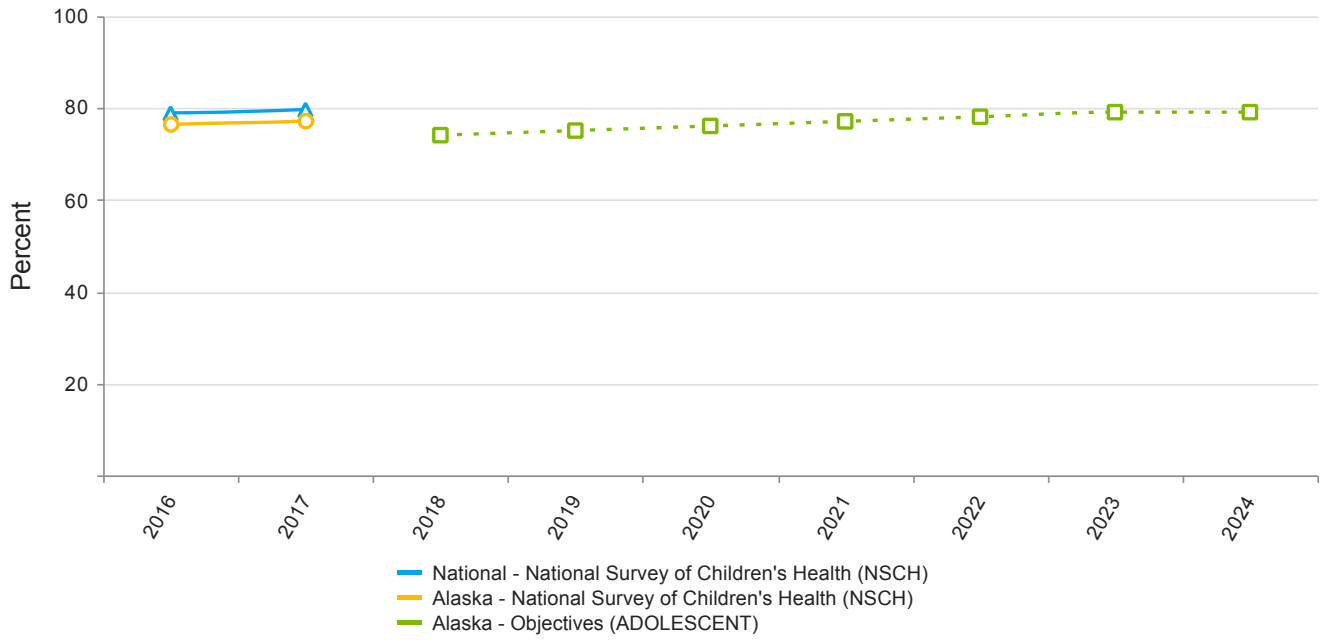
Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2016_2017	11.6 %	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	92.1 %	NPM 13.2

National Performance Measures

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



NPM 13.2 - Adolescent Health

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	**2017**	**2018**
Annual Objective			74
Annual Indicator		76.4	77.0
Numerator		132,693	133,177
Denominator		173,803	173,033
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	75.0	76.0	77.0	78.0	79.0	79.0

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - Number of oral health pocket guides distributed

Measure Status:						Active
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	125.0	150.0	175.0	200.0	225.0	225.0

ESM 13.2.2 - Number of school nurses trained on oral health

Measure Status:					Active
Annual Objectives					
	2020	2021	2022	2023	2024
Annual Objective	75.0	90.0	105.0	120.0	135.0

State Performance Measures

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

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		86.1	86.3
Annual Indicator	85.7	82.5	82.5
Numerator	1,182	1,073	1,073
Denominator	1,379	1,301	1,301
Data Source	CDC Youth Risk and Behavioral Surveillance	CDC Youth Risk and Behavioral Surveillance	CDC Youth Risk and Behavioral Surveillance
Data Source Year	2015	2017	2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	86.5	86.7	87.0	87.3	87.5	87.7

State Action Plan Table

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

Priority Need

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

NPM

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

Objectives

Increase the percent of Alaska children ages 1-17 years who had a preventative dental visit in the past year to 77% by 2021.

Strategies

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

NPM 13.2 Collaborate with Division of Health Care Services to increase preventative dental visits with children ages 1-20 enrolled in Medicaid program.

NPM 13.3. Strategy retired in 2019 (please see 5 Year Action plan report)

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

NPM 13.5 Continue to lead and facilitate the Alaska Dental Action Coalition (ADAC) quarterly meetings.

NPM 13.6 Strategy retired in 2019 (please see 5 year action plan report)

ESMs	Status
ESM 13.2.1 - Number of oral health pocket guides distributed	Active
ESM 13.2.2 - Number of school nurses trained on oral health	Active

NOMs

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

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

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

Priority Need

Increase healthy relationships.

SPM

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

Objectives

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

Strategies

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

SPM 2.2 Strategy retired in 2019 (please see 5 year action plan report)

SPM 2.3 Strategy retired in 2019 (please see 5 year action plan report)

SPM 2.4 (NEW) Support statewide training and dissemination of Coaching Boys into Men (CBIM), a comprehensive violence prevention curriculum for coaches and their athletes developed by Futures without Violence.

SPM 2.5 (NEW) Maintain statewide dissemination of Teen Speak publications and Adolescent Focused Motivational Interviewing Skills training and resources for Supportive Adults, Parents, Caregivers and Clinicians

ADOLESCENT HEALTH

REPORT FOR THE APPLICATION YEAR: OCT 2017- SEPT 2018

NPM 13: Percent of children, ages 1 to 17 years, who had a preventative dental visit in the last year.

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

WCFH staff distributed 50 Bright Futures Oral Health Pocket Guides at the following events:

- School Health and Wellness Institute -- October 2018
- Alaska Public Health Summit – January 2018
- School Nurses' Annual Conference – April 2018
- Alaska Dental Hygienists' Association Training – August 2018
- Maternal Child Health and Immunization Conference - September 2018
- Alaska Dental Action Coalition (ADAC) Meetings – quarterly

The Section of Chronic Disease and Health Promotion also assisted in distributing guides to stakeholders. The associated ESM measure was retired this year because it didn't accurately capture the efforts or impact of WCFH around oral health. The newly created measure will more accurately capture our partnership with the school health nursing system addressing oral health in children. Due to restraints within TVIS, and because this measure was created last year, this measure was not able to be inactivated within the system but will be next year.

NPM Strategy 13.2: Collaborate with Division of Health Care Services to improve preventative dental visits with children ages 1-20 enrolled in Medicaid program.

We had planned to use Medicaid data to analyze preventative dental visits by Alaska Native Tribal Health corporations so that targeted education to medical and dental providers in tribal programs could be conducted. However, due to a lack of staff time available for analyzing Medicaid data as well as limited staff working on oral health issues during the past year, this analysis was not completed.

The Medicaid program (EPSDT Coordinator) continued to participate in the WCFH-led Alaska Dental Action Coalition.

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

Over a 6 month period in 2018, WCFH staff participated in the AMCHP Data Communications E-Learning Collaborative with Section of Chronic Disease Prevention and Health Promotion staff and focused their product on perinatal oral health. The E-Learning Team participated in monthly didactic trainings, peer-to-peer sharing, and engaged one-on-one with a national communications expert - all leading to a final issue brief showcasing PRAMS data on perinatal oral health. The target populations for the materials were women under the age of 25 and those on Medicaid. Two fact sheets were created, one for perinatal health care providers and one for patients. The products were posted online on the Oral Health Program website in a call-out box, were shared directly with providers at meetings and conferences, and will continue to be distributed in the future.

The MCH Epidemiology Unit published an Epidemiology Bulletin in February 2019 reporting on Alaska CUBS data that showed an increase in early dental visits during 2009-2017.

This strategy is being retired due to the completion of multiple publications over the past year related to oral health and a lack of capacity to realistically produce additional publications or analyses in the upcoming year.

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

Oral Health Training was provided to 98 school nurses in April 2019 at their annual conference. This included how to perform oral health screenings, dental emergencies and resources for low-cost dental services for families. Sugary

drink tool kits, “When Sugar is not so Sweet" were handed out to 16 school nurses from several school districts, including Fairbanks, Denali Borough, Anchorage and Mat-Su. Several school nurses reported much interest from students and staff after displaying these booklets. One school nurse from Palmer had a bulletin board on oral health displayed outside her office that helped many students and staff become more educated on the importance of oral health.

NPM Strategy 13.5: Continue to lead and facilitate the Alaska Dental Action Coalition (ADAC) quarterly meetings.

WCFH oral health staff continued to lead and facilitate the Alaska Dental Action Coalition, which is the only group in Alaska which takes a multidisciplinary approach to improving oral health. This group consists of several stakeholders such as private dentists, dental hygienists, federally qualified health centers, Medicaid, the Alaska Dental Society, the Alaska Primary Care Association, the Alaska Native Tribal Health Consortium, the Alaska Mental Health Trust Authority, the Governor’s Council on Disabilities and Special Education, and the University of Alaska Anchorage. The group met quarterly and provided input on the HRSA Oral Health Workforce Activities grant application, the Dental Consultant RFP, community fluoridation issues, Project Access, Free Dental Days, and the needs of vulnerable populations, including children and youth with special health care needs. Because of the potential elimination of adult dental services in the Governor’s proposed budget, committee members discussed the status of Medicaid in Alaska as a priority item.

NPM Strategy 13.6: Collect and report statewide water fluoridation data to the CDC Water Fluoridation Reporting System – Strategy retired

WCFH staff submitted community fluoridation reports throughout the reporting period into the Water Fluoridation Reporting System (WFRS), an online tool that helps states manage the quality of their water fluoridation programs. WFRS information is also the basis for national surveillance reports that describe the percentage of the U.S. population on community water systems who receive optimally fluoridated drinking water. The system was developed by CDC in partnership with the Association of State and Territorial Dental Directors (ASTDD). This NPM is being retired because WCFH currently has little ability to commit staff to oral health activities. As well, community fluoridation reports are also collected by the Alaska Native Tribal Health Consortium. Collecting and reporting this data does not align with the oral health work plan in WCFH. We are hopeful that the implementation of the HRSA grant, and addition of the Dental Consultant contractor and oral health program manager, will increase WCFH capacity in the future. Because of the federal funding, the work will be focused on grant-related activities. Water fluoridation does not fit into those activities and therefore this strategy is being retired. However, the WCFH Title V Director is participating in the Healthy Alaskans 2030 workgroup focused on water fluoridation.

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

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

Due to staff vacancies during his reporting period, this strategy was not completed. This activity remains relevant in the Five Year Action Plan. A new Public Health Specialist starts in June 2019 who will be focused on the Fourth R. The incumbent left the position in February 2019 which left a vacancy for several months.

SPM Strategy 2.2: Create fact sheets and promotional materials related to the five focus areas of the Alaska Adolescent Health Program. – Strategy retired

The WCFH Adolescent Health Program completed this work. The five focus areas of the program are: 1) violence and bullying prevention, 2) unintended pregnancy and sexually transmitted infections prevention, 3) substance use and abuse prevention, 4) mental health and wellness promotion, and 5) positive youth development and resiliency promotion. The final fact sheets and promotional materials can be found here: http://dhss.alaska.gov/dph/wcfh/Pages/adolescent/default.aspx. These materials will be revised as needed.

SPM Strategy 2.3: Support implementation of the Alaska Safe Children's Act recommendations for age-appropriate model curricula and teacher training materials – Strategy retired

The Alaska Safe Children’s Act (also known as Erin’s and Bree’s Law) went into effect June 30, 2017. The

recommendations are related to suicide prevention training, sexual abuse and sexual assault awareness training and prevention, dating violence and abuse awareness training and prevention, and alcohol and drug related disabilities training and education.

- AS 14.30.355 (Erin's Law) requires that the governing body of each school district to adopt and implement a policy, establish a training program for employees and students, and provide parental notices relating to sexual abuse and sexual assault awareness and prevention for students enrolled in grades kindergarten through twelve.
- AS 14.30.356 (Bree's Law) requires that the governing body of each school district shall adopt and implement a policy, establish a training program for employees and students, and provide parental notices relating to dating violence and abuse in grades seven through twelve. A training program adopted under this section must emphasize prevention and awareness.

The WCFH Adolescent Health Program are key stakeholders and partners in these prevention activities, however, the Department of Education and Early Development has dedicated staff to provide technical assistance to school districts and teachers, dedicated funding to assist with training, and are charged with authoring statewide teen dating violence prevention curriculum. The WCFH Adolescent Health Program will continue to assist as needed, but it appropriate to let the Department of Education and Early Development take the lead on overseeing implementation.

ADOLESCENT HEALTH

PLAN FOR THE APPLICATION YEAR: OCT 2019- SEPT 2020

NPM 13: Percent of children, ages 1 to 17 years, who had a preventative dental visit in the last year.

NPM Strategy 13.1: (Revised) Distribute the Bright Futures Oral Health Pocket Guide to all providers who have the opportunity to promote children's oral health.

The Bright Futures Oral Health Pocket Guide is a resource for all health professionals (medical and dental) that discusses oral health and dental care for pregnant and post-partum women, infants, children and adolescents. The guide highlights the need for early dental visits (within 6 months of the eruption of the first tooth and no later than age 12 months) and aspects for subsequent dental visits, assessment of caries risk, education on factors to reduce risk of early childhood caries, appropriate oral health interview questions and anticipatory guidance/education at each stage for the above populations. The pocket guide information supports provider referral or provision of appropriate preventive dental services. The Child and Adolescent Health Program will still distribute this resource at all relevant conferences and meetings during the upcoming year. Nevertheless, we have determined that the related ESM on the number of guides distributed will be retired in preference of a new ESM related to oral health work into which we are putting greater effort, as well as work that likely has a higher impact on the NPM of children who had a preventative dental visit in the last year**.**

NPM Strategy 13.2: (Revised) Collaborate with Division of Health Care Services to increase preventative dental visits with children ages 1-20 enrolled in Medicaid program.

The Alaska EPSDT Coordinator from Medicaid will continue to participate in the Alaska Dental Action Coalition. In addition, the Title V Director and MCH Epidemiology Unit Manager will continue to participate on a Children's Core Set Workgroup with the EPSDT Coordinator and Medicaid Medical Director. This group meets on an ad hoc basis. The goals of the workgroup are to improve the number of children evaluated for Core Sets standards and improve the reporting of data to CMS related to Core Set standards. One of the Child Core Set measures is the percentage of eligibles who received preventive dental services.

NPM Strategy 13.3: Strategy retired in 2019, please see Report narrative

NPM Strategy 13.4: Develop a strategy with school nurses to examine opportunities for school nurses to connect students to oral health services.

School interventions were found to have moderate evidence for effectiveness in improving dental utilization in childhood (Johns Hopkins University, Aug 2017). The Title V funded School Health Nurse Consultant will continue to facilitate or coordinate trainings on oral health at the annual conference for school nurses. This will include how to perform oral health screenings, recognize dental emergencies and provide resources for low cost dental services for families. School nurses will be trained in how to encourage more children and families to seek dental primary homes and have regular dental visits. District nurse leaders will be encouraged to include on yearly health history forms whether a child has a dental home and date of last dental exam. We are adding this year a new ESM that will track the number of school nurses trained in oral health topics.

NPM Strategy 13.5: Continue to lead and facilitate the Alaska Dental Action Coalition (ADAC) quarterly meetings.

WCFH oral health staff will also continue to lead and facilitate the Alaska Dental Action Coalition. This group consists of several stakeholders such as private dentists, dental hygienists, federally qualified health centers, Medicaid, the Alaska Dental Society, the Alaska Primary Care Association, the Alaska Native Tribal Health Consortium, the Alaska Mental Health Trust, the Governor's Council on Disabilities and Special Education, and the Alaska University of Alaska-Anchorage. This is the only group in Alaska which takes a multidisciplinary approach to improving oral health in Alaska. The group last met in April 2019, and the next convening is scheduled for July 2019.

NPM Strategy 13.6: Strategy retired in 2019, please see Report narrative

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

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

The WCFH Adolescent Health Program will create Alaska-tailored toolkit for families who have students participating in the Fourth R healthy relationship curriculum at school. The goal of the toolkit is to provide practical and usable information, resources, and strategies related to health education that aligns with what a child is currently learning in class. WCFH Adolescent Health Program will seek to aim to produce one toolkit for 7th, 8th, and 9th grade.

SPM Strategy 2.2: Strategy retired in 2019, please see Report narrative.

SPM Strategy 2.3: Strategy retired in 2019, please see Report narrative.

SPM Strategy 2.4: (NEW) Support statewide training and dissemination of Coaching Boys into Men (CBIM).

The WCFH Adolescent Health Program will partner with the Alaska School Activities Association to implement a statewide training of trainers program for Alaska's athletic coaches. Coaching Boys into Men (CBIM) is an evidence-based prevention program that trains and motivates high school coaches to teach their young male athletes healthy relationship skills and that violence never equals strength. This comprehensive violence prevention curriculum for coaches and their athletes was developed by Futures without Violence. The curriculum provides high school athletic coaches with the resources they need to promote respectful behavior among their players and help prevent relationship abuse, harassment, and sexual assault. The curriculum consists of a series of coach-to-athlete trainings that illustrate ways to model respect and promote healthy relationships. The curriculum instructs coaches on how to incorporate themes associated with teamwork, integrity, fair play, and respect into their daily practice and routine. This is funded by CDC Rape Prevention Education dollars.

SPM 2.5 Strategy: (NEW) Maintain statewide dissemination of Teen Speak publications and Adolescent Focused Motivational Interviewing Skills training and resources for Supportive Adults, Parents, Caregivers and Clinicians.

Research shows Motivational Interviewing (MI) is one of the most effective behavior-change strategies with youth. In fact, MI has been shown to decrease substance use, reduce stress and risky sexual behaviors, improve eating habits, and increase exercise – and even to reduce injuries and hospitalizations! This initiative will utilize the highly rated book, online learning system and interactive workshops which equips parents, clinicians and supportive adults to use motivational interviewing strategies to improve their ability to identify risks, communicate effectively with youth, and motivate adolescents toward healthy decisions.

The Adolescent Health Program will continue utilizing the P4C online course specifically designed for clinicians that work with adolescent patients and the online training pieces for parents and supportive adults, in addition to seeking collaborations with the Department of Education and Early Development for an online teacher and supportive adult training. This work will be done in collaboration with Dr. Jennifer Salerno, founder of Possibilities for Change (P4C) and author of Teen Speak. Nearly 75% of serious injury and adolescent death is a result of preventable, risky behaviors. As some of the most trusted adults in an adolescent's life, the role of supportive adults helps to identify risky behaviors and save lives.

Children with Special Health Care Needs

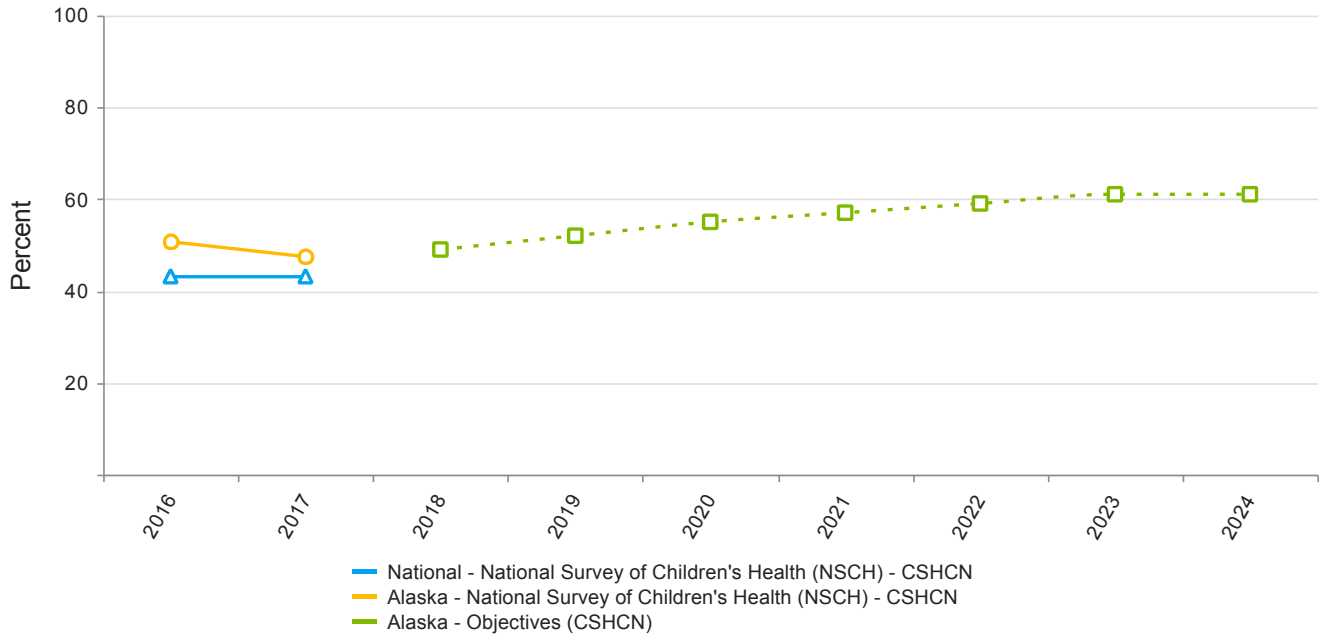
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2016_2017	19.1 %	NPM 11
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2016_2017	59.8 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	92.1 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year	NSCH-2016_2017	4.0 %	NPM 11

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - CSHCN			
	2016	**2017**	**2018**
Annual Objective			49
Annual Indicator		50.5	47.3
Numerator		15,088	14,959
Denominator		29,864	31,621
Data Source		NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	52.0	55.0	57.0	59.0	61.0	61.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		0.5	0.6
Annual Indicator	0	90.9	98.9
Numerator	0	10	366
Denominator	1	11	370
Data Source	Help Me Grow Alaska database	Help Me Grow Alaska database	Help Me Grow Alaska database
Data Source Year	NA	2018	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	99.0	99.0	99.0	99.0	99.0	99.0

State Action Plan Table

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

Priority Need

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

NPM

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Objectives

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

Strategies

NPM 11.1 Strategy retired 2018

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

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

NPM 11.4. Strategy retired 2019 (please see 5 year action report)

NPM 11.5 Partner with tribal health and UAA Center for Human Development to implement project ECHO related to autism and other developmental disabilities.

NPM 11.6 Improve the quality and availability of data related to the CYSHCN by collaborating with state, private and non-profit programs to remove barriers to data sharing and centralized data collection.

NPM 11.7 Partner with statewide agencies to provide Family Navigation services for families of CYSHCN and develop and implement Family Engagement training.

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

NPM 11.9 Strategy retired 2019

NPM 11.10 (NEW) Collect, analyze, and disseminate data relevant to Children and Youth with Special Health Care Needs through population-based surveillance systems included the Alaska Birth Defects Registry and Childhood Understanding Behaviors Survey.

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

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

CHILDREN & YOUTH WITH SPECIAL HEALTH CARE NEEDS

REPORT FOR THE APPLICATION YEAR: OCT 2017- SEPT 2018

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

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

We are retiring the strategy to increase CYSHCN access to cross-systems care coordination using the Shared Plan of Care concept and inactivating the associated ESM 11.1, which measured the percent of CYSHCN in pilot schools with a shared plan of care. This strategy and ESM focused on a pilot project aimed at improving care coordination for medically complex students. The project involved an Anchorage-Based Pediatrician's office and the Anchorage School District and attempted to give school nurses real-time access to student's electronic medical records from the pediatrician's office. Unfortunately technical and technology issues made sharing information between the medical provider and the school district difficult, and ultimately it was not possible to complete this project. However, as a result of efforts made to share medical information, the Anchorage School District has now incorporated into their beginning of the year paperwork a Release of Information form that parents can sign to give permission to release health information between medical providers and the school district.

When this strategy began, WCFH staff worked with the pediatrician's office and Anchorage School District using funding from the HRSA Systems Integration for CYSHCN grant. Since this federal grant ended, the School Nurse Consultant is now funded using the Title V Block Grant and the Shared Plan of Care concept will be incorporated into work being done around adolescent healthcare transition.

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

Experts agree that early detection and connection to services lead to the best outcomes for children with developmental and/or behavioral challenges. Help Me Grow Alaska (HMG AK), under the umbrella of the All Alaska Pediatric Partnership (AAPP), is a centralized call center system aimed at improving family access to existing resources and services for children ages 0 to 8. HMG AK also seeks to build collaboration across community agencies offering services to children and families in need.

HMG AK launched in January 2018, and was initially offered within the three place-based communities receiving funds through the Early Childhood Comprehensive Systems federal grant. Services offered include: a centralized access point, family and community outreach, child health provider outreach, and ongoing data collection and analysis. The centralized call center is staffed by thread, Alaska's Child Care Resource and Referral Network. The thread staff and care coordinators are trained in Strengthening Families, family navigation, motivational interviewing and other relevant techniques that help assess needs and build relationships. Care coordinators provide families with informational resources, opportunities to complete the Ages and Stages Questionnaire (ASQ) for developmental screening, and referrals to services using a warm handoff model. HMG AK has a website that includes a portal to an online ASQ for families and providers to use that is offered in both English and Spanish. The child health provider outreach training offered educates providers about HMG AK services, how to implement developmental screening in the clinic, and how to use developmental monitoring tools for parent education. Finally, data collection and analysis tools to identify gaps and barriers for using the HMG AK call system have been developed in an effort to continually improve services.

During 2018, 190 unique families in Alaska received services from HMG AK, and 370 individual family and/or provider contacts were made with the system. The families' needs were met in the vast majority of contacts (ESM 11.2). Through these contacts, care coordinators provided families with resources on parenting skills, child development, and community services and programs. Families were also given opportunities to complete developmental screening for their child, and referrals for services were provided as needed. Seventy-two children completed an ASQ, with over 400 resources provided to families to promote healthy development, while 20 children were referred for additional services.

Ongoing data collection and analysis of HMG AK was measured through satisfaction surveys sent to those who received services. Current survey results show families rated care coordinators highly in terms of professionalism,

politeness, communication, knowledge of the area of concern or question presented, ability to help with the concern or question, and follow-up. The resources and referrals received by the majority of families were found to be very helpful and almost all families reported their needs had been met from using the call center.

Title V funding helped to support an effort during the past year to measure awareness about HMG AK services among parents of young children across Alaska. We added a supplemental question to two surveillance surveys for mothers of young children that are coordinated out of the MCH Epidemiology Unit in WCFH. The first survey is the Alaska Pregnancy Risk Assessment Monitoring System (PRAMS) survey, sent to women recently delivered a live birth in Alaska. The second survey is the Alaska Childhood Understanding Behaviors Survey (CUBS), sent out to the same mothers when the child is three years of age. Survey responses are collected by phone and mail. The supplemental question added to the end of both surveys asked, “Before today, had you ever heard about Help Me Grow Alaska?” Mothers who responded to CUBS were more likely to have heard of HMG-AK than mothers who responded to PRAMS, with 11% of PRAMS respondents saying they were aware of HMG AK, and 14% of the CUBS mothers having heard of HMG AK. Mothers in the Mat-Su, Northern, and Gulf Coast regions, regions where the three ECCS pilot communities are located, were most likely to know of HMG AK, with almost one-fifth of surveyed mothers in Mat-Su saying they had heard of HMG AK. This question will again be asked on the CUBS survey in 2020 to measure changes as HMG continues to expand.

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

Alaska’s five year CYSHCN State Plan 2016-2021 is based on broad stakeholder input using the National Standards for CYSHCN as a framework. The state plan focuses on six of the ten National Standard domains for CYSHCN developed by AMCHP:

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

The CYSHCN State Plan continues to be periodically reviewed through engagement meetings with families and other CYSHCN stakeholders, to ensure strategies being developed continue to address the needs of the CYSHCN population.

Adolescent healthcare transition to adult care has been an identified need since the CYSHCN State Plan was developed. This past year WCFH hired a Public Health Specialist with experience working on adolescent healthcare within a hospital system. Since starting in April 2018, she has been working to increase awareness about the importance of a planned healthcare transition process for adolescents, while offering resources that will help track the process of adolescents moving towards independence with their healthcare. A range of resources from Got Transition and Healthy Transitions NY are being adapted for use in Alaska. In person presentations have been made to various medical providers, including 14 school nurses during their annual meeting and 20 participants who attended Pediatric Grand Rounds at Providence Hospital in Anchorage. Presentations have also been made to adolescents through educational sessions offered remotely to 17 special education students attending SERRC Alaska’s Educational Resource Center transition camps around State. In the coming year the potential exists to offer many more educational presentations to different professional groups who work with adolescents, as well as adolescents and families seeking resources to make transition a better planned process.

WCFH continues to provide access to care for some specialty clinics. The Metabolic Clinic in Anchorage and Fairbanks serves pediatric and adult patients and is managed by WCFH. Title V dollars continue to be given to Providence Pediatric Subspecialty Clinic in Anchorage, to pay for a genetic counselor.

NPM Strategy 11.4: Expand provider access to medical home concepts, training and tools through education and statewide technical assistance. - Strategy retired

Alaska’s distance delivered, university-based “Principles of Pediatric Care Coordination” continuing education course was adapted from the Boston Children’s Medical Center and MCHB’s “Care Coordination Curriculum” by Title V and the All Alaska Pediatric Partnership in 2014. The care coordination course was used as a foundational curriculum for Family Navigation training. Navigators are trained providers who work with clients/patients and their

families to connect them to resources and reduce barriers to quality care.

WCFH contracted with the University of Alaska – Center for Human Development so the Family Navigation Course could be integrated into the Pediatric Care Coordination course. By doing this, the Family Navigation Course has become sustainable and is supported in the University system. The first revised course is scheduled for June 2019. Since the goal of creating an educational tool for those wanting to become family navigators has been reached, this strategy is now being retired.

NPM Strategy 11.5: Partner with tribal health and UAA Center for Human Development to implement Project ECHO related to autism and other developmental disabilities. Contract with the University of Massachusetts to develop an online curriculum to train primary care providers to diagnose children at high risk for autism and/or ADHD.

Project ECHO: WCFH continues to partner with UAA Center for Human Development (CHD), tribal health, and physicians to hold project ECHO (Extension for Community Healthcare Outcomes) trainings in Alaska. CHD is Alaska's University Center for Excellence in Developmental Disabilities (UCEDD) in Education, Research, and Service. For training to be accessible to those interested throughout Alaska, the Zoom platform is used to provide remote communication and Box is used for document sharing. This technology also ensures that each ECHO is able to have a didactic presentation and discussion between the hub team and members of the spokes.

Over the past year there were three Project ECHO focus areas: Neurodevelopmental; Applied Behavioral Analysis (ABA); and a Family ECHO. The first Project ECHO in Alaska focused on autism and has since expanded to be the Neurodevelopmental ECHO due to the desires of the learning community. There are two ABA Project ECHOs, one for Board Certified Behavior Analysts (BCBA) and one for Registered Behavior Technicians (RBT). The success of the ABA Project ECHOs has led to them becoming part of the professional training and education offered by the Capacity Building for Autism Interventions to undergraduate and graduate-level students pursuing Board Certification in Behavior Analysis. The newest addition to Project ECHO is the Family ECHO. This ECHO focuses on difficult behaviors experienced by individuals, primarily children, and their families. Discussion focuses on the management of difficult situations and offers the opportunity to share cases and resources, as well as come to collaborative agreement for recommendations. Members of the group include field experts, family members of individuals with challenging behavior, John Cartwright (the WCFH Family Engagement Lead), a speech therapist, occupational therapist, BCBAs, an early hearing detection and intervention program staff member. This work is supported by State mental health dollars.

Autism Curriculum: WCFH worked with the University of Massachusetts Medical School and their collaborating partners to develop and implement a curriculum for online competency-based training modules for primary care providers in Alaska. The goal of the training was to improve provider skills in understanding how to provide a 'certifiable' diagnoses for patients who qualified, so patients could receive treatment and support services through the state. This was done by developing clinical providers' skills for completing a diagnostic work up for neurodevelopmental disorders such as ASD and ADHD, in collaboration with other team members. In 2017, four Alaska primary care providers participated in piloting the 8 module sessions. Unfortunately, the time commitment needed for providers to complete the training was found to be a barrier. Additionally it was also difficult to adapt the UMass curriculum in Alaska due to technological issues, so the trainings have been discontinued. The goal is to integrate the content of the course into the Autism Project ECHO didactic component in the future.

To fill the gap left without the UMass curriculum, a partnership between UAA CHD and Vanderbilt University was developed to facilitate STAT-MD training in Alaska for diagnostic skills. A one and a half day live and distance delivered training was offered, teaching medical and early intervention enhanced diagnostic consultation and screening procedures for young children aged 18-36 months. Staff from Vanderbilt University traveled to Alaska to facilitate the training, which was attended by 23 participants from multiple professional disciplines. The STAT-MD trainers followed up with post-workshop surveys and found the training was so successful, a second training is being planned. This was supported by State mental health dollars.

Autism Clinic: WCFH used Block Grant funding to contract with the Seattle Children's Hospital and Medical Center and the University of Virginia Children's Hospital for Pediatric Neurodevelopmental Specialists (PDNS) to travel with the Neurodevelopmental Outreach Clinics to rural areas of Alaska. During the State Fiscal Year 2019, five communities were served by the autism clinic and 56 patients were seen. Ninety-five percent of patients scheduled attended, with five percent canceling due to weather or illness. Patients and their families received recommendations and resources relating to ADHD, cognitive impairment, trauma, or Fetal Alcohol Spectrum Disorder. Twenty-five percent of all patients seen received an autism diagnosis.

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

Title V epidemiologists supported CYSHCN program staff in identifying data sources and conducting ongoing monitoring and quality improvement initiatives related to CYSHCN. The Childhood Understanding Behaviors Survey (CUBS) collected population-based data from mothers of Alaskan 3-year-olds, including self-reported data on having a medical home, well-child checks in the previous year, problems getting health care for their child when he or she was sick, and four questions to screen for special health care needs of the child. Although CUBS had planned to revise the survey in 2018, the revision has been put off until fall 2019 due to the construction of a new database to house and manage CUBS operational and survey data. All CUBS data through 2017, including all questions related to CYSHCN, are currently available online where they can be searched within the custom query module of AK-IBIS.

Although Title V and Medicaid had previously discussed over many years a vision to leverage state and federal CHIP funds through one or more Health Services Initiatives to improve child and maternal health, these discussions have ended for the foreseeable future due to staff and other changes within the Medicaid program, including the retirement of the long-time CHIP Director in April 2019.

The Alaska Birth Defects Registry (ABDR) is statutorily mandated (Alaska Administrative Code 7 AAC 27.012) to collect and maintain a registry of all listed birth defects that occur in Alaska. Title V funding supports the ABDR and those working on the registry. In 2018, staffing within WCFH for the ABDR was reorganized and an Epidemiology Specialist II was hired as the ABDR manager and lead epidemiologist of the program. A Health Program Associate and one Research Analyst also support the work of the registry, while the whole ABDR team is supervised by the Senior Epidemiologist of the MCH Epidemiology Unit.

Over the past year the ABDR update of state regulation was completed. The recent update means: 1) health insurers and diagnostic laboratories that collect, or maintain health care records related to screening and/or diagnoses are now required to report to ABDR; 2) new data elements have been added to the requested report (mother's first and last name and date of birth) to facilitate linkage with the birth record; 3) reporting age at time of service has been lowered, from less than six years to less than age three years, to improve timeliness of ABDR data and reports; and 4) to reduce reporting burden, agencies are now required to report to the registry semi-annually rather than monthly. These regulatory updates aim to improve the accuracy and timeliness of the data in the registry. Onboarding of these new reporting agencies through health insurers and laboratories, is ongoing, but ABDR has already seen improvement in reporting.

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

Title V Block grant funds continue to support contracted Parent (Family) Navigation through Stone Soup Group. Parent (Family) Navigation services were offered in the Neurodevelopmental and Cleft, Lip and Palate Pediatric Specialty Clinics. In 2018, 127 families received Family Navigation Services at the Cleft, Lip and Palate Clinic. While the Early Hearing Detection and Intervention (EHDI) program continued to partner with Stone Soup Group to provide family navigation for families with a child who diagnosed with a hearing loss. Thirteen families received parent navigation services in 2018. Meetings between WCFH and Stone Soup Group were scheduled quarterly to review outreach to EHDI families and to identify what is going well and where opportunities and challenges exist to improve outreach.

In 2018, to ensure ongoing family engagement in identifying needs, the EHDI program contracted with Alaska's University Center of Excellence (USED), the UAA Center for Human Development (CHD) to conduct family surveys. Surveys conducted in 2018-2019, aimed to identify barriers to timely diagnosis and Early Intervention (EI) enrollment. The family surveys were conducted by parents of children who are deaf or hard of hearing. The goal of the surveys was to identify barriers that prevented families from accessing services. Ninety-five families were eligible to receive the survey, with forty-one families responding. Of this number, only four families had a child with a diagnosed hearing loss and none of the families chose to enroll in EI services. Due to the small number of families responding and the fact that none of them enrolled in EI, it was not possible to determine the current practices found to be supportive for families following up with services nor parent perceptions of support services offered. It has since been decided that for next year the type of families surveyed will be expanded. This project was paid for by HRSA newborn hearing screening dollars.

NPM Strategy 11.8: Partner with audiologist and Early Intervention to increase referrals and enrollment by

6 months of age for children diagnosed with a hearing loss.

In 2018, EHDI planned to begin referring all children identified at risk for hearing loss, not just those with a diagnosed hearing loss, to the EHDI Family Navigator and Audiologists. However, due to previous Audiology contracts, this plan has been delayed and will now begin during State Fiscal Year 2020. Despite this delay, outreach between EDHI staff and audiologists continued in 2018. Referrals were made to audiologists whenever they indicated in the statewide reporting database no referral had been made to EI for a child identified with hearing loss.

The EDHI Advisory Committee met regularly with Early Intervention staff members, ILP, EDHI grantees, and audiologists to discuss how to increase referrals and enrollment by 6 months of age for children with diagnosed hearing loss. Data sharing between EI/ILP and the EHDI program also occurred on a regular basis. While EI/ILP having a representative on the EHDI Advisory Committee also allowed for communication about EI/ILP program goals and priorities for the EDHI population.

During 2018, EHDI family leaders and program staff presented on EHDI to numerous groups in Alaska. The EHDI program maintained an agreement with Early Intervention for EHDI program staff and/or parent leaders to present to Early Intervention providers at in person or webinar meetings twice a year. A parent panel from EHDI family leaders group and the EHDI program manager presented to the 2018 Alaska Association for the Education of Young Children (AEYC) conference. The presentation provided information about the EHDI referral process, while three parents spoke on the three different communication options their children with hearing loss use. Parents discussed why they chose the modality their child used and answered audience questions that arose. Parents discussed the use of ASL alone, the use of Listen Spoken Language alone, and a blend of both ASL and Listen Spoken Language.

The EDHI program manager also gave two presentations at the national EDHI conference in 2019, in Chicago. The presentations entitled ‘Expanding tele-audiology services in Rural Alaska: An EDHI state-funded pilot program’, focused on lessons learned from how Alaska offers audiology services when, due to a lack of pediatric audiologists in Alaska, several regions do not have a resident audiologist. This telehealth pilot program showed that it was possible to reduce delays in screening and diagnosis for much of rural Alaska, because families who may be resistant to travelling for care for a variety of reasons found face-to-face consultations to improve communication and understanding of the reason for a child to receive follow up services. The program was started in 2017, when the Alaska EHDI program partnered the Norton Sound Health Corporation (NSHC), a tribal health partner, to expand the existing telehealth practice at NSHC to include tele-audiology capabilities in six of their remote locations. NSHC serves 15 communities with populations ranging from 150 to 750 residents located within 44,000 square miles (roughly the size of Kentucky). The equipment was first placed in several remote communities served by NSHC and when the initial results of the project showed promise, NSHC has now expanded to include seven more communities.

NPM Strategy 11.9: Update the Oral Health Dental Guide for Families with CYSHCN. - Strategy retired

The “Children’s Oral Health Information Packet” was updated during the past year and was distributed by our partners, the Stone Soup Group. This guide was designed for parents and caregivers of CYSHCN and provides Alaska-specific information. The packet offered tips, tricks, and information about special tools that can be used to assist in the oral health care of CYSHCN. This project was completed in 2018. Therefore at this time, this strategy has been retired.

CHILDREN & YOUTH WITH SPECIAL HEALTH CARE NEEDS

PLAN FOR THE APPLICATION YEAR: OCT 2019- SEPT 2020

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

Strategy 11.1: Strategy retired 2018 – please see 5YAP Report.

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

WCFH will continue to partner with the All Alaska Pediatric Partnership and Help Me Grow Alaska. The plan in the coming year is to adapt a marketing strategy to promote Help Me Grow Alaska, a centralized call center that offers shared medical and provider resources for families and primary care providers. The call center began in the three ECCS placed-based communities and has been expanded statewide. The plan to offer services throughout Alaska also includes hiring a full time outreach coordinator and full-time resource manager.

The CYSHCN Program Manager will begin participating in advisory committee meetings for the new Alaska Partnership Access Line. The Partnership Access Line-Pediatric Alaska (PAL-PAK) is a new partnership between Division of Behavioral Health and Seattle Children's Hospital PAL line, which is also supported by the Mental Health Trust and All Alaska Pediatric Partnership. PAL-PAK aims to offer prescribing pediatric care providers in Alaska support when they have questions about child and adolescent mental healthcare. Assistance offered will include diagnostic clarification, medication adjustment and treatment planning. This initiative is in direct response to the lack of psychiatrists available in Alaska to treat pediatric patients with mental health needs. If non-prescribing providers call for assistance, they will be directed to HMG-AK for assistance.

NPM Strategy 11.3: (Revised) Implement the state CYSHCN priority for transition to adult care.

This strategy includes work to identify resources for adolescents to develop independence skills to manage healthcare needs and for transition to adult care, develop partnerships with those working with adolescents, and increase education about healthcare transition for adolescents, their caregivers, and medical and community providers.

The CYSHCN Program Manager plans to increase awareness about the importance for a planned adolescent healthcare transition process through presentations to special educators and healthcare professionals at state conferences over the coming year. Technical assistance is planned for some individual medical practices, school nurses, school-based clinics, public health nurses, and community agencies working with adolescents, to improve knowledge about how to offer effective healthcare transition services. Resources and tools specific for Alaska are also being created and will be shared with adolescents, families, and providers. The CYSHCN Program Manager will coordinate some of this work in partnership with the WCFH School Nurse Consultant, who is working to improve communication of medical information between school nurses and medical providers outside the school system. Finally opportunities will be explored to offer education and resource tools for planned healthcare transition to providers and adolescents in the foster care system. This will be supported with Block Grant funds.

NPM Strategy 11.4: Strategy retired 2019 - please see 5YAP Report.

NPM Strategy 11.5: (Revised) Partner with tribal health and UAA Center for Human Development to implement Project ECHOs on topics that include neurodevelopmental and behavioral health needs of children.

WCFH will continue to partner with UAA Center for Human Development (CHD), tribal health, and physicians to hold Project ECHO (Extension for Community Healthcare Outcomes) trainings in Alaska. WCFH will continue to partner with UAA CHD to facilitate the Neurodevelopmental ECHO and the newly developed Behavior Intervention for Early Childhood ECHO. The Neurodevelopmental ECHO will continue to ask subject matter experts to present and discuss case studies related to neurodevelopmental topics. This ECHO will include advanced nurse practitioner, a licensed clinical social worker, child neuropsychologist, a developmental pediatrician, and a parent advocate. The Behavior Intervention for Early Childhood ECHO is planned to start in the fall of 2019 and will have a behavior and mental health focus. It will bring a multidisciplinary team of childcare providers and preschool providers together to discuss behavior challenges as well as help providers incorporate evidence-based practices into their own early

intervention strategies.

NPM Strategy 11.6: (Revised) Improve the quality and availability of data related to CYSHCN by collaborating with state, private and non-profit programs to remove barriers to data sharing and centralized data collection.

The Alaska Birth Defect Registry (ABDR) will continue to meet with the Early Hearing Detection and Intervention (EHDI) program to arrange regularly scheduled data sharing. The data shared will provide the EHDI program with information that will allow them to identify children with a hearing loss but who have not been reported to EHDI. We anticipate that reporting may not be completed through the online reporting database either due to an error in the system or the reporting facility is located out of state. During the upcoming year, it is expected that this newly developed match process will allow the EHDI program the ability to offer follow-up, parent navigation, and early intervention services to families of children with a hearing loss who are identified through the data sharing.

During June 2019, the MCH Epidemiology Unit worked with a Masters in Biostatistics student who analyzed Alaska CYCHSN data from the National Survey of Child Health. During the upcoming months, we will use her analyses to update the Alaska Children with Special Health Care Needs Fact Sheet that is currently on the CYSHCN program website and was last updated in March 2017.

In conjunction with a variety of early childhood needs assessment and strategic planning efforts, we will continue to participate in coordinated discussions about data sharing and centralized data collection related to the early childhood population. These efforts are in the early stages in 2019 and will continue over the next couple of years.

NPM Strategy 11.7: (Revised) Partner with statewide agencies to provide Family Navigation services for families of CYSHCN and develop and implement Family Engagement training.

The EHDI program has partnered with Stone Soup Group to provide family navigation to families with a child who is diagnosed with a hearing loss. In 2019/2020, the partnership agreement is being expanded so family navigation and outreach will now also be offered to all families of children at-risk of hearing loss after failing their newborn hearing screening. An EHDI parent task group will review SSG resources and scripts to assure the materials are up to date and complete for this new activity.

Family surveys, which began in 2018-2019, will continue in 2019-2020, through an ongoing contract between the EHDI program and the Alaska's University Center of Excellence (USED), the UAA Center for Human Development (CHD). The family surveys will be conducted by parents of children who are deaf or hard of hearing and analyzed by UAA CHD once complete. The families surveys will be expanded to include all families' with infants identified as at-risk for a hearing loss, those referred and awaiting a diagnostic assessment, and infants diagnosed with hearing loss, who have not enrolled in Early Intervention (EI). It is hoped through the surveys to identify: barriers to timely diagnosis and EI enrollment; the effectiveness of tools and resources used by parents to complete follow up recommendations and; parent perceptions of support services offered and where improvements can to be made.

The new EHDI Shared Plan of Care tool will be offered this year by the Family Navigator to families identified as having a child at-risk for hearing loss. The tool aims to help families centralize information about their child's medical needs, as well as determine the types of services needed and how to access them. This tool will be available to families in both paper and electronic form. Throughout the year, Family Navigators collect information to identify how best to share this tool with families in need and how effective the tool is in helping families organize medical information and access care.

In 2019, DEED and WCFH are partnering to offer Family Engagement training, using funds from Alaska's Preschool Development Grant. The WCFH Family Engagement Lead is developing the training and will recruit family members and caregivers to participate. The training will promote parent engagement and seeks to increase parent's confidence in advocating for their children. There will be 20 learning modules, each lasting 15 minutes. The training will be offered online through ZOOM, so participants can complete the course at their own pace. In 2020, UAA CHD will also partner with this project to offer participating parents an honorarium, in an effort to make the training accessible for all interested parents.

Family navigation services are also offered at the pediatric specialty clinics and encouraged to be used. The contracts for navigation services are funded in part with Title V funds. WCFH continues to fund parent navigation services for families of children with suspected or diagnosed hearing loss, cleft lip/palate disorders, and autism/neurodevelopmental conditions. The Title V CYSHCN programs meet on a quarterly basis with the parent

navigation grantee.

NPM Strategy 11.8: Partner with audiologists and Early Intervention to increase referrals and enrollment by 6 months of age for children diagnosed with a hearing loss.

In 2019-2020, the Family Navigator and Early Interventionists will receive referrals for all children identified at-risk for a hearing loss, not just after receiving a hearing loss diagnosis. Changing when families are referred for assistance will enable more families to receive help navigating barriers that make it challenging for children to receive an audiology diagnosis and subsequently enroll with EI/ILP. It is also hoped this change in the referral process will increase utilization of a medical home for children with hearing loss.

The new EDHI Shared Plan of Care will be offered to families with children who are identified as having a hearing loss. A quality improvement project is planned to see how best to disseminate the new EHDI Shared Plan of Care. Two hospitals and two early education providers will offer this tool to families of children at-risk for hearing loss, to determine how best to share the tool and also how effective the tool is in providing families assistance as they seek services for their children.

The EHDI program staff and parent leaders will continue to offer presentations twice a year to Early Intervention programs through in-person or webinar meetings. The EHDI Advisory Committee, which includes Early Intervention staff and EDHI grantees along with audiologists and EDHI staff and parents, will continue to focus on pediatric audiology services in Alaska and facilitating communication through quality improvement projects, to increase referrals and enrollment by 6 months of age for children with diagnosed hearing loss.

NPM Strategy 11.9: Strategy retired 2019 – please see 5YAP Report.

NPM Strategy 11.10: (NEW) Collect, analyze, and disseminate data relevant to Children and Youth with Special Health Care Needs (CYSHCN) through population-based surveillance systems including the Alaska Birth Defects Registry and Childhood Understanding Behaviors Survey (CUBS).

The Alaska Birth Defects Registry (ABDR) data are used to estimate the prevalence and trends of defects as well as provide data on the allocation of services for CYSHCN resulting from birth defects. ABDR plans to continue to onboard the new reporting agencies outlined in its updated state regulation. Since hiring a dedicated Epidemiologist and Program Manager, we now have the capacity to update and publish comprehensive reports on all 47 nationally reportable conditions on the ABDR website. We also are planning to publish a report about ABDR's unique methodology for data collection in a peer review journal with the hope of garnering feedback that can be used to further refine prevalence estimates. All ABDR staff are partially or fully funded by Title V.

The CUBS survey will continue to collect information on early childhood health and development and use of health care services from mothers of 3-year-olds. During the upcoming year, CUBS will continue to work with IT programmers to develop a new database to house and manage CUBS operational and survey data so that the program can be more efficient and responsive to data requests. During fall 2019, the CUBS survey questions will be revised with plans to roll out the Phase VI survey instrument in 2020. CYSHCN program staff and external partners will be an integral part of the survey revision process and will be invited to participate in polling and ranking of topics via email as well as Steering Committee meetings and one-on-one discussions to talk about data needs related to young children with special health care needs. Updated CUBS data will also be included along with National Survey of Child Health data on the CYSHCN Fact Sheet previously mentioned, which will be revised in 2019.

NPM Strategy 11.10: (NEW) Support pediatric clinics to provide gap-filling services for children statewide

Title V Block Grant funding is used to administer two gap-filling clinics for Alaska. Federal Title V funding supports the metabolic clinic physician, dietician, and other supporting costs such as transcription, while state general fund-mental health dollars are used to fund the autism clinic.

Metabolic physician and dietician services will continue to be offered three times a year in person, at clinics in Anchorage and Fairbanks. Clinics are offered in February, June, and October, with patients being seen over two days in Anchorage and one day in Fairbanks. Pediatric and adult patients are served in this clinic, with many pediatric patients referred for services after having an abnormal result from the newborn bloodspot screen. During the rest of the year metabolic consultation services are offered remotely to patients, families, and medical providers, by the same physician consultant and dietician. A Program Manager and Office Assistant in WCFH are the main point of contact for physician and dietician services and help coordinate with providers and patients when prescriptions and formulas need ordering, and also contact health insurance companies to discuss coverage and

eligibility for specific treatments.

There are three pediatric autism diagnostic centers in Alaska and all are located in the Anchorage and Mat-Su area with one center only serving tribal beneficiaries. In the past, when rural Alaskan patients needed pediatric autism diagnostic services, they had to travel to receive services that were only available in Anchorage or outside of Alaska. To address this challenge, WCFH will continue to contract with the Seattle Children's Hospital and Medical Center and the University of Virginia Children's Hospital for Pediatric Neurodevelopmental Specialists (PDNS) to travel with the Neurodevelopmental Outreach Clinics to rural areas of Alaska. The PDNS will work alongside a clinic coordinator (LCSW) and a Title V Block Grant funded Parent (Family) Navigator. Children from 12 months to 12 years old, and their families, are served in these clinics, which offer screenings, evaluations, diagnoses, follow up referrals, and recommendations for treatment, care, early intervention, and education. All of the outreach clinics are scheduled during times of the year that are convenient to family traditions such as fish camp, hunting and school schedules. To assure that families are an active part of the team in decision making, family navigation services are offered at the clinics and encouraged to be used.

The PNDS and a Neurodevelopment Partners Group, facilitated by UAA CHD and WCFH, are developing a new Multi-tiered Autism Diagnostic Process to streamline how to determine where and how to treat children with an unambiguous neurodevelopmental diagnosis.

Cross-Cutting/Systems Building

Cross-Cutting/Systems Builiding - Annual Report

No content was entered for the Cross-Cutting/Systems Building - Annual Report in the State Action Plan Narrative by Domain section.

Cross-Cutting/Systems Building - Application Year

No content was entered for the Cross-Cutting/Systems Building - Application in the State Action Plan Narrative by Domain section.

III.F. Public Input

WCFH, the Title V agency, relies on on-going, continuous engagement with stakeholders for meaningful public participation. WCFH works with and sponsors numerous advisory committees composed of health care providers, parents, consumers, coalition members, and public health staff from across Alaska. They meet on a regular basis, usually once per quarter, to provide input on program's needs, assess quality, and provide ideas for future directions. In addition, all the agencies within the Department of Health and Social Services who offer MCH services, including WCFH and Title V specifically, 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.

Public comment was collected through an online survey created in Survey Monkey, as well as through direct email communication with the Title V Block Grant Coordinator. We created an Alaska Snapshot of Title V that was adapted from the AMCHP state profile combined with our five year action plan to highlight Alaska's Title V efforts to address our identified priority needs. This Snapshot was disseminated via direct emails to all of our partners and advisory committee members as well as by DHSS Facebook and Twitter posts to solicit public comment. A link to the Alaska Title V webpage was provided, where commenters could access prior applications and state and national performance measure narratives (http://dhss.alaska.gov/dph/wcfh/Pages/titlev/default.aspx). As well, the Alaska Division of Public Health GovDelivery system was used to send the solicitation for public input to the following distribution lists (5,897 total recipients):

- AK Public Health Alert network
- Healthy Alaskans
- Public Health Announcements
- Chronic Disease Prevention and Health Promotion Announcements
- Perinatal News

The email containing the Alaska Title V Snapshot and survey link was distributed by WCFH staff to members of the following groups:

- Alaska's Early Childhood Coordinating Council
- Alaska Perinatal Quality Collaborative
- Children and Youth with Special Healthcare Needs Advisory Committee
- Governor's Council on Disabilities and Special Education (and GCDSE Facebook)
- Maternal Child Death Review Advisory Committee
- Newborn Metabolic Screening Advisory Committee
- Early Hearing Detection & Intervention (EHDI) Advisory Committee
- Posted to "Alaska Parents of Children with Special Health Care Needs" Facebook group (1,350 parents)

During June 2019, there were 30 respondents who provided public comment either directly via email or through SurveyMonkey. A summary of the comment themes for MCH areas our Title V agency should focus on and relevant direct quotes of comments were shared with the WCFH Program Managers and are summarized below.

Women's Health themes	Example Quote:
Mental Health – anxiety/depression Substance use/alcohol use Access to behavioral health treatment, not enough providers in Alaska Trauma and resiliency	"The existing strategies appear to remain useful in increasing access to reproductive health services. It is vital to ensure access to care, and engaging strategic partnerships like the Division of Behavioral Health in screening for mental or behavioral health issues such as anxiety, depression or substance use disorders. We are supportive of the newly added strategy focusing on engaging hospitals and birthing facilities in data driven quality improvement to reduce maternal morbidity."

Infant Health themes	Example Quotes:
Implement Plans of Safe Care Confirmation of alcohol exposure in hospitals for FASD diagnosis Lactation support and paid maternity leave policies Prenatal substance use Access to programs that treat perinatal/postpartum depression	"Embracing a model of universal screening that would include alcohol/drug related questions for all infants and youth is recommended" "Lactation support and encouragement in crucial to enhancing lifelong health of the infant. Recommendations to implement paid maternity leave should be mentioned at any opportunity if we can hope to change policy around maternity leave."

Child Health themes	Example Quote:
Trauma/ACES Support child development screening Housing instability's negative effect on child health	"Addressing access to preventative care, and addressing trauma and adverse childhood experiences is vital. We support the newly added strategy focused on increasing the number of children receiving developmental screenings as part of a universal screening strategy. The strategies appear to be supporting the elimination of systems of care siloes as it relates to data – especially with public health and behavioral health – improved data in this area is vital!"

Adolescent Health themes	Example Quote:
Interpersonal violence programming Suicide prevention School based behavioral health services	"Allow Medicaid billing of onsite mild to moderate behavioral health services in schools as accessible and preventable care toward more severe and costly services. These services would address a gap in mental health care services and is an early intervention for students prior to potential escalation of more severe behaviors."

CYSHCN Health themes	Example Quote:
Consider data driven decision making for program development based on prevalence of condition Focus on transitional youth in health care with FASD Recruitment of specialty providers	"Currently there is a lack of coordinated or integrated care for youth with special health care needs. Where possible, it is recommended that strategies focus on collaborations with other systems such as the behavioral health system."

III.G. Technical Assistance

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

- Support for the convening of our annual Perinatal Quality Collaborative meeting to be held in January 2020. This will be our first annual meeting following the launch of the PQC in 2019. The meeting is being planned by the PQC Steering Committee which consists of perinatal health providers, hospital association representatives, and other key stakeholders.
- Training on querying and analyzing Medicaid claims data for MCH surveillance and evaluation. This is an ongoing need for the MCH Epidemiology Unit as Medicaid data becomes more critical to understanding needs of women and children in the state, especially because our hospital discharge data is limited by not including identifiers so it can't be linked to birth certificates.
- Funding to support a speaker or trainer to address maternal mortality issues at the MCDR maternal review meeting in September 2019 or at the PQC annual meeting in January 2020.
- Support for a local expert to conduct vicarious trauma training for the Maternal Child Death Review Team.

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

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Medicaid_MOU.pdf

V. Supporting Documents

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

Supporting Document #01 - WCFH Strategic Plan One Pager.pdf

Supporting Document #02 - 2019PublicInputAKSnapshot.pdf

Supporting Document #03 - WCFHProgramDescriptions.pdf

Supporting Document #04 - MCH Epi publications.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - Combined.Org.Chart.2019.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Alaska

	FY 20 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 1,078,526	
A. Preventive and Primary Care for Children	$ 323,558	(30%)
B. Children with Special Health Care Needs	$ 323,558	(30%)
C. Title V Administrative Costs	$ 107,852	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 754,968	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 9,500,000	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 26,000	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 9,526,000	
A. Your State's FY 1989 Maintenance of Effort Amount $ 4,471,700		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 10,604,526	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 6,745,094	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 17,349,620	

OTHER FEDERAL FUNDS	FY 20 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 150,000
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) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 2,204,831
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 157,500
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 240,916
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Unexpected Infant Death (SUID) Case Registry Program	$ 33,600
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 1,952,247
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 580,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$ 426,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health	$ 400,000

	FY 18 Annual Report Budgeted		FY 18 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 1,051,157		$ 1,051,157	
A. Preventive and Primary Care for Children	$ 315,592	(30%)	$ 315,600	(30%)
B. Children with Special Health Care Needs	$ 346,881	(33%)	$ 388,928	(36.9%)
C. Title V Administrative Costs	$ 105,100	(10%)	$ 105,100	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 767,573		$ 809,628	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 11,490,000		$ 10,080,107	
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)	$ 0		$ 25,965	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 11,490,000		$ 10,106,072	
A. Your State's FY 1989 Maintenance of Effort Amount $ 4,471,700				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 12,541,157		$ 11,157,229	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 6,240,749		$ 6,240,749	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 18,781,906		$ 17,397,978	

OTHER FEDERAL FUNDS	FY 18 Annual Report Budgeted	FY 18 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 250,000	$ 250,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 159,308	$ 159,308
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 2,136,924	$ 2,136,924
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 175,000	$ 175,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 339,535	$ 339,535
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	$ 249,447	$ 249,447
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Unexpected Infant Death (SUID) Case Registry Program	$ 32,320	$ 32,320
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 1,703,815	$ 1,703,815
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Implementation Grants for Systems of Services for CYSHCN	$ 250,000	$ 250,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 100,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 299,400	$ 299,400
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 545,000	$ 545,000

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: These figures are based on current expenditures and projections for the remainder of the year. At the time of submission, we have not fully expended the grant.	
2.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: More expenditures were charged to this category than originally budgeted. The requirement of at least 30% was met. These figures are based on current expenditures and projections for the remainder of the year. At the time of submission, we have not fully expended the grant.	
3.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: These figures are based on current expenditures and projections for the remainder of the year. At the time of submission, we have not fully expended the grant.	
4.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: The State match has again decreased. The State of Alaska continues to experience decrements to State General Funds.	
5.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Program income was greater than anticipated. The same amount of clinics occurred; however, it appears we were more successful in collecting revenue from insurance and Medicaid.	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Alaska

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Pregnant Women	$ 145,601	$ 98,590
2. Infants < 1 year	$ 177,957	$ 142,939
3. Children 1 through 21 Years	$ 323,558	$ 315,600
4. CSHCN	$ 323,558	$ 388,928
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 970,674	$ 946,057

IB. Non-Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Pregnant Women	$ 600,000	$ 661,644
2. Infants < 1 year	$ 1,000,000	$ 1,156,313
3. Children 1 through 21 Years	$ 1,100,000	$ 1,107,117
4. CSHCN	$ 5,800,000	$ 5,947,829
5. All Others	$ 1,000,000	$ 1,207,204
Non-Federal Total of Individuals Served	$ 9,500,000	$ 10,080,107
Federal State MCH Block Grant Partnership Total	$ 10,470,674	$ 11,026,164

Form Notes for Form 3a:

Federal Total does not include admin costs.

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Alaska

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 269,632	$ 262,789
3. Public Health Services and Systems	$ 808,894	$ 788,368
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Federal Total	$ 1,078,526	$ 1,051,157

IIB. Non-Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 7,125,000	$ 7,599,269
3. Public Health Services and Systems	$ 2,375,000	$ 2,480,838
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Non-Federal Total	$ 9,500,000	$ 10,080,107

Form Notes for Form 3b:

Federal Total includes admin costs. Federal funds for enabling services are used for clinics for children over age 1, not for pregnant women or infants.

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Alaska

Total Births by Occurrence: 9,964 **Data Source Year: 2018**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Screen	(B) Aggregate Total Number Presumptive Positive Screens	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	9,882 (99.2%)	455	15	15 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Holocarboxylase Synthase Deficiency	Homocystinuria
Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Methylmalonic Acidemia (Cobalamin Disorders)
Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type 1	Primary Congenital Hypothyroidism	Propionic Acidemia	S, ßeta-Thalassemia
S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency
Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy		

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

The state of Alaska NBMS program follows infants from screening to diagnosis, and then referral to treatment. The program captures a treatment start date if applicable for certain disorders. The program does not do long term follow up, although WCFH manages metabolic clinic for all children in the state with a metabolic disorder, including those identified by newborn screening.

Form Notes for Form 4:

Alaska changed NBS labs on 7/1/2018, resulting in some different methodology of reporting abnormal results. Old lab did not report metabolic abnormals by condition (i.e. just by amino acid or fatty acid). New lab does report by disorder, with the only general abnormal being for infants on TPN. Carnitine palmitoyltransferase type I Arctic variant (CPT1A) is a secondary RUSP condition. In Alaska, the CPT1A Arctic Variant is very common but difficult to detect using tandem mass spectrometry. All infants are screened for homozygosity for the CPT1A Arctic Variant by DNA. Infants who also had an elevation in their fatty acid oxidation reflective of Arctic Variant are not included in the total FAO & OA presumptive positive screens. Abnormal results for amino acids, fatty acid oxidations disoders and organic acidemias are not separated out by disorder unless confirmatory diagnosis is made. The CCHD program did not receive reports from all facilities in Alaska during this reporting period. Alaska does not collect confirmed cases for CCHD, only infants screened, infants with abnormal screens, and infants not screened because of caregiver refusal or facility error.The form includes 4 categories for aggregate data from facilities: total live births, total screened normal, total screened abnormal, and total refusal.

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2018**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: There is a difference between Total Number of Births in Form 4 and Form 5 and 6 due to two different data sources. Form 4 and Form 6 only include deliveries that occurred in Alaska based on birth certificate data. Form 5 number of infants is based on population data from the Alaska Department of Labor.	
2.	**Field Name:**	**Data Source Year**
	Fiscal Year:	**2018**
	Column Name:	**Data Source Year Notes**
	Field Note: Total birth by occurrence in Alaska regardless of residency from January 1 - December 31, 2018.	
3.	**Field Name:**	**Core RUSP Conditions - Receiving At Least One Screen**
	Fiscal Year:	**2018**
	Column Name:	**Core RUSP Conditions**
	Field Note: In CY 2018, there were 10,114 birth certificates issued for births occurring in Alaska. 99.2% of children (9,982) received a first screening. In CY 2018 there were 16 documented refusals, 15 infants not screened due to palliative care at birth, and 39 for whom screening was not provided and refusal was not documented.	
4.	**Field Name:**	**Core RUSP Conditions - Positive Screen**
	Fiscal Year:	**2018**
	Column Name:	**Core RUSP Conditions**

	Field Note: The number of presumptive positive screens, reflects all unduplicated children who had an abnormal result on the first screen for a RUSP condition. Alaska changed NBS labs on 7/1/2018, resulting in some different methodology of reporting abnormal results. Old lab did not report metabolic abnormals by condition (i.e. just by amino acid or fatty acid). New lab does report by disorder, with the only general abnormal being for infants on for formula (TPN). Changing methodologies in Cystic Fibrosis (CF) screening resulted in 48/54 of the abnormal results being in the first six months of the year, with the old lab.	
5.	**Field Name:**	**Core RUSP Conditions - Confirmed Cases**
	Fiscal Year:	**2018**
	Column Name:	**Core RUSP Conditions**
	Field Note: Alaska does not do follow up or receive confirmation of diagnosis for critical congenital heart disease. There are likely diagnosed cases of which we are unaware.	
6.	**Field Name:**	**Core RUSP Conditions - Referred For Treatment**
	Fiscal Year:	**2018**
	Column Name:	**Core RUSP Conditions**
	Field Note: All infants identified by bloodspot screening were referred. Alaska does not collect data on critical congenital heart disease referrals.	

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Alaska

Annual Report Year 2018

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	3,431	39.0	0.0	58.0	3.0	0.0
2. Infants < 1 Year of Age	3,931	47.0	0.0	41.0	10.0	2.0
3. Children 1 through 21 Years of Age	4,018	36.0	0.0	55.0	8.0	1.0
3a. Children with Special Health Care Needs	2,088	47.0	0.0	51.0	2.0	0.0
4. Others	0					
Total	11,380					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	10,445	No	11,445	95	10,873	3,431
2. Infants < 1 Year of Age	10,353	No	10,828	100	10,828	3,931
3. Children 1 through 21 Years of Age	211,591	No	229,045	50	114,523	4,018
3a. Children with Special Health Care Needs	38,150	No	31,621	56	17,708	2,088
4. Others	517,105	Yes	517,105	1	5,171	0

Form Notes for Form 5:

There is a difference between Total Number of Births in Form 4 and Form 5 and 6 due to two different data sources. Form 4 and Form 6 only include deliveries that occurred in Alaska based on birth certificate data. Form 5 number of infants is based on population data from the Alaska Department of Labor.

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2018**
	Field Note: There are no federal Title V dollars used to pay for direct or enabling services for pregnant women such as payment for prenatal, delivery or postpartum care, case management, or insurance eligibility insurance. In FFY18, State MCH funds supported the WIC program, which had 18,944 encounters for enabling services from pregnant women. Participants are counted each time they receive benefits in a month, so this does not represent a unique number of women. Pregnant women are seen by a counselor or they do nutrition education every 3 months from when they enter the WIC program. According to the most recent data from Alaska PRAMS, among women who delivered in 2017, 34% were on WIC during their pregnancy. Applying this percentage to the 10,090 births in 2018, this would indicate that 3,431 women received services from WIC in CY2018.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2018**
	Field Note: No federal Title V dollars are used to pay for direct or enabling services for infants. State MCH funds served a total of 3,931 infants through support of the following programs in FFY18: • Parents as Teachers , 74 infants. • WIC, 47,104 encounters with infants. (Participants are counted each time they receive benefits in a month, so this does not represent a unique number of infants. We are estimating 3,431 infants for WIC based on the PRAMS data described in the note for row 1.) • The Office of Children's Services, 426 infants in out-of-home care in FFY18. (Age is calculated on 10/1/2017 for children removed before FFY18 and on the date of removal for those removed during FFY18.) The Alaska Immunization Program is also supported by state MCH funds. This program provided 16,401 vaccines for infants in FFY18, however these numbers are not reflected above because their data system cannot pull the number of unique individuals who received state-supplied vaccine.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2018**
	Field Note: Federal Title V dollars are used to pay for a contract for reproductive health services for adolescents at 4 high school-based health centers in Juneau, Alaska. A total of 119 clients were seen in FFY18. State MCH funds served a total of 3,899 children through support of the following programs in FFY18: • Parents as Teachers, 137 children ages 1-5 years • The Office of Children's Services, 3,762 children ages 1-18 in out-of-home care The Alaska Immunization Program is also supported by state MCH funds. This program provided vaccines for 75,619 children ages 1-18 years, however these numbers are not reflected above because their data system cannot pull the number of unique individuals who received state-supplied vaccine. Primary Source of Insurance Coverage Estimates: CHIP and Medicaid coverage are combined and reported under column B. Estimates from the 2016-2017 National Survey of Child Health for all Alaska children ages 0-17 years.	

4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2018**

Field Note:
Count includes infants and children > 1 year of age with special health care needs. The unduplicated count of clients diagnosed or referred from: cleft lip & palate clinics (70), autism/neurodevelopmental screening and diagnostic clinic (47), genetics & metabolic clinics (68) during 2018 is 185. Although WCFH no longer directly administers the genetics and cleft lip & palate clinics for the state, we continue to utilize federal Title V dollars to support those services. In addition, state MCH funds served a total of 1,903 children with special needs through support of the EI/ILP program, which served 714 infants and 1189 children ages 1-3 in FFY18.
Primary Source of Insurance Coverage Estimates: CHIP and Medicaid coverage are combined and reported under column B. Estimates from the 2016-2017 National Survey of Child Health for Alaska children with special health care needs ages 0-17 years.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2018**

Field Note:
There are no Title V dollars used to pay for direct or enabling services for “Others” such as payment for well-woman visits or education or family centered care provided to parents.

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2018**

Field Note:
It is estimated that 95% of pregnant women receive services through Title V. The total number of pregnant women (11,445) is all term pregnancies + ITOPS + fetal deaths counted (Data Source: Alaska HAVRS, CY2018). In addition to the direct and enabling services described in Form 5a, Title V dollars funded staff time to:
• Promote evidence based screening for perinatal depression, smoking, and substance use.
• Analyze data related to severe maternal mortality and other perinatal issues and conditions
• Conduct outreach to hospitals to screen for substance use and distribute prevention educations materials.
• Administer the Maternal Child Death Review Program
• Facilitate the Alaska Perinatal Quality Collaborative and AIM participation
Title V funds were also used to purchase incentives and pay for postage and printing for PRAMS, which collects data on pregnancies and provides sampled women with a comprehensive resource list. About one out of every 6 Alaska births is sampled for PRAMS.

2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2018**

Field Note:
100% of infants are served through Title V. The total number of infants (10,828) is all infants less than 1 year old (Data Source: Alaska Department of Labor Population Estimates as of July, 2018). In addition to the services described in Form 5a, Title V dollars funded staff time to:
• Administer the newborn screening program, which serves all infants in the state
• Administer the Alaska Birth Defects Registry program
• Conduct outreach to child welfare workers regarding safe sleep practices
• Partner with home visiting programs to provide staff training and promote education on safe sleep practices
• Implement workplace breastfeeding promotion projects
• Administer the Maternal Child Death Review Program
• Facilitate the Alaska Perinatal Quality Collaborative
Title V funds were also used to purchase incentives and pay for postage and printing for PRAMS, which collects data on mothers and infants.

3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2018**

Field Note:
It is estimated that 50% of children 1 through 21 years are served through Title V. The total number of children ages 1 through 21 years old is 229,045 (Data Source: Alaska Department of Labor Population Estimates as of July, 2018). In addition to the services described in Form 5a, Federal Title V dollars funded staff time to:
• Promote programs and education targeting oral health, adolescent wellness visits and dating violence reduction education, school health, child maltreatment prevention, and developmental screening.
• Administer the Maternal Child Death Review Program, which reviews all deaths of children < 18 years
• Administer ALCANLink to monitor statewide child maltreatment data
• Administer the CUBS survey. Title V funding was also used to purchase incentives and pay for postage and printing for CUBS, which collects data on 3-year-old children and their families and provides sampled mothers with a comprehensive resource list.

4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2018**

Field Note:
Title V dollars were used to:
• Support the genetics and cleft lip & palate clinics
• Advance systems of care for CYSHCN
• Administer the Alaska Birth Defects Registry program
• Provide genetics counseling services
• Provide Parent Navigation services
We assume that CYSHCN are served by the programs described in #3 at the same rate as all children. The unduplicated count of clients diagnosed or referred from: cleft lip & palate clinics, autism/neurodevelopmental screening and diagnostic clinic, genetics & metabolic clinics and the EI/ILP Part C program during 2018 was 2,088. The Alaska Birth Defects Registry recorded services received by 1,367 CYSHCN during FFY18. We multiplied the estimated total number of CYSHCN (31,621) by 50% and then added 3,455 to get a total number of CYSHCN receiving services (19,265, which is 61% of the total CYSHCN population). However, this formula assumes no overlap in services received. Thus we are reporting the mid-point of 56% for CYSHCN.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2018**

Field Note:

Title V dollars supported services to 5,790 individuals served by Title V programs or Title V partners:

• The Ladies First program, provided breast and cervical screenings to 3,646 clients

• Title X Reproductive Health Clinics, served 1,982 men and women 20 years and older

• MIECHV program, served 162 clients ages 22 to 44

Data Alerts: None

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

State: Alaska

Annual Report Year 2018

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	9,964	5,007	274	798	1,893	636	300	1,018	38
Title V Served	9,964	5,007	274	798	1,893	636	300	1,018	38
Eligible for Title XIX	4,634	1,266	122	79	1,918	195	193	219	642
2. Total Infants in State	11,317	5,721	393	897	1,844	484	164	1,814	0
Title V Served	11,317	5,721	393	897	1,844	484	164	1,814	0
Eligible for Title XIX	7,128	1,998	239	202	2,504	397	372	525	891

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2018**
	Column Name:	**Total**
	Field Note: Data Source: Alaska Health Analytics and Vital Records. All categories except multiple race are single race reported only. There is a difference between Total Number of Births in Form 4 and Form 5 and 6 due to two different data sources. Form 4 and Form 6 only include deliveries that occurred in Alaska based on birth certificate data. Form 5 number of infants is based on population data from the Alaska Department of Labor.	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2018**
	Column Name:	**Total**
	Field Note: Data Source: Alaska Health Analytics and Vital Records. All pregnant women and infants receive Title V services.	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2018**
	Column Name:	**Total**
	Field Note: Data Source: Alaska Medicaid data linked to birth certificates	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2018**
	Column Name:	**Total**
	Field Note: Data Source: Alaska Department of Labor Population Estimates as of July 2017. Race includes Hispanic and Non-Hispanic therefore Hispanic are counted twice due to limitation of Department of Labor statistics.	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2018**
	Column Name:	**Total**

	Field Note: Data Source: Alaska Department of Labor Population Estimates as of July 2017. All infants receive Title V services through infrastructure building and population based services such as Newborn Hearing and Metabolic Screening, and educational/outreach programs. A small portion receive direct care services and enabling services.	
6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2018**
	Column Name:	**Total**
	Field Note: Data Source: Alaska Medicaid Infant Medicaid data for CY2018. All members under 1 year of age (as of 1/1/2018) during the 2018 CY and those born during CY2018 with a Medicaid Subtype category NOT “BA: Newborn Coverage & mom is eligible on DOB”. This would result in the deliveries being a subset of the infants (report design suggests this is the case), as many babies can have multiple subtypes throughout the year.	

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

State: Alaska

A. State MCH Toll-Free Telephone Lines	2020 Application Year	2018 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 799-7570	(800) 799-7570
2. State MCH Toll-Free "Hotline" Name	Women's Children's & Family Health	Women's Children's & Family Health
3. Name of Contact Person for State MCH "Hotline"	Janet Antonio	Janet Antonio
4. Contact Person's Telephone Number	(907) 334-4494	(907) 334-4494
5. Number of Calls Received on the State MCH "Hotline"		523

B. Other Appropriate Methods	2020 Application Year	2018 Annual Report Year
1. Other Toll-Free "Hotline" Names	NA	NA
2. Number of Calls on Other Toll-Free "Hotlines"		0
3. State Title V Program Website Address	http://dhss.alaska.gov/dph/wcfh/Pages/titlev/default.aspx	http://dhss.alaska.gov/dph/wcfh/Pages/titlev/default.aspx
4. Number of Hits to the State Title V Program Website		8,153
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:

The Title V Agency does not have it's own social media account per DHSS policy, but utilizes the Department's Facebook and Twitter account to share our work.

Form 8
State MCH and CSHCN Directors Contact Information

State: Alaska

1. Title V Maternal and Child Health (MCH) Director	
Name	Rebekah Morisse
Title	Title V Director
Address 1	3601 C Street
Address 2	Suite 322
City/State/Zip	Anchorage / AK / 99503
Telephone	(907) 334-2424
Extension	
Email	rebekah.morisse@alaska.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Christie Reinhardt
Title	CSHCN Director
Address 1	3601 C Street
Address 2	Suite 322
City/State/Zip	Anchorage / AK / 99503
Telephone	(907) 269-4762
Extension	
Email	christie.reinhardt@alaska.gov

3. State Family or Youth Leader (Optional)	
Name	John Cartwright
Title	Title V Family Leader
Address 1	3601 C Street
Address 2	Suite 322
City/State/Zip	Anchorage / AK / 99503
Telephone	(907) 334-2420
Extension	
Email	john.cartwright@alaska.gov

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Alaska

Application Year 2020

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

Form 9 State Priorities-Needs Assessment Year - Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Reduce substance abuse among families, including alcohol, tobacco and drugs.	Continued	
2.	Increase access and preventative health care services to Alaskans and their families.	New	
3.	Increase healthy relationships.	New	
4.	Increase access to reproductive health services that adhere to national best practice guidelines.	New	
5.	Improve system of care for families with children and youth with special health care needs	Continued	
6.	Reduce the rate of child maltreatment	Continued	
7.	Increase evidence based screening for all MCH populations for behavioral and mental health problems	New	

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10
National Outcome Measures (NOMs)

State: Alaska

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	75.8 %	0.4 %	7,747	10,222
2016	75.0 %	0.4 %	8,270	11,021
2015	74.4 %	0.4 %	8,170	10,986
2014	72.6 %	0.4 %	7,829	10,778
2013	70.7 %	0.4 %	7,722	10,920

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	155.9	15.4	104	6,672
2012	145.4	14.0	110	7,564
2011	150.6	14.3	113	7,506
2010	158.4	14.6	119	7,513

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	7.2
Numerator	
Denominator	
Data Source	Maternal Child Death Review Program Data
Data Source Year	2013-2017

NOM 3 - Notes:

Pregnancy-related mortality reported as 5-yr rolling averages on final year (ie, 2016 data is for 2012-2016)

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	6.2 %	0.2 %	647	10,444
2016	5.9 %	0.2 %	661	11,201
2015	5.8 %	0.2 %	653	11,278
2014	5.9 %	0.2 %	672	11,385
2013	5.8 %	0.2 %	658	11,441
2012	5.7 %	0.2 %	632	11,167
2011	6.0 %	0.2 %	690	11,449
2010	5.7 %	0.2 %	651	11,459
2009	5.9 %	0.2 %	666	11,315

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	9.0 %	0.3 %	937	10,440
2016	8.9 %	0.3 %	999	11,204
2015	8.9 %	0.3 %	1,008	11,268
2014	8.5 %	0.3 %	967	11,368
2013	8.5 %	0.3 %	968	11,333
2012	7.6 %	0.3 %	851	11,164
2011	8.9 %	0.3 %	1,010	11,369
2010	8.3 %	0.3 %	939	11,353
2009	9.0 %	0.3 %	1,010	11,243

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	26.1 %	0.4 %	2,722	10,440
2016	25.9 %	0.4 %	2,899	11,204
2015	24.9 %	0.4 %	2,801	11,268
2014	25.4 %	0.4 %	2,882	11,368
2013	25.2 %	0.4 %	2,852	11,333
2012	25.3 %	0.4 %	2,829	11,164
2011	25.3 %	0.4 %	2,874	11,369
2010	24.8 %	0.4 %	2,812	11,353
2009	25.4 %	0.4 %	2,851	11,243

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

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

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017/Q2-2018/Q1	3.0 %			
2017/Q1-2017/Q4	3.0 %			
2016/Q4-2017/Q3	3.0 %			
2016/Q3-2017/Q2	3.0 %			
2016/Q2-2017/Q1	3.0 %			
2016/Q1-2016/Q4	3.0 %			
2015/Q4-2016/Q3	3.0 %			
2015/Q3-2016/Q2	3.0 %			
2015/Q2-2016/Q1	3.0 %			
2015/Q1-2015/Q4	4.0 %			
2014/Q4-2015/Q3	3.0 %			
2014/Q3-2015/Q2	2.0 %			
2014/Q2-2015/Q1	1.0 %			
2014/Q1-2014/Q4	2.0 %			
2013/Q4-2014/Q3	3.0 %			
2013/Q3-2014/Q2	3.0 %			
2013/Q2-2014/Q1	4.0 %			

Legends:

Indicator results were based on a shorter time period than required for reporting

NOM 7 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	6.5	0.8	73	11,255
2015	5.5	0.7	62	11,317
2014	5.0	0.7	57	11,423
2013	4.4	0.6	51	11,477
2012	5.5	0.7	62	11,223
2011	4.6	0.6	53	11,492
2010	3.7	0.6	42	11,500
2009	4.2	0.6	48	11,352

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	5.2	0.7	58	11,209
2015	6.9	0.8	78	11,282
2014	6.7	0.8	76	11,392
2013	5.8	0.7	66	11,446
2012	5.1	0.7	57	11,187
2011	3.8	0.6	44	11,456
2010	3.6	0.6	41	11,471
2009	6.9	0.8	78	11,324

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	2.8	0.5	31	11,209
2015	3.8	0.6	43	11,282
2014	3.1	0.5	35	11,392
2013	2.6	0.5	30	11,446
2012	3.0	0.5	34	11,187
2011	2.2	0.4	25	11,456
2010	1.9	0.4	22	11,471
2009	2.7	0.5	31	11,324

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	2.4	0.5	27	11,209
2015	3.1	0.5	35	11,282
2014	3.6	0.6	41	11,392
2013	3.1	0.5	36	11,446
2012	2.1	0.4	23	11,187
2011	1.7 ϟ	0.4 ϟ	19 ϟ	11,456 ϟ
2010	1.7 ϟ	0.4 ϟ	19 ϟ	11,471 ϟ
2009	4.2	0.6	47	11,324

Legends:

Indicator has a numerator <10 and is not reportable

ϟ Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	107.1	30.9	12	11,209
2015	186.1	40.7	21	11,282
2014	96.6	29.1	11	11,392
2013	87.4	27.6	10	11,446
2012	125.1	33.5	14	11,187
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	106.0	30.6	12	11,324

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	116.0 ϟ	32.2 ϟ	13 ϟ	11,209 ϟ
2015	186.1	40.7	21	11,282
2014	263.3	48.1	30	11,392
2013	157.3 ϟ	37.1 ϟ	18 ϟ	11,446 ϟ
2012	116.2 ϟ	32.3 ϟ	13 ϟ	11,187 ϟ
2011	87.3 ϟ	27.6 ϟ	10 ϟ	11,456 ϟ
2010	122.0 ϟ	32.6 ϟ	14 ϟ	11,471 ϟ
2009	291.4	50.8	33	11,324

Legends:

🚩 Indicator has a numerator <10 and is not reportable

ϟ Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

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

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	6.3 %	1.0 %	627	10,008
2016	4.2 %	0.7 %	448	10,729
2015	6.8 %	0.9 %	730	10,701
2014	6.4 %	0.9 %	695	10,891
2013	7.8 %	1.0 %	851	10,936
2012	6.6 %	1.0 %	705	10,688
2010	7.0 %	1.0 %	765	10,889
2009	5.6 %	0.8 %	606	10,864
2008	6.1 %	0.9 %	664	10,940
2007	5.1 %	0.8 %	545	10,627

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	9.4	1.0	83	8,828
2015	10.4	1.3	69	6,653
2012	6.2	0.9	47	7,585
2011	4.6	0.8	34	7,472
2010	4.1	0.7	31	7,489

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

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

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

NOM 12 - Notes:

None

Data Alerts: None

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

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

NOM 13 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	11.6 %	1.4 %	19,940	172,408
2016	12.4 %	1.9 %	21,549	174,458

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	35.8	6.1	34	95,056
2016	26.0	5.2	25	96,253
2015	35.4	6.1	34	95,972
2014	25.1	5.1	24	95,484
2013	31.3	5.7	30	95,894
2012	18.9 ϟ	4.5 ϟ	18 ϟ	95,022 ϟ
2011	21.0	4.7	20	95,013
2010	27.6	5.4	26	94,055
2009	25.0	5.2	23	92,116

Legends:

🏴 Indicator has a numerator <10 and is not reportable

ϟ Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	67.5	8.4	65	96,265
2016	62.2	8.0	61	98,046
2015	45.3	6.8	44	97,215
2014	40.4	6.4	40	98,952
2013	45.0	6.7	45	99,908
2012	36.9	6.1	37	100,332
2011	54.6	7.3	56	102,518
2010	56.3	7.4	58	102,957
2009	49.9	6.9	52	104,166

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2017	14.0	3.1	20	143,010
2014_2016	15.1	3.2	22	145,378
2013_2015	7.5 ϟ	2.3 ϟ	11 ϟ	146,860 ϟ
2012_2014	9.4 ϟ	2.5 ϟ	14 ϟ	148,644 ϟ
2011_2013	9.3 ϟ	2.5 ϟ	14 ϟ	150,915 ϟ
2010_2012	9.1 ϟ	2.4 ϟ	14 ϟ	153,574 ϟ
2009_2011	9.6 ϟ	2.5 ϟ	15 ϟ	156,901 ϟ
2008_2010	13.8	2.9	22	159,365
2007_2009	19.1	3.4	31	161,945

Legends:

Indicator has a numerator <10 and is not reportable

ϟ Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2017	35.7	5.0	51	143,010
2014_2016	35.1	4.9	51	145,378
2013_2015	37.5	5.1	55	146,860
2012_2014	30.3	4.5	45	148,644
2011_2013	22.5	3.9	34	150,915
2010_2012	23.4	3.9	36	153,574
2009_2011	22.9	3.8	36	156,901
2008_2010	28.9	4.3	46	159,365
2007_2009	25.3	4.0	41	161,945

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	17.0 %	1.5 %	31,621	186,111
2016	16.1 %	1.7 %	29,864	185,519

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	19.1 %	3.6 %	6,046	31,621
2016	19.2 %	4.3 %	5,736	29,864

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	2.2 %	0.6 %	3,301	151,816
2016	1.6 % ϟ	0.5 % ϟ	2,413 ϟ	152,420 ϟ

Legends:

Indicator has an unweighted denominator <30 and is not reportable

ϟ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	8.0 %	1.2 %	12,177	151,427
2016	7.6 %	1.3 %	11,510	151,643

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	59.8 %	5.7 %	11,894	19,892
2016	54.6 %	7.4 %	7,764	14,222

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	92.1 %	1.1 %	170,934	185,606
2016	93.5 %	1.3 %	172,610	184,511

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	19.1 %	0.5 %	1,063	5,552
2012	20.6 %	0.4 %	1,860	9,019
2010	21.2 %	0.4 %	2,139	10,108
2008	20.6 %	0.4 %	1,856	9,020

Legends:

Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	13.7 %	1.0 %	3,999	29,233
2015	14.0 %	1.2 %	4,044	28,978
2013	12.3 %	1.1 %	3,548	28,889
2011	11.6 %	1.0 %	3,526	30,354
2009	11.7 %	1.1 %	3,776	32,206
2007	10.9 %	1.1 %	3,586	33,006

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	12.6 %	1.9 %	9,308	73,892
2016	15.4 %	2.8 %	11,082	71,937

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	9.5 %	1.2 %	17,673	185,791
2016	10.7 %	1.5 %	20,119	187,970
2015	9.2 %	1.1 %	17,034	186,248
2014	12.2 %	1.4 %	22,710	185,701
2013	11.7 %	1.5 %	22,012	188,692
2012	13.4 %	1.7 %	24,672	184,564
2011	13.8 %	1.4 %	25,932	187,825
2010	9.3 %	1.1 %	17,626	188,833
2009	12.8 %	1.2 %	23,508	183,524

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children, ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	69.5 %	3.2 %	10,924	15,725
2016	68.9 %	3.2 %	10,856	15,768
2015	66.3 %	3.2 %	10,158	15,312
2014	67.3 %	3.7 %	10,040	14,909
2013	63.9 %	3.5 %	8,792	13,752
2012	59.5 %	3.5 %	7,822	13,146
2011	64.7 %	3.7 %	8,059	12,463
2010	58.4 %	3.5 %	7,299	12,505
2009	53.3 %	4.2 %	8,379	15,712

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	48.4 %	2.2 %	84,181	174,072
2016_2017	45.8 %	3.1 %	78,279	170,878
2015_2016	47.9 %	2.0 %	83,314	174,114
2014_2015	53.6 %	1.9 %	92,261	172,289
2013_2014	51.0 %	2.2 %	89,222	174,881
2012_2013	46.4 %	2.3 %	81,214	175,079
2011_2012	38.8 %	2.5 %	65,071	167,830
2010_2011	46.8 %	5.5 %	77,020	164,573
2009_2010	39.4 %	2.7 %	63,257	160,552

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	64.5 %	3.0 %	31,109	48,247
2016	61.1 %	3.1 %	28,046	45,902
2015	49.1 %	3.2 %	22,641	46,141

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	78.9 %	2.6 %	38,053	48,247
2016	79.4 %	2.5 %	36,453	45,902
2015	69.7 %	3.0 %	32,161	46,141
2014	73.8 %	2.8 %	34,730	47,037
2013	74.3 %	3.0 %	36,128	48,629
2012	77.1 %	2.6 %	38,740	50,238
2011	65.6 %	3.6 %	33,417	50,915
2010	63.9 %	3.1 %	32,983	51,601
2009	55.8 %	3.4 %	28,817	51,617

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	68.4 %	2.9 %	33,024	48,247
2016	67.0 %	2.9 %	30,750	45,902
2015	55.7 %	3.2 %	25,718	46,141
2014	57.0 %	3.1 %	26,786	47,037
2013	55.2 %	3.3 %	26,862	48,629
2012	52.7 %	3.2 %	26,488	50,238
2011	46.1 %	3.7 %	23,474	50,915
2010	41.0 %	3.3 %	21,129	51,601
2009	40.2 %	3.4 %	20,746	51,617

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	22.0	1.0	486	22,093
2016	25.8	1.1	583	22,610
2015	29.2	1.1	662	22,706
2014	27.9	1.1	645	23,083
2013	30.3	1.1	708	23,333
2012	34.4	1.2	817	23,761
2011	36.1	1.2	880	24,356
2010	38.4	1.2	956	24,867
2009	43.2	1.3	1,106	25,602

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	13.4 %	1.3 %	1,320	9,842
2016	14.1 %	1.3 %	1,478	10,507
2015	12.7 %	1.2 %	1,352	10,658
2014	11.9 %	1.2 %	1,280	10,716
2013	11.4 %	1.1 %	1,237	10,865
2012	12.3 %	1.3 %	1,298	10,539

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	4.0 %	0.8 %	7,425	184,703
2016	5.0 %	1.2 %	9,152	183,138

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Alaska

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

Federally Available Data			
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)			
	2016	**2017**	**2018**
Annual Objective	62	64	58
Annual Indicator	55.6	56.1	49.0
Numerator	71,071	73,578	64,062
Denominator	127,889	131,127	130,730
Data Source	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	50.0	51.0	52.0	53.0	54.0	55.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2016	**2017**	**2018**
Annual Objective	76	78	80
Annual Indicator	75.4	77.0	80.0
Numerator	7,980	8,028	7,777
Denominator	10,583	10,427	9,722
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2017

State Provided Data			
	2016	**2017**	**2018**
Annual Objective	76	78	80
Annual Indicator	79.4	80	
Numerator	8,198	7,777	
Denominator	10,320	9,722	
Data Source	PRAMS	PRAMS	
Data Source Year	2016	2017	
Provisional or Final ?	Final	Final	

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	82.0	84.0	86.0	88.0	90.0	90.0

Field Level Notes for Form 10 NPMs:

None

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2018
Annual Objective	
Annual Indicator	22.9
Numerator	2,158
Denominator	9,416
Data Source	PRAMS
Data Source Year	2017

State Provided Data		
	2017	**2018**
Annual Objective		
Annual Indicator	20.3	22.9
Numerator	2,078	2,158
Denominator	10,213	9,416
Data Source	PRAMS	PRAMS
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	22.0	24.0	26.0	28.0	30.0	32.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: This is 2016 PRAMS data.	

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2018
Annual Objective	
Annual Indicator	34.8
Numerator	3,252
Denominator	9,351
Data Source	PRAMS
Data Source Year	2017

State Provided Data		
	2017	**2018**
Annual Objective		
Annual Indicator	30	34.8
Numerator	3,034	3,252
Denominator	10,128	9,351
Data Source	PRAMS	PRAMS
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	32.0	34.0	36.0	38.0	40.0	42.0

Field Level Notes for Form 10 NPMs:

None

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	**2017**	**2018**
Annual Objective			47
Annual Indicator		46.8	42.3
Numerator		12,033	9,801
Denominator		25,736	23,177
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	48.0	49.0	50.0	51.0	52.0	52.0

Field Level Notes for Form 10 NPMs:

None

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - CSHCN			
	2016	**2017**	**2018**
Annual Objective			49
Annual Indicator		50.5	47.3
Numerator		15,088	14,959
Denominator		29,864	31,621
Data Source		NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	52.0	55.0	57.0	59.0	61.0	61.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**

Field Note:
Due to changes in methodology for the National Survey of Child Health and the National Survey of Children with Special Healthcare Needs, current data is not comparable to data collected in 2009/10

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

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	**2017**	**2018**
Annual Objective			74
Annual Indicator		76.4	77.0
Numerator		132,693	133,177
Denominator		173,803	173,033
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	75.0	76.0	77.0	78.0	79.0	79.0

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Alaska

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

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		26	25
Annual Indicator	31.9	32.2	32.9
Numerator	1,749	1,998	1,812
Denominator	5,489	6,202	5,500
Data Source	AK PRAMS Phase 7 Q38. 2014 data most recent avail	AK PRAMS Phase 8 Q40	AK PRAMS Phase 8 Q40
Data Source Year	2015	2016	2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	30.0	29.0	28.0	27.0	26.0	25.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Annual objectives were adjusted due to a change in indicator measurement. Goals are conservative due to limited statewide activities on pre-pregnancy drinking prevention.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: 2016 most recent available data. Annual objectives were adjusted due to a change in indicator measurement. Goals are conservative due to limited statewide activities on pre-pregnancy drinking prevention.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: 2017 most recent available data. Goals are conservative due to limited statewide activities on pre-pregnancy drinking prevention.	

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

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		86.1	86.3
Annual Indicator	85.7	82.5	82.5
Numerator	1,182	1,073	1,073
Denominator	1,379	1,301	1,301
Data Source	CDC Youth Risk and Behavioral Surveillance	CDC Youth Risk and Behavioral Surveillance	CDC Youth Risk and Behavioral Surveillance
Data Source Year	2015	2017	2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	86.5	86.7	87.0	87.3	87.5	87.7

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: 2022 goal based on 2007-2015 YRBS trend data.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Results are for Alaska traditional high school students. There was not a statistically significant long-term (2007-2017) change. However, there was a statistically significant (based on t-test analysis, $p<0.05$) short-term (2015-2017) decrease.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Results are for Alaska traditional high school students. There was not a statistically significant long term (2007-2017) change. However, there was a statistically significant (based on a t-test analysis, $p<0.05$) short term (2015-2017) decrease.	
4.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**
	Field Note: Objectives are based on 2007-2015 trend data. We will reevaluate future objectives once the 2019 YRBS data is released to assess if the 2017 decline was an anomaly or if the declining trend continued.	

SPM 5 - Percent of deaths among children ages 0-17 years classified as maltreatment-related by the Maternal Child Death Review (MCDR) committee.

Measure Status:	Active

State Provided Data		
	2017	2018
Annual Objective		
Annual Indicator	22.4	15.5
Numerator	26	18
Denominator	116	116
Data Source	Maternal Child Death Review Program	Maternal Child Death Review Program
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	16.0	15.5	15.0	14.5	14.0	13.5

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
In 2017, 116 deaths among children 0-17 were reviewed by MCDR, among which ,1% occurred during 2014. 9% during 2015, 52% during 2016, and 39% during 2017. Infants (<365 days old) accounted for 40% of deaths reviewed. This indicator utilizes a narrow classification of maltreatment (abuse an neglect indicated), if however we include poor parental supervision and other negligence, 65.5% of all deaths reviewed are maltreatment related. Stratified by infants and non-infant deaths we find that the narrow classification indicates 13% of infant deaths are maltreatment related and 63% with a broader classification, and 33% and 79% respectively among non-infants. This indicator focuses on the narrow definition of maltreatment due to potential differences in preventability.

2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
The source of the data is the Maternal Child Death Review (MCDR) program. To allow for annual reporting we report on the review data year opposed to the death year. This is due to limitations with lag in reviewing of some deaths that have a delay in data collection. 2016 was the first full year of data collection and review of all child deaths ages 0-17 years. For this indicator we will only count maltreatment deaths identified for children <6 years of age. This is due to the fact that for this age group it is recommended that they have constant (within sight and sound) supervision. Ages beyond result in much more ambiguity and will require additional research to inform classification. For the next reporting year, this measure will most likely be changed to a count instead of percent.

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Alaska

ESM 1.3 - Percent of rarely or never screened women who receive a Pap smear paid for by the Ladies First program.

Measure Status:	Active

State Provided Data		
	2017	2018
Annual Objective		
Annual Indicator	14.7	14.2
Numerator	394	350
Denominator	2,672	2,460
Data Source	Ladies First Database	Ladies First Database
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	20.0	20.0	20.0	20.0	20.0	20.0

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2017**

   Column Name: **State Provided Data**

   Field Note:
   Alaska's BCHC program will maintain our goal that at least 50% of women who receive a Pap smear through a program have not had a cervical cancer screening in the last five years.

2. **Field Name:** **2018**

   Column Name: **State Provided Data**

   Field Note:
   Percentage was changed from 50% to 20% to align with CDC program performance indicators.

ESM 1.4 - Percent of women with persistent new-onset severe hypertension treated with first line medications within 60 minutes.

Measure Status:					Active
Annual Objectives					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	60.0	70.0	80.0	90.0	93.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**

Field Note:
The AIM hypertension initiative launched March 2019 with data collection beginning in May. It is expected that preliminary data from facilities with early enrollment in the initiative will be available by December 2019.

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

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		80	80
Annual Indicator	80	100	94.4
Numerator	20	26	17
Denominator	25	26	18
Data Source	Maternal Child Death Review (MCDR) Database	Maternal Child Death Review Committee Database	Maternal Child Death Review Committe Database
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	90.0	90.0	90.0	90.0	90.0	90.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
This was the first year of this new ESM, and based the initial annual objectives on historical information. The Medical examiners office has stressed the importance of the SUID form to law enforcement and the MCDR program has improved in obtaining these completed forms. Combined, the result has been a drastic improvement in a short period of time. Based on this we've corrected our annual objectives and will center MCDR activities around maintaining relationships and identifying and building new ones.

2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
This indicator is based on the number of SUID deaths reviewed during the prior year and included 12 deaths that occurred in 2016 due to a lag in obtaining records from one source, and 1 from 2015 that was previously not identified. The law enforcement and investigative agencies have drastically improved their utilization of the SUIDI form and MCDR will continue to monitor this measure and maintain relationships to ensure this information is obtained and available for reviews by the CDR committee.

3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
This indicator is based on the number of SUID deaths reviewed during the prior year and included 12 deaths that occurred in 2016 due to a lag in obtaining records from one source, and 1 from 2015 that was previously not identified. The law enforcement and investigative agencies have drastically improved their utilization of the SUIDI form and MCDR will continue to monitor this measure and maintain relationships to ensure this information is obtained and available for reviews by the CDR committee.

4.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**

Field Note:
The objective is to maintain above 90%.

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

Measure Status:	Inactive - Birth facilities have expressed initial enthusiasm about pursuing certification, but have been unable to maintain that momentum. Because their window	
State Provided Data		
	2017	**2018**
Annual Objective	1	1
Annual Indicator	1	0
Numerator		
Denominator		
Data Source	List of birthing hospitals (20)	List of birthing hospitals (20)
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: While no birthing hospitals obtained Cribs for Kids certification in FY17, one applied and more are preparing their applications.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Based on feedback from birthing facilities, MCDR data identifying highest risk families, and the success of outreach efforts outside of the hospital system, Alaska will continue to focus on developing partnerships with agencies and community groups who work with families during pregnancy and through infancy, and retire this ESM.	

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

Measure Status:	Inactive - Data is based on total births in 2018 (using vital statistics data) as denominator with numerator of facilities with active safe sleep policies/work:

State Provided Data		
	2017	2018
Annual Objective	53	59
Annual Indicator	57.1	60.7
Numerator	6,030	5,999
Denominator	10,564	9,890
Data Source	Infant Safe Sleep Program and Vital Statistics	Infant Safe Sleep Program
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2017**

   Column Name: **State Provided Data**

   Field Note:
   Birthing hospitals includes Joint Base Elmendorf-Richardson (JBER), Providence Alaska Medical Center (PAMC), Fairbanks Memorial Hospital (FMH), & Alaska Native Medical Center (ANMC). JBER has submitted their application to Cribs for Kids. The others are working on it. All Objectives were also updated from 2017 goals.

2. **Field Name:** **2018**

   Column Name: **State Provided Data**

   Field Note:
   Based on feedback from birthing facilities, MCDR data identifying highest risk families, and the success of outreach efforts outside of the hospital system, Alaska will continue to focus on developing partnerships with agencies and community groups who work with families during pregnancy and through infancy, and retire this ESM. Birth facilities have expressed initial enthusiasm about pursuing certification, but have been unable to maintain that momentum. Because their window of contact with families is comparatively short, focused efforts with child protection, tribal non-profit organizations, primary care providers, and child care providers offer more opportunities for long-term engagement with families.

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

Measure Status:	Active

State Provided Data		
	2017	2018
Annual Objective	50	60
Annual Indicator	47.8	83.3
Numerator	11	15
Denominator	23	18
Data Source	Maternal Child Death Review Committe	Maternal Child Death Review Committee
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	85.0	85.0	90.0	95.0	95.0	95.0

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2017**

   Column Name: **State Provided Data**

   Field Note:
   The MCDR review committee utilizes the CDC classification Matrix for classifying SUID deaths. After classification, the MCDR staff enter these data into the online case reporting system. The current agreement is based on two factors, the first is due to MCDR staff consistently missing an expanded field when completing data entry. These errors are noted during our quarterly call with CDC and subsequently updated. The second is when the committee makes a classification with the full information and CDC uses only the information provided in the case reporting system. In this instances we believe the State based classification and do not update which is why we likely will never have 100% agreement with CDC post-hoc classification.

2. **Field Name:** **2018**

   Column Name: **State Provided Data**

   Field Note:
   Initial SUID cases that were excluded from the MCDR consensus form were included in the estimation of this indicator.

ESM 5.8 - The number of maternity care providers participating in Alaska Breastfeeding Initiative trainings with integrated sharing of PRAMS data and information about safer sleep

Measure Status:					Active
Annual Objectives					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	70.0	70.0	70.0	70.0	70.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**

Field Note:
The goal is to train train a minimum of seventy people each year who are maternity care providers as part of the Alaska Breastfeeding Initiative that incorporate safe safe sleep education.

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

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		94	94.5
Annual Indicator	93.4	89.9	76.1
Numerator	114	107	67
Denominator	122	119	88
Data Source	Nurse Family Partnership Program Data	Nurse Family Partnership Program Data	Nurse Family Partnership Program Data
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	75.0	75.0	75.0	75.0	75.0	75.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: 2021 goals based on 2014-2015 Nurse Family Partnership Program data. 2014 was 77.7% and 2015 was 77.9%. Goal is .05% increase annually.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Children who were not screened by the NFP home visiting program may have received development screenings in other places.	
3.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**
	Field Note: The goals have been changed to better reflect the conditions within Alaska that have changed how and when children are screened, and how the data is captured by MIECHV: 1) Among the NFP population, missed visits result in the inability to screen children within the Bright Futures scheduled time points. 2) Children that are involved with child protective services (OCS) skip the screening process and go directly to evaluation by Alaska Part C Early Intervention due to CAPTA state regulations. 3) Alaska does not automatically screen as part of Part C Early Intervention Child Find activities. Children born with medical conditions that may lead to developmental delay (Down Syndrome, Cerebral Palsy, Deaf/Hard-of-Hearing) will also bypass the screening process and go directly to evaluation by Early Interventio	

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

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		0.5	0.6
Annual Indicator	0	90.9	98.9
Numerator	0	10	366
Denominator	1	11	370
Data Source	Help Me Grow Alaska database	Help Me Grow Alaska database	Help Me Grow Alaska database
Data Source Year	NA	2018	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	99.0	99.0	99.0	99.0	99.0	99.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Data not available. The Help Me Grow Alaska system entered the installation phase of implementation in early 2017 through a contract with the All Alaska Pediatric Partnership, but has not yet begun to provide family referral and support through a call center. The call center will be established by the end of 2017 with preliminary service linkage data anticipated in early 2018.

2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
The Help Me Grow Alaska System launched January 15, 2018. Since launch 11 Families have been served, 10 follow up calls have been made, and 5 ASQ-3 screenings completed. The Help Me Grow Alaska call center staff have completed a number of trainings to prepare for the launch and continue knowledge.

3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
The Help Me Grow Alaska System launched January 15, 2018, starting in three target communities and then expanding statewide. Milestones for the first year include establishing the Central Access Point with a website with a portal for the Ages and Stages Questionnaire (ASQ) and a phone number staffed by care coordinators, extensive staff training, resource directory development and community outreach efforts. This year 190 unique families were served by HMG-AK; there were 370 family and/or provider contacts. Families received resource information, referrals, developmental screenings and follow-ups, with 401 resources provided. Community liaisons identify community resources and create resource dictionaries and increase awareness through outreach efforts. Developmental screening or questions about development were the most common reasons for families contacting HMG-AK and 72 children completed ASQ screenings with 20 of those screened being referred for further evaluation and services.

ESM 13.2.1 - Number of oral health pocket guides distributed

Measure Status:						Active
Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	125.0	150.0	175.0	200.0	225.0	225.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**

Field Note:
This measure was retired because it didn't accurately capture the efforts or impact of WCFH around oral health. The newly created measure (13.2.2) will more accurately capture our partnership with the school health nursing system addressing oral health in children. Due to restraints within TVIS, and because this measure was created last year, this measure was not able to be inactivated within the system but will be next year.

ESM 13.2.2 - Number of school nurses trained on oral health

Measure Status:					Active
Annual Objectives					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	75.0	90.0	105.0	120.0	135.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**

Field Note:
Counts are from the number of nurses that attended an oral health training at the annual state school nurse conference in April 2019.There has not been data previously available to measure this outcome. The goal is to increase the number of nurses trained by 15 each year. The school health nurse consultant will collect this data from state wide end of the year school nurse reports.

Form 10
State Performance Measure (SPM) Detail Sheets

State: Alaska

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

Measure Status:	Active
Goal:	Reduce poor birth outcomes related to alcohol use during pregnancy.
Definition:	

Numerator:	Number of women who responded yes to drinking any alcohol during the 3 months before pregnancy AND who said "yes" to the question, "when you got pregnant with your new baby, were you trying to get pregnant?"
Denominator:	Number of Alaska-resident women delivering a live-born infant who indicated on the survey that they were trying to become pregnant.
Unit Type:	Percentage
Unit Number:	100

Healthy People 2020 Objective:	MICH-11.1 Increase abstinence from alcohol among pregnant women MICH-11.2 Increase abstinence from binge drinking among pregnant women
Data Sources and Data Issues:	Pregnancy Risk Assessment Monitoring System (PRAMS)
Significance:	Since 1990, Alaska Pregnancy Risk Assessment Monitoring System (PRAMS) has conducted ongoing surveys of mothers of newborns and collected population-based data on maternal attitudes and experiences before, during, and after pregnancy. Approximately one of every six mothers of newborns is randomly selected for PRAMS from birth records at the Bureau of Vital Statistics. Women from some groups are sampled at a higher rate to ensure adequate data are available in smaller but higher risk populations. Data collection procedures and instruments are standardized to allow comparisons between states. PRAMS survey asks these mothers about their intention to become pregnant and their use of alcohol in the 3 months prior to pregnancy and during the pregnancy of the current newborn. Data will measure use of alcohol before and during pregnancy and allow for cross tabulation of alcohol use with pregnancy intention among those mothers.

SPM 2 - Percent of students who report that they would feel comfortable seeking help from at least one adult besides their parents if they had an important question affecting their life.
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	Increase healthy relationships. The goal is to reach 87% by 2021. The goal is based on 2007-2015 YRBS trend data.
Definition:	**Numerator:** Number of students who report they would feel comfortable seeking help from at least one adult besides their parents if they had an important question affecting their life. **Denominator:** Number of students who take the survey **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	AH-3.1 Increase the proportion of adolescents who have an adult in their lives with whom they can talk about serious problems
Data Sources and Data Issues:	Biennial CDC Youth Risk Behavioral Surveillance System
Significance:	The percent of students who report that they would feel comfortable seeking help from at least one adult besides their parents if they had an important question affecting their life data collected for SPM #2 is a recognized protective factor against a variety of public health challenges, including bullying/violence. In 2014, the CDC released its “Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence” report. In it, a list of shared risk and protective factors which research showed either increased the likelihood (risk factor) or decreased the likelihood (protective factor) of experiencing and/or perpetrating multiple forms of violence were summarized. Family support/ connectedness, connection to a caring adult and connection/commitment to school were listed as protective factors against child maltreatment, teen dating violence, youth violence, bullying and/or suicide. For this reason, we selected the existing YRBS protective factor measure as one of our SPMs. Research indicates that a high-quality youth–adult relationship is associated with positive social, academic, and health-related behaviors. Evidence indicates that strong, positive relationships with parents and other caring adults protect adolescents from a range of poor health-related outcomes and promote positive development. Youth–adult connectedness appears to be foundational for adolescent health and well-being. Program, practice, and policy decisions in the Alaska Adolescent Health Program consider what strengthens or hinders caring, connected youth–adult relationships. Evidence based programs Alaska Adolescent Health Program, such as the Fourth R, 3R's, Bringing in the Bystander, Healthy Relationships Plus, Coaching Boys into Men, Athletes as Leaders, youth advisory committees, and youth leadership summits all work to strengthen the protective factor of healthy youth-adult relationships.

SPM 5 - Percent of deaths among children ages 0-17 years classified as maltreatment-related by the Maternal Child Death Review (MCDR) committee.
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Improve the consistent classification of maltreatment deaths over time to enable tracking of statewide child maltreatment primary prevention efforts over time.
Definition:	

Numerator:	Annual number of deaths classified as "yes" or "yes probably abuse or neglect" related among children 0-17 years of age among cases reviewed.
Denominator:	Annual number of children reviewed by MCDR for children 0-17 years of age.
Unit Type:	Percentage
Unit Number:	100

Healthy People 2020 Objective:	IVP-37 Reduce child maltreatment deaths IVP-38 Reduce nonfatal child maltreatment
Data Sources and Data Issues:	The source of the data is the Maternal Child Death Review (MCDR) program. To allow for annual reporting we report on the review data year opposed to the death year. This is due to limitations with lag in reviewing of some deaths that have a delay in data collection. 2016 was the first full year of data collection and review of all child deaths ages 0-17 years. For this indicator we combined all deaths where the committee believed maltreatment caused or contributed to the death and only that were indicated as abuse or neglect. Additional information in the narrative described the impact of poor parental supervision and age group differences.
Significance:	Child maltreatment is a substantial public health issue with family discord and trauma contributing to the situations that result in disproportionate infant/child mortality. Fatalities resulting from maltreatment are strong sentinel events that can be used to provide meaningful information related to prevention. The problem is that no standard exists for classification. For this reason we've focused our outcomes on improving and standardizing our classification so that we can accurately and consistently document the number of deaths due to child maltreatment each year. This new indicator is timely and responsive to our interventions and much more reflective of the work supported by Title V in Alaska.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Alaska

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Alaska

ESM 1.3 - Percent of rarely or never screened women who receive a Pap smear paid for by the Ladies First program.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase the number of women who seek preventive medical visits by using patient navigators and health education messaging to reduce barriers to breast and cervical cancer screening.
Definition:	**Numerator:** Number of women who report not having cervical cancer screening in the last 5 years who received their first Ladies First-paid Pap test in a calendar year. **Denominator:** Total number of women who received a Ladies First-paid Pap test in a calendar year. **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Ladies First Database
Significance:	Women who have not had cervical cancer screening in over 5 years are 60% more likely to be diagnosed with cervical cancer. Low income women are more likely to not have received a Pap test in over 5 years. Patient navigators and outreach will be used to target low income women to provide health information about cervical cancer screening. This NPM strategy uses evidence based practices to identify low income women and link them with a practice that offers sliding fee schedules in order to make preventive screenings possible.

ESM 1.4 - Percent of women with persistent new-onset severe hypertension treated with first line medications within 60 minutes.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Among hospitals and birthing facilities participating in the Alliance for Innovation on Maternal Health (AIM) hypertension initiative, increase the percentage of women with severe hypertension receiving early treatment according to nationally recogni
Definition:	
	Numerator: Number of women with new-onset severe hypertension treated within 60 minutes with first line medications.
	Denominator: Number of deliveries among women with severe hypertension at hospitals and birthing facilities participating in AIM hypertension initiative.
	Unit Type: Percentage
	Unit Number: 100
Data Sources and Data Issues:	Alliance for Innovation for Maternal Health (AIM) Data Center
Significance:	Improperly managed severe maternal hypertension is a significant contributor to severe maternal morbidity (SMM) and maternal mortality. Early treatment of severe hypertension in pregnancy has been shown to reduce SMM by nearly 30%. The American College of Obstetricians and Gynecologists (ACOG) recommends evidence-based strategies included in the AIM-supported hypertension safety bundle to increase the percentage of women with early treatment of severe hypertension.

ESM 5.3 - Percent of SUID cases reviewed in prior year with complete SUID Investigation Reporting Forms NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Increase the percent of SUID cases reviewed to 90% by 2021
Definition:	
	Numerator: Number of SUID cases reviewed with complete SUID Investigation Reporting Forms
	Denominator: All SUID cases reviewed
	Unit Type: Percentage
	Unit Number: 100
Data Sources and Data Issues:	Maternal Child Death Review Database
Significance:	In order to prevent SUID deaths, it is necessary to understand the exact circumstances in which each such death occurs. Knowing these circumstances enables the Maternal Child Death Review (MCDR) program to determine underlying risk factors and craft prevention measures. The SUID Investigation Reporting Form guides law enforcement personnel to collect data that are relevant and necessary to understand the cause, manner and circumstances of each death. By increasing the percentage of SUID deaths that have a completed SUID Reporting Form we can better understand the causes of such deaths and work to prevent them.

ESM 5.5 - Number of birthing facilities with a Safe Sleep Certification from Cribs for Kids in Alaska.
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Inactive - Birth facilities have expressed initial enthusiasm about pursuing certification, but have been unable to maintain that momentum. Because their window
Goal:	Increase the proportion of Alaska infants placed to sleep on their backs by supporting facilities in obtaining National Safe Sleep Certification, with 5 facilities certified by 2021
Definition:	**Numerator:** Number of birthing facilities with a Safe Sleep Certification from Cribs for Kids. **Denominator:** Number of birthing facilities in Alaska **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	Alaska Infant Safe Sleep Program Records
Significance:	Post-partum and infant nurses play a powerful role in teaching and modeling infant sleep practices. The first 24-48 hours following birth is the critical period to influence parents. Research shows that caregivers often use the same sleep position for their babies at home that they see being used at the hospital. Sources: http://www.cribsforkids.org/hospitalinitiative/. The State has elected to discontinue the Alaska Safe Sleep Toolkit, therefore ESM 5.1 has been replaced with ESM 5.5. ESM 5.5 activities encompass state Title V partnering with Cribs for Kids in promoting the use of its national hospital safe sleep certification program and tracking the number of facilities with a Cribs for Kids certification rather than the now-discontinued Alaska program. Cribs for Kids' program is more comprehensive than the Alaska toolkit, has more technical assistance capacity and is able to keep the certification up to date with best practices, and is endorsed by multiple national organizations due to its use of evidenced-based strategies to reduce sleep related infant death.

ESM 5.6 - Percent of infants born at a facility with Cribs for Kids Safe Sleep Certification or a safe sleep policy in place and has initiated the certification process.
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Inactive - Data is based on total births in 2018 (using vital statistics data) as denominator with numerator of facilities with active safe sleep policies/work:
Goal:	Increase the proportion of Alaska infants placed to sleep on their backs by increasing the number of facilities with a certification or policy and plan for certification from 53% to 65% by 2021.
Definition:	**Numerator:** Number of births at birthing facilities with a Safe Sleep Certification or with a safe sleep policy in place and certification process initiated. **Denominator:** Number of births in Alaska **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Alaska Infant Safe Sleep Program Records
Significance:	Post-partum and infant nurses play a powerful role in teaching and modeling infant sleep practices. The first 24-48 hours following birth is the critical period to influence parents. Research shows that caregivers often use the same sleep position for their babies at home that they see being used at the hospital. Sources: http://www.cribsforkids.org/hospitalinitiative/. The State has elected to discontinue the Alaska Safe Sleep Toolkit, therefore ESM 5.2 has been replaced with ESM 5.6. ESM 5.6 activities encompass state Title V partnering with Cribs for Kids in promoting the use of its national hospital safe sleep certification program and tracking the tracking the percentage of infants born at a facility with a Cribs for Kids certification rather than the same measure for the Alaska program. The Cribs for Kids' program is more comprehensive than the Alaska toolkit, has more technical assistance capacity and is able to keep the certification up to date with best practices, and is endorsed by multiple national organizations due to its use of evidenced-based strategies to reduce sleep related infant death.

ESM 5.7 - Percent of SUID cases reviewed in prior year and classified using CDC categories that agree with CDC post-hoc classification.
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Increase the accuracy of SUID classification among cases reviewed to 90% by 2021
Definition:	

Numerator:	Number of SUID cases reviewed in prior year and classified by MCDR using CDC categories that agree with CDC post-hoc classification
Denominator:	All cleaned SUID cases reviewed and classified by CDC
Unit Type:	Percentage
Unit Number:	100

Data Sources and Data Issues:	Maternal Child Death Review (MCDR) database
Significance:	The CDC categorization matrix for SUID deaths allows the MCDR to track how consistent SUID deaths are being classified and how factors such as unsafe sleeping conditions contribute to such deaths. By increasing the number of SUID cases that are accurately and consistently classified using the CDC categories, we will be able to identify gaps in our data. Doing so will enable us to improve our data collection methods and determine what risk factors should be targeted for strategic interventions.

ESM 5.8 - The number of maternity care providers participating in Alaska Breastfeeding Initiative trainings with integrated sharing of PRAMS data and information about safer sleep
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Train a minimum of seventy people each year who are maternity care providers as part of the Alaska Breastfeeding Initiative that incorporate safe safe sleep education.
Definition:	

Numerator:	umber of maternity care providers participating in Alaska Breastfeeding Initiative trainings with integrated sharing of PRAMS data and information about safer sleep.
Denominator:	N/A
Unit Type:	Count
Unit Number:	70

Data Sources and Data Issues:	Alaska Breastfeeding Initiative Program Data
Significance:	In collaboration with the Alaska Section of Chronic Disease Prevention and Health Promotion five year grant funding from CDC is being used to conduct training for clinical providers in evidence-based maternity care practices. Trainings are conducted at birth facilities across the state. Funding allows for up to eight facilities to have on-site training annually. The breastfeeding training curricula will include the addition of PRAMS data on infant safe sleep practices for each region where trainings are being conducted. Alaska Safe Sleep program messages regarding evidence-based safer sleep messages and practices will be incorporated into each two day training. Sign in sheets from each training will be used to determine the number of maternity care providers participating. Regional WIC staff will also participate and be included in the counts.

ESM 6.1 - Percent of eligible screening time points with a completed Ages and Stages Developmental Screen, among families participating in MIECHV program
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Increase developmental screenings in children by supporting MIECHV program to provide Ages and Stages Developmental Screening tool with clients.
Definition:	

Numerator:	Number of children enrolled in home visiting with at least one screening with a validated parent complete too (ASQ) within AAP-defined age groups during the reporting period.
Denominator:	Number of children enrolled in home visiting reaching the specified time frame during the reporting period eligible for screening.
Unit Type:	Percentage
Unit Number:	100

Data Sources and Data Issues:	Nurse Family Partnership Program Data
Significance:	The American Academy of Pediatrics recommends routine developmental screening for infants and young children based on the Bright Futures periodicity schedule. Home visiting nurses have ongoing opportunities to complete these screenings with parents. The Ages and Stages Questionnaire (ASQ) is a validated tool for use in infants and children from 4 to 60 months of age.

ESM 11.2 - Percent of families/providers who obtain needed support from Help Me Grow Alaska for a needed specialist, support or service.
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Increasing utilization of a medical home by increasing access to resources for families and primary care providers of CYSHCN by using Help Me Grow model.
Definition:	**Numerator:** Number of family/provider contacts where the family's needs were met **Denominator:** Number of family/provider contacts with Help Me Grow Alaska (HMG-AK) **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Help Me Grow database
Significance:	Help Me Grow is a system designed to help states and communities leverage existing resources to identify vulnerable children, link families to community-based services, and empower families to support their children's healthy development. This system is structured to include four interconnected core components: 1. Child Health Provider Outreach 2. Family and Community Outreach 3. Centralized Access Point 4. Ongoing Data Collection and Analysis The data collected for this ESM will measure the progress towards a streamlined screening and referral system for early detection and intervention for at-risk children. HMG-AK's centralized resource and care coordination hub links families with screenings, information and services and collects meaningful data. Data collected will help identify gaps and barriers to support ongoing pediatric systems development, enhancement and quality improvement.

ESM 13.2.1 - Number of oral health pocket guides distributed
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Increase percent of adolescents who have had a preventative dental visit
Definition:	

Numerator:	Cumulative number of oral health pocket guides distributed
Denominator:	NA
Unit Type:	Count
Unit Number:	500

Data Sources and Data Issues:	Alaska Oral Health Program data
Significance:	The Bright Futures Pocket Guide is a resource for all health professionals (medical and dental) that discusses oral health and dental care aspects for pregnant and post-partum women, infants, children and adolescents. The guide highlights the need for early dental visits (within 6 months of the eruption of the first tooth and no later than age 12 months) and aspects for subsequent dental visits, assessment of caries risk, education on factors to reduce risk of early childhood caries, appropriate oral health interview questions and anticipatory guidance/education at each stage for the above populations. The pocket guide information supports provider referral or provision of appropriate preventive dental services.

ESM 13.2.2 - Number of school nurses trained on oral health
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
ESM Subgroup(s):	Children 6 through 11, Adolescents 12 through 17
Goal:	Increase percentage of school nurses trained in oral health screening by 7% each year.
Definition:	**Numerator:** Number of school nurses trained in Alaska the state fiscal year **Denominator:** Number of schools nurses in Alaska **Unit Type:** Count **Unit Number:** 215
Data Sources and Data Issues:	Alaska Oral Health Program data
Significance:	School nurses serve as an extension of the public health system. They support student success by providing health care assessment, intervention, and follow-up for all children within the school setting. In 2018, 215 school nurses were employed by 7 of Alaska's largest school districts. Some school districts support part time school nurses in their schools. School nurses are integral part of the healthcare system for the 133,000 children that attend Alaska's 54 public school districts. School nursing protects and promotes students oral health and facilitates optimal development. School nurses, grounded in ethical and evidence-based practice, are the leaders who bridge health care, provide care coordination, and advocate for quality student-centered care. The WCFH School Nurse Consultant surveys and monitors the professional development needs and trainings of school nurses and will be responsible for annually compiling the data for this ESM. Oral health decay is one of the five greatest chronic diseases in Alaskan children. WCFH will assure school nurses statewide are properly trained to conduct oral health screenings. Using the evidence based strategy to properly screen and refer students to appropriate community resources we will increase the percent of Alaska children ages 1-17 years who had a preventative dental visit.

Form 11
Other State Data

State: Alaska

The Form 11 data are available for review via the link below.

Form 11 Data