



State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (<http://www.mchdata.net>).

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1.4 Overview of the State

The Section of Maternal, Child and Family Health (MCFH), the agency which administers the State of Alaska's Title V funds, provides health services and support to families, child-bearing women, and children with special health care needs (CSHCN). MCFH functions within the Division of Public Health, in the Alaska Department of Health and Social Services. While there are numerous factors that influence the way in which both MCFH and its many programs operate, a synopsis of four which will have or are perceived to have, the greatest impact on operations in the next year are included below.

Increased Federal Support

Alaska has enjoyed increased federal support for a number of health and social service programs in the last year. A telemedicine program to link rural villages to health care facilities in large Alaska cities, immunization programs, and an initiative for childhood injury reduction are but a few of the areas that have received new or additional federal funding in the last fiscal year. The infusion of dollars for health and social services has meant that needed health programs have been able to be established and where programs were already in place, expanded to meet burgeoning demand.

Alaska State Legislature

The Republican party has held the majority of seats in the Alaska State Legislature since the early 1990's. While numerous Republican candidates are up for re-election in November 2000, the balance of power is not expected to significantly change. While Alaska has had a Democratic Governor since 1994, the presence of a conservative Republican majority has had a financial impact on the entire Department of Health and Social Services in recent years. Of note is the FY98 move to eliminate the General Relief Medical Program which provided coverage for very low income persons with one of the following five conditions: Hypertension, Seizure Disorder, Diabetes Mellitus, Cancer requiring chemotherapy and Schizophrenia. Specific to MCFH has been the FY99 reduction in funding for the Healthy Families Alaska Program. Because increased federal support has allowed needed services and programs to be provided at little or no cost to the state, it is of concern to MCFH that the conservative majority will formulate an unrealistic

view as to the actual cost of providing services and hold steady, or even reduce their portion of funding for services in the coming years.

On a more positive note is the possible introduction of “prescriptive equity” legislation in the next fiscal year. Scheduled to be introduced when the State Legislature convenes in January 2001, the measure would mandate insurance coverage for birth control for women in Alaska. Passage of such a law could increase access to birth control by reducing the financial barriers that many women face when managing their fertility. If introduced, MCFH will monitor with interest the movement of this legislation because of its positive impact on the health of women in Alaska.

State Hiring/Travel Freeze

By gubernatorial mandate, a state government hiring and travel freeze was implemented in 1999 that resulted in MCFH having 13 vacant positions for over 9 months. While the freeze has been lifted and the Section is now able to hire at will, a cap on out of state travel remains. Once the quota for Section out of state travel has been reached, staff who need to attend conferences or required program trainings must do so on their own. This cap presents an interesting challenge for many of the programs within MCFH and is expected to be in place indefinitely.

Denali KidCare (Children’s Health Insurance Program)

Alaska’s S-CHIP program, Denali KidCare, was implemented on March 1, 2000. Alaska chose to expand its Medicaid program to maximize services rather than create another administrative structure with the additional federal funding. During the first year of operation, the program’s main efforts centered on outreach and enrollment of children. By the end of the first federal fiscal year (7 months from the programs inception), the Medicaid program as a whole saw an increase of 7,130 children enrolled (58,266 in FFY98 to 65,396 in FFY99). S-CHIP enrollment (Title XXI) was 8,033. By the end of its first full year of operation, the program had exceeded its three-year enrollment goal of 11,600 children.

While it is difficult to precisely determine the increased Title XIX enrollment as the result of the increased outreach efforts, the Department of Health and Social Services is certain this occurred. As with many other states, there have been decreasing numbers of

children enrolled in Medicaid in conjunction with implementation of welfare reform efforts. In Alaska the number of children enrolled in Title XIX did not reflect a dramatic decrease however, and dropped only 1.6% from 58,266 in FFY98 to 57,363 in FFY99.

Following the success of its outreach and enrollment efforts, the program has shifted its focus to improve access to care. While children are able to access acute medical need services in a timely manner, there is some delay in access to well child exams and other preventive services, especially those related to dental health. Efforts to increase private dental participation in Medicaid/Denali KidCare have been among the programs highest priorities. The Division of Medical Assistance has been meeting regularly with the state dental association to develop strategies and recommend changes to the current administrative process that serve as barriers to provider participation in the program. At this time it is difficult to evaluate any increased access to dental services as a result of the work currently underway.

1.5 The State Title V Agency

1.5.1 State Agency Capacity

1.5.1.1 Organizational Structure

Organizational charts are included in Section V – Supporting Documents, pages 243-247. The MCFH Organizational Chart includes positions by program, as well as job classification.

1.5.1.2 Program Capacity

The overall program capacity of MCFH has increased over the past year and is expected to continue. The redesign of MCFH databases to make them relational and allow for greater transference and sharing of information; the building of new systems to better track program indicators; the integration of programs into the Section (i.e., the Breast & Cervical Health Check Program) and the hire of a Pediatric Epidemiologist are all measures which have positively impacted program capacity. In the upcoming year, further integration of programs (i.e., the Teen Pregnancy and Parenting Program, currently housed in Juneau, Alaska) and increased federal support for specific MCFH efforts (i.e., the FAS Program) will allow for continued capacity

building through more seamless delivery of services and greater collection, management and warehousing of data.

1.5.1.3 Other Capacity

The Section of Maternal Child Family Health employs seventy six (76) staff members and has thirteen (13) vacancies; 28 clerical and administrative staff support the work of 48 technical and program specialists. Three staff members have Ph.D.s, one is an M.D., and 75% of the technical/program specialists have master's degrees. The senior level program management employees (Section Unit Managers) all have master's degrees.

1.5.2 State Agency Coordination

No Changes or Updates.

II. REQUIREMENTS FOR THE ANNUAL REPORT

2.1 Annual Expenditures

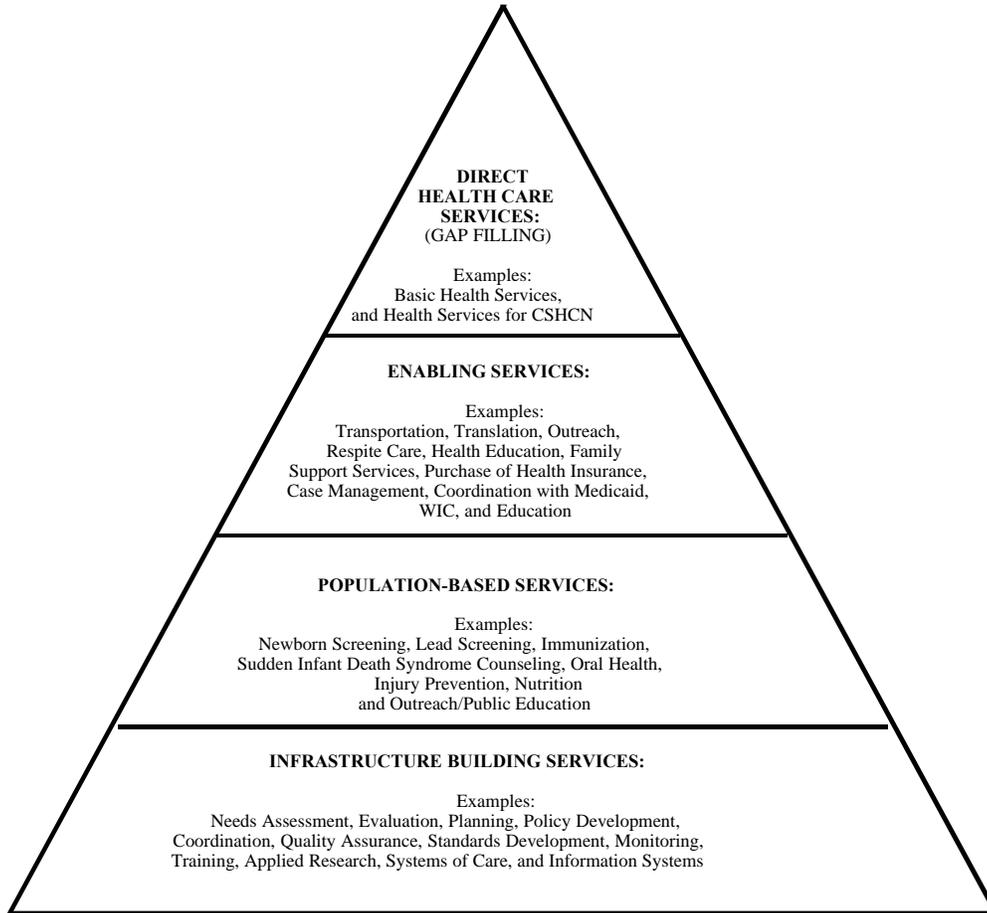
Forms 3 – 5 can be found in Section 5.8, All Other Forms, pages 152-157. **Form 3** details the State MCH Funding profile. **Form 4** details the budget by types of individuals served. **Form 5** details the State Title V Programs Budget and Expenditures by Types of Service.

The decrease in the amounts expended versus budgeted noted on Forms 3 – 5 is the result of significant cuts to the MCFH budget during FY99. Several programs (Prenatal Care II and Prematernal Grants) were eliminated due to legislative reductions and shifting coverage for eligible participants to Denali KidCare. In addition, the Health Families Alaska Program sustained a \$388,500 legislative reduction.

MCFH's "pyramid" of services is not true to form due to the large amount of dollars being expended on enabling services and fewer dollars on population-based services. The enabling services level of the pyramid includes WIC and Part C programs – two of the largest budgeted programs offered by MCFH. Additionally, the direct services level of the pyramid remains large due to MCFH taking over the Alaska Breast and Cervical Health Check Program, funded by the Centers for Disease Control and formerly administered out of the Public Health Division's Section of Epidemiology.

Figure 2

**CORE PUBLIC HEALTH SERVICES
DELIVERED BY MCH AGENCIES**



2.2 Annual Number of Individuals Served

Form 6, Number of Percentage of Newborns and Others Screened, Confirmed and Treated; **Form 7**, Number of Individuals Served (Unduplicated) Under Title V; **Form 8**, Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX; and **Form 9**, MCH Toll-Free Telephone Line Reporting Form are included in Section 5.8, All Other Forms, pages 158-161.

2.3 State Summary Profile

Form 10, Title V Maternal and Child Health Block Grant Services Profile is included in Section 5.8 , All Other Forms, pages 162-163.

2.4 Progress on Annual Performance Measures; and

2.5 Progress on Outcome Measures

Alaska has made progress on the national and state performance measures to varying degrees. Many of the national performance measures are not tracked internally at MCFH and require coordination with other public health sections and Department divisions. The most recent data is presented for all measures. Data come from many sources and the availability varies.

Direct Health Care Services

Pregnant Women, Mothers, and Infants

Included in FFY99 direct health care services to pregnant women, mothers, and infants were family planning services. The family planning program sought to ensure that no births were unintended. An examination of the most recent (CY98) Pregnancy Risk Assessment Monitoring System (PRAMS) data indicates that 43% of all births were unintended. MCFH will continue its efforts towards *reducing the % of unintended births* (State Performance Measure #1) in the next fiscal year. State Performance Measure #1 relates to National Outcome Measure #1 – the infant mortality rate.

Data from SFY99 indicates that teens comprised 34% of those accessing clinical family planning services through public health centers and MCFH family planning nonprofit grantees. The providers that MCFH contracted with during that time had specific training and experience

in working with teens. The Adolescent Health Coordinator worked with the Alaska Adolescent Health Advisory Committee to develop, distribute and promote a health plan that outlined a framework for adolescent services and programs including family planning. In FFY99 the Teen Abstinence grant program directed funds to locally based abstinence education efforts resulting in direct services being provided to 65 teens in Southeast and Southcentral Alaska.

Children

In SFY99, the audiology program served a total of 1273 people. Of these, 642 were children from birth to age 21, and 631 were adults. Services were offered in areas unserved by the private sector and in general, were rural and remote sites.

Children With Special Health Care Needs

Alaska continued to provide direct services to CSHCN by offering subspecialty services including genetics, cleft lip and palate, cardiac and neurodevelopmental clinics in various communities across the state.

Alaska's Fee for Service Regulations, 7 AAC 80, were revised and became effective during FFY98. Unlike the previous regulations, charges to third party payors and families for all specialty clinic services are now based upon the most current Medicaid reimbursement rates, and fee reduction schedules linked to the most current Federal Poverty Guidelines for Alaska. Revenue generated by Alaska's delivery of direct services to CSHCN is monitored yearly.

Alaska's Medicaid program covers rehabilitative services for all eligible children. During FY99, all *SSI beneficiaries less than 16 years of age were Medicaid eligible and received rehabilitative services through Medicaid funding (Core Performance Measure #1)*.

Enabling Services

Pregnant Women, Mothers, and Infants

Located on the enabling services pyramid level, the Healthy Families Alaska (HFAk) program is designed to prevent child abuse and neglect and improve childhood health and well-being through an intensive home visitation program. High-risk families may be offered services prenatally or at the time of birth, and may continue services for three to five years.

In SFY 99, MCFH funded this program in seven urban and rural sites. Service providers, including community nonprofit organizations and in one site, the Section of Public Health Nursing, collaborated closely with other resources to maximize service delivery to families. The focus of the home visitation included supporting the parents as well as facilitating parent-

child interaction and child development. HFAk's FFY99 goal of outreach to 400 families was surpassed as 437 families were reached.

The *rate of substantiated reports of harm to children* (State Negotiated Performance Measure #2), was established last year in conjunction with the development of the FFY99 MCFH Block Grant. The SFY99 performance indicator was 17 per 1,000 for children less than 18 years of age. Since child abuse and neglect continue to be a top priority of the Department of Health and Social Services and the Governor, and additional resources have been allocated and changes made to the child protection system, MCFH anticipates that future performance objective targets will be achieved. This MCFH activity should positively impact all six of the National Outcome Measures.

In FFY99 nearly 30,000 women, infants and children below 185% of the poverty level were eligible for WIC services. By providing nutrition education and supplementation to pregnant women, the WIC program may have helped to *decrease the percent of very low birth weight live births*. (Core Performance Measure #15) The WIC program also promoted the inclusion of folic acid in the diet that contributes to the reduction in *the rate of neural tube defects*. (State Negotiated Performance Measure #9)

Children With Special Health Care Needs

Enabling services to pregnant women, mothers and infants includes the Early Intervention/Infant Learning Program (EI/ILP) which is guided by federal and state laws and regulations. Alaska's EI/ILP (including Part C of IDEA) provided comprehensive, collaborative, community-based, family-centered services that were designed to meet the developmental needs of children with or at risk for developmental delays within a family context. In SFY99, 1,862 children were referred and 1,622 were enrolled in the EI/ILP. The EI/ILP was the pivotal MCFH activity that contributed to *assuring family participation in program and policy activities in the State CSHCN program*. (Core Performance Measure #14). Programmatically, families participated in the development of individual family service plans (IFSP) and served on program advisory committees for individual EI/ILP grantees. Families were involved in policy activities in the State CSHCN program by serving as members on the Interagency Coordinating Council (ICC) and by advising CSHCN staff on various issues.

Accomplishments in the EI/ILP in FFY99 included the development of outcomes and performance measures, creation of an analyst position in the State EI/ILP, development of a

new data system in collaboration with EI/ILP providers, and implementation of a voluntary credentialing system. Collection of data for many of the CSHCN and other performance measures is being incorporated into new system designs. These efforts will provide trackable data regarding Alaska's progress toward increasing *the percentage of CSHCN enrolled in the program with a source of primary and specialty care insurance* (Core Performance Measure #11).

Fee-for-service billing was ongoing for EI/ILP grantees and has impacted the adoption of the revised Fee for Service Regulations, 7 AAC 80. MCFH assisted programs by providing ongoing technical assistance, support and assistance with interpretation and implementation for grantees and their contractors. Children and families enrolled in the EI/ILP and other CSHCN programs in FFY99 were not routinely queried about whether or not they had a medical home and, therefore, the performance indicator for Core Performance Measure #3 remained very low. This data element however, is being included in the new data collection system. Additionally, specialty and genetics clinics (see Direct Human Services, CSHCN) programs began to collect medical home data during this reporting period.

Population-Based Services

Pregnant Women, Mothers, and Infants

Activities that are part of the population-based services level of the pyramid include those in which preventive interventions and personal health services have been developed and are available to the entire MCFH population in Alaska.

One of these projects was the Alaska Domestic Violence Prevention Project (ADVPP) which, in FFY99, provided training on domestic violence and child abuse in fifteen rural communities; provided training to various health care provider groups throughout Anchorage; coordinated with the Alaska Network on Domestic Violence and Sexual Assault the Alaska "Ten State Initiative" funded by the Family Violence Prevention Fund; developed family violence prevention curriculum for use by the Ten State Initiative program and people trained by it; expanded the family violence lending library; and provided technical assistance to providers across the state.

The performance measure related to family violence was changed from *percentage of all injuries from domestic violence* to the *percentage of people who experience intimate partner violence during their lifetime* (State Performance Measure 7). Baseline data was collected in

CY99 using a question added the Behavioral Risk Factor Survey. MCFH believes the efforts of ADVPP noted above will help to lower the rate of abuse identified in this performance as well as in the *percentage of physical abuse to women by their partners surrounding the prenatal period*. (State Performance Measure #5)

The Newborn Screening program (NBS) provided testing of infants for inborn metabolic disorders in FFY99. Alaska law requires that all infants be screened within the first week of life for six disorders, including phenylketonuria (PKU); hypothyroidism; galactosemia; maple syrup urine disease; congenital adrenal hyperplasia; biotinidase deficiency and, by special request, hemoglobinopathies (including sickle cell). MCFH employed a genetic counselor and contracted with the Northwest Regional Newborn Screening Program and Oregon Public Health Laboratory (OPHL) for laboratory services and screening consultation. The contractors and MCFH staff ensured that screening was satisfactorily completed and that infants with abnormal tests began treatment as soon as possible and before 15 days of age. During this reporting period, express mail service to improve options for improving the timely transport of specimens from all Alaska birth facilities to OPHL was implemented in an effort to reduce the number of unsatisfactory specimens, delayed identification, and treatment. This program provided the data for CY99 for *the percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, and hemoglobinopathies* (Core Performance Measure #4).

In FFY99 the Family and Community Nutrition Program (FCNP) continued its work with the Eat Smart Alaska Coalition and the 5 A Day for Better Health program. According to the 1998 Alaska Behavioral Risk Factor Survey, *the percentage of people who eat five or more daily servings of vegetables and fruits* (State Negotiated Performance Measure #8) for the general population of adults is 23% as compared to 17% in the Alaska Native population. A grant from the National Cancer Institute to promote canned and frozen fruits and vegetables in rural Alaska is hoped to reduce this disparity in the next fiscal year.

In FFY99, FCNP staff continued their work on the folic acid awareness campaign committee, by providing oversight on behalf of MCFH with community partners. During 1999 Staff also conducted a survey of women of childbearing age to determine their knowledge and use of folic acid. Preliminary data has been analyzed and the Epidemiology and Evaluation Unit anticipates producing a *Family Health Dataline* that will discuss the survey, its final results, and recommendations. Other FCNP folic acid activities in FFY99 included

development and distribution of an Alaska-specific poster and brochure; production of folic acid issue of Alaska Nutrition News; and presentation of survey results at the National Birth Defects Prevention Meeting Annual Meeting by the Birth Defects Registry Coordinator. In FFY99 the FCNP also continued its work with the Section of Epidemiology and the Take Heart Alaska Coalition on cardiovascular disease prevention activities.

In SFY99 MCFH distributed approximately 10,000 copies of “Myself, My Baby Health Diary.” The *Healthy Baby Diary* contains a wide variety of information, including: changes occurring throughout pregnancy; fetal and infant health promotion (no smoking, alcohol or street drug use, nutrition including use of folic acid, breastfeeding information, immunizations, contraception, back to sleep, child safety tips, etc); and a place to record health care provider visits including weight gain in pregnancy, test results, immunizations and infant growth and development through the infant’s second birthday. The *Diaries* were distributed to health care providers in bulk who then distributed them to their clients. MCFH’s goal was that each pregnant woman/parent of a newborn would receive and use the diary.

Infrastructure Building Services

Pregnant Women, Mothers, and Infants

Many of the MCFH’s programs are reflective of services and activities that are directed at improving and maintaining the health status of all women and children. MCFH provides support for development and maintenance of comprehensive health services systems including the development and maintenance of health services standards/guidelines, training, data, planning and evaluation systems.

In FFY99 the Oral Health program staff provided technical support to the Prevent Abuse and Neglect through Dental Awareness Coalition (PANDA). PANDA began in 1994 with the development of a group concerned about oral health for Head Start children. A decision was made to focus on early intervention efforts for pregnant women and young children and strategies for prevention and early intervention were developed. The dental group has put much of its effort in the past two years into educating peers about their responsibilities to recognize and report child abuse and neglect.

In FFY99, MCFH assisted PANDA with the development of training curriculum for dental providers to use in educating their peers about child abuse; collaborated with the dental community in planning a child abuse and neglect workshop for non-dental providers; and

supported the development and distribution of a survey of dental providers regarding their training needs. MCFH had not dedicated resources to collecting data on this performance measure in FFY99 and currently is exploring ways to gather it. There is no central data collection point for this information though MCFH has sought it through the Alaska Dental Society.

The Epidemiology and Evaluation Unit of MCFH will be closely monitoring national and state performance measures through several distinct but related activities. The PRAMS Project is an ongoing population-based surveillance system that collects information on Alaskan mothers' prenatal and postpartum experiences and perceptions. The PRAMS Project has population-based data which estimates the prevalence of a wide variety of pregnancy-related behaviors, perceptions, and risks among Alaskan mothers and was responsible for generating data on the following performance measures:

- *% of Mothers who Breastfeed Their Infants At Hospital Discharge* (National Performance Measure #9)
- *% of Unintended Births* (State Performance Measure #1)
- *% of Women Who Smoke Prenatally* (State Performance Measure #3)
- *% of Women Who Drink Prenatally* (State Performance Measure #4)
- *% of Women Experiencing Physical Abuse by Husbands/Partners Surrounding the Prenatal Period* (State Performance Measure #5)
- *% of Mothers Putting Infant Down to Sleep in the Supine Position* (State Performance Measure #6)

The Birth Defects Registry was established in January 1996 and is a population-based surveillance system of birth defects, as defined by the Ninth Revision of International Classification of Diseases. Accomplishments for FFY99 included enhancement of the data collection system and registry database, conduction of a statewide folic acid survey with women of childbearing age, and active involvement in the Alaska Folic Acid Campaign. Statewide presentations were also conducted to educate health care professionals about the registry, and to increase reporting compliance.

The Maternal and Infant Mortality Review (MIMR) Program is a coordinated statewide program developed in response to Alaska's high postneonatal mortality rate. A coordinator and MIMR statewide committee review all infant deaths under 1 year of age and maternal deaths occurring within one year postpartum. The committee reviews information from several

sources including family interviews. The information is entered into various databases for further analysis and recommendation of prevention strategies.

Children

In FFY99 the adolescent health project provided training and technical assistance to communities and state agencies where programs/services for adolescents were planned, implemented and evaluated. The adolescent health staff assisted the work of the Alaska Adolescent Health Advisory Committee by coordinating the logistics of meetings and providing professional staff support.

The Adolescent Health Program was responsible for distributing, “What Kids Need to Succeed – Alaskan Style.” With input from 114 Alaskan communities, the book was developed for rural Alaska and is based on the SEARCH Institute’s Youth Developmental Asset Model. The book has received national recognition and is now being used in several states. In addition to twenty five thousand (25,000) copies of it being made available in FFY99, numerous Youth Developmental Asset workshops were conducted statewide

Children With Special Health Care Needs

During FFY99, MCFH continued its work on the development of an SSDI/CSHCN database system and focused on data systems development. The expansion of the Epidemiology and Evaluation Unit has built capacity and infrastructure for CSHCN and other programs.

The EI/ILP Paraprofessional Project continued during FFY99 with a focus on development of video training modules and accompanying written materials in collaboration with the University Affiliated Program (UAP). Paraprofessionals from 15 EI/ILPs were participants in the project.

III. REQUIREMENTS FOR THE APPLICATION [Section 505]

3.1 Needs Assessment of the Maternal and Child Health Population

3.1.1 Needs Assessment Process

In compliance with Maternal and Child Health Bureau regulations, MCFH engaged in a comprehensive five year needs assessment as completion of the fifth year

of its previous five year needs assessment project period will have occurred on June 30, 2000.

Beginning in January 2000 and in conjunction with significant data stakeholders and the MCFH Advisory Committee (comprised of 18 health and social service professionals and parents), MCFH conducted a comprehensive evaluation of all health status indicators [as well as block grant performance measures (both federal and state) and outcome measures (both federal and state.)] While data for some measures that is difficult to obtain had previously been identified (i.e., hospital discharge data), MCFH staff, in particular the Pediatric Epidemiologist and Epidemiology and Evaluation Unit continue their efforts to identify possible options to obtain more appropriate data.

Following the review of data sources and availability and comprehensive evaluation of health status indicators and performance/outcome measures with stakeholders and Advisory Committee members, a consolidated “needs assessment” report was presented to, and input solicited from, all MCFH employees.

3.1.2 Needs Assessment Content

3.1.2.1 Overview of the Maternal and Child Health Population’s Health Status

To best indicate the health status of the MCFH population, an analysis of the State Systems Development Initiative, Core Health Status, and Developmental Health Status indicators are presented below:

State Systems Development Initiative Indicators

Access to care

1. Percent of women delivering live births who received adequate prenatal care.

Data for this indicator come from birth certificate data from the Bureau of Vital Statistics linked to Alaska PRAMS. Adequacy of prenatal care was based on the Kotelchuck index. During 1998-99, 68% of women received adequate prenatal care. Alaska 2000 goals were established based on the Kessner index. Using this index, the 2000 goal for Alaska is >80%. The proportion of women in the US as a whole receiving adequate prenatal care during 1995 based on the Kessner index was 71%, compared to 61% in Alaska.

2. Uninsured and Medicaid Eligible Alaskans

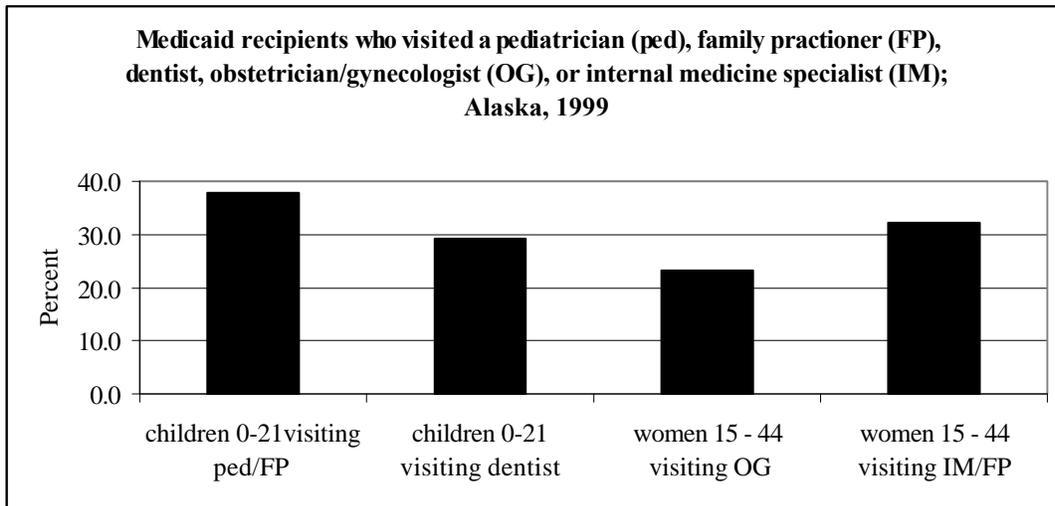
Data for this indicator comes from the Division of Medical Assistance. During 1999, an estimated 82,000 (12%) Alaskans and 23,500 (10%) Alaskans less than 20 years of age were without insurance. During the same period, 23,653 women and 63,009 children 1-20 years of age enrolled in Medicaid. Alaska's Children's Health Insurance Program (CHIP) is called Denali Kid Care and has greatly increased the financial limit for children to qualify for Medicaid services. This has had a substantial but unmeasured impact on the number of uninsured children.

3. Percent of Medicaid enrollees under 1 year of age who received at least one Early and Periodic Screening and Developmental Testing (EPSDT) screen.

Data for this indicator come from the Medicaid Services Unit. During 1999, 76% of Medicaid enrollees under 1 year of age received at least one EPSDT screen.

4. Percent of Medicaid eligible persons utilizing services

Regardless of the type of service measured, less than 40% of Medicaid eligible persons were seen by particular medical specialists during 1999.



5. The number of health care providers enrolled in Medicaid (provider type 1-96).

During 1999, 5432 providers were enrolled in Medicaid.

6. Percent of women receiving a physical examination within the last two years or pap smear within the last year.

Data for these indicators comes from the Behavioral Risk Factor Surveillance System (BRFSS). During 1998, 78% of women reporting having received a physical examination during the previous two years while 79% reported having received a pap smear during the previous one year. During 1994, BRFSS reported that 90% of women 18 years of age and older had received a pap smear during the previous three years, compared to 77% for the US as a whole and an Alaska Year 2000 goal of >85% for all demographic groups.

7. Percent of 3-5 year olds enrolled in Headstart.

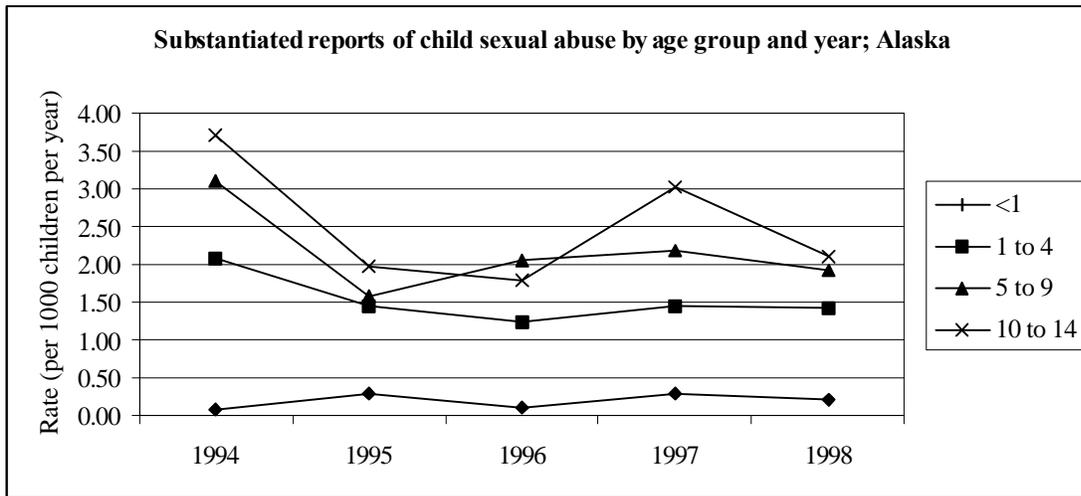
During 1999, 23% of eligible children 3 to 5 years of age were enrolled in Headstart.

Child Abuse

1. Substantiated reports of sexual abuse of children.

Data for this indicator come from the Division of Family and Youth Services (DFYS). While substantiated reports likely represent a more stable indicator than all reports it is nevertheless subject to bias. In addition to reflecting the true number of cases of sexual abuse, the value at a particular time may reflect the level of funding and staffing at DFYS, public attitudes and perceptions, the legal authority

given to DFYS, and other unmeasured factors. During 1994 there were 542 substantiated reports of sexual abuse of children under 18 years of age. Since that year, the number has fluctuated between 265 and 406 with no noticeable trend. The highest rate of substantiated sexual abuse is among children 10-14 years of age. Since 1994, rates have not declined appreciably for any age group measured.



7. Ratio of substantiated abuse of female to male children, 0-17

Data for this indicator come from DFYS. During 1994-97 as a whole this ratio was 2.7 and ranged from 2.8 to 4.1.

8. Percent of investigated reports of harm to children that are substantiated.

During 1998, 44% of reports of harm to children were substantiated.

9. Annualized average of substantiated reports of harm, by type of abuse.

Of the various types of abuse compiled by DFYS during 1993-98, the most common was neglect (8.7 per 1000 per year) followed by physical abuse (4.5), sexual abuse (1.8), mental injury (0.4), and abandonment (0.1). During 1993, the rate of alleged maltreatment of children (per 1000 less than 18 years of age per year) was 56 in Alaska compared to 42 in the US as a whole. The value for the most recent year available (1997) was 56 compared to an Alaska Year 2000 goal of <50.

Child Morbidity

1. The percent of children enrolled in Infant Learning Program (ILP) services

During 1999, the percent of Alaskan children 0-3 years of age enrolled in ILP services was 2.7%. This figure reflects services actually provided but does not address the number of children who would qualify for services but who are not currently served.

2. The percent of Women, Infants, and Children (WIC) recipients age 0-5 with anemia.

The WIC database provided information on this indicator. During 1998, 11% of WIC enrollees age 0-5 years of age had anemia (as defined by age-appropriate standards) compared to 12% during 1999. WIC primarily approaches anemia as a nutritional issue. An unknown proportion of anemia cases in Alaska, though, are due to non-nutritional causes such as *Helicobacter pylori* infection. In particular, studies have demonstrated high rates of *H. pylori* infection among Alaska Natives with anemia. Consequently this indicator may not reflect nutritional services provision or need.

During 1994, 23% of WIC recipients 12-23 months of age had anemia as defined by a hemoglobin <5th percentile for age compared to 13% for the US as a whole and the Alaska Year 2000 goal of no more than 19%. Among children 2-4 years of age the percent fell to 19% but the percent in the US as a whole was only 6%; among Alaska Native WIC recipients, the proportion was 24%.

3. Prevalence rate per 1000 live births of congenital defects.

General. Birth defects surveillance systems have been established in many states. The quality of these systems, though, varies considerably. Some states use birth certificate check boxes, a notoriously poor source of information. Other states such as California employ dozens of people and review the medical records of all newborns within prescribed study areas. Alaska uses a passive surveillance system that relies on health care provider reporting of birth defects identified during the first year of life (with the exception of fetal alcohol syndrome that is up to the sixth birthday).

Fetal alcohol syndrome (FAS). FAS is one of the most common preventable birth defects. FAS prevalence was determined by the Alaska Fetal Alcohol Syndrome Project, a multiyear investigation by the State of Alaska and the Centers for Disease Control and Prevention. Cases are identified through a variety of data sources and then validated through medical chart reviews. Because few states put forward this degree of effort to identify FAS cases, the prevalence in Alaska cannot be compared to other areas. Additionally, no gold standard test exists for the identification of FAS. Consequently, reported prevalences may reflect differences in awareness and training of health professionals, demands by parents for services, and other factors. During 1995-97, the estimated FAS rate in Alaska varied from 1.0-1.4 per 1000 live births, depending on the case definition used.

Neural tube defect (NTD). A proportion of NTDs are preventable through appropriate prenatal use of folic acid. NTDs included spina bifida, anencephaly, and hydrocephaly. Data were derived from the Alaska Birth Defects Registry, which has been operational only since 1998. NTD prevalence may be subject to considerable ascertainment bias since asymptomatic spina bifida occulta represents the most common form of NTD. Nevertheless, interstate comparisons are probably reasonably valid since generally only clinically significant lesions are reported to birth defects registries. During 1996 there were 0.56 NTDs per 1000 live births. Because this rate is based on only six cases, it is unstable.

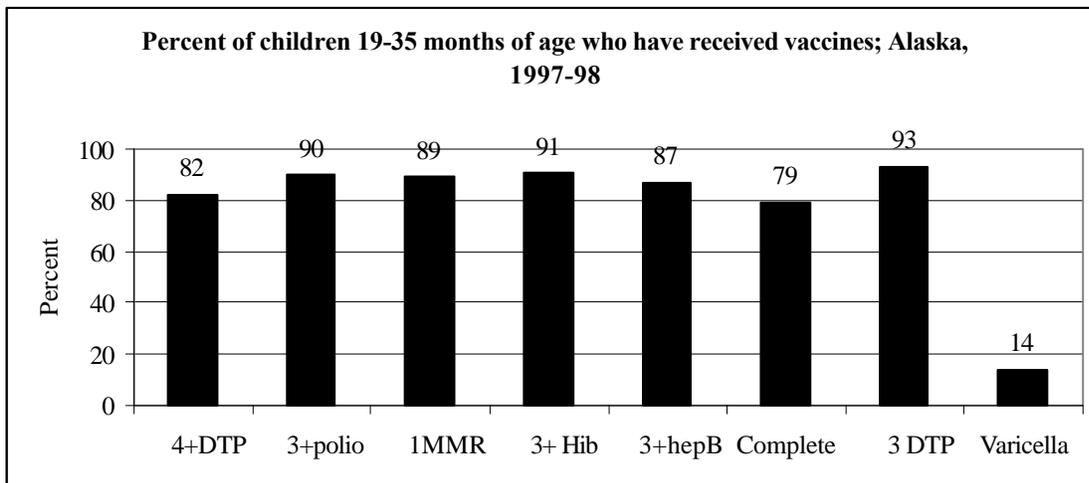
Cleft lip and palate. While cleft lip and palate is in general not preventable, it is common and amenable to surgical repair making it an important measure to monitor. Again, data come from the Alaska Birth Defects Registry. During 1996, 12 cases of cleft lip and palate were reported for a prevalence of 1.2 per 1000 live births. By comparison, the prevalence in California (a large state with a comprehensive birth defects surveillance system) was 1.0 during 1995.

Down syndrome. Because the incidence of Down syndrome increases with advancing maternal age, it is potentially preventable, either through decreased child bearing among older women or elective abortions. In Alaska during 1996, there were 1.3 cases of Down syndrome for every 1000 live births. This is identical to the prevalence found in California during 1995.

4. Vaccination coverage.

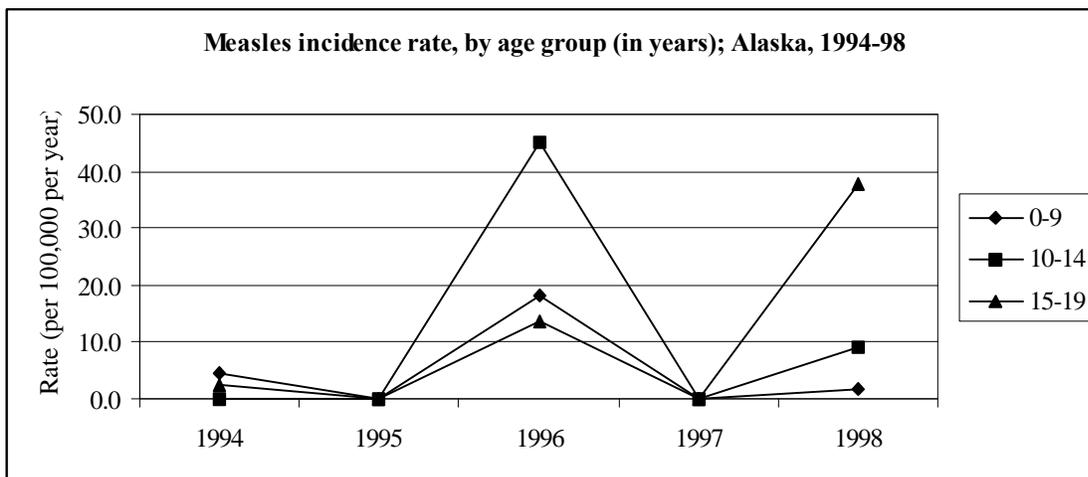
Data on vaccination coverage comes from the Alaska Section of Epidemiology. It is based on a retrospective review of school immunization records as no well-functioning statewide immunization tracking system currently exists.

During 1997-98, over 80% of children received 4+ DPT, 3+ polio, 3+*Haemophilus influenzae* type b (Hib), and 3+hepatitis B while 79% had received all of these vaccines by the age of 36 months. The Alaska Year 2000 goal is for 90% of children to have had all of these immunizations before their third birthday while the proportion for this outcome among all US children was 77% during 1996.



5. Vaccine-preventable diseases among persons 0-9, 10-14, and 15-19 years of age.

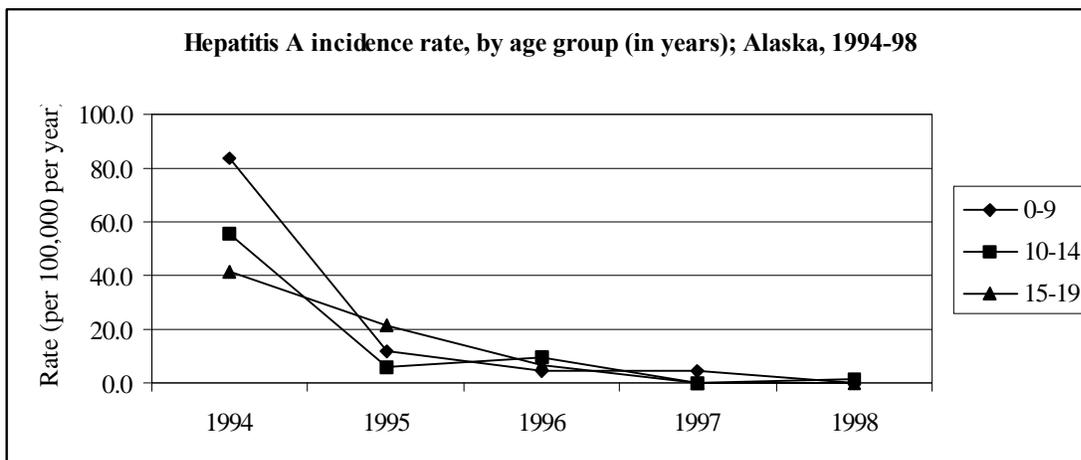
Measles. The total number of measles cases during 1994-98 among persons <20 years of age was 81 reflecting an outbreak during 1996 and a smaller one during 1998. During 1996, rates were higher among children 10-14 years of age while in 1998 rates were higher among children 15-19 years of age. Overall, during 1994-98 measles rates were 4.8, 11, and 11 per 100,000 per year among children 0-9, 10-14, and 15-19 years of age, respectively. The Alaska Year 2000 goal for measles cases is zero.



Mumps. Twenty-one cases of mumps were reported during 1994-98, with at least two cases occurring every year examined. Fourteen cases were among children 0-9 years of age (rate, 2.5 per 100,000 per year), five among children 10-14 years of age (rate, 1.9), and two among older persons (rate, 0.9). The Alaska Year 2000 goal for mumps is less than two cases per year.

Hepatitis B. Three cases of hepatitis B were reported during 1994-98, one in each age group (rates, 0.2, 0.4, and 0.5 per 100,000 per year among progressively older age groups). The hepatitis B incidence rate among all age groups in Alaska during 1997 was 2.5 per 100,000 per year compared to 23 among the US as a whole (during 1995) and an Alaska Year 2000 goal of <3.5.

Hepatitis A. During 1994-98, 185 cases of hepatitis A were reported. Incidence rates during this period were 21, 14, and 13 per 100,000 persons per year among progressively older age groups. The great majority of these cases occurred during an outbreak in 1994-95. The hepatitis A incidence rate among all age groups in Alaska during 1997 was 5.4 per 100,000 per year compared to 33 among the US as a whole (during 1995) and an Alaska Year 2000 goal of <10.



Haemophilus influenzae type b (Hib). Thirteen cases of Hib disease occurred during 1994-98, all among children less than nine years of age (rate, 2.4 per 100,000 persons per year). Nine of these cases occurred during 1996-97 following a change in vaccine formulation. The original vaccine preparation has now been reinstated.

Pertussis. Twenty-six cases occurred during 1994-98, all but four among children <10 years of age (rates, 4.0, 0.7, and 0.9 per 100,000 persons per year among progressively older age groups). All but three cases occurred during 1997-98. The Alaska Year 2000 goal is less than five cases per year.

6. Sexually transmitted diseases

Gonorrhea. During 1998, incidence rates for gonorrhea among persons 0-9, 10-14, and 15-19 years of age were 1.8, 13, and 170 per 100,000 persons per year, respectively. The Alaska Year 2000 objective for persons 15-19 years of age is <328 per 100,000 persons per year while the national rate during 1995 was 665.

Chlamydia. During 1998, incidence rates for chlamydia among persons 0-9, 10-14, and 15-19 years of age were 3.7, 53, and 1535 per 100,000 persons per year, respectively. No Alaska Year 2000 goal was set. Furthermore, rates of this disorder are likely less stable than gonorrhea because chlamydia reporting only recently began in Alaska and chlamydia infections may more commonly be asymptomatic.

Children's Behavioral Health

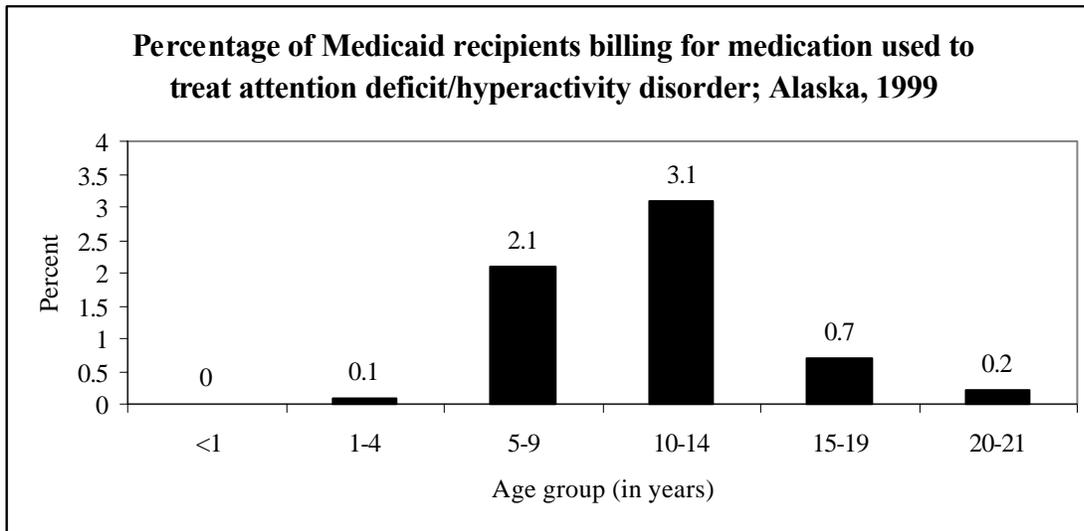
1. Percent of Infant Learning Program (ILP) clients 0 to 3 years of age with behavioral health issues, by age group.

We were not able to obtain age group specific values for this indicator. On the Individualized Family Service Plan, the person completing the form (usually the early intervention teacher) may check a box indicating behavioral health concerns, not otherwise specified. The Infant Learning Program (ILP) identified 6.7% of clients served for whom this box was checked. The biases inherent in this estimate are numerous and may include the skill, motivation, and education of the teacher, diagnostic bias related to the uneven provision of diagnostic services in different areas of the state, and others.

2. Percent of Medicaid children on medication for attention deficit/hyperactivity disorder (ADHD) by age.

No readily available data sources exist for estimating this value for all children in Alaska. Consequently, we relied on Medicaid claims data from the Division of Medicaid Assistance. Furthermore, the only year available for analysis was 1999 because of changes in Medicaid billing practices from the Alaska Area Native Health Services.

During 1999, 1.3% of persons 0-21 years of age who received Medicaid services billed for a prescription for one of the common medications used to treat ADHD, including methylphenidate, dextroamphetamine, and pemoline. The highest proportion of users was among the 10-14 year old age group, with 3.1%. In addition to true differences in the occurrence of symptomatic ADHD, differences in age groups may reflect differences in physician diagnostic patterns, differences in school attendance, or other biases.



3. School drop out rate per 100 students, grade 7 – 12.

Using data from the Department of Education, the school drop out rate for grades 7-12 declined from 4.1 per 100 students during 1996 to 3.4 per 100 students during 1997-98, a decline of 17%.

4. Percent of mothers who binge drink after delivery.

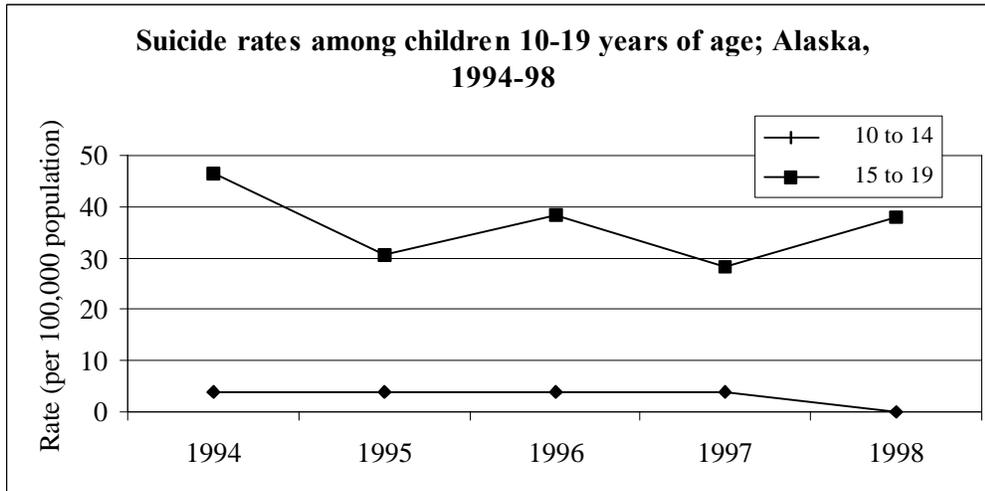
The Alaska Pregnancy Risk Assessment Monitoring System surveys mothers of live born infants. The average infant age at the time of the survey is 4 months. A question on binge drinking was added during the 1998 survey. During 1998, 9% of mothers who had a live born infant had an episode of binge drinking post delivery.

5. Suicide rate by age group

The Alaska Bureau of Vital Statistics collects cause of deaths from death certificates. We evaluated suicide rates by age group and year for persons under 10-19 years of age during 1994-98. We did not evaluate younger groups because of the difficulty ascribing the notion of intent to kill oneself to children less than 10 years of age.

The overall suicide rates during 1994-98 for children 10-14 and 15-19 years of age were 3.0 and 36 per 100,000 population per year. By comparison, the suicide rate among persons 15-19 years of age in the US as a whole during 1995 was 10.5 per 100,000 per year. The suicide rate in Alaska did not decrease during the study period. It must be recognized that assignment of suicide as a cause of death implies

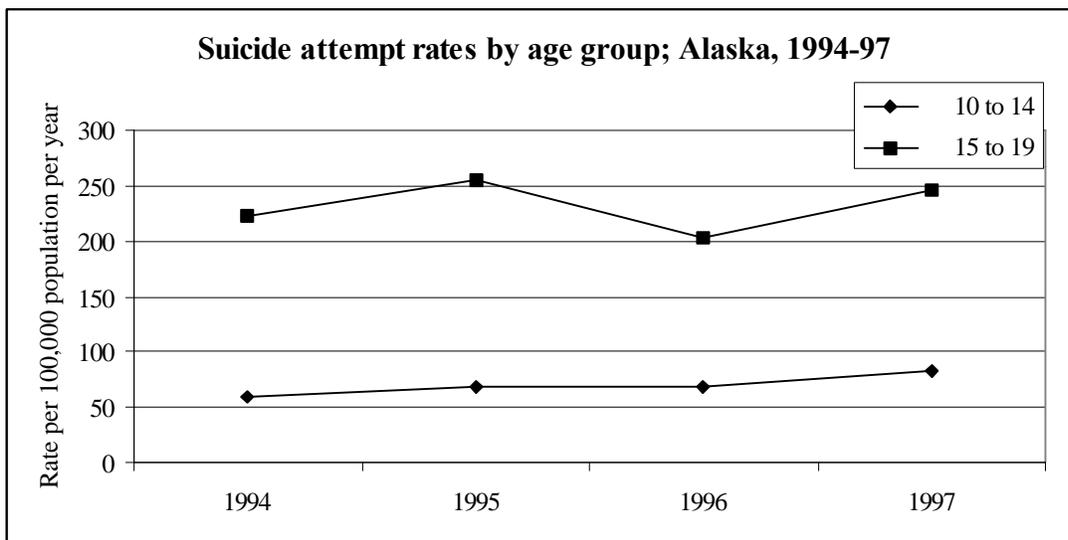
knowledge of intent. Consequently, suicide rates may be biased due to changes in cultural acceptance of suicide, racism, and other unmeasured factors.



6. Suicide attempts by age group.

Suicide attempts are difficult to define because many if not most persons who attempt but do not succeed at suicide may never report to a clinical facility. The Alaska Trauma Registry collects data on suicide attempts seen in emergency rooms and we report this here. These data should be interpreted as minimum rates.

During 1994-97, the suicide attempt rates among persons 10-14 and 15-19 years of age were 70 and 232 per 100,000 persons per year, respectively. Comparison data for the remainder of the United States are difficult to obtain. Youth Risk Behavior Survey data for 1995 found that 4.4% of high school girls reported a suicide attempt that required medical attention, compared to 3.4% for the United States as a whole.



Intentional Injury

1. The percent of pregnant women experiencing physical abuse by partners.

Data for this indicator come from Alaska PRAMS. Consequently, it reflects data for women who have had a live birth rather than pregnant women. Women who spontaneously or electively terminate their pregnancy may differ from women who complete their pregnancy with respect to the experience of violence. During 1998, 7.1% of women who had a live birth reported experiencing physical abuse by their partners.

2. Rapes per 100,000 females

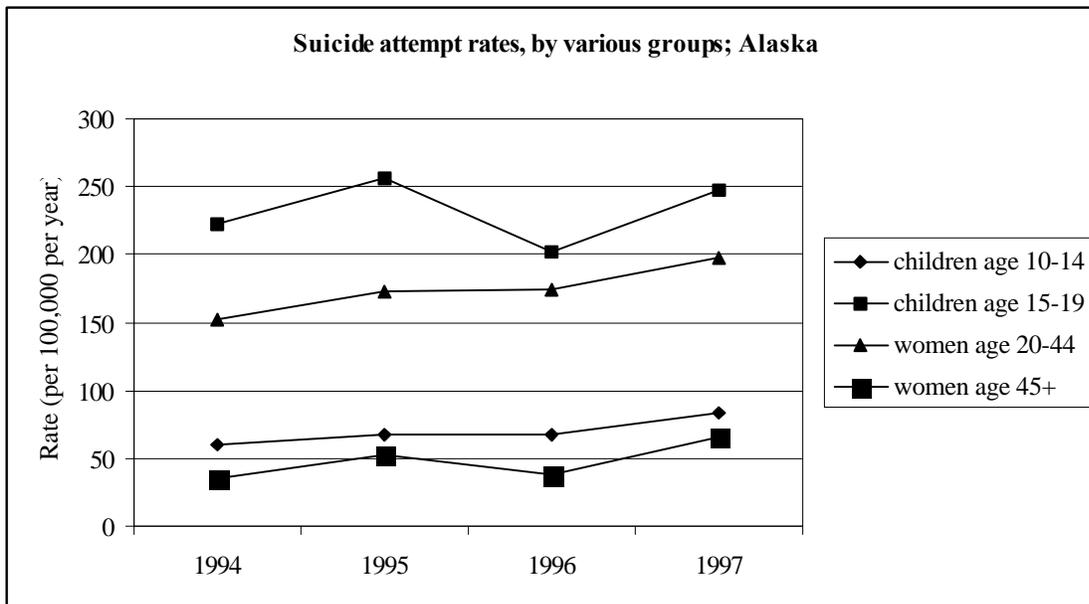
Data for this indicator come from police reports for only the Municipality of Anchorage. Data for other areas of Alaska are not readily available. Rape is defined as the carnal knowledge of a female forcibly and against her will; statutory rape and other sex offenses are excluded. The SafeCity Program provided this data to MCFH. The rate of rapes per 100,000 females per year has remained essentially constant during 1994-97, ranging from 137-164. The Alaska Year 2000 goal for the rate of rape and attempted rape is less than 150 per 100,000 women per year. During 1996, the rate of rape and attempted rape in the US as a whole (from the Uniform Crime Report) was 71 per 100,000 per year.

3. Suicide attempts.

Data for this indicator come from the Alaska Trauma Registry. This database provides information only for persons who present to a hospital emergency room. Furthermore, because of the social stigma associated with suicide attempts it is likely that some children who attempt suicide and present to a hospital receive a different diagnosis. For these reasons, it is likely that the data presented here represent minimum estimates

During 1994-97, there were three reported suicide attempts among children less than 10 years of age and thus they are excluded from further analysis. The annualized average suicide attempt rates for children 10-14 and 15-19 years of age during 1995-97 were 73 and 235 per 100,000 children per year, respectively. Suicide attempt rates have not declined during 1994-97 and for younger children appear to have increased.

Among women 20-44 and those at least 45 years of age, the annualized average suicide attempt rates were 137 and 50 per 100,000 per year, respectively. Again, rates have not decreased and for younger women appear to have increased.



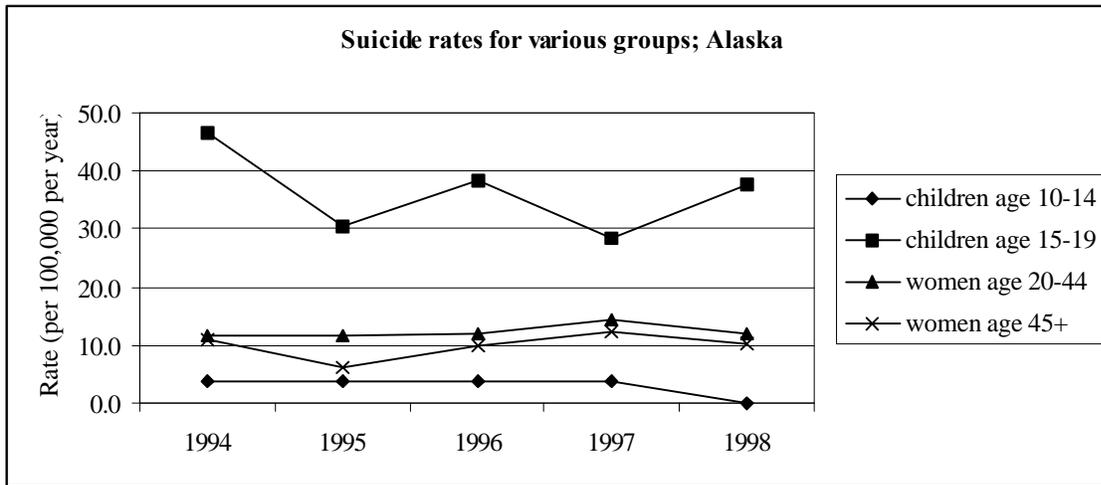
4. Suicide rates.

Data for this indicator come from the Bureau of Vital Statistics. Similar to suicide attempts, it is likely that successful suicide rates represent an underestimate

of the true rate because of misdiagnosis of the cause of death. During 1994-98, there was one successful suicide among a child under 10 years of age and so this group was excluded from further analysis.

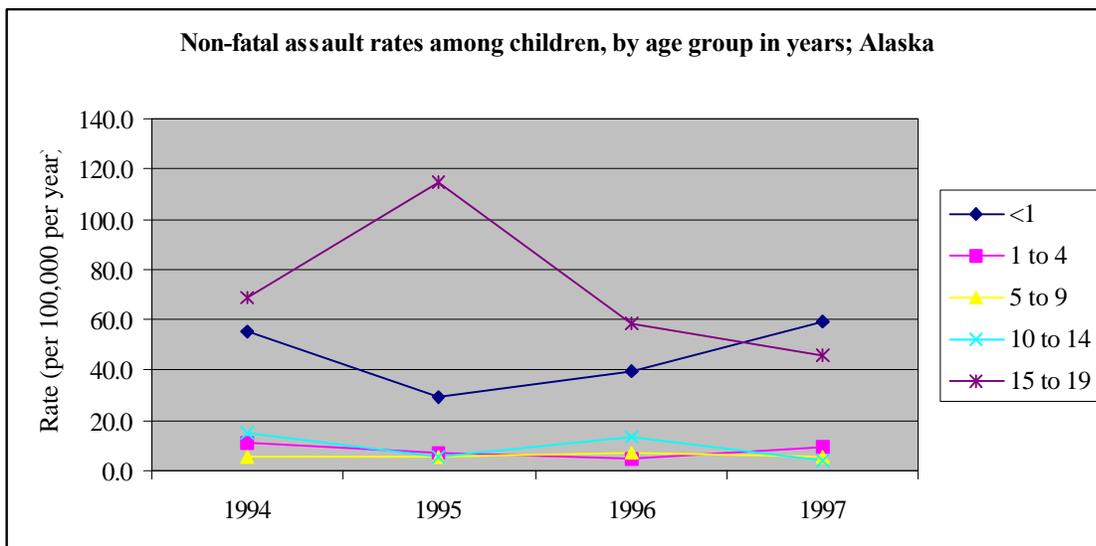
The annualized average suicide rates for children 10-14 and 15-19 years of age during 1996-98 were 2.5 and 35 per 100,000 children per year, respectively. Suicide rates have not declined during 1994-98. The suicide rate among 15-19 year old persons in the US as a whole during 1995 was 11 per 100,000 per year, while the Alaska Year 2000 goal is 29.

Among women 20-44 and those at least 45 years of age, the annualized average suicide rates were 13 and 11 per 100,000 per year, respectively. Again, rates have not decreased.



5. Non-fatal injuries due to assault per 100,000.

Data for this indicator come from the Alaska Trauma Registry and are subject to similar limitations to those described under the section on suicide attempts. The annualized average non-fatal assault rates for children <1, 1-4, 5-9, 10-14 and 15-19 years of age during 1995-97 were 43, 7.0, 5.9, 7.5, and 72.2 per 100,000 children per year, respectively. Suicide rates have not declined during 1994-98.



Among women 20-44 and those at least 45 years of age, the annualized average non-fatal assault rates were 36 and 18 per 100,000 per year, respectively. Again, rates have not decreased. During 1994-97, rates have increased from 38 to 50 per 100,000 per year among younger women and have increased from 16 to 22 per 100,000 per year for older women.

According to the Department of Public Safety, the overall assault rate in Alaska during 1994 was 1870 per 100,000 persons per year compared to data from the Uniform Crime Report for the US as a whole that found a rate of 1270 per 100,000 per year.

6. Homicide rates per 100,000.

Data for this indicator come from the Bureau of Vital Statistics and in general are subject to similar limitations to those described for suicides. Additionally, homicide is a legal diagnosis rather than a medical diagnosis and must meet the legal standards for defining homicide. Thus homicide rates are influenced by the well-functioning of the criminal justice system within a particular jurisdiction.

The annualized average homicide rates for children <1, 1-4, 5-9, 10-14 and 15-19 years of age during 1996-98 were 17 (n=5), 4.0 (n=5), 1.8 (n=3), 2.5 (n=4), and 10.2 (n=14) per 100,000 children per year, respectively. Because of the small number of homicides, comments on trends cannot be made.

Among women 20-44 and those at least 45 years of age, the annualized average homicide rates were 5.9 (n=22) and 4.1 (n=9) per 100,000 per year, respectively.

Again, because of the small number of homicides, comments on trends cannot be made.

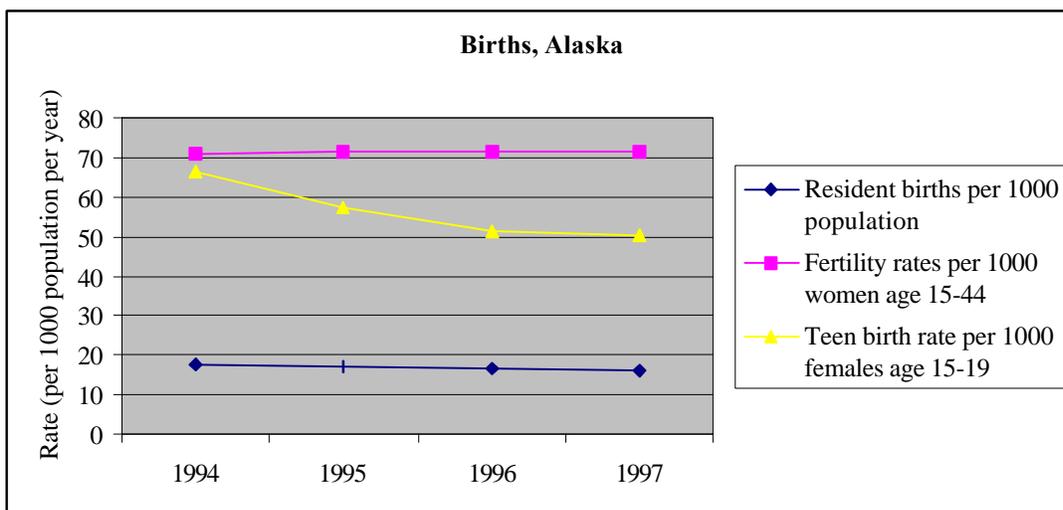
The overall homicide rates in Alaska and the US as a whole during 1995 were 10.1 and 9.2 per 100,000 per year. The Alaska Year 2000 goal is less than 7.2.

Reproductive Health

1. Births.

Data for this indicator come from the Bureau of Vital Statistics, Alaska PRAMS, and the Behavioral Risk Factor Surveillance System (BRFSS). During 1998, the average maternal age was 27 years. During 1997, there were 16.3 resident births per 1000 population, 71.4 births per 1000 women aged 15-44 years, and 50.2 births per 1000 women aged 15 to 19 years. While birth and fertility rates have remained constant during 1994 to 1997, teen birth rates have declined. The Alaska Year 2000 goal for teen births is less than 50 per 1000 per year. This compares to a rate of 55 per 1000 per year for the US as a whole during 1996.

According to PRAMS data, during 1998, 43% of births were unintended. This compares to 49% in the US as a whole during 1995 and an Alaska Year 2000 goal of less than 25%. According to BRFSS data, 34% of women at least 18 years of age were pregnant during the preceding five years.



2. Infectious diseases.

Data for this indicator come from the Section of Epidemiology passive surveillance system. During 1998, the numbers of chlamydia and gonorrhea cases reported per 100,000 women 15-44 years of age were 1026 and 123. The overall annual incidence of gonorrhea (per 100,000 population per year) during 1995 was 107 in Alaska and 150 in the US as a whole. The Alaska Year 2000 goal is less than 74 per 100,000 per year. Because of the newness of chlamydia reporting comparison data and goals are not available.

3. Contraceptive use.

Data for this indicator come from BRFSS. The proportion of sexually active females at least 18 years of age who reported using birth control of any method during 1998 was 67%. The proportion of sexually active females at least 18 years of age using vasectomy (in their partner) or tubes tied as a birth control method during 1998 was 42%.

Substance Abuse

1. Percent of Alaskans with alcohol dependency or abuse.

Based on the Alaska Adult Household Telephone survey, conducted by the Gallup Organization, the Division of Alcoholism and Drug Abuse determined that 14% of Alaskan residents 18 years of age and older had alcohol dependency (9.7%) or abuse (4.1%). This compares with 7.4% for the US as a whole. Alcohol dependency was fairly consistent across regions in Alaska, varying from 8.5% among Gulf Coast communities to 12% among Bush communities.

2. Percent of clients in state-funded alcohol treatment programs with children in the home.

During 1997-99, the Division of Alcoholism and Drug Abuse found that 43-45% of clients in state-funded alcohol treatment programs had children in the home.

3. Percent of pregnant women using alcohol, cigarettes, and illicit drugs.

The Alaska Pregnancy Risk Assessment Monitoring System (PRAMS) was used to determine this indicator for 1998. Because of the question wording on

PRAMS, alcohol and cigarette use was determine for the third trimester while illicit drug use was determined for the entire pregnancy. Data are self-reported and are subject to the biases common to other self-reported survey data, including recall bias, deceit, and under ascertainment of high risk groups.

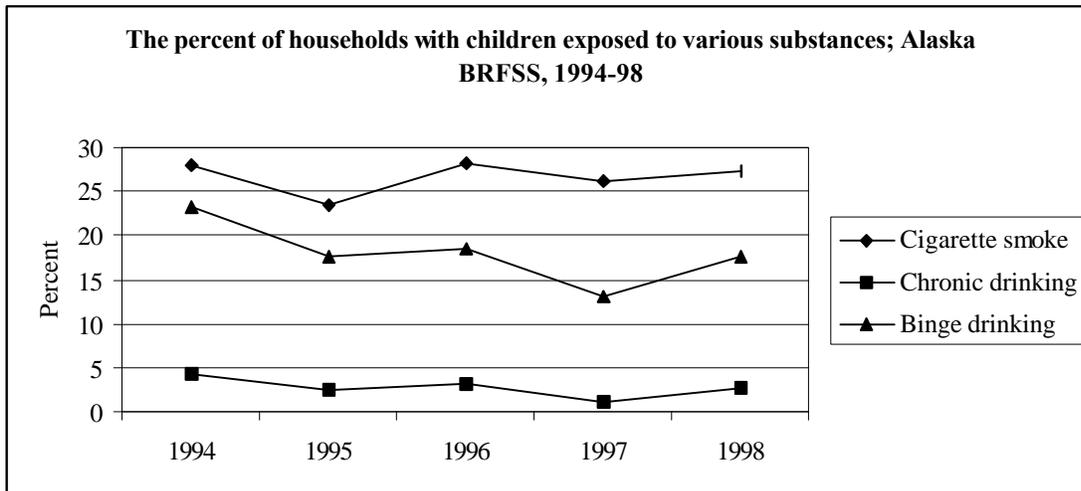
During 1998, the same proportion of women reported using alcohol and illicit drugs during pregnancy (4%), while a much higher proportion used cigarettes (19%). The values for alcohol and illicit drugs are within the Alaska Year 2000 goals, while cigarette use remains above the goal of <15% and is higher than the US proportion of 14%.

4. Percent of household with children exposed to cigarette smoke, binge drinking, and chronic drinking.

The Behavioral Risk Factor Surveillance System provided data for this indicator. The percent of households with children exposed to cigarette smoke remained static during 1994-98 and varied from 23-28%. Comparison data for this indicator is not available. BRFSS, however, indicates that the smoking prevalence among persons over 18 years of age in Alaska is approximately the same as that in the United States as a whole (29 vs. 26% during 1994); the Alaska Year 2000 goal for this outcome is <15%.

The percent of households with children exposed to binge drinking varied from 13-23% during 1994-98 with no noticeable trend. Again, comparison data for this outcome are not available. In 1995, though, BRFSS found that 19% of Alaskan adults engaged in binge drinking compared to 14% in the United States as a whole.

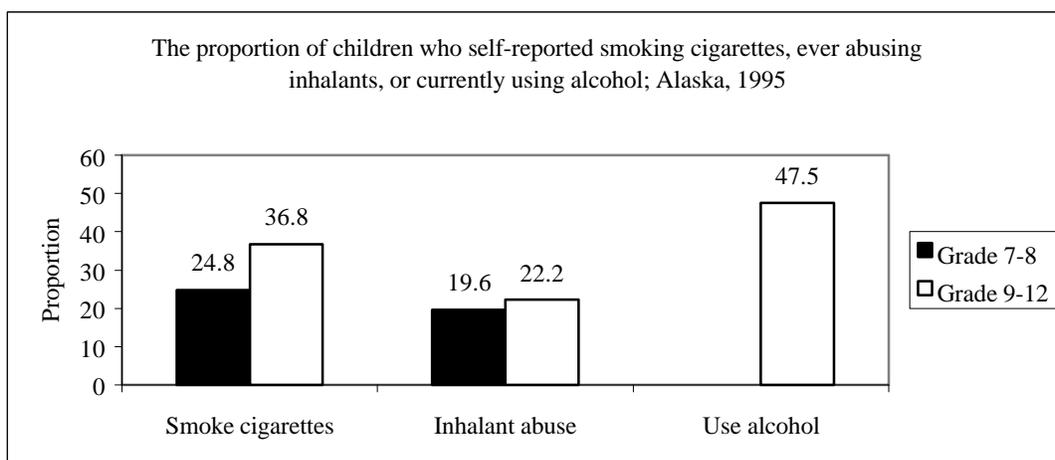
The percent of households with children exposed to chronic drinking varied from 1.2-4.3%, again with no noticeable trend. Again, comparison data for this outcome are not available. In 1995, though, BRFSS found that 3% of Alaskan and US adults engaged in chronic drinking.



- Percent of children who smoke cigarettes, ever abused inhalants, or currently use alcohol.

The Youth Risk Behavior Survey provided data on this indicator. Data for alcohol use was only available for grades 9-12. Data is only available for 1995 because of restrictions placed on administration of the survey by the Alaska legislature.

During 1995, a high proportion of children in grades 9-12 reported all three types of substance use, although alcohol use was more common than cigarette and inhalant use. A considerable proportion of children in grades 7-8 also reported cigarette or inhalant use. Alaska has achieved the Year 2000 goal of less than 55% for alcohol use and is lower than the 52% in the US as a whole. Binge drinking among Alaska youth continues to be high with 31% of 12th graders having reported drinking five or more alcoholic drinks on at least one occasion during the previous month. The Alaska Year 2000 goal for this is <20 while the value for the US as a whole is 33%.



Unintentional injuries

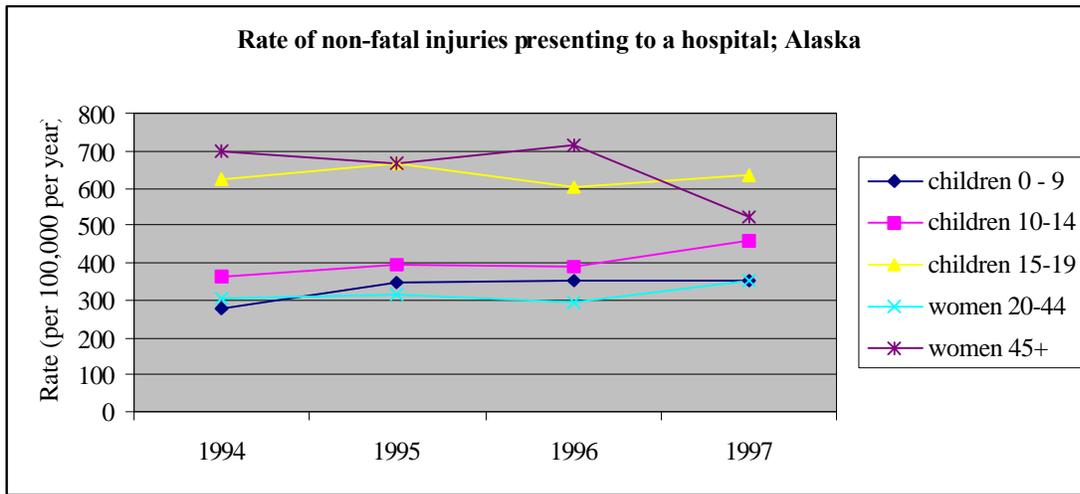
1. Injury rate for non-fatal, unintentional injuries, all causes.

Data for this indicator come from the Alaska Trauma Registry. Consequently, the data reflects injuries that led to presentation to a hospital rather than the rate of all injuries. During 1995-97, the injury rates per 100,000 persons per year for various age groups are listed below:

Age group (in years)	Number	Rate (per 100,000 per year)
children 0 - 9	1159	351.3
<1	101	331.4
1-4	505	392.8
5-9	553	323.7
children 10-14	667	415.5
children 15-19	843	634.4
women 20-44	1138	241.0
women 45+	1518	687.7

The rate of nonfatal unintentional injuries resulting in hospitalizations among all Alaskans during 1995 was 631 per 100,000 per year compared to 635 among US residents as a whole. The Alaska Year 2000 goal is a rate of less than 600 per 100,000 per year.

The rate of non-fatal injuries presenting to a hospital did not change appreciably during 1994-97 for any of the groups evaluated.



2. Injury rate for non-fatal, unintentional injuries, specific causes.

The top ten causes of non-fatal unintentional injuries presenting to a hospital in Alaska during 1995-97 for all age groups were (in order) falls, highway motor vehicle use, off-road vehicle use, fire/burns, exposure, poisoning, bicycle use, water transport use, firearm use, and swallowing foreign objects. We examined rates (per 100,000 per year) for the top three causes of hospitalization by specific causes during 1995-97:

Age group (in years)	Falls	Highway vehicle use	Off-road vehicle use
children 0 - 9	135.2	32.4	11.2
<1	150.9	19.7	3.3
1-4	125.2	37.3	7.0
5-9	139.9	31.0	15.8
children 10-14	127.1	56.1	64.2
children 15-19	120.4	225.0	76.8
women 20-44	96.8	72.9	13.6
women 45+	515.6	81.5	10.9

By far the highest rate of fall injuries was among women 45+ years of age, with all other groups having a relatively equal rate. By contrast children 15-19 years of age had by far the highest rate of injuries related to highway vehicle use and children 10-19 years of age had the highest rate of injuries related to off-road vehicle use.

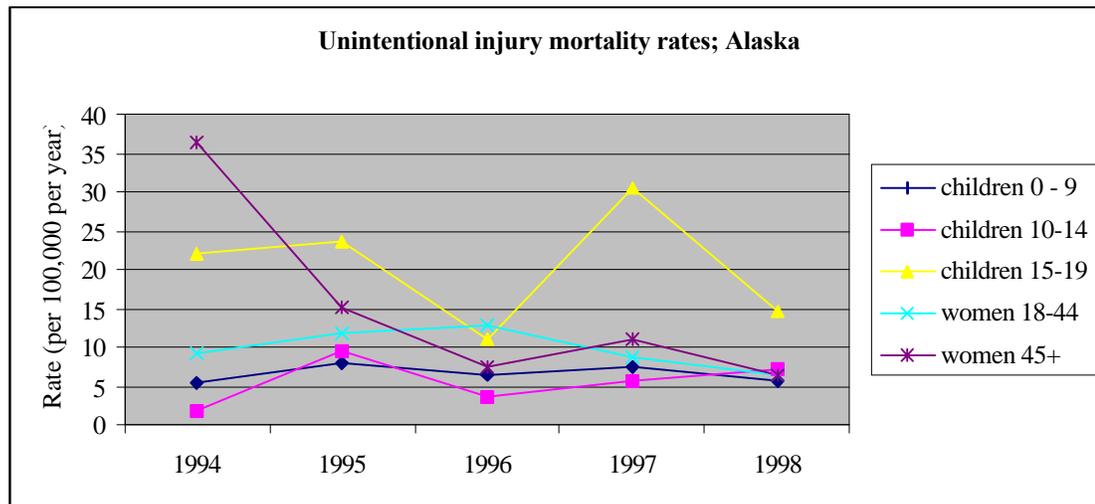
3. Unintentional injury mortality, all causes.

Data for this indicator come from the Alaska Bureau of Vital Statistics. During 1995-97, the fatal injury rates per 100,000 persons per year for various age groups during 1996-98 are tabled below:

Age group (in years)	Number	Rate (per 100,000 per year)
children 0 – 9	66	20.2
<1	13	43.1
1-4	31	24.6
5-9	22	12.9
children 10-14	28	17.2
children 15-19	75	54.4
women 18-44	89	23.7
women 45+	88	39.9

During 1995, the unintentional injury death rate among all Alaskans was 56 per 100,000 per year compared to 31 among US residents as a whole. The Alaska Year 2000 goal for this indicator is <50 per 100,000 per year.

The unintentional injury mortality rate has stayed relatively constant during 1994-98 for most groups examined. The main exception to this was among women 45+ years of age whose mortality rate decreased.



4. Unintentional injury mortality, specific causes.

The top ten causes of non-fatal unintentional injuries presenting to a hospital in Alaska during 1995-97 for all age groups were (in order) motor vehicle injury, drowning, burns, suffocation, firearm injury, air transport injuries, other, exposure,

falls, and poisoning. We examined rates (per 100,000 per year) for the top three causes of death by specific causes during 1996-98. Mortality rates for motor vehicle use and drowning were highest among children 15-19 years of age while mortality rates for burns were highest among the youngest and oldest groups examined:

Age group (in years)	Motor vehicle use	Drowning	Burns
children 0 - 9	6.4	2.8	2.1
<1	0.0	6.6	3.3
1-4	11.1	3.2	3.2
5-9	4.1	1.8	1.2
children 10-14	6.8	2.5	2.5
children 15-19	23.9	8.7	0.0
women 20-44	8.8	4.0	1.1
women 45+	9.5	6.8	4.5

The motor vehicle crash death rate per 100 million vehicle miles traveled for all Alaskans during 1995 was 1.7 (Department of Transportation), identical to that among US residents as a whole. During 1995 there were 2.8 residential fire deaths per 100,000 persons among all Alaskan residents compared to 1.2 among US residents as a whole and an Alaska Year 2000 goal of less than 4. During 1995 there were 8.5 drowning deaths per 100,000 persons among all Alaskan residents compared to 1.7 among US residents as a whole. Similarly, during 1995 there were 5.9 drowning deaths per 100,000 children under 5 years of age in Alaska compared to 3.7 among US residents as a whole.

Core Health Status Indicators

CORE HEALTH STATUS INDICATOR #01 (Ambulatory Sensitive Condition)

The number per 10,000 hospitalizations for asthma (ICD-9 Codes: 493.0-493.9) among children less than five years old.

Alaska does not have legislation allowing for the collection of uniform hospital discharge billing information. As a proxy for this measure, we examined Medicaid billing information. Because Medicaid data for Alaska Natives was batch-billed until 1998, we do not have information for earlier periods. During 1998, 246 of 10,541 hospitalizations among children less than 5 years of age were billed to ICD-9 codes 493.0-493.9 (proportion = 233 per 10,000 admissions). The proportions for Natives and non-Natives were 255 and 205 per 10,000 admissions, respectively. The Healthy People 2000 objective for the United States is 50 per 10,000 admissions. It is good to keep in mind that asthma admissions may be billed for under ICD-9 codes other than those evaluated; consequently it is likely that the reported numbers represent a lower limit.

CORE HEALTH STATUS INDICATOR #02A and 02B (Adequacy of Primary Care)

The percent of Medicaid and CHIP enrollees whose age is less than one year during the reporting year who received at least one initial or periodic screen.

Alaska collects Medicaid billing data. During 1998, 3,822 of 5,028 children enrolled in Medicaid received at least one initial or periodic screen (proportion = 76%). During 1998, 65 of 112 (58%) of children enrolled in CHIP received at least one initial or periodic screen. For Medicaid enrollees, the Healthy People 2000 objective for the United States is 100%. In Alaska, it is possible that some children who did not bill Medicaid or CHIP actually did receive a screen. For example, some children might have been screened after they moved out of Medicaid eligibility.

CORE HEALTH STATUS INDICATOR #03 (Prenatal Care Participation)

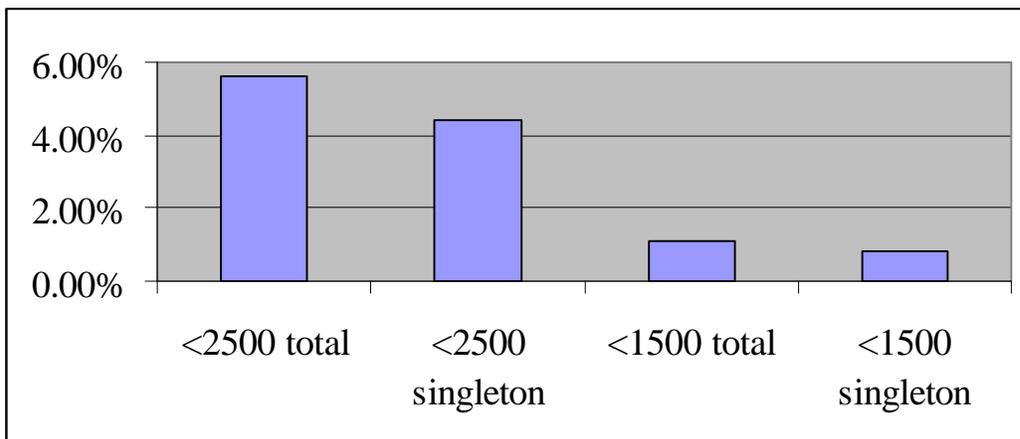
The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

Birth certificates from the Alaska Bureau of Vital Statistics provided this information. Birth certificates may be an inaccurate source of prenatal care since this information may not be available to the person completing the birth certificate. During 1998, 8,634 of 9,920 (87%) of women 15-44 with a live birth had an observed to expected prenatal visits ratio of at least 0.80. The Healthy People 2000 objective for the United States is 90%.

CORE HEALTH STATUS INDICATOR #04A, 04B, 05A, 05B (Low Birth Weight)

The percent of live and live singleton births weighing less than 2,500 grams and less than 1500 grams.

Data for this outcome come from birth certificates provided by the Alaska Bureau of Vital Statistics. The percent of total live and live singleton births less than 2500 or 1500 g are as follows:



By comparison, in the US as a whole during 1995 7.3% of all births were <2500 g and 1.4% were less than 1500 g. The Healthy People 2000 objectives for the United States are <5% of all live births resulting in a low birth weight (<2500 g) infant and <1% resulting in a very low birth weight (<1500 g) infant.

CORE HEALTH STATUS INDICATOR #06A

The percent of low birth weight infants by Medicaid payment status.

While 6% of all infants were born low birth weight (<2500 g), 7.5% of infants whose birth was billed to Medicaid were low birth weight compared to 4.9% of non-

Medicaid births. The Healthy People 2000 objective is <5% for all births; no objective has been set for Medicaid births.

CORE HEALTH STATUS INDICATOR #06B

Infant deaths per 1000 live births by Medicaid payment status.

During 1998, the overall infant mortality rate (IMR) was 5.8 per 1000 live births. This outcome was concentrated among Medicaid recipients who had an IMR of 7.5 compared to 4.5 per 1000 live births among non-Medicaid recipients. During 1995, the overall US IMR was 7.5 per 1000 live births, with large differences among different racial groups. The Healthy People 2000 objective is <7 per 1000 live births; no objective has been set for Medicaid births.

CORE HEALTH STATUS INDICATOR #06C

Percent of pregnant women entering care in the first trimester by Medicaid payment status.

During 1998, 82% of all pregnant women entered care during the first trimester, compared to 75% of Medicaid recipients and 86% of non-Medicaid recipients. During 1995, 81% of pregnant women in the US as a whole entered care during the first trimester. The Healthy People 2000 objective is >90%; no objective has been set for Medicaid births.

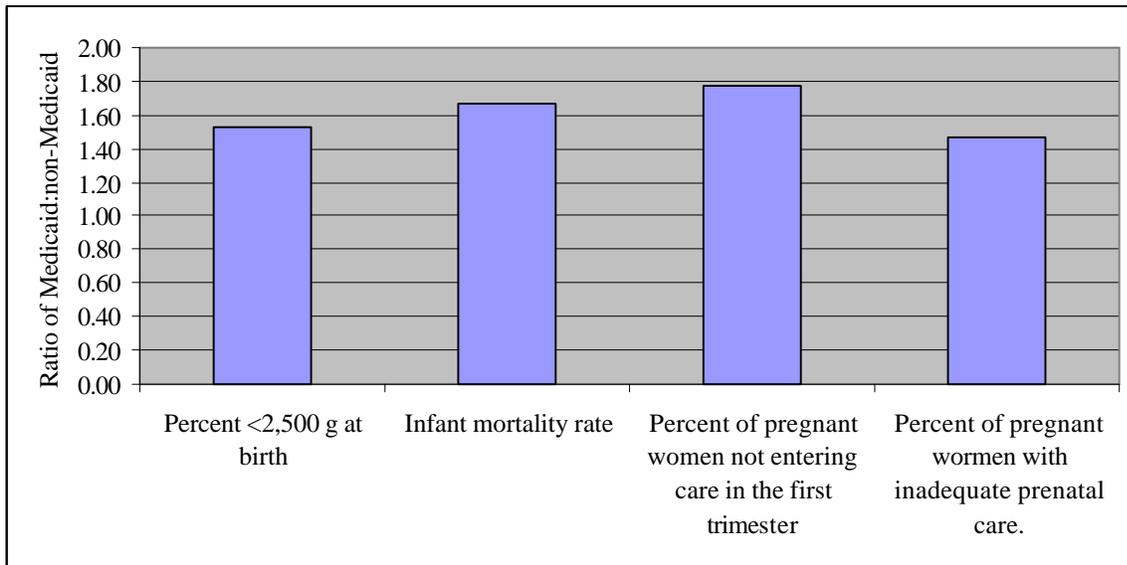
CORE HEALTH STATUS INDICATOR #06D

Percent of pregnant women with adequate (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index]) prenatal care by Medicaid payment status.

During 1998, 67% of all pregnant women had adequate prenatal care compared to 59% of Medicaid recipients and 72% of non-Medicaid recipients. The Healthy People 2000 objective is >90%; no objective has been set for Medicaid births.

SUMMARY, CORE HEALTH STATUS INDICATOR 6

The following shows the ratio of Medicaid to non-Medicaid recipients for the four outcomes reported in indicator 6. For all measured outcomes, Medicaid recipients fared 40-80% more poorly than non-Medicaid recipients.



CORE HEALTH STATUS INDICATOR #07

Medicaid and CHIP eligibility levels.

During 1999, the percent of poverty level for eligibility in Medicaid and CHIP (Denali Kid's Care) programs are reported below. The Healthy People 2000 objective for the United States is that no American will have a financial barrier to receiving the screening, counseling, and immunization services recommended by the US Preventive Service Task Force.

Age	Medicaid	CHIP
Infants (<1 year)	133	200
Children 0-5	133	200
Children 6-14	100	200
Children 15-21	71	200 (<18)
Pregnant women	200	N/A

Developmental Health Status Indicators

DEVELOPMENTAL HEALTH STATUS INDICATOR #1

Fatal unintentional injuries.

Data for this indicator come from death certificates provided by the Alaska Bureau of Vital Statistics. The death rates per 100,000 among children aged 14 years and younger due to unintentional injuries and motor vehicle crashes were 15 and 6.0, respectively. The death rate among persons 15-24 years of age was 20. The US Healthy People 2000 objective for motor vehicle crash fatalities is <5.5 among persons under 14 years of age and <33 among persons 15-24 years of age.

DEVELOPMENTAL HEALTH STATUS INDICATOR #2

Non-fatal unintentional injuries.

Data for this indicator come from the Alaska Trauma Registry as Alaska does not have a uniform hospital discharge data requirement. From either source, data reflects injuries that led to presentation or admission to a hospital rather than the rate of all injuries. The non-fatal injury rates per 100,000 among children aged 14 years and younger due to all unintentional injuries and motor vehicle crashes were 389 and 42, respectively. The non-fatal motor vehicle crash induced injury rate among persons 15-24 years of age was 216. The US Healthy People 2000 objective among all age groups for nonfatal unintentional injury hospitalizations is <754 per 100,000 per year.

DEVELOPMENTAL HEALTH STATUS INDICATOR #3

Chlamydia infection.

Data for this indicator come from the Section of Epidemiology passive surveillance system. Chlamydia infection rates are imprecise because many infections are asymptomatic or minimally symptomatic, providers may treat a patient based on symptoms without performing a diagnostic test, providers may not report to the Section of Epidemiology even if they obtain a positive diagnostic test, and patients may report multiple times to different providers for the same infection. During 1998, among every 100,000 women 15-19 and 20-44 years of age there were 1261 and 584 cases of *Chlamydia trachomatis* infection reported to the Section of Epidemiology,

respectively. For the US population as a whole (including all ages and both genders), the Healthy People 2000 objective is <170 per 100,000 per year.

DEVELOPMENTAL HEALTH STATUS INDICATOR #4

EPSDT dental health services.

The data for this indicator come from Medicaid Services and the EPSDT program. The percent of EPSDT eligible children aged 6 through 9 years who received any dental services during 1998 was 42% (5,950 or 14,057). No Healthy People 2000 objective for this indicator exists. Two related objectives aim to reduce the proportion of children 6-8 years of age with one or more caries and with untreated caries to less than 35% and 20%, respectively.

DEVELOPMENTAL HEALTH STATUS INDICATOR #5

Adolescent tobacco use.

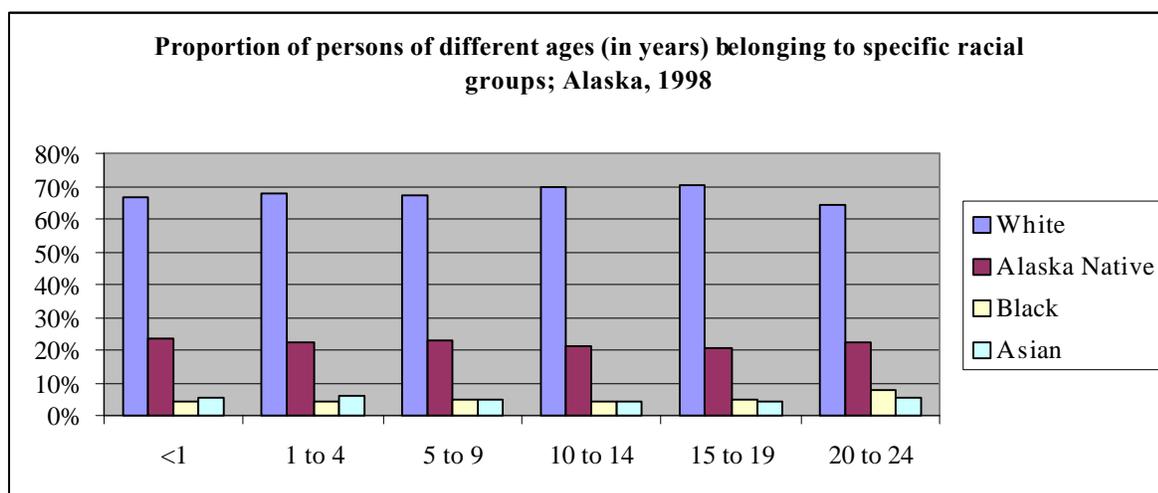
Data for this indicator come from the Youth Risk Behavior Survey, a questionnaire administered to school-age children. In Alaska, 37% of children in grades 9 through 12 reported using tobacco during the previous month. No specific Healthy People 2000 objective exists for this indicator. Nevertheless, a related objective aims to reduce the initiation of smoking by children and youth so that no more than 15 percent have become regular cigarette smokers by age 20 years.

DEVELOPMENTAL HEALTH STATUS INDICATOR #6

Population.

Data for this indicator come from projections provided by the Alaska Department of Labor. The predominant race in Alaska is white followed by Alaska Native for every age group examined. This comparison, however, masks important demographic distinctions. For example, Alaska Natives predominate in most small, rural villages in the state. The proportion of blacks in the 20-24 year age group is higher than in other age groups because of the high concentration of blacks in the military. Only 5.5% of persons age 20-24 years of age in Alaska are of Hispanic ethnicity.

Age group (in years)	All races	White	Alaska Native	Black	Asian
0 to 1	9,968	6,624	2,343	446	555
1 through 4	42,064	28,435	9,326	1,869	2,434
5 through 9	57,820	38,757	13,373	2,819	2,871
10 through 14	55,753	38,947	11,938	2,426	2,442
15 through 19	48,620	34,187	9,965	2,445	2,023
20 through 24	34,482	22,101	7,726	2,718	1,937
Total	248,707	169,051	54,671	12,723	12,262

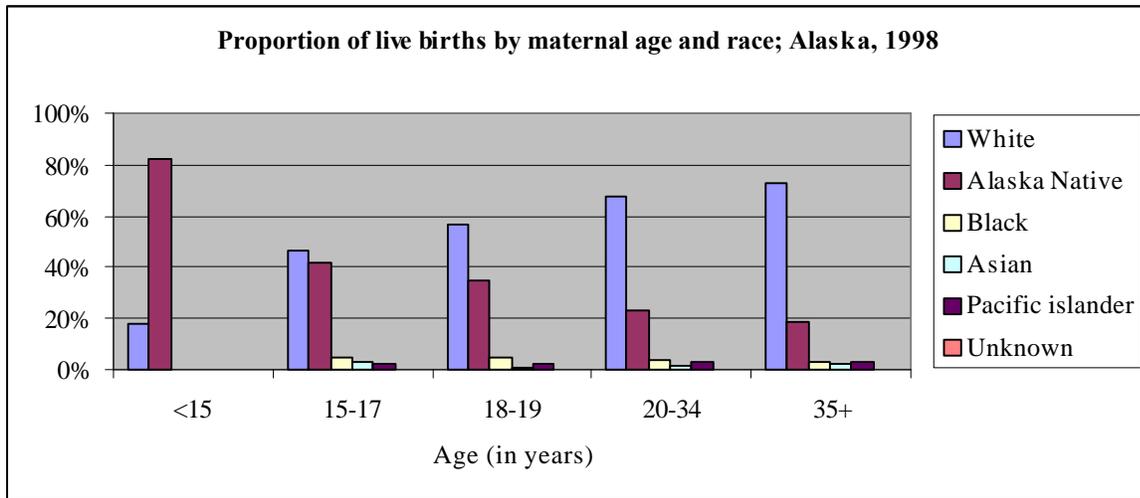


DEVELOPMENTAL HEALTH STATUS INDICATOR #7

Births.

Data for this indicator come from the Alaska Bureau of Vital Statistics. As with population data, the majority of births in Alaska are to white women followed by Alaska Native women. Alaska Native women tend to have births at a younger age than white women do. Hispanics comprise 6% of all live births.

Age group (in years)	All races	White	Black	Alaska Native	Asian	Pacific islander	Unknown
All ages	9,920	6,614	395	2,411	187	293	20
<15	11	2	0	9	0	0	0
15-17	386	181	19	163	13	10	0
18-19	717	407	34	252	6	17	1
20-34	7,478	5,055	302	1,743	142	222	14
35+	1,328	969	40	244	26	44	5

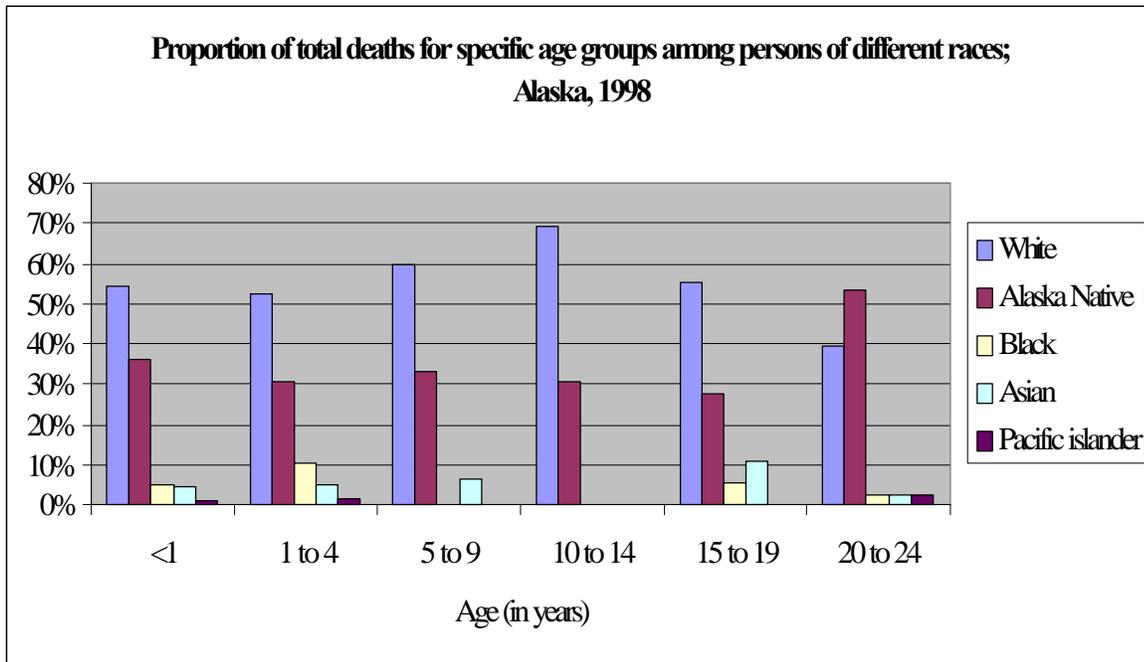


DEVELOPMENTAL HEALTH STATUS INDICATOR #8

Deaths

Data for this indicator come from the Alaska Bureau of Vital Statistics. As with population and birth data, the majority of deaths in Alaska are to whites followed by Alaska Natives. Among different age groups, the relative proportion of deaths contributed by different racial groups remains relatively constant except among persons 20-24 years of age. In this age group, Alaska Natives contribute a relatively larger share, primarily due to intentional and unintentional injuries. Persons of Hispanic ethnicity contributed 8.2% of all deaths to persons 0-24 years of age during 1998.

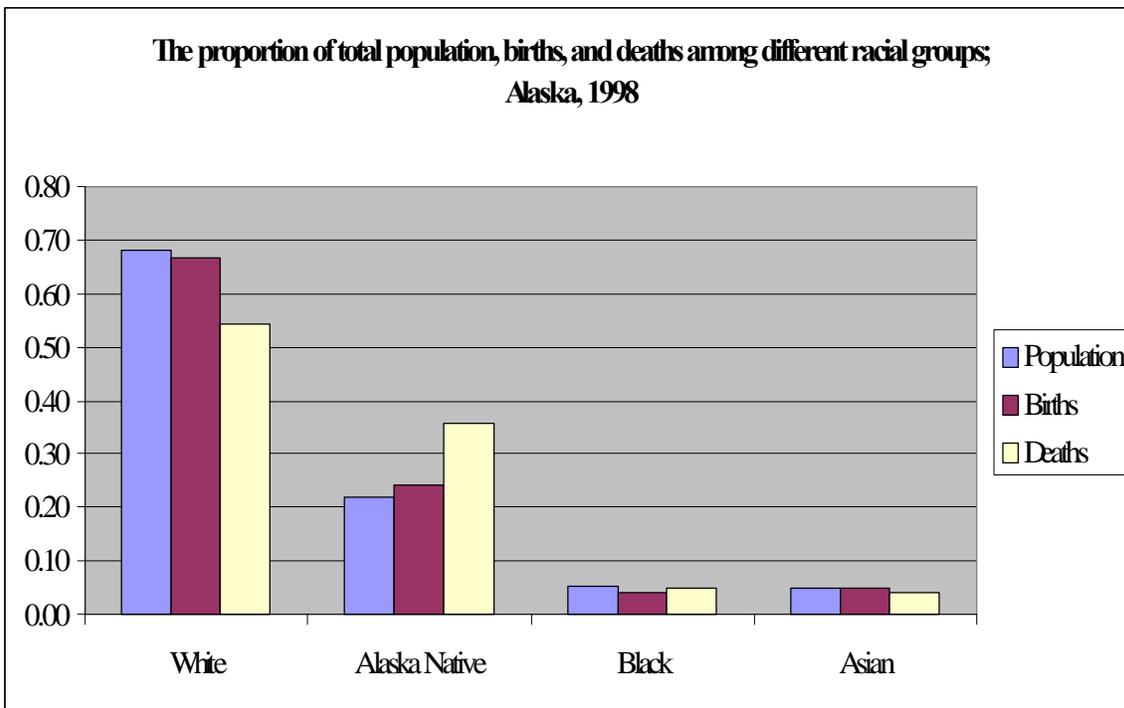
Age group (in years)	All races	White	Black	Alaska Native	Asian	Pacific islander
Total	212	115	10	76	9	2
<1	59	31	6	18	3	1
1 to 4	15	9	0	5	1	0
5 to 9	13	9	0	4	0	0
10 to 14	18	10	1	5	2	0
15 to 19	43	17	1	23	1	1
20 to 24	64	39	2	21	2	0



DEVELOPMENTAL HEALTH STATUS INDICATOR #6-8

Summary

Compared to whites, Alaska Natives make up a relatively high proportion of deaths in Alaska relative to the proportion that they contribute to the total population and births. There is no particular pattern for blacks and Asians.



The comprehensive five-year needs assessment undertaken earlier this year and review of all indicators (analysis listed above) led to the development of a new list of Section priorities. Each of those priority needs by population group (pregnant women, mothers and infants; children; CSHCN) are discussed below, both in relation to respective placement on any or all pyramid levels (Direct Health Care Services, Enabling Services, Population Based Services, Infrastructure Building Services) and in relation to primary care and preventive services.

3.1.2.2 Direct Health Care Services, and

3.1.2.3 Enabling Services

Direct health care and enabling services combined encompass seven of the ten MCFH identified priority needs. For pregnant women, mothers and infants, there is the immediate need to reduce drug use among families, primarily excessive alcohol intake and cigarette use. Of concern but of less public health importance (because of its lower frequency) is illicit drug use. Women also need continued access to comprehensive family planning services, including emergency contraception. Unplanned and unwanted infants are frequently the victims of abuse and neglect, and may permanently affect a woman's or family's economic advancement and future job opportunities.

Both children and children with special health care needs in Alaska need improved access to dental care. There are few dental providers who participate in either Medicaid and/or Denali KidCare in urban areas, and in many rural areas, services are simply not available by any type of provider payor source. Itinerant providers do travel to rural areas to offer services, but frequency is often limited.

Alaska has one of the highest teen suicide rates in the world, which is often attributed to family disintegration and lack of educational and economic opportunities in rural communities. While comprehensively addressing this need for Alaska's children will require collaboration between top federal and state policymakers, health and social services providers and economic development strategists, MCFH believes it paramount to address what many teens see as their only option – suicide.

Many individuals in all population groups (pregnant women, mothers, infants; children; and children with special health care needs) may require intervention in an effort to reduce child abuse and neglect in Alaska. The incidence rates of documented abuse and neglect are fairly high in Alaska and imply a cumulative prevalence of abuse and neglect over the 18 years of childhood of 5-10%. The cumulative prevalence of alleged abuse in Alaska is several fold higher. Because the experience of abuse has been associated with future criminal behavior, earlier and more frequent risk taking behavior such as unprotected sex and drug use, becoming an abuser and other adverse outcomes, MCFH believes that every effort should be undertaken to provide access to comprehensive activities designed to prevent abuse and neglect.

Rates of postneonatal mortality remain high in Alaska and are one of the highest in the nation. MCFH has been working to increase the capacity of systems which appropriately identify and provide treatment for illness to prevent long term sequela for children and children with special health care needs.

In regard to direct health care, MCFH both coordinates and provides services that seek to address the needs outlined above. The Alaska Primary Care Association estimates that only 10% of communities in Alaska (nearly all of which are urban) have physician coverage. Increased federal support for telemedicine projects to electronically connect rural and urban providers and sites may help to alleviate this disparity. Additionally, the Alaska Family Practice Residency Program graduated its first class of family practice physicians in May 2000, all of whom have been trained to work specifically in rural areas. Maps indicating underserved areas are included with this document.

Like direct care, access to enabling services for individuals in all population groups differs within the State. While much of the variance in both categories of service (direct care and enabling services) can be attributed to Alaska's vast size, MCFH works creatively to ensure provision of services – food boxes delivered via the post office for WIC recipients in rural areas where allowable WIC food items may not be available commercially is but one example. MCFH continues to contract with specialists from “down below” (the contiguous United States) for specialty services (ie., genetics, neurodevelopment) and will fly providers of these services to urban and rural Alaska on a regularly scheduled basis.

An increasing number of federally funded Community Health Centers has increased access to primary care for persons requiring care on a sliding fee scale. The number of CHC sites has increased from one site in 1995 to over 13 in 2000, including the Eastern Aleutian Tribes, a cluster of rural tribal health clinics. It should be noted that an increasing number of Section 638 tribal run health consortiums are now operating in the State. With many services for Natives in both rural and urban Alaska being provided by these organizations, many view services as more culturally appropriate than they have been in past years.

3.1.2.4 Population-Based Services

A reduction in the rates of domestic violence, child abuse and neglect and post neonatal mortality, and increased rates in the surveillance and reporting of asthma in children are among the MCFH identified population based services needs. MCFH has identified target activities which will aim to impact each of these rates in an appropriate manner.

MCFH is involved in a number of other population based services programs including those related to newborn screening, immunization, teen birth rate, children's dental health, breastfeeding, newborn hearing screening, women who smoke and drink prenatally, mothers who place infants down to sleep in the supine position, fruit/vegetable consumption and neural tube defect. Alaska's vast size makes collaboration with other groups essential in being able to make these disease prevention, health promotion and outreach programs widely available and accessible to all Alaskans.

3.1.2.5 Infrastructure Building Services

MCFH seeks to continue improving and maintaining the health status of its target populations by providing support to development of standards, training, information systems and systems of care. As a single category, Infrastructure Building Services encompasses the largest number of MCFH identified priority needs, including decreased rates of drug use, unwanted pregnancies, post-neonatal mortality, and rates of very low birth weight babies; increased access to dental care; and the implementation of a comprehensive integrated system on children's behavioral health issues. Increased

capacity building, primarily through the MCFH Epidemiology and Evaluation Unit will serve to address these needs. There is considerable coordination between MCFH and major providers of health care, as well as federal and state funded agencies, local non-profits and tribal consortiums. Collaboration is essential due to the enormous geographic distances between communities in the State.

MCFH has directed considerable effort to enhance CSHCN service system coordination in the past five years and will continue to do so in the future. Entities with well-established Title V CSHCN connections include Indian Health Services (IHS), the Division of Mental Health and Developmental Disabilities (DMHDD), Section of Public Health Nursing, Governor's Council on Disabilities and Special Education (GCDSE) which functions as the Intra-agency Coordinating Council for Part B, Part C and Developmental Disabilities, Medicaid Services Unit, the All-Alaska Pediatric Partnership (AAPP) and its Subspecialty and CSHCN workgroups, the Department of Education and Early Development (DEED), the Bureau of Vital Statistics (BVS), the Children's Hospital at Providence (CHAP), the Stone Soup Group, a family support organization, Family Voices, and PARENTS, Inc., Alaska's parent training center.

State support for communities primarily occurs through the working relationships described above. The statewide EI/ILP provides technical assistance training, establishes data protocols, and provides financial resources to ensure the delivery of EI services. This model will be explored as an option for additional community-based service system enhancements.

Mechanisms also exist for the coordination of health components in community-based systems as a result of the interactions among and between the state and private sector stakeholders who work with Title V CSHCN programs. Future community development is likely to occur through comprehensive support for "grass-roots" efforts, whenever possible. As an example, the coordinated planning for Specialty Clinic services involves IHS, CHAP, the AAPP and PHN. This is expected to continue and may involve privatization of services of services and increased referral and support services for families in the future.

3.2 Health Status Indicators

Completed core health status indicator forms and developmental health status indicator forms are located in Sections 5.4 and 5.6, respectively.

3.2.1 Priority Needs

MCFH established its goals and performance measures based on the priority needs which resulted from its five-year statewide needs assessment. Focus for MCFH will be on prevention and early intervention services related to family violence, child abuse and neglect, young children's behavioral health and reduction of unintended pregnancy. Direct health care services will focus on family planning and breast and cervical cancer early detection and screening. MCFH will continue to rely upon its Epidemiology and Evaluation Unit to support programs and monitor activity effectiveness through its development, implementation of data systems and analysis of relevant data. A summary of MCFH's needs assessment and planning process has been condensed into a list of priority needs and is enumerated on Form 14, located in Section 5.8, All Other Forms.

3.3 Annual Budget and Budget Justification

3.3.1 Completion of Budget Forms

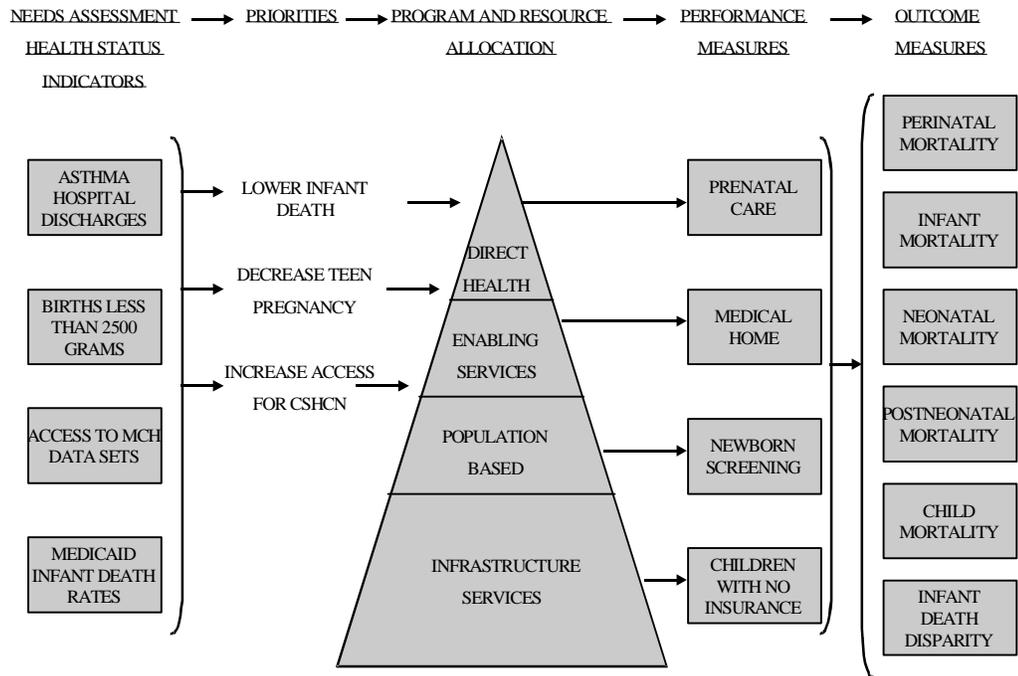
Forms 2-5 are included in Section 5.8, All Other Forms, pages 151-157. For FY2001, children's preventive and primary care comprise 32.97% of the federal allocation and include the Healthy Families Alaska (HFAK) program. Children with special health care needs reflect 37.97% of the federal allocation and include services such as specialty and genetics clinics and the Health Care Program for Children with Special Needs. Administrative costs include salaries to support the Title V Program and are 4.44% - less than one half of the 10% allowable allocation.

3.3.2 Other Requirements

The Alaska Mental Health Trust Authority continues to provide funding for the case/control study of the Healthy Families Alaska Program. This funding will be available throughout the duration of this five-year evaluation.

3.4 Performance Measures

Figure 3
**TITLE V BLOCK GRANT
 PERFORMANCE MEASUREMENT SYSTEM**



3.4.1 National “Core” Five Year Performance Measures

Note: Having collected this data for several years and noting the fluctuation of some of the measures, we believe it to be more appropriate to use 5-year moving averages for some measures. We were not able to implement this change during this year, but do plan to implement for next year’s grant application.

It should also be noted that in past MCFH grant applications, new Performance Measure targets were discussed in relation to available data, which rarely corresponded with the grant application period. For example, if only FFY98 data were available for Performance Measure #1, that information was reported, and the next target rate listed would be for FFY99, even though that time period had already passed and the grant application period being written for was FFY00. This resulted in Performance Measure Targets for many different time periods being listed throughout a single grant application. In an effort to maintain consistency throughout the grant application and for the reader, all Performance Measure targets reflect the new grant application period 10/1/00 – 9/30/01 (FFY01). Progress reporting on performance measure still reflects the most recent available data, which varies between individual measures.

3.4.1.1 Five Year Performance Targets

Performance Measure #1: In Alaska, all SSI beneficiaries less than 16 years old requesting rehabilitative services from the state CSHCN program are eligible for Medicaid. Further, Medicaid covers rehabilitative services for all eligible children (ages 0 – 21) who are SSI beneficiaries. Even as Medicaid is expanded to the 200% of poverty level in Alaska, MCFH anticipates that this population of children will continue to be covered by Medicaid for rehabilitative services, thereby maximizing the use of Title V to fund other programs and services for CSHCN who are without alternative resources.

Performance Measure #2: Children with special health care needs may receive six of nine services in Alaska. (See Attachment #2 on page 165.) For the birth to three year age group, six of nine services are provided by the EI/ILP program. MCFH anticipates that this trend will continue for the next five years. There is considerable interest among many CSHCN stakeholders to have care coordination and case management readily accessible and reimbursable by third party payers. Until state Medicaid regulations change or managed care penetrates the Alaska health care market however, this is unlikely to occur.

Performance Measure #3: During SFY99, only the target set for the medical home prevalence among CSHCN served by Title V programs was met. The projected prevalence of CSHCN with medical homes in the general population was not met for several reasons. Alaska derives its CSHCN number by estimating it to be 10% of the population of children 0 –21.

Until strategies for statistical estimation are improved, this methodology will continue to be used. Benchmarks set for this and subsequent years have been determined to be unrealistic and largely unmeasurable, particularly in regard to CSHCN receiving services outside of those funded or related to Title V programs and activities. As a result, all projected targets are being revised and lowered substantially. As MCFH continues to focus on determining the population size and characteristics of CSHCN in Alaska, it is anticipated that more comprehensive data will be available for the purposes of estimating the prevalence of medical homes. The ability to capture this data has been enhanced during this year with the implementation of a new data system for our Early Intervention/Infant Learning Program. MCFH is in the process of implementing a new data system for its State Specialty Clinics program that will also include “medical home” data collection.

Performance Measure #4: MCFH has been successful in screening a high percentage of births that occur in the state and anticipates that this percentage will be maintained over the next five years. It is important to note the denominator for the newborn screening rate is the Bureau of Vital Statistic’s CY 1999 occupant state births, and the numerator is the total number of initial newborn screening tests conducted. Because it is not possible to separate out newborn screening tests that occur to Alaska residents from those that occur to non-residents, the screening rate reported is greater than 100%. Implementation of a real-time electronic birth certificate by the Bureau of Vital Statistics which will contain a metabolic screening sample bar code is predicted to enhance the screening process, automatically match data and allow for more accurate and rapid follow-up of unmatched specimens. MCFH expects the full implementation of this system within the next two years.

Performance Measure #5: Although not programmatically responsible for immunizations, MCFH will work through its WIC and CSHCN program activities to increase immunization compliance over the next five years. MCFH staff works in collaboration with the Section of Epidemiology to promote increased immunization rates by requiring immunization data reporting for MCFH programs that focus on young children. As reported last year, Alaska ranked 48th in the nation for immunization among two-year olds in 1996. The State responded, making immunization a strong priority and in 1997, Alaska ranked 32nd – a strong improvement. Results from the 1998 National Immunization Survey results showed that 81% of Alaskan two-year olds were appropriately immunized and efforts continue to further

increase both the State's percentage and ranking. Alaska exceeded its last performance objective in this area and has set a target of 85% for FY2001.

Performance Measure #6: MCFH is responsible for adolescent health activities which include those focusing on reducing unwed and unintended pregnancies. Efforts to meet its target rate include support of public health centers and MCFH family planning nonprofit grantees who provide teen family planning; coordination of an Abstinence Grant; membership by the Adolescent Health Coordinator in the statewide Teen Pregnancy Awareness Month Coalition; and maintenance of the statewide Adolescent Health Advisory Committee which provides program activity guidance to the Adolescent Health Coordinator. Alaska has maintained its performance level at 23.0 for FFY01 and seeks to meet an objective of 19.0 per 1,000 births by 2003.

Performance Measure #7: This measure remains difficult in Alaska as the Alaska Dental Society does not collect data related to children who receive protective sealants. The methodology chosen by the State to derive a percentage of children who do involves using the number of dental sealants placed on 8 and 9 year-old Medicaid recipients as a numerator, and the number of all 8 and 9 year-old Medicaid recipients at a point in time as the denominator. The ensuing percentage is then applied to the estimated 8 and 9 year old state population which is obtained by using 40 percent of the 5-9 year old population projection for July 1, 1999. The last reportable periods objective was set at 20% and this goal was nearly met at 19%. Nonetheless MCFH wishes to raise the standards of children's dental care and so has increased its performance objective 24% for FFY01. While it has proven difficult to assess this measurement, there is considerable interest in the dental health of Alaska's children. Other groups, including the Child Health Indicator Project, continue to struggle with finding a good measure for children's oral health in Alaska. Lack of dental resources make it difficult to provide both preventative and restorative dental services especially to rural Alaska. There are even fewer resources available to collect dental data in any uniform manner. Careful consideration of other ways to obtain this data has failed to produce a better alternative than the strategy outlined above. MCFH remains fully committed however to responding to the dental needs of Alaska's children and to finding the most appropriate way to collect and maintain data. This performance measure is one that will receive special attention in Alaska's SSDI application.

Performance Measure #8: Alaska ranks high in deaths to children. In addition to motor vehicle crashes, the state continues to experience significant numbers of deaths to children due to fire and drowning. Prevention activities at MCFH include an infant safety seat program, participation in drowning and fire death prevention activities, and staff participation on safety coalitions sponsored by other organizations. MCFH has one staff member partially dedicated to the prevention of childhood injury programs. This staff member conducts numerous safety presentations in the community including the correct installation of child safety seats for automobiles and through a technician training program, expanding the number of individuals qualified to teach child passenger seat use. Alaska's target objective for FFY01 is 6.4 deaths to children by motor vehicle crashes per 100,000 children.

Performance Measure #9: Alaska exceeds the Healthy People 2000 objective regarding percentage of mothers who breastfeed their infants before hospital discharge. Alaska continues to recommend that this performance measure be revised to examine breastfeeding practices at three or six months postpartum. Alaska has continually met this performance objective and expects to be able to maintain its current rate of 88% of mothers who breastfeed their infants before hospital discharge through FFY01. MCFH's nutrition program continues to provide educational activities about breastfeeding through its continued alliance with the Alaska Breastfeeding Coalition.

Performance Measure #10: Alaska's efforts to increase newborn hearing screening are just beginning through collaboration with a voluntary group of audiologists. Data reported are from hospitals with voluntary universal newborn hearing screening programs, and Providence Hospital's Neonatal Intensive Care Unit (NICU). During CY99, approximately 26% of all births statewide received screening from these participating facilities. Alaska's CSHCN Director was designated as the Title V point person and during FFY99 worked closely with a group of audiologists toward the implementation of universal newborn hearing screening for all children born in Alaska. Alaska was successful in obtaining a universal newborn hearing screen grant and expects to see the level of activity expand in this area. Given that, the target level for this performance measure has been raised to 45% for FFY01.

Performance Measure #11: The source of data for this performance indicator is the population of children receiving services from the EI/ILP, Specialty and Genetics Clinics and the Health Care Program for Children with Special Needs. Eighty-eight percent (88%) of the children being served by the state's CHSCN program have a source of insurance for primary

and specialty care. The state's CHSCN program serves only a small portion of the estimated CHSCN population and we cannot comment about the insurance coverage for that group. The FFY01 target level has been set at 90%.

Performance Measure #12: Census survey data were used to determine the measurement of this performance indicator – the percentage of children without health insurance. MCFH anticipates this percentage to decrease as Medicaid expansion occurs through CHIP. MCFH had hoped to have more recent data available for this measure; however, the pooled Census Bureau Current Population Survey March Supplement data for 1994-1996 remains the most appropriate data source. The State has recently contracted with a firm to provide data from a more recent three-year period. MCFH is a member of the workgroup that is obtaining this data, preparing a report, and making recommendations for its use. Since new data for this measure is not available now however, the performance objective of 8% has not been altered.

Performance Measure #13: The SFY1997 Medicaid data provide the most recent numbers which MCFH uses to estimate the percentage of potentially Medicaid eligible children who have received a service paid by the Medicaid Program. The methodology used to arrive at the percentage includes using the number of children who had a paid service as the numerator and the number of eligible children plus the estimated 5,000 eligible under CHIP (Denali KidCare) criteria as the denominator. MCFH had set a performance target of 77% for FFY1999 and fell somewhat short of it at 73%. Nonetheless, the FFY01 performance measure target has been raised to 79% which we believe to be attainable given existing information.

Performance Measure #14: MCFH expects to maintain its efforts in assuring family participation in program and policy activities in the state CSHCN program. Although MCFH does not directly hire family members as paid staff or consultants, MCFH provides grant funding and works closely with Stone Soup Group, a local agency which advocates for and provides assistance to families of CSHCN to navigate the often complicated and difficult system of specialty care services. Additionally, the EI/ILP relies heavily on parent involvement and support at many levels – needs assessment, program and policy development, priority identification, service delivery, and local and statewide program evaluation, primarily through the Early Intervention Interagency Coordinating Council (EI/ICC) of The Governor's Council on Disabilities and Special Education. Additionally, the EI/ILP monitoring and quality assurance reviews have also occurred through grant funding to Northern Community

Resources, whose lead staff are themselves parents of CSHCN. The target level for FFY01 has been set at 15%.

Performance Measure #15: Alaska has met the 1% performance objective of very low birth weight live births and expects this success to continue. MCFH does not believe that it can realistically reduce any this measure any further and so has chosen to monitor it over time.

Performance Measure #16: Suicide is a significant problem among Alaska's youth and one that continues into adulthood. While Alaska exceeded the performance objective for this measure, suicide rates per 100,000 15 – 19 year olds have fluctuated considerably from 41.2 (CY96), to 28.3 (CY97), 37.0 (CY98). Given the considerable data fluctuations, MCFH has considered using a 5-year moving average but has not yet made a decision regarding this. It is unlikely however that these changes would be statistically different. While MCFH's adolescent health program continues to promote activities aimed at assisting Alaska's youth in developing healthy lifestyles, Alaska still has far to go in providing adequate mental health support systems, especially in rural areas where suicide rates are high. A target measure of 29.2 per 100,000 has been set for FFY01.

Performance Measure #17: Alaskan women with high risk pregnancies are often required to travel far from their home and support systems there is only one facility, located in Anchorage, for high risk deliveries and neonates. While this facility serves as the referral source for most of rural and interior Alaska, many residents of southeast Alaska travel to the State of Washington for this type of medical care. While it may be more desirable for pregnant mothers to remain in their home community, it is unlikely that the services required for high-risk pregnancies will become locally or even regionally available. Alaska has had a past performance target of 67% for this measure but has stayed fairly constant at 65%. Given the health care delivery practices and infrastructure in Alaska, this may be a realistic plateau. Discussions with Alaska's Bureau of Vital Statistics have indicated that we cannot determine this measure for Alaska resident births that occur out of state. Further, given Alaska's geographic issues, it is difficult to transport women who unexpectedly go into labor with a very low birth weight infant until after the delivery. Dialogue with providers indicates that most would prefer that women who are likely to deliver a very low birth weight infant be transported in advance to the appropriate facility.

Performance Measure #18: MCFH had hoped to see an upward trend for the percentage of infants born to pregnant women receiving prenatal care beginning in the first

trimester. While about 80% of women initiate prenatal care during the first trimester as reported on birth certificates, CHIP implementation is fairly new and may still impact the outcome of this measure. Thus the FFY01 target has been raised to 85%. Lack of resource for many women in some geographic areas and for most immigrant women in all geographic areas remain as the major challenge to this outcome measure.

3.4.2 State Negotiated Five Year Performance Measures

3.4.2.1 Development of State Performance Measures

MCFH has reviewed its State Performance and Outcome Measures for this application period. Because of concern in the past few years surrounding two “placeholder” measures being used (one for family violence and one for adolescent resiliency), new replacement measures have been developed and added to this application. They are reflected as State Performance Measures #7 and #10.

3.4.2.2 Discussion of State Performance Measures

State Performance Measure #1: The percentage of unintended births was selected as a state performance measure because a major initiative has been launched to reduce unintended pregnancies in Alaska. Alaska’s PRAMS project provides reliable data to monitor progress related to this measure. The measure has been placed in the direct health care level of the pyramid and reflects the priority need for expanded family planning services. The unintended births measure may be linked to the outcome measures of neonatal mortality rate; postneonatal mortality rate; the perinatal mortality rate; and the infant mortality rate.

State Performance Measure #2: Substantiated cases of child abuse and neglect was chosen as a state performance measure because of Alaska’s high rate of child abuse and neglect. Alaska ranks third in the nation for children substantiated as sexually abused, according to the Child Welfare League of America STAT Book, 1997. The measure has been placed on the enabling services level of the pyramid because a major MCFH program activity, Healthy Families Alaska (HFAk), will continue in the coming year. HFAk is a home visitation program offering support to families at risk for child abuse and neglect, prenatally through age five. Other activities that focus on this measure include *Never Shake A Baby* awareness campaign and the EI/ILP which provides support to families of CSHCN. This performance

measure is linked to all of the national outcomes since child abuse and neglect can occur at any time and at any age and contributes to mortality rates.

State Performance Measure #3: The percentage of women who smoke prenatally was selected as a performance measure because of Alaska's high rate of smoking during pregnancy. In Alaska, according to 1998 PRAMS data, the percentage of women smoking in the third trimester of pregnancy was 19% as compared to the Healthy People 2000 goal of 14%. Through all of MCFH's activities, but particularly family planning and adolescent health, smoking during pregnancy will be highlighted through awareness materials such as the *Baby Diaries* in the coming year. The outreach and public education activities directed toward reducing the number of pregnant women who smoke place it on the population-based services level of the pyramid. The PRAMS and WIC will continue to provide data to monitor and track progress. This performance measure is associated with all of the national outcome measures. Additionally, women who smoke during pregnancy are likely to continue smoking after pregnancy putting their infant at increased health risk.

State Performance Measure #4: The percentage of women who drink prenatally was selected as a performance measure because of its association with MCFH's priority need for reducing preventable birth defects and its FAS surveillance project. According to MCFH's 1991-1995 FAS population-based surveillance project funded by CDC, as many as 6.7 Alaska Native children per 1,000 live births require follow-up evaluation by specialty health and social services because of suspected FAS.

Fetal alcohol syndrome is a high profile issue in Alaska with members of Alaska's legislature and the commissioner of the Department of Health and Social Services convening statewide meetings during the past two years. Public health, education, social services agencies and other interested groups and individuals came together to develop a unified and collaborative approach to FAS. As a result, a statewide FAS coordinator position was established, reporting directly to the commissioner. MCFH's FAS project staff is working closely with the FAS Coordinator so that all DHSS activities related to FAS are based on sound epidemiology.

Performance Measure #4 is placed on the infrastructure building level of the pyramid because of the program activities directly related to the FAS surveillance project. This performance measure is linked to National Outcome Measures #1, #3-6.

State Performance Measure #5: The percentage of women experiencing physical abuse by husbands/partners surrounding the prenatal period is a state performance measure that is related to Alaska's priority of decreasing the rates of family violence. Its placement on the population-based services level of the pyramid reflects the activities that will occur in the coming year. While PRAMS has supplied, and will continue to supply, the data related to this measure, activities will focus on increasing awareness and public education about this issue. The family violence project at MCFH will continue to work with community-based providers in offering training on family violence, with an emphasis on making the connection between family violence and child abuse. This activity relates to National Outcome Measure #5.

State Performance Measure #6: The percentage of mothers putting their infant down to sleep in the supine position is an important state performance measure because of its relationship to sudden infant death syndrome (SIDS). Numerous studies have demonstrated that placing infants on their backs greatly reduces the risk of SIDS. This performance measure is related to National Outcome Measures #1, #3 - #4.

Section activities will focus on the population-based services level of the pyramid with increased availability of awareness materials and public service announcements for radio and television.

State Performance Measure #7: During CY99 Alaska added several state specific questions to the Behavioral Risk Factor Survey to obtain population-based information on family and domestic violence. One question inquires about the percent of respondents who experience intimate partner violence during their lifetime. Alaska is in the process of analyzing the entire state-added module and will advocate for routine collection of some of the state-added questions on a routine basis. Activities will focus on the population based services level of the pyramid.

State Performance Measure #8: The percentage of people who eat five or more daily servings of vegetables and fruits is a state performance measure that highlights the importance of nutrition's role in the development or prevention of four of the top ten leading causes of death in Alaska and the United States. According to *Eat Smart Alaska! Nutrition-Related Chronic Disease in Alaska Base-line Needs Assessment, 1997*, only 19% of Alaskan adults in CY94 consumed the minimum recommendation of "5 A Day," by CY98 this had risen to 23%. In response to that information, MCFH launched its Eat Smart Alaska! Project that seeks to increase consumption of complex-carbohydrate and fiber-containing food, and reduce the

population's daily average dietary intake of fat. The Statewide *Eat Smart Alaska!* Coalition will continue working towards development of local coalitions to sponsor activities that support this effort. MCFH will coordinate the development and dissemination of new materials and resource packets to these local coalitions which will use them in their own communities to promote "5 A Day" awareness.

The performance measure is placed on the population-based services level of the pyramid because activities related to the *Eat Smart Alaska!* Project will be focused on outreach and public education. This performance measure is directly linked to the national outcome measures of neonatal mortality and perinatal mortality.

State Performance Measure #9: Reduction of Neural Tube Defects (NTD) was selected as Alaska's negotiated CSHCN performance measure because NTDs are significant in terms of associated mortality and lifelong morbidity which is largely preventable. As NTD's are also strongly associated with neonatal mortality, postneonatal mortality, perinatal mortality, infant and child mortality rates, this measure is an example of a population-based activity directed towards risk factor reduction.

Reduction of NTDs is related to all of the major program components within MCFH: nutrition; special needs services; family and community services; and epidemiology/ evaluation units. Collaborative activities will include education, interventions to facilitate folic acid supplementation, surveillance and evaluation. Data are available from Bureau of Vital Statistics and the Birth Defects Registry which is housed in MCFH.

State Performance Measure #10: MCFH has been committed to including one priority performance measure which specifically addresses adolescents. While it was somewhat difficult to find a positive standard, MCFH established as its measure the percentage of high school youth who feel supported at school. While its believed that this is a better measure than the one used in previous years (Number of Community Based Organizations that have Utilized the Youth Developmental Assets/Resiliency Model When Working With Youth), it is not without its challenges. Although data will come from surveys done in high schools, it may be biased as surveys are conducted only by school districts that volunteer to participate. Further bias may occur as active parental consent is now required for the administration of any school based survey. Nevertheless, MCFH is excited about this positive measure for Alaska's youth and expect it will become further refined as time goes on.

Figure 4
PERFORMANCE MEASURES SUMMARY SHEET

National Performance Measure	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a “medical/health home”		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g. the sickle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN program				X		X	
15) Percent of very low birth weight live births				X			X
16) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester				X			X

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

State Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) Percentage of Unintended Births	X						X
2) Rate of Substantiated Reports of Harm to Children		X					X
3) Percentage of Women Who Smoke Prenatally			X				X
4) Percentage of Women Who Drink Prenatally			X				X
5) Percentage of Women Experiencing Physical Abuse by Husbands/Partners Surrounding Prenatal Period			X			X	
6) Percentage of Parents Putting Infant Down to Sleep in the Supine Position (On Their Backs)			X				X
7) Percentage of People Experiencing Intimate Partner Violence During Their Lifetime			X			X	
8) Percentage of People Who Eat Five or More Daily Servings of Fruits and Vegetables			X		X		
9) Rate of Neural Tube Defects			X				X
10) Percentage of Youth Who Feel Supported at School				X		X	

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services
 IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

3.4.2.3. Five Year Performance Targets

Five year performance targets were established based on current trends in Alaska. Special consideration was given to initiatives and priorities that may have significant impact on measures. The five-year targets were reviewed by MCFH senior management staff and have been adjusted where appropriate.

3.4.2.4 Review of State Performance Measures

State Performance Measure #1: Reducing the percentage of unintended births continues to be a priority for Alaska. Alaska's 1998 PRAMS data indicate that 43% of Alaska's births were unintended. Alaska continues to have considerable activities surrounding this measure including work with adolescents, the unintended pregnancy prevention initiative, family planning and emergency contraception. The goal for FFY01 is to reduce the percentage of unintended births to 38%.

State Performance Measure #2: Child abuse and neglect continues to be a high priority to the state. MCFH had hoped to see a decline in the substantiated reports of harm to children to 16 per 1,000, yet the rate for this reporting period remained at 17 per 1,000. There is some concern by the Division of Family and Youth Services that the data captured by the reporting system underreports the amount of substantiated abuse and neglect. Given this, it is possible that as the data collection becomes more stable, the accuracy in reporting may mistakenly be classified as a rise in rates of harm. This situation will make it difficult to interpret this data in the next few years. Despite this, MCFH believes this measure to be of sufficient interest to retain it as one of our stated-added performance measures and has maintained its rate of 17 per 1,000.

State Performance Measure #3: Based on PRAMS data, Alaska has exceeded its past performance measures of mothers who report smoking during their prenatal period. MCFH anticipates being able to meet or exceed its set performance objective of 16% during FFY01.

State Performance Measure #4: Alaska had hoped to see a downward trend in the number of women who report drinking during the third trimester of pregnancy, yet 1998 PRAMS data still shows this figure to be 4%. MCFH has retained the 4% mark as its performance measure target and anticipates being able to maintain this in FFY01. Fetal Alcohol Syndrome and other alcohol-related birth defects continue to be of considerable concern in this

state. Media campaigns as well as targeted educational programs continue and it is hoped this will impact prenatal drinking.

State Performance Measure #5: MCFH continues to be concerned with the percentage of women experiencing physical abuse by their husbands/partners during the prenatal period. CY 1998 PRAMS data reported that 7% of women experienced physical abuse by husbands/partners in the time surrounding their prenatal period. Recognizing that this is a difficult measure to impact, MCFH anticipates that it will remain stable at the set target rate of 7% during FFY01. Prevention and intervention activities for family violence continue to be of a high priority both to MCFH and the Department of Health and Social Services.

State Performance Measure #6: It has been well documented that putting babies on their backs to sleep reduces the risk of Sudden Infant Death Syndrome. Alaska launched a large media and materials campaign effort and the most recent PRAMS data show considerable improvement on this measure with 59% of mothers reporting putting their infant down to sleep in the supine position. Because of continual improvement with this measure, MCFH has raised its target to 70% for FFY01.

State Performance Measure #7: CY99 Behavioral Risk Factor Survey data indicates that 23% of respondents report having experienced intimate partner violence during their lifetime. This number will serve as the baseline for this new performance measure. MCFH is exploring options for collecting this data on a routine basis but anticipates not having new information available until CY01. MCFH will initially aim for maintaining the current level of 23% and will re-evaluate when more information becomes available.

State Performance Measure #8: Fewer Alaskans are consuming five or more daily servings of vegetables and fruits than anticipated. CY98 Behavioral Risk Factor Survey data indicates that only 23% of Alaskans are consuming the recommended daily servings – far short of MCFH’s set performance objective of 36%. Consequently, MCFH has set more realistic performance objectives for the upcoming years and will continue to work with many partners to improve this behavior. The target rate for FFY01 is 23%.

State Performance Measure #9: Based on national data, MCFH projected identifying approximately one child per 1,000 live births with a neural tube defect. For children born in 1998, the rate was 0.8 per 1,000 live births. Alaska has a relatively new birth defects registry, so MCFH is unsure whether or not there are missing children with the diagnosis or if fewer

events are occurring in Alaska. In either case, MCFH has elected to keep the performance objective set at 10 per 10,000 live births (or 1 per 1,000 live births).

In an effort to reduce neural tube defects, Alaska has formed a community-based partnership to launch a widespread folic acid information campaign and the Folic Acid Coalition continues to work on increasing use of folic acid by women of childbearing age.

State Performance Measure #10:

New this year is the performance measure that looks at the percentage of high school youth who feel supported at school. The baseline measure is 43% and we would like to increase it by 5% per year. While Alaska has long been interested in measures that look at positive behavior and resiliency, there was considerable difficulty in finding a measure to adopt. The Needs Assessment conducted in preparation for this grant proposal demonstrated a lack of ability to accurately measure protective factors for adolescent behavioral health. Nonetheless, MCFH is committed to developing strategies for measurement of protective factors, with the caveat that current data capacity in this area is very low.

The baseline figure of 43% was derived by averaging the survey findings of six communities who administered developmental assets surveys among high school aged-students during 1997-99. The question: “My teachers really care about me” was analyzed by calculating the percent of students who participated in the survey and who answered either “strongly agree” or “agree” to this survey question. This percentage was then applied to the total number of high school students in the state for a population based estimate of the number of youth who feel supported in school.

Of note is the consistency found for responses to this question. The measure for individual schools ranged from 40% to 57% and the median value was 44%. Further reliability and stability may be demonstrated when findings from surveys due to be administered later in 2000 are available from the state’s largest school districts.

MCFH plans to improve capacity to measure the proportion of youth who feel supported at school by:

1. Advocating for the inclusion of this, and other, questions that assess protective factors on the state’s upcoming YRBSS;
2. Developing a composite score for questions based on the concept of “connectedness” which can then be used to more accurately reflect the concepts relevance as a protective factor;

3. Utilizing previously developed models for assessing connectedness at school;
4. Exploring other indicators for the prevalence of identified protective factors among Alaska youth; and,
5. Obtain the results of future surveys in larger communities to fine-tune the baseline estimate we have used this year.

3.4.3 Outcome Measures

Alaska's MCFH has included an outcome measure that focuses on the rate of fatalities to children between the ages of birth and 19 years due to unintentional injuries. Since Alaska has one of the highest rates of fatalities due to unintentional injuries, we believe it is important to focus on this significant problem and work to decrease its prevalence.

National Outcome Measures #1-#5 deal with infant mortality. Alaska is meeting its outcome objectives for measures #1,#3-#4 and #5. As regard Outcome Measure #2, Alaska has a higher than expected ratio of black to white infant mortality – 3.2, which was greater than the target of objective for this measure of 1.6. Alaska does not have a large black population and when the number of deaths fluctuates, this rate can be quite unstable. Nevertheless, MCFH will strive to meet the target of 1.6.

National Outcome Measure #6 looks at the death rate per 100,000 children aged 1-14. Related to this outcome measure is the State Outcome Measure – the death rate per 100,000 children aged 0-19 due to unintentional injuries. Alaska met its outcome objective for both of these measures. MCFH continues to have an active role in the injury community and is hopeful that these activities will continue to result in less childhood mortality. However the concern remains with the small number of events and the natural fluctuation that occurs from year to year. Last year MCFH did not meet either of these targets and this year met both. Given the small numbers issue, we have elected to leave the target numbers unchanged.

IV. REQUIREMENTS FOR THE ANNUAL PLAN [Section 505 (a)(2)(A)]

4.1 Program Activities Related to Performance Measures

In Alaska, MCFH's strategies to improve maternal and infant health outcomes are broad and varied. MCFH seeks to make those improvements through a system of providing

leadership, coordinating with private and public provider entities within the health care system and delivering preventive and clinical services to the childbearing population.

As required by the block grant guidance, MCFH has listed those activities by pyramid level and population type that are related to performance measures.

Direct Health Care Services

Pregnant Women, Mothers, and Infants

In FFY01 direct health care services to pregnant women, mothers, and infants will include family planning services. The Family Planning Program seeks to ensure that all births are intended and their work in FFY01 will be critical in *reducing the % of unintended births by 3%* (State Performance Measure #1).

In SFY00, the Family Planning Program expanded its programmatic activities by implementing a fee for service system for clinical providers and changing its focus from clinical contracts within the public health centers to monitoring Section of Nursing employees hired specifically to provide family planning services in the Southcentral and Fairbanks regions. The non-scalpel vasectomy project, implemented in the Anchorage in 1998 with Title X funds was expanded to include two of the three priority areas with the highest number of unplanned births in Alaska – the Kenai Peninsula and Matanuska-Susitna Valley. The third priority area, Fairbanks, is scheduled to be on line with this project by November 2000. Efforts to increase access to emergency contraception for women who have had unprotected sexual intercourse will continue to be an area of focus during the next project year. Efforts will continue to include MCFH staff as well as community partners such as Planned Parenthood and local medical providers. In order to ensure that as many medical providers are made aware of the efficacy and availability of emergency contraception, MCFH will add a medical provider education component to its list of activities for the coming year. Statewide distribution of emergency contraception education packets and coordination of statewide conferences will be the responsibility of the Family Planning Program.

The 1996 welfare reform block grant program, Temporary Assistance for Needy Families (TANF) includes a Bonus to Reward Decrease in Illegitimacy and in SFY00 monies were transferred from the State Division of Public Assistance to MCFH to increase family planning and decrease illegitimacy. Eighty five percent of women served during this time period were of the target population of unmarried women.

The Family Planning Program includes as a priority meeting the family planning needs of teens. Currently, teens comprise 33% of those accessing clinical family planning services through public health centers and MCFH family planning nonprofit grantees, all of whom have specific training and experience in working with teens. In FFY01 the oversight of the Teen Pregnancy and Parenting Program, currently housed in the Division of Public Assistance in Juneau, Alaska will be transferred to MCFH in Anchorage. This transfer will allow for better coordination of teen pregnancy and parenting services and other health services/ programs offered by the Adolescent Health Unit. Additionally in FFY01, MCFH will continue to coordinate an Abstinence Grant focusing on teen abstinence as a means of preventing pregnancy.

All family planning program activities are designed to help Alaska meet its *teen (aged 15 through 17) birth rate target objective of 25 per 1000 live births* (Core Performance Measure #6).

New to the Direct Health Care Services level of the pyramid for FFY01 is MCFH's FAE/FAS Motivational Interviewing Program. Through an MCFH sub-grant to a local Community Health Center working with the Department of Corrections, misdemeanor women of childbearing age in Anchorage are being actively case managed, provided with access to family planning, free contraception, and referrals to substance abuse treatment. These efforts will be critical in *reducing the percentage of unintended births* (State Negotiated Performance Measure #1) and *reducing the percentage of women who drink prenatally* (State Negotiated Performance Measure #3).

Children

The audiology program that provided services to children up to 21 years of age, has been eliminated as it is projected that this population is now being served by Alaska's S-CHIP Program, Denali KidCare. MCFH continues to provide nominal funding to two Native corporations to support their audiology programs.

Children with Special Health Care Needs (CSHCN)

Alaska provides direct services to CSHCN by offering genetics and subspecialty services including cleft lip and palate, cardiac and neurodevelopmental clinics. In Alaska, all *SSI beneficiaries less than 16 years of age are Medicaid eligible and receive rehabilitative services through Medicaid funding* (Core Performance Measure #1). Medicaid responsibility for CSHCN rehabilitative services is expected to continue in FFY01. At this time, the total

population of CSHCN is unknown for Alaska, but is estimated to be approximately 10% of all children ages 0 – 21 years. Scheduled for Fall 2000, the State will participate in the National State and Local Area Telephone Survey (SLAITS), the results of which will allow Alaska to more accurately assess the number of children with special health care needs. While in house data systems currently provide information on the number of children and families served by the Title V CSHCN program, third party payer coverage and CSHCN services delivered but not subsidized by other resources, SLAITS data will allow the State to determine what proportion of services provided to all CHSCN in Alaska are subsidized by the CHSCN program, or other payers.

Enabling Services

Pregnant Women, Mothers, and Infants

The Healthy Families Alaska (HFAk) program is the central program activity on the enabling services pyramid level to pregnant women, mothers, and infants with regard to performance measures for MCFH. The HFAk program was established by the Alaska State Legislature in SFY95. The program is designed to prevent child abuse and neglect and improve childhood health and well-being through an intensive home visitation program. High-risk families may be offered services prenatally or at the time of birth, and may continue services for three to five years.

For FFY01, MCFH plans to continue this program in the seven urban and rural sites where it currently exists and expects to provide services to approximately 400 families. Programs are delivered by community nonprofit organizations and in one site, by the Section of Public Health Nursing, and collaborate closely with other resources to maximize service delivery to families. The focus of the home visitation includes supporting the parent as well as facilitating parent-child interaction and child development. An important component of the program is supporting families in accessing needed treatment services such as mental health counseling, substance abuse and domestic violence services. A five-year randomized trial of the program, established in July 1999 and being conducted by Johns Hopkins University School of Medicine will continue in 2001.

The HFAk program is pivotal to MCFH's effort to reduce the rate of child abuse and neglect. The *rate of substantiated reports of harm to children* (State Negotiated Performance Measure #2), will offer data from Alaska's child protection agency to indicate progress made.

Nearly 30,000 women, infants and children will be potentially eligible for WIC services in FFY01. WIC services are currently delivered by 17 nonprofit, local government and regional health corporation agency grantees throughout the State. In some communities, WIC participants receive services through local WIC clinics in conjunction with pediatric and prenatal health services. In more remote communities submission of applications and receipt of nutrition education and food packages occurs through the mail. WIC staff provide onsite visits to remote communities annually, at a minimum. In FFY01 it is projected that WIC will serve nearly 25,000 women, infants and children per month. By providing nutrition education and supplementation to pregnant women, WIC may help to decrease *the percent of very low birth weight live births* (Core Performance Measure #15), increase *the percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza and Hepatitis B* (Core Performance Measure #5), and increase the *percentage of mothers who breastfeed their infants at hospital discharge* (Core Performance Measure #9). The WIC program also promotes the inclusion of folic acid in the diet that contributes to the reduction in *the prevalence of neural tube defects*. (State Negotiated Performance Measure #9).

Support at the federal level will allow the WIC program to more appropriately allocate resources and define eligibility for geographically isolated women in Alaska in the coming year. Additionally, the USDA has approved several changes, including the substitution of canned pink salmon for dried eggs for women in remote areas which will improve services by making them more culturally and regionally appropriate. Additional highlights for the coming year include further implementation of the WIC Competent Professional Authority (CPA) Training Curriculum which allows local agency paraprofessionals to perform certification and basic nutrition education counseling functions, a Consultant analysis of the overall efficiency and effectiveness of the WIC Program, and the opening of a clinic on the Anchorage military base (Army/Airforce) to serve military families.

Children

Families are enrolled in the HFAk program during pregnancy or shortly after the birth of the target child. Services are offered intensively and continue until the target child is three to five years old or the family chooses to leave services. All pregnant women and families of newborns in the program's geographic region are screened for risk factors; those who screen positive are offered assessments, those who assess positive are offered voluntary home visiting

services. While services are geared toward the target child, program staff assure that older children living in the home also receive needed services. In the past year, MCFH has responded to numerous requests for information about the program from the legislature and public. To aid in such requests, as well as to build the capacity and measure the effectiveness of this program, an extensive database has been specifically established for the program.

HFAk will continue as a participant in a randomized study being conducted by Johns Hopkins University School of Medicine. The purpose of the study is to establish the impact that HFAk has on reducing child abuse and neglect and other poor childhood outcomes in families enrolled in the program as compared to families not enrolled in the program. The study design includes evaluation of program process measures as well as outcome measures. This activity was mandated by the Alaska State Legislature and funded for a five year period by the Alaska Mental Health Trust Authority.

The HFAk program continues to be a key MCFH activity in the effort to reduce child abuse and neglect. The *rate of reports of harm to children* (State Negotiated Performance Measure #2) is the measure to indicate progress in this area.

Population-Based Services

Pregnant women, mothers, and infants

Activities which are a part of the population-based services level of the pyramid include those in which preventive interventions and personal health services have been developed and are available to the entire MCH population in Alaska. An example of these types of projects is the Alaska Family Violence Prevention Project (AFVPP) which provides multidisciplinary training on family violence for health care and service providers.

In the past, the AFVPP project has focused on increasing collaboration between the domestic violence advocates and the medical community; enhancing medical care provider knowledge about domestic violence and increasing provider screening of women for domestic violence; increasing the number of referrals by medical providers of their clients to domestic violence shelters; promoting an understanding of the connection between domestic violence and child abuse; and the negative impact of children witnessing domestic violence. The project has been a key link in the system, which provides information, training and services to communities across the state.

The AFVPP is vital to decreasing the number of women who experience domestic violence by their partners through promoting early screening and referral to domestic violence treatment programs. Central to determining this decrease is the reporting of *the percentage of abuse among female patients as perceived by physicians* (State Performance Measure #7). In addition to this state performance measure, the AFVPP will also be instrumental, through its training and education materials, in decreasing the *percentage of physical abuse to women by their partners surrounding the prenatal period* (State Performance Measure #5).

For FFY01, the AFVPP will focus on research that examines the link between family violence and child abuse. The Project Coordinator has conducted literature searches on the relationship between domestic violence and child abuse and developed training materials designed to raise provider awareness about this problem. Providers serving children and providers tending domestic violence victims must consider the child's/children's risks of harm. The training material will undergo continued development and be used in training provided for multidisciplinary workshops in communities across the state.

The Newborn Screening Program (NBS) provides testing of infants for inborn metabolic disorders. Alaska law requires that all infants be screened within the first week of life for the following six disorders: phenylketonuria (PKU); hypothyroidism; galactosemia; maple syrup urine disease; congenital adrenal hyperplasia; biotinidase deficiency and by special request, hemoglobinopathies, including sickle cell. MCFH, which employs a genetics counselor, contracts with the Northwest Regional Newborn Screening Program and Oregon Public Health Laboratory for laboratory services and screening consultation. The contractors and MCFH staff ensure that screening is satisfactorily completed and that infants with abnormal tests begin treatment as soon as possible and before 15 days of age. This program provides information about *the percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies* (Core Performance Measure #4). A new Universal Newborn Hearing Screening (UNHS) program will greatly enhance the State's ability to impact *the number of infants who receive newborn hearing screening before hospital discharge* (Core Performance Measure #10). Begun in April 2000, this HRSA funded four year demonstration project will allow the State to plan, develop and implement a sustainable statewide UNHS Program and ensure that early identification and early intervention become the standard of care for all children with significant hearing loss. In FFY01 the CSHCN Director will participate in the Directors of Speech and Hearing Programs in State

Health and Welfare Agencies (DSHPSHWA) annual meeting in order to gain information and network with national leaders so that Alaska's efforts in this field are enhanced.

The Family and Community Nutrition Program (FCNP) works primarily to reduce dietary risk for chronic diseases among Alaskans. The program first assesses needs, then designs, implements and evaluates interventions aimed at preventing development of cancer, heart disease and diabetes. The program also works on other nutrition issues affecting Alaskans such as food access and availability. Goals of the program are achieved by collaborating with partners from private industry, the health field, state entities, consumers and the media. Highlights for FFY01 include continuation of a program designed to promote canned and frozen fruit and vegetable consumption in rural Alaska, folic acid education in rural Alaska, and an Anemia Prevention Project in the Yukon Kuskokwim Delta, also in rural Alaska. Activities conducted by the Family and Community Nutrition Program are related to increasing the *percentage of people who eat five or more daily servings of vegetables and fruits* (State Negotiated Performance Measure #8).

The integrated infant health awareness campaigns that were conducted by MCFH in SFY99 and SFY00 continue to generate requests for information. The distribution of the MCFH created *Healthy Baby Diary* is an activity which relates to reducing the *percentage of women who smoke prenatally* (State Negotiated Performance Measure #3), reducing the *percentage of women who drink prenatally* (State Negotiated Performance Measure #4), and *reducing the prevalence, at birth, of neural tube defects* (State Negotiated Performance Measure #9). Over 10,000 copies of the *Healthy Baby Diary* were distributed in SYF00, a similar number are anticipated to be distributed in the coming year.

“Back to Sleep;” “Never Shake A Baby;” “Preconception/Prenatal Folic Acid;” “Watch Me Grow, Play With Me, Keep Me Safe;” and Infant/Child Safety Seat use educational materials are widely distributed throughout the state via medical providers, public health nurses, the WIC program, infant learning programs, Head Start programs, home visiting programs, and day care providers, among many others. Providers remain enthused about partnering with MCFH in distributing these materials to parents, families and caregivers.

Folic acid awareness campaigns continue and materials are distributed with the *Healthy Baby Diary*. An interactive display emphasizing folic acid and birth defects developed in FFY00 will continue to be used in FFY01 and will provide the major thrust of activities related to *reducing the prevalence of neural tube defects at birth* (State Performance Measure #9).

This collaborative project involves MCFH and other community partners including the March of Dimes.

In the area of childhood injury prevention, MCFH will continue to work in FFY2001 with the Alaska Safe Kids Coalition in promoting the proper use of child protection seats. The project includes a child safety seat loaner program, surveillance in use of safety seats, and a train-the-technician program. Additionally, MCFH will distribute personal flotation devices, bicycle safety helmets and smoke detectors at Health Fairs and other health-related public events to encourage child injury prevention. All efforts are directed at reducing unintentional injuries in Alaska.

In FFY01 the Nutrition Unit of MCFH will continue to support the activities of the Alaska Breastfeeding Coalition in the Breastfeeding Initiative which began in 1997. Nutrition staff network with the Coalition and provide information materials through WIC Campaigns which promote breastfeeding awareness, initiate breastfeeding promotions and increase breastfeeding education. Nutrition staff will also continue to be actively involved in the annual World Breastfeeding Week promotion and continue with the peer counselor breastfeeding program. A new project scheduled for FYF01 is the adaptation of Oregon Health Departments "Breastfeeding Friendly" campaign. Together with WIC and the Alaska Breastfeeding Coalition, MCFH will target businesses, stores and restaurants to promote breastfeeding and encourage them to both become, and post information to declare that they are "breastfeeding friendly." All of the above mentioned activities will be key in addressing *the percentage of mothers who breastfeed their infants at hospital discharge* (Core Performance Measure #9).

Infrastructure Building Services

Pregnant Women, Mothers, and Infants

Many of the MCFH's programs are reflective of services and activities that are directed at improving and maintaining the health status of all women and children. MCFH provides support for development and maintenance of comprehensive health services systems including the development and maintenance of health services standards/guidelines, training, data, planning and evaluation systems.

MCFH will continue in FFY01 to focus on child oral health, prenatal through age 4 years. This program began in 1994 with the development of a group concerned about oral health for Head Start children. In conjunction with other partners, this group worked together to develop

educational materials to improve childhood oral health. A decision was made to focus on early intervention efforts for pregnant women and young children and strategies for prevention and early intervention were developed. MCFH provides educational materials on childhood oral health for use by both dental and other providers of services to children.

A Prevent Abuse and Neglect Through Dental Awareness (PANDA) Coalition has been established and continues to meet, develop and distribute educational materials designed to help dental providers understand child abuse and neglect and their role in reporting suspected cases. Several dentists and dental hygienists continue to offer presentations on child abuse recognition, reporting, and prevention to their peers and community groups. MCFH will work with the state's dental director in gathering data related to the Core Performance Measure of the *percentage of third grade children who have received protective sealants on at least one permanent molar tooth* (Core Performance Measure #7).

The MCFH Epidemiology and Evaluation Unit will be closely monitoring national and state performance measures through several distinct but related activities. The Pregnancy Risk Assessment Monitoring System (PRAMS) Project is an ongoing population-based surveillance system which collects information on Alaskan mothers' prenatal and postpartum experiences and perceptions. The PRAMS Project has population-based data which estimates prevalences of a wide variety of pregnancy-related behaviors, perceptions, and risks among Alaskan mothers. PRAMS continues to be vital in gathering data on the following performance measures:

- *% of Mothers who Breastfeed Their Infants At Hospital Discharge* (Core Performance Measure #9);
- *% of Unintended Births* (State Negotiated Performance Measure #1);
- *% of Women Who Smoke Prenatally* (State Negotiated Performance Measure #3);
- *% of Women Who Drink Prenatally* (State Negotiated Performance Measure #4);
- *% of Women Experiencing Physical Abuse by Husbands/Partners Surrounding the Prenatal Period* (State Negotiated Performance Measure #5); and
- *% of Mothers Putting Infant Down to Sleep in the Supine Position* (State Negotiated Performance Measure #6).

The Birth Defects Registry which began in SFY98 is a population-based surveillance system of birth defects as defined by the Ninth International Classification of Diseases. The system determines statewide prevalence and incidence rates for birth defects and provide

evidence of geographic, temporal, or racial clustering of specific birth defects. While the system does not provide direct services, it does offer information designed to direct the development and implementation of recurrence prevention strategies, including those which reduce the incidence of specific defects by identifying defect associated risk factors.

MCFH's Fetal Alcohol Syndrome Surveillance Project focuses on population-based surveillance of fetal alcohol syndrome. A large federal allocation in SFY00 will allow MCFH to expand its efforts in this area in the coming year, primarily through building capacity in the Epidemiology Evaluation Unit. MCFH will hire an FAS Information Specialist who will coordinate statewide data and information on prenatal alcohol use and FAS. A comprehensive chart extraction of data for children born in 1995 onward with alcohol related conditions or maternal alcohol use will be conducted, which will allow the Section to better ascertain the rate of FAS in Alaska's children. Multiple challenges exist in this area for MCFH, most notably the tendency by state policy makers, teachers, foster parents who overuse "FAS" terminology and incorrectly label children as having FAS/FAE. MCFH will continue collecting data on prevalence, characteristics, secondary disabilities and maternal demographics, as well as train health care providers and develop appropriate prevention programs in FFY01. It is anticipated that these efforts will assist in reducing *the percentage of women who drink prenatally* (State Performance Measure #4).

The Maternal and Infant Mortality Review (MIMR) Program is a coordinated statewide program developed in response to Alaska's high postneonatal mortality rate. A coordinator and MIMR statewide committee review all infant deaths under 1 year of age and maternal deaths occurring within one year postpartum. Information from several sources including family interviews is reviewed, then entered into various databases for further analysis and recommendation of prevention strategies. Ongoing collaboration with the Bureau of Vital Statistics has resulted in having more complete infant death cohorts available for analysis, efforts will continue in FFY01 to capture more complete maternal death cohorts. Other highlights for MIMR in FFY01 include the comprehensive examination of the incidence of individuals co-sleeping with infants at the time of infant death and investigation of a means to better disseminate MIMR findings to all Alaskans.

Children

In FYF01, MCFH will continue to base many of its activities for children and youth on the *Assets* framework. Based on research from the Search Institute in Minnesota, the Assets

framework correlates the number of assets a youth has to the likelihood that s/he will make good decisions and grow to be healthy and successful. In FFY2000, MCFH distributed 25,000 copies of the Alaska Assets book “What Kids Need to Succeed – Alaskan Style” to all school districts and youth related agencies statewide. In FFY01, it is anticipated that an similar number of copies will be distributed. Assets training to local communities will continue, but will be coordinated by the Alaska Association of School Boards, rather than MCFH. The Adolescent Health Coordinator will play a contributing role in the development of the body of knowledge which explores the use of resiliency models as indicators of adolescent health. She will be participating in regular meetings with other nationally-recognized leaders in this area.

The Adolescent Health Program Coordinator will also continue to support and monitor the efforts of Alaska’s two Abstinence grantees as they begin their second year of funding.

4.2 Other Program Activities

Direct Health Care

Children

MCFH will no longer provide children’s audiology services except indirectly through nominal grants to two Native Health Corporations. Children previously eligible for services through MCFH’s Audiology Program are now Denali KidCare. MCFH anticipates that any audiology needs not covered by Denali KidCare will be addressed through other resources such as Health Care Program for Children with Special Needs, Early Intervention/Infant Learning Program and local school districts.

Enabling Services

Pregnant Women, Mothers and Infants

A primary information and referral source for the MCFH population is AK Info which satisfies the requirements of Title V of the Social Security Act as amended by the Omnibus Reconciliation Act of 1989 (OBRA ‘89) legislation and Part C of IDEA. This legislation requires each state to have a toll-free 800 number through which families can access information about health care providers and practitioners who provide services for women, infants, and children. Alaska’s MCFH manages a contract to provide this toll-free telephone number with the United Way of Anchorage. The 24 hour per day toll-free service also provides families with information on available resources, programs, and other services. In SFY98 the

toll-free telephone line received 1500 calls. Additionally the database which supports the statewide telephone service is available to providers and families via the Internet at www.ak.org receives about 500 inquiries per month. MCFH expects to experience an increase in the number of people who access the information online via the Internet as individuals and agencies continue to move towards Internet based activities.

Family Health Dataline is an MCFH publication that features one health topic in each bi-monthly issue. The *Dataline* provides an opportunity to share data and information with other health professionals such as physicians, nurse practitioners, physician assistants, public health nurses, child protection workers and others so that all can use this information on behalf of the populations that they serve. Topics of recent inclusion are: Infant Mortality in Alaska: A Historical Perspective; The Maternal Infant Mortality Review (MIMR) Process; Alaska Newborn Screening Program; Pregnancy Planning and Wantedness Among Mothers of Alaska; 1997 Alaska Maternal-Infant Mortality Review Results; and Domestic Violence in Alaska Among Women Who Delivered a Live Infant, 1996-1997. The *Dataline* is an MCFH activity that is central to communicating with others in Alaska about MCFH issues and will be one vehicle to discuss progress on various performance measures.

Children With Special Health Care Needs

In conjunction with the University Affiliated Program, the EI/ILP has developed a paraprofessional system for delivery of early intervention services. Designed to increase the quality and quantity of services, the program hires and trains local paraprofessionals who implement the activities on the Individualized Family Service Plans with families. The paraprofessional system has developed job descriptions, roles and competencies, training and program standards. Since its 1996 implementation, twenty three (23) individuals have been involved in training to varying degrees, twelve (12) have been fully trained and employed in thirteen (13) programs statewide. Minimal, ongoing support for this program is expected to continue through the first part of the fiscal year.

The Health Care Program for Children with Special Health Care Needs (HCP-CSN) funds the cost of covered medical services up to a capitated limit for eligible children. During SFY99, 32 of the 72 enrolled children received HCP-CSN funded health care. It is expected that at least 30 children will receive HCP-CSN services during the coming fiscal year. While the adoption and implementation of Alaska's CHIP Program, Denali KidCare during SFY99 has

impacted the number of children eligible for HCP-CSN Program services, it nonetheless remains an important payor of last resort for children without other resources for care.

The Alaska Transition Training Initiative (ATTI) coordinates and provides training to assist community agencies in developing effective transition models for children moving from early intervention/infant learning programs to school district preschools, Head Start and/or other community programs. At least three, two-day workshops designed to promote teamwork and collaboration will be presented in during FFY01 for school district staff, Head Start and preschool staff, Early Intervention/Infant Learning Program staff, parents, public health nurses, child care providers and others involved in the transition process.

In preparation for a Fall '01 audit of State Part B & C Programs by the Office of Special Education Programs, a state transition team has been created. By working together to monitor and review the current Part C to Part B transition, top policy makers anticipate continued development towards a timely, seamless and family friendly progression between programs.

Infrastructure Building

Children

In FFY01, MCFH will continue to build on its young children's behavioral health initiative that began last year. With carry over Part C funding and additional monies secured through the Alaska Mental Health Trust Authority, MCFH will hire a Childhood Behavioral Health Specialist who will coordinate its efforts in this area. One training of local early intervention providers with local mental health providers occurred in SFY00, two additional trainings will occur in the next fiscal year. Trainings cover children's behavioral health issues in the context of family. In September 2000, national children's behavioral health specialists will meet with key stakeholders in Alaska to discuss systems of care for children. With relatively few providers who are able to provide these services in Alaska, this area remains a challenge for MCFH.

Children with Special Health Care Needs

A new program which will impact children with special health care needs in Alaska in FFY01 is the Genetics Planning Project (GPP). Funded by HRSA, the two year GPP will allow Alaska to integrate electronic birth certificates with newborn metabolic screening results and conduct a statewide needs assessment for genetic and related programs. The integration of data systems and results from the needs assessment will then contribute to the development

and implementation of a comprehensive State Genetics Plan for Alaska. Activities associated with the GPP are related to the *percent of newborns with at least one screening for PKU, Hypothyroidism, galactosemia and hemoglobinopathies* (Core Performance Measure # 4) and *the rate of neural tube defects* (State Negotiated Measure #9).

4.3 Public Input [Section 505(a)(5)(F)]

The Application for Title V MCH Block Grant was made available for public comment from June 16, 2000 through July 15, 2000. Newspaper advertisements were placed in Anchorage, Fairbanks and Juneau which have statewide circulation. The public was directed to call or write to MCFH for a copy of the application and to make public comment. We received no written or verbal comments on this year's application.

4.4 Technical Assistance [Section 509 (a)(4)]

Young children's behavioral health issues continue to be a high priority for MCFH and we anticipate requesting technical assistance again in this area.

V. SUPPORTING DOCUMENTS

5.1 Glossary

GLOSSARY

Adequate prenatal care - Prenatal care were the observed to expected prenatal visits is greater than or equal to 80% (the Kotelchuck Index).

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see “Needs Assessment”)

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, “What does the State need to achieve the results we want?”

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for Children With Special Health Care Needs (CSHCN, see definition below) - those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. [*Title V Sec. 501(b)(3)*]

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous years MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. (*Title V Sec. 501(b)(4)*)

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - (*For budgetary purposes*) Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. (*For planning and systems development*) - Those children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations. States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.
2. State Support for Communities. State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CSHCN are met.
3. Coordination of Health Components of Community-Based Systems. A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.
4. Coordination of Health Services with Other Services at the Community Level. A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - authorized persons to be served with Title V funds. See individual definitions under “Pregnant Women,” “Infants,” “Children with Special Health Care Needs,” “Children,” and “Others.”

Community - a group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - services provided within the context of a defined community.

Community-based Service System - an organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - the recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - the ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - women who received a medical care procedure (were provided prenatal, delivery or postpartum care) associated with the delivery or expulsion of a live birth or fetal death.

Direct Health Care Services - those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

EPSDT - Early and Periodic Screening, Diagnosis and Treatment - a program for medical assistance recipients under the age of 21, including those who are parents. The program has a Medical Protocol and Periodicity Schedule for well-child screening that provides for regular health check-ups, vision/hearing/dental screenings, immunizations and treatment for health problems.

Family-centered Care - a system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - the entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Jurisdictions - As used in the Maternal and Child Health block grant program: the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshal Islands, the Federated States of Micronesia and the Republic of Palau.

Kotelchuck Index - An indicator of the adequacy of prenatal care. See *Adequate Prenatal Care*.

Local Funding (as used in Forms 2 and 3) - Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - an individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.[Title V, Sec. 501 (b)(2)]

MCH Pyramid of Health Services - (see “Types of Services”)

Measures - (see “Performance Measures”)

Needs Assessment - a study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is to aimed at determining: 1) What is essential in terms of the provision of health services; 2) What is available; and, 3) What is missing

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also “Performance Objectives”)

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, HIV/AIDS monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, "Why does the State do our program?"

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - a narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: "The rate of women in [State] who receive early prenatal care in 19__." This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

PRAMS - Pregnancy Risk Assessment Monitoring System - a surveillance project of the Centers for Disease Control and Prevention (CDC) and State health departments to collect State- specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - the provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated

and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, "Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?"

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

State - as used in this guidance, includes the 50 States and the 9 jurisdictions. (See also, Jurisdictions)

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

Systems Development - activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - the process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration and, identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block grant allocation, the *Applicant's* funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH dedicated funds from local jurisdictions within the state), *Other* federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by state MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building", "Population Based Services", "Enabling Services" and "Direct Medical Services".

YRBS - Youth Risk Behavior Survey - A national school-based survey conducted annually by CDC and State health departments to assess the prevalence of health risk behaviors among high school students.

5.2 Assurances and Certifications

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.
3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)
14. Will comply with P.L.93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

- (a) are not presently debarred, suspended proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled "Certification Regarding Debarment, Suspension, In-eligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions" in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about-

- (1) The dangers of drug abuse in the workplace;
- (2) The grantee's policy of maintaining a drug-free workplace,
- (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
- (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
 - (1) Abide by the terms of the statement; and
 - (2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
 - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
 - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
 Office of Management and Acquisition
 Department of Health and Human Services
 Room 517-D
 200 Independence Avenue, S.W.
 Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may

result in the imposition of a monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

Alaska Primary Care HPSAs

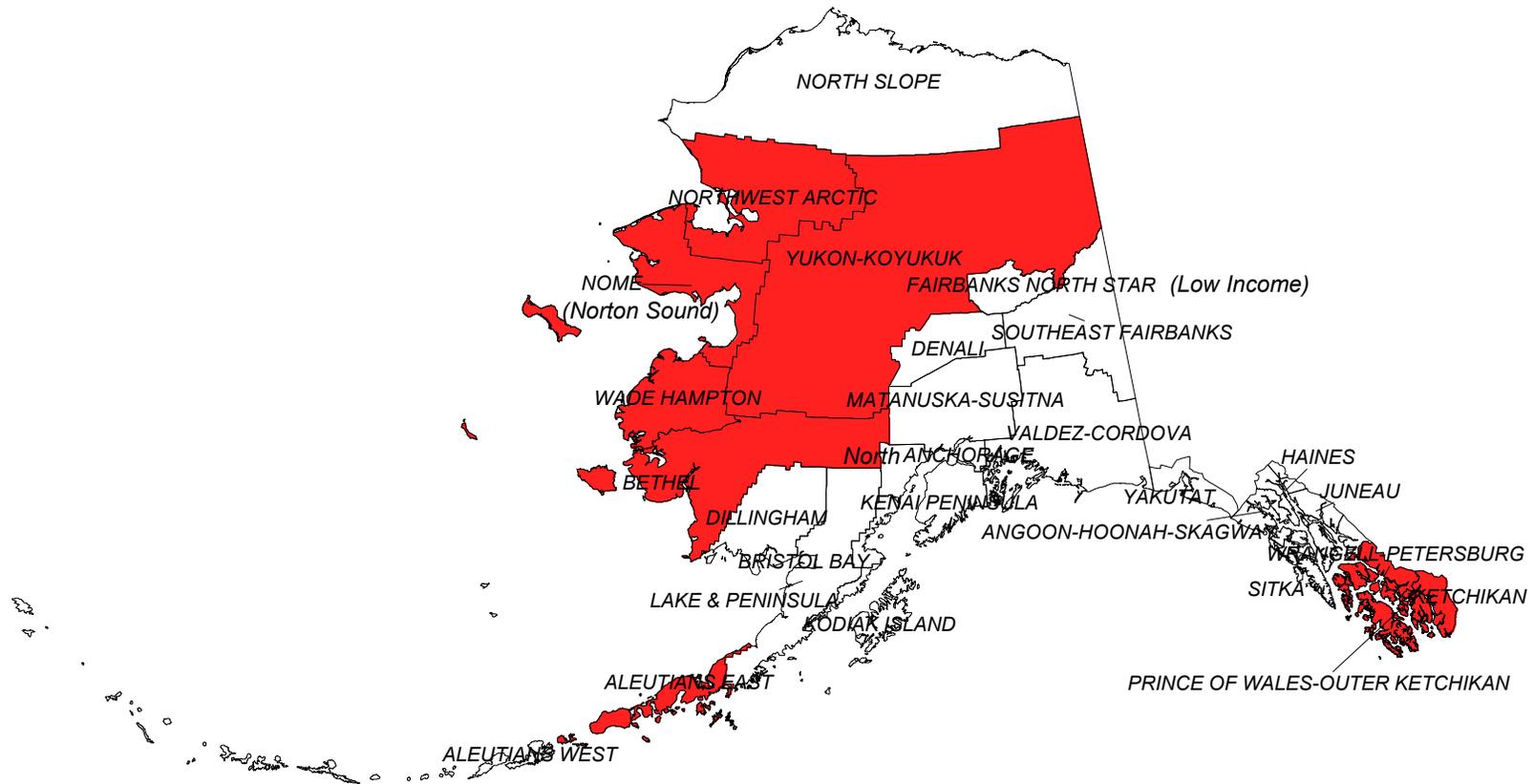
(Shaded Areas and Points are Designated)



Source: State of Alaska, Dept. of H&SS, Division of Public Health, CHEMS Unit

Alaska Mental Health HPSAs

(Designated HPSAs are shaded or points)



Source: State of Alaska, Dept. of H&SS, Division of Public Health, CHEMS Unit