



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 Title V Program is administered by the Alabama Department of Public Health (ADPH, or Department) through its Bureau of Family Health Services (BFHS, or Bureau). BFHS does not directly administer aspects pertaining to children with special health care needs (CSHCN), however, but contracts with the Children's Rehabilitation Service (CRS), within the Alabama Department of Rehabilitation Services (ADRS), which administers services to this population. In addition to the Title V Program, BFHS administers the Title X Family Planning Grant, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), the State Perinatal Program, and the State Dental Program. (Acronyms and abbreviated names used in this report are shown in Appendix A.)

Addressing the service delivery needs of Alabama's CSHCN presents special challenges. The State is predominantly rural in nature, and in the rural areas more risk factors exist that could potentially increase the percentage of CSHCN among the general child population—such as higher levels of poverty, low weight births, and lower educational attainment. The five counties with the highest percentage of children receiving Supplemental Security Income (SSI) are all in the rural, southern portion of the State. Pediatric subspecialists and allied health professionals with pediatric experience are primarily located in the two largest urban areas (Birmingham and Mobile), necessitating travel to access pediatric expertise. The State, however, has poor public transportation systems. Thus, CRS continues to have an integral direct service role in the State's system of care for CSHCN via its 15 community-based offices. Through the provision of multidisciplinary medical specialty clinics in over 15 locations in the State and community-based rehabilitation, support, and coordination services, more CSHCN have access to quality services within their natural communities. Through CRS's memorandums of agreement with the two tertiary level pediatric hospitals in the State, CSHCN can access all or part of their medical care at these institutions while receiving community-based coordination, support, and follow-up by CRS staff. These public/private partnerships enable CRS to bridge gaps in the system of care that promote addressing the health, social, and educational needs of Alabama's CSHCN, including SSI beneficiaries under age 16 years. Through its intradepartmental collaboration with the Adult Vocational Rehabilitation Service (AVRS), CRS promotes the transition of adolescents with special health care needs, including SSI beneficiaries, from school to work and to independence.

Changes in the Health Care Environment

The State's Maternal and Child Health Services Block Grant annual reports for fiscal year (FY) 1997 and FY 1998 (submitted in July of 1998 and 1999) described notable changes that had been occurring in Alabama's health care environment. Most notably, initiatives (described below) involving the Alabama Medicaid Agency's (Medicaid's) Managed Care Programs, the Children's Health Insurance Program, and CSHCN have continued to evolve since

the State's *Maternal and Child Health Services Block Grant 1998 Annual Report/2000 Application* (subsequently termed "the 1998 report/2000 application") was submitted. Since submission of that document, Alabama has seen a continuing shift in the provision of direct medical services from county health departments (CHDs) to private providers. This shift has been especially evident in the child health and maternity programs. As described in the 1998 report/2000 application, changes in the health care environment have prompted a paradigm shift regarding the roles of CHDs—toward a greater emphasis on the core public health functions of assessment, policy development, and assurance.

Medicaid Managed Care Programs

By the time the 1998 report/2000 application was submitted, Medicaid had developed and received approval for the Medicaid Maternity Care Program to replace the then current maternity "waiver," under which ADPH had been the primary provider of prenatal care for 23 of the State's 67 counties and a subcontractor for prenatal care in many other counties. The new State Plan for maternity care began in June 1999, was fully implemented on October 1, 1999, and is located statewide in 13 Medicaid maternity districts. Under this new plan, ADPH is not a direct provider of maternity services but is a sub-contractor for case management in 54 counties and a sub-contractor for prenatal care in 14 counties. (See Appendix B for a list of primary contractors and implementation dates.) Under this new program, there has been a significant decrease in the number of patients receiving prenatal care in ADPH clinics (see discussion of Form 7 in Section 2.2). Data quantifying this decrease will not be available until the end of FY 2000, however. A primary concern continues to be access to care for uninsured patients. (See *Selected Changes in Alabama's Population* for further discussion of this issue.)

As stated in the 1998 report/2000 application, Medicaid completed implementation of Patient 1st, its Primary Care Case Management (PCCM) Program, with the initiation of services in Jefferson County on November 1, 1998. Throughout FY 1999 all of Alabama's counties except Mobile continued to utilize the PCCM model. This model assigns all Medicaid recipients, including CSHCN, in a county to a medical home that manages their health care needs, including appropriate referrals for specialty care and pre-authorization of specified Medicaid services. PCCM has been successful in increasing access to primary care for Medicaid recipients, including CSHCN, throughout the State. Over 1,000 private primary care physicians are participating. Although a few CHDs provide some child health services through memorandums of understanding (MOUs) with private providers, the number of ADPH child health patients has declined about 26% in FY 1999 relative to FY 1997 (further discussed under Form 7 in Section 2.2). PCCM and a prior increase in willingness of private providers to see patients whose health care was paid for by Medicaid have been major factors in this decline.

Throughout FY 1999 Mobile County utilized the BAY Health Plan, Medicaid's 1115(a) research and demonstration waiver administered by Prime Health, Inc. Due to providers withdrawing from the program, the

BAY Health Plan was dissolved on September 30, 1999. Since October 2000 Medicaid has worked to bring Mobile County into their other managed care plans (Maternity Care Program and Patient 1st) and is including Mobile in their plan for the 1115(a) Medicaid Family Planning Waiver.

Medicaid and ADPH staff continued to work on an 1115(a) Family Planning Waiver Proposal, which was submitted to the Health Care Financing Administration (HCFA) in March 1999. This waiver proposal has been recommended for approval by HCFA and is scheduled for implementation following approval of HCFA's terms and conditions (possibly May or June 2000). The waiver will expand Medicaid eligibility for family planning services for women aged 19-44 years to 133% of the federal poverty level (FPL). (The current eligibility cutoff is about 16% of the FPL). Family planning services for adolescents less than 19 years of age are now covered by the Alabama Child Health Insurance Program, which provides for Medicaid coverage for those at or below 100% of the FPL and private insurance coverage for those between 100% and 200% of the FPL. Care coordination and outreach are major components of the Family Planning Waiver Proposal.

The Children's Health Insurance Program (SCHIP)

With the creation of Alabama's Children's Health Insurance Commission in August 1997, the State Legislature appropriated \$5 million for SCHIP in FY 1998 and designated ADPH as the lead agency for this program. SCHIP has been planned and implemented in Alabama using a broad-based work group, formed in September 1997, to research and recommend how services for the uninsured could best be developed. The work group included other State agencies (Medicaid, Department of Human Resources [DHR], Department of Mental Health and Mental Retardation [MHMR], Department of Education, and State Employee's Insurance Board), advocacy groups (Alabama Arise, Family Voices, and Voices for Alabama's Children), hospitals, community health centers, and various professional associations. Phase I, a limited Medicaid expansion, was begun in February 1998. Phase II (the ALL Kids Program), a private insurance package for children between 100% and 200% of the FPL, began in September 1998. As of September 30, 1999, 42,909 children had been enrolled in Alabama's SCHIP (16,696 in Phase I and 26,213 in Phase II). Due to CHIP outreach, an additional 30,000 children have been added to the Sixth Omnibus Budget Reconciliation Act (SOBRA) Medicaid rolls. FY 1999 appropriations were also \$5 million, but \$11.2 million were appropriated for FY 2000. Title V (both BFHS and CRS) staff have been heavily involved with the Department's effort, serving on workgroups to develop enhancement packages and recommendations on how the program should work.

Alabama SCHIP has experienced many distinctive achievements. Alabama was the first state in the nation to have a federally approved SCHIP State Plan as well as the first to have a major plan expansion. Because Alabama is on the forefront of SCHIP, the State was chosen as one of seven states to pilot a federal communications outreach

project, which was implemented in the fall of 1999. Alabama was also one of 11 states chosen to participate in the pilot of the national White House initiative, *Insure Kids Now*, which produced and paid for air time for both television and radio commercials in Alabama, which aired February through July 1999. In addition, Alabama was one of six states chosen by the national Association of Maternal and Child Health Programs (AMCHP) to participate in special training in January 1999 to better evaluate the impact of SCHIP. Moreover, the American Institute for Research selected Alabama as one of six states upon which to conduct an in-depth case study, published in July 1999, on the early implementation of SCHIP. Specific activities of SCHIP staff are described in Section 2.4.D.2 under CP# 12.

ADPH’s Strategic Direction Project and Work Group

Recognizing that recent changes in the health care environment will fundamentally change the way ADPH works to improve the public’s health in Alabama for the 21st century, the Department formed a Strategic Direction Project in late summer of FY 1998. The Bureau’s Director has been heavily involved in this process as a member of the Work Group. This project is further discussed in Section 2.4.E.

Selected Changes in Alabama’s Population

Increase in Hispanic Births

As described in the 1998 report/2000 application, an increase in Hispanic births has constituted a major change in Alabama’s population, especially in several counties. That is, according to birth certificate data, patient encounter form data and informal, verbal reports, Hispanic individuals have continued to increase in number. Based on birth certificate data, the number of live births to Hispanic Alabama residents has increased more than four-fold in 10 years: from 344 in 1990 to 1,595 (preliminary) in 1999. As shown below, the largest absolute increase in numbers occurred in 1998 and the second largest in 1999.

<u>Year</u>	<u>No. of Live Births to Hispanic Alabama Residents</u>	<u>% Increase Relative to Previous Year</u>	<u>Absolute increase Relative to Previous Year</u>
1990	344	—	—
1991	400	16.3%	56
1992	444	11.0%	44
1993	509	14.6%	65
1994	579	13.8%	70
1995	758	30.9%	179
1996	936	23.5%	178
1997	1,055	12.7%	119
1998	1,343	27.3%	288

1999 1,595* 18.8% 252*

*Preliminary

Statewide in 1998, 2.2 % (1,343/62,025) of live births to Alabama residents were to Hispanic mothers (up from 1.7% in 1997). Most (65.7%) of these 1,343 births were to Mexican women, 10.3% to Central or South American women, 5.6% to Puerto-Rican women, 1.6% to Cuban women, and 16.7% to other Hispanic women. Ten percent or more of residential live births in four counties were to Hispanic mothers, and 5% of such births in two other counties were to Hispanic mothers. The percentage of live births that were to Hispanic mothers in 1997 and 1998 is shown below for these six counties. In five of the six counties, most (56.5% to 95.6% in 1998) of these Hispanic mothers were of Mexican origin. The exception was Dale County, where 30.8% of Hispanic women having live births were Puerto-Rican, 28.2% “other” Hispanic, and 25.6% Mexican. As shown below, Marshall and DeKalb Counties tied for the largest absolute increase in numbers of Hispanic live births (34 additional births each), and Blount County had the second largest increase (27 additional births).

County	1997		1998		% increase Relative to Previous Year***	Absolute Increase Relative to Previous Year
	n*	%**	n*	%**		
Franklin	45	10.2	62	14.9	47.1	17
Marshall	143	11.8	177	14.6	23.5	34
DeKalb	62	7.9	96	11.2	42.2	34
Blount	41	6.9	68	10.0	45.3	27
Morgan	70	4.7	83	5.4	14.5	13
Dale	32	4.3	39	5.0	16.4	7

*No. of live births in county that were to Hispanic mothers

**% of live births in county that were to Hispanic mothers

***% increase in proportion, eg, from 10.2% in 1997 to 14.9% in 1998

Twenty-seven percent of the Hispanic live births in 1998 were uncompensated (using the “Self Pay” response to birth certificate question about “main source of payment for this birth” as a surrogate for uncompensated care). Per verbal reports of CHD staff, most of these individuals are immigrants coming to Alabama to work in poultry processing plants. Most of these immigrants have no health insurance and, by law, are ineligible for Medicaid for 5 years after their arrival (if after 8/22/96). Furthermore, many immigrants may be unwilling to apply for Medicaid out of a concern that to do so will jeopardize immigrant status. The inability of these immigrants to access care in the private medical community is a very serious problem. Most of them do not speak English and require an interpreter. Most CHDs either do not have an interpreter or have limited access to interpreter services. The increase in numbers of Hispanics, along with the shift from the Medicaid Maternity Waiver to the Medicaid Maternity Care Program, has adversely affected the ability of CHDs to provide prenatal care to the uninsured

population. (As stated previously, ADPH provides prenatal care in only 14 counties in the State.) This effect is especially exacerbated in counties not having other reimbursable maternity clinic activities to subsidize services to unattached clients such as illegal Hispanic residents. The CHD with the highest influx of Hispanics is Marshall, where 178 Hispanic maternity patients were being served by the CHD in April 1999. With the change in the Medicaid environment, the ability to continue providing prenatal services to uncompensated patients (lacking the cost shifting resources from compensated patients) in Marshall County has been compromised, and the consequences are imminent. A BFHS consultant is working with an agency task force to develop a plan to address the challenge of uncompensated maternity care throughout the State. Technical assistance is currently being provided to area and CHD staff on addressing the language issue through Spanish language training and translations of health department forms and materials. This assistance is made available through a WIC contract with Auburn University at Montgomery (AUM). Via this contract, AUM provides translations and Spanish language training for health departments. Both WIC and non-WIC health department personnel participate in the training. The feasibility of developing and funding a pilot project to address the issue of uncompensated care is being considered.

Decline in Total Numbers of Children and in Children Living in Poverty

The proportion of the State's population comprised of children has continued to gradually decline: Children 19 years of age or younger comprised 28.8%, 28.7% and 28.6% of Alabama's population in 1996, 1997 and 1998 respectively, versus 29.2% in 1993. Absolute numbers of these children have also declined. That is, there were 1,186,816 children in this age group in 1998—6,047 fewer than in 1993.

External factors affecting infant mortality include poverty and characteristics linked with poverty. As described in the previous two MCH Block Grant reports/applications, the percentage of the State's children living in poverty had steadily declined from 31% in 1987 to 23% in 1993 (*1999 Kids Count Data Book*. The Annie E. Casey Foundation). Since 1993 this rate has remained fairly stable at 24%, 23%, and 24% in 1994, 1995, and 1996 respectively. Moreover, the percentage of Alabama Children at or below 200% of poverty has generally declined during recent 3-year periods: from 49.3% in 1993-95 to 47.1% in 1994-96, up slightly to 47.8% in 1995-97, then down to 44.6% in 1996-98. In absolute terms, the *number* (rounded to 1,000s) of State children at or below 200% of poverty has declined from 597,000 in 1993-95 to 489,000 in 1996-98, a decline of about 108,000 children or about 18%. This decline in the numbers of low-income children could contribute to a small degree to the decline in ADPH child health patients, but changes in the health care environment are the major factors in the decline in patients.

1.5 The State Title V Agency

1.5.1 State Agency Capacity

1.5.1.1 Organizational Structure

The Alabama Department of Children's Affairs, DHR, MHMR, and Medicaid are all cabinet level agencies. The Governor directly appoints their commissioners. ADPH, the State Department of Education (SDE, which includes the State's two disability determination units), and ADRS are not cabinet level agencies, though ADPH and SDE participate in cabinet meetings. As their respective boards appoint the heads of these three departments, they have experienced more stability and continuity in their leadership, enabling a more consistent program direction. However, these departments have relatively less access to the Governor. Linkage for communication and organizational cooperation exists on two levels for ADRS and ADPH. The State Health Officer and the ADRS Commissioner work together on matters of mutual concern, as well as the CRS and BFHS Directors. Staff members from CRS and BFHS meet quarterly to discuss programmatic and administrative issues pertinent to maternal and child health (MCH) services. Organizational charts for ADPH, BFHS, ADRS, and CRS are in Appendix C.

ADPH continues under the direction of the State Board of Health and is not under the direct authority of the Governor. BFHS, which remains a major unit within ADPH, was reorganized in September 1999. Three of the Bureau's four major divisions retained the same name: Administration, WIC, and Women's and Children's Health. The previous Dental Health/Community Development/Clinical Support Services Division became the Community Development/Professional Support Division. The reorganization has better integrated related functions into existing units and added several branches, which particularly enhanced the Bureau's capacity for community development and data analysis. Changes within divisions included the following:

- The **Administration Division's** Planning and Evaluation/Data/Contract Management Branch became two branches: the Contract Management Branch and the Epidemiology/Data Management Branch, with a mid-level research analyst position and two entry-level epidemiologist positions added to the latter branch. (Positions were filled in December 1999.)
- The **Community Development and Professional Support Division** was created to foster and support the paradigm shift mentioned in Section 1.4 (under *Changes in the Health Care Environment*). This division incorporated the previous Clinical Support Branch and added a social work consultant position. The Division provides technical assistance and training to public health staff and awards grants to communities for community systems development that address MCH problems at the local level. The Community Development Branch (previously the Community and Systems Development Branch), which is within this division, added a position for a community development specialist, which was filled in March 2000.

- In the *Women's and Children's Health Division*, the Women's Health Branch incorporated functions related to family planning and maternity, which had previously been in the Healthcare Delivery Systems Branch. The Special Projects Branch was added and incorporated functions pertaining to perinatal issues, Smoking Cessation and Reduction in Pregnancy (SCRIPT), teen pregnancy, and the Office of Adolescent Pregnancy Prevention (OAPP), all of which had previously been in the Women's Health Branch. Additionally, the Quality Assurance Branch was added to this division, and the Abstinence Program was added to the Child Health Branch. Furthermore, in February 2000 the Alabama Unwed Pregnancy Prevention Program was established within the Women's Health Branch in the Division of Women's and Children's Health. This program provides competitive grant funding to programs that implement pregnancy prevention strategies.

The Alabama Board of Rehabilitation Services, whose members are appointed by the Governor, oversees ADRS, which consists of four major divisions: Alabama's Early Intervention System (AEIS), CRS, AVRS, and the State's Independent Living Program. The current chairperson of the Board is a parent of a child with special needs. As previously stated, ADPH contracts with CRS for services to CSHCN. CRS has administrative responsibility for the State Title V CSHCN Program as well as the Alabama Hemophilia Program.

Some Statutes Relevant to the Title V Program

Salient legislation pertaining to the Title V Program includes the following:

- ***CRS Statutory Authority***—The State statutory authority for the CRS program is in Code of Alabama 1975 § 21-3-1 et seq. The administrative responsibility for the program was given to SDE due to its administration of a State program for CSHCN prior to passage of the Social Security Act in 1935. The Alabama Hemophilia Program was created in Code of Alabama 1975 § 21-8-1 et seq. and placed in CRS administratively. Code of Alabama 1975 § 21-9-1 et seq. created ADRS by moving the former division, with all its component programs, out of SDE on January 1, 1995. The major impact of these legislative acts is that CRS is administratively under ADRS rather than ADPH and serves, in addition to CSHCN, adults with hemophilia and related bleeding disorders through the Alabama Hemophilia Program.
- ***Alabama Perinatal Health Act***—The Perinatal Health Act was enacted in 1980 in an effort to confront the State's high infant mortality rate. The statute established the State Perinatal Program and the mechanism for its operation under the direction of the State Board of Health and the State Perinatal Advisory Committee (SPAC), with the latter representing the Regional Perinatal Advisory Committees (RPACs). The RPACs make recommendations to SPAC regarding perinatal concerns. SPAC advises the State Health Officer in the planning, organization, implementation, and evaluation of the State Perinatal Program. The State Perinatal Program is based on the concept of regionalization of health care, a systems approach in which program components in a geographic area are defined and coordinated to ensure that pregnant women and their

newborns have access to care at the appropriate level.

- ***Child Death Review***—Legislation creating the Alabama Child Death Review System was enacted in 1997 and has a mandate to review all unexpected/unexplained deaths of children in Alabama from birth through 17 years (HB.26,97-893). Reviews include children who die from a vehicle accident, drowning, fire, sudden infant death syndrome (SIDS), child abuse, asthma, infections, etc. Deaths from prematurity or birth defects, as well as deaths of children from terminal illnesses, are not reviewed by these teams. The purpose of these reviews is to identify trends in unexpected/unexplained childhood deaths, educate the public about the incidence and causes of these deaths, and engage the public in efforts to reduce the risk of such injuries and deaths. Funding for this program will come from the national settlement with the tobacco industry and will be disbursed through the Children’s First legislation described below. The Child Death Review portion of this allotment of money, \$300,000 per year, has not been disbursed for FY 2000 because of legal and legislative delays. However, the Governor feels confident that these moneys will be released shortly. Until that time, the Bureau has committed to subsidizing the program.
- ***Alabama Act 98-611***—This legislation supports development of the recently initiated Alabama Trauma Registry, which involves collection, storage, and subsequent manipulation of trauma-related data on a statewide level. The Head and Spinal Cord Injury Registry and Traffic Injury Registry, along with additional trauma elements, are incorporated into a centralized database managed by ADPH’s Injury Prevention Division. This data base is further discussed in Section 3.1.2.4 under CP #08.
- ***School Nurse Law Act 98-672***—This act, passed by the Alabama Legislature in 1998, mandates a school nurse for each school district in FY 1999 and a school nurse for every 2,000 students by 2010.
- ***SCHIP***—See Section 1.4, under *Changes in the Health Care Environment*.
- ***Children First***—A major legislative event was the passage by the Alabama Legislature of the Children First bill (in April 1999), which allocates some of the money (\$650 million in FY 2000) the State would receive from the national settlement with the tobacco industry to various programs to improve the welfare of Alabama children.
- ***The Department of Children's Affairs (DCA)***—Legislation created this new State department in 1999. In 2000, legislation passed expanding the powers and duties of this department to include creating and maintaining a “repository for information” regarding children’s programs in Alabama, reviewing budget requests, and reporting annually to the Governor and State legislature on the activities and expenditures of State and local agencies related to children. DCA will gather information for the purpose of acquiring additional funding for children. ADPH and ADRS, including both CRS and AEIS, were specifically included in this legislation. The impact of this legislation on children's services in the State is still unclear, but a coordinating role is clearly within the scope of its authorizing legislation.

1.5.1.2 Program Capacity

ADPH Program Capacity

The Title V Program has maintained its capacity to provide services to the three Title V population groups. As described in the 1998 report/2000 application, substantial reductions in ADPH funding had occurred by FY 1999. These reductions, which began occurring in about October 1998, were due to changes in the federal Home Health Care Program, an increase in the State costs of insurance coverage for State employees, and a legislated (but not totally funded) 8% cost-of-living raise for State employees in October 1998. This reduction in funding resulted in significant layoffs (about 1,400) in CHDs from October 1998 to September 1999 and a reduction in State funding provided by the State Health Officer to other BFHS programs (family planning, child death review, etc.). Area-level staff, specifically the Area Family Health Services (FHS) Coordinator positions, were eliminated in January 1999. The Area Nursing Directors have assumed many of the FHS Coordinator responsibilities. Some State-funded vacant personnel positions within ADPH's central office have not been filled and, as described in the 1998 report/2000 application, many employees in State-funded positions were placed in vacant federal positions if feasible. In the short term, the Department's financial setbacks have been partly offset by House Bill 188, which became law in June 1999 and provided supplemental funding for FY 1999 for several State agencies. ADPH was to receive \$4.7 million in supplemental funds provided by this legislation.

Though not at previous levels, ADPH funding has stabilized in FY 1999, and further massive layoffs are not anticipated. Moreover, as described in Section 1.5.1.3, additional personnel were added to the Bureau's staff in FY 2000, enhancing the Bureau's infrastructure. Thus, the Title V Program is now better equipped to accomplish its mission and effect the strategy described in the 1998 report/2000 application (and updated in Section 2.4.E) than it had been in FY 1999.

CRS Program Capacity

The mission of CRS is to enable children and adolescents with special health care needs to achieve their maximum potential within a community-based, family-centered, comprehensive, culturally sensitive, and coordinated system of services. CRS is organized in three levels: State, district and local, to provide a statewide community-based system of care that collaboratively identifies and utilizes resources while avoiding duplication of services. At the State level, administrative staff provide program direction through policies and protocols, staff resource development, program planning and evaluation, data analysis, quality assurance, technical assistance, and fiscal management. The State team includes a specialty medical consultant, a pediatric medical consultant, and a State parent consultant. Three State advisory committees (parent, medical, and hemophilia), as well as local parent advisory committees that meet in every district office, ensure consumer and provider input into the program.

Collaborative planning occurs at the State level with public and private agencies to develop and enhance systems of services for CSHCN and their families and is described in Section 3.1.2.5. Mechanisms for systems development include interagency agreements, training/in-service activities, data sharing, task forces and committees, and State legislation.

The State is divided into seven service districts for CSHCN, each managed by a supervisor responsible for personnel, service implementation and maintenance, and office operations. Fifteen local offices around the State provide community-based services to children and families through outpatient specialty medical clinics; care coordination activities; home, school, and community visits; and agency consultations. Office locations are listed in Appendix C. Staff composition in these offices is detailed in Section 1.5.1.3. Specialty medical staff are recruited from the public and private sector and credentialed by the CRS medical consultant. They may provide services in their home community or travel to CRS clinic sites in rural areas where specialty services are not otherwise available.

County care coordinators, generally nurses or social workers, travel within their assigned counties to meet families, arrange services, and maintain working relationships with other service programs/providers. These coordinators also work to develop the State's system of care by identifying local providers with expertise related to CSHCN and working on planning issues related to CSHCN with community groups. CHDs usually provide office space in outlying counties for these visits. Care coordinators have access to a team of CRS specialists to deliver community-based patient care or education, consultation, or therapy services. CRS staff members are mobile and not restricted by district boundaries in the effective delivery of services. Families are similarly unrestricted by district boundaries and may access services in any CRS office.

Any State resident from birth to 21 years of age who has a special health care need is eligible for CRS services. Financial assistance and family participation is determined by the program's sliding fee scale. Families with incomes below FPL receive full assistance. Children who are Medicaid recipients are automatically eligible for full assistance as well. SSI beneficiaries less than 16 years old are eligible for rehabilitation services not covered by Medicaid, for which they are automatically enrolled. Referrals on children evaluated for SSI are received in the State office from the State disability determination units in Birmingham and Mobile and processed to the appropriate local office, where families are contacted to offer CRS services, including care coordination. Additionally, families of SSI beneficiaries in the State not active with CRS are re-contacted on the child's fifth, ninth, and fourteenth birthdays to offer assistance with unmet needs. Special flyers with the State toll-free number and a listing of CRS services are distributed through the local offices of the Social Security Administration (SSA). Protocols for SSI referrals are in Appendix D.

CRS operates six service programs to serve CSHCN and their families. Services provided in each of these programs and paid for in full or in part by Title V funds are located in Appendix E. The capacity of CRS to facilitate development of community-based systems of care for CSHCN is discussed in Section 3.1.2.5. The six programs are:

- Information and Referral—provision of information on resources available in the community, with provision of educational materials related to pediatric specialty health care, community resources, etc.
- Specialty Clinical Services/Clinical Medical—clinics directed by physicians and staffed by multidisciplinary teams for provision of diagnosis, evaluation, treatment, and related services
- Specialty Clinical Services/Clinical Evaluation—physician-supervised clinics to provide functional evaluation and planning services by multidisciplinary teams
- Client/Family Education—provision of information to clients and their families that is necessary for carrying out prescribed treatment regimens and making informed choices about services that best meet their needs
- Care Coordination—arrangement of services to assist clients and families in identifying, accessing, and utilizing health and related resources to effectively meet their needs
- Parent Connection—provision of family-to-family support and information through State and local parent consultants, a parent-to-parent network, family resource centers, sibling support activities, and publication of the *Parent Connection* newsletter.

1.5.1.3 Other Capacity

ADPH's Other Capacity

About 199.2 FTEs worked on Bureau MCH programs during FY 1999: 15.62 at the State and Area office levels and 183.58 at the county level. The following classifies these Title V full time equivalents (FTEs) by major professional or technical category: MD 4.62, nurse practitioner 5.27, nurse 70.32, social worker 59.22, clerical support 37.15, health administrator 2.0, health educator 2.32, dental specialist 0.19, aide 9.23, nutritionist 0.06, interpreter 0.95, lab specialists 4.15, epidemiologist 1.0, and other 2.72. Brief biographies of selected key Title V personnel in BFHS follow.

Thomas M. Miller, MD, MPH, FACOG, the Bureau's Director, has been with ADPH since 1987. His varied roles as clinician, consultant, and Assistant State Health Officer for Public Health Area V have particularly qualified

him to serve as Bureau Director—a role he assumed in 1993. Additional experience includes work as an obstetrics/gynecology clinician in the private sector (before joining ADPH) and occasional labor and delivery coverage for the Montgomery County Maternity Waiver Program and for a private practitioner. He is a member of the Medical Association of the State of Alabama, a fellow of the American College of Obstetricians and Gynecologists (ACOG), and a member of the Alabama Section of ACOG, where he has been a Board member since 1992. Academic credentials include studies in medicine and public health.

Chris R. Haag, MPH, Director of the Bureau's Administration Division, worked in the Madison County Health Department in Alabama for 2 years, where his duties included direction of health education activities and outreach services. He joined the Bureau in 1989 to direct an adolescent pregnancy prevention project. After the completion of that project, Mr. Haag held various positions with the Bureau before accepting his current position in July 1998. Academic credentials include studies in education and public health.

Sharon Gerogiannis, LCSW, Staff Assistant to the Bureau Director and Director of the Bureau's Community Development/Professional Support Division, brought 20 years of social work experience to the Bureau. She joined the Bureau as a Social Work Consultant in 1995 and was promoted to her present position when the Division was created in 1999. Academic credentials include studies in medical social work and health administration.

Sherry K. George, BS, MPA, Director of the Bureau's Division of Women's and Children's Health, has been with the Bureau for 25 years. During this time she has become familiar with issues pertaining to perinatal health, child health, and family planning; visited many CHDs; and developed excellent working relationships with health professionals around the State. Academic credentials include studies in business management and public administration (health care specialty) and a publication about drug abuse screening of child-bearing age women in a leading medical journal.

Dianne M. Sims, BSN, RN, Director of the Child Health Branch and the Quality Assurance Branch, has been with ADPH since 1981 and joined BFHS in 1999. Her experience as a public health nurse and administrator at the county, area, and State levels well qualifies her to serve in this role. Previous positions include those of family health services coordinator, staff development coordinator, and acting director of Program Integrity. Academic credentials include studies in social work, nursing, child development, and early childhood education.

Phyllis J. Gilchrist, RN, BSN, brought 20 years of nursing experience to the Bureau, which she joined in 1994. She served as Director of the Bureau's Special Projects Branch (or its predecessor) until February 2000, when she became Director of the Bureau's Alabama Unwed Pregnancy Prevention Program. Academic credentials include studies in nursing and public administration. Work experience includes nursing administration, nursing assistant

instructorship, and licensure and certification regulation. Currently she is pursuing studies in master's level public administration.

Charlena M. Freeman, LCSW, Director of the Bureau's Professional Support Branch, brought 19 years of medical social work experience to the Bureau, which she joined in 1996. Academic credentials include advanced degrees in social work and counseling.

Mary Scisney, MSN, CPNP, Director of the Bureau's Community Development Branch, brought 10 years of nursing experience to the Bureau, which she joined in 1992. Academic credentials include studies in nursing, pediatrics, and pediatrics administration, as well as studies earning certification as a pediatric nurse practitioner. Ms. Scisney has been the lead person for planning and implementing the community forums and focus groups described in Section 3.1.1 under *ADPH Needs Assessment Process*.

Anita J. Cowden, DrPH, Director of the Epidemiology/Data Management Branch, joined the Bureau in 1998. She brought extensive experience as a registered nurse (including several years as a certified family nurse practitioner) in a variety of settings, brief (about 2 years) part-time experience as a registered dietitian, and 8 years of experience as a perinatal epidemiologist (in the Department's Bureau of Disease Control) to BFHS. She has served as coordinator/contributing editor for the MCH Block Grant annual reports/applications and as coordinator of the Bureau's ongoing 5-year MCH needs assessment.

The Bureau has notably enhanced its analytic capacity by adding two entry-level epidemiology positions and a mid-level research analyst position. Though efforts to recruit persons to fill these positions began in FY 1999, they were not filled until December 1999, which hampered progress in conducting the MCH needs assessment. Two of the Branch's new staff members have devoted most of their time to the needs assessment, however: Kelly Kline, MPH, an epidemiologist funded largely through the State Systems Development Initiatives (SSDI), and Tammie Martinez, BS, an experienced public health research analyst funded largely through Title V funds. These persons have greatly enhanced the Bureau's capacity to analyze data from the ongoing MCH needs assessment and, once these data are more fully analyzed, plan and implement new surveys if indicated. Jennifer Foster, MPH, the other epidemiologist who recently joined the Bureau, is funded through the lead grant and enhances the Bureau's capacity to more fully analyze the lead database.

A major loss to the Bureau was the resignation (in July 1999) of Dr. A. Conan Davis, who had directed the Bureau's Dental Health/Community Development/Clinical Support Services Division. Dr. Davis' expertise in administration and in dentistry has been greatly missed. Moreover, the Oral Health Branch lost a Dental Education Consultant I in February 1999. In spite of these losses, under the Acting Director, Sherry Goode, RDH,

much has been accomplished with respect to networking, data collection, and analysis. These accomplishments, as well as findings from studies, are discussed in several places in this document. Additionally, in December 1999 the WIC Division's Nutrition Services Administrator, Martha Kreauter, MS, RD, LD, retired. She had worked with WIC for 13 years, and her expertise in administration and nutrition, especially maternal, child and infant nutrition, is greatly missed.

Although not reflected in the FTEs reported on the previous page, Title V staff have access to extensive nutritional expertise, through collaboration with registered dietitians in the Bureau and in ADPH's Office of Professional and Support Services' Nutrition Section. As shown in BFHS's organizational chart (Appendix C), the WIC Division is a major unit within the Bureau. The presence of the WIC Division within BFHS facilitates collaboration between Title V staff and the four registered dietitians in WIC's Nutrition Services Branch. Moreover, opportunities exist for collaboration with dietitians in ADPH's Nutrition Section. Additionally, though she has not maintained her dietetic registration, the Bureau's MCH epidemiologist's experience includes about 2 years (part-time) as a dietetic consultant; in meeting requirements for her DrPH, completion of a dissertation on dietary and erythrocyte zinc in women; and assistance to ADPH's Nutrition Section with the design, data management, analysis, and report for a federally funded evaluation of the *5 a Day for Better Health Program* in a minority-owned grocery chain.

CRS's Other Capacity

CRS has a strong multidisciplinary emphasis at both district and State office levels. Currently, there are 200.55 FTEs in the field: 7 district supervisors, 6.55 physical therapists, 7 nutritionists, 5 speech-language pathologists, 4 audiologists, 6.5 parent consultants, 28 nurses, 47 social workers, 2.5 service coordinators, and 86 clerical support team members. The staff in the State office consists of 9.5 FTEs with administrative responsibilities and 4 FTE clerical support team members. The following disciplines are represented in the State office administrative staff: 2 social workers, 1 nurse, 1 speech-language pathologist, 2 special educators, 2 rehabilitation counselors, 1 business manager, and 1 parent consultant.

Key senior administrative staff of CRS include the Division's Director, State Supervisor of Field Services, State Supervisor for Professional Services, Grants Management Specialist, Pediatric Medical Consultant, and Specialty Medical Consultant. Planning, evaluation, and data analysis are in the purview of the Grants Management Specialist. Brief biographical information on these persons follows.

J. Christine Kendall, MSW, MBA is Assistant Commissioner of ADRS and Director of CRS. She brought to this position, which she assumed in 1997, 28 years of professional experience in child welfare, including experience with EPSDT, Medicaid waivers, rehabilitation, and targeted case management. Prior to rejoining ADRS she was the State Director of Family and Children's Services in DHR. During her previous tenure with ADRS, she served

as coordinator of AEIS for 3 years. She serves on the board of the Alabama Foster Parent Association and the National Association of Social Workers and is a member of the National Rehabilitation Association. Academic credentials include studies in sociology, social work, and business administration.

Elizabeth Prince, MA is the State Supervisor of Field Services. Ms. Prince, with over 10 years of administrative experience, oversees all field-related aspects of the CRS program. Previously Ms. Prince served as the Early Intervention Liaison for CRS. Prior to her employment at CRS she was the statewide director of The Arc of Alabama and has expertise in both community and leadership development. She directly supervises the district supervisors and is responsible for program policy development and implementation in all 15 district offices. Her academic preparation includes a graduate degree in special education with endorsement in mental retardation.

David H. Savage, BA, MSC is State Supervisor for Professional Services. His professional experience includes 27 years as a speech-language pathologist in educational and rehabilitation settings. Areas of professional expertise include staff training, quality assurance, and augmentative communication technology. He is a member of the American Speech-Language and Hearing Association and the Speech and Hearing Association of Alabama. He served on the Alabama Board of Speech Pathology and Audiology from 1985 through 1988. Academic credentials include undergraduate and graduate degrees in speech-language pathology.

Dawn E. Ellis, RN, MPH is the Grants Management Specialist. She brought to this position, which she assumed in February 1998, a variety of experience in pediatric nursing and administration, including 12 years as a neonatal intensive care nurse, 3 years as an early intervention specialist, and 4 years as a CRS district supervisor. She is a member of the American Public Health Association (APHA) and the National Rehabilitation Association. Academic credentials include an undergraduate degree in nursing and a graduate degree in MCH.

Mary Ann Pass, MD, MPH is the Pediatric Medical Consultant. She brings to this part-time position a wealth of professional expertise in public health practice (including MCH and community-based primary care/systems development) and perinatal health. She is a member of APHA, the American Academy of Pediatrics (AAP), the Alabama Chapter of AAP, and the Association of Teachers of MCH. In addition to her other responsibilities, Dr. Pass is presently the chairperson of SPAC. Academic credentials include studies in chemistry, medicine, and public health.

William G. Watson, MD is the Specialty Medical Consultant. His professional experience includes over 30 years of medical practice, the last 16 years of which have been as a pediatric subspecialist in neurology. His clinical work with CSHCN includes CRS clinics for cerebral palsy, seizures, and neurology. He is a member of the American Academy of Cerebral Palsy and Developmental Medicine as well as the Alabama Chapter of AAP. His

medical degree is from the Medical College of Alabama, with board certification by the American Board of Psychiatry and Neurology with special qualifications in child neurology.

CRS employs 13 parents of CSCHN, including the State Supervisor of Field Services and the State Parent Consultant. The State Supervisor of Field Services provides consumer input; the State Parent Consultant's role includes advising regarding collaborative interagency efforts, recruiting/supporting additional parent participation, facilitating the State Parent Advisory Committee, coordinating the parent-to-parent network, and publishing the *Parent Connection* newsletter. CRS contracted through Auburn University at Montgomery (AUM) for supervision of the 11 part-time Local Parent Consultants and the 14 Local Parent Advisory Committees. The contract allows the Local Parent Consultants to have leave and holiday benefits, streamlines paperwork and the hiring process, and funds additional training for parents.

With respect to leadership changes, Commissioner Lamona Lucas, who served as the leader of ADRS for the past 16 years, retired effective December 31, 1999. Mr. Steve Shivers, former director of AVRS, was appointed as Commissioner effective January 1, 2000. Mr. Shivers has 28 years of experience serving Alabamians with disabilities.

1.5.2 State Agency Coordination

BFHS and CRS have collaborated closely via attending the quarterly meetings described below and networking with one another in such tasks as preparing the Title V annual reports/applications and planning for the 5-year MCH needs assessment. State program collaboration regarding CSCHN, including the Department of Children's Affairs, is discussed in Section 3.1.2.5. *The following discussion, therefore, focuses on various collaborations or coordinated activities in which ADPH is involved.*

BFHS collaborates with numerous other groups, including several institutions of higher learning. For example, staff from the Bureau, CRS, Medicaid, University of Alabama at Birmingham (UAB) School of Public Health's MCH Department, UAB's Civitan Center, and Children's Hospital's Pediatric Pulmonary Center (in Birmingham) meet quarterly to keep abreast on activities of common concern and to plan for coordinated initiatives affecting children. Examples of other ongoing BFHS collaborations include (1) quarterly meetings of BFHS staff with SPAC; (2) receipt of the Day Care grant from DHR; (3) collaboration (by the Women's and Children's Health and WIC Divisions) with UAB to assess smoking prevention methods; (4) continuation of administrative and programmatic support to CHDs; and participation in monthly meetings of ADPH Public Health Area Nursing Directors, Area Social Work Directors, and Area Administrators to share/obtain information and provide technical assistance. Moreover, UAB's School of Public Health and the Alabama Cooperative Extension System (the latter

through Alabama A&M University and Auburn University) work with the Bureau's Community Development/Professional Support Division to facilitate the paradigm shift mentioned in Section 1.4 (under *Changes in the Health Care Environment*).

Additionally, UAB's School of Public Health is providing consultation to the Bureau and selected CHDs to facilitate development of overall program evaluation and evaluation of community systems development initiatives (both existing and new projects). UAB's School of Public Health has developed and implemented the Scientific Method for Community-Based Evaluations Model within the State. Also part of this evaluation initiative, the Cooperative Extension is providing the Bureau's Community Development Branch with technical assistance and training in community development activities that require involvement of multiple organizations and individuals—such as community needs assessment, health promotion initiatives, and coalition building. BFHS currently has no written agreements with the Cooperative Extension, but close ties are maintained among the Community Development Branch, UAB, and the Cooperative Extension.

Other current collaborations (several of which are elaborated on elsewhere in this document) include the following:

- The Bureau's Oral Health Branch collaborated with ADPH's Bureau of Health Promotion and Information's (HPI) Tobacco Use Prevention and Control Branch to conduct the statewide Survey of Alabama Dentists in November 1999 (see Sections 3.1.1 and 3.1.2). The collected data ranged from opinions about access to services for low income populations to tobacco cessation counseling activities for dental patients. The Oral Health Branch developed the tool, conducted the mailing/compiling phase, and entered data, while HPI analyzed the data.
- Staff from the Children's Health Branch continue to collaborate and coordinate with SDE to provide education and conferences for teachers, administrators, parents, students, and newly recruited school nurses. The Bureau encourages CHD collaboration with local school systems, hospitals, and other entities to provide public health assistance as SDE implements the School Nurse Act (described in Section 1.5.1.1).
- The Children's Health Branch continues to collaborate with DHR and other agencies or private groups such as MHMR, the Cooperative Extension, Medicaid, the public school system, the faith community, businesses, and the civic community to develop Family Resource Centers. These centers mainly offer community-based preventive activities designed to alleviate stress and promote parental competencies and behaviors that (1) increase the ability of families to successfully nurture their children, (2) enable families to use other resources available in the community, and (3) create supportive networks to enhance child rearing abilities of parents and help compensate for the increased social isolation and vulnerability of families. Examples of services likely to be available are drop-in child care centers; integrated eligibility establishment for SCHIP, Temporary

Assistance for Needy Families (TANF), WIC, supplemented child care etc.; Head Start; employment services; life skills training; substance abuse services for youth; teen pregnancy prevention; teen parent programs; adult education programs; self-help groups; health services; before and after school programs; tutoring; and family resource rooms.

- C BFHS continues its commitment to ensuring that children and women of child bearing age receive adequate treatment for PKU. With the assistance of a dietitian from the Inborn Errors of Metabolism Clinic at UAB's Sparks Clinic, Bureau staff modified the State formulary to reflect current best practices. Nine medical foods were added to the formulary for this purpose.
- Family Planning Program staff collaborate with numerous statewide and community groups and various levels of governmental and private organizations to address a variety of issues: such as with the Alabama Chapter of the March of Dimes (MOD) on a folic acid campaign; with UAB to assess smoking prevention methods in selected CHDs; with DHR to purchase Depo-Provera and implement an Office of Unwed Pregnancy Prevention; with Medicaid on an 1115(a) Family Planning Waiver, as well as through monthly Medicaid/ADPH meetings about other issues pertaining to family planning; with the Domestic Violence Coalition to place domestic violence posters in CHDs; with the Medical Association of the State of Alabama, the Alabama College of Obstetricians/Gynecologists, and the Alabama Chapter of AAP to obtain funds for teen pregnancy prevention activities; with the Governor's Children's Commissioner, other State and local agencies, the faith community, and State legislators to form the Alabama Campaign to Prevent Teen Pregnancy; and with Medicaid, AUM School of Nursing, and the Pharmacia/Upjohn Company on the PT+3 Educational Model for family planning.
 - Staff from the Epidemiology/Data Management Branch have collaborated with a professor in UAB School of Public Health's Department of Epidemiology to complete and submit for publication a manuscript about adolescent pregnancy, source of payment for delivery, and infant mortality.
 - In conducting the 5-year MCH needs assessment, the Bureau has collaborated with many persons from other agencies and organizations. Moreover, Bureau staff have collaborated with several members of other Department units in this process. Additionally, the Bureau's Needs Assessment Coordinator has collaborated extensively with other Bureau members throughout the needs assessment process. This process is described more fully in Section 3.1.1.
 - In addition to the external collaborations mentioned above, many collaborations occur within the Bureau and among Bureau staff and staff from other ADPH units. For example, Bureau Family Planning staff collaborate

internally with many ADPH units/programs at the State and local level to coordinate projects and provide input/technical assistance regarding family planning issues. Four Family Planning projects/activities coordinated internally are the Title X Infertility Prevention Project with the Bureau of Disease Control's Sexually Transmitted Diseases Division and State Laboratory; the Centers for Disease Control and Prevention's (CDC's) Pregnancy Risk Assessment Monitoring System (PRAMS) Project with the Department's Center for Health Statistics (CHS); the Title X Regional Network for Data Management and Utilization (RNDMU) Project with CHS; and the Title X Training activities with the Public Health Nursing Section. Moreover, Epidemiology/Data Management Branch staff collaborate with many persons from the Bureau and other Department units in the preparation of the Title V annual reports/applications. Multiple other collaborations, too numerous to mention here, are described throughout this document. These include, but are not limited to, collaboration by WIC with multiple external groups and collaboration of the Bureau with UAB to implement the SCRIPT trials.

II. REQUIREMENTS FOR THE ANNUAL REPORT

2.1 Annual Expenditures

See Forms 2-5. Form 2 reflects budgets for the MCH Program within ADPH and the CRS Program within ADRS. Some State and federal funds under the control of such programs as WIC, Immunizations, and Family Planning cannot be separated from these budgets and are not under the control of the MCH Program, but are used to serve all Title V populations, including CSHCN.

Variations in Expenditures

ADPH

The only significant variations in expenditures for ADPH in FY 1999 were in Form 3, line 1 (Federal allocation); Form 4, line c (Children 1 to 22 years); and Form 5, line III (population based). These variations are explained below.

Form 3, Line 1 (Federal Allocation)—This line indicates that, in FY 1999, ADPH expended \$10,191,308 of the Federal award of \$12,248,237. The carryover will be approximately \$2,056,929. At the close of FY 1998 the BFHS chief financial officer, Mr. Larry Gulley, retired. Following the retirement of Mr. Gulley, who had been managing Alabama Title V funds for almost 20 years, Mr. Chris Haag became the Bureau's chief financial officer. FY 1999 was a transitional period, during which Mr. Haag was becoming oriented to the financial operations of the Department and the Bureau (including Title V regulations). During this transition, he monitored Title V expenditure but did not have the experience necessary to forecast total expenditures for FY 1999.

Form 4, line c (Children 1 to 22 years)–This line indicates that during FY 1999 ADPH budgeted \$17,255,208 for Children 1 to 22 years old. This line also indicates that FY 1999 expenditure were \$4,198,958. This significant change was due to the effects of SCHIP and Medicaid Managed care (Patient 1st) on the numbers of children coming to CHDs for care. That is, children who have traditionally come to CHDs for services are now seeking care via their medical homes (generally private physicians).

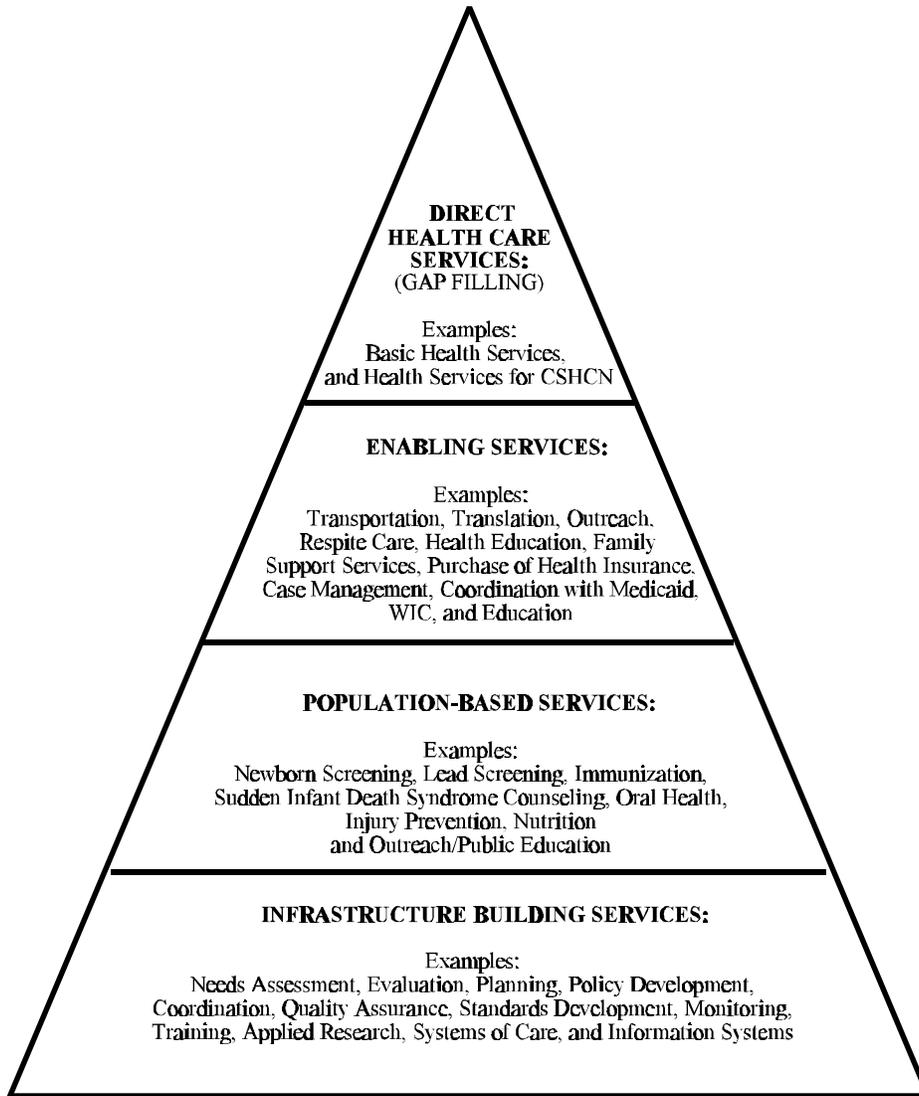
Form 5, line III (population based)–This line indicates that ADPH has a declining expenditure in population-based services. Explaining the precise reason for this occurrence is challenging. After careful investigation, it appears that CHD staff reductions (layoffs) during FY 1999 had a negative impact on provision of population-based services. In addition, it appears that the cost accounting system used to track activity was not designed to adequately track services classified as being population based. The cost accounting issue is being addressed now.

CRS

The only significant variations in expenditures for CRS in FY 1999 were in Other Funds (Form 3, Line 5) and Program Income (Form 3, Line 6). Funds from AEIS for serving infants and toddlers with disabilities were \$316,000 less than anticipated. Although anticipated program income appears to have fallen short by about \$1 million, third party reimbursement claims for FY 1999 are still being processed. CRS received a \$1.35 million increase in State funds for FY 1999.

Figure 2

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



2.2 Annual Number of Individuals Served

See Forms 6, 7, 8, and 9.

Form 6

Findings reported on this form are discussed in Section 2.4.C.1 under CP #04.

Form 7

See notes to Form 7 for data-related issues. All numbers for Form 7 pertain to FYs.

Two notable changes occurred in numbers of Title V clients served:

- Most notably, CHDs served 20% fewer *pregnant women* in 1999 than in 1998 (21,395 versus 26,850). Moreover, comparing 1999 to 1997, when 28,989 pregnant women were served in CHDs, the number of Title V served pregnant women declined by 26%. Changes in the health care environment that have contributed heavily to this decline are discussed in Section 1.4.
- Numbers of children served in CHDs declined by about 8% or 9% in 1999 relative to 1998 (56,504 versus about 61,772; minor changes in reporting preclude precise comparisons). Furthermore, comparing 1999 to 1997, when about 76,357 *children* were served in CHDs, the number of children served in CHDs declined by about 26%. As previously mentioned, PCCM and a prior increase in willingness of private providers to see patients whose health care was paid for by Medicaid have been major factors in this decline.

The paradigm shift prompted by the factors contributing to the above declines is discussed in Section 4.1.

Numbers of infants and CSHCN served remained stable in 1999 versus 1998, and the number of “others” served declined by 2.5% in 1999 relative to 1998. Infants served reflect those who are screened for metabolic disorders, not those served in CHDs.

Form 8

See corresponding note to Form 8 for data-related issues. Numbers for Form 8 pertain to calendar year (CY) 1998 if from vital statistics records and FY 1999 if from administrative (e.g., Medicaid database or encounter form database) records.

With respect to service data,

- Based on vital statistics records, there were 62,616 deliveries in the State in 1998, up 2.0% from 1998. Deliveries of white individuals increased by 2.7% and those of African American individuals by 1.3%, while deliveries of Asian or Pacific Islander individuals declined by 27%. Deliveries of Hispanic individuals

increased by 27%: from 1,064 in 1997 to 1,350 in 1998.

- Based on a ratio using 1999 encounter form data for the numerator and 1998 vital statistics data for the denominator, roughly one-third of all deliveries (21,395/62,616) were Title V served deliveries: with 20% fewer **Title V served deliveries** in 1999 than in 1998 and 26% fewer than in 1997. These findings are consistent with trends in numbers of Title V served pregnant women, discussed under *Form 7*. Over the 2-year period (FY 1999 versus FY 1997), the decline in numbers of Title V served deliveries was the same for white and for African American individuals. The proportion of Title V served deliveries varied notably by race and ethnicity: ranging from 24% of deliveries of white individuals being Title V served to 78% of deliveries of Hispanic individuals being Title V served. Corresponding proportions were 26% for Asian or Pacific Islander individuals, 51% for African Americans, and 66% for American Indians.
- With respect to Title XIX eligible deliveries, estimated per birth records (which report source of payment for birth), 27,724 deliveries in 1998 were eligible for Title XIX, about the same number as in 1997 and 2.4% fewer than in 1996. The proportion of **deliveries that were Title XIX eligible** also varied notably by race and ethnicity—ranging from 23% for Asian and Pacific Islander individuals to 69% for African American individuals. Corresponding proportions were 32% for white individuals, 39% for Hispanic individuals, and 57% for American Indians.
- The **ratio of the number of Title V served deliveries versus the number of Medicaid eligible deliveries** serves as a rough estimate of the degree to which the Title V Program provides uncompensated maternity care. That is, if the ratio exceeds 1, uncompensated maternity care is probably being provided by the Title V Program. This ratio was 2.03 (1,058/521) for Hispanic women, 1.17 (96/82) for American Indian women, and 1.12 (95/85) for Asian or Pacific Islander women. Thus, from the perspective of the Title V Program, the problem of uncompensated maternity care pertains mainly to the Hispanic population. This issue is discussed under *Selected Changes in Alabama's Population* in Section 1.4, as well in as the context of the Department's Strategic Work Group described in Section 2.4. (Corresponding ratios for the total population, for whites, and for African Americans were less than 1.)
- As previously stated, "Title V served infants" pertains to the estimated number of newborns screened for metabolic disorders, so the number of infants served by CHDs is not reflected. Moreover, race-specific trends in these numbers do not merit analysis in the context of Form 8, since they were estimated from the racial distribution of live births. (Pregnancy-related indicators are discussed in Section 3.1.2.1.B.)
- Based on Medicaid eligibility files, however, notable changes occurred in the numbers of **infants who were**

eligible for Title XIX. In 1999, 48,450 infants were enrolled in Medicaid, 45% more than in 1998 and 41% more than in 1997. There were 23,260 Medicaid-enrolled white infants in 1999—47% more than in 1998 and 68% more than in 1997. There were 23,472 Medicaid-enrolled African American infants in 1999—39% more than in 1998, but only 18% more than in 1997. In 1999, 144 American Indian infants were enrolled in Medicaid, 41% higher than in 1998 and 80% higher than in 1997. Also in 1999, 219 Asian or Pacific Islander infants were enrolled in Medicaid, 39% higher than in 1998 and 50% higher than in 1997. The number of Hispanic Medicaid-enrolled infants was somewhat erratic—from 393 in 1997, up sharply to 742 in 1998, then down sharply to 340 in 1999. The general (with the exception of Hispanic infants) increase in the number of Medicaid-enrolled children is consistent with the apparent decline in the proportion of children who were uninsured, discussed under CP #12 in Section 2.4.D.2.

Form 9

There were 1,274 calls to the Bureau's MCH Hotline (Healthy Beginnings) during FY 1999, 42% fewer than in FY 1998. Provision of information through other means presumably accounts for this decline. For example, a major factor in the reduction of calls about prenatal care is the role of ADPH under the new State Maternity Plan that was implemented in June 1999, with the Department's role being that of a subcontractor rather than a primary contractor. The primary contractors have the responsibility of providing a 1-800 line for prenatal care information. Furthermore, fewer WIC calls have been received since WIC revised the letter informing Medicaid-eligible individuals about the WIC program. Due to this revision, the current letter better describes the eligibility criteria for WIC, thus reducing the need for calls about WIC. Additionally, the number of Medicaid calls is down because Medicaid has out-stationed workers in CHDs, hospitals, and other sites, and these workers can respond on site to inquiries about Medicaid eligibility. Moreover, the SCHIP toll-free telephone line appears to have reduced the number of calls received through the Healthy Beginnings line.

In FY 1999, 37,984 calls were received via CRS' toll-free hotline, 6% more than in FY 1998.

2.3 State Summary Profile

See Form 10.

2.4 Progress on Annual Performance Measures

Accomplishments/activities in which ADPH and CRS participated during FY 1999 are discussed under the most pertinent core performance measures and State performance measures respectively. Additional activities essential to addressing identified priority needs are subsequently described under the most appropriate level of the pyramid.

Notes on Methods #1:

Various notes on methods are placed throughout this document, preceding the first place where the note applies. Borders are placed around these notes to facilitate distinction between general methodological notes and descriptive material. Notes applying mainly to a particular item, however, are integrated with the description of findings pertaining to that item.

Precision to one-tenth of a percent is generally deemed unwarranted in this document's narrative, so percentages are generally rounded to whole numbers in the narrative. (The main exceptions to this rule are percentages of about 3 percent or lower, percentages ending in .5 if rounded to one decimal, and percent changes in indicators.) Relative risks and other figures derived from percentages are based on un-rounded numbers, however, so may differ slightly from corresponding numbers that the reader may derive from the rounded percentages. Rates, for example, rates per 1,000, are generally rounded to one decimal.

2.4.A Direct Services

2.4.A.1 Direct Services: Pregnant Women, Mothers and Infants

SP #01—The degree to which the Bureau of Family Health Services (BFHS) addresses the folic acid intake of women of childbearing age.

Status: 10 in FY 1999 (scale 0-18)

1999 target: 6

Trends: The score for this indicator improved from 2 in FY 1997 to 6 in FY 1998 to 10 in FY 1999. The improvement in FY 1999 occurred due to fully meeting objectives pertaining to (1) distributing folic acid pamphlets in CHDs and (2) urging public- and private-sector physicians to make such pamphlets available to their patients of childbearing age and emphasize the value of the nutrient to these patients. No progress was made on objectives pertaining to planning and conducting a survey of women of childbearing age regarding knowledge, consumption, or biochemical indices of folic acid. (See relevant checklist in Appendix F for full description of objectives.)

Discussion: One of the checklist items for this performance measure has been revised slightly for FY 1999 and subsequent years. That is, "Implement a major media campaign..." has been changed to "Participate in a major media campaign...."

Activities/Accomplishments:

- In FY 1999 and thus far in FY 2000, CHDs have continued to provide preconceptional counseling focusing on folic acid to all family planning clients during their initial and annual visits. Family Planning staff have

continued to collaborate with the WIC Program in providing the WIC folic acid pamphlet to family planning clients during their initial and annual visits. Additionally, posters about family planning have been displayed in CHD clinics. Furthermore, Family Planning staff have received training on providing preconceptional counseling and nutritional counseling throughout the life cycle. BFHS clinic protocols for family planning have continued requiring the use of the pamphlet *Folic Acid for Women for Healthy Babies*, as well as *Before You Get Pregnant...Planning is the Key* or *Plan Ahead for a Healthy Baby*.

- The Bureau Director participated in the MOD's Alabama Folic Acid Council (AFAC) and on numerous occasions has collaborated with MOD to promote folic acid consumption by women of childbearing age. During the past year, he hosted the organizational meeting of AFAC and participated in a satellite conference on folic acid. AFAC established subcommittees on professional education, media, consumers, and community action. As a result of the partnership with MOD, CHDs sent letters to obstetricians, gynecologists, and family practice doctors in their local areas. These letters included information from CDC about folic acid, explained the statewide folic acid campaign, and asked for physicians' support of the campaign. CHDs have also partnered with MOD to provide preconceptional health education at community forums and fairs, such as the National Peanut Festival. Through the development of a nutrition education plan pertaining to folic acid, WIC staff have actively promoted adequate folic acid consumption by women of childbearing age. Their activities are described in Section 2.4.C.1 under SP #04.

2.4.A.2 Direct Services: Children

SP# 02—The gonorrhea case rate per 100,000 youths aged 15-19 years.

Status: In FY 1999, 1137.1 cases per 100,000 youth aged 15-19 years

1999 target: 1179.8 cases per 100,000 youth aged 15-19 years

Trends: Per 100,000 youth, this rate declined sharply over 3 years from 1704.3 cases in 1995 to 1295.2 cases in 1997, then declined slightly to 1288.2 cases in 1998, and declined again to 1137.1 cases in 1999 (see *Data issues*). From the 1995 baseline, the average annual decline was about 9.6% per year. The observed rate in 1999 was 3.6% below the target rate for that year.

Data issues: Cases of infection, not unduplicated counts of individuals, are reported. Some under-reporting (especially of cases diagnosed by private providers on a clinical basis rather than through laboratory tests) and, on the other hand, some duplicate reporting of cases are ongoing issues in surveillance of gonorrhea, but these factors are presumably stable. Notwithstanding the reporting issues, the gonorrhea case rate in 15-19 year-old adolescents has clearly declined since the very high rate in 1995.

Activities/Accomplishments: As in previous years, CHDs assessed and treated patients as indicated for gonorrhea. CHD staff made persistent efforts to contact persons diagnosed at their clinics as having gonorrhea. In addition, staff from ADPH's Bureau of Disease Control's Sexually Transmitted Diseases Division made efforts to contact persons, whether from the private or public sector, if requested to do so by physicians. Reasons for the decline in the gonorrhea rate in 1998 are unclear, since resources were channeled into projects geared towards human immunodeficiency virus infection (HIV) and syphilis rather than gonorrhea.

ADPH instituted statewide chlamydia screening for all women seen in CHD sexually transmitted diseases (STD) or family planning clinics for FY 1999. This was the first year that universal screening was done for an entire year, so reported chlamydia rates increased dramatically. Due to the increased emphasis on chlamydia, which is addressed in the chlamydia health status indicator (HSI), the gonorrhea-related performance measure is no longer operative.

2.4.A.3 Direct Services: CSHCN

CP #01–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.

Priority need: Improve health status of CSHCN

Status: 22%

FY 1999 Target: 22%

Trends: This performance measure has remained stable over the past 3 years. Data prior to FY 1997 were not collected. The number of CRS enrollees less than 16 years old who are SSI beneficiaries increased slightly from 4,373 in FY 1998 to 4,416 in FY 1999.

Data issues: The numerator is programmatic data. The denominator of this measure was obtained from SSA, with assistance from the Institute of Child Health Policy. In reviewing progress on this measure, it must be taken into consideration that the FY 1999 denominator data source differs from the previous 2 years.

Discussion: SSI eligible children are eligible for CRS services. Referrals are also accepted on children who applied for SSI and were not eligible, but have special health care needs.

Accomplishments/Activities:

- Contacts offering assistance with service needs were made at the local level with all children newly awarded SSI within the State.
- Upon request, SSA offices in the State received information on resources available through CRS by

replenishment of CRS brochures and information leaflets for families of CSHCN.

- CRS developed a tracking system and periodicity schedule for State SSI beneficiaries less than 16 years old to facilitate contacts with those who are not active with CRS. Through information received from Medicaid, the CRS State Office developed a system to send a "Birthday Letter" offering assistance with unmet service needs to these families during the month of the child's fifth, ninth, or fourteenth birthday. CRS workers were provided with a suggested list of topics for discussion when calls were received. The initial mail-out of 351 letters was sent in September 1999 and resulted in many contacts by families with local offices.
- Due to the resignation of the contract information specialist, CRS had insufficient staff to design new user-friendly guides to the SSI application process as planned.

CP #02–The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty clinic services, including care coordination, not otherwise accessible or affordable to its clients.

Priority need: Improve health status of CSHCN

Status: 9 (scale 0-9)

FY 1999 Target: 9

Trends: In FY 1999 CRS served 22,391 children, a slight increase over the 22,300 children served in FY 1998, following a 2-year trend of reduction in the total number served. There was, however, a 3% reduction in total number of children enrolled in CRS during FY 1999 (from 14,917 in FY 1998 to 14,425). Thus, children served through the CRS Information and Referral Program (7,966 in FY 1999) accounted for the improvement. The number of newly enrolled children was 2,345 in FY 1999, compared with 2,386 in FY 1998.

Discussion: CRS has historically offered all nine categories of services.

Accomplishments/Activities:

- CRS held 1,565 pediatric specialty clinics, responded to 7,966 requests for information and referral, and furnished 70,703 encounters by physicians, dentists, and CRS staff (a 16% increase over FY 1998).
- Of the 153 referrals sent through the transition system formalized last year, 99 CRS adolescents were successfully enrolled in vocational rehabilitation services. Dissemination of a survey developed in FY 1998 to monitor adolescent/family satisfaction regarding the referral process was begun in July 1999. Survey forms were sent to families when a referral disposition was returned to the CRS State Office.

- The first teen transition clinic was held in Birmingham during August 1999. Team members for this clinic come from CRS, Lakeshore Rehabilitation Hospital, UAB's Departments of Physical Medicine and Rehabilitation, UAB's Departments of Pediatrics, and AVRS to focus on life planning for adolescents with special health care needs to promote an optimal transition to adult care and independence. Developmentally and culturally appropriate handouts, references, videotapes, and other materials supportive of transition were made available to families in all clinics.
- CRS resumed coverage of cardiac conditions effective February 1, 1999. Diagnostic procedures, medications, hospitalization, and surgery are covered services. CRS staff services in local offices include patient education, care coordination, nutrition, and transportation reimbursement.
- New clinic initiatives were begun in two offices to increase access to community-based services for CSHCN: a seizure/neurology clinic in Anniston and a neurology/orthopedic clinic in Tuscaloosa.
- A recycling center for durable medical equipment was initiated in Anniston to serve North Alabamians with disabilities of all ages. This was accomplished through a local grant in which CRS, AVRS, and the local Arc Center participated.
- The Birmingham office sponsored the First International Costello Syndrome Conference, which lasted 4 days, with families and physicians from around the world. The office coordinated in-kind contributions and donations to facilitate this effort at the request of a CRS family. Conference evaluations indicated it was very well received.

2.4.B Enabling Services

2.4.B.1 Enabling Services: Pregnant Women, Mothers and Infants:

No measure

2.4.B.2 Enabling Services: Children

SP #03—*The proportion of Alabama public high school students who have smoked cigarettes during the past 30 days.*

Status: 36.6% in FY 1999

1999 target: 36%

Trends: At 36% in FY 1997, this indicator was about 16% higher than the corresponding prevalence of 31% in 1995. It remained stable from 1997 through 1999.

Discussion: In the context of the worsening of this indicator between 1995 and 1997, its stability between 1997 and 1999 suggests an improvement over previous trends. Since one of the newly developed core health status indicators is almost identical to this performance measure, the Bureau considers this performance measure to be no longer operative as of FY 2000. We will monitor trends in the corresponding health status indicator with great interest, however. Plans pertaining to this indicator will therefore be discussed in Section 4.2 and cross-referenced in Section 3.2 under the corresponding HSI.

Activities/Accomplishments: During FY 1999 ADPH continued to coordinate with UAB to implement Phase 3 of the National Institutes of Health-funded Smoking Cessation and Reduction in Pregnancy Trial (SCRIPT) Project. This project, begun in 1997 and now implemented in eight counties (Jefferson, Covington, Lee, Houston, Calhoun, Cullman, Walker, and St. Clair), is a randomized clinical trial to evaluate and document the effectiveness of smoking cessation and reduction patient education methods that can be delivered to pregnant smokers by ADPH maternity staff without disrupting the typical clinic routine. (By ADPH protocol, all maternity patients are questioned regarding smoking and, if they smoke, counseled regarding the importance of stopping.) By October 5, 1999 SCRIPT had recruited and randomized 1,088 patients, representing more than 75% of all pregnant smokers at the eight sites. Although the project does not target adolescents in particular, pregnant adolescent smokers are encouraged to participate.

Most of the Department's activities pertaining to adolescent tobacco consumption are carried out by HPI's Tobacco Compliance Branch. Highlights of their activities or those of other groups with whom they collaborated during FY 1999 or early FY 2000 included the following:

- In March 1999, the Branch launched its web page containing information about its activities.
- Over 40 members of the Alabama Tobacco Use Prevention and Control Task Force reconvened to update the State Plan to comply with CDC's Best Practices. A satellite conference is planned to unveil the Plan.
- Branch staff collaborated with the Coalition for a Tobacco Free Alabama, a 501(c)(3) organization, by serving as Education Committee chair and committee members. The HPI Director holds the position of Secretary on the Coalition's Executive Board.
- The nine Public Health Area Coordinators established or strengthened 10 local coalitions to implement the State Plan on the local level.
- Branch staff collaborated with HPI's Cancer Prevention and Cardiovascular Health Branches, BFHS' Oral Health Section, the American Lung Association of Alabama, and UAB to obtain data on city ordinances;

local taxes on tobacco products; local cessation programs; work site policies concerning tobacco use; youth beliefs, attitudes, and behaviors concerning tobacco use; exposure to second-hand smoke in the home; restaurants with smoke-free dining; and dental health professionals' practices concerning provision of tobacco use information to patients.

- The Public Health Area Coordinators are certified trainers in the Teens Against Tobacco Use Program (TATU), a peer-based youth tobacco use prevention program and the "Not on Tobacco Program" (NOT), a teen tobacco use reduction or cessation program. Although the American Lung Association has been using the TATU Program for 4 years, TATU was a new initiative for ADPH in 1999. Training for NOT occurred in 2000.
- The *Smoking is Old, Be Young* media campaign was created using the FY 1999 Legislative Appropriation for a statewide anti-smoking campaign for youth. The campaign included billboards and the printing and distribution of mouse pads, screen savers, and book covers to schools statewide.
- Over \$800,000 of billboard advertising was obtained to promote tobacco use prevention messages through the Master Settlement Agreement at a cost of \$40,000 for printing.
- Based on data collected by local coalition members and ADPH's environmentalists, smoke-free dining guides were developed for six cities to publicize restaurants that are smoke free and encourage other restaurants to go smoke free. The guides are disseminated through chambers of commerce, hotels, rest areas, restaurants, and colleges and universities.
- About 2,900 compliance checks of retailers selling tobacco products were conducted by the Tobacco Compliance Branch with funding from the U.S. Food and Drug Administration to enforce federal regulations concerning the sale of tobacco to youth under age 19.
- Several local coalitions participated in the Campaign for Tobacco-Free Kids' *Kick Butts Day* in April 2000 by conducting *yuck, muck ugly face* contests, letter writing campaigns to city governments, and poster contests.

2.4.B.3: Enabling Services: CSHCN

CP #03–The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home."

Priority need: Improve health status of CSHCN

Status: 82%

FY 1999 Target: 79%

Recent trends: The percentage of CRS-enrolled children with a primary care physician has steadily increased since data collection began in FY 1995. This trend continued with an increase of 4% (per difference in percentages), from 78% in FY 1998 to 82% in FY 1999. There has been an overall increase of 20% (per difference in percentages) in this indicator from the baseline of 62% in FY 1996, the first year for which complete data were available.

Data issues: CRS continues to accept the AAP's definition of a "medical/health home." Programmatic data were again utilized in this report as no known data source collects this information. Efforts to obtain this information from Medicaid, the Children's Health System, and the ALL Kids Program have not met with success due to the difficulty in identifying these children, particularly when utilizing the federal Maternal and Child Health Bureau's (MCHB) broad-based definition of CSHCN. The FY 2000 target was revised to reflect reporting on CRS programmatic data as progress in identifying comprehensive statewide data on this measure has been slow.

Discussion: In addition to the agency's efforts, the full implementation of Patient 1st and ALL Kids undoubtedly facilitated the placement of CRS clients within a medical home.

Accomplishments/Activities:

- CRS staff met with new providers to identify primary care physicians willing to accept CSHCN as patients.
- Families without medical homes were assisted at the local level with linkage to appropriate, community-based primary care providers. A database report of the major primary care providers for CRS enrollees assisted in the identification of local providers with experience with CSHCN to facilitate placements.
- CRS achieved successful enrollment of 177 CRS enrollees in the ALL Kids Program, thereby providing them with resources to access a medical home. There were 555 CRS enrollees with Medicaid through SCHIP expansion in FY 1999 who were provided a medical home through the Patient 1st Program.
- CRS enhanced its communication with its medical staff, including medical home providers, by the publication of a physician newsletter during the spring, which advised of programmatic changes and the development of ALL Kids Plus.

2.4.C Population-Based Services

2.4.C.1 Population-Based Services: Pregnant Women, Mothers and Infants

CP #04—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).

Status: 101.1% in FY 1999 (See *Data Issues/Findings*)

1999 Target: 100.0%

Trends: Since 1993 or earlier, this indicator has remained at 99% or higher.

Data Issues/Findings: Some submitting providers mark the second and repeat tests as initial specimens; therefore, an unknown quantity of second and repeat tests are counted in the numerator data for initial screens. As a corollary, the numerator for this estimate sometimes exceeds the denominator (accounting for the current estimate of 101.1%). The Newborn Screening and Follow-up Program is a collaborative effort between ADPH's Bureau of Clinical Laboratories (BCL) and BFHS. According to data received, Alabama screens more than 99% of its 60,000 or more newborns. However, obtaining good programmatic data for this measure remains difficult due to staffing limitations and other detrimental funding issues. The Bureau remains unable to match newborn screening records with birth certificates to ensure that 100% of newborns are screened. Title V funds are used to monitor newborns for PKU, hypothyroidism, galactosemia, hemoglobinopathies, and adrenal hyperplasia identified by BCL.

Discussion: The goal of BCL is to provide testing for disease of public health significance, offer diagnostic capabilities unavailable in the private sector, provide private laboratories with reference services, administer regulations, provide education services, institute new testing procedures, and provide data to agencies. BCL serves as the legislated central laboratory for the Alabama Newborn Screening Program. BCL determines if a specimen is satisfactory according to the criteria of The Newborn Screening Specimens Collection Schedule. The Newborn Screening Program is a five-part preventive health care system designed to identify and treat selected heritable conditions that otherwise would become catastrophic health problems. The system includes (1) screening, i.e., universal testing of neonates, (2) follow-up, i.e., rapid retrieval and referral of the positive neonate, (3) diagnosis, i.e., confirmation or denial of a positive screening test result, (4) management, i.e., rapid implementation and long-term planning of therapy; and (5) evaluation, i.e., of testing procedures, follow-up, intervention, and benefits of the program. The Newborn Screening Follow-up Program is an ongoing collaborative effort between public and private sectors and is targeted toward genetic and metabolic disorders. The Program maintains active files on more than 822 infants with phenylketonuria, congenital hypothyroidism, galactosemia, hemoglobinopathies (sickle cell disease), and congenital adrenal hyperplasia. The major benefits in identifying the newborn with medically significant hemoglobinopathies are to prevent death from overwhelming infection and to educate and counsel parents.

Health care providers for children with hemoglobinopathies include CHD nurses and social workers and the seven contracted community-based Sickle Cell Organizations (CBSSOs), as well as private physicians. Case

management and referral services are provided in the absence of a primary care physician. Due to the Medicaid Patient 1st managed care program, prompt identification of primary care physicians continued to be problematic, both for BCL and BFHS. However, the Department's excellent working relationships with metabolic specialists, CHDs, and CBSSOs continued to provide a safety net for early identification and initiation of treatment.

Activities/Accomplishments:

- In FY 1999, 62,025 newborns were reported as screened for one or more of the five chemical disorders mentioned above (see Form 6). Among the clinically significant findings, 10 newborns were identified as potentially having galactosemia (10 presumptive positives). Diagnostic follow-up by a metabolic specialist revealed five newborns as having Duarte galactosemia (DG) carrier and three as having classical galactosemia. Two infants were diagnosed as having PKU and treated at the Sparks Genetics Center, where they are regularly monitored. Three women with PKU gave birth in 1999, with all infants being normal and unaffected by maternal PKU.

- 67 newborns were identified as potentially having congenital hypothyroidism; 12 of these were confirmed by a pediatric endocrinologist as having primary hypothyroidism.

- 51 newborns were identified as having hemoglobinopathies: 42 were confirmed as having medically significant hemoglobin and nine were not. However, 45 of the 51 identified as having hemoglobinopathies were treated with prophylaxis penicillin, beginning as early as 2 months of age. All of the 29 newborns identified with sickle cell disease (FS, or sickle beta zero thalassemia), 13 of the 17 identified with sickle hemoglobin SC disease (FSC), and 3 of the 5 clients with possible sickle beta + thalassemia disease (FSA THAL) were treated. The BFHS State Coordinator for Newborn Screening is following up to ascertain the status of the untreated cases of FS and FSC.

- C The Automated Voice Response System (begun in 1995), which reports results 24 hours a day, was continued. This system allows authorized physicians, nurse practitioners, and nurses to call and obtain the test results or the status of specimens received at the BCL at least 24 hours prior to the call. The users may dial 1-800-566-1556, 24 hours a day, to receive test results (in 30 seconds or less). Registration has attracted almost 1,000 physicians to the system.

- C Training was provided to Shelby Baptist Medical Center and Gadsden Regional Medical Center to help personnel with collection and follow-up to reduce unsatisfactory specimens. BCL and BFHS are formulating plans to train as needed in 2000.

- C The BCL County Assistance Section provided assistance to CHD staff. About 144 on-site visits were made in 1999.

- C The Alabama Sickle Cell Disease Client Registry, for which the pilot phase ended in September 1998, has been maintained. Data collection sites included Birmingham, Gadsden, Huntsville, Mobile, Montgomery, Selma, Tuscaloosa, and Tuskegee. Plans are to include other counties and collect data from hospitals, e.g., Cooper Green Hospital, Children’s Hospital, and UAB. Data will include socio-demographic and health care data on persons with sickle cell disease and will be used to (1) describe the frequency and demographics of sickle cell disease in Alabama; (2) document the prevalence of self-reported illness, experiences, health and human services access, and use of such services by persons with the disease; and (3) plan clinical care, case management, and further research.

- C CBSSO conducted a survey of parents to assess the effectiveness of parental counseling education services. The 9-month survey was helpful to personnel and to parents, though return rates for forms were somewhat lower than expected, which may have biased results. Generally, parents surveyed expressed satisfaction with counseling services and were interested in receiving additional information about sickle cell disease.

CP #05–Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.

Status: From July 1998-June 1999, 73% (95% confidence interval [CI] ± 5) of 19- to 35-month-old children had completed immunizations for measles, polio, diphtheria, tetanus, pertussis, *Haemophilus influenza*, and hepatitis B.

1999 target: 86%

Trends: The estimate of 73% for 1999 is not comparable to estimates for 1998 or earlier years. The reason for this lack of comparability is that the only available estimates approximating this performance measure for 1998 and earlier years pertain to completed immunizations for measles, polio, diphtheria, tetanus, pertussis, and *Haemophilus influenza* (subsequently termed “major series”) and do not include hepatitis B. However, this indicator notably worsened even when comparing estimates for the major series. That is, the proportion of children through age 2 years who had completed the major series of immunizations significantly declined from 87.0% (CI: ± 3.2) in 1998 to 77.6% (CI: ± 4.9) in 1999. Reporting methods utilized by CDC changed somewhat in FY 1999, and this change might have caused some—but probably not all—of the reported worsening of this measure. Staff from ADPH’s Immunization Division believe that this measure did indeed worsen in FY 1999, i.e.,

proportionately fewer of Alabama's children through 2 years of age were fully immunized for the major series in 1999 than in 1998. At any rate, for the major series in 1999, the State was apparently about 10% below the target for that year. Potential reasons for this setback are described in the last paragraph under *Activities/Accomplishments*.

Data issues: See issues described under *Trends*, as well as the corresponding note to Form 11.

Activities/Accomplishments: ADPH's Immunization Division (in the Department's Bureau of Disease Control), the Bureau's WIC Division, and staff in CHDs have worked diligently to keep the State on track for achieving the Year 2000 objective that 90% of 2-year-old children will be fully immunized. The Immunization Division continued work on building an immunization registry for use among public and private providers. Alabama's registry currently includes ADPH clinics located throughout the State. The registry captures all vaccines administered in ADPH clinics and vaccines given by outside providers to ADPH clients who present with records showing these vaccines. If needed, offices of private providers are called to inquire about the vaccine history of patients. Inclusion of vaccines provided by outside providers in the registry occurs most frequently in WIC clinics, suggesting that efforts of WIC staff to promote provision and documentation of immunizations is successful. The registry uses this information to feed the "overdue report" that each CHD uses to track patients needing vaccines. An internet web application was completed and is currently being tested in 13 federally qualified community health centers (FQHCs). The Web-based system will face modifications this year before being offered to other vaccine providers. Vaccine billing data from Blue Cross Blue Shield was added to the registry and will be updated regularly. InfoSolutions, a Blue Cross software package, offers Blue Cross providers throughout the State access to the registry. In 2000, vaccine billing data from Medicaid will be added to the registry.

Other activities of the Immunization Division in FY 1999 included:

- Sending a pamphlet to the home of each 4-month-old infant in the State and a postcard to each 11-month-old infant in the ADPH data base to remind their care givers of needed upcoming immunizations
- Hiring a public health nurse, in an agreement with the Alabama Primary Care Association, to conduct immunization audit and training activities in FQHCs around the State. This initiative keeps FQHC staff up to date on recommendations and policies.
- Proctoring sites where satellite courses from CDC and ADPH can be viewed by all vaccine providers in the State. These courses keep providers abreast of new or changing recommendations.
- Operating a "high risk" program to locate babies meeting criteria for certain high risk classifications to

ensure that they are vaccinated as recommended by the second birthday

- Administering the Vaccines for Children (VFC) program. The Division ships vaccine to 500 sites throughout the State. VFC providers are regularly sent updates including vaccine recommendations, program updates, and other vaccine-related information.
- Working with all providers of primary care to children to stress the concept of assessing the vaccine history of each patient at each clinic visit and to vaccinate when appropriate.

In spite of these efforts, as described under *Trends*, Alabama apparently experienced a setback in 1999, with proportionately fewer children 2 years of age and younger being fully immunized than in 1998. Reasons for this setback are not clear. There is some speculation, however, partly based on occasional unconfirmed verbal reports, that this apparent decline in immunization levels is related to Medicaid's PCCM Program. One speculative factor pertains to the need for children to re-certify for PCCM at 13 months of age. Conceivably, some of Medicaid's addresses for these children may be old so that letters are not received; moreover, some of those receiving letters may not promptly have their children re-certified. Thus, some children's Medicaid cards may have expired when immunizations are due, and health care providers might therefore not immunize them. The second speculative factor, based on several unsubstantiated reports, is that re-certified children are sometimes assigned to a different provider—sometimes two counties away from the child's residence. To reiterate, these potential factors are offered as speculation, not as fact. They merit exploration in FY 2001, however.

CP #09—Percentage of mothers who breastfeed their infants at hospital discharge.

Status: 42.0% in FY 1998 1998 target: 51.5% 1999 target: 58.4%

Trends: After improving notably in 1996 and slightly in 1997, this measure has remained at 42% in 1997 and 1998. Reasons for this apparent lack of recent improvement are not known.

Data issues: See corresponding note to Form 11.

Activities/Accomplishments: During FY 1999, about 35% of WIC participants breastfed their infants. The following activities occurred during that year:

- The 1999 Hospital Breastfeeding Database Survey was conducted. The purpose of this survey was to provide a consistent statewide mechanism of reporting breastfeeding data among private and public health organizations. It was distributed to every Alabama hospital providing obstetrical services. Fifty-two hospitals returned the surveys, for a response rate of 72%. Results were similar to corresponding results per

PRAMS data.

- The 1999 *Alabama Breastfeeding Resource Guide* was distributed to all WIC clinic sites and all Alabama hospitals providing obstetrical services. The guide is an annual publication that facilitates networking among health care professionals in public and private sectors.
- Sixteen Mom's Helper Program assistants were provided breastfeeding training. This program is a joint effort between ADPH and the Cooperative Extension.
- The 1999 WIC Breastfeeding Training Workshop was held in October in Montgomery, Alabama. A total of 110 nurses and nutritionists attended the training.
- Breastfeeding training was conducted by the WIC Breastfeeding Coordinator for several Alabama hospitals. Obstetrical staff received continuing education units and resources to enhance their education.

CP #10—Percentage of newborns who have been screened for hearing impairment before hospital discharge.

Status: 60.2% in FY 1999

1999 target: 65.6%

Trends: This indicator improved remarkably in the 1990s, from 27.3% in 1996 to 53.3% in 1998, with further improvement to 60.2% in 1999. Based on the improvement in 1998, targets were revised sharply upward as the 1998 report/2000 application was being prepared.

Activities/Accomplishments: The Birmingham Ear Institute (BEI) and BFHS have collaborated for the last 2 years to provide technical assistance to Alabama's birthing hospitals in order to facilitate voluntary implementation of a hospital-based newborn hearing screening program. Although this collaboration has resulted in 50% of the birthing facilities screening for hearing loss, no infrastructure or standards are available. In FY 2000 BFHS and BEI jointly submitted a grant proposal to facilitate full implementation of a statewide universal newborn hearing screening program, but this proposal was not funded. Nevertheless, we believe that much of the improvement in this indicator during the 1990s was due to the efforts of BEI.

SP# 04—The number of women and infants (combined) participating in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Status: 63,940 in FY 1999

1999 target: 63,794

Trends: The average caseload of WIC-enrolled and participating women and infants declined slightly (by

0.2%)—from 64,089 persons in FY 1998 to 63,940 persons in FY 1999. This decline was the first since FY 1996, when this indicator declined by 2%.

Discussion: Other measures have been deemed more directly related to newly identified priority MCH needs. For this reason and because identifying an appropriate denominator for tracking the proportion of WIC-eligible women and infants who are enrolled is problematic, this performance measure is no longer operative as of FY 2000. Because WIC is a very important adjunct to care, however, many WIC-related activities will be described in Section 4.2 and wherever they pertain to performance measures.

Activities and Accomplishments:

Even with the slight decline in numbers, the target for FY 1999 was met. In FY 1999, WIC experienced numerous changes that may explain the decline and may cause further decline in the future. The implementation of income documentation requirements has had some effect on the number of people being income eligible. The implementation of our statewide Public Health of Alabama County Operations Network (PHALCON) computer system was necessary to meet Y2K compliancy. Training issues pertaining to PHALCON may have also impacted the effectiveness of WIC or the documentation of numbers being served.

WIC was a major adjunct to care in FY 1999, with the following activities occurring in FY 1999 and early FY 2000:

- Media outreach, including statewide press releases, occurred. An interview on a television station covering central Alabama and two interviews on the Alabama Radio Network were done. Much media attention accompanied WIC's 25th anniversary celebration in 1999. The Alabama Grocers' Association donated cakes to several clinics throughout the State, and local government officials were invited to celebrate the anniversary with the local clinic staff and participants. The Governor signed a proclamation designating May as WIC 25th Anniversary Month in Alabama. Additional media outreach occurred in FY 2000.
- WIC's Outreach Coordinator and WIC nutritionists attended several statewide events and provided materials to attendees. These events included the AAP's conference, the Alabama College of Obstetrics/Gynecology conference, and several local health fairs across the State.
- State WIC staff continued to identify potential out-stationing needs and maintained several of their out-stationing programs, e.g., the WIC clinic at the Jacksonville State University Health Clinic in Calhoun County, The Mother/Baby Unit at Huntsville Hospital in Madison County, and the out-stationing of two WIC nutritionists in satellite clinics at DHR. WIC home visits in Calhoun County continued, where a nurse who provides family planning and EPSDT visits to Medicaid patients also performs WIC assessments on

newborns and postpartum and breastfeeding women.

- In FY 1999, WIC collaborated with the Farmers' Market Authority and the Cooperative Extension to establish and implement a pilot Farmer's Market Program at two WIC clinics in Montgomery County. At these clinics, women and children participating in WIC received coupons to purchase "Alabama grown" fruits and vegetables. This program generates revenue within the State and complements the statewide *5-a-Day for Better Health* Campaign, a national campaign administered through the National Cancer Institute and the National Produce for Better Health Foundation. The Farmer's Market pilot project was so successful that in FY 2000 the Farmer's Market Program will be available in all WIC clinics in Montgomery, Dallas, and Madison Counties. All of these counties have large WIC caseloads and are densely populated.
- WIC continues collaborating with ADPH's Immunization Division. Infants or children seen in CHDs for WIC certification or re-certification were assessed regarding immunization status and referred for immunizations if found to be due or overdue for vaccination. WIC will continue obtaining immunization histories (sometimes contacting private providers) and assuring that immunizations are documented on medical records and in the computerized immunization file.
- In FY 1999 WIC launched a nutrition education plan, *Folic Acid Supplementation Interventions to Lower Infant Mortality in Alabama*. This plan was implemented in 10 of 11 public health areas. Each local WIC clinic administered folic acid pre- and-post surveys to their prenatal, postpartum, and breastfeeding participants. An article about folic acid was placed in *Alabama's Health* (the Department's newsletter) and the *Starlights* (a WIC breastfeeding newsletter), and a news release was distributed. As mentioned in Section 2.4.A.1 under SP #01, each CHD sent outreach letters to physicians in their local area asking them to inform their female patients of child bearing age about the importance of Folic Acid in their diet. Additionally, WIC collaborated with MOD and used some MOD folic acid information, including a poster. This poster was displayed on bulletin boards in each of the WIC clinics. WIC staff, as well as other BFHS staff, participated in the previously discussed AFAC. One of the press conferences held by AFAC was attended by representatives of the Alabama Legislature. In FY 2000, WIC is launching another nutrition education plan, *Increasing Folic Acid Consumption Among WIC participants of childbearing age in Alabama*. The objectives of this nutrition education plan are to (1) increase knowledge of health care providers about the relationship between folic acid and neural tube defects, (2) develop ways health care providers can use this knowledge to educate women of childbearing age, and (3) increase knowledge of postpartum and breastfeeding WIC participants about the relationship between folic acid and neural tube defects.

2.4.C.2 Population-Based Services: Children

CP #06–The rate of births (per 1,000) for teenagers aged 15 through 17 years.

Status: 39.7 live births per 1,000 females in this age group, in CY 1999 (very preliminary)

1999 target: 42.8 per 1,000

Trends: From the 1994 baseline, this adolescent pregnancy rate declined by an average of 4.9% per year by 1999, when it was about 7% below (better than) the target for that year.

Data issues: Projected population estimates are used for the denominator. Conceivably, the farther the year from the 1990 census, the farther the estimated population may be from the actual population. Though not subsequently mentioned, this caveat pertains to any measures using projected population as the denominator.

Activities/Accomplishments:

The Bureau and other entities have continued many activities that we believe have helped the State achieve, and even exceed, adolescent pregnancy targets. Activities in which the Bureau has been involved include:

- Use of the PT+3 teaching model to improve compliance in young or low-literacy family planning patients.

- Maintenance of the OAPP's Adolescent Family Life abstinence-based adolescent pregnancy prevention project, which offers a series of educational sessions in schools by CHD staff in eight counties, and application for continued funding of this project. Technical assistance was provided by the program director, program coordinator, and county public health nurses to two additional counties to implement the pregnancy prevention curricula used in the project.

- Maintenance of the Alabama Abstinence Education Program (AAEP), which continued funding in FY 1999 for 25 grants—16 to community-based agencies/organizations and 9 to county school systems. In FY 2000, funding continued for 18 projects—12 to community-based agencies/organizations and 6 to county school systems. Project activities are held in private health care settings, educational facilities, and city/county/State social services agencies/organizations. Grantees use the funds for new abstinence-only educational programs and to provide direct services and offer educational, recreational, and peer/adult mentoring programs. Their goals are to promote abstinence-only-until-marriage and reduce the occurrence of sexual activity among adolescents 18 years of age and younger. The 25 projects were not funded until June 1998, so only a few projects were implemented in FY 1998. However, responses from youth and communities to the projects were optimistic, which facilitated elimination of potential barriers. All 25 projects were implemented in FY 1999, and preliminary evaluation data are being compiled to facilitate a more stringent analysis of outcomes. In FY 1999 a statewide media campaign, which included audio/video public service announcements and project enhancements/incentives, was launched.

- Operation of InfoConnection, a toll-free hotline providing abstinence and abstinence-based information to teens. InfoConnection also provided information to parents and health and educational professionals and provided family planning referral services for women of childbearing age. About 1,300 calls were received in FY 1999.
- Provision of family planning services at 113 clinic sites. CHDs provided comprehensive family planning services to 28,199 adolescents during FY 1999, serving 29% of adolescents in need of family planning services. The Bureau prioritized appointments to teens in family planning clinics statewide. Moreover, recognizing Depo-Provera as the preferred contraceptive method for many teens, ADPH worked to make it available and received TANF funding to increase availability of Depo-Provera, especially for teenagers, and to implement the Office of Unwed Pregnancy Prevention.

Milestones, new initiatives or special events in FY 1999 or early FY 2000 included the following:

- Completion of adolescent focus group sessions in 10 counties throughout the State to help identify reasons that teens become sexually involved and what they recognize as “helpful” in preventing early sexual involvement. ADPH coordinated the sessions and contracted with the Alabama Public Health Association (ALPHA) to conduct the sessions. The focus groups were conducted in communities at locations such as churches, community facilities, and schools. Groups including males and females aged 10-14 years of age and 15-18 years of age participated. Information from these sessions is being compiled for distribution to agencies and community-based organizations working with adolescents. Findings from sessions will be published and distributed in CY 2000. However, in the future, better demographic data should be collected to better target funding.
- In April 1999, participation in the *Teen Power: Building Healthy Communities Through Strong Youth* conference in Mobile, Alabama. This 1-day interactive program was sponsored by the U.S. Department of Health and Human Services and the U.S. Department of Education Regional Offices in cooperation with Emory University Training Center. The conference was designed for adults who work with teens. Its purposes were for participants to develop skills in building teens’ competence; preventing teenage pregnancy; and preventing alcohol, tobacco, and other substance abuses. Alabama-specific information about current risks and various youth-relevant programs sponsored by ADPH were discussed. Additionally, information about teen pregnancy prevention and about alcohol, tobacco, and other substances was available, and free incentives for attending the session were provided.
- Participation in the White Ribbon Campaign’s Teen Pregnancy Prevention Rally in Birmingham, Alabama in

May (Teen Pregnancy Prevention Month) 1999. The theme of the rally was *Love Can Wait*. The goals of the White Ribbon Campaign are 1) to increase awareness of the problems pertaining to teenage sexuality, strengthen existing educational programs regarding teenage sexuality or prevention of adolescent pregnancy, and stimulate community-based activities through concerned parents, business leaders, churches, civic, social, and youth programs; and 2) to build, establish, and maintain a Teen Pregnancy Prevention Coalition to reduce the teen pregnancy rate in Jefferson County by one-fourth by the year 2005. ADPH participated in the rally by reading and presenting a copy of the State Proclamation by the Governor denoting May as Adolescent Pregnancy Prevention Month.

- Attendance in October 1999 at the National Campaign to Prevent Teen Pregnancy's Southeast Conference, the purpose of which was to address teen pregnancy and consider preventive strategies. As a result of this conference, the Alabama Campaign to Prevent Teen Pregnancy was established and held its first meeting in December 1999. BFHS participates in this coalition, which includes State and local agencies such as the Children's Commissioner, ADPH, DHR, Children and Society, and the Cooperative Extension to address teen pregnancy in Alabama. Additionally, the Montgomery Campaign to Prevent Teen Pregnancy was implemented and held its kickoff session in December 1999.
- Distribution in December 1999 of a video cassette developed by the National Campaign to Prevent Teen Pregnancy, entitled *Jessica's Story*. The video is a short (about 10 minutes) compilation of scenes from a major story line from the soap opera *One Life to Live*. The protagonist is a young woman who, subsequent to casual drinking, engaged in sexual activity that resulted in pregnancy. Over 400 copies of the video were distributed to various public and private agencies—including community-based organizations, churches, and CHDs—throughout Alabama. Included with the video were a cover letter from the National Campaign to Prevent Teen Pregnancy, a teaching/discussion guide, and a pamphlet. Recipients were encouraged to share the video with others, including every teen possible. Comments from these agencies about the video were shared with the National Campaign.
- Purchase in June 1999 of the *Wise Guys* curriculum, developed in North Carolina and being implemented in several states. The purpose of this male responsibility curriculum is to stimulate development of teen pregnancy prevention programs geared toward educating the young male population. The curriculum was approved as a course in the Adolescent Pregnancy Prevention Project by Medicaid and is being conducted in eight counties throughout the State, as well as by Birmingham's Children's Aid Society in their male outreach program.

Setbacks:

- Due to lack of funding and staff resources, a plan to develop a resource directory listing local programs/projects involved in adolescent pregnancy prevention activities was not implemented in 1999, but implementation will begin in 2000.
- Bureau staff were unable to continue efforts to estimate the proportion of all ADPH maternity patients and adolescent maternity patients who return for family planning services. This disruption of efforts was due to several factors: lack of Bureau epidemiologic/analytic staff, prioritization by the sole (in FY 1999) Bureau MCH epidemiologist of the 5-year MCH needs assessment over other analytic tasks, and prioritization by Computer Systems Technology staff of development of the new PHALCON data base. As discussed in Section 4.1.C.2 under this performance measure, in FY 2001 the Epidemiology/Data Management Branch will resume efforts to estimate this proportion.

CP #07–Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Status: 36.3% in FY 1999 (provisional) 1999 target: 36%

Trends: Only two estimates are available for this indicator through 1999: that of 20% for 1991 and the above estimate of 36%, which is 81.7% above the estimate for 1991. These estimates were based on very different methods, however, so may not be comparable. Nevertheless, allowing for statistical uncertainty and potential improvement, the estimate for 1999 is consistent with a provisional estimate obtained from the Telephone Survey of Alabama Households with Children conducted in early 2000 (discussed extensively throughout Section 3.1): that 45.5% of children aged 8 to 13 years had dental sealants.

Data issues: As stated in previous MCH Block Grant annual reports/applications, the Bureau’s dental health services’ staff anticipated that a standardized screening tool to estimate the prevalence of dental sealants, for use in all states, would be developed through a cooperative agreement between CDC’s Division of Oral Health and the Association of State and Territorial Dental Directors. The tool was not developed in time for the Oral Health Branch to repeat its statewide dental disease prevalence survey though. (The tool is now available, however; see plans under this performance measure in Section 4.1, *Program Activities Related to Performance Measures.*)

Because examination-based dental sealant data from a representative sample of third-grade students are not available for recent years, in FY 1999 the Bureau’s Oral Health Branch conducted, in collaboration with involved schools, a survey of the prevalence of dental sealants based on parental report. The provisional estimate that 36% of third grade children have received protective sealants on at least one permanent molar tooth is from this survey. (Findings from this survey were described in the 1998 report/2000 application but are described again here since it

was conducted in the reporting year.) The study population consisted of 1,794 public-school third graders whose parents or custodians returned a completed survey form asking whether the referent child had dental sealants. (The survey form included an explanation of what sealants are.) Although the participating schools were selected based on feasibility rather than systematic or random selection, information collected for each school about the percentage of children who received free lunches suggests that a range of household incomes was represented among the children studied. Specifically, in the sampled schools, from 15% (“high income” schools) to 98% (“low income” schools) of children received free school lunches, with a median of 50% of children receiving free school lunches.

As detailed in the 1998 report/2000 application, this study had major limitations and the estimate of 36% may overestimate the true proportion. In spite of these limitations, the survey provides very useful information for interim planning, until resources become available for conducting an examination-based survey of children from a wide range of socioeconomic groups.

- The first major implication of the preliminary findings is that interventions (whether through education or removal of barriers) to provide appropriate dental care to young children are needed. Even if the estimated proportion of 36% is valid (and, as a corollary, we have actually met the 1999 target), interventions are needed to promote further progress.
- The second major implication of the preliminary findings is that interventions are especially needed for low-income families. Based on quartiles of the free-school-lunch percentage, the 63 participating schools were divided into four income groups (high, medium high, medium low, low). (The “low-income” group, for example, was comprised of the schools with the highest percentages of children receiving free lunches.) As expected, there was a strong and consistent inverse relationship between income composition of households represented in the schools and the percentage of children having dental sealants ($P=0.000$, per linear trend in proportions). Reported percentages of children having sealants were 46% for high-income schools, 38% for medium-high income schools, 28% for medium-low income schools, and 17% for low income schools. Accordingly, children from high-income schools were reportedly 2.7 times more likely to have dental sealants than children from low-income schools. Our assumption that the reported proportions (e.g., that 17% of children in low-income schools have sealants) may notably overestimate the true proportions underscores the urgency of interventions to assure that children from low-income families get appropriate dental care.

Reported findings remain provisional. Rather than further analyzing data from this survey, however, the Bureau has devoted resources to developing and implementing a survey of Alabama dentists (mentioned under *Activities/Accomplishments*) and the Households with Children Telephone survey (described in Section 3.1.1), both of which included questions pertaining to dental sealants. Based largely on findings from the dental sealant survey

described above and the survey of dentists, one of the priority MCH needs and two of the newly developed State-negotiated performance measures pertain to oral health of children. Oral health is therefore further discussed in several places in Section III.

Activities/Accomplishments:

Based on reports from CHD and school-based dental clinics, 35,395 protective dental sealants were placed in children's permanent teeth in FY 1999, 18% (5,369) more than in FY 1998. These sealants were placed through programs targeting low income populations. In FY 1999, the Bureau's Oral Health Branch continued the following promotional strategies to increase dental sealant placement through CHDs, as well as through private dental offices:

- Loaned portable dental equipment to CHD dental staff for use in community-based sealant projects
- Provided videos and educational material promoting sealant placement to CHD dental clinics, private dental offices, and schools as requested
- Donated sealant supplies/equipment to two school-based dental clinics serving low-income children
- Maintained representation on the Alabama Medicaid Dental Task Force to address access disparities, low reimbursement fees, and a broad range of other dental issues that impact the oral health of underserved populations
- Continued partnering with UAB School of Dentistry to collect Early Childhood Caries data in the WIC population and to develop appropriate educational models for use in WIC clinics statewide
- Monitored monthly activity reports from CHD and school-based dental clinics
- Compiled year-end data and compared findings (1999) to established 1-year objective (1998).

Thus far in FY 2000, the Bureau has conducted the following activities pertaining to oral health.

- Transferred \$25,000 in MCH funds to a CHD site for sustaining a community-based sealant project in schools with substantial enrollment of low-income children
- Allocated MCH funding for oral health initiatives by two additional community-based projects. One of these projects was to develop oral health infrastructure throughout the community, and the other to provide targeted case management for medically at risk children experiencing chronic dental problems.

- In collaboration with HIP, developed, conducted, and began analyzing a survey of Alabama dentists as part of the 5-year MCH needs assessment. This survey collected critical oral health data regarding services for maternal and child populations. Highlights regarding methods and preliminary findings are respectively described in Sections 3.1.1 (*Needs Assessment Process*) and 3.1.2 (*Needs Assessment Content*).
- Collaborated with CHS who, in collaboration with CDC, added two oral health questions to the Alabama PRAMS data collection tool
- Included oral health questions in the Households with Children Telephone Survey developed and conducted by the Bureau, in collaboration with UAB's Survey Research Unit and the Bureau's MCH Needs Assessment Advisory Committee (Bureau's Needs Assessment Committee)
- Was awarded a fluoridation Grant by CDC to increase the number of systems providing fluoridated water
- Began planning for three new public health dental clinics for three impoverished counties with one or no Medicaid dental providers.

CP #08–The rate of deaths to children aged 0-14 caused by motor vehicle crashes per 100,000 children.

Status: 7.5 deaths per 100,000 children aged 0-14 years, in CY 1999

1999 target: 6.9 per 100,000

Trends: Comparing the preliminary rate of 8.5 deaths per 100,000 in 1997-1999 to the rate of 8.2 deaths per 100,000 in 1995-1996, this measure worsened by 2.9%. Although the very preliminary rate for 1999 is the lowest for the surveillance period, the strong possibility that it will be revised upward, as well as the instability of the rate due to small numbers in the statistical sense, precludes projections regarding the direction in which this rate is likely to go.

Data issues: Per recent correspondence from MCHB, the definition of this measure has been changed to include infants. Accordingly, the age group specified in this narrative, and to which the estimates pertain, differs from the age group specified in the electronic reporting package. Moreover, because the definition changed recently, obtaining estimates for years prior to 1995 has not been feasible, so trends are based on few years of data.

Two sources of data can be used to describe this measure: the Fatality Analysis Reporting System (FARS) and vital statistics. The CSN National Injury and Violence Prevention Resource Center suggests that both systems be

used since they have different criteria, but our results are based solely on vital statistics.

Activities:

- The review of child deaths from motor vehicle crashes by the Local Child Death Review Teams has identified the inexperienced first year driver to be at higher risk for a fatal traffic accident. Any one variable, such as rain, darkness, drinking, horseplay, etc. added to their driving inexperience has been found in cases reviewed. These findings have supported legislation currently being introduced (HB.9) calling for graduated vehicle licensure. This legislation will put restrictions on teenage drivers to help better prepare them to be a safe driver. (HB.9 has passed the House and is on the Senate calendar.)
- Using required National Highway Traffic Safety Administration (NHTSA) guidelines for surveillance, HPI's Injury Prevention Division conducted its 10th annual safety belt, child restraint, and motorcycle helmet usage survey. The NHTSA sampling system provides data from both rural and urban highways and includes about 57% of Alabama's residents in the sample pool. Twenty-three sites are randomly selected in each county, including areas of low (0-4,999 vehicles), medium (5,000-10,499 vehicles), and high (10,500-75,000 vehicles) traffic volume. At least one of each type of site was surveyed in each selected county. For the 1999 survey, 345 sites were selected and observed for a 1-hour period. The surveyor counted the number of passengers in the front outboard seats of the car and the number of those wearing their safety belts, the number of children in the car and the number of those restrained, and the number of motorcyclists wearing helmets. Per observation of 89,153 front seat occupants, 2,286 children, and 173 motorcyclists, estimated usage rates were as follows: safety belt usage, 58% (tied for the highest usage rate for the surveillance period of 1990-1999); child restraint usage, 60% (tied for the third highest usage rate during the surveillance period); and motorcycle helmet usage, 100%. The Injury Prevention Division is currently in the data collection phase of the 2000 survey.

SP #05--The percentage of blood lead levels exceeding 15 ug/dl among children aged 6 months through 5 years.

Status: 2.6% in CY 1999

1999 target: 2.2%

Trends: From a baseline of 2.5% in 1996, this measure increased notably to 3.1% in 1997, then declined to 2.6% in 1998 and remained there in 1999, when it was above the target for that year.

Data issues: The Alabama Childhood Lead Poisoning Prevention Project emphasizes screenings for Medicaid eligible children and for children in the higher-risk targeted areas. Selecting a denominator for this measure is problematic since not all children in this age group are screened and some are screened more than once if an elevated lead level is found. The denominator used, the number of tests performed by the State lab, presumably over-represents high-risk children. Because the lab does not differentiate children with repeat tests from children with only one test, this measure cannot demonstrate the actual number of children tested . The reported 2.6%

prevalence for this group is likely higher than the prevalence in the entire State. Since all children are not screened, however, including all children in the specified age group in the denominator would probably notably underestimate the prevalence of this condition. Due to these problems, this performance measure is inoperative as of FY 2000. It is therefore not discussed as a performance measure under the annual plan, but is discussed under Section 4.2 (*Other Program Activities*).

Data collection on the number of children screened for lead by private providers and private laboratories remains problematic. Primary causes include the continuing exodus of child health patients from health department clinics to private providers reimbursed by Medicaid. This has resulted in a shift from blood tests being processed at the State lab to tests being processed at private labs. Private labs are only required to submit elevated levels, not all test results, and therefore are excluded from our analysis as it would result in a falsely elevated prevalence. This shift in providers has greatly lowered our screening numbers.

Activities/Accomplishments: The purpose of the Alabama Childhood Lead Poisoning Prevention Project is to reduce blood lead levels among Alabama children, thereby preventing childhood lead poisoning in Alabama. This program is funded through a federal grant from CDC and targets poor, urban, and minority children living in high-risk communities. Twelve counties are targeted for universal lead screening: Barbour, Bullock, Chambers, Conecuh, Dallas, Jackson, Jefferson, Lowndes, Mobile, Pickens, Pike, and Wilcox. However, all CHDs screen children for elevated blood lead levels. The Project Coordinator coordinates all program activities with the Bureau of Environmental Services, which provides environmental case management and investigates the home for lead, and BCL, which processes the blood lead and environmental samples. The Project Health Educator/Case Manager developed and dispersed educational materials about lead; provided medical case management for all children with a confirmed elevated blood lead level of $\geq 10 \mu\text{g/dL}$; and provided technical assistance, consultation, and referrals.

Selected activities/accomplishments follow:

- C Screening for high blood lead levels and, when necessary, follow-up was provided for all CHD patients aged 12 or 24 months, and once in CHD patients 36-72 months of age who had not been previously screened. In addition, children identified through community outreach activities were screened. The number of tests screening for high blood levels that were processed at the State lab dropped sharply (by 35.9%) from 30,367 in FY 1998 to 19,453 in CY 1999.

- C CHDs provided medical case management for 147 children considered to be at risk of lead poisoning (an 18.3% drop from the 180 such children case managed by ADPH in FY 1998). Follow-up included such measures as referrals to local physicians and, if necessary, to Children's Hospital in Birmingham.

- 294 environmental investigations of family residences occupied by children with confirmed elevated blood lead levels and investigations of 18 low income single and multi-housing units thought to contain lead hazards were conducted.
- C The Project Environmentalist provided risk assessments and environmental inspections statewide for 97% of the homes of children known to have venous blood lead levels of $\geq 15 \mu\text{g/dL}$. Other properties thought to contain lead hazards were also inspected.
- C The Lead Advisory Committee developed a statewide blood lead screening plan for Alabama in 1999 to increase screening and follow-up care of children at high-risk of elevated blood lead levels.

SP #06—The degree to which injury in child day care facilities is addressed by the Maternal and Child Health (MCH) Program.

Status: 12 (scale 0-15) in FY 1999

1999 target: 9

Trends: This indicator has notably improved from a rating of 2 in 1997, to 7 in 1998, to 12 in 1999, and has exceeded targets for the past 2 years.

Data Issues: See Appendix F for checklist on which scale is based. In reference to the automated injury reporting data system for collecting empirical data for analysis, the Bureau has been unsuccessful in getting a designated person at DHR, the State agency responsible for licensing and monitoring Alabama's day care centers and homes, to enter injury report data and maintain their system. BFHS therefore maintains the automated data system using reports provided by DHR, but the system is fragmented in that the recommended forms for reporting injuries are not being used universally. In addition, DHR is not enforcing the use of the recommended incident form. In FY 1999 the Healthy Child Care Alabama Project Coordinator, a Bureau employee, continued developing and analyzing a list of major injuries and causes of death that occur in out-of-home child care programs. The observed progress in this performance measure was largely due to her efforts and to activities conducted by other groups, as well as partnerships among groups (see *Activities/Accomplishments*).

Discussion: Because this performance measure is not strongly related to any of the priority MCH needs reported in Section 3.2.1, it is no longer operative as of FY 2000. The Bureau still considers day care injuries an important issue, however. Accordingly, though the performance measure is inoperative, plans pertaining to day care facilities are described under Section 4.2 of the *Annual Plan (Other Program Activities)*.

Activities/Accomplishments:

- C Day care centers continued sending their accident reports to the Office of Day Care at DHR. The centers in Madison and Mobile counties and all day care homes in the State send their accident reports to the county DHR offices. These data have not been fully utilized and provided limited information.

- C In July 1999, the Health Systems Development in Child Care Conference was again convened in Montgomery, Alabama by Health Systems Services Research, Inc. (HSR), a private consulting research firm providing technical assistance to State Community Integrated Services Systems (CISS) grantees regarding specific needs and evaluation. Representatives from the CISS Project, Healthy Child Care Alabama, and their systems development partners such as DHR, Medicaid, CRS, AEIS, Head Start, Commission on Child Abuse, child care providers, and ADPH central office staff participated in the meeting. The meeting was facilitated by HSR's liaison to the CISS Project in Region IV states. This conference provides a forum for CISS grantees to showcase their projects, get feedback from others, and form more partnerships with other providers to form a seamless web of services for families in need of child care services. A report about the injury data analysis conducted using injury reports provided by DHR and entered into the data base maintained at ADPH was also presented and discussed.

- C The nurse health consultants for the 15 targeted counties organized and conducted health events (such as fairs); educated parents, children, and community members about health and safety issues and AEIS; and wrote newspaper articles to promote community advocacy for quality child care. These efforts developed collaborative opportunities to encourage improvement of health and safety, including infection control in out-of-home child care. An 18-member Advisory Committee provides recommendations and support regarding the nurse health consultants model being used.

- C Other partnerships—such as the Children's Hospital and their Catch HMO Network and the Alabama Consortium for Child Care Policy Center at UAB's Civitan International Research Center—are occurring to increase parents' and community members' knowledge of quality child care.

2.4.D Infrastructure-Building Services

2.4.D.1 Infrastructure-Building Services: Pregnant Women, Mothers and Infants

CP #15—Percent of very low birth weight live births.

Status: 2.0% in CY 1999 (very preliminary)

1999 target: 1.9%

Trends: As stated in Alabama's 1997 report/1999 application, due to the upward trend in the prevalence of low birth weight, targets are based on halting the increase, rather than decreasing prevalence. After declining to 1.89% in 1997 (the first decline during the period from 1991 to 1997), the reported prevalence of very low birth weight

(VLBW) live births increased slightly to 1.97% in 1998 and to 2.04% in 1999. Comparing 3-year periods, the prevalence increased by 4.8%, from 1.88% in 1994-1996 to 1.97% in 1997-1999.

Data issues: The degree to which these reported increases reflect actual increases versus variations over time in reporting cannot be assessed from vital statistics data alone. Researchers in Alabama have previously reported their perception that reporting of under 500 gram births, for which “the dividing lines between live birth, stillbirth, and spontaneous mid-trimester abortion are...often difficult to determine,” had certainly increased.¹ Conceivably, this perceived increase in reporting of extremely low birth weight infants had actually occurred and has continued. The potential for variations in reporting across geographic areas or across socioeconomic groups, as well as over time, is discussed in several places in Section 3.1.2.

Discussion: Several hypothetical explanations for this reported increase merit consideration and data-based assessment. First, the multiple birth ratio (the number of live births in deliveries involving twins, triplets, etc. per 1,000 live births) has notably risen in Alabama (from 24.3 per 1,000 in 1991 to 30.7 per 1,000 in 1998) and the Nation, and has influenced low birth weight (LBW) levels (see Section 3.1.2.1). Moreover, in Alabama the number of live-born triplets has increased from 46 in 1991 to 87 in 1998 (highest number since 1980 was 97 in 1997), and the number of live-born quadruplets or greater from 0 in 1991 to 17 in 1998 (highest number since 1980 was 19 in 1996). Second, the reporting issues described above merit consideration. Third, the possibility that advances in prenatal and perinatal care have resulted in live births of some VLBW babies who would have died before birth in the absence of such care should be considered. Finally, the possibility of unfavorable trends in risk markers for women giving birth should be explored. The first two issues—the multiple birth ratio and reporting issues—were considered during the 5-year needs assessment, so are further addressed in Section 3.1.2. Moreover, issues pertaining to VLBW among African Americans are discussed in that section.

There is no single solution to the complex problem of LBW. Various studies have found that programs initiated to prevent preterm delivery and LBW—including social support for pregnant women, early prenatal care, education to increase awareness of signs of preterm labor, and tocolytic therapy—have been largely unsuccessful.² One promising finding has been that treatment with certain antibiotics reduced rates of premature delivery in women who had bacterial vaginosis and were at high risk of preterm delivery.³ Measures that have historically been thought to reduce the prevalence of LBW include prevention of adolescent pregnancy, unintended pregnancy, and short inter-pregnancy intervals, and the assurance of early and adequate prenatal care.

Activities/Accomplishments:

- Teen births, late or inadequate care, and unintended pregnancy have been linked with VLBW. Activities

pertaining to adolescent pregnancy and increasing the use of early prenatal care are described under CP #06 (teen births) and CP #18 (prenatal care).

- Inadequate maternal weight gain and consumption of tobacco, alcohol, and some illicit drugs have been linked with LBW. Poor maternal weight gain is addressed by activities described under SP #04 (WIC). During FY 1999, ADPH continued to coordinate with UAB to implement SCRIPT, which addresses smoking by pregnant women (see Section 2.4.B.2 under SP #03). If successful, these efforts to stop consumption of tobacco and to promote maternal weight gain should help halt the increase and, preferably, bring a decrease in the prevalence of VLBW.
- All ADPH maternity patients were risk assessed and referred, if appropriate.

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

Status: 78.3% of VLBW (<1,500 g) live births in CY 1999 (very preliminary) 1999 target: 76.4%

Trends: The percent of VLBW infants delivered at facilities for high-risk deliveries and neonates worsened during 1995 to 1997, with an average annual decline of 4.5%. Encouragingly, however, this indicator then improved markedly, from 69% in 1997 to 77% in 1998, surpassing the target for that year. Per very preliminary estimates for 1999, this indicator improved slightly in 1999, when about 78% of live-born VLBW infants were apparently born at perinatal centers. Because of its very preliminary nature, however, the estimate for 1999 is subject to notable revision.

Data issues: The reported numbers pertain to live-born infants delivered at perinatal centers, defined as any hospital (teaching or non-teaching) with one or more full-time neonatologists, a neonatal intensive care unit, and two or more obstetricians.

Activities/Accomplishments:

Previous activities pertaining to regionalization of perinatal care, including the following, were continued:

- The State Perinatal Program, including the Perinatal Program Coordinator and SPAC, continued to review data provided by CHS related to this indicator.
- Through funds provided by SPAC, the Perinatal Outreach Education Programs provided seminars, conferences, and educational offerings to health care providers regarding medical care and transport of the newborn. Standardized perinatal educational offerings included, for example, intervention and stabilization,

neonatal and maternal assessment, and emergencies.

- SPAC continued to meet quarterly and make recommendations to ADPH pertinent to regionalization and perinatal care in Alabama.

CP #18–Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Status: 82.9% of live-born infants in CY 1999 (very preliminary)

1999 target: 85.0%

Trends: This measure increased by an average of 2.6% per year from 1991 to 1994, but by only 0.5% per year from 1994 to 1999. The very preliminary estimate for 1999 was 2.4% below the target for that year.

Discussion: Managed care for Medicaid-eligible pregnant women has improved access to private medical providers throughout the State. For women who are uninsured, access to care is more difficult since many of the Medicaid providers do not provide services for the uninsured women, and CHDs are only providing prenatal care in 14 of Alabama's counties through agreement with some of Medicaid's Primary Contractors. As discussed in Section 1.4, the increase in numbers of births to apparently uninsured Hispanic women, along with the shift from the Medicaid Maternity Waiver to the Medicaid Maternity Care Program, has adversely affected the ability of CHDs to provide prenatal care to the uninsured population. This increase in apparently uninsured pregnant Hispanic women probably slightly slowed the rate of improvement in the proportion of women receiving early prenatal care, but does not largely explain the slower improvement during the last several years. Other reasons for the slower rate of improvement are unclear. BFHS has a plan in place, however, to address the issue of uninsured pregnant women by using Title V funds to pay limited costs for prenatal care (private provider or health department) as long as there is a system of care in place (medical network). Implementation of the plan has just begun. Several of ADPH's prenatal-care related activities during 1999 are listed below.

Activities/Accomplishments:

- ADPH provided prenatal services to 21,395 women during FY 1999. Of these women, about 70% came in during the first trimester.
- The Medicaid waiver maternity system was in place in 43 counties; this system addressed the issues of early entry into care, compliance with care, referral patterns, and delivery services.
- All family planning clients were provided information about the importance of early and continuous prenatal care. In addition, community education was provided throughout the State in an effort to encourage women to seek care in the first trimester.

- A toll-free hotline was operated to help pregnant women access providers and to provide educational materials about pregnancy.

SP #07–The degree to which key maternal and child health data bases are developed and analyzed, with pertinent findings reported to and utilized by the Bureau of Family Health Services (BFHS).

Status: 5 in FY 1999 (scale 0-18)

1999 target: 14

Trends: Although this score improved from 2 in 1997 and 1998 to 5 in 1999 (and to 9 thus far in 2000), we are below the target.

Discussion: Though not reflected in scores for 1999 or early 2000, substantial progress has occurred in the area of data capacity in 1999. For example, as discussed in Section 1.5.1.3, two Bureau epidemiologist positions and one Bureau research analyst position were filled in FY 2000. The Bureau’s status with respect to the checklist criteria for this measure (Appendix F) is described below. One reason that further progress as measured by these criteria did not occur is that staff from the Epidemiology/Data Management Branch have been almost entirely committed to conducting and reporting the needs assessment reported in this document (Sections 3.1.1 and 3.1.2), obtaining and reporting estimates for the health status indicators (Section 3.2), and obtaining and reporting estimates for this document’s performance and outcome measures. Lack of funding was a major impediment to progress on child death review. Nevertheless, as described later under this performance measure, notable progress has been made in child death review.

Progress Regarding Checklist Criteria:

- “At least one functional infant death review team will be established in each of the designated geographic areas...”–See *Fetal/Infant Mortality Review Teams* subsequently described further on under this performance measure.
- “At least one functional child death review team will be established in each judicial circuit...”–See discussion of *Child death Review Teams*, further on under this performance measure.
- “ADPH will develop and distribute a “Women’s Health Report”–Though not completed in FY 1999, this report was completed and distributed in FY 2000.
- “ADPH will conduct a stratified... analysis of VLBW live births by category of perinatal care...and of birthweight-specific neonatal mortality by category of perinatal care, and report results to SPAC”–No

progress was made on this issue in FY 1999. Findings from stratified analyses of VLBW live births by category of perinatal care, performed in FY 2000, are reported in Section 3.1.2.1.B. Birthweight-specific neonatal mortality has been analyzed by category of care but, with one exception, these findings have not yet been reported. Moreover, birthweight-specific analyses of VLBW categories should be controlled by 30-gram increments in birth weight before being interpreted. The only recent report to SPAC has been in the form of findings from Section 3.1.2.1.B, which were recently distributed to interested members of SPAC as part of a draft of this 1999 report/2001 application.

- “ADPH will conduct a study of birthweight-specific neonatal, postneonatal and infant mortality for each of the 11 public health areas, and report results to the State Perinatal Advisory Committee”–No progress was made on this issue in FY 1999. Area- and birthweight-specific infant mortality have been analyzed in FY 2000 as part of the 5-year MCH needs assessment. Except for distribution of the draft document as mentioned above, these findings have not been reported to SPAC.
- “ADPH will utilize findings of above studies, when available, in making decisions pertaining to programs and policy and/or in promoting better understanding of key issues”–The main progress in FY 1999 with respect to utilization of findings pertained to the areas of infant and child death review. Findings pertaining to the last three criteria are being utilized in FY 2000 as part of the needs assessment.

Activities/Accomplishments/Setbacks:

The new ADPH computer system, ***PHALCON***, was fully implemented by December 1999. Though not pertaining directly to the criteria on which SP #07 is based, PHALCON pertains to ADPH's, and therefore the Bureau's, data capacity. PHALCON has many more options and abilities than were available before—such as the ability to open multiple screens at one time to compare information, overnight replication of data from county to central office for communication purposes such as billing, ability to pull data for county-specific reports such as for Pap smear follow-up, and local productivity reports. More enhancements will be phased in, such as a plan to connect BCL directly to CHDs for reporting results. This system has the ability to become an electronic medical record. Better follow-up of family planning patients through this system may help prevent unintended pregnancies. Though PHALCON has great potential, certain limitations are problematic. For example, the Mobile and Jefferson CHDs do not submit data for PHALCON, so Bureau staff can no longer obtain numbers of encounters (such as numbers required for Forms 7 and 8 of this document) from a single database. Additionally, requests for these numbers from certain public health area staff suggest that area or county staff do not have access to all of the reports and/or have not been effectively trained about how to access the reports electronically. Certain other limitations of these data are discussed in Section 2.2 under Forms 7 and 8 or related notes. The Bureau's recently hired research analyst has been designated the Bureau's contact person for these issues and is serving as a catalyst for

identification and potential resolution of existing problems.

Fetal/Infant Mortality Review Teams

After receiving a Healthy Start Grant, The Alabama Child Death Review System (CDRS) facilitated the development of a ***Fetal Infant Death Review*** process for Mobile County. Modeled after a national program, this type of review uses a community based multi-disciplinary approach in reviewing fetal/infants deaths. The Mobile County Task Force included representation from both community professionals and concerned citizens. CDRS partnered with MOD to provide a hands-on, practical workshop, *How to Build A Fetal/Infant Mortality Review*. Speakers from other states shared how fetal/infant mortality review (FIMR) evolved in their states, citing both pros and cons of their programs. As a result of that workshop the Task Force was motivated to design a FIMR specific to their needs. Currently the Mobile Health Department has identified a full time nurse to coordinate the program. She will be responsible for extracting information on all fetal/infant deaths in Mobile County, summarizing an individual report and presenting information concerning all aspects of the death to the FIMR team. The team will then look for trends, make recommendations, and seek the partnership of the “Action Arm” of the FIMR process to implement needed changes. These efforts are expected to serve as a pilot for other teams around the State. These reviews are very time consuming, requiring extractors to research extensive records and possibly interview parents to determine any problem areas. The Jefferson County Health Department has a very modified FIMR effort for their county that only uses the information from linked birth and death certificates and the UAB maternal database.

In an effort to confront Alabama’s rising infant mortality rate, CDRS partnered with SPAC to implement a statewide review of fetal and infant deaths beginning January 1999. This process differs from Mobile and Jefferson County in that only the linked birth/death certificates are reviewed without consideration of any further information. The CDRS Director met with SPAC members across the State to garner support for the review concept. In accordance with the view that local providers need to be aware of fetal and infant deaths occurring in their own community, it was agreed that the regional SPAC chairpersons would review deaths specific for their areas. This multi-disciplinary review would be done by professionals who serve on local SPAC committees. The review currently consists of looking at linked birth/death certificates, discussing the cases, and collecting basic data that is sent to CDRS for compilation. Deaths from prematurity, birth defects, infections etc. are included for review. Comments from reviewers have been extremely supportive of the process. Several issues have already been identified as needing attention, such as clarification and/or improvement of the “standard” definition of “live birth” and support services for families who have suffered the loss of an infant. All reviewers agreed that information on the birth/death certificates is often incomplete and does not explain the etiology of death. Examples are “cardiac arrest” of a 2-month-old infant without any underlying causes and a 1-month-old infant reportedly dying from “complications of spina bifida” with no birth defects shown on the birth certificate. CDRS will issue an annual report of findings.

Lack of funding stability for FY 1999 has hindered the ***Child Death Review Teams*** Program’s ability to hire appropriate staff. In the interim, a retired air force colonel volunteered his time and expertise. He worked closely with the CDRS Director and the UAB School of Public Health’s Department of Health Services Administration to develop a new database, identify the type of software and hardware needed, and do whatever else was necessary to keep the program moving forward. In July 1999, this volunteer was hired as a full time assistant to the program

and is responsible for entering and analyzing data from child death and fetal/infant death reviews.

Twenty-six of the 41 Judicial Circuits in Alabama have sent in completed data reporting forms. Local teams in these 26 circuits continue to review unexpected/unexplained child deaths. To date, 517 child death certificates (CY 1999) have been sent to local teams. Cases have been reviewed and data forms returned and entered into the CDRS database for 48.4% (250/517) of these cases. CDRS continues to receive certificates for deaths occurring in 1999 from CHS, and these cases are sent out monthly to local teams for review. The lag in obtaining certificates has created a problem in producing an annual report. Local teams have applauded the review process and commented on how CDRS efforts have helped. For example, the process or findings have been utilized to change agency policy/procedures, distinguish intentional deaths from accidental, and develop new programs that might prevent child deaths. The following are a few examples:

- The Mobile area team identified a large number of newborn infants along the Gulf Coast who had been abandoned. That area's Child Death Review Chairperson partnered with the local media and built a program called "Safeplace." The program allows mothers to leave newborns less than 72 hours old at hospital emergency departments with no questions asked. The hospital will offer medical care to the mother and infant if needed and then call child protection services to take custody of the newborn. Police are not called (as long as the baby has not been abused) and there is no threat of prosecution. Five babies have entered the program, and the concept has generated interest around the country. The Child Death Review Chairperson, a reporter, and the district attorney who proposed the idea have been on Good Morning America, The Today Show, and numerous other news programs. Numerous states, including Florida, Texas, and Minnesota, have passed legislation for similar programs. Legislation for Alabama's program was signed into Alabama law on May 25, 2000.
- Local child death reviews have had many concrete results: 19 cases were re-opened for additional investigations, 24 cases led to changes to agency policies or procedures, and 21 reviews resulted in new prevention activities being initiated.
- In keeping with the CDRS mission to help educate team members, a grant was obtained enabling six medical examiners from the Alabama Department of Forensic Sciences to attend a national meeting focusing on pediatric forensic issues. CDRS has worked with seven other southeastern states to offer the Southeastern Conference on Child Fatalities to be held in May 2000 in South Carolina, where pediatric forensic professionals from the eight southern states will share their expertise.
- CDRS is working with DHR to establish a statewide Quality Assurance effort that will critically review every death of a child in that agency's custody.

- CDRS continues to serve on the National Child Fatality Review Advisory Committee, which provided a national teleconference on child fatalities.

Though CDRS has been in existence for only 2 years, it has been used as a model by several other states. CDRS goals for the remainder of FY 2000 and for FY 2001 are to (1) secure funding, (2) increase local child death review team participation to 100%, (3) work with the State Child Death Review Team to identify priority areas and produce a report, (4) collaborate with other agencies and the legislature to advocate for children's issues, (5) support SPAC regional FIMR teams, (6) continue supporting training opportunities for local team members, (7) work closely with Alabama Department of Forensic Sciences and law enforcement entities to develop guidelines for child death investigation, and (8) work with hospitals and mental health agencies to offer support services to all parents who suffer the loss of an infant or child.

2.4.D.2 Infrastructure-Building Services: Children

CP #12—Percent of children without health insurance.

Status: 17.9% in CY 1998; 8.4% (95% confidence interval: 6.2% - 11.2%) in CY 2000 (preliminary)

1998 target: 14.4% 1999 target: 11.8% 2000 target: 11.7%

Trends: Per inspection of estimates provided by the United States (U.S.) Census Bureau, there was not a consistent trend in the measure from 1993 through 1998. Specifically, about 15% of children were estimated to be without health insurance in 1993, but the corresponding estimate for 1994 was about 20%. Estimates for 1995, 1996, and 1997 were lower: respectively, 13%, 13%, and 14%. Then, 18% of children were estimated to be without health insurance in 1998. This apparent lack of consistent improvement through 1998 is not surprising, since Phase I of SCHIP began in February 1998 and Phase II in September 1998. Moreover, full implementation of SCHIP may not have occurred until several months later. Although the 1998 and 2000 estimates are from different data sources (and the high estimate for 1998 may be partly due to statistical imprecision), the notably lower estimate for 2000 is consistent with a view that SCHIP, perhaps together with an improved economy, has indeed made a difference and has moved many children from uninsured status to insured status. Findings from the Telephone Survey suggest that the 2000 target has been achieved. Moreover, since the Telephone Survey was conducted early in CY 2000, the 1999 target may have also been achieved.

Data Issues: The estimates shown may not be comparable, since they are from very different data sources. The reference for the 1998 estimate is Health Insurance Historical Table 5, obtained from a U.S. Census Bureau Web site.⁴ The estimate for 2000 is from a telephone survey of Alabama households with children 17 years of age and younger, conducted as part of the 5-year MCH needs assessment and described extensively in Section 3.1. The confidence interval shown is per the Fleiss 95% quadratic method. See corresponding note to Form 11 for fuller

description of data issues.

Activities/Accomplishments: Overall accomplishments have been described in Section 1.4. Outreach for SCHIP in FY 1999 included contact with Medicaid-recipient families with middle and/or older teens in the family, press releases, distribution of publications regarding the expansion, etc. A detailed information brochure with application and stamped, self-addressed envelope was used as the primary outreach tool. Specific activities/accomplishments of SCHIP during FY 1999 included the following:

- SCHIP staff (1) convened live satellite conferences for providers and staff, advocacy group members, enrollment workers, Health Department staff, and other stakeholders to update them on SCHIP activities, explain revised application and ALL Kids re-enrollment procedures, and answer questions; (2) produced instructional videos for pediatricians, family practice physicians, emergency room physicians, dentists, and pharmacists and distributed these through professional associations' annual meetings, mail-outs, etc.; (3) participated in regional provider meetings with Medicaid to update providers about ALL Kids services; (4) attended various professional association annual meetings to explain the ALL Kids Program; and (5) made ALL Kids presentations at regional Hospital Association meetings.
- An interagency work group began meeting in February 1999 to develop the ALL Kids Plus Plan, an enhancement package for CSHCN. Consequently, SCHIP staff have developed a second major amendment to SCHIP, approved in September 1999. This amendment was implemented in October 1999 and provides coverage, called ALL Kids Plus, for services for CSHCN that the ALL Kids basic package does not cover or covers in a limited manner. Partners in this effort include CRS, Alabama's Early Intervention System, MHMR, DHR, the Developmental Disabilities Planning Council, and both tertiary-level pediatric hospitals. Participation in the ALL Kids Plus plan is limited to State agencies able to provide matching funds.
- The joint application form and ALL Kids brochure were translated into Spanish, and a Spanish-speaking enrollment worker was employed in the ALL Kids enrollment office in FY 1999. Revisions are currently being made in FY 2000.

CP #13—Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.

Status: 86.8% in FY 1999

1999 target: 87.0%

Trends: Per the method used for making estimates, this indicator improved markedly from 80% in 1998 to 87% in 1999. We do not have enough confidence in the estimates to firmly conclude that the improvement was of this magnitude or, therefore, that the target was actually met. However, though the degree of improvement may be

overestimated, it is quite likely that some improvement indeed did occur and that SCHIP—by identifying potentially Medicaid-eligible children—was a major contributor to this improvement. Moreover, conceivably, by encouraging greater involvement of the private sector, PCCM may have increased the percentage of Medicaid-eligible children who receive a paid Medicaid service.

Data issues: Selecting a denominator for this measure continues to be exceptionally problematic. Because a suitable denominator could not be estimated from available age and poverty distributions, the number of Medicaid-enrolled children was used as the denominator. Thus, the estimate shown almost certainly overestimates the proportion of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program during the reporting year. However, since comparable methods were used for the estimates for 1998 and 1999, comparison of the estimates may be reasonably valid. Nevertheless, we have very limited confidence in estimates for this indicator. Per Medicaid eligibility files, the number of Medicaid-enrolled children aged 18 years and younger increased by 7% in 1999 relative to 1998. Whether a similar increase occurred in the number of potentially Medicaid-eligible children is not known. See corresponding note to Form 11 for a full description of methods and data-related issues.

Activities/Accomplishments: CHDs are not providing direct patient services to the numbers of children served in the past. Although many former ADPH patients have moved into the managed care environment, ADPH continues to support and promote activities to ensure that all children potentially eligible for Medicaid have the opportunity to enroll and subsequently receive regular checkups.

Activities for 1999 included the following:

- SCHIP outreach (described in Section 1.4 and in this section under CP #12), which helps to promote enrollment in Medicaid and, therefore, receipt of Medicaid-paid services, was continued. Additionally WIC, as an adjunct to good health, is required by law to refer patients to other programs (including SCHIP, Medicaid, and TANF). CHDs promoted enrollment in Medicaid by offering joint SCHIP/SOBRA Medicaid applications. In fact, about one-half of all applications received in the ALL Kids enrollment office are for Medicaid-eligible children.
- Out-stationed Medicaid eligibility workers were located in every CHD, 19 hospitals, 12 FQHCs, and one private physician's office to help families apply for Medicaid.
- Subcontracts were in place with Maternity Care Primary Providers in selected counties to provide home visits to infants and post partum patients by nurses and social workers.
- EPSDT and Patient 1st providers received a periodic rescreen list each month of participants who were due for

screening that month. The provider was to notify the patient and schedule the visit within a specified time frame. In selected CHDs, the local staff developed lists for providers showing patients due for screening. In one county, the Patient 1st providers came to the CHD every month to see patients.

- Social Workers continued to be available in all CHDs to help children and families with removal of barriers to health care.
- Targeted Case Management for the Medically at Risk Program was implemented on November 1, 1999. This program serves Medicaid-eligible persons having a medical condition or need and exhibiting significant multiple lifestyle, psychological, and/or environmental risk factors that may or may not have negatively impacted their health status. A referral from the primary provider or dentist is required.
- Case management was provided to children with severe disabling conditions requiring extensive medical and habilitative or rehabilitative services—conditions such as sickle cell disease, HIV, and elevated lead levels.

CP #16—The rate (per 100,000) of suicide deaths among youths aged 15-19.

Status: 8.8 deaths per 100,000 youth in this age group in CY 1999 (very preliminary)

1999 target: 8.7 per 100,000

Trends: From the 1991 baseline of 9.2 deaths per 100,000, the suicide rate in 15 to 19 year old adolescents increased each year through 1994. The rate then declined 3 successive years, before increasing in 1998, where (per a very preliminary estimate) it apparently remained in 1999 and, therefore, did not meet the target for that year. Comparing the preliminary 3-year rate of 8.6 deaths per 100,000 in 1997-1999 to the rate of 11.7 deaths per 100,000 in 1994-1996, the rate declined by 26.2%.

Activities/Accomplishments: Although the Bureau does not focus on prevention of suicide deaths, the Child Death Review Program (see Section 1.5.1.1, under *State Statutes Relevant to the Title V Program*, and Section 2.4.D.1, under SP #07) is designed to collect data regarding unexpected deaths, which should include any suicide deaths of children or youth.

2.4.D.3 Infrastructure-Building: CSHCN

CP #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.

Priority need: Improve health status of CSHCN

Status: 84% in FY 1999

FY 1999 Target: 82%

Recent trends: The percentage of CRS enrollees with third party coverage increased from 80% in FY 1998 to 84% in FY 1999. Although the number of uninsured children in the program had slightly increased in the last reporting year, it declined by 21% in this reporting year: from 2,956 in FY 1998 to 2,347 in FY 1999. The disparity between counties in the percentage of uninsured children continued, with a seven-fold difference noted, from a low of 4.1% of CRS clients without any coverage in Conecuh County to a high of 30.8% in Shelby County.

Data issues: Good programmatic data exist due to data linkages with Medicaid.

Discussion: Reported insurance information reflects the status of children who completed the enrollment procedures. The SCHIP insurance expansions undoubtedly contributed to this improvement.

Accomplishments/Activities: CRS performed the following activities in FY 1999:

- Continued to identify children at enrollment with no health insurance who may be eligible for Medicaid, SCHIP, SSI, or the Child Caring Foundation and assist with the application process
- Facilitated enrollment of 177 children in ALL Kids, through intensive outreach efforts via mail and client contacts. Additionally, 555 adolescents in the CRS Program received Medicaid coverage through SCHIP expansion, a 44% increase over FY 1998. CRS actively monitors children with ALL Kids coverage to assist them with annual re-enrollment, including financial assistance with the annual premiums at family request.
- Paid premiums for seven clients whose families were unable to afford the premiums for insurance coverage accessible through employment, Consolidated Omnibus Budget Reconciliation Act (COBRA), or SCHIP
- Provided leadership and technical assistance in developing the ALL Kids Plus amendment to Alabama's SCHIP Plan submitted by ADPH to HCFA on July 1, 1999 and approved on September 24, 1999. The purpose of the plan is to enhance the benefit package for CSHCN enrolled in ALL Kids and receiving services through a State-funded entity.
- Participated in ALL Kids-sponsored public forums in Birmingham and Mobile to inform providers and the general public about the Plus services available through CRS to CSHCN
- In June 1999, provided a statewide training to staff and families on third party reimbursement issues. MCHB technical assistance money partly funded this event. A representative from the Institute for Child Health Policy provided the family perspective, and another from the Brain Injury Association provided the national

perspective in the keynote sessions. Post-conference evaluations were overwhelmingly positive.

CP #14–The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.

Priority need: Increase family participation

Status: 16 (scale 0-18) in FY 1999

FY 1999 Target: 16

Recent trends: CRS continued to expand its commitment to family participation within the program, particularly through support of family advocacy efforts and training opportunities for families.

Discussion: Members of the State Parent Advisory Committee rated the agency's performance on this measure at the March 2000 meeting. This group was selected due to their knowledge of CRS efforts to assure family participation. The total number of families participating was 23. The median of their ratings was used to obtain the agency's score on this measure.

Accomplishments/Activities:

- Employment of the State Parent Consultant and 10 Local Parent Consultants continued. Local Parent Consultants completed 11,217 hours of service, a 36.5% increase over FY 1998.
- A new data system was initiated to capture various types of activities in which Local Parent Consultants were involved. They made 2,289 contacts with families at CRS clinics, responded to 780 requests for information/resources from families, attended 30 Individualized Education Plan (IEP) meetings with families, provided support to 392 families, researched information for 243 families, and made 69 home visits.
- The State Parent Advisory Committee held three meetings in FY 1999. The first meeting was held in conjunction with the 1999 Early Intervention and Preschool Conference to facilitate family participation in both events.
- Local Parent Advisory Committees were active in every CRS district.
- Family members were included on all CRS committees and task forces.
- Local Parent Consultants attended the following ADRS sponsored training: the 1999 Early Intervention and Preschool Conference, the CRS Hemophilia Evaluation and Learning Program (HELP) Clinic training,

Pediatric cardiology training, third party reimbursement training, statewide ADRS "Blueprint for the 21st Century" meetings, medical aspects training, pediatric traumatic brain injury conference, and other events, including computer training. Both presenters at the third party reimbursement training were parents of CSHCN, one of whom is the Family Voices Coordinator from Florida. Family members were presenters at all of the conferences and training sessions. Several of the Local Parent Consultants were co-presenters at the Early Intervention and Preschool Conference.

- Local Parent Consultants participated in numerous training opportunities in their communities, such as *Dealing with Grief, Stress and Changes*, The Alabama Administrative Code for Special Education, The Governor's Conference on Education, Parents as Partners, ADA Basics, Adaptive Technology Workshop, and *Special Education-What I Need to Know*.
- Local Parent Consultants participated in several MCH-related events in FY 1999. The State Parent Consultant and one Local Consultant attended the annual AMCHP meeting and served as family mentors, led activities at a dinner for family members, and co-presented at a breakout session. Another Local Parent Consultant attended the MCH Southeast Regional Conference, while another accompanied the State Parent Consultant in attending the MCH/Title V Block Grant Training in New Orleans, Louisiana.
- Local Parent Consultants were active in Early Intervention District Coordinating Councils. The State Parent Consultant was a member of the Early Intervention Self-Study Steering Committee and the Program Planning and Evaluation Subcommittee, and served as chair for the Governor's Interagency Coordinating Council for Early Intervention (ICC) Family Involvement Task Force.
- The State Parent Consultant participated in State work groups for the ALL Kids and ALL Kids Plus Programs. She also participated in the Robert Wood Johnson *Covering Kids* grant planning committee. A parent, financially sponsored by CRS, has been named to serve on the Medicaid Medical Advisory Committee.
- CRS continued to encourage the sharing of information with families by publishing the Parent Connection newsletter and disseminating information from Family Voices statewide.
- The Parent Connection parent-to-parent support network continued to expand, and an automated database and training manual were developed to facilitate matching families. A training module for prospective "supporting parents" was developed and presented in one location.

- The Parent Resource Libraries received additional resources this year and are available in 10 locations across the State, each with Internet access for families.

SP #08–The degree to which the State assures a system to coordinate services exists for Children with Special Health Care Needs (CSHCN) who are enrolled in the State CSHCN Program.

Priority need: Improve health status of CSHCN

Status: 7 (scale 0-15) in FY 1999

FY 1999 Target: 5

Recent trends: CRS has struggled with defining levels of care coordination services for clients in its clinical medical and clinical evaluation programs due to large caseload numbers. However, through its MCHB-funded pediatric traumatic brain injury (TBI) grant, a unique opportunity developed to pilot an intensive care coordination program for TBI survivors and evaluate its efficacy.

Discussion: This measure was placed under the Infrastructure Building Services due to its relationship to quality assurance and standards development.

Accomplishments/Activities:

- A task force was formed to define care coordination services within the CRS clinical medical and specialty evaluation programs and met in January 1999.
- The agency chose children and adolescents with TBI as its pilot population for an intensive care coordination program. Clients and their families had several instruments administered at enrollment to establish a baseline of client and family functioning. As the clients complete 1 year of participation, the instruments are re-administered to determine effectiveness of services.
- A draft model for community-based care coordination was developed and is now being revised into guidelines to facilitate re-integration of children and adolescents with TBI into home, school, and community settings through intensive care coordination.
- CRS was awarded an MCHB genetics demonstration grant in September 1999 to demonstrate that access to early, coordinated services through care coordination and an integrated health care system will improve outcomes for newborns with selected genetic conditions.
- CRS Program Specialist for Social Work conducted in-service training in 12 CRS offices on the intensive care coordination program for children and adolescents with TBI.

- CRS Program Specialists for Nursing and Social Work conducted in-service training in six CRS districts on care coordination activities, emphasizing the development and utilization of the CRS Service Plan.

SP #09–The degree to which the State assures a system of quality assurance and evaluation exists to monitor the quality of direct services delivered to Children with Special Health Care Needs (CSHCN) through the State CSHCN program.

Priority need: CSHCN quality assurance

Status: 14 in 1999 (scale 0-15)

FY 1999 Target: 11

Recent trends: CRS has aggressively pursued development of a quality improvement program since the need was identified in the previous needs assessment.

Discussion: Due to its relationship to quality assurance and standards development, this measure was placed under Infrastructure Building Services.

Accomplishments/Activities:

- Formal quality assurance monitoring was conducted in the final four CRS district offices: Muscle Shoals, Gadsden, Jackson, and Andalusia. As the Talladega CRS office conducts no clinics, the formal monitoring criteria were not applicable there. Corrective action plans were submitted and implemented in the offices monitored in FY 1998. The four largest offices submitted reports on the effectiveness of the corrective action plans submitted in FY 1997.
- Based on the outcome indices developed in FY 1998, information on measuring outcomes for CSHCN was gathered by an agency team. A system for measuring outcomes was then developed, including an Access database. A pilot of this system was begun in March 1999 focusing on Feeding Intervention and Nutritional Development Clinic. It is anticipated that the knowledge gained from this pilot will be applied to collecting and analyzing data for the outcome measures developed for Augmentative Communication/Technology Clinic and Hearing Aid Clinic in FY 1998.
- Quality Care Guidelines for 12 diagnostic categories developed in FY 1997 and distributed in FY 1998 continued to be a resource for all CRS district offices and other appropriate entities involved with health care for CSHCN, such as ADPH and Medicaid.
- CRS was unable to arrange a presentation of the Quality Care Guidelines to the Alabama Quality and

Utilization Alliance, the State managed-care quality assurance organization.

2.4.E Other Program Activities

Pregnant Women, Mothers and Infants; Children

Enabling

To ***provide school-based services***, Alabama has 40 school-based clinics or medical rooms operated by 26 public health nurses, five nurse practitioners, and five medical social workers. These school-based programs were located in elementary, middle, and high schools, as well as special needs and migrant school age programs. The public health nurses provided 3,589 off-site EPSDT comprehensive screening, assessment, planning, intervention, evaluation, management and/or referral services and have served as a link among physicians, families, and community agencies to assure access and continuity of health care for students. The nurses also engaged in outreach efforts to enroll children in SCHIP. The school-based public health nurses were actively involved in abstinence-based pregnancy prevention education, violence prevention, tobacco use prevention, and conflict resolution training. Utilizing their knowledge of community health services systems and resources, the nurses also provided consultation and referrals for CSHCN.

CHDs continued to provide maternity care coordination as well as ***targeted case management*** services to children with certain disabling health conditions and patients with HIV. ADPH recently expanded targeted case management services with the addition of a new targeted group. That is, targeted case management for Medically At Risk children in Medicaid's managed care program (Patient 1st) was implemented statewide November 1, 1999. These services help patients remove barriers to medical care and access needed medical, social, and educational services, as well as community resources. BFHS social work staff developed and provided orientation and training for all new case managers/care coordinators on a regular basis.

In October 1999, the Bureau's Women's and Children's Health Division participated in ***Domestic Violence Month*** by disseminating posters about the issue to all CHDs. These posters, donated to ADPH by the Alabama Coalition Against Domestic Violence, included a toll-free number and tear-off sheets with safety tips.

Population-Based

BFHS again partnered with AAP to promote October as ***Child Health Month***. The theme was substance abuse, with a focus on inhalants. A gubernatorial proclamation started the activities. Promotional packages were sent to each CHD and to school nurses. Activities were initiated statewide.

Infrastructure

The ***David B. Monsky Developmental Clinic*** continued offering comprehensive, multi-disciplinary out-patient

services to children aged birth to 21 years who presented unusual or complex problems interfacing with academic achievement, social adjustment, or mobility. During FY 1999, 747 children received evaluations, 222 children received comprehensive evaluations, 479 infants were seen in the High Risk Clinic, and 46 infants and toddlers received intensive developmental screening following referral from physicians or other clinics.

In FY 1999, the *Alabama SSDI Program* began shifting its focus from supporting and further developing State- and area-level infrastructure to conducting MCH needs assessments and assisting with estimates for performance and outcome measures included in the Title V Block Grant annual/reports applications. The Community Development Branch's Director, who serves as SSDI Project Director, consults closely with the Bureau's Needs Assessment Coordinator and spearheaded the community forums and focus groups held throughout the State as part of the needs assessment (see Section 3.1.1). Essential to analysis of data from these forums, completion of the needs assessment, and compilation of some core and many developmental health status indicators was allocation of SSDI funds for 70% of an epidemiologist's salary. The Administration Division therefore recruited a full-time epidemiologist who joined the Bureau in December 1999, serves as SSDI Project Epidemiologist, and has devoted essentially all of her time to assisting with the Title V Block Grant needs assessment (especially with respect to analyzing qualitative data from community forums and focus groups), health status indicators, and performance measures. She is supervised by the Director of the Epidemiology/Data Management Branch, who serves as Needs Assessment Coordinator. In addition to providing partial support for an epidemiologist, SSDI further supported the needs assessment by providing about \$15,000 for a telephone survey of households with children (see Section 3.1).

In seeking to decrease the State's infant mortality and morbidity rate, *SPAC* continued providing funding for (1) high risk infant developmental follow-up in which regional developmental clinics provided comprehensive developmental evaluations for infants with birth weights under 1,000 grams; (2) outreach education and network coordination to provide health care delivery providers with educational offerings, updates, and technical training; and (3) community-based projects to support medical care, transportation, and social service programs for women, teens, and infants at high risk of death or major handicapping conditions but unable to pay for appropriate care. In addition, a bill supported by SPAC was passed to update Alabama's law about screening for congenital syphilis in newborns as recommended by AAP and ACOG.

The *Strategic Direction Work Group*, formed in the late summer of FY 1998 to develop a framework for responding to recent and continuing changes in the very dynamic health care environment, continued to function. The Work Group has representation from the State, area, and local levels, as well as many public health disciplines. As described in the 1998 report/2000 application, the Work Group has been engaged in a process to (1) determine the most critical external forces affecting the Department, (2) identify and prioritize Alabama's most

pressing health needs, (3) evaluate Department programs regarding the degree that they and other organizations address those health needs and how they relate to the Department's mission, and (4) define what roles public health and particularly the Department should fill to address those needs. The Work Group met six times from July through November 1998, and identified the emerging public health program priorities for the Department and the beginning of an overall strategic plan of necessary actions. This Work Group's Phase I Report was distributed to key State and area staff in February 1999. Five overarching themes, listed below, emerged from the Work Group's Phase I deliberations:

- Acknowledgment of the trend away from provision of direct patient services in public health clinics toward more of a community focus, where public health workers assume new leadership roles to create healthy Alabama communities
- The increasing importance of an assurance role (going beyond provision of direct services, which is itself part of assurance) for public health within the community-wide focus
- The need for coordination of certain programs and services into a chronic disease entity for the Department
- The importance of maintaining a close association between the Department's mission and its programs, services, and grant pursuits
- The immediate need for a set of directional statements from the State Health Officer to guide and reassure Department staff as the business of public health changes and they begin this journey into the future.

The Work Group met in March 2000 to do the first annual review of the strategic plan. They have written the draft for a second report, which includes some revisions and clarifications to the initial plan and is now being reviewed by the State Health Officer. As an adjunct to the overall Strategic Direction Work Group, several work groups are doing strategic operations planning to accomplish the directions recommended in the original strategic plan. Two of these areas pertain directly to Title V populations: (1) uncompensated care (with a focus on maternity) for non-English speaking people and (2) WIC. The Bureau director is a member of the Strategic Directions Work Group, and certain other Bureau staff are part of the work groups addressing uncompensated care and WIC. In fact, Ben Swiderick, formerly a BFHS Maternity Waiver Consultant, has been employed by the Bureau to address uncompensated maternity care.

CSHCN: Population-Based

Priority need: Early identification of CSHCN

Accomplishments/Activities:

- The HRSA manual *Implementing Universal Newborn Hearing Screening Programs* was sent to all of the State's birthing hospitals. CRS staff visits to all birthing hospitals in Alabama with a newborn hearing screening program are underway. This activity, originally scheduled for FY 1999, is being completed in FY 2000.
- The Governor's Advisory Panel on the Prevention of Disabilities did not meet in FY 1999.
- ADPH, the lead agency for the Alabama Head Injury and Spinal Cord Injury Registry established in FY 1998, began a data collection pilot with University Hospital in Birmingham and Druid City Hospital in Tuscaloosa during the summer of 1999. The Trauma Registry of the American College of Surgeons software is being utilized to store and manage the data. It is anticipated that data on Alabamians with head and spinal cord injuries will start being electronically transferred to ADRS during FY 2000. Procedures were established to offer linkage to services through a centralized 1-800 number. Children and adolescents will be offered referral to CRS.

2.5 Progress on Outcome Measures

As was true for all vital-records-based performance measures, estimates for 1999 did not become available until this document was being finalized, so analyses of trends are rather superficial (with no tests of statistical significance), and additional data analyses cannot be done before submission of this document. Because the vital-statistics-based estimates provided for 1999 are *very* preliminary and subject to notable change, they are not assumed to be fact. Moreover—because mortality-related findings for the State often fluctuate markedly from year to year due to small numbers in the statistical sense—even final, verified findings for a single year should not be assumed to represent a trend or even a suitable baseline. For all of these reasons, vital-statistics-based estimates for 1999 have played only a peripheral role, if any role, in the needs assessment, and some of the following comparisons compare 1996-1998 to a baseline, rather than 1997-1999 to a baseline. Also for these reasons, the BMT will not be able to fully consider the implications of recent findings until after this document is submitted.

As is discussed more fully in Section 3.1.1, estimates reported in this section are necessarily based on period files, because period files become available much sooner than birth cohort files do. Infant-mortality-related findings reported here, therefore, may differ slightly from any corresponding findings reported in Section 3.1.2.

Since calendar year (CY) 2000 is only about half over, where deemed appropriate, targets for CY 2000 onward are revised to proceed from the preliminary baselines for 1997-1999. These 3 year baselines are used, rather than the

very preliminary rates for 1999, to account for the reporting issues mentioned above.

2.5.A. Individual Outcome Measures

CO #01—*The infant mortality rate per 1,000 live births.*

Status: 9.7 deaths per 1,000 live births in CY 1999 (very preliminary)

1999 target: 8.9 per 1,000

Trends: After increasing to 10.5 deaths per 1,000 live births in 1996, the State's infant mortality rate dropped to 9.5 deaths per 1,000 live births in 1997, then increased to 10.2 deaths per 1,000 live births in 1998. Comparing 3-year rates, the rate did not improve at all in 1996-1998 relative to 1993-1995: Specifically, it remained static at 10.1 infant deaths per 1,000 live births in those 3-year periods. The possible decline to 9.7 infant deaths per 1,000 live births in 1999, though very encouraging if true, should not be assumed to herald a downward trend. If the estimate is reasonably correct, the State's infant mortality rate was about 9% above the target for 1999. Targets for 2000-2001 have been revised, and subsequent targets set, to require a mean annual decline of 1.0% from the preliminary 1997-1999 baseline of 9.8 infant deaths per 1,000 live births. Given the static nature of the rate between 1993-1995 and 1996-1998, the preliminary nature of the baseline, and some major issues affecting the reported infant mortality rate that are not mainly within ADPH's sphere of influence,¹ more aggressive targets are not considered realistic at this time. If rates do indeed begin to consistently decline, more aggressive targets will be considered.

CO #02—*The ratio of the black infant mortality rate to the white infant mortality rate.*

Status: 2.3 in CY 1999 (very provisional)

1999 target: 1.8

Trends: From 1994 to 1997, infant mortality among whites increased by an average of 2.4% per year, while that among African Americans declined markedly. In fact, the infant mortality rate among African Americans declined by an average of 5.6% per year during that period, for an overall decline of 16.0%. Thus, the African American:white infant mortality ratio declined from 2.4 in 1994 to 1.8 in 1997. In 1998, however, the infant mortality rate among African Americans increased sharply, from 13.8 deaths per 1,000 births in 1997 to 15.5 deaths per 1,000 live births in 1998. On the other hand, the rate among whites declined, from 7.5 deaths per 1,000 in 1997 to 7.3 deaths per 1,000 in 1998. Accordingly, the racial infant mortality ratio worsened from 1.8 in 1997 to 2.1 in 1998. According to very preliminary estimates, the reported racial gap widened much more in 1999, with

¹These issues, which include reporting issues and increasing numbers of multiple births, are discussed in several places in Section 3.1.2.

African American infants being 2.3 times more likely to die than white infants. The gap widened because the reported infant mortality rate for African American infants increased in 1999, while that for white infants apparently declined.

The ratio of the African American infant mortality rate to the corresponding white rate, however, is influenced by factors other than survival versus non-survival of African American infants. For example, the reported worsening of this ratio is difficult to interpret, given the possibility of under-reporting of extremely low birth weight African American live births, discussed in several places in Section 3.1.2.1.B. If this under-reporting indeed exists and was more widespread several years ago than currently, the widening of the gap may be spurious. On the other hand, an increase in mortality among white infants (due to, for example, increasing numbers of multiple births) during any given year could cause the gap to narrow without improved survival of African American infants. For such reasons, the degree to which the mortality rate ratio reflects the well being of African American infants varies, and the Bureau is instead focusing on African American infant mortality and issues pertaining to it. Moreover, because the racial mortality ratio has reportedly worsened in two successive years, as well as because it may be influenced by reporting issues or factors that do not reflect the well being of African American infants, aggressive targets to quickly narrow the ratio do not seem realistic. Accordingly, targets require that it gradually narrow to 2.0 and stabilize there. If the gap narrows and potential reporting issues are deemed to have little effect on the ratio, more aggressive targets will be considered.

Whether the racial infant mortality gap is truly widening or simply becoming more apparent due to better reporting, the high infant mortality rate among African Americans is unacceptable and calls for *information-based, well considered, appropriate* action by all concerned. The Bureau has therefore identified a priority MCH need to reduce infant mortality in the African American population. Another priority MCH need strongly related to the racial infant mortality ratio (and also very susceptible to reporting artifacts) is the need to reduce the prevalence of VLBW in the African American population. Accordingly, these issues are further discussed in Sections 3.1.2 and 3.2.1.

CO #03—The neonatal mortality rate per 1,000 live births.

Status: 6.2 deaths per 1,000 live births in CY 1999 (very preliminary)

1999 target: 5.8 per 1,000

Trends: The neonatal mortality rate increased from 6.1 deaths per 1,000 live births in 1997 to 6.7 deaths per 1,000 in 1998. The 3-year rate in 1996-1998 was 6.6 deaths per 1,000 live births, slightly above the corresponding rate of 6.5 deaths per 1,000 live births in 1993-1995. According to very preliminary estimates, however, the rate might have declined to about 6.2 neonatal deaths per 1,000 live births in 1999. Though indeed encouraging if it is real

(though still above the 1999 target), the caveats discussed regarding the 1999 estimate for the infant mortality rate also apply to the neonatal mortality rate. Moreover, the neonatal mortality rate is especially susceptible to any variations that may occur in reporting of live births. Accordingly, the targets are again modest, requiring a mean annual decline of 1.0% from the very preliminary 1997-1999 baseline of 6.3 neonatal deaths per 1,000 live births. (A 1% annual decline does not always appreciably reduce [within 1 year] a rate rounded to one decimal). If rates begin to consistently decline, more aggressive targets will be considered.

CO #04—*The postneonatal mortality rate per 1,000 live births.*

Status: 3.6 deaths per 1,000 live births in CY 1999 (very preliminary)

1999 target: 3.2 per 1,000

Trends: The postneonatal mortality rate increased from 3.4 per 1,000 in 1997 to 3.5 per 1,000 in 1998 and, according to preliminary estimates, rose again to 3.6 per 1,000 in 1999, which was notably above target. Comparing 3-year rates, the rate had previously declined slightly (by 2.2%) from 3.6 per 1,000 in 1993-1995 to 3.5 per 1,000 in 1996-1998. The targets parallel those set for infant and neonatal mortality: That is, they were determined by subtracting the target for the neonatal mortality rate from the corresponding target for the infant mortality rate and generally require a mean annual decline of about 1.0%.

CO #05—*The perinatal mortality rate per 1,000 live births.*

Status: 14.3 deaths per 1,000 live births plus fetal deaths in CY 1999 (very preliminary)

1999 target: 12.7 per 1,000

Trends: This rate declined slightly (by 2.5%) from 14.6 per 1,000 in 1993-1995 to 14.2 per 1,000 in 1996-1998 and, per a very preliminary estimate, was 14.3 per 1,000 in 1999. Speculatively, it is conceivable that better prenatal/perinatal care and/or more complete reporting of extremely low birth weight live births might be postponing a few fetal deaths into the neonatal period, at least per vital statistics records. However, as stated, this is a speculative hypothesis, particularly since perinatal mortality did not markedly decline and since this performance measure counts early (under 7 days) neonatal deaths. Full investigation of this hypothesis would require further analysis of existing data (especially trends in fetal deaths, <1 day neonatal deaths, 1-6 day neonatal deaths, and later neonatal deaths) as well as gathering of qualitative data from providers of perinatal care. Moreover, reporting issues surrounding deaths at around 20 weeks gestation would need to be considered.

Targets parallel those for infant and neonatal mortality, requiring a mean annual decline of 1.0%, from a preliminary 1997-1999 baseline of 14.1 deaths per 1,000.

CO #06—The child death rate per 100,000 children aged 1-14.

Status: 36.3 deaths per 100,000 children aged 1-14 years, in CY 1999 (very preliminary)

1999 target: 34.2

Trends: Comparing 3-year rates, this rate declined by 8.2%, from 38.4 deaths per 100,000 in 1993-1995 to 35.3 deaths per 100,000 in 1996-1998. If the very preliminary rate for 1999 is correct, the rate during that year was higher than for any year since 1995. If considering the preliminary 3-year rate (for 1997-99) of 35.5 deaths per 100,000 to represent 1998 and the corresponding rate for 1993-1995 to represent 1994, the mean annual decline was 2.0%. Thus, targets for 2000 onward require a mean annual decline of 2.5% from a baseline of 35.5 deaths per 1,000, which aims for a slightly greater, but potentially achievable, rate of improvement.

SO #01 The percentage of all live births that are described as unintended.

Status: 47.9% in calendar year (CY) 1998

1998 target: 45.5%

1999 target: 44.1%

Trends: The live birth prevalence of unintended pregnancy has not changed notably during recent years, and Alabama is not on track to achieve targets. The prevalence of 47.9% in 1998 tied with that in 1996 for the lowest estimated prevalence from 1993 through 1998 (with the highest estimated prevalence being 50.6% in 1993). The estimated prevalence fluctuated rather than declining steadily, however, and all 95% confidence intervals for individual years overlapped with one another. Alabama is not on track to achieve targets.

Activities: During FY 2000 ADPH's Family Planning Program was involved in the following activities designed to reduce the prevalence of unintended pregnancy:

- BFHS staff continued to work with Medicaid on an 1115(a) Family Planning Waiver Proposal (intended for implementation in the near future), which was submitted to HCFA in March 1999. This waiver proposal has not been approved by HCFA. During the year, ADPH staff worked with Medicaid staff responding to two sets of questions from HCFA. In November 1999, Medicaid revised the waiver proposal in order to add Mobile County, which had been in the Bay Health Managed Care Plan, which covered women for family planning 2 years postpartum but was dissolved September 30, 1999.
- Care coordination and outreach are major components of the Family Planning Waiver Proposal. If approved, the waiver will expand Medicaid eligibility for family planning services for women aged 19-44 years to 133% of FPL. (The current eligibility cutoff is about 16% of FPL). Family planning services for adolescents less than 19 years of age are now covered by SCHIP, which provides for Medicaid coverage for those at or below 100% of FPL and private insurance coverage for those between 100% and 200% of FPL.

- The Women's Health Branch collaborated with the Department's Women's Health Work Group on development of a Women's Health Status Report Card and, along with the Epidemiology/Data Management Branch, participated on a subcommittee to address indicators to be included in a report card. The four-sectioned card is divided by age groups (10-17, 18-44, 45-64, and ≥ 65 years) and race, with indicators (for which data are available) of greatest concern for a given age group listed. Some of the family-planning-related indicators include pregnancies in females aged 10-17 years and unintended births for age 18-44 years. The card will be distributed statewide by the end of FY 2000.
- During FY 1999 or early FY 2000, the Bureau was involved in many efforts, described in Section 2.4.C under CP #06, to prevent adolescent pregnancy. These included maintenance of OAPP's Family Life abstinence-based adolescent pregnancy prevention project; maintenance of the Alabama Abstinence Education Program; continuation of the toll-free hotline providing abstinence and abstinence-based information to teens and referral for family planning services to women of childbearing age; prioritization of family planning appointments for teens requesting them; receipt of TANF funding to increase availability of Depo-Provera, especially for teenagers and implement the Office of Unwed Pregnancy Prevention; completion of adolescent focus group sessions held in ten counties throughout the State; establishment of the Alabama Campaign to Prevent Teen Pregnancy; distribution of a video, *Jessica's Story*, received from the National Campaign to Prevent Teen Pregnancy; and purchase of the *Wise Guy's* male responsibility curriculum.
- The Department's recently implemented PHALCON encounter-form data base, discussed in Section 2.4.D.1 under SP #07, should facilitate better follow-up of family planning patients and, therefore, may help prevent unintended pregnancies among these patients.
- Results of the Family Planning Population-Based Survey about knowledge and perceptions of Alabama's general population regarding family planning services were shared with area-level health department staff for outreach planning in their counties. Based on the survey, 66% of the 572 respondents indicated that they knew women could get family planning services at CHDs, but only 29% knew that men could get family planning services at CHDs. Over 65% indicated that they would consider using the health department for their family planning services. Of the 572 individuals surveyed, 58% were female and 32% male, and 70% were white, 27% African American, and 3% other race. About 36% of respondents had an income of less than \$20,000, 36% between \$20,000-\$50,000, and 22% \$50,000 or more.
- BFHS continued to address cultural diversity by providing educational materials (pamphlets, fact sheets and video tapes) in Spanish to improve lines of communication between Spanish-speaking clients and CHD staff.

Interpreters are contracted for services or are on staff in pockets of need throughout the State. Spanish language training for health professionals has been provided throughout the State and via a WIC contract with AUM.

- The Bureau developed an MOU to formalize relationships with CHDs in order to bridge the gap between area, county, and State level entities with a new level of accountability. This MOU is scheduled for implementation during FY 2000.
- Comprehensive family planning services were provided at 113 sites statewide, including CHDs, community health agencies, and colleges. Family planning services were provided to 87,358 clients during FY 1999. This number represented 44.3% of the low income women in need of subsidized services and is a slight decrease from the number of patients (89,533) served last year. A large portion of this decrease was in Public Health Area 4 (Jefferson County) and possibly due to a reduction in clinic staff resulting in elimination of Saturday and after-hours clinics.
- Client education and counseling using the PT+3 method, a specific teaching model, continued to be provided in Family Planning Program clinics. This model is designed to improve contraceptive compliance in young or low literacy patients. PT+3 was recently incorporated into clinic protocols to allow family planning counseling to be tailored more to the patient's needs, rather than providing a dialogue of required criteria. A train-the-trainer workshop was held in January 2000 to train area staff to provide training to local staff in this updated methodology.
- BFHS staff collaborated with DHR staff during FY 1999 to obtain TANF funding to address pregnancy prevention. This collaborative effort resulted in an Interagency Agreement in August 1999, whereby DHR is providing \$850,000 on an annual basis for the purchase of Depo-Provera for ADPH family planning clients. This was an immediate need of the State Family Planning Program because ADPH budget cuts resulted in Depo-Provera being prioritized during the year to teens and patients at medical/social high risk.
- DHR partnered with BFHS to implement the Office of Unwed Pregnancy Prevention. Priorities are to (1) develop a media campaign to address unwed pregnancy prevention and (2) provide competitive grant funding for projects that address unwed pregnancy prevention. During the first year (3-year plan for \$10 million), DHR will provide ADPH \$2.9 million (includes \$850,000 for Depo-Provera). This initiative was implemented in February 2000.

Setbacks: The development of a marketing packet for CHD staff was not realized due to continued budget reductions and staff shortages. Furthermore, as described in Section 2.4.C.2 under CP #06, Bureau staff were unable to continue efforts to estimate the proportion of all ADPH maternity patients who return for family planning services, but in FY 2001 will explore the feasibility of making such estimates.

Discussion: Based on input from the Bureau's Needs Assessment Committee and the fact that another federal grant (Title X) funds the Bureau's Family Planning Program, provision of family planning services was not selected as a priority MCH need with respect to the Title V Program. Accordingly, the State outcome measure pertaining to prevention of unintended pregnancy is no longer operational. (The needs assessment process, selection of priority needs, and the new State outcome measure are described in Section 3.1.1, 3.2, and 3.4.3.) Prevention of unintended pregnancy remains a major part of the Bureau's role, however, so related activities will be described in Section 4.2.

SO #02—The homicide/legal intervention death rate for 15-19 year-old African American males per 100,000 African American Males aged 15-19 years.

Status: 63.1 deaths per 100,000 African American males aged 15-19 years in CY 1998

1998 target: None

1999 target: None

Discussion: This newly developed State-negotiated outcome measure is described in a detail sheet and reported on Form 12. Since it was not operative during the reporting year and was not developed until CY 1999, however, it is not discussed here and no targets were set for 1998 or 1999.

2.5.B Collective Contribution of Performance Measures to Outcome Measures

Estimates for 1999 or 2000 were reported for 17 of the 18 core performance measures, all of the nine previously developed State-negotiated performance measures (some of which are inoperative as of FY 2000), and all of the core outcome measures. (For the remaining core performance measure and the State-negotiated outcome measures, estimates are reported for 1998. Two of these items [CP #09 and SO #01] are from the PRAMS data base which, as explained in notes to Forms 11 and 12, is not available for the reporting year when this document is submitted.) The third item (SO #02) is from vital statistics data, and preliminary estimates for homicide death rates in 1999 are not available. Targets were virtually met (i.e., within 1.00% of being achieved), met, or exceeded for 11 of the 18 core performance measures and six of the nine previously developed State-negotiated performance measures.

Targets were not met for performance measures pertaining to immunizations (CP #05), mortality from motor vehicle crashes (CP #08), breastfeeding (CP #09), newborn hearing screening (CP #10), VLBW (CP #15), suicide (CP #16), prenatal care (CP #18), cigarette smoking in adolescents (SP #03), blood lead levels (SP #05), and MCH

data bases (SP # 07). Potential reasons for failure to meet these targets and/or activities by ADPH to move toward achieving them have been fully discussed under the respective performance measures. Moreover, VLBW is extensively discussed in Section 3.1.2.1.B.

With respect to achievements, the Bureau is encouraged by the apparent improvement in CP# 17, the percent of VLBW infants delivered at perinatal centers. After worsening somewhat in 1996-1997 compared to the previous 2 years, this indicator improved notably in 1998 and, based on a very preliminary estimate that is subject to change, may have improved again and surpassed its target for 1999.

As has been stated in previous reports/applications, the relationship between the degree to which performance measures are met and their collective impact on outcome measures is very complex. VLBW has an especially strong effect on infant mortality. As has been discussed in Section 2.4.D.1 (in this document, as well as in previous reports/applications), there is no single solution to the complex problem of LBW, and programs initiated to prevent preterm delivery and VLBW have been largely unsuccessful.² Moreover, attempts to explain increases in VLBW should consider several factors as potential contributors, ranging from the increase in multiple births to potential variations in reporting to unfavorable trends in risk markers for women giving birth. The acknowledged uncertainty as to how to effectively prevent VLBW underscores the need for more information, rather than overly simplistic solutions with attendant unrealistic expectations. VLBW, as well as other issues pertaining to infant mortality, is therefore addressed extensively in Section 3.1.2.1.B.

If the very preliminary estimates for 1999 are reasonably correct, the higher proportion of VLBW infants born at perinatal centers may have contributed to the apparent reduction in infant mortality in 1999. To reiterate previous caveats, however, estimates for 1999 are subject to notable change. Moreover, preliminary estimates often underestimate the infant mortality rate.

The bad news with respect to outcome measures is that, if the very preliminary estimates for 1999 are correct, the child death rate increased in 1999. Though this rate is statistically unstable and the change may not herald a worsening trend, the change is cause for concern and the rate bears continued monitoring.

As stated in previous reports/applications, the FIMR Projects and the Child Death Review System have the potential to help the State better prevent perinatal deaths, infant deaths, and child deaths. Moreover, the ongoing MCH needs assessment—the Year 2000 phase of which is extensively reported in Section 3.1—provides an opportunity and a challenge to further analyze the rich data bases available, fully consider findings internally and in consultation with groups external to ADPH (such as SPAC), prepare and disseminate reports for use by the public and groups who influence MCH policy, and translate findings into appropriate MCH policy and programs.

III. REQUIREMENTS FOR THE APPLICATION [Section 505]

3.1 Needs Assessment of the Maternal and Child Health Population

3.1.1 Needs Assessment Process

ADPH, through BFHS, was the lead agency for assessing needs pertaining to two of the Title V populations: pregnant women, mothers and infants, and children. ADRS, through CRS, was the lead agency for assessment of CSHCN. The Director of the Bureau's Epidemiology/Data Management Branch coordinated the Bureau's needs assessment, and the CRS's Grants Management Specialist coordinated their needs assessment. The two coordinators collaborated closely with one another, and each attended some of the statewide Needs Assessment Advisory Committee meetings convened by the other's agency.

3.1.1.A. ADPH Needs Assessment Process

ADPH's needs assessment process consisted of several major components: (1) an MCH Needs Assessment Advisory Committee, (2) community forums and focus groups, (3) analysis of existing data, (4) three mailed surveys (primary care medical practices, non-medical MCH organizations, and dentists), and (5) a telephone survey of households with children. Twenty of the State's 67 counties were selected to assist with two of the three mailed surveys (the medical practices and non-medical MCH organizations surveys) and to serve as a location for the community forums and focus groups. Though these counties were selected partly based on feasibility, they represented all 11 of the State's public health areas (PHAs), both urban and rural counties, and all major geographic areas of the State. A description of the process for each of the needs assessment components, as well as a caveat regarding the preliminary nature of findings, follows.

ADPH Process: MCH Needs Assessment Advisory Committee

Three meetings of the MCH Needs Assessment Advisory Committee were held from May 1999 through March 2000. Prior to convening the first meeting, the Needs Assessment Coordinator (the director of the Bureau's Epidemiology/Data Management Branch), in consultation with other Bureau staff, developed a list of invitees representing a variety of organizations, including faith-based and civic groups, universities (including a historically African American university), public schools, hospitals, a rural health care facility, the Governor's Children's Commission, Blue Cross Blue Shield of Alabama, State agencies, CHDs and regional ADPH offices, and BFHS and other units within ADPH. Based on the most recent advisory committee directory and on the Needs Assessment Coordinator's recall, about 84 persons were invited: 50 from other organizations or agencies, 12 from regional ADPH staff or CHDs, 7 from ADPH central office staff outside of the Bureau, and 15 from the Bureau. Invitations were generally by letter, followed by telephone calls when feasible. The first two meetings were about 2 hours long and the last one was nearly 4 hours long. A meal was provided at two of the meetings.

BFHS first convened the MCH Needs Assessment Advisory Committee in May 1999. The main purposes of this meeting were to (1) provide overviews of the MCH Program and the needs assessment process and (2) solicit input into the process. From 60 (per the signed roster) to about 72 (per observation and number of meeting folders taken) persons attended the meeting. In addition to persons representing organizations, five individuals from the Montgomery area, including one woman from a public housing community, attended. During the main plenary session, overviews of the MCH Program and the MCH Services Block Grant (including the 1997 report/1999 application and the components of a needs assessment) were respectively presented by the Bureau Director and the Needs Assessment Coordinator. Attendees then joined one of three concurrent discussion groups: one on existing data, one on new surveys, and one (the largest group) on community forums. Though only 16 persons returned completed (anonymous) evaluation forms, their responses were informative. Per check box responses, the meeting was described as “very interesting” by 11 respondents and “somewhat interesting” by remaining respondents (no one checked “not interesting”). In response to the question, “How useful do you think the needs assessment will be?” 11 respondents answered “very useful,” while five answered “somewhat useful.” In response to an open-ended question, one respondent replied, “Overall, this was a very productive meeting. I learned a great deal, although I was reluctant to attend. I am now motivated to go back to my community and work with MCH to identify the needs and implement plans and programs to effectively address these needs.”

The main purposes of the second meeting of the MCH Advisory Committee, held in August 1999, were to (1) present an overview of selected MCH indicators, (2) review the status of tools being developed for the surveys and community forums, and (3) seek input. The Bureau Director gave a slide presentation about selected indicators of MCH in Alabama, and the Needs Assessment Coordinator reviewed the then-current status of data collection tools for the anticipated new surveys. A draft of the tool for surveying non-medical organizations serving the MCH population was distributed, and volunteers for piloting the tool were solicited (several persons volunteered). Additionally, attendees were invited to help develop or pilot the then-undeveloped survey tool for medical practices (no one volunteered). The draft interview tool for the telephone survey of households with children was demonstrated in an unrehearsed “interview” of a Bureau staff member. Three concurrent breakout sessions then occurred: one on existing data, one on new surveys, and one on community forums. The existing data discussion group reviewed the *Health Status Indicators Pilot Project* draft and recommended that efforts to collect data specifically addressing the required health status indicators be deferred until the final list of health status indicators was made available. The new surveys discussion group reviewed the draft telephone survey tool from an analytic perspective and made several suggestions for revisions. The community forums group discussed the draft telephone survey tool from a potential interviewee’s perspective and also made several suggestions for revisions. The latter group then participated in a mock community forum, using the *Healthy People in Healthy Communities: A Dialogue Guide Project of the Coalition for Healthier Cities and Communities*, and suggested revisions or additions to the questions.

The third and final meeting of the Bureau's Needs Assessment Committee was convened in March 2000. The main purposes of this meeting were to (1) present preliminary findings from the needs assessment, (2) provide a community perspective on welfare reform, and (3) obtain participants' input regarding priority MCH needs. Due to the extensive material to be covered, this meeting was scheduled for 4 hours (with a lunch break, changes in pace or focus, and multiple opportunities for group discussion). Four presentations were made about preliminary findings from the needs assessment: (1) *Existing Data: What Does It Tell Us?*, (2) *Community Forums and Focus Groups: What Do Participants Say?*, (3) *Surveys of Medical, Dental, and MCH Organizations: What do Professionals Say?*, and (4) *Telephone Survey (in Progress) of Households with Children: What Do Parents Say?* (The latter was brief and included only a few findings from about 30 then-completed interviews). Additionally, a local pastor (also a member of the Montgomery County welfare to work board) spoke eloquently of his perspective on welfare reform, based on his efforts to help women move from welfare to work. After all other presentations had been made, the Bureau Director presented *Potential Priority Maternal and Child Health Needs* (12 potential priority needs were presented), and individual participants were asked to anonymously rate the needs (using a form that had been provided). Participants were then asked to join breakout groups, and each group was asked to collectively identify and rank the top five priority MCH needs. (Groups and individuals were invited to add other priority needs if they wished, but none did.) Following active discussions within each group, all participants reconvened and each group presented their top five priority needs. Bureau staff suggested (and participants agreed) that this would be the final meeting, but participants were invited to provide further input by contacting the Needs Assessment Coordinator if they wished. At the close of the meeting one participant said that, contrary to what she had expected, the nearly 4-hour meeting had maintained her interest and time had passed quickly.

ADPH Process: Implementation of Community Forums and Focus Groups

A Community Forum Discussion Work Group (Forum Work Group) with representatives from various Alabama agencies and organizations was convened to plan the community forums, and met several times (by phone or in person) from June through October 1999. Financial assistance from the national and local MOD was critical to the success of this process. An important goal of the work plan was reaching out to the community through people who live and/or work in the community. The Forum Work Group decided that at least one community forum and one focus group (professional, consumer or teen) would be held in each of 20 counties (representing all 11 PHAs).

Community Forums

Purposes of the community forums were to (1) create opportunities for community dialogue about missing essential services for pregnant women, mothers, infants, children, and adolescents and (2) engage participants in identifying the strengths and weaknesses of MCH services. The *Healthy People in Healthy Communities Dialogue Discussions Guide* questions were modified to collect this information, with input from the Forum Work Group. The group was aware of barriers that would exclude people from participating and tried to encourage participation

through such means as offering child care, transportation, food and prizes, and holding meetings in familiar, comfortable places (e.g. schools, community centers, CHDs, and recreational facilities). They attempted to inform the community about who was gathering the information, why it was being gathered, and how it would be used. Special attention, when feasible, was given to including ethnic minorities and publicizing meetings in ways that would encourage attendance from all sectors of the communities.

Focus Groups

Three topic guides for focus groups were developed: (1) one for professionals, to learn whether they were aware of community/county services for women and ascertain their views about how successful these services were; (2) one to learn whether teens were aware of services specific to their age group and (if aware) their views of the services, and where they obtained information about services for teens; and (3) one for consumer representatives in order to identify critical child health issues in communities. Three concern surveys were developed to accompany topic guides so participants could express their opinions even if they did not speak publicly. The main data collection tools used in community forums and focus groups consisted of the following:

- The *Membership* surveys asked about demographic data. Forum and focus group participants were asked, but not required, to complete this survey.
- The *Children's Health Survey* (Appendix G), distributed at or in advance of the focus groups for consumers, asked respondents to rank various issues (such as infant mortality, premature sexual activity among youth, and domestic violence) regarding their seriousness; to state what role they felt ADPH should have in promoting health and safety of infants, children, and teens; how effective CHD programs were; and what two things they would like to change about the health care system.
- The *Women's Health Survey* (Appendix G), distributed at or in advance of focus groups for professionals, asked respondents to rank issues, state the role ADPH should have in promoting the health of pregnant adults and pregnant adolescents, describe the effectiveness of CHD programs, state where women go or take their children for care, and list barriers to health care for women.
- The *Teen Leadership Survey* (Appendix G), distributed at or in advance of teen focus groups, asked where teens usually go for health information, what concerns were important to them, community problems that they felt needed more attention, strengths of and problems faced by their families and communities, and whether their health care providers respected cultural values.

Documentation of Proceedings

Information from all forums and focus groups was recorded in handwritten field notes. At the end of each session,

these notes were summarized for the groups and participants were asked to correct any errors or add important material. These notes were one of the main sources of information used to prepare summaries of forum and focus group discussions. Each facilitator was supported by the Bureau Liaison, who was responsible for taking notes, recording the discussion on audio tape (which was often not done, however), and verifying notes with the group.

Selection and Training of Facilitators

BFHS enlisted volunteers from the Forum Work Group to coordinate community forums and focus groups. Local MOD volunteers and CHD staff, who lived and worked in the selected communities, served as local facilitators and/or moderators. The experience of facilitators varied greatly. Diversity was encouraged regarding age, gender, race, profession, experience, religion, professional affiliation, and geographic residence. Recruiting was done in a manner to promote diversity. Most facilitators were associated with a human services network such as a hospital, State agency, or local MOD; their experience in facilitating groups varied greatly. Three facilitator training sessions were held over a 2-month period. Dr. Joseph Telfair, UAB School of Public Health, and Dr. Kathleen Tajeu, Cooperative Extension, have considerable experience with this type of research and helped develop and implement the training, which included about 12-15 instructional hours. The manual *Conducting Focus Groups and Community Forums: A Guide for the Local Facilitator*, a product of the facilitators' training, set forth action steps.

Publicity and Invitations

Target populations for the forums included parents of children and other persons interested in MCH—regardless of socioeconomic status. Local coordinators were to advertise **community forums** via personal invitation, newspapers, radio announcement, flyers, posters, letters, and word-of-mouth. In some PHAs, announcements of forums were delivered by volunteers to households, and posters were placed in high traffic areas. Publicity materials were translated into Spanish for use with the Hispanic population. Some of the local newspapers wrote feature articles and carried reports of forum meetings, and some local news media staff covered the forums.

Recruitment of Participants

Focus group participants were recruited by personal invitation, (letter, phone, or in person). To the degree feasible, composition of groups reflected the character and diversity of the community along several dimensions, including age, gender, race/ethnicity, educational attainment, and household income. However, since the participants were selected by the local coordinator affiliated with the CHD or MOD, groups to which the coordinator had access or in which they had a special interest may have been over represented.

Success of recruiting community participants in forums and focus groups varied. Over 400 citizens attended 17 community forums. Collectively, more than 270 persons participated in 25 focus groups (9 teen groups, 5

consumer groups, 9 professional groups, 2 groups with unspecified participants). Of 271 surveys, a total of 207 concern surveys were completed correctly. The diversity among participants made for active discussions. The membership surveys had a high percentage of non-respondents, especially in smaller communities. Accordingly, demographic information about participants is limited. Moreover, the surveys did not distinguish CHD staff from community participants, and many of the forums were mainly attended by CHD staff. Per the perceptions of the BFHS Community Forum Coordinator, CHD staff tended to be from local communities and to reflect views of local communities. Per a collective description of participants in forums and focus groups, based mainly on completed demographic surveys: 90% were women, 50% were white and 50% African American, all had completed high school, and most were from households with children aged 2-15 years. Three participants were Native Americans and 75 were Hispanics. Annual household income varied widely (from “under \$ 10,000” to “over \$75,000.”) Most participants had prior contact with the CHD. One forum was comprised exclusively of Hispanic individuals. The Franklin County Hispanic Coalition was involved in the planning, implementation, and moderation of this Hispanic forum.

ADPH Process: Analytic Methods for Qualitative Data from Community Forums and Focus Groups

Analysis of Data From Community Forums

The analysis reported for this needs assessment was a phase one analysis. Due to current time constraints, further analyses will be conducted in the coming year. This analysis focused on questions from the community forums and focus group surveys that pertained directly to the setting of Alabama’s priority needs.

Three questions from the community forums were analyzed. For each individual question, responses from all forums were compiled, and responses to that question were analyzed separately from those to other questions. First, responses to a question were reviewed to identify common themes. Once these main themes were identified, responses were grouped by theme. Each theme was then further reviewed to identify any common sub-themes, and responses were then further categorized into their respective sub-themes. The next step was to identify “key words/phrases” within the sub-themes so responses could be categorized even further. Once the sub-themes were divided into key words/phrases, the number of responses for each theme, sub-theme, and key word/phrase were calculated. When answers were too vague and the intent of the response was unknown or the response was inappropriate for the question asked, responses were coded either non-specific or out of bounds. In addition, although the themes, sub-themes, and key words/phrases were selected by the epidemiologist, other Bureau staff reviewed the materials to decrease the likelihood of bias. Furthermore, responses remained as they were received by the epidemiologist; that is, responses were not altered or paraphrased at all during the analytic process, so as not to lose the richness of the data.

Analysis of Data from Focus Groups

The survey forms distributed at the focus groups were analyzed quantitatively. Those questions that lent themselves to quantitative analysis were entered into a database created in Epi Info. Frequencies and means were then calculated using that software. For multiple-choice questions, percentages were calculated for each response. For questions where options were ranked, the mean of the responses was computed. Then, the means were arranged from lowest to highest because a score of one denoted greatest importance and the higher the score the less important a response was deemed overall.

ADPH Process: Analysis of Existing Data

Performing a comprehensive needs assessment required multiple analyses of existing data from a variety of sources. The nature of these analyses depended on their purpose, the nature of the reference or database used, and the time constraints existing when analyses were performed. Accordingly, the analytic methods, as well as data sources and study populations, varied. These issues will therefore be discussed under *Notes on Methods* accompanying the findings being reported. Because of the broad scope and descriptive (rather than hypothesis-testing) nature of the needs assessment, as well as previously mentioned staffing limitations, detailed statistical analyses (i.e., p-values, confidence intervals, etc.) of existing data were not always performed. When utilized, they were generally based on Cochran-Mantel-Haenszel statistics computed by SAS⁵ or Epi Info⁶, or Fleiss 95% quadratic confidence intervals, per Epi Info.

ADPH Process: Three Mailed Surveys

Tools for the three mail surveys are in Appendix G. Planning and implementation of each mail survey follows.

Survey of Alabama Primary Care Medical Practices Serving Pregnant Women, Mothers, Children or Youth

The *development of the survey tool* involved extensive collaboration, including consultation with key Bureau staff, other ADPH staff, the CRS Needs Assessment Coordinator, and persons from other organizations. The first draft of the tool was developed by the Bureau's Needs Assessment Coordinator—based on the then-available needs assessment guidance,⁷ a review of selected medical texts, and her perception of what information would best inform Bureau policy. With permission of the AAP, selected items in a draft tool developed for their organization (and cited on page 2 of the Bureau's survey tool, which is in Appendix G) were adapted as one component of the Bureau's survey form. The draft tool was then presented to the Bureau Management Team, from which several persons were recruited to serve on a committee to finalize the tool. The nearly final draft of the tool was then reviewed by the Bureau Director and the Director of HPI's Communications Design Division. Subsequently, the next-to-final draft was piloted on about 10 practicing physicians, about half of whom returned the questionnaire. Minor revisions were then made to develop the final version of the tool for the FY 2000 phase of the needs assessment (Appendix G). The tool has several major sections: (A) Identifying Information; (B) Type, Scope, Staffing and Reimbursement of Practice; (B) Accessibility, Family Centeredness, Comprehensiveness,

Coordination and Cultural Competence; (C) Direct Health Services; and (D) General Priorities and Issues. Section D included several open-ended questions about high priority MCH issues, strengths of the MCH care system, and barriers/gaps or weaknesses in care, as well as a check-box question about the effects of certain changes in the health care environment. (The labeling of two sections as “B” was inadvertent and regrettable, but presumably did not interfere with completion of the questionnaire.) To facilitate description of findings for specific Title V populations, Section C was divided into a sub-section for pregnant women, another for nonpregnant females of childbearing age, and another for children and youth.

CHD and area-level staff were key to *implementation of the Medical Practices Survey*. In early November 1999 the Bureau mailed to PHA contact persons a letter about the impending survey, a document detailing CHD tasks for implementing the survey, a sample cover letter for recipients of the survey tool, and a time frame for the data collection phase. Additionally, a tentative list of Alabama-licensed obstetricians, gynecologists, pediatricians, and family practitioners in active practice (based on a data base provided to ADPH by the State’s medical licensure board) was provided for each participating county. These contact persons were to promptly forward the information to responsible persons in the involved county/counties in their areas. Staff from each CHD were asked to develop a recipient list of practices serving the maternal and child population in their county (sampling frame), select a specified number of practices from the sampling frame in a way that would maintain its diversity, mail the survey tools (which they would receive by November 2) by November 5, log returned questionnaires and forward them to the Bureau in weekly batches, and contact non-respondents one additional time. The suggested number of surveys to be mailed by each CHD was roughly based on the number in their sampling frame and on the distribution of live births among participating counties. Surveys were to be mailed to practices—not physicians. That is, no more than one physician in a given practice was to receive the survey. The tasks and time frame (which was unavoidable, due to the Bureau’s previously discussed then-limited analytic/community development resources) caused a good deal of consternation among some area/county staff, which was addressed during discussions among Bureau and area staff at an area nurses’ meeting in October. On the whole, CHD and area staff exerted great effort to implement the data collection phase of the survey, particularly given their numerous concurrent responsibilities. Certainly their involvement was essential to implementation of the survey. Around November 5 (with a few exceptions), survey forms were mailed (mostly by 20 CHDs) to 638 practices in all. Of these 638 practices, 147 (23.0%) returned questionnaires, and 142 completed questionnaires were analyzed. The 142 analyzed questionnaires include those mailed during the pilot phase, since the pilot-phase draft was very similar to the final draft. (Unanalyzed questionnaires were not sufficiently complete for meaningful analysis.)

Most of the *142 respondents* were from solo, 2-physician, or group practice settings; and family medicine was the most frequently reported medical field. Specifically, 44% of respondents were in solo or 2-physician practices; 34% in group practices; and only a few (8 or fewer respondents) each in public health departments, community

Figure 5. All Practices: Setting (n=142)

Question: Select the one phrase that best describes your practice or facility.

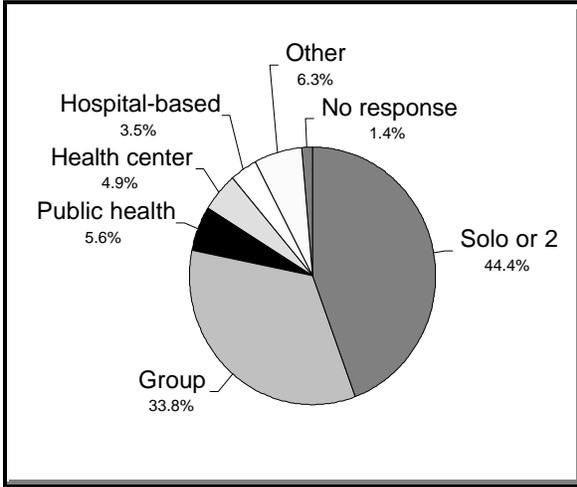
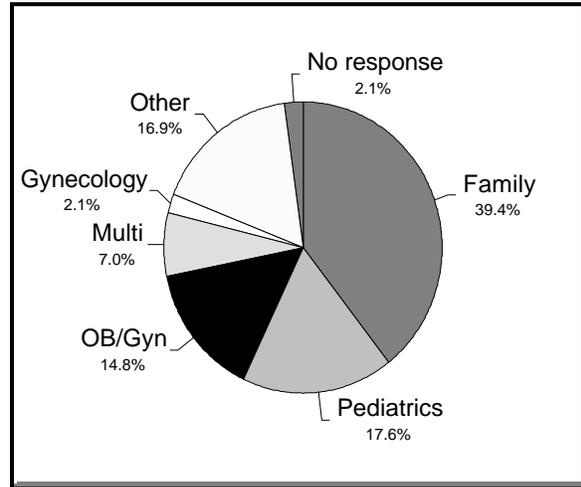


Figure 6. All Practices: Medical Field (n = 142)

Question: Select the one phrase that best describes the scope of your practice.



health centers, hospital-based ambulatory care settings, and other settings (Figure 5). With respect to medical scope, 39% of practices were family medicine, 18% pediatrics, 15% obstetrics/gynecology, 7% multi-specialty, 17% other, and very few (n=2) gynecology without obstetrics (Figure 6).

Although the recipient list of surveys was not a “random sample” of practices, based on conversations with CHD staff and review of recipient lists, recipients adequately represented physicians serving maternal and child populations in the 20 involved counties. Indeed some CHDs mailed surveys to all physicians known by them to serve their respective counties’ maternal and child populations. Although neither all counties nor a random sample of counties participated in the survey, participating counties were deemed to adequately represent the State’s population (see introductory paragraph to 3.1.1.A). *The major limitation of the survey is the low response*

rate, which does not permit confident generalization of findings to the total population of physicians serving maternal and child populations. Though desirable, a higher response rate was not feasible, given historically poor response rates among physicians and the very limited resources that could be devoted to the survey. Specifically, given the lack of Bureau staff/time to garner advance support by involving key medical organizations and the lack of CHD staff/time to provide intensive follow-up, the response rate of 23% was about what we expected and better than what we had feared. Another limitation of the methods was that Bureau staff apparently had not clearly conveyed to CHD staff that they too should complete the surveys. Accordingly, only 8 of the 20 CHDs returned a survey. In spite of these limitations, ***the survey permits description of the nature and stated priorities of up to 142 practices who chose to respond.*** (Not all practices responded to open-ended questions about MCH priorities, strengths of the system, or barriers to health care.) It therefore has provided previously unavailable information that is an important component of the needs assessment.

Survey of Alabama Organizations Serving Women of Childbearing Age, Children, Youth, and/or Families

The ***development of this survey tool*** also involved extensive collaboration, including consultation with key Bureau staff, other ADPH staff, and the MCH Advisory Committee. This tool was also developed by the Bureau's Needs Assessment Coordinator—based on her interpretation of then-available MCHB guidance, review of a less detailed tool previously developed and utilized by another organization, and her perception of important health issues that may conceivably be addressed by a variety of organizations. The initial draft was presented to the Bureau Management Team, after which two Bureau social workers helped refine the tool. Subsequently, as previously mentioned (under *ADPH Process: MCH Needs Assessment Advisory Committee*), input from the MCH Advisory Committee was solicited, and several volunteers were recruited for piloting the tool. Final revisions were made based on comments from the Advisory Committee and persons piloting the tool. The final tool for the FY 2000 survey (Appendix G) has five major sections plus a completely opened-ended section. The five major sections are (A) Introduction; (B) Services Provided to Individuals; (C) Community-wide Outreach/Education; (D) Services Provided Through Contracts, Grants, or Other Funding Arrangements; and (E) Your Views (similar to Section D of the Medical Practices Survey tool).

The ***implementation of this survey*** paralleled that of the Medical Practices Survey (described in corresponding subheading). Briefly, the time frame was the same as that for the Medical Practices Survey, and the previously mentioned document detailing CHD tasks for the Medical Practices Survey also detailed those for the MCH Organizations Survey. Potential recipients of the MCH Organizations Survey were all key non-medical organizations serving pregnant women, mothers, children, youth, and/or families in the participating counties. Based on published sources and their own experience or knowledge, CHDs were to identify all such organizations serving their respective counties (sampling frame). They were advised to include a variety of organizations/practices that together represented diversity in organizations, populations served, and views. From

the sampling frame they were to select a specified number, roughly based on the sampling frame’s size and the distribution of live births among participating counties, in a manner that would represent the diversity of the sampling frame. Survey forms were mailed to 736 organizations. Of these, 323 organizations (43.9%) responded, and 319 completed questionnaires were analyzed.

Respondents represented the private and public sectors, and their organizations addressed a variety of issues. The highest percentage of respondents were from private nonprofit organizations (37%), but substantial numbers were from public agencies (20%) and public educational institutions (16%). As shown in Figure 7, others were from private for-profit businesses/services; associations, civic groups, or faith-based groups; “other” types of organizations, and private educational institutions (only 7 respondents from the latter) . (“Other” responses have not been further analyzed for any of the surveys conducted.) With respect to their organizational focus, education was chosen by 25% and social services by 20% of respondents. Other concerns viewed as the main issue were “other” (32%—showing that the tool did not specify the main issues addressed by many organizations), physical health, mental health, spiritual health, and training/employment (only 7 respondents chose the latter) (Figure 8).

Figure 7. All Organizations (n=319)
 Question: Check the one phrase that best describes your organization.

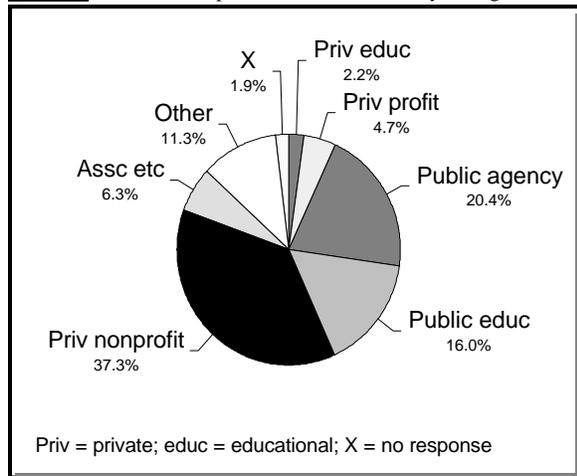
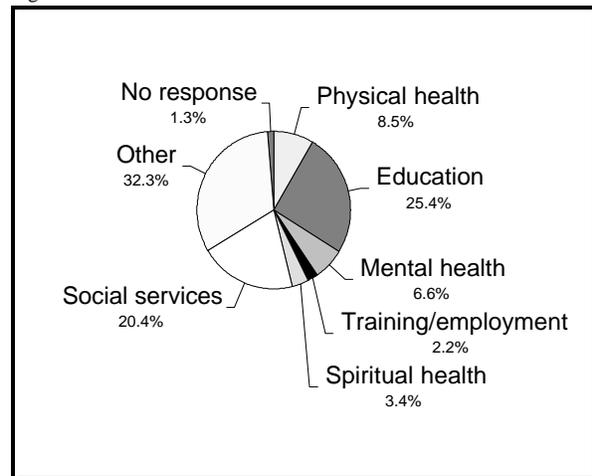


Figure 8. All Organizations (n=319)
 Question: Check the one phrase that best describes the main issue your organization addresses.



Survey of Alabama Dental Practices

Implementation

The Oral Health Branch (OHB) within the BFHS collaborated with HPI to implement the Survey of Alabama Dental Practices. The BFHS worked with HPI to develop the survey tool itself (Appendix G). The OHB included questions about practices within the office regarding counseling, payment sources accepted, procedures performed, etc., while HPI surveyed the dentists more specifically on tobacco use and cessation counseling within the practice. The survey was then mailed out to all licensed dentists in Alabama, i.e., active and retired as well as general practitioners and specialists. The mailing list was provided by the Alabama Board of Dental Examiners, who keep

a database of all licensed dentists in the State. The survey was mailed to 1,878 licensed dentists throughout all 67 counties of the State; however, 5 of these surveys were returned due to insufficient addresses etc. Of the remaining 1,873 surveys, 920 completed surveys were returned prior to analysis. Three additional surveys were returned following preliminary analyses and were consequently excluded. Of the 920 completed surveys returned, only one was excluded from analysis. The return rate for completed questionnaires, therefore, was 49% (919/1,873).

Analytic Methods

A preliminary analysis was completed by an epidemiologist in the HPI as part of the collaborative effort between the two Bureaus. The findings reported in this document are from this particular analysis. This analysis focused on descriptive statistics such as proportions. Further analyses may be performed for use by the Tobacco Prevention and Control Branch in HPI or by the OHB in BFHS, but the Epidemiology/Data Management branch will not be analyzing data from this survey.

ADPH Process: Telephone Survey of Households with Children

Implementation and Study Population

The initial draft of the survey tool was designed by the Bureaus' Needs Assessment Coordinator, in consultation with several other members of the Bureau. Because of time constraints, a "pilot" of the tool was limited to roughly ten Bureau staff members. The tool was revised somewhat based on responses during the limited pilot study, and feedback was subsequently solicited from the MCH Needs Assessment Advisory Committee as previously described. The feedback received showed clearly that further refinement of the tool was necessary, so such refinement was included in the contract with the Survey Research Unit that conducted the telephone phase of the study.

ADPH contracted with UAB's Survey Research Unit (SRU), for their staff to work with Bureau staff to finalize an acceptable survey instrument, as well as to conduct the telephone phase of the survey and provide an electronic data base and corresponding documentation (see Appendix H for contract). The survey tool included many questions adapted from the National Health Interview Survey, as well as questions adapted, with permission, from the Foundation for Accountability's *Screener for Identifying families with children with chronic conditions* (HEDIS Version–Mail or Telephone). SRU's staff and the Bureau's Needs Assessment Coordinator consulted intensively in finalizing the survey tool for the purpose of the survey conducted (see Appendix G). (Further refinements will be considered in the future.)

The telephone-interviewing phase of the survey began on March 7, 2000 and was completed on June 1, 2000. The study population for the survey consisted of children from households with children aged 17 years or younger. These households were identified by SRU staff from a random digit dialing sample (generated through Stratified

sampling procedures) purchased by UAB from Survey Sampling, Inc. The focal child in each participating eligible household was randomly selected through the use of computer-assisted telephone interviewing (CATI) technology. Calls were made by SRU staff from 10 a.m. until 3 p.m. and 4 p.m. until 9 p.m. Monday through Thursday, and from 10 a.m. until 3 p.m. on Fridays and Saturdays. Interviewers were monitored by a supervisor at all times. Standard calling protocol was to wait 1 hour between calling attempts, and to call a given number up to three times per shift. If an interview was not obtained (or confirmation of a nonresidential, non-working, or otherwise inaccessible number was not established) after 15 attempts were made on various days/times that included days, evenings, and weekends, a phone number was coded as a final “no answer.” In addition, if a respondent declined to be interviewed at that time on two occasions, she/he was coded as a refusal and not contacted again. Additional details about the telephone phase of the survey are in Appendix I.

Findings reported here are provisional and based on the 517 interviews that had been completed in time for inclusion in the analyses on which findings reported in this document are based. (Shortly before completing this document, Bureau staff learned that SRU staff had continued calling persons from the random digit dialing sample and, by the completion of the telephone phase, had obtained 578 completed interviews, for a response rate of 77%. During FY 2001, a report focusing solely on the telephone survey will be prepared. **All findings reported in this document pertain to the 517 interviews available when analyses were performed**-not to the total surveyed population of 578 respondents. Thirty-five of the referent children were less than 1 year of age, and 482 from 1 through 17 years of age. Key findings pertaining to the 35 infants are described, to the degree feasible given the small numbers, in Section 3.1.2.2.A. Major analyses focused, however, on the 482 children aged 1 through 17 years, and these are discussed in multiple places in Section 3.1.2. Demographic characteristics pertaining to these 482 children are described in Section 3.1.2.1.C.

A SAS database was generated by SRU personnel, submitted to logic and range checks, and provided, along with documentation, to Bureau staff.

Analytic Methods

Although data collection for this survey was not completed until June 1, 2000, findings from the partially complete data base (517 records) have been analyzed rather extensively. Because the study population was a sample, rather than essentially the entire population as is true for vital records, numerous statistical tests were performed and numerous confidence intervals estimated. Because information about analytic methods may be key to understanding terminology etc. used in Section 3.1.2.1.C to report findings from this study, methods are described in *Notes on Methods #4*, Section 3.1.2.1.C, where the main discussion of findings from this survey begins.

As stated earlier, these are Phase I analyses. Whether more sophisticated analytical techniques (such as weighting,

or use of statistical tests designed for complex sampling procedures) could and should be used has not yet been explored.

Preliminary Nature of ADPH Needs Assessment Analyses

Although the Bureau has intensively and, in our view, comprehensively addressed the needs assessment, findings should be viewed as being from initial analyses and part of work in progress—for several reasons. First, although the Bureau began planning for the needs assessment during the first quarter of FY 1999, had begun developing survey tools by April 1999, and convened the first advisory committee meeting in May 1999—neither the Bureau’s Epidemiology/Data Management Branch nor its Community Development Branch were fully staffed until early in FY 2000. Accordingly, neither the new surveys, community forums, focus groups, nor analysis of existing data could proceed within the optimum time frame. The needs assessment is therefore work in progress, with analysis and reporting to continue through FY 2001. In particular, qualitative data from mailed surveys has been reviewed for only a few records, and only the most pertinent questions from focus groups could be analyzed for this report. Moreover, a model for reporting area- and county-specific data in a manner that complements the county profiles already published by CHS, minimizes the statistical uncertainty of small-area analyses, and includes available qualitative data is still being developed. Additionally, further consideration of findings from existing data may lead to further statistical analysis of these findings, as well as implementation of other studies. The view of these findings as part of work in progress is consistent with the Bureau’s view that MCH needs assessment should be an ongoing process, rather than a single report submitted every 5 years. Similarly, the view of needs assessment as ongoing is consistent with a view that the State should cycle from the analytic phase to identifying priority needs, establishing performance measures, setting targets, and developing annual plans—rather than arbitrarily terminate the needs assessment process.

3.1.1.B CRS Needs Assessment Process

CRS convened the CRS Needs Assessment Advisory Committee in January 1999 to assist the agency in planning and implementing the CSHCN component of the needs assessment, as well as with analyzing and prioritizing the results. All State agencies and other organizations with an interest in children, non-profit service and advocacy organizations, and representatives from families of CSHCN, churches, child care, professional organizations, primary care and specialty care providers, and CRS staff were invited to participate for a total membership of 47 committee members. The group met four times (January, March, July, and October 1999) to discuss and review the status of the needs assessment with an average attendance of 23. With the approval of this diverse group of stakeholders, CRS pursued three distinct methodologies in gathering qualitative and quantitative data to determine the priority needs of Alabama's CSHCN:

- Qualitative data from the family perspective were gathered through eight family forums held throughout the State at varying times and days of the week to accommodate diverse family schedules. The forums were

conducted from May through July and were located in Montgomery, Boaz, Selma, Jasper, Andalusia, Anniston, Bay Minette, and Birmingham. All sites were in accessible public facilities, such as post-secondary educational buildings, community meeting centers, and a tertiary level children's hospital, with free child care and donated refreshments available on site. Facilitators contracted through AUM conducted the 2-hour meetings and provided a written report of each meeting and a summary report on statewide trends. More than 60 families participated statewide in the forums.

- Qualitative and quantitative data were gathered from the perspective of county level public providers coordinating care for CSHCN through county level surveys. These surveys were developed from a similar survey compiled and utilized by the UAB School of Public Health in the 1994 MCH needs assessment to facilitate analysis. Data gathered through the surveys included information on availability of health care facilities and services for CSHCN; on perceived barriers to care; and on the status of family-centered care, care coordination, cultural competence, and strategic planning related to this population of children. A total of 68 individuals participated in the completion of the surveys, including 12 parents of children with special health care needs. The surveys were completed mainly by CRS staff and public health nurses with representation from AEIS, the Alabama Institute for Deaf and Blind, and special education in some counties. The CRS district supervisors and office coordinators distributed the surveys in April 1999 and returned them by June 1999. Follow-up was conducted with county-level workers to address missing information in July and August 1999. The results were compared with the analysis for CSHCN from the 1994 survey.
- A county profile for CSHCN was developed for each of Alabama's 67 counties that included demographic information, community/environmental indicators, service system indicators, and service utilization indicators. The data were further compiled to produce a CRS district profile for CSHCN for each of the seven CRS districts. Available statistical information was gathered from the *1999 Alabama's Kids Count*; CRS county-level staff; the professional licensing boards for nutrition, medicine, dentistry, nursing, psychology, speech-language pathology and audiology, physical therapy, and occupational therapy; the Region IV Administration for Children and Families Head Start Program; the Alabama Institute for Deaf and Blind; the Arc of Alabama; United Cerebral Palsy; Medicaid; and SDE, DHR, MHMR, ADPH, and ADRS. Information was collected only through age 20 years.
- The final advisory committee meeting, convened in October 1999, focused on presenting the findings of the gathered data and obtaining input from committee members on suggested priority needs for CSHCN. In a series of two 2-day planning meetings, the CRS Administrative Team members and CRS family representatives reviewed the findings and the public input to distinguish the top priority needs that CRS has the mission and the capacity to address. The requirements for the Block Grant reporting, the six new

performance outcomes from the National Agenda for CSHCN, and information concerning the development of performance measures were also discussed. Through a group consensus process, seven areas were identified as priorities for improvement and three State-negotiated performance measures were proposed from them for further development. A core planning team within the State Office later studied the recommendations in light of available resources and chose to fully develop two performance measures. This team also set the annual targets for the upcoming 5-year period for both the national and State-negotiated performance measures through data review and trend analysis. Annual plan activities to address the performance measures were drafted through working committees. The proposed priority needs, State-negotiated performance measures, and annual plan activities were then presented to the State Parent Advisory Committee in March 2000 and the Medical Advisory Committee in April 2000 for approval.

The strengths of methodology utilized in this needs assessment were the collaboration of families and other key stakeholders in the development of the procedures and dissemination of information on the family forums; the effort to obtain wide family input through the family forums; the utilization of a similar county-level survey of services and facilities in both 1994 and 1999 to easily distinguish areas of improvement; and the development of quantitative county profiles for CSHCN to establish baseline community/environmental, service system, and service utilization indicators to facilitate future analysis. The weaknesses were largely due to resource limitations and included the inability to obtain wider participation in the completion of the county-level surveys to increase representativeness, the inability to achieve more public awareness of the family forums to increase attendance, and the lack of baseline data on CSHCN, including data on the service system and service utilization indicators. A large-scale survey of families of CSHCN was not conducted because families on the CRS Advisory Committee were outspoken against yet another survey.

3.1.2 Needs Assessment Content

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

3.1.2.1.A Overall Demographics: Pregnant Women, Mothers and Infants; Children

Numbers of persons in various demographic groups are shown on Form D2. These are developmental indicators from a variety of sources. Because we are not aware of information pertaining to their validity, numbers regarding ethnicity, program utilization, juvenile arrests, and high school dropouts should be interpreted with caution. Nevertheless, the following estimates derived from numbers on Form D2 merit discussion, since they are the Bureau's best estimates regarding important demographic and social characteristics. Highlights based on estimates from these numbers, which pertain to 1998 unless stated otherwise, follow ("American Indian or Native Alaskan" is termed "American Indian")

- ***Distribution of live births with respect to race, ethnicity, and maternal age*** (DHS #07A-#07B)--In 1998,

66.8% of live births were white, 32.2% African American, 0.6% Asian, and 0.2% American Indian. Regarding race and maternal age, 13.3% of white infants and 25.2% of African American infants were born to adolescents (≤ 19 years). Conversely, 9.0% of white infants and 6.6% of African American infants were born to women 35 years of age and over. Regarding ethnicity of live births, 2.2% of infants were Hispanic, and 14.2% of Hispanic infants were born to adolescents. The marked increase in Hispanic births has been discussed in Section 1.4 under *Selected Changes in Alabama's Population*. (Ethnic groups overlap with racial groups.)

- ***Distribution of children/youth (0-24 years) with respect to race and ethnicity*** (DHS #06A-#06B)—66.4% were white, 32.4% African American, 0.8% Asian, and 0.4% American Indian. Regarding ethnicity of children/youth in this age group, 1.3% were Hispanic. Based on inspection of rates, neither the percentage of African American children nor the percentage of Hispanic children notably correlated with age.
- ***Utilization of TANF, SCHIP, Foster Care, and Food Stamps by children aged 0-19 years***—(DHS #09A-#09B)—Expressed as a percentage of the total number of children aged 0-19 years, 17.0% were in the food stamp program, 2.9% in TANF families, 2.1% in SCHIP, and 0.4% in foster care. (SCHIP and foster care numbers are for FY 1999, and TANF and food stamp program data are for March 2000.) Available race-specific and ethnic-specific findings (shown below) suggest that African Americans were more likely than others to be in TANF and food stamp programs; American Indians more likely than others to be in SCHIP; and, where numbers are available, Hispanics and Asians less likely than others to be in the above programs.
 - < % in TANF—1.1% of whites and 6.6% of African Americans.
 - < % in SCHIP—2.1% of whites and of African Americans, 1.2% of Asians, 3.6% of American Indians, 2.1% of non-Hispanics, and 1.7% of Hispanics.
 - < % in foster care—0.4% of non-Hispanics and 0.2% of Hispanics.
 - < % in food stamp program—9.3% of whites, 32.8% of African Americans, 4.2% of Asians, 8.6% of American Indians, 17.2% of non-Hispanics, and 3.8% of Hispanics.
- ***WIC utilization***—In contrast to the race-specific program utilization indicators discussed above, Hispanics were apparently more likely than other groups to be enrolled in WIC. That is, expressed as the number of WIC enrollees per 100 children aged 0-4 years (because WIC serves children through 4 years of age), this ratio was 33.5 WIC enrollees per 100 children aged 0-4 for non-Hispanics and 65.6 WIC enrollees per 100 such children for Hispanics. By race, the corresponding ratio ranged from 24.8 per 100 children aged 0-4 years for whites to 53.9 per 100 such children for African Americans. At 26.7, the corresponding ratio for Asians was similar to that for whites.

- **Juvenile arrest rate**—Expressed as the number of juvenile crime arrests for every 100 children aged 10-19 year, this ratio was 6.2 arrests per 100 juveniles for the total group, 4.7 arrests per 100 juveniles for whites, and 9.2 arrests per 100 juveniles for African Americans. This ratio should be viewed with particular caution, since ages used for denominators may not correspond well to ages of “juveniles.” (Corresponding numbers reported on Form D2 (DHS #09A) are per 100,000 children aged 10-19 years.)
- **High school dropout rate**—Based on numbers provided by SDE for the 1998-99 academic year, 4% of public high school students dropped out during that time period. Corresponding race- or ethnic-specific rates were 4% for white students and African American students, and 2% for American Indian and Asian students, and 6% for Latino students. Students attending private schools, who presumably have a lower high school dropout rate, are not included in these numbers.

3.1.2.1.B Health Status: Pregnant Women, Mothers and Infants

Findings from Community Forums and Focus Groups

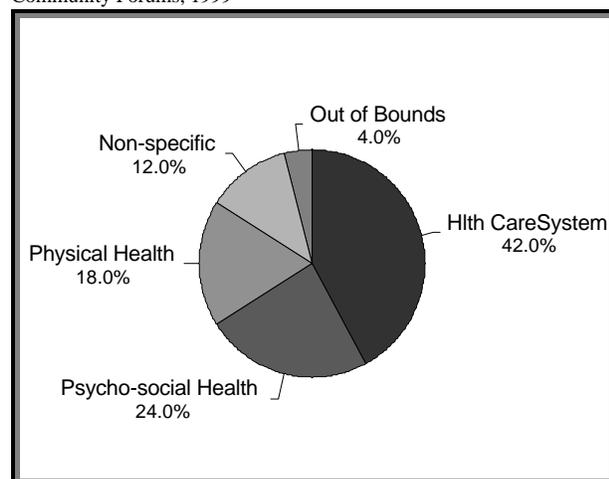
Note: Findings from community forums and focus groups are overarching and apply to children as well as to pregnant women, mothers and infants.

Community Forum Findings

Although many of the same themes arose throughout, every community forum and focus group produced vastly different individual results. The types of concerns that were raised at community forums differed from those brought up at focus groups, and each kind of focus group had its own priorities. Comments by participants were varied but thoughtful and important to people at the community level. Many of the concerns expressed were those that had been raised by Bureau staff or other professionals external to the Department in other aspects of the Needs Assessment process.

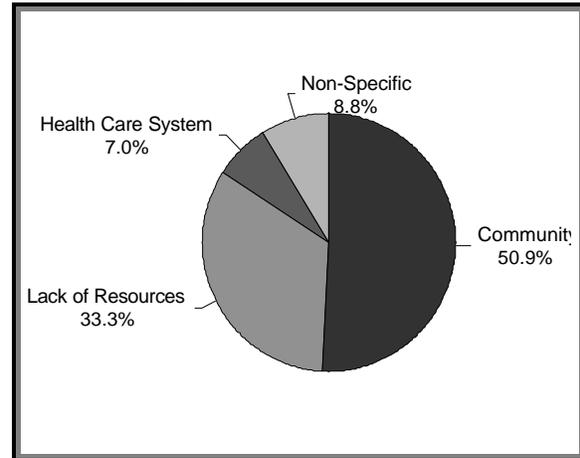
During the community forums, respondents were asked, “What do you believe are the **2-3 most important health care problems** that must be addressed to improve the health and quality of life of children and families in our community?” (Figure 9). The overwhelming theme of the responses was problems with the health care system (42.0%). Specifically, communities are concerned about gaps within the system, limitations of the system, and access to the system. Individual examples include

Figure 9. Themes of Important Health Care Problems, Alabama, Community Forums, 1999



“too many of the working class do not have insurance” and “lack of understanding by community of available resources.” The communities are concerned about not only having the necessary services in place but also allowing everyone physical and monetary access to those services. In addition to the health care system, Alabamians are concerned about their psychosocial health (24.0%) as well as their physical health (18.0%). Interestingly, physical health responses were third in frequency.

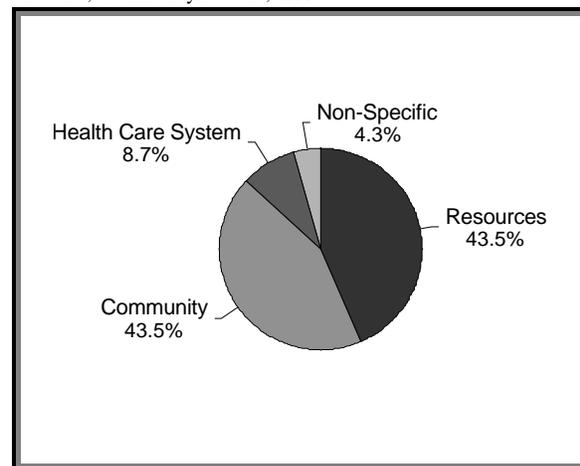
Figure 10. Themes of Barriers to Access to Adequate Health Care, Alabama, Community Forums, 1999



In addition to health care problems in Alabama, community members were asked, “What do you believe is *keeping our community from doing what needs to be done* to improve access to adequate health care for families and children in our community?” Surprisingly, most responses fell into the theme regarding *barriers within the community itself* (50.9%) (Figure 10). For example, within the community barriers theme, residents were concerned very much about the support and attitude of the community (51.7%) as well as leadership support (24.1%). Another big issue within the community barriers theme was communication within the community (24.1%). Specific examples of responses to this question included “the county needs to make a paradigm shift in thinking—the vision to see the bigger picture” and “city governments don’t communicate with one another thus increasing disconnectedness.” The second important barrier to access was the *lack of resources* within the communities (33.3%). The lack of resources theme included the following sub-themes: lack of personal and organizational funding (42.1%), lack of time (10.5%), lack of education (10.5%), and lack of manpower (5.3%). One community member said, “Normal time constraints in a day. Spirit is there but time don’t permit to do things in community that they would like to do.”

When asked, “What do you believe are the *underlying causes or reasons for these barriers* to health care?”, respondents listed two main problems: resources (43.5%) and community issues (43.5%) (Figure 11). Within the *resources* theme, residents were having trouble obtaining health care because they lacked money (50.0%), transportation (30.0%), education (12.0%), and child care (10.0%). Important concerns within the *community issues* theme included lack of effective

Figure 11. Themes of Underlying Causes of Barriers to Access, Alabama, Community Forums, 1999



communication (60.0%), problems with family dynamics and parenting skills (30.0%), and lack of leadership (10.0%). Community members expressed that “educating parents to get involved in children’s educational and personal lives” is important. Moreover, “no one (knowing) whose responsibility it is to inform the community regarding services” is a challenge.

Overall, most (67.7%) responses were concerns with a deficiency in resources (38.3%) and issues concerning the community (29.4%) such as communication, cultural differences, support, and leadership. In addition, the forums revealed that residents are not nearly as concerned with physical health problems themselves but with other aspects of health care such as system failures. Responses are discussed further in Sections 3.1.2.2-3.1.2.5, where many are categorized based on the core public health service levels.

Focus Group Findings

The focus groups studied—respectively targeted to teenagers, parents, and professionals caring for women—also supported findings similar to those found in other analyses. Furthermore, although the populations in the three types of focus groups were very different, often similar concerns were raised. Although most comments were included, some were excluded from any category as they were nonspecific or out of bounds.

Adolescent Focus Groups

The adolescents were given surveys to complete at their focus groups. The teens were asked, “***What types of concerns are important*** to you in your life—things that you think a lot about or are concerned about?”.

Respondents were free to check as many of the following choices as applied: being depressed, not graduating, teen pregnancy, contracting STDs, being angry, being poor, being abused, other concerns, and no health care. Being depressed (40.2%) was of greatest concern to the teens. Following second was not graduating (37.9%). Teen pregnancy and contracting STDs tied for third (26.4%). The other types of concerns ranged from 21.8% for being angry down to 14.9% for having no health care.

In another question, teens were asked to ***rank the top five problems*** that they thought needed more attention out of the sixteen problems listed: early sexual activity, teen pregnancy, alcohol abuse, cigarette smoking, depression, drunk driving, assault and homicide, drug and alcohol abuse, suicide, youth gangs, school violence, lack of recreational facilities, community violence, mental illness, injuries, and other problems. The problems that teens thought needed more attention than any other were early sexual activity and teen pregnancy. A graph showing the other rankings can be found in Appendix J.

The third question analyzed asked teenagers, “What ***health care services*** are needed by many teens you know?”. Respondents were given the following options and instructed to select as many as applied: family planning, child

health clinics, teen clinics or centers, maternity clinic, more local physicians, walk-in STDs including AIDS testing, community health centers, and other. The two most needed services according to this group of teens were a teen clinic (52.2%) and an STDs and AIDS clinic (38.3%). The remaining selections were chosen 32.2% (family planning) of the time to 5.2% (other services) of the time.

Finally, teens were asked to rank the three main *reasons that services were unavailable* to them from the following list: none provided in area, no health insurance, have insurance but provider will not accept the insurance plan, have health insurance but no provider, no transportation, or other. No insurance was ranked first among these reasons as to why teens were unable to get services. None provided was ranked second with the “other” category last behind no provider.

Women’s Health Focus Groups

Professionals who care for women were also surveyed at a focus group on women’s health. Professionals were given a chart listing a series of *health concerns*. Each professional was asked to respond regarding whether the issue was not a problem at all, somewhat of a problem, or a very serious problem. The following issues are those that the professionals were asked to evaluate: premature sexual activity in teens, unplanned pregnancy, illicit alcohol and drug use, single parenting, infant mortality, domestic violence between adults, violence in the community, lack of appropriate recreational facilities for children, sexual abuse of children, physical abuse of children, low household income, depression, low educational achievement, access to quality day care, and other. The results were tallied to determine what percentage of the participants responded “a very serious problem” to each issue. Results were then ordered by percentage to denote importance to the population questioned. Early sexual activity (85.7%) and unplanned pregnancy (76.2%) seemed to be of greatest concern to this group followed by alcohol and drug use (71.4%) and single parenting (66.7%). Of least importance to this group was infant mortality (28.6%), access to day care (28.6%), depression (19.0%), and other (9.5%).

Professionals caring for women were also asked *why* they thought that *services were unavailable for pregnant and nonpregnant women* of child-bearing age. The following options were provided: lack of transportation, no health insurance, service not covered, service not provided, insurance not accepted, have insurance but there is no provider, and other. Overwhelmingly, the professionals felt that lack of transportation (71.4%) was the reason that pregnant women were unable to access services. In contrast, for nonpregnant women, lack of transportation (47.6%) and no health insurance (47.6%) were given equal weight in denying women access to services. “Other” (4.8% and 0%, respectively) and lack of a provider that would accept insurance (4.8% and 4.8%) were not felt to be barriers for either pregnant or nonpregnant women.

Focus Group Targeting Consumers of Health Care for Children

The final type of focus group conducted was for adult consumers of health care for children. The participants included caretakers of children. When asked to **rank the same issues as potential problems** that the women's professionals did, they too thought, overall, that early sexual activity (88.7%) in teens was the most serious problem. Alcohol and drug use (84.5%), single parenting (76.1%), and unplanned pregnancy (73.2%) were also on the list of very serious problems. Like the women's health professionals, consumers viewed access to day care (35.2%), infant mortality (29.6%), and other (14.1%) as much less serious.

Responses obtained through community forums and focus groups often times reinforced the Bureau's findings from other data sources. However, the communities' input into the Needs Assessment enriched the process and helped Bureau staff to include the people of Alabama in the effort to identify the State's priority needs.

Vital Statistics: Pregnancy-Related Indicators

Notes on Methods #2:

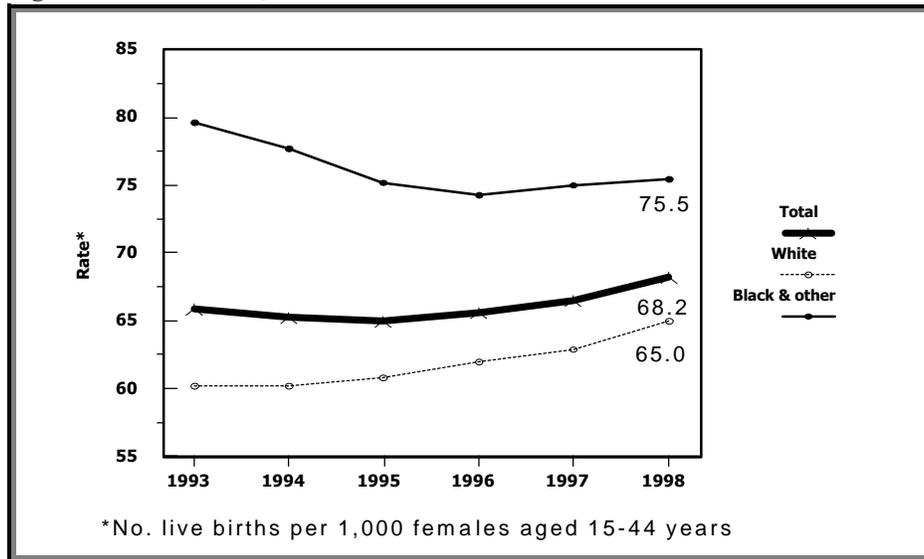
Sources for numbers pertaining to fertility or birth rates, pregnancy rates, abortion rates, and adolescent/teen pregnancy rates are various annual CHS publications or preliminary numbers provided by CHS for CY 1998. These publications use the race-specific categories of white and "black and other," so findings in this document based on these publications use that terminology. The term "significantly," when used, pertains to statistical significance or the lack thereof at the 0.05 level, per comparison of 95% confidence intervals based on the Fleiss quadratic method. Differences were deemed not to be statistically significant if confidence intervals overlapped. The statistical significance of year-to-year changes is not generally mentioned (though often assessed) in this subsection, however, unless deemed necessary to emphasize a notable change or restrain over-interpretation of a potentially minor change. The most recent values for each pregnancy-related indicator are shown in figures, so are not generally repeated in the narrative.

Various pregnancy-related indicators, though analyzed as part of the Bureau's Family Planning Needs Assessment and reported in that program's recent progress report/application, pertain to Title V's Pregnant Women, Mothers and Infants population.

Women of Childbearing Age

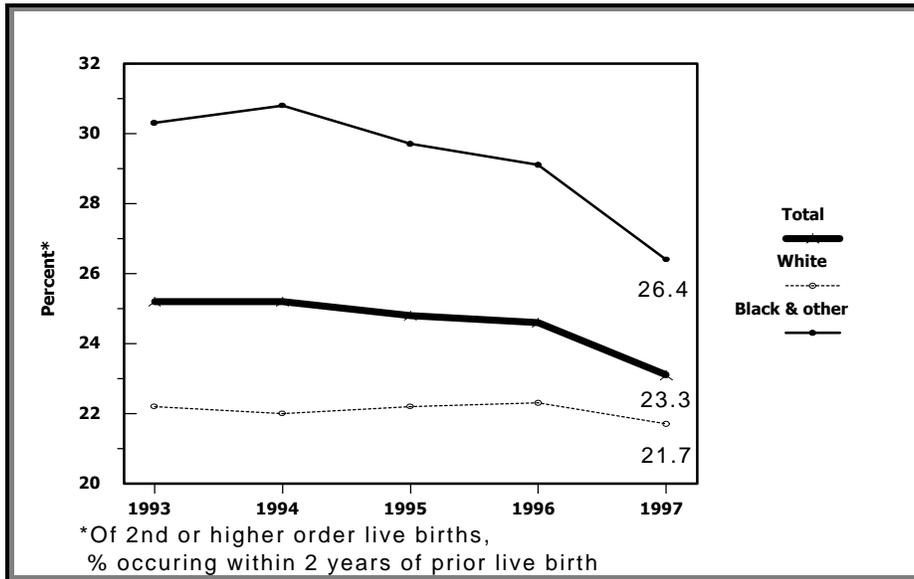
- The **general fertility rate** (number of live births per 1,000 females 15-44 years of age) declined in 1994 and 1995, then increased each year through 1998, when it was 3.5% above the 1993 baseline. Among white women, after remaining stable for 2 years, the rate increased each year through 1998, when it was 8% above the 1993 baseline. The rate among black and other women declined early in the surveillance period before increasing in 1997 and again in 1998, when it was 5% below the 1993 baseline (Figure 12).

Figure 12. General Fertility Rate, Alabama, 1993-1998



- The percentage of *births that occur within 2 years of a previous birth* is an important indicator of the effectiveness of efforts to space pregnancies in an optimal manner. This indicator is reported here only for live births: that is, as the percentage of live born infants who were born within 2 years of a previous live birth. Trends in this indicator from 1993-1997 are shown in Figure 13. From the 1993 and 1994 baselines, this indicator of short inter-pregnancy interval declined in 3 successive years and was 7% lower (better) in 1997 than in 1994. Among white females, this indicator was stable for 4 years, then declined 2.5% (not significantly) in 1997. Among black and other females, however, after increasing in 1994, this indicator declined in 3 successive years and, in 1997, was 14% lower than in 1994.

Figure 13: Percentage of Live Births that Occurred Within 2 Years of a Previous Live Birth, Alabama Residents, 1993-1997



- The *live birth prevalence of unintended pregnancy* was about 48% in 1998. In that year, it tied for the lowest prevalence during individual years from 1993-1998. However, each of the 95% confidence intervals for individual years overlaps with one another (Figure 14). The overall live birth prevalence of unintended

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Figure 14. Live Birth Prevalence of Unintended Pregnancy (with confidence intervals), Alabama Residents, 1993-1998

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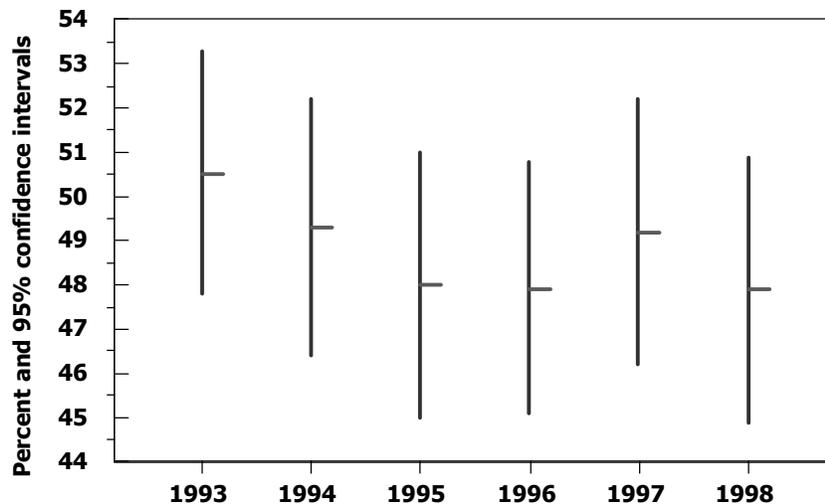
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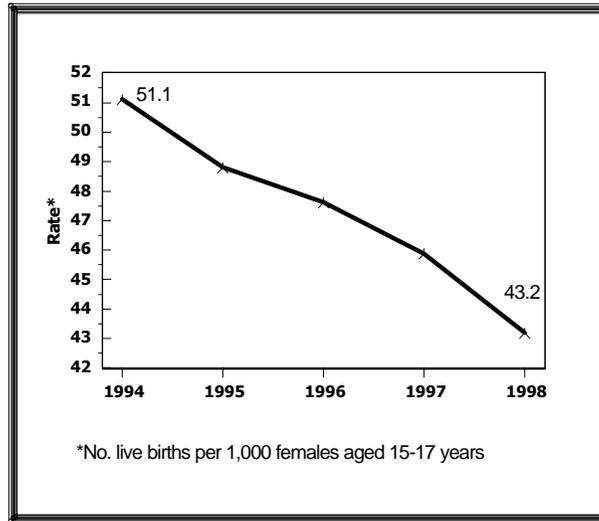
Estimated % of live births that were from unintended pregnancies, per PRAMS data (horizontal lines), with 95% confidence intervals (vertical lines)

Adolescent Pregnancy

Various socioeconomic disadvantages and suboptimal health outcomes, including infant mortality, have been linked with ***adolescent pregnancy***. Though these links are not necessarily causal, some factors that predispose an adolescent to become pregnant may also place her infant at higher risk of death. Prevention of adolescent pregnancy is generally desirable, therefore, to allow the adolescent additional time to mature and avail herself of social and economic opportunities before assuming the responsibilities of motherhood. Moreover, even though links between adolescent pregnancy and adverse pregnancy outcomes should not be assumed to be causal in nature, the adolescent live birth rate is an important indicator of infants who may be at greater risk of morbidity and mortality.

- Figure 15 shows the ***live birth rate for adolescents aged 15-17 years (CP #06)***, which notably declined (by an average of 4% per year), from 51.1 births per 1,000 females in this age group in 1994 to 43.2 births per 1,000 such females in 1998.

Figure 15. Adolescent Live Birth Rate, 15-17 Years of Age, Alabama, 1994-1998



- Repeat adolescent pregnancies especially merit monitoring, since they may represent missed opportunities by health care providers to encourage pregnancy prevention. The *“repeat adolescent live birth rate”* (number of live births of second or higher live birth order to adolescents aged 10-17 years, per 1,000 such female adolescents) for 1993-1998 is shown in Figure 16. After remaining stable for 3 years, this rate declined 3 years in succession and was 25% lower in 1998 than in 1993, with this decline occurring in black and other females. That is, the rate among black and other adolescents declined each year (from the 1993 baseline), and was 34% lower in 1998 than in 1993. Among white adolescents, the rate increased early in the surveillance period, then declined to the 1993 level.

Figure 16. Repeat Adolescent (10-17 Years of Age) Live Birth Rate, Alabama, 1993-1998

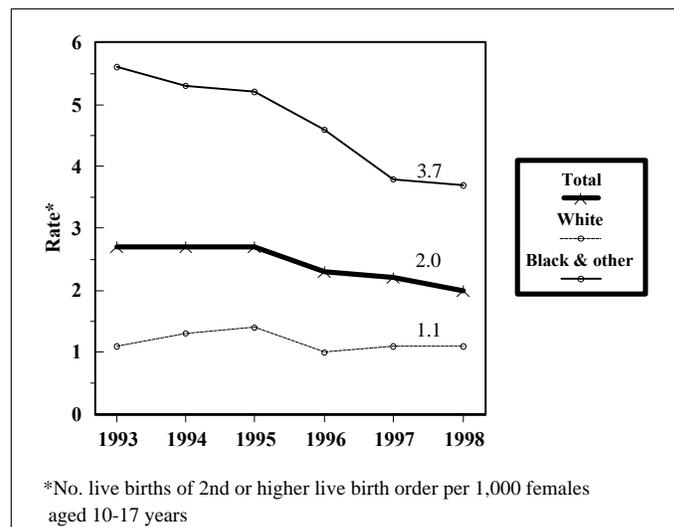


Figure 17. Adolescent (<=19 Years of Age) Pregnancy Rates, Alabama, 1994-1998

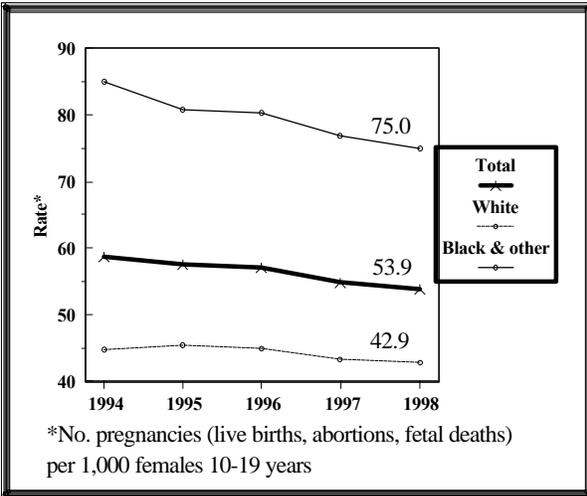


Figure 18. Youngest (< 15 Years of Age) Adolescent Pregnancy Rates, Alabama, 1994-1998

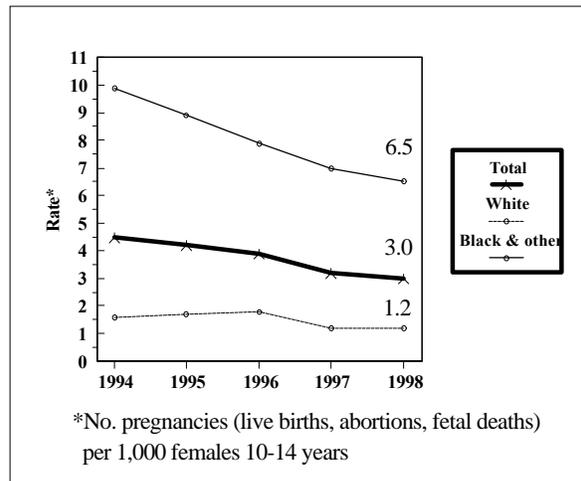


Figure 19. Middle (15-17 Years of Age) Adolescent Pregnancy Rates, Alabama, 1994-1998

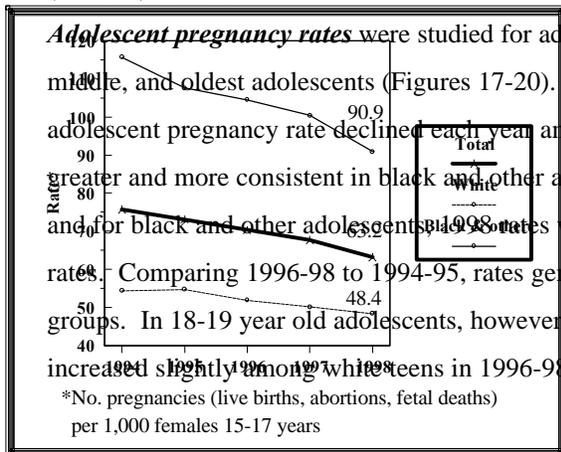
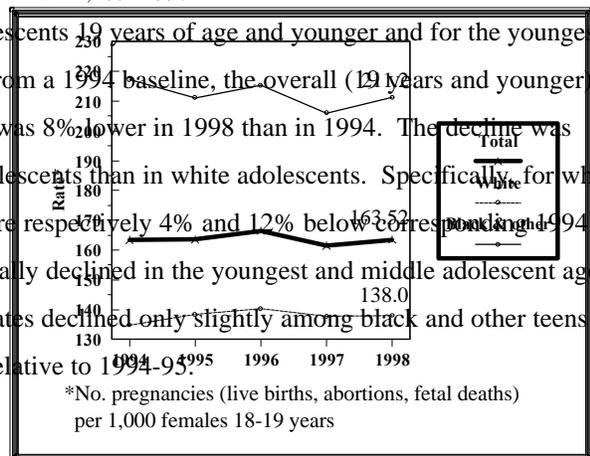


Figure 20. Oldest (18-19 Years of Age) Adolescent Pregnancy Rates, Alabama, 1994-1998



- Adolescent pregnancy rates** were studied for adolescents 19 years of age and younger and for the youngest, middle, and oldest adolescents (Figures 17-20). From a 1994 baseline, the overall (19 years and younger) adolescent pregnancy rate declined each year and was 8% lower in 1998 than in 1994. The decline was greater and more consistent in black and other adolescents than in white adolescents. Specifically, for white and for black and other adolescents, 1998 rates were respectively 4% and 12% below corresponding 1994 rates. Comparing 1996-98 to 1994-95, rates generally declined in the youngest and middle adolescent age groups. In 18-19 year old adolescents, however, rates declined only slightly among black and other teens and increased slightly among white teens in 1996-98 relative to 1994-95.

- After perhaps declining slightly in 1996 and again in 1997, the *live birth prevalence of unintended*

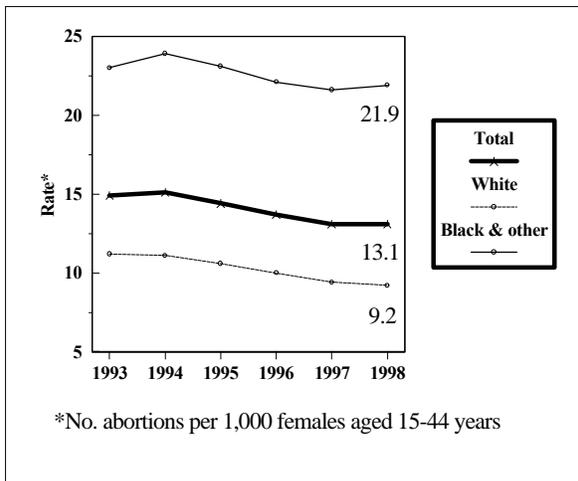
pregnancy among adolescents (age 10-19) may have increased in 1998. That is, per PRAMS estimates, 80% of live births to Alabama adolescents were from unintended pregnancies in 1998—up from 74% in 1997. Data for estimating confidence intervals were not available to Bureau staff, however, so the increase may have been due to random fluctuation (especially since PRAMS is based on a sample, rather than the total population).

Abortion Rates

Ceteris paribus, effective family planning programs should reduce **abortion rates**, which are depicted in Figures 21-24.

- After rising by 1% in 1994, the rate declined for 3 successive years. Though the rate did not decline further in 1998, it was 13% lower than in 1994 (Figure 21). Among white females, the rate declined every year (from the baseline) and was 18% lower in 1998 than in 1993. Among black and other females, the rate increased slightly in 1994, then declined in 3 successive years, but increased slightly (by 2%) in 1998.

Figure 21. Abortion Rates, Alabama, 1993-1998



and other older adolescents, and was 23% lower in 1998 than in 1994. Among black and other younger adolescents, the rate increased (not significantly) in 1998, but was still 34% lower than in 1994. Among 20-49 year old black and other women, however, the rate increased notably (by 4%), though not significantly, in 1998.

- Figures 22-24 depict abortion rates by race and age group (10-14, 15-19, and 20-49 years) for 1994-1998. During the surveillance period, rates generally declined among white females of all ages (notable exception: white adults in 1995). The rate also consistently declined among black

Figure 22. Abortion Rates for Adolescents 10-14 Years of Age, Alabama, 1994-1998

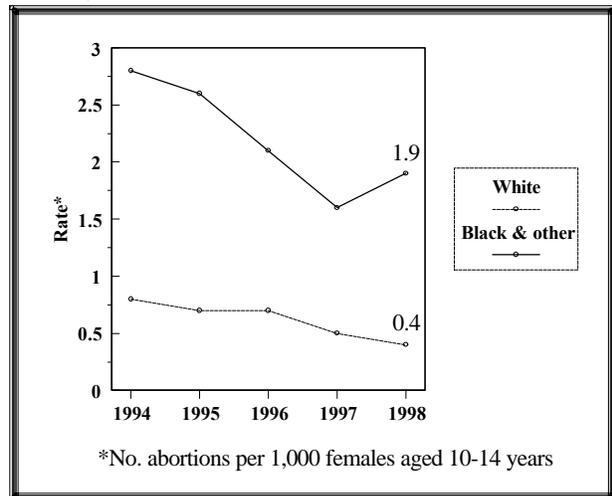
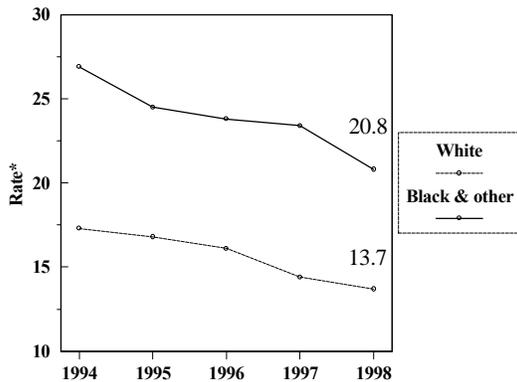
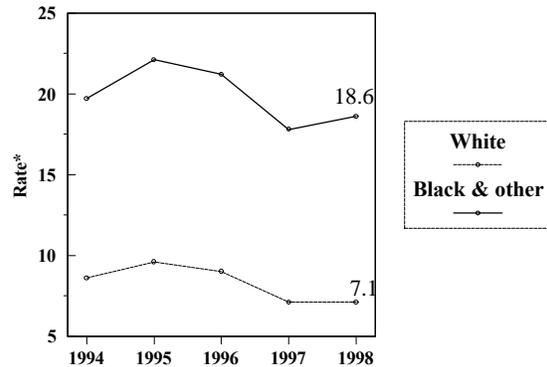


Figure 23. Abortion Rates for Adolescents 15-19 Years of Age, Alabama, 1994-1998



*No. abortions per 1,000 females aged 15-19 years

Figure 24. Abortion Rates for Women 20-49 Years of Age, Alabama, 1994-1998



*No. abortions per 1,000 females aged 20-49 years

Vital Statistics: Overview of Pregnancy, Perinatal, and Infant Mortality Indicators by Selected Subgroups

Notes on Methods #3:

A review of NCHS definitions for birth cohort linked files versus period linked files is pertinent to understanding the various data sources utilized for findings presented in this document regarding live births and infant (less than 1 year of age) deaths. In a period linked file the numerator file consists of all infant deaths of babies who *died* during the specified year or period, e.g., 1997, that have been linked to their corresponding birth certificates, whether the birth occurred in that year (per this example, 1997) or the previous year (per this example, 1996). In contrast, in the birth cohort linked file for 1997, for example, the numerator file consists of all infant deaths to babies *born* in 1997, whether the death occurred in 1997 or 1998. For both types of files, the denominator file is the natality file for the specified year (per this example, 1997), which contains all live births during that year.

Because birth cohort linked files have methodological advantages and are generally somewhat more complete and more fully edited than ADPH's period files, most of the findings reported in *Section 3.1* for years through 1997 are based on analyses by Bureau staff of birth cohort linked files. Because birth cohort files have not been prepared for 1998, any findings for that year are based on period files. Certain assumptions are required for interpretation of infant mortality estimates from period files, and these assumptions become increasingly less valid as the size of subgroups being analyzed diminishes. Thus, most infant mortality findings reported in *Section 3.1* are for 1997 or earlier years, not for 1998. Any mortality findings pertaining to 1998 are based on period files. Findings based on analysis by Bureau staff of birth cohort files through 1997 or period files for 1998 are likely to differ slightly from corresponding estimates shown on this document's electronic reporting package forms. The reason for these differences is two-fold. First, birth and mortality data reported on forms are necessarily based on ADPH's period

files (described below). Secondly, when analyzing 1998 period files, Bureau staff selected infant deaths based on the mother's residence, while the statistical files described below select them based on the decedent's residence. Because of the methodological advantages of the birth cohort linked files, however, the Bureau's analytic staff consider them preferable for purposes of the needs assessment and have used them whenever feasible.

The main advantages of period files are that they are available in a more timely fashion and less time consuming to prepare. (In contrast, birth cohort files cannot be prepared until the close of the year following the births in order to include all infants who died before their first birthday.) For these reasons, ADPH's "statistical" files, which are period files, are used for all estimates reported on forms. Estimates reported from these files for 1998 are still somewhat preliminary, in the sense that many of them were taken from draft CHS publications which had not been fully edited. Moreover, any estimates for 1999 are *extremely* preliminary, since editing of 1999 files is in the very early stages. They are reported on forms (and occasionally discussed in the narrative pertaining to health status indicators) to meet federal reporting requirements, but should not be utilized for policy decisions until the files have been further edited. Final mortality rates are often slightly higher than preliminary estimates and, given the extremely preliminary nature of our 1999 estimates, final mortality estimates for 1999 may be notably greater than those reported in this document.

Findings reported under the subheading to which this *Notes on Methods* applies are based on analysis of recent 3-year periods: 1996-98 for natality (birth certificate) estimates and 1995-97 for mortality estimates. Unless stated otherwise (for fetal deaths, for example), all findings pertain to Alabama residential live births during the specified 3-year period. The rationale for combining 3 years of data is to minimize statistical imprecision, which, *ceteris paribus*, increases as the size of the subgroup analyzed decreases.

The source of payment for delivery designation is based on birth certificate data. Alabama's birth certificate includes an item inquiring about the main source of payment for the birth, with the following check box items: Medicaid, private insurance, self pay, and other. Presumably, many of the "self pay" group have no health insurance and are unable to fully pay the cost of delivery. Mothers whose delivery was funded by Medicaid are referred to in this document as Medicaid-enrolled mothers, though many of them were probably not enrolled in Medicaid at the beginning of their pregnancy. Race is according to the mother's race.

Cause of death classifications used for this report differ somewhat from those used by NCHS. For example, deaths described in this report as being due to infections include some infections that may not be included in NCHS categories designated for infections, and deaths due to prematurity, as designated in this report, include conditions related to prematurity that are not included in the ICD-9-CM category of short gestation and related disorders.

Most of the methodological notes above apply to all analyses of vital statistics data reported for the needs assessment, with the exception that single years, rather than 3-year periods, are often studied.

Reducing disparities in health status is a major concern of the State, as well as the Nation. Accordingly, many indicators have been respectively analyzed by race and, as a surrogate for socioeconomic status, source of payment for delivery. Additionally, most of these indicators have been analyzed by maternal age.

The following discussion of Figures 25-50 organizes indicators according to whether they pertain mainly to the relatedness of the characteristics used to define the subgroups (race, source of payment, and maternal age); to other risk markers; to health care system issues, pregnancy outcome, or mortality; or to effect modification. Although the indicators pertaining to systems issues pertain to several levels of the service pyramid, they are discussed here in order to provide a more comprehensive picture of the subgroups under discussion. Because the purpose is to describe general patterns observed (as well as because of time constraints), the discussion does not consider statistical significance of findings or precision of estimates. (Unless stated otherwise, findings with fewer than 16 events in the numerator are not displayed, however.) These findings, highlights of which are summarized at the end of this subheading, present a wide-angle snapshot of a 3-year period, rather than a description of trends or a focused description of one or two subgroups. Following the concluding summary of this subsection, discussion will focus on trends in selected indicators and especially on racial disparities.

Figures 25-28 illustrate that ***race, source of payment for delivery (a surrogate for economic status), and maternal age are related***. Deliveries of African American babies were more likely to be Medicaid funded than deliveries of white babies or babies of other races. Similarly, deliveries of babies born to adolescent mothers were more likely to be Medicaid funded than deliveries of babies born to older mothers (Figure 25). Deliveries of infants of other races were notably more likely to be self pay than deliveries of white or African American infants (Figure 26). African American babies and babies whose delivery was funded by Medicaid were more likely to have adolescent mothers (whether younger or older adolescent) than, respectively, white babies and babies whose mothers had private insurance (Figure 27). Similarly, African American babies and babies whose mother was enrolled in Medicaid were more likely to have adolescent mothers who had previously been pregnant than were, respectively, white babies or babies whose mothers had private insurance (Figure 28). Thus, the subgroup-defining characteristics are related to one another. Accordingly, any racial differences, for example, may be partly or largely due to socioeconomic differences. Similarly, differences among maternal age groups may be partly or largely due to socioeconomic differences, rather than maternal age per se, especially for older adolescents (17-19 years).

Figure 25. Percent of Medicaid-funded Deliveries, Alabama, 1996-1998

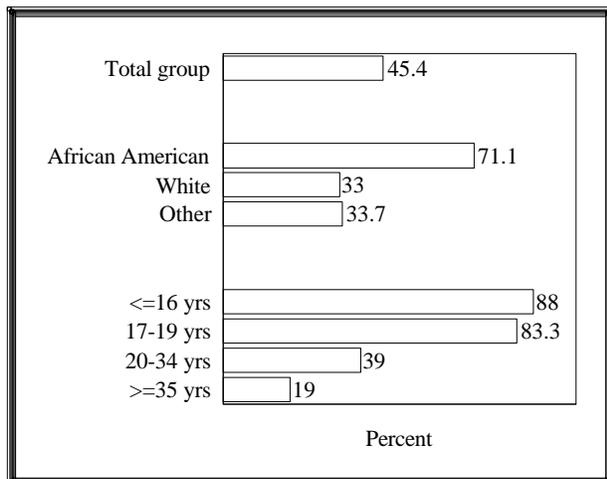


Figure 26. Percent of Self Pay Deliveries, Alabama, 1996-1998

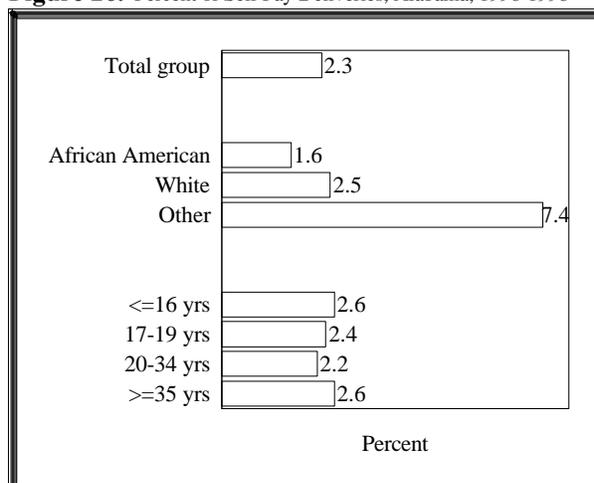


Figure 27. Percent of Infants Born to Adolescent Mothers, Alabama, 1996-1998

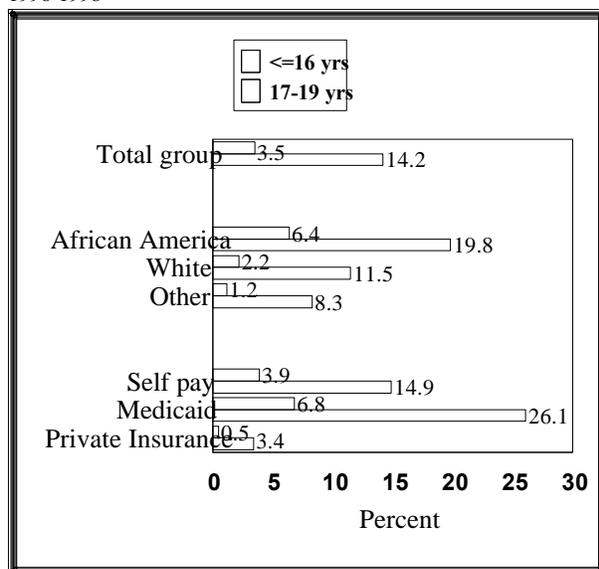
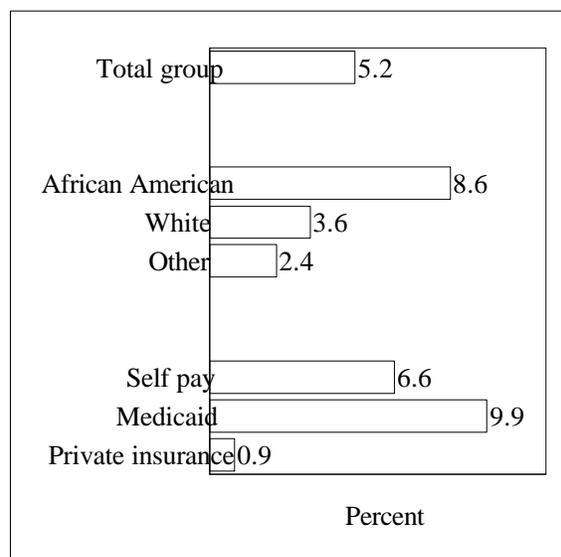


Figure 28. Percent of Infants from Repeat Adolescent Pregnancies, Alabama, 1996-1998



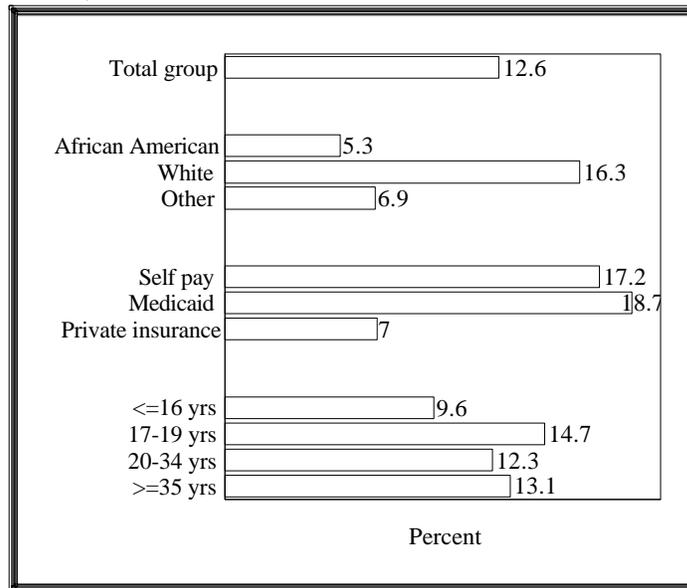
Other Risk Markers

Compared to white mothers or mothers of other races, African American mothers were more likely to have previously had a *live-born infant who later died* (1.8% of African American mothers, versus 1.1% of white mothers and 1.5% of other mothers). With respect to source of payment for delivery, mothers who “self paid” for the delivery were more likely to have had a previous live-born infant who died than either mothers with Medicaid or mothers with private insurance. Medicaid enrolled mothers were more likely to have this history than private

insurance mothers.

African American mothers and mothers of other races were less likely to have *used tobacco during the pregnancy* than white mothers were. In fact, white mothers were about three times more likely to have smoked during pregnancy than African American mothers (Figure 29). Medicaid-enrolled and self-paying mothers were more likely than privately insured mothers to have smoked during pregnancy, and older adolescent mothers more likely than any other age group to have done so.

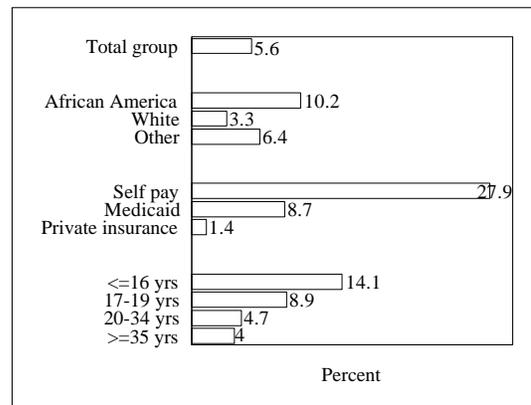
Figure 29. Percent of Infants Whose Mother Used Tobacco During Pregnancy, Alabama, 1996-1998



Health Care Systems Issues

Whether defined as receiving inadequate prenatal care, receiving no prenatal care, or receiving late (after the first trimester) prenatal care, African American women were more likely to receive *insufficient prenatal care* than white women or women of other races (Figures 30-32). Women of other races were more likely, however, to receive insufficient prenatal care than white women. Self-paying mothers were much more likely to receive inadequate prenatal care or no prenatal care than either Medicaid-enrolled mothers or privately insured mothers, and about as likely as Medicaid-enrolled mothers to enter care after the first trimester. No matter how defined, both Medicaid-enrolled mothers

Figure 30. Percent of Women Receiving Inadequate Prenatal Care (Kessner Index), Alabama, 1996-1998



and self-paying mothers were more likely to receive insufficient prenatal care than privately insured mothers. In general, the younger the mother's age, the more likely she was to receive insufficient prenatal care.

Figure 31. Percent of Infants Born to Mothers with No Prenatal Care, Alabama, 1996-1998

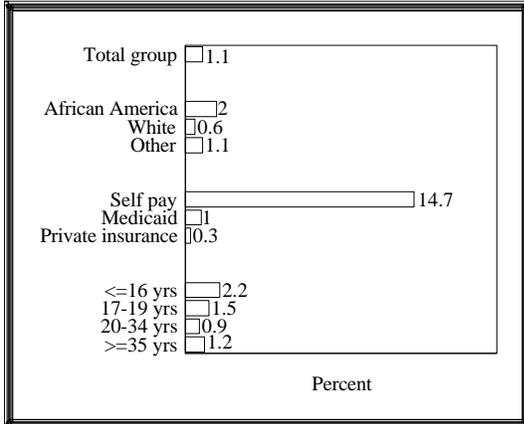
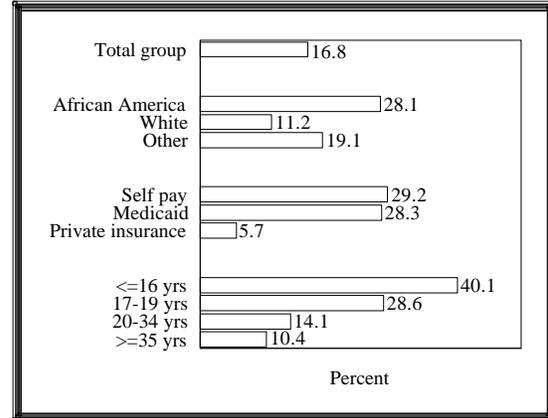
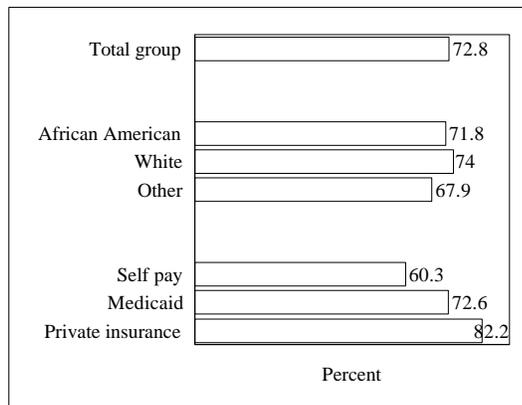


Figure 32. Percent of Infants Born to Mothers Receiving Late Prenatal Care, Alabama, 1996-1998



The percentage of VLBW (<1,500 g) infants born at perinatal centers did not notably vary by race, but did notably vary by source of payment for delivery (Figure 33). VLBW babies of self-paying mothers were least likely to be born at perinatal centers, and VLBW babies of Medicaid-enrolled mothers were less likely to be born at perinatal centers than babies of privately insured mothers.

Figure 33. Percent of <1,500g Infants Born at Perinatal Centers, Alabama, 1996-1998

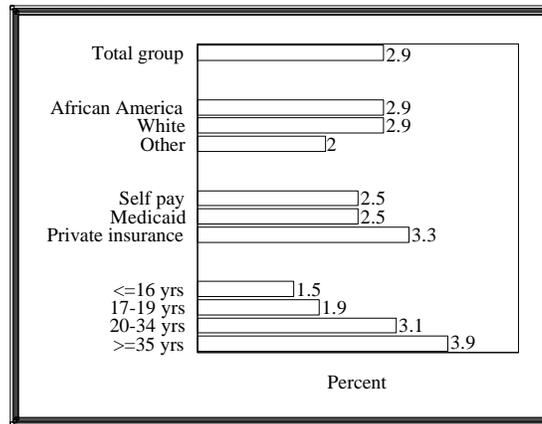


Pregnancy Outcomes

African American mothers and white mothers were more likely than mothers of other races to have *multiple births* (twins, triplets, etc.), and privately insured mothers were more likely than self-paying or Medicaid-enrolled

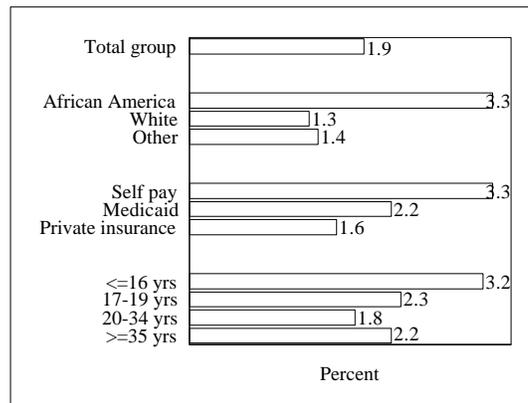
mothers to have such births (Figure 34). The proportion of multiple births increased with maternal age.

Figure 34. Percent of Infants from Multiple Births, Alabama, 1996-1998



African American mothers were more than twice as likely to have *VLBW* babies than white mothers or mothers of other races, with the latter two groups having similar proportions of *VLBW* infants (Figure 35). Self-paying mothers were notably more likely than either Medicaid-enrolled mothers or privately insured mothers to have *VLBW* babies, and Medicaid-enrolled mothers more likely than privately insured mothers to have *VLBW* babies. Adolescent mothers were more likely than older mothers to have *VLBW* babies, with the youngest adolescents being most likely to have such babies.

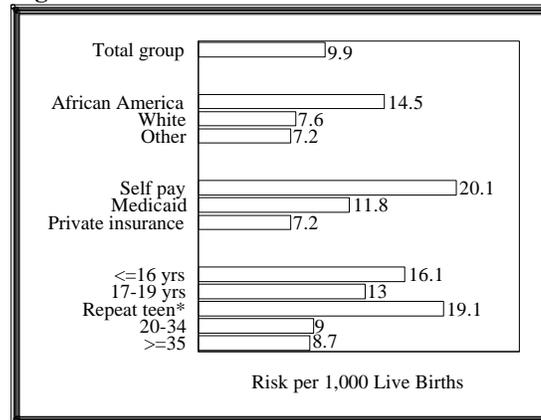
Figure 35. Percent of Live-Born Infants who were *VLBW*, Alabama, 1996-1998



Mortality

African American babies were at greater risk of *infant death* than white babies (Figure 36). With respect to source of payment for birth, infants of self paying mothers were most likely to die, and infants of Medicaid-enrolled mothers more likely to die than those of privately insured mothers. With respect to maternal age, infants of adolescents who had been pregnant before the referent pregnancy were most likely to die. Infants of younger adolescents were more likely to die than those of older adolescents, and infants of both younger and older adolescents were more likely to die than those of older mothers.

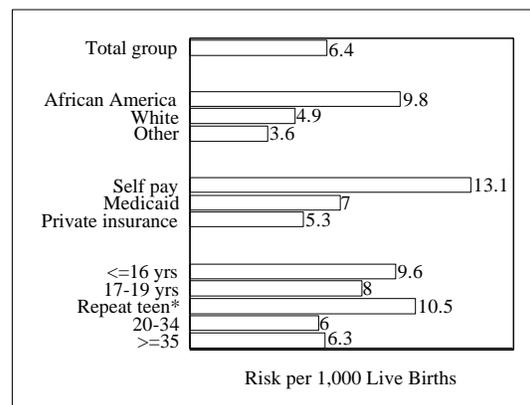
Figure 36. Risk of Infant Death, Alabama, 1995-1997



Similar patterns were

observed with respect to *neonatal death*. The African American versus white mortality gap was wider for deaths under 1 day of age than for overall neonatal mortality, and that for overall neonatal mortality wider than that for postneonatal mortality (Figures 37-39). On the contrary, the self-pay versus private-insurance mortality gap and the Medicaid versus private-insurance gap were widest for postneonatal mortality. For all mortality indicators shown in Figures 36-39, self payment for delivery was a stronger risk marker than Medicaid payment or African American race. For overall infant mortality and neonatal mortality,

Figure 37. Risk of Neonatal Death, Alabama, 1995-1997



African American race was a stronger risk marker than Medicaid payment. That is, the racial gap in infant and neonatal mortality was wider than the Medicaid versus private insurance gap. Conversely, Medicaid payment was a stronger risk marker than African American race for postneonatal mortality. Later in this report, adolescent pregnancy is assessed as a risk marker for infant mortality per analyses stratified by race and by source of payment.

Figure 42. Risk of Infant Death, 500-2,499g Infants, Alabama, 1995-1997

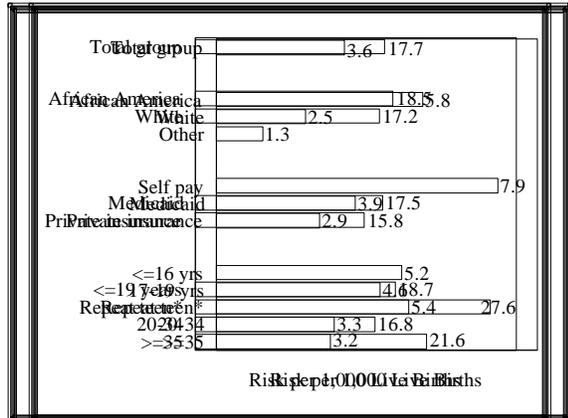
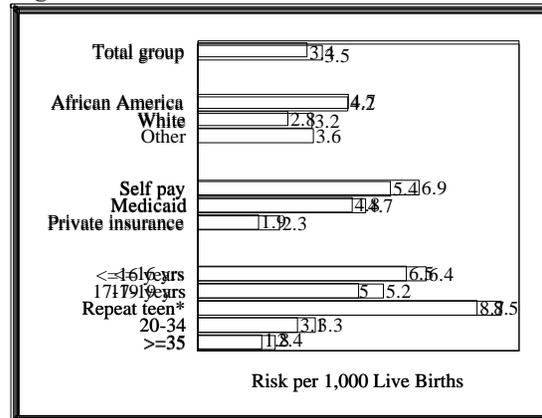


Figure 43. Risk of Infant Death, 2,500-4,249g Infants, Alabama, 1995-1997



Infant mortality within each subgroup studied was *stratified by birth weight* (Figures 40-43). For both VLBW categories, as expected, African American infants were reportedly at lower risk of death than white infants. For 500-749 gram (g) infants, the direction of risk was also reversed with respect to source of payment: That is, in this weight group, babies of self paying mothers were reportedly at lower risk than those of Medicaid-enrolled mothers, who were at lower risk than those of privately insured mothers. Normal birth weight African American infants were 1.3 times more likely to die than their white counterparts, so the well known higher prevalence of low birth weight among African American versus white infants partly explains, but does *not* entirely explain, the racial infant mortality gap. Young maternal age was a stronger risk marker within the normal birth weight subgroup than within the lower birth weight groups.

Figure 40. Risk of Infant Death, 500-749g Infants, Alabama, 1995-1997

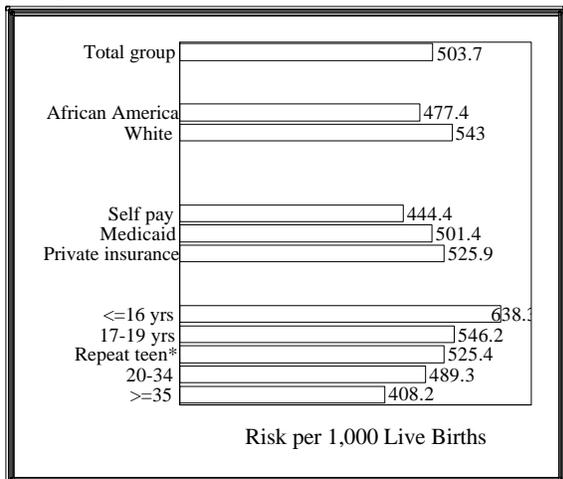
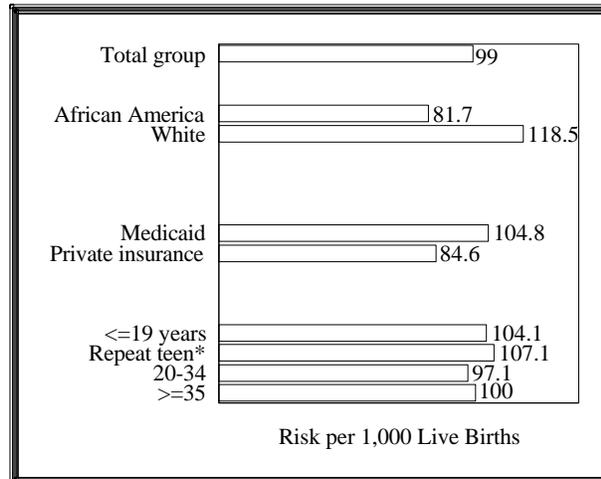


Figure 41. Risk of Infant Death, 750-1,499g Infants, Alabama, 1995-1997



Cause-specific risks of infant death are shown in Figures 44 to 47. As expected, racial and socioeconomic (self pay versus private insurance) gaps were especially wide for deaths due to prematurity and related causes. Disparities (based on race, socioeconomic status, and maternal age) in risk of SIDS, deaths due to external causes, and deaths due to infection were in the expected directions.

Figure 44. Risk of Infant Death Due to Prematurity, Alabama, 1995-1997

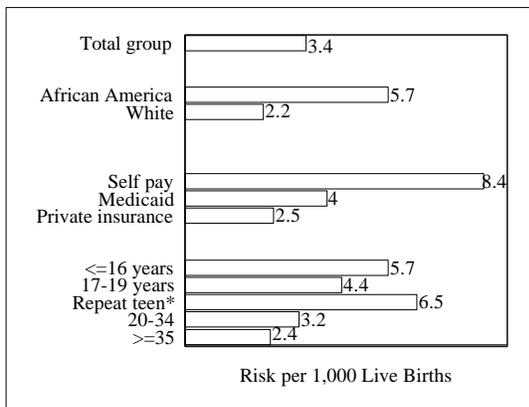


Figure 45. Risk of SIDS, Alabama, 1995-1997

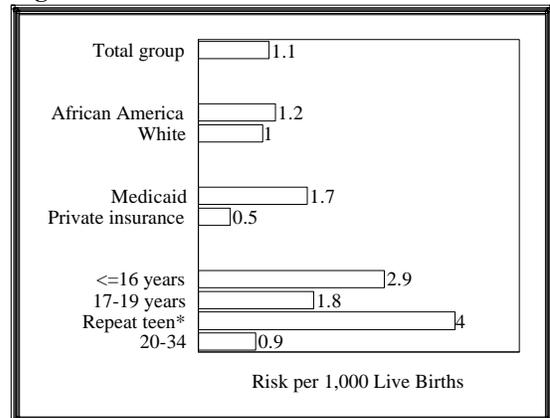


Figure 46. Risk of Infant Death Due to External Causes, Alabama, 1995-1997

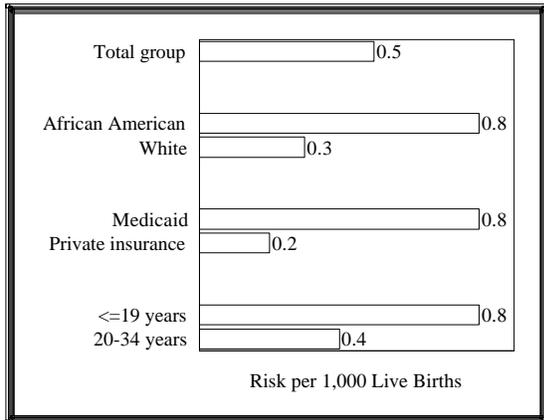
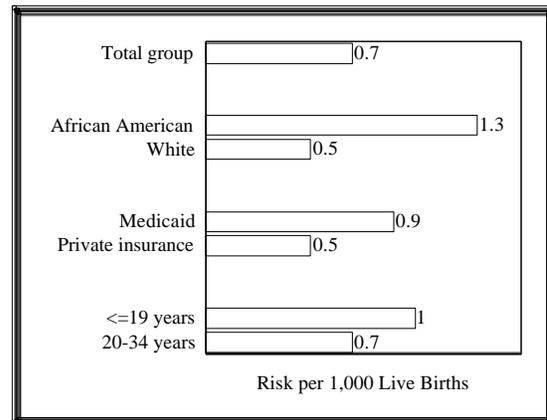


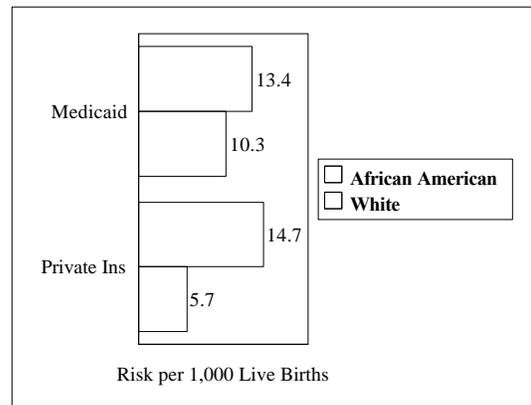
Figure 47. Risk of Infant Death due to Infection, Alabama, 1995-1997



Effect Modification

In order to roughly assess the *effect of socioeconomic status on the African American versus white infant mortality gap*, race-specific infant mortality rates were stratified by source of payment for delivery (Figure 48). The racial mortality gap was much wider for privately insured mothers than for Medicaid-enrolled mothers. That is, babies of privately insured African American mothers were about 2.6 times more likely to die before their first birthday than babies of privately insured white mothers. The gap was reportedly narrower in the Medicaid-enrolled group, where babies of African American mothers were about 1.3 times more likely to die than babies of white mothers. Most surprisingly, infants of privately insured African American mothers were reportedly slightly *more* likely to die than infants of Medicaid-enrolled African American mothers. Though this difference was slight, the observation that higher socioeconomic status, as measured by private insurance versus Medicaid coverage, was reportedly protective for white infants but *not* for African American infants is disconcerting. A similar pattern occurred for African American singleton births, so this apparent lack of protection is not explained by potential differences in multiple births. Furthermore, during this period, 2.1% of reported live births to privately insured African American women, versus 1.5% of reported live births to Medicaid-enrolled African American women, weighed less than 1,000 g. Since reporting issues are especially likely to affect vital statistics records of extremely small live births, the specter of potentially less complete reporting of extremely low birth weight live births to lower income African American women, versus extremely small births to other women, arises. Whether this apparently similar risk of infant death in African American infants of

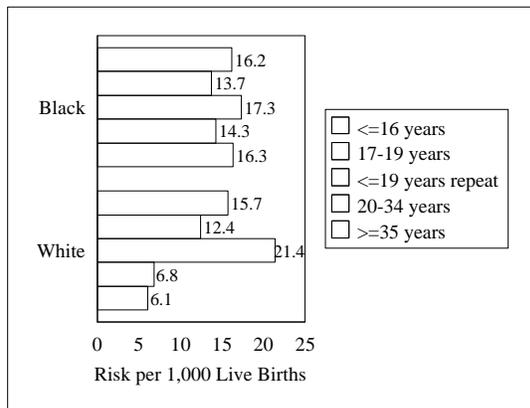
Figure 48. Risk of Infant Death, Alabama, 1995-1997



presumably higher socioeconomic status versus those of lower socioeconomic status reflects reality and/or reporting issues (which are alluded to several places in this report) cannot be determined from data utilized for this needs assessment.

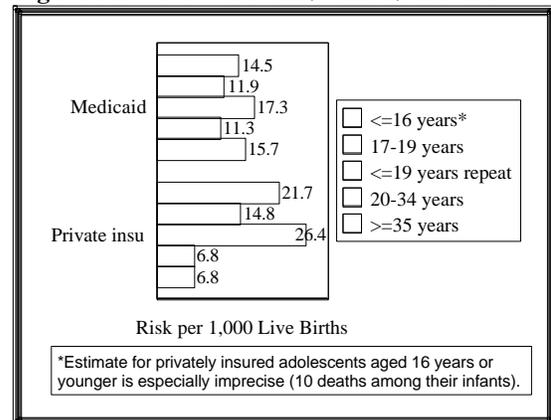
In order to assess the *effects of race and of socioeconomic status on the relationship between maternal age and infant mortality*, maternal-age-specific risks of infant death were respectively stratified by race and source of payment. In both racial groups, infants of younger (<16 years) adolescent mothers and of any adolescent mother with a previous pregnancy were at higher risk of death than those of 20-34 year-old mothers (Figure 49). Infants of white older adolescent (17-19 years) mothers were at higher risk of death than those of 20-34 year-old white mothers. However, because infants of African American mothers aged 20 years and older were also at high risk, older adolescent pregnancy was not a risk marker for infant death within the African American population. Stated another way, infants of older adolescent African American mothers were at high risk of death, but so were infants of African American mothers aged 20 years and older. Stratification by source of payment yielded similar findings, with older adolescent pregnancy being a very weak risk marker within the Medicaid group (Figure 50). Accordingly, programs to prevent adolescent pregnancy, *though important to the well being of mothers and children*, should *not* be expected to notably reduce infant mortality among African Americans or within low income groups *in the short term* (i.e., over the next several years). Moreover, such programs should occur in tandem with policies and programs to promote well being

Figure 49. Risk of Infant Death, Alabama, 1995-1997



among African American or low income females of

Figure 50. Risk of Infant Death, Alabama, 1995-1997



all ages, as well as their families.

Highlights of this Subsection

The findings reported in this subsection clearly show racial, socioeconomic (per insurance status), and maternal age-related disparities with respect to history of a previous live-born sibling dying, health care systems issues, VLBW, and infant mortality. Most, though not all, of these gaps were disadvantageous to babies of self-paying mothers, Medicaid-enrolled mothers, and African American mothers. Only those findings most pertinent to infrastructure building activities or to identification of priority MCH needs are reiterated here.

- ***Health care systems issues.*** Of all subgroups studied, self-paying mothers were most likely to receive inadequate or no prenatal care, though Medicaid-enrolled and African American mothers were more likely than their respective referent groups to receive such care. With respect to VLBW births occurring at perinatal centers, babies of self-paying mothers were again at the greatest disadvantage, but VLBW babies of Medicaid-enrolled mothers were also less likely to be born at perinatal centers than those of privately insured mothers. There was not a notable racial gap regarding this issue.
- ***Pregnancy outcome issues.*** Findings illustrated the well known socioeconomic and racial disparity in the prevalence of VLBW, with babies of self paying and African American mothers being at greatest risk.
- ***Mortality.*** Similarly, findings illustrated the well known socioeconomic and racial gaps in infant mortality. The gap was widest for babies of self-paying mothers versus privately insured mothers, but wider for African American versus white babies than for babies of Medicaid-enrolled mothers versus those of privately insured mothers. The exception to the latter rule was that the Medicaid versus private insurance gap in postneonatal mortality, which was greater than the corresponding racial gap. The racial infant mortality gap was not entirely explained by the higher prevalence of VLBW among African American babies. Most surprising was the observation that higher socioeconomic status, as roughly measured by private insurance versus Medicaid enrollment, was not accompanied by lower infant mortality in the African American population. Moreover, the higher prevalence of <1,000 g live births to privately insured versus Medicaid-enrolled African Americans, which is contrary to what we expected, raises the issue of potential under-reporting of extremely low birth weight live births to low income African American women.

Implications of Preceding Findings

As discussed in several places in this document, potential variations in perceived viability of infants (and therefore reporting of live births) is sometimes problematic with respect to interpreting trends in infant mortality or geographic variations in infant mortality. Though a potentially important infrastructure issue, this concern has not itself led to identification of a priority need. The effects of race and socioeconomic status on the relationship between maternal age and infant mortality do not diminish the importance of programs to prevent adolescent pregnancy. Instead, they advise against setting unrealistic mortality-related objectives for such programs. The following priority MCH needs arise from the preceding findings:

- Reduce infant mortality in the African American population.
- Reduce the prevalence of VLBW in the African American population.
- Assure access to prenatal care, especially for low income, minority, and (though discussed elsewhere in this document) immigrant populations.

Vital Statistics: Prevalence of Risk Markers for Infant Death

Rationale for Analyses

To the degree that risk markers for infant mortality are causal, their prevalence influences that outcome. Even if a risk marker *per se* is not causally linked with infant mortality, it identifies women at high risk of poor pregnancy outcome or infants at high risk of death. Surveillance of salient risk markers is, therefore, an important component of MCH needs assessments. All findings reported here (under *Prevalence of Risk Markers...*) pertain to Alabama residential live births. Data sources are computerized birth cohort files.

Low Birth Weight and Multiple Births

- ***LBW*** (under 2,500 grams), and ***especially VLBW*** (under 1,500 grams), are strongly and causally linked with infant death. In 1998, 9.3% of live births were LBW and 2.0% were VLBW (Form C-1 CHS # 04A and CHS# 05A.) Infants whose delivery was funded by Medicaid, subsequently termed “Medicaid infants,” were 1.5 times more likely to be LBW than remaining infants (11.3% versus 7.7%, per Form C2--CHS #06A). Because VLBW is a much stronger risk marker for infant death than moderately low birth weight (MLBW, or 1,500-2,499 grams), analyses focused on VLBW rather than overall LBW. Because infants from multiple births (twins, triplets, etc.) are about 9 times more likely to be VLBW than singleton infants (14.6% versus 1.6% in 1996-98), trends in VLBW should be viewed in the context of trends in multiple births.
- The proportion of ***infants who were from multiple births*** increased from 2.5% in 1993 to 3.1% in 1998,

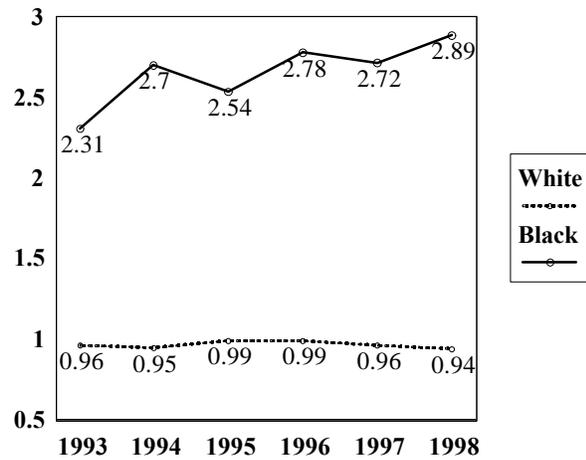
declining only one time (1995) in the surveillance period. This proportion increased for both white and African American infants: from 2.5% in 1993 to 3.1% in 1998 for white infants, and from 2.6% in 1993 to 3.0% in 1998 for African American infants. Because multiple-birth infants are five or six times more likely to die than singleton infants, this increase in multiple births certainly pushed upward on infant mortality, as well as the prevalence of VLBW, in both races.

- The *prevalence of VLBW* among all infants (all races, both multiple and singleton births) increased from 1.7% in 1993 to 2.0% in 1998.

To remove the effects of increases in multiple births from trends in VLBW, trends were described for singleton births, and they differed markedly by race (Figure 51). ***The proportion of singleton infants who were VLBW stayed about the same for white infants from 1993 to 1998 (0.96% and 0.94% in those respective years), but increased markedly for African American infants: from 2.3% in 1993 to 2.9% in 1998.*** Whether this reported increase is real or is at least partly due to reporting artifacts cannot be determined from vital records alone, but surely merits exploration (via quantitative data, qualitative data from providers of perinatal care, and review of salient literature). Whether real or a reporting artifact or a combination of these potential explanations, the reported increase in VLBW among African American infants exerted an upward force on their reported mortality.

- Because of the marked increase in VLBW among singleton African American infants, a study was done to further assess this trend and describe ***risk markers for VLBW in singleton African Americans***. The following characteristics were evaluated as potential risk markers: maternal ages of <16 years, 17-19 years, and >35 years; repeat adolescent (<19 years) pregnancy; non-graduation from high school and no formal post-high-school education; unmarried marital status; Medicaid and “self pay” as source of payment for birth; death of previous live-born infant; birth orders of 1, 3-5, and >6; tobacco use during pregnancy; and inadequate, intermediate, “adequate plus,” no, and late prenatal care. Among singleton African American infants, comparing 1996-98 to 1993-95, the prevalence of <500 g births increased by 13.5% (from 0.3% to 0.4%), that of 500-749 gram births by 27% (from 0.5% to 0.6%), and the prevalence of 750-999 g births by 18% (from 0.5% to 0.6%). Significant (P<0.05) risk markers for VLBW in this population in both 1993-95 and 1996-98 were history of previous live-born infant who died, tobacco use in pregnancy, inadequate and “adequate plus” prenatal care per Kotelchuck Index, no prenatal care, and “self pay” method of payment. (Remaining characteristics studied were not

Figure 51. Percent of Singleton Infants Weighing <1,500g Alabama, 1993-1998



significant high-risk markers during at least one of the 3-year periods studied.) Population attributable risk percents (PARPs) in 1996-98 were highest for “adequate plus” care (43%) and no prenatal care (7%). (PARPs are utilized here to identify risk markers that occur in many women. In the context of this document, they are *not* intended to imply causal relationships.) Even though the high risk of death among infants born to African American women receiving “adequate plus” prenatal care is presumably largely due to selection bias, these women and their infants should be followed to assure that they and their infants have access to appropriate care (including family planning services for the mother).

Race-Specific Trends in Selected Risk Markers Among Singleton Births

Multiple characteristics have historically been linked with infant mortality in the general population. However, based on the racial disparity in VLBW and infant mortality, two of the State’s priority MCH needs are to reduce VLBW and infant mortality among African American babies. Characteristics that are risk markers within the African American population are therefore of particular interest. Accordingly, the following description of trends in risk markers focuses on trends in several of the risk markers mentioned above: previous live-born infant who died, smoking in pregnancy, inadequate prenatal care per the Kessner Index, no prenatal care, inadequate and “adequate plus” prenatal care per the Kotelchuck Index (for African Americans only), and self payment. Because the reported increase in prevalence of VLBW among singleton African American infants is of particular concern, trends are described for singleton births.

All of the findings in the six bullets below pertain to women having live *singleton* births during the specified years. All comparisons (i.e., increases or declines) are based on comparing 1996-98 (as a single 3-year period) to 1993-95. “Other,” as used below, pertains to mothers of races other than white or African American.

- The proportion of mothers who had previously had a live-born infant who died stayed about the same for white infants, worsened (increased) slightly for African American infants, and worsened notably for other infants. Specifically, the proportion of African American infants whose mothers had previously borne a live infant who later died increased from 1.6% in 1993-95 to 1.7% in 1996-98 (P=0.266). The corresponding proportion for infants of other races increased from 0.8% to 1.6% (P=0.032).
- The proportion of mothers who had used tobacco during the pregnancy improved (declined) significantly for white and for African American infants (P=0.001). It also improved, though not significantly, for other women. Among women having live singleton births in 1996-98, 16% of white mothers, 5.3% of African American mothers, and 7% of other mothers reported using tobacco during the pregnancy.
- The proportion of mothers who had received *inadequate* prenatal care (per the Kessner Index) improved (declined) significantly for white mothers and for African American mothers and improved slightly for other mothers. In 1996-98, 3% of white mothers, 10% of African mothers, and 7% of other mothers had received

inadequate prenatal care. (Per the Kotelchuck Index, the proportion of African American women receiving inadequate prenatal care improved slightly, from 22% in 1993-95 to 20.5% in 1996-98 [P=0.369].)

- The proportion of women *receiving no prenatal care* worsened (increased) significantly for white mothers, improved (declined) significantly for African American mothers, and worsened somewhat for other mothers. In 1996-98, 0.6% of white mothers, 2% of African American mothers, and 1% of other mothers had received no prenatal care.
- Per the Kotelchuck Index, the proportion of African American women receiving “adequate plus” prenatal care increased significantly, from 24% in 1993-95 to 28% in 1996-98.
- The proportion of women who were “*self payers*” *for the delivery* declined (not significantly) for white mothers (from 2.6% in 1993-95 to 2.5% in 1996-98). This proportion increased slightly for African American mothers (from 1.5% in 1993-95 to 1.6% in 1996-98) and for mothers of other races (from 7.3% in 1993-95 to 7.4% in 1996-98). African American mothers were least likely to be classified as self payers, and mothers whose race was other than African American or white were most likely to be classified as self payers.

Implications of Preceding Findings

The marked increase in the reported prevalence of VLBW among African American singleton infants, in the absence of such worsening among white singleton infants, reinforces the identified priority need to reduce the prevalence of VLBW in the African American population. Among African American mothers, trends in use of tobacco during pregnancy and the proportion receiving inadequate (per the Kessner Index) or no prenatal care improved during the study period, so did not account for the reported increase. Though two risk markers (history of a previous live-born infant dying, self payment for delivery) worsened slightly during the study period for African Americans, these slight changes presumably did not account for the worsening of the VLBW indicator. Whether reporting issues played a role in the apparent increase in VLBW among African American infants cannot be determined from data analyzed for this needs assessment.

Vital Statistics: Trends in VLBW Live Births at Perinatal Centers

Findings in this paragraph pertain to all VLBW live births, regardless of plurality. One group of investigators studied a strategic framework for reducing infant mortality in “Healthy Start” cities (of which Birmingham is one).⁸ They

estimated that, of the strategies they studied, ensuring access to risk-appropriate perinatal and neonatal care had the greatest potential to reduce infant mortality in the cities studied. In fact, they estimated that ensuring such access could reduce infant mortality by 12% in those cities. This finding underlines the need for continued vigilance to assure that infants at high risk of death are born in perinatal centers. CP #17, the percent of VLBW (<1,500 gram) infants delivered at facilities for high-risk deliveries and neonates, is discussed in Sections 2.4.D.1 and 4.1.D.1. To reiterate, after worsening during 1995 to 1997, the percent of VLBW infants delivered at perinatal centers improved markedly, from 69% in 1997 to 77% in 1998. For whites and for African American VLBW babies, this percentage was lower (worse) in 1996 and 1997 than in 1995, but increased (improved) in 1998. Comparing 3-year periods, it improved slightly for white infants (from 72.5% in 1993-95 to 74% in 1996-98) and worsened slightly for African American infants (from 73.9% in 1993-95 to 71.8% in 1996-98). Although the improvement in this indicator in 1998 is encouraging, its failure to improve in preceding years reinforces the need to continue monitoring the effectiveness of the State's efforts to assure that VLBW infants are born at facilities that are well equipped to care for them.

Vital Statistics: Trends in Infant Mortality

As described in Sections 2.5 A and 2.5.B, infant mortality and neonatal mortality did not improve in 1996-98 relative to 1993-95, and postneonatal mortality improved only slightly during these periods. As part of the needs assessment, infant mortality has been further described by certain characteristics, including cause of death.

- Among singleton infants, risk of death declined by 2.6%, from 9.1 deaths per 1,000 singletons in 1993-95 to 8.9 deaths per 1,000 in 1996-98.

- Trends in infant death differed among birth weight categories:
 - < Among 500-1,499 gram infants, risk of death has been increasing slightly in recent years. This slight increase was due to a shift toward lower weights, even within this birth weight category. Had that shift toward lower weights not occurred, risk of infant death would have declined in this weight group (per control for birth weight in 30 gram increments, using the Mantel-Haenszel method).
 - < Among MLBW infants, after declining in 3 successive years, risk of death increased in 1998. Whether this is due to downward shifting of weights within this category has not been assessed.
 - < Risk of death for normal birth weight infants steady declined, from 4.1 deaths per 1,000 live births in 1993 to 3.2 deaths per 1,000 live births in 1998.

Vital Statistics: "Excess" Deaths Among African American Infants in 1995-97

- In 1995-97 among the total population of infants, about one in three (34%) infant deaths were due to prematurity or certain related conditions, one in five (20%) to congenital anomalies, and one in ten (11%) to sudden infant death syndrome (SIDS). Various infections caused 7.5% of deaths, external causes 5%, certain obstetric conditions 4%, and residual conditions 18%.

- “Excess” deaths among African American infants born in 1995-97 were estimated by applying the mortality rate for white infants to the number of live-born African American infants. That is, if only 7.6 per 1,000 African American infants had died (as was true for white infants), only about 452 African American infants would have died (rather than the 855 who did die). So, about 403 more African American infants born during those 3 years died before their first birthday than would have died if their rate had been the same as that for white infants. One in two (51%) of these 403 “excess” deaths among African American infants were due to prematurity and related conditions, and one in ten (11%) to various infections. External causes accounted for 7% of these excess deaths, certain obstetric conditions for 5%, SIDS for 3%, congenital anomalies for 2.5%, and residual conditions for 20%. These findings again reinforce the priority MCH need to reduce the prevalence of VLBW among African Americans.

Vital Statistics: Infant Mortality Among Hispanic Infants

Various demographic characteristics of infant deaths are described on Form D2 for FY 1998 (DHS #08A-DHS #08B).

Vital Statistics: Selected MCH Indicators by Public Health Area

Initial Work Toward Developing Area Profiles

The Department’s CHS annually publishes several documents reporting many county-specific MCH indicators, including selected 3-year rates in order to account to some degree for the general imprecision of estimates for small areas. For example, *Selected Maternal and Child Health Statistics, Alabama 1998*, is part of a series developed several years ago at the request of, and in consultation with, Bureau staff. Examples of race-specific 3-year rates reported for individual counties include infant, neonatal, and postneonatal mortality rates; perinatal mortality rates; and fetal mortality ratios. This publication also includes many detailed tables for county-specific, single-year estimates for a wide range of characteristics or events: such as Hispanic ethnicity, birth intervals less than 1 or 2 years, adolescent pregnancy rates, prevalence of cigarette smoking during pregnancy, prenatal care, birth of low birth weight infants in perinatal centers, etc. Another very useful CHS annual publication, *Pregnancy Statistics*, reports on many pregnancy indicators—some for multiple years. Yet another CHS annual publication, *County Profiles*, very nicely summarizes (on three pages) for each county a variety of demographic and health-related indicators, many of which pertain to the maternal and child populations: for example, estimated pregnancies for all women and for adolescents; live births by maternal age; infant, neonatal, postneonatal, perinatal, and fetal deaths; maternal deaths; health care facilities and practitioners; frequency of certain crimes; age- and race-specific population projections; and poverty status and income figures. Moreover, the *Alabama Kids Count 1998 Data Book*, one of a series of annual publications by Voices for Alabama’s Children, reports and ranks counties on such indicators as the infant mortality rate, low weight births, the high school graduation rate, a children’s health index, “preventable teen deaths,” juvenile violent crime arrest rate, etc. (See Appendix K for a hard copy of CHS’s profile for the State as a whole, an example of their profile for one

county, maps respectively showing adolescent pregnancy rates and infant mortality rates by county, and a description of one county from the *Alabama Kids Count 1998 Data Book*. Detailed profiles for each of the State's 67 counties is beyond the scope of this report.)

The Bureau sees its role as informing county and area staff about the above publications, rather than developing another county-level summary that simply includes selected items from the above summaries. Instead, the challenge for the Bureau is to effectively motivate (and, if necessary, train) area and county staff to utilize the above publications appropriately when assessing needs in their own local areas. Moreover, a major immediate challenge for the Bureau is to develop an area-level profile, and eventually a county-level profile, with information not readily obtained from existing publications. This profile would be for use by local staff to enhance their own knowledge of area-specific MCH issues and to educate their constituents about these issues. (Conceivably, two versions of a profile would be needed to achieve these purposes.) The profile is envisioned as including both quantitative and qualitative data, including information (for the 20 involved counties) from community forums/focus groups, the Medical Practices Survey, and the MCH Organization Survey. The Bureau has not had the resources to develop such a profile, even at the area level, within the time constraints of this phase of the needs assessment.

We are in the process, however, of compiling vital-statistics-based information about MCH Indicators for potential inclusion in such a profile. The final choice of indicators to be selected, as well as the format in which to present them, will be made in consultation with Bureau Management Team staff, area staff, SPAC, and perhaps several other interested groups. Nevertheless, information from initial work toward this profile merits inclusion in this application/annual report, to illustrate in a very preliminary way the different circumstances and issues faced by the State's 11 public health areas (PHAs). This area-specific information is summarized in the next table.

- Information is derived from analyzing 23 demographic or MCH indicators for a single 3-year period (1996-98 for birth data; 1995-97 for mortality data). (See Notes on Methods #3, following the next table, for a list of these indicators, other details, and caveats. Graphs depicting these indicators, by PHA, have been drafted but are considered beyond the scope of this report.)
- The purpose of the second column in the table is to note tentatively identified issues that may especially merit attention in the PHA. Generally, an issue is noted if the PHA received one of the three worst ranks with respect to that indicator.
- The purpose of the third column is to provide a rank of the PHA with respect to a single issue or a composite (mean) rank for two or more related issues. In general a rank of "1" means that the area had the "worst" score for that indicator.

The main advantage of compiling information in the following manner is that it provides, in a sense, an overall view of potentially important issues pertaining to pregnancy, pregnancy outcome, and infant mortality for each PHA. For example, information compiled for PHA 7 is noteworthy in that this area, relative to other PHAs, had the worst fetal mortality rate and the worst postneonatal mortality rate, yet had one of the five better neonatal mortality rates. Similarly, it was ranked as having one of the three better mortality rates for both VLBW mortality rates, versus being tied for the second highest mortality rates for normal birth weight infants. Moreover, PHA 7, relative to other counties, has the highest percentage of infants born to African American mothers and of infants whose delivery was paid for by Medicaid, with both of these populations generally being at higher risk of neonatal death than white infants or infants with private insurance. Additionally, this area had multiple issues regarding access to or utilization of the health care system (high percentage of women with no, inadequate, or late prenatal care, and low percentage of VLBW births occurring at a perinatal center.) As discussed elsewhere in this document, classifying extremely small or extremely morbid newborns as being fetal deaths or live-born infants who soon expire is not straightforward—even with use of the World Health Organization’s (WHO) definition of a live birth. Moreover, physicians’ perceptions of viability may vary. Thus, findings for PHA 7 collectively raise the question of whether live births are as fully reported in this area as they are in some other areas of the State.

<i>PHA</i>	<i>Notable Risk Markers or Issues*</i>	<i>Rank (1 = “worst”, 11 = “best”)</i>	
			<i>Rank</i>
1	Racial distribution: 89.8% white, 9.6% African American, 0.6% other	<i>Risk markers</i>	
		Adolescent pregnancy**.....	9.3
		Tobacco use during pregnancy.....	1
	Hispanic mother: 2.3%	<i>Systems issues</i>	
	Source of payment for delivery: 50.0% private insurance, 45.2% Medicaid, 1.8% self pay	Prenatal care***.....	10.3
		% of VLBW births occurring at perinatal centers.....	6
	<i>Risk marker issue:</i> tobacco use during pregnancy	<i>Pregnancy outcomes</i>	
		% of infants that were VLBW (<1,500 g)	9
		% of infants that were from multiple births (twins, triplets, etc).....	11
	<i>Mortality issues:</i>	<i>Mortality</i>	
	Infant mortality in 500-749 g babies	Overall infant mortality.....	9.5
	Infant mortality in normal birth weight babies	Fetal mortality (>20 weeks gestation).....	9
	Postneonatal mortality	Neonatal (<28 day) mortality.....	10
		<1day.....	10
		1-27 days.....	4.5
		Postneonatal mortality.....	3
		Birthweight-specific infant mortality	
		500-749 g.....	1
		750-1,499 g.....	6

PHA Notable Risk Markers or Issues*

Rank (1 = “worst”, 11 = “best”)

	Issue	Rank
	MLBW (1,500-2,499 g).....	10
	Normal birth weight (2,500-4,249 g)....	3
	SIDS.....	5.5
2	Racial distribution: 82.9% white, 15.5% African American, 1.6% other	
	Hispanic mother: 3.6%	
	Source of payment for delivery: 57.0% private insurance, 37.8% Medicaid, 3.4% self pay (second highest percentage for self pay)	
	Risk markers	
	Adolescent pregnancy**.....	9.8
	Tobacco use during pregnancy.....	5
	Systems issues	
	Prenatal care***.....	8.2
	% of VLBW births occurring at perinatal centers.....	9
	Pregnancy outcomes	
	% of infants that were VLBW (<1,500 g)	10.5
	% of infants that were from multiple births (twins, triplets, etc).....	5.5
	Mortality	
	Overall infant mortality.....	
	Fetal mortality (>20 weeks gestation).....	11
	Neonatal (<28 day) mortality.....	8
	<1day.....	11
	1-27 days.....	11
	Postneonatal mortality.....	6.5
	Birthweight-specific infant mortality	9.5
	500-749 g.....	
	750-1,499 g.....	8
	MLBW (1,500-2,499 g).....	7
	Normal birth weight (2,500-4,249 g)....	8
	SIDS.....	5
		9
3	Racial distribution: 61.4% white, 38.0% African American, 0.6% other	
	Hispanic mother: 0.7%	
	Source of payment for delivery: 45.5% private insurance, 47.7% Medicaid, 2.8% self pay (third highest percentage for self pay)	
	Risk markers	
	Adolescent pregnancy**.....	6.3
	Tobacco use during pregnancy.....	9
	Systems issues	
	Prenatal care***.....	3.7
	% of VLBW births occurring at perinatal centers.....	10
	Pregnancy outcomes	
	% of infants that were VLBW (<1,500 g)	1.5
	% of infants that were from multiple births (twins, triplets, etc).....	2
	System issues:	
	Inadequate prenatal care	
	No prenatal care	
	Pregnancy outcome issues:	
	Mortality	

PHA Notable Risk Markers or Issues*

Rank (1 = “worst”, 11 = “best”)

	Issue	Rank
	VLBW	Overall infant mortality..... 4
	Multiple births	Fetal mortality (>20 weeks gestation)..... 10
		Neonatal (<28 day) mortality..... 1
	Mortality issues:	<1 day..... 1
	Overall neonatal mortality	1-27 days..... 11
	<1 day mortality	Postneonatal mortality..... 11
	Infant mortality in MLBW babies	Birthweight-specific infant mortality
		500-749 g..... 6
		750-1,499 g..... 11
		MLBW (1,500-2,499 g)..... 3
		Normal birth weight (2,500-4,249 g).... 11
		SIDS..... 9
4	Racial distribution: 52.9% white, 46.1% African American, 1.0% other	Risk markers
	Hispanic mother: 1.6%	Adolescent pregnancy**..... 7.8
	Source of payment for delivery: 54.5% private insurance, 43.9% Medicaid, 1.1% self pay	Tobacco use during pregnancy..... 10
		Systems issues
		Prenatal care***..... 7.5
		% of VLBW births occurring at perinatal centers..... 11
	Pregnancy outcome issues:	Pregnancy outcomes
	VLBW	% of infants that were VLBW (<1,500 g) 3
	Multiple births	% of infants that were from multiple births (twins, triplets, etc)..... 2
	Mortality issues:	Mortality
	Overall infant mortality	Overall infant mortality..... 2
	Overall neonatal mortality	Fetal mortality (>20 weeks gestation)..... 4
	<1 day mortality	Neonatal (<28 day) mortality..... 2
	1-27 day neonatal mortality	<1 day..... 3
	Infant mortality in 750-1,499 g babies	1-27 days..... 1
		Postneonatal mortality..... 5
		Birthweight-specific infant mortality
		500-749 g..... 7
		750-1,499 g..... 3
		MLBW (1,500-2,499 g)..... 9
		Normal birth weight (2,500-4,249 g).... 8
		SIDS..... 7
5	Racial distribution: 90.4% white, 8.6% African American, 0.8% other	Risk markers
	Hispanic mother: 3.4%	Adolescent pregnancy**..... 11
	Source of payment for delivery: 60.1% private insurance, 35.2% Medicaid, 2.6%	Tobacco use during pregnancy..... 3
		Systems issues
		Prenatal care***..... 10.2
		% of VLBW births occurring at perinatal

PHA Notable Risk Markers or Issues*

Rank (1 = “worst”, 11 = “best”)

	Issue	Rank
	self pay	centers..... 7
	Risk marker issue: Tobacco use during pregnancy	Pregnancy outcomes % of infants that were VLBW (<1,500 g) 10.5 % of infants that were from multiple births (twins, triplets, etc)..... 7.5
	Mortality issues: Infant mortality in 750-1,499 g babies	Mortality Overall infant mortality..... 9.5 Fetal mortality(>20 weeks gestation)..... 11 Neonatal (<28 day) mortality..... 9 <1day..... 9 1-27 days..... 8.5 Postneonatal mortality..... 5 Birthweight-specific infant mortality 500-749 g..... 4 750-1,499 g..... 2 MLBW (1,500-2,499 g)..... 5 Normal birth weight (2,500-4,249 g).... 9 SIDS..... 5.5
6	Racial distribution: 68.2% white, 31.1% African American, 0.6% other Hispanic mother: 1.1% Source of payment for delivery: 43.3% private insurance, 52.0% Medicaid, 1.5% self pay	Risk markers Adolescent pregnancy**..... 2.0 Tobacco use during pregnancy..... 2
	Risk marker issues: Maternal age <16 years Repeat adolescent pregnancy Tobacco use during pregnancy	Systems issues Prenatal care***..... 6.8 % of VLBW births occurring at perinatal centers..... 5
	Mortality issues: Fetal mortality 1-27 day mortality Infant mortality in 500-749 g babies Infant mortality in MLBW babies	Pregnancy outcomes % of infants that were VLBW (<1,500 g) 7.5 % of infants that were from multiple births (twins, triplets, etc)..... 9
		Mortality Overall infant mortality..... 5 Fetal mortality (>20 weeks gestation)..... 2 Neonatal (<28 day) mortality..... 4 <1day..... 4.5 1-27 days..... 2 Postneonatal mortality..... 5 Birthweight-specific infant mortality 500-749 g..... 3 750-1,499 g..... 4.5 MLBW (1,500-2,499 g)..... 2 Normal birth weight (2,500-4,249 g).... 5 SIDS..... 4

<i>PHA</i>	<i>Notable Risk Markers or Issues*</i>	<i>Rank (1 = “worst”, 11 = “best”)</i>	<i>Rank</i>
7	<p>Racial distribution: 28.1% white, 71.4% African American, 0.5% other</p> <p>Hispanic mother: 0.6%</p> <p>Source of payment for delivery: 24.2% private insurance, 62.9% Medicaid, 2.0% self pay</p> <p>Risk marker issues: Maternal age <16 years Repeat adolescent pregnancy</p> <p>System issues: Inadequate prenatal care No prenatal care Late prenatal care Low percentage of VLBW births occurring at a perinatal center</p> <p>Pregnancy outcome issue: VLBW</p> <p>Mortality issues: Overall infant mortality Fetal mortality Postneonatal mortality Infant mortality in normal birth weight babies SIDS</p> <p><i>Question: Are live births of very tiny or very ill babies being as fully reported in PHA 7 as they are in some other parts of the State?</i></p>	<p>Risk markers Adolescent pregnancy** 1.0 Tobacco use during pregnancy..... 11</p> <p>Systems issues Prenatal care*** 1.7 % of VLBW births occurring at perinatal centers..... 2</p> <p>Pregnancy outcomes % of infants that were VLBW (<1,500 g) 1.5 % of infants that were from multiple births (twins, triplets, etc)..... 10</p> <p>Mortality Overall infant mortality..... 3 Fetal mortality (>20 weeks gestation)..... 1 Neonatal (<28 day) mortality..... 7 <1day..... 7 1-27 days..... 8.5 1 Postneonatal mortality..... 1 Birthweight-specific infant mortality 500-749 g..... 10 750-1,499 g..... 4 MLBW (1,500-2,499 g)..... 1.5 Normal birth weight (2,500-4,249 g).... 2.5 SIDS.....</p>	
8	<p>Racial distribution: 54.6% white, 44.2% African American, 1.2% other</p> <p>Hispanic mother: 1.1%</p> <p>Source of payment for delivery: 41.9% private insurance, 45.5% Medicaid, 1.6% self pay</p> <p>System issue: Low percentage of VLBW births occurring at a perinatal center</p>	<p>Risk markers Adolescent pregnancy** 4.8 Tobacco use during pregnancy..... 8</p> <p>Systems issues Prenatal care*** 4.7 % of VLBW births occurring at perinatal centers..... 1</p> <p>Pregnancy outcomes % of infants that were VLBW (<1,500 g) 5 % of infants that were from multiple births</p>	

PHA Notable Risk Markers or Issues*

Rank (1 = "worst", 11 = "best")

	Issue	Rank
	Mortality issue: Infant mortality in 500-749 g babies	(twins, triplets, etc)..... 7.5
		Mortality
		Overall infant mortality..... 6.5
		Fetal mortality (>20 weeks gestation)..... 6
		Neonatal (<28 day) mortality..... 8
		<1day..... 8
		1-27 days..... 4.5
		Postneonatal mortality..... 7
		Birthweight-specific infant mortality
		500-749 g..... 2
		750-1,499 g..... 4.5
		MLBW (1,500-2,499 g)..... 7
		Normal birth weight (2,500-4,249 g).... 10
		SIDS..... 11
9	Racial distribution: 68.0% white, 30.7% African American, 1.3% other	Risk markers
	Hispanic mother: 0.9%	Adolescent pregnancy**..... 6.3
	Source of payment for delivery: 42.1% private insurance, 48.9% Medicaid, 2.5% self pay	Tobacco use during pregnancy..... 6
		Systems issues
		Prenatal care***..... 5.5
		% of VLBW births occurring at perinatal centers..... 3
	System issue: Low percentage of VLBW births occurring at a perinatal center	Pregnancy outcomes
		% of infants that were VLBW (<1,500 g)..... 7.5
		% of infants that were from multiple births (twins, triplets, etc)..... 5.5
	Mortality issue: SIDS	Mortality
		Overall infant mortality..... 6.5
		Fetal mortality (>20 weeks gestation)..... 7
		Neonatal (<28 day) mortality..... 5.5
		<1day..... 4.5
		1-27 days..... 10
		Postneonatal mortality..... 8
		Birthweight-specific infant mortality
		500-749 g..... 9
		750-1,499 g..... 9
		MLBW (1,500-2,499 g)..... 11
		Normal birth weight (2,500-4,249 g).... 5
		SIDS..... 2.5
10	Racial distribution: 66.8% white, 31.9% African American, 1.2% other	Risk markers
		Adolescent pregnancy**..... 5.0

PHA Notable Risk Markers or Issues*

Rank (1 = “worst”, 11 = “best”)

	Issue	Rank
	Hispanic mother: 2.0%	Tobacco use during pregnancy..... 7
	Source of payment for delivery: 47.8% private insurance, 48.6% Medicaid, 1.3% self pay	Systems issues
		Prenatal care***..... 5.7
		% of VLBW births occurring at perinatal centers..... 4
	System issue:	
	Late prenatal care	Pregnancy outcomes
		% of infants that were VLBW (<1,500 g) 6
		% of infants that were from multiple births (twins, triplets, etc)..... 4
	Mortality issue:	
	Fetal mortality	Mortality
	Infant mortality in 750-1,499 g infants	Overall infant mortality..... 8
		Fetal mortality (>20 weeks gestation)..... 3
		Neonatal (<28 day) mortality..... 5.5
		<1day..... 6
		1-27 days..... 6.5
		Postneonatal mortality..... 9.5
		Birthweight-specific infant mortality
		500-749 g..... 5
		750-1,499 g..... 1
		6
		MLBW (1,500-2,499 g)..... 7
		Normal birth weight (2,500-4,249 g).... 9
		SIDS.....
11	Racial distribution: 57.0% white, 41.3% African American, 1.7% other	Risk markers
		Adolescent pregnancy**..... 3
		Tobacco use during pregnancy..... 4
	Hispanic mother: 0.8%	Systems issues
		Prenatal care***..... 1.8
		% of VLBW births occurring at perinatal centers..... 8
	Source of payment for delivery: 43.2% private insurance, 50.7% Medicaid, 4.4% self pay (highest percentage of self pay)	Pregnancy outcomes
		% of infants that were VLBW (<1,500 g) 4
		% of infants that were from multiple births (twins, triplets, etc)..... 2
	Risk marker issues:	
	Maternal age <16 years	Mortality
	Repeat adolescent pregnancy	Overall infant mortality..... 1
		Fetal mortality (>20 weeks gestation)..... 5
		Neonatal (<28 day) mortality..... 3
		<1day..... 2
		1-27 days..... 3
		Postneonatal mortality..... 2
	System issues:	
	No prenatal care	
	Inadequate prenatal care	
	Late prenatal care	
	Pregnancy outcome issue:	
	Multiple births	

PHA Notable Risk Markers or Issues*

Rank (1 = “worst”, 11 = “best”)

<i>Issue</i>	<i>Rank</i>
Mortality issues:	
Birthweight-specific infant mortality	11
Overall infant mortality 500-749 g.....	8
Overall neonatal mortality 750-1,499 g.....	1
<1 day mortality MLBW (1,500-2,499 g).....	1.5
1-27 day mortality Normal birth weight (2,500-4,249 g)....	1
Postneonatal mortality SIDS.....	
Infant mortality in MLBW babies	
Infant mortality in normal birth weight babies	
SIDS	

*Generally based on having one of the three “worst” ranks (i.e., ranks of 1, 2, or 3) for an indicator

**Mean of respective ranks for percentage of births to mothers aged 16 years or younger and percentage of births to mothers 19 years of age or younger who have previously been pregnant. For each percentage, the denominator is the number of live births (regardless of maternal age or birth order) in the PHA.

***Mean of respective ranks for percentage of mothers having no prenatal care, percentage having inadequate prenatal care (per Kessner Index), and percentage entering care after the first trimester

Notes on Methods #3:

Twenty-three indicators (except for fetal mortality, all pertaining to live births) were analyzed. Three of these were demographic in nature: racial distribution (mothers’); ethnic distribution (mothers’); and source of payment for delivery. Remaining indicators are listed below, with several related ones grouped to form a composite. With the exception noted, the PHA with the highest percentage for an indicator received a rank of 1 (the “worst” rank):

- Adolescent pregnancy—mean of ranks for percent of infants born to mothers 16 years of age or younger and percent of infants from a repeat adolescent pregnancy (see footnote [to preceding table] regarding denominator)
- Tobacco use during pregnancy—single indicator for percentage of mothers reporting tobacco use during the pregnancy
- Prenatal care—mean of ranks for respective percentages of mothers receiving no prenatal care, inadequate prenatal care, and late prenatal care for the referent pregnancy
- Percent of VLBW births occurring at perinatal centers. In this case the lowest percentage received the “worst” rank (of 1).
- Percentage of infants that were VLBW
- Percentage of infants that were from multiple births (twins, triplets, etc.)
- Overall infant mortality--risk of infant (<1 year) death per 1,000 live births
- Fetal mortality ratio—number of fetal deaths >20 weeks gestation, per 1,000 live births
- Neonatal mortality—risk of death under 28 days of age, per 1,000 live births

<1 day—risk of death under 1 day of age, per 1,000 live births

1-27 day mortality—risk of death from 1 through 27 days of age, per 1,000 live births

- Postneonatal mortality—risk of death from 28 through 364 days of age, per 1,000 live births
- Birthweight-specific infant (<1 year) mortality—risk of death for the following birthweight categories, per 1,000 live births in the respective weight groups: 500-749 g, 750-1,499 g, MLBW (1,500-2,499 g), and normal birth weight (2,500-4,249 g)
- Risk of SIDS, per 1,000 live births.

A qualification is indicated with respect to multiple births: Higher percentages of multiple births were assigned “worse” ranks than lower percentages because they are at greater risk of morbidity and mortality. We recognize, however, that many infants from these births have often been long awaited and are the result of successful treatment of fertility problems.

A major caveat regarding the information shown is that, even when combining 3 years of data to minimize the random fluctuation of estimates for small areas, such fluctuation is not erased. Moreover, findings are based on ranking PHAs with respect to each other, not on statistical analysis of significant differences. In particular, counties receiving the worst three ranks for an indicator may be very similar with respect to that indicator to several other counties, though often notably worse with respect to that indicator than PHAs receiving the “best” ranks. In the next stage of these analyses, techniques to assess statistical uncertainty (e.g., confidence intervals or Z-scores) will be used if feasible.

Even with these limitations, the information summarized provides an overview of potentially important issues pertaining to pregnancy, pregnancy outcome, and infant mortality for each PHA. Describing indicators that have not typically been described for the State’s PHAs (for example, early versus later neonatal mortality and birthweight-specific infant mortality)—both in a quantitative and narrative fashion—should facilitate identification of priority needs for each PHA. Finally, this compilation of PHA-specific information can facilitate a discussion within the Bureau and eventually beyond the Bureau of how area-level information can best be summarized in a meaningful way. Ultimately, such information could become part of a comprehensive PHA-specific profile of MCH indicators, which should pave the way for development of a similar county-level profile. (The latter may need to include 5 years of data to adequately allow for statistical uncertainty.)

Implications of Public Health Area Analyses

Implications of these analyses pertain mainly to infrastructure issues, rather than to currently identified priority MCH

needs. Specifically, the variation in salient issues among public health areas reinforces the need for analysis and reporting of findings at the area level. Moreover, potential reporting issues pertaining to African American live births are again raised.

Selected Indicators of Morbidity

VLBW is associated with increased morbidity in infants, as well as being a very strong risk marker for infant death. Because ***VLBW*** is a much stronger risk marker for infant death (and presumably for morbidity) than ***MLBW*** is, discussions in this document have focused on ***VLBW*** rather than on ***LBW*** overall. ***VLBW*** is discussed, for example, under CP #15 in Sections 2.4.D.1 and 4.1.D.1, under *Pregnancy Outcomes* previously in this section, and in Section 3.2.1. Moreover, ***VLBW*** has been discussed by public health area (in this section, under *Vital Statistics Data: Selected MCH Indicators by Public Health Area*). To fulfill reporting requirements, however, the prevalence of ***LBW*** (9.4% in CY 1999, per a very preliminary estimate, and 9.2% in CY 1998) is shown on the *Core Health Status Indicators* form (CHS #04A). Similarly, the following indicators are reported on the *Core Health Status Indicators* form: ***LBW*** in singleton births (CHS A#04B, ***VLBW*** (CHS #05A), and ***VLBW*** in singleton births (CHS #05B). Furthermore, the prevalence of ***LBW*** is shown by Medicaid status on Form C2 (CHS #06A). As expected (based on previously conducted surveillance), Medicaid infants were more likely to be ***LBW*** than non-Medicaid infants (11.3% versus 7.7% in CY 1998).

As shown on the Developmental Health Status Indicators form (DHS #03B), the ***chlamydia rate per 1,000 women aged 20-44 years*** was 7.7 in FY 1999, the highest reported rate during the surveillance period (1995-1999). Whether this increase was real or due to better reporting has not been discussed with the Department's STD staff. Potential reasons for this reported increase (including the possibility of better reporting) will be explored, to the degree feasible, during FY 2001.

3.1.2.1.C Health Status: Children

Telephone Survey of Alabama Households with Children

Notes on Methods #4:

The Telephone Survey of Households with Children has proven informative with respect to health status of children and disparities in health. The following findings are based on study of all completed interviews for children aged 1 through 17 years of age. "Their child" pertains to the child about whom the adult (termed "respondent") was interviewed, that is, the referent child. Of the 482 persons interviewed about children in this age group, 88% were parents of the referent child, 11% other relatives, and 0.6% non-relatives. Most (77%) of the respondents were women.

As previously stated (in Section 3.1.1), findings reported here are preliminary and pertain to interviews for which data were available when analyses were performed. Data for the total surveyed population (578 respondents for

children from birth through 17 years of age) will be analyzed in FY 2001.

Responses to the questions of major interest were analyzed for the entire population of children in this age group and by subgroups: mainly lower income (<\$25,000 annually) versus higher income (>\$25,000 annually), African American versus white, Medicaid versus private health insurance, and no health insurance versus any health insurance. Unless stated otherwise in the narrative or per a parenthetical p-value >0.05, any disparities mentioned in the narrative are significant at the 0.05 level, generally per the Cochran-Mantel-Haensel (CMH) p-value for a general association, per SAS. (Occasionally EPI INFO's STATCALC program was used to estimate the Mantel-Haenszel statistic.) The CMH p-value was apparently more liberal than comparison of the Fleiss 95% quadratic equation confidence intervals (per EPI INFO). That is, the CMH p-value was sometimes significant at the 0.05 level when the quadratic confidence intervals overlapped. (Confidence intervals were not estimated in all instances.)

Because income, race, and insurance coverage are related to one another, differences according to one characteristic (especially Medicaid versus private insurance, or African American versus white) should not be assumed to be due to that characteristic per se. Specifically, differences in Medicaid and private-insurance populations are often partly (though not necessarily totally) due to differences in income and income-related characteristics. Similarly, racial differences are often largely due to income or income-related characteristics, rather than race per se. For these reasons, significant differences between African Americans and whites or between Medicaid children and private insurance children were generally assessed again, controlling for income (using eight income categories and the unreported income category), per stratified analyses and CMH statistics. Differences in uninsured children and children with any health insurance were not controlled for income. Partly due to the limited sample size and partly to the time constraints of this Phase I analysis, the potential for effect modification was not generally assessed. (Effect modification pertains to whether the relationship between two variables, such as race and asthma, differs between two subgroups defined by another variable, for example low income and higher income groups).

The absence of a significant difference between two groups does not necessarily mean that there is not a difference of public health significance. This is especially true for comparisons of uninsured children to children with any type of health insurance. Because there were only 43 uninsured children in the sample, any estimates for this group have very wide confidence intervals and differences are less likely to be statistically significant. On the other hand, a statistically significant difference is not necessarily of public health significance, particularly since multiple comparisons such as those made in these analyses may yield some significant findings by chance alone. Accordingly, patterns and context and potential public health significance, as well as an understanding of the statistical uncertainty involved, is necessary for appropriate interpretation of findings.

Bar graph figures depict the most salient findings for the subgroups of interest, with the bar for each generally “high risk” group (low income, African American, Medicaid, and no insurance groups) paired with that for its referent group (respectively, higher income, white, private insurance, and “any health insurance” groups). If the members of a pair differed significantly with respect to the finding depicted, one member of the pair is marked with an asterisk. If the test was significant per the CMH p-value but not per comparison of quadratic confidence intervals (termed “CIs” in figures), a note to that effect appears below the graph.

Based on the demographic comparisons shown below, African American *children* (not necessarily households) were probably somewhat under-represented in the survey, and white children slightly over-represented. Race-specific analyses were performed, however, and notable racial differences pertinent to the needs assessment are mentioned in the narrative, especially if they remain after control for income. Additionally, to the degree that the proportion of live births occurring to unmarried mothers indicates the proportion of single-parent households in FY 2000, single-parent households were probably slightly under-represented. To some degree, the analysis of income-specific data addressed this issue, since respondents from low income households were 4.6 times more likely to be headed by a single parent. By definition, homeless families and households without telephones were not represented at all in the survey.

The rigorous sampling techniques, telephoning protocol, and high response rate are collectively a major strength of the telephone survey, however. ***Because of them, this survey more closely approximates a representative sample of the State’s families with children than any of the other surveys, forums, or focus groups that comprised this needs assessment. Moreover, it provides previously unavailable information about 1-17 year old Alabama children.***

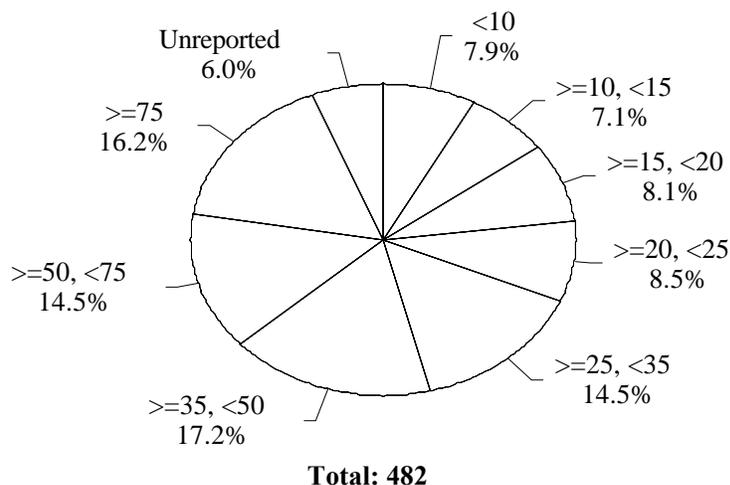
Demographic Characteristics of Children in Telephone Survey

Because they are related to health status, a few demographic characteristics of the 1-17 year-old children to whom this discussion pertains are of interest. Moreover, some of these serve to roughly assess how well the survey households represent Alabama households. The implications of these comparisons have been discussed in *Notes on Methods #4*.

- 72% were white, 26% African American, and 2.1% other races. Per Form D2, DHSI #06A, in 1998 racial distribution of *children* aged 1-19 years of age was as follows: 66% white, 33% African American, and 1.1% other races.
- 3.3% (CI: 2.0% - 5.4%) were of Hispanic origin. Per Form D2, DHSI #06B, in 1998, 1.4% of Alabama children aged 1-19 years were Hispanic in origin. As described in Section 1.4, however, the number of Hispanic live births has been increasing. Accordingly, the ethnic distribution of the respondents (with respect to Hispanic origin) may be quite similar to the ethnic distribution of the statewide population in FY 2000.

- Annual household incomes ranged from low to high (Figure 52). We are not aware of a comparable, current data source pertaining to income of Alabama households with children.

Figure 52. Annual Household Income Distribution in Dollars.
Telephone survey. Children 1-17 years, Alabama 2000



- 30% were from single-parent households. As a rough reference, 34% of Alabama residential live births in 1998 were to unmarried mothers.
- Most (64%) had private health care insurance, 17% had Medicaid coverage, 2.7% were covered by CHIP, 5% had other health insurance, and 9% (CI: 7% - 12%) had no health care coverage. (Some of the Medicaid-covered children and Blue Cross-covered children were enrolled through CHIP, and those reported as being CHIP were covered by Medicaid or Blue Cross/Blue Shield.

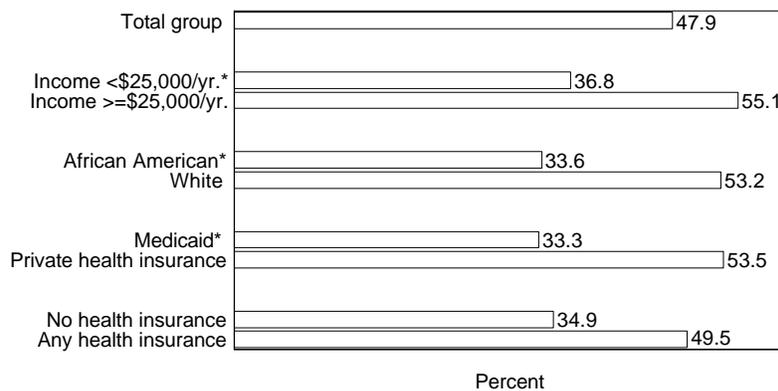
Health Status of Children in Telephone Survey

Highlights of findings regarding health status of children aged 1-17 years (n=482) follow:

- Nearly half (48%) of the respondents described their child's health as excellent, one-third (33%) as very good, and 14% as good (Figure 53). As a corollary, 5% and 0.6% (n=3) described their child's health as, respectively, fair and poor. Income, racial, and insurance-status disparities existed regarding perceived health status. Low income respondents, African American respondents, and Medicaid respondents were significantly less likely to describe their child's health as excellent than their referent groups were. Additionally, respondents with no health insurance for their child were less likely than those whose child had insurance to rate their child's health as excellent (P=0.067). In general, because only 43 study children had no health insurance, findings for these children are

imprecise and often not statistically significant. (The “respective referent group” for the low income group is the higher income group, that for African American respondents is comprised of white respondents, that for Medicaid respondents is comprised of private insurance respondents, and that for respondents whose child had no health insurance is comprised of respondents whose child had health insurance of any type.) This racial disparity in perceived health was present even *within* the higher income group and remained significant with control for income (that is, was not largely explained by differences in income). The Medicaid versus private insurance difference in satisfaction levels was largely related to differences in income.

Figure 53. Percent of respondents rating the child’s general health as excellent. Telephone survey. Children 1-17 years, Alabama 2000



*Significantly higher than referent group--both per CMH p-value and quadratic CIs
The higher risk among African Americans remained significant with control for income.

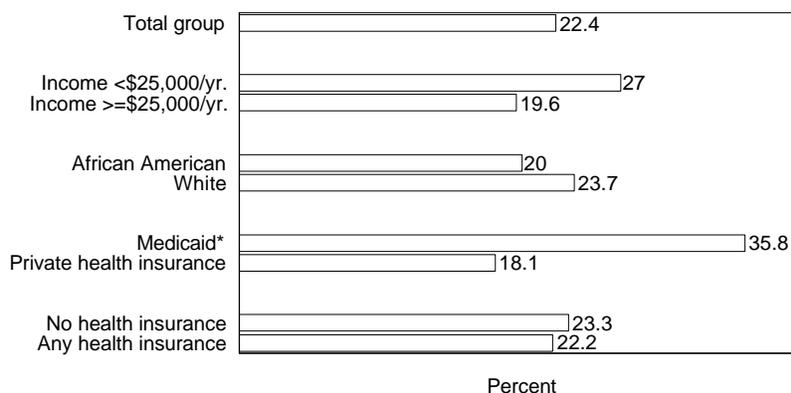
• 22% (108/482) had one or more chronic conditions, as identified per questions incorporated into the Bureau’s survey tool from the *Screener for Identifying*

Families with Children with Chronic Conditions (H E D I S Version–Mail or Telephone). The five characteristics identified per this screener are: (1) current need or use of medicine (other than vitamins) prescribed by a doctor due to any medical, behavioral or other condition that has lasted or is expected to last at least 12 months (termed “chronic condition” throughout this bullet); (2) need for or use of more medical care, mental health or educational services than usual for most children of the same age, due to

any chronic condition; (3) inability or limited ability to do things most children of the same age can do, due to any chronic condition; (4) need for or use of special therapy (such as physical, occupational or speech therapy), due to any chronic condition; and (5) any emotional, developmental or behavioral problem that has lasted or is expected to last for at least 12 months and for which he/she needs or gets treatment or counseling.

- < Neither race nor lack of insurance were notably related to the presence of chronic conditions, but income and type of insurance were. Low income children were notably more likely than higher income children to have a chronic condition ($P=0.074$), and Medicaid children were significantly more likely to have a chronic condition than children enrolled in private insurance (Figure 54). Not surprisingly, the higher prevalence of chronic conditions among Medicaid children was mainly due to income or income-related characteristics (i.e., the disparity notably lessened with control for income).

Figure 54. Percent of children having one or more chronic condition(s).
Telephone survey. Children 1-17 years, Alabama 2000

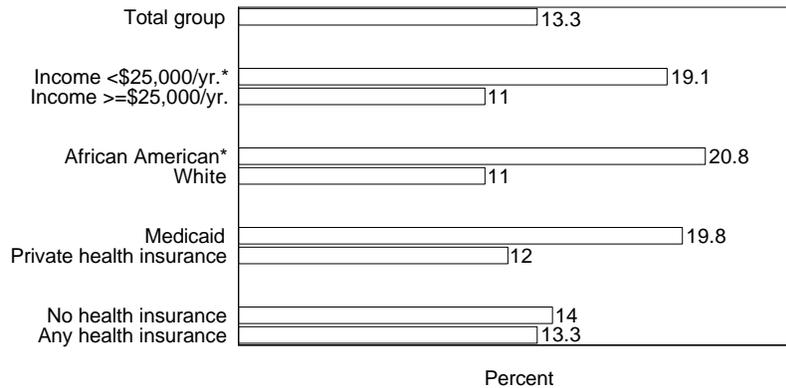


*Significantly higher than referent group--both per CMH p-value and quadratic CIs.
The disparity notably lessened with control for income.

< As expected, the health status of children with chronic conditions (who are subsequently termed “CSHCN,” since the Bureau and CRS deem them to be such) was generally described as less optimum than that of remaining children. Specifically, though about one in five (22%) of the CSHCN were said to be in excellent health, one in three (32%) in very good health, and one in four (26%) in good health, they were 60% less likely to be described as being in excellent health than remaining children were. As a corollary, they were 14.5 times more likely to be described as being in fair or poor health than remaining children (19% versus 1.3%). The positive side of the coin, however, is that four out of five of CSHCN (81%) were described as being in good, very good, or excellent health.

- 13% of respondents said that a doctor or other health professional had said that their child had asthma (Figure 55). Notable income and racial disparities existed regarding the history of asthma. That is, low income respondents and African American respondents were notably more likely than their respective referent groups (higher income respondents and white respondents) to answer affirmatively to this question.

Figure 55. Percent of respondents who had been told that their child had asthma. Telephone survey. Children 1-17 years, Alabama 2000



All Fleiss 95% quadratic confidence intervals (QCIs) overlapped.
 *Significantly higher than referent group per CMH p-value, but not per QCIs.

Health Status of Children: Mortality Data

Selected mortality indicators are reported on the *Developmental Health Status Indicators* form:

- The fatal unintentional injury death rate, per 100,000 children aged 14 years and younger, was 16.0 deaths per 100,000 in CY 1998 (DHS #01A). During the surveillance period (1996-1998), this rate ranged from 15.1 per 100,000 in 1996 to 18.5 per 100,000 in 1995. Per inspection of estimates for individual years, there was no clear trend.
- During the surveillance period (1995-1999), the death rate from unintentional injuries due to motor vehicle crashes among children aged 14 years and younger ranged from 7.5 deaths per 100,000 in CY 1999 (a very preliminary estimate and subject to change) to 9.1 deaths per 100,000 in 1997 (DHS #01B). Per inspection of estimates for individual years, there was no clear trend.
- During the surveillance period (1995-1998), the death rate from unintentional injuries due to motor vehicle crashes among children aged 15 through 24 years ranged from 44.9 deaths per 100,000 in CY 1998 to 51.2 deaths per 100,000 in 1996 (DHS #01C). Though this rate declined in 1997 and again in 1998, two successive declines do not necessarily signify a trend.

3.1.2.1.D Health Status: CSHCN

The description (in Section 3.1.2.1.C) of children identified through the Household Telephone Survey as having special health care needs applies to this population. Obtaining further information regarding the status of Alabama's CSHCN is difficult because no single source of data exists for this population within the State. Various programs and agencies

compile service utilization data, but these data are not aggregated into a single source of unduplicated data. The following statistical information regarding Alabama's CSHCN was gathered as part of the needs assessment process:

Utilizing the MCHB definition of CSHCN, it has been estimated that 18.7% of children living in the South could meet the criteria for this designation (Newacheck, PW, et al. *Pediatrics*, 1998 Jul;102:117-123). Using population estimates, there could be 233,387 CSHCN under age 20 years in Alabama. Of the 60,261 live births in 1998, 515 (.86% of all live births) were reported to have congenital anomalies. The Bureau of Vital Statistics considers this to be under reported. This percentage has remained fairly consistent since the 1994 needs assessment.

In FY 1998, there were 31,188 children under age 20 years in Alabama who received Supplemental Security Income at any time during the year. This represents approximately 2.5% of the total child population under 20 years. This percentage varied across the state from a high of 8.5% in Wilcox County in rural South Alabama to a low of 0.6% in Shelby County located within the greater Birmingham area. To contrast these two counties, of the 42,111 children in Shelby County, 11% live in poverty, 72% graduate from high school, and only 6.3% are Medicaid recipients. Of the 4,838 children in Wilcox County, 52.7% live in poverty, only 60.6% graduate from high school, and 53.4% are Medicaid recipients. This illustrates the wide variation of health risk factors between the economically prosperous and depressed areas within the state. Of the children under age 20 years enrolled in CRS, 39.7% are SSI recipients.

In FY 1998, CRS served 22,300 CSHCN under 21 years of age. This represents approximately 9.6% of the estimated CSHCN in the state.

- Alabama's Early Intervention System served 3,090 infants and toddlers with a 25% developmental delay in at least one domain during FY 1998.
- Head Start served 2,134 children with disabilities statewide in FY 1998.
- There were 853 children in Medicaid sponsored longterm care placements and 256 children with known physical disabilities in foster care.
- The Department of Mental Health and Mental Retardation served 24,148 children through community-based early intervention and mental health programs as well as institutional placements.
- The State Department of Education reported 99,297 children, aged 3 to 21, receiving special education services statewide at the 1998 December Child Count. Of these, 40,739 (41%) were served under the exceptionality of specific learning disabilities, 22,062 (22%) under mental retardation, and 20,950 (21%) under speech/language impairments. These three exceptionalities accounted for 84% of the children served by special education (the gifted were not included in this count).

Primary data from families and providers were collected to supplement the scarce secondary data in assessing the current status of the State's CSHCN. The discussion guide for the family forums was adapted from the suggested format in *FOCUS on Children Community Planning Manual: Needs Assessment and Health Planning for Children, including Children with Special Health Care Needs* (October 1996), published through a MCHB funded grant by the University of Illinois at Chicago Division of Specialized Care for Children and the Illinois Department of Public Health. Families provided information on eight specific aspects of the State's service system for CSHCN, which are summarized below:

- *Family:* Families of CSHCN feel isolated and want resources and supports to enable more effective integration into their own communities.
- *Medical:* Families feel that community health care providers are uncomfortable with or unprepared for treating CSHCN. They find a lack of coordination of services between levels of care and a lack of sensitivity at all levels of care.
- *Education:* Families find the services available to CSHCN through local education systems inadequate. Families want more emphasis on functional life skills and effective transitions to meet the educational, vocational, and independent living needs of their children.
- *Recreation:* Families value play, but generally find community recreational activities are not available, accessible or inclusive.
- *Finances:* Families find that costs of transportation, insurance, equipment, and supplies create financial stress that lowers their quality of life, restricts participation in community and family activities, and necessitates, in some cases, working additional hours for financial survival.
- *Transportation:* Families must travel to obtain many services for their children, but find access to transportation inside and outside their communities unavailable or inadequate.
- *Systems:* Families find Alabama's service system for CSHCN complex and difficult to negotiate without resource information or assistance.
- *Community:* Families rely heavily on their extended families, churches, and service providers for support, but desire better community awareness of and sensitivity to CSHCN, including better accessibility of facilities/programs.

Secondary data and primary data from providers and families of CSHCN were remarkably congruent regarding the priority health problems, service gaps, and status of the present service system. The most significant priority health problems and service gaps were in the following areas: (1) inadequate access to care, including lack of transportation, knowledge of resources, adequate financing, and availability of providers; (2) inadequate family supports, which included inadequate access to respite care, mental health counseling, and parent support/advocacy networks; and (3) inadequate integration of CSHCN into their communities, which included inadequate educational and health related services from public education, accessibility of facilities, community recreational opportunities, and transitions from school to work and independence. The service system, while providing high quality specialty/subspecialty medical care and allied health services, is complex and difficult for families to negotiate without cognizance of available resources. Primary care providers lack adequate knowledge of CSHCN, and providers at all levels struggle with incorporating principles of family-centered care. Due to the rural nature of the State, the most appropriate providers may be at a distance from the family, making transportation an issue. The barriers to accessing health care for CSHCN identified in the 1999 county level provider survey are compared with those in the 1994 survey in Table 1 located in Appendix L. Table 2 compares the ranking of the 1999 barriers by urban, rural north, and rural south counties to delineate differences. The geographical categories for counties were utilized from the report *Health Status of Rural Alabamians* published by ADPH's Office of Rural Health, which based its designation on inclusion in a Metropolitan Statistical Area (MSA).

3.1.2.2 Direct Health Care Services

3.1.2.2.A Direct Services: Pregnant Women, Mothers and Infants

Direct Services for Pregnant Women, Mothers and Infants and Children: Community Forums

Because the forums were not designed to organize discussions according to which population they applied to (such organization would have been artificial and limiting), findings from forums cut across populations. That is, they apply to children, as well as to pregnant women, mothers, and infants—and do not lend themselves to classification under one or the other of these populations. Accordingly, though discussed under *Pregnant Women, Mothers and Infants* throughout this document, they apply also to children.

Though Direct Health Care Services were of concern to respondents at ADPH community forums, their concerns are mainly addressed through lower levels of the service level pyramid, including enabling services that allow persons to better seek direct health care services. A few examples of some concerns included the lack of certain types of care (3% of all responses): preventive care, dental care, cancer detection programs for young women, and emergency care. In addition, some residents voiced concerns about the high incidence or apparent increase of certain conditions (4% of all responses) such as cancer, diabetes, HIV/AIDS, and eating disorders. Some of these issues, however, can be addressed at the Infrastructure Building Services level. In sum, the main implications from ADPH-sponsored focus

groups for ADPH-sponsored programs and policies pertain to other levels of the pyramid, rather than to direct services.

Direct Services for Pregnant Women, Mothers and Infants: Household Telephone Survey

Only 35 of the referent children in the Household Telephone Survey were infants, and many of the questions in that survey did not apply well to infants. Several findings regarding these children pertain to direct care so are of interest, however, with the caveat that estimated percentages are very imprecise, due to the small numbers involved (the denominator for each percent is 35).

- With respect to having a medical home, all respondents said that there was a place their child usually went when sick or when advice was needed about the child's health.
- 86% of the infants received their health care at a doctor's office or HMO, and 14% (n=5) at a clinic or health center. As would be expected, nearly all (n=34) the children had received a well baby checkup during the previous 12 months.
- 14% (n=5) of the infants had been to a hospital emergency room during the previous 12 months.
- Most (86%, n=30) respondents were very satisfied with their child's health care, four were somewhat satisfied, and one wasn't sure.

None of the above findings are unexpected. Due to the small numbers involved, they have no clear implications for planning or policy development.

3.1.2.2.B Direct Services: Children

Direct Services for Children: Telephone Survey

Methods Notes: Methodological notes in Section 3.1.2.1.C apply to the findings below. When deemed important to allow for the statistical imprecision of percentages reported, Fleiss 95% quadratic confidence intervals are included in the narrative.

The following findings from the Telephone Survey pertain to direct services:

- **Medical home.** Virtually all (99%) the 482 respondents said that there was a place their child usually went when sick or when advice was needed about the child's health. Most (76%, 365/482) children went to a doctor's office or HMO for care, 19% to a clinic or health center, 1% to a hospital emergency room (n=7) or hospital outpatient department, and a 2% to some other place. Respondents saying that their child usually went to a clinic or health center for care were asked a follow-up question: "Is that a Health Department clinic?" Based on their response to this question, a health department clinic was the usual place of care for 10% (47/482) of the children (CI: 7% -

13%).

- < Of the four children who did not have a usual source of care, two were lower income, three were African American, one was enrolled in Medicaid, and one had no insurance. Though the African American children were “significantly” (in the statistical sense) more likely to not have a usual place of care, the small number involved precludes firm conclusions.

- < As would be expected, compared to children from higher income households, children from low income households were about three times more likely to receive care at a clinic or health center and about 15 times more likely to receive care at a health department. (Those receiving care at a health department were a subgroup of those receiving care at a clinic or health center.) Though low income children were much more likely than other children to receive care at a health department, many low income children received care elsewhere. In fact, 40% (CI: 24% - 58%) of children with annual household incomes under \$10,000 received care at a doctor’s office or HMO. Furthermore, taken as a whole, over half (57%; CI: 49% - 65%) of the lower income children (annual household incomes below \$25,000) received care in a doctor’s office or HMO, while one-fourth (26%; CI: 19% - 33%) received care in a health department.

- < African American children, Medicaid-enrolled children, and children without health insurance were all more likely to receive care at a health department than elsewhere. Nevertheless, most received care in other settings. Specifically,
 - T** Of the 125 African American children, 58% (CI: 49% - 67%) received their care in a doctor’s office or HMO, 23% (CI: 16% - 32%) in a health department, and the remainder elsewhere.
 - T** Of the 81 Medicaid-enrolled children, 53% (CI: 42% - 64%) received their care at a doctor’s office or HMO, 27% (CI: 20% - 41%) at a health department, and the remainder elsewhere.
 - T** Of the 43 children without health insurance, 47% (CI: 31% - 62%) received their care in a doctor’s office or HMO, 30% (18% - 46%) in a health department, and the remainder elsewhere.

- **Well child checkups.** Four out of five (79%) children had received a well child check up or physical examination during the previous 12 months. Conversely, one in five (20%) children had not received a check up/exam during that time (CI: 17% - 24%). Neither lower income children, African American children, nor Medicaid-enrolled children were significantly less likely to have received a well child checkup/physical exam than their respective referent groups (higher income children, white children, and children with private insurance). Children without health insurance, however, were twice as likely **not** to have had a well child checkup/physical exam during that time period (37% versus 19%) as were children with some type of insurance.

- **Emergency room use.** Three out of four (76%) children had not been to the emergency room for care during the

preceding 12 months, 17% had been there one time, 6% two or three times, and 0.6% (n=3) 4-9 times. Thus, one-fourth (CI: 21% - 29%) of the children accounted for all emergency room use by the study children, and 7% (CI: 5% - 10%) of children for potentially heavy (2 or more times per year) use. Children from low income households were 2.4 times more likely to have used the emergency room two or more times than children from higher income households (12% versus 5%). As a corollary, Medicaid enrolled children were 3.3 times more likely to have used an emergency room than children with private insurance. As expected, the latter disparity lessened with control for income. That is, when accounting for differences in income, Medicaid-enrolled children were 1.9 times more likely to have used the emergency room two or more times than those with private insurance (P=0.145). Emergency room use by children without health insurance was very similar to that of those with insurance.

- **Satisfaction with health care.** Three-fourths (75%) of respondents were very satisfied with their child's health care, 22% somewhat satisfied, and 2% (CI: 1% - 4%) not satisfied. Combining the latter two groups and the single "don't know" response, one in four respondents were less than totally satisfied with their child's health care. Respondents for low income households, African American children, Medicaid-enrolled children, and children without health insurance were less likely to be very satisfied with their child's health care than their respective referent groups. The lower satisfaction level among African Americans, however, was largely due to racial differences in income or income-related characteristics. That is, with control for income, respondents for African American children were only 5% less likely to be very satisfied with care (P=0.455). When accounting for income differences, respondents for Medicaid children were still somewhat (12%) less likely to be very satisfied than respondents for remaining children (P=0.235). Not surprisingly, respondents for uninsured children were notably less likely to be very satisfied with care than other respondents. (Findings pertaining to the uninsured group were not controlled for income.)

Though they should be interpreted very cautiously due to statistical imprecision, findings for the 47 children receiving care at a health department clinic might provide tentative insights about CHD child health patients and their service needs. At a minimum, some of these findings suggest issues for further study. Salient findings pertaining to these presumably CHD child health patients (subsequently termed "CHD children") are therefore described below. (Due to a few unknowns, some percentages for CHD children are based on 45 or 46 children.)

- **Demographics.** CHD children were more likely to be African American than remaining children (62% versus 22%). As expected, CHD children were more likely than remaining children to be from low income families (88% versus 27%). They were also more likely to be from single-parent homes (68% versus 26%).
- **Health care coverage.** Half (51%) of the CHD children (CI: 36% - 66%) were enrolled in Medicaid, and about one-fourth (28%) had no health insurance (CI: 16% - 43%). Fifteen percent (7% - 29%) were enrolled in private insurance. Additionally, 2 children were in CHIP, meaning that they could have been covered through Medicaid

or Blue Cross/Blue Shield.

- ***Well child checkups and emergency room use.*** CHD children did not notably differ from remaining children with respect to whether they had undergone a well child checkup/physical exam (85% of CHD children versus 80% of remaining children). Neither did they notably differ regarding emergency room use.
- ***Satisfaction with care.*** When asked about satisfaction with their child's care, 55% of respondents for CHD children said they were very satisfied, 40% that they were somewhat satisfied, and 4% (2/47) that they were not satisfied). Respondents for CHD children were 28% less likely to be very satisfied with their child's health care than other respondents (55% versus 77%). With control for income, this disparity in satisfaction lessened and was no longer significant (16% less likely to be very satisfied, $P=0.195$), but did not disappear. Further control considering race and health, along with income, did not further lessen the disparity.

Highlights of Telephone Survey Findings Regarding Direct Services to Children

Financial Access

Though financial access affects whether children receive direct services, the Bureau addresses financial issues mainly through enabling services. This issue is therefore addressed in Section 3.1.2.3 (*Enabling Services*).

Cultural Acceptability

As previously described per the Telephone Survey, satisfaction of respondents with their child's health care varied by income, race, type of insurance, and presence of insurance. That is, lower-income respondents, African American respondents, respondents for Medicaid-enrolled children, and respondents for children without health insurance were less likely to be very satisfied with their child's health care than their respective referent groups (higher income respondents, white respondents, respondents for children with private insurance, and respondents for children with any insurance). As was stated, several of these latter disparities lessened with control for income. These findings suggest that services might not be culturally sensitive to low income populations and, secondarily (i.e., mainly due to income or related characteristics), to African Americans or families of Medicaid-enrolled children. The lower satisfaction levels of respondents for children with no health insurance may have been related to poor access to care, as well as to cultural issues.

The Bureau's role in addressing cultural sensitivity of services provided in non-CHD settings would mainly pertain to enabling or population-based services. With respect to direct care, the lower satisfaction level of respondents for CHD children versus those for other children is of particular concern. As stated, differences in income or income-related characteristics among CHD families versus other families partly explained the lower satisfaction level among respondents for CHD children. Nevertheless, the existence of this disparity—regardless of cause—is regrettable.

Accordingly, satisfaction of families of CHD children should be further studied through such means as surveys, forums, or focus groups targeting care givers of these children. If such studies confirm lower satisfaction levels among care givers of CHD children, reasons for these lower levels should be explored and measures to address them implemented.

Availability of Prevention and Primary Care Services

As previously stated, virtually all respondents in the Telephone Survey said that there was a place their child usually went when the child was sick or the care giver needed advice. By implication, therefore, in the eyes of the family nearly all children have a medical home. The number without a medical home (four children) was too small to definitively show that any subgroup is less likely to have a medical home, but the possibility of disparities in having a medical home should be explored through a telephone survey with a larger sample or through other sources of data.

Though potential differences regarding having a medical home could not be adequately assessed through this survey, findings pertaining to emergency room suggest that children from low income households need more emergency care and/or are more likely to use the emergency room instead of a non-emergency medical home. Additionally, per Telephone Survey findings, about one in five children had not received a well child check up or physical examination during the preceding 12 months and, by implication, had not received preventive services during that period. Children without health insurance were more likely than others not to have had a well child checkup/exam, suggesting that especially they did not have access to preventive care. Since CHD children did not notably differ from remaining children with respect to these issues, the Bureau's activities to further address primary and preventive care issues pertain mainly to lower levels of the service level pyramid.

Findings suggest that parents of CHD children may be less satisfied with their children's health care than parents of children receiving care elsewhere. Some, but perhaps not all, of this disparity is apparently due to the lower household income for CHD children versus other children or to characteristics linked with lower income. However, the sample size is too small to definitively assess the degree to which income or related characteristics contribute to the apparent disparity in satisfaction. Instead, these findings suggest a need for further study of how well parents of CHD children are satisfied with their children's health care.

Geographic Distribution of Primary Care Providers

A table, Primary Care Physicians in Rural Alabama—Percent Change (3 Yrs. 1996-1999), is located in Appendix K. As shown in this table, eight counties had a population:physician ratio exceeding 3,000:1 (i.e., had the fewest physicians in relation to their population). These counties were not concentrated in any single area, however, but were collectively located in seven of the State's 11 public health areas. The report in which the table appears⁹ was prepared by ADPH's Office of Primary Care and Rural Health. Per this report, rural hospital closings, population decreases, Medicare and Medicaid payment levels, and average family income are some of the factors that will determine future

physician supplies in rural areas. Rural hospital closings are usually followed by reductions in the number of health professionals in an area. Medicare and Medicaid reimbursements are often the main source of revenue for rural health care providers, so any change in payment levels will likely produce a corresponding change in rural health care providers. Improved transportation routes and better automobiles have produced a more mobile population that is willing to travel farther for health care services. The danger associated with the latter factor is that emergency services may not be available when needed. Geographic distribution of health care providers is discussed from CRS' perspective under *Availability of Care* in Section 3.1.2.2.C, where additional maps (also in Appendix K) showing family practitioners, pediatricians, dentists, psychologists, registered dietitians, physical therapists, occupational therapists, speech-language pathologists, registered nurse practitioners, and registered nurses are referenced.

3.1.2.2.C Direct and Enabling Services for CSHCN

Discussion of Alabama's priority concerns regarding access to health care and health-related services follows under the appropriate sub-topic.

Financial Access

Lack of health insurance was identified by 64.2% of the counties as a major access barrier for CSHCN in the county level provider survey. It was reported as a major barrier by 81% of the rural northern counties, which have higher educational attainment and employment. The related problem of under-insurance for special needs was identified as a problem by 56.7% of the counties. While ALL Kids has improved financial access for children under age 18 years from 100% to 200% of FPL and boosted Medicaid enrollment, third party coverage for the older adolescent with or without special needs remains a problem. At CRS, in FY 1998, 16.2% of the children under age 20 enrolled were uninsured; for all enrolled children under age 21 years, it was 20%, a 3.8% increase by adding clients who were aged 20. This suggests a much higher rate of un-insurance for older adolescents/young adults. While uninsured CSHCN may access CRS as a safety net provider for their specialty care, primary or acute care is often sought in emergency rooms. Underinsurance for habilitation and rehabilitation services is a problem for nearly all CSHCN with private insurance coverage. CRS often provides the additional financing for necessary services, such as augmentative communication devices. As previously noted, families reported during the public forums that costs of travel to medical care, insurance premiums and co-pays, and uncovered equipment and supplies forced many of them to make serious financial choices, which lowered their quality of life.

Blue Cross/Blue Shield of Alabama remains the dominant private sector insurer in the State, providing about 85% of private insurance coverage. Thus, managed care organizations (MCOs) have not penetrated deeply into the insurance market in Alabama. Both of the State's tertiary level pediatric hospitals are providers in nearly all the MCO networks. Access to pediatric sub-specialty services, then, is more often limited by the primary care provider functioning as a "gatekeeper," rather than from a lack of providers in the network. One particular problem with MCOs for CSHCN

has been the limited provider network for related services, particularly for durable medical equipment. The DME provider network of MCO's often does not include a provider with expertise in pediatric seating and positioning. Due to the relatively few number of CRS enrolled children in any specific MCO, CRS has been more successful in negotiating services (or exceptions) for children on an individual basis rather than enrolling as a provider in the network for this low incidence population.

Medicaid has implemented managed care programs during the past 5 years for more cost-effective utilization of services. BAY Health, an 1115 waiver granted to the Alabama Medicaid Agency for Mobile County, had fiscal problems and ceased providing services on October 1, 1999. Mobile County Medicaid recipients have subsequently received care on a fee-for-service basis, but will be enrolled as the final county in Patient 1st on June 1, 2000. Medicaid's PCCM Waiver, Patient 1st, introduced in January 1997, has been more successful. This model assigns all Medicaid recipients, including CSHCN, within a county to a medical home that manages their health care needs, including appropriate referrals for specialty care and pre-authorization of specified Medicaid services. PCCM has been instrumental in increasing access to primary care for Medicaid recipients, including CSHCN, throughout the State. It may have been a factor in decreasing private providers' reluctance to accept Medicaid. This reluctance was reported as a barrier in only 53.7% of the counties in 1999, compared to 62.7% of the counties in 1994. CRS continues to work closely with Medicaid on all issues related to services for CSHCN, and was particularly active in the areas of hearing aids, augmentative communication, and dental services, including medically necessary orthodontia, during the last year.

The impact of the changing SSI regulations in welfare reform for CSHCN, including financial access, is unclear. The number of SSI recipients under 18 years of age in Alabama, as reported by SSA in a "snapshot" format, has fallen from 24,530 in December 1997 to 23,630 in December 1999, a 4% decrease. Although the number of children receiving SSI has declined, the relative proportions of children with behavioral, cognitive, and physical impairments have not changed significantly. In FY 1997, of the referrals received by CRS from SSA, the breakdown by primary diagnosis was 11.2% behavioral conditions, 35.2% cognitive impairments, and 53.5% physical conditions or impairments. In a sample of referrals received during the first quarter of 2000, the breakdown by primary diagnosis was 14.7% behavioral conditions, 32.4% cognitive impairments, and 52.9% physical conditions or impairments.

Cultural Acceptability

Cultural and language barriers were reported as problematic by 52.2% of the counties in 1999, compared to 31.7% of the counties in 1994. This over 20% increase is indicative of the growing diversity within the State. The State is beginning to address the problems with cultural diversity regarding access to care. In the county survey, 76.1% of Alabama's counties reported that providers reflected the cultures in the county. Training was available to health care providers on cultural diversity in 61.2% of the counties, and 56.7% of counties had translation assistance for families.

Health promotion and education activities relevant to the cultures in the county were reported by 55.2% of the counties. CRS contracted with AT&T for utilization of language translation lines to ensure timely access to interpretation across the State.

Availability of Care

The number and distribution of specific types of providers was identified by 59.7% of the counties as a problem, ranking much higher among the rural counties as contrasted with urban counties. The distribution of many professionals providing health care and related services to children in Alabama, including those with special health care needs, remains problematic, particularly in rural areas. Table 3 indicates the county distribution of selected health professionals in the State. One limitation of the reported licensure data is that some of the providers listed may not be in active practice or practice in their county of residence. Family practice physicians, dentists, and registered nurses have the best distribution throughout the state. More specialized allied health professionals often utilized by CSHCN are fewer in number and most frequently found in urban areas. Maps of the following data are in Appendix K.

Percentage of Alabama's 67 Counties with Selected Health Professional Ratios per 10,000 Residents, 1999 Data.

Profession	% Counties with No Provider (n)	% Counties with < 1/10,000 Residents (n)	% Counties with < 2/10,000 Residents (n)	% Counties with < 3/10,000 Residents (n)
Family practice				
physicians	0% (0)	6.0% (4)	14.9% (10)	55.2% (37)
Pediatricians *	34.3% (23)	35.8% (24)	49.3% (33)	70.2% (47)
Dentists	2.9% (2)	8.9% (6)	32.8% (22)	64.2% (43)
Psychologists	49.3% (33)	86.6% (58)	94.0% (63)	97.0% (65)
Nutritionists	13.4% (9)	56.7% (38)	88.1% (59)	95.5% (64)
Physical therapists	14.9% (10)	50.8% (34)	68.7% (46)	85.1% (57)
Occupational				
therapists	29.9% (20)	70.2% (47)	92.5% (62)	95.5% (64)
Speech language				
pathologists	20.9% (14)	61.2% (41)	83.6% (56)	98.5% (66)
Nurse practitioners	13.4% (9)	34.3% (23)	80.6% (54)	94.0% (63)
Profession	% Counties with No Provider (n)	% Counties with < 60/10,000 residents	% Counties with < 80/10,000 residents	% Counties with <100/10,000 residents
Registered nurses	0% (0)	32.8% (22)	67.2% (45)	88.1% (59)

* For pediatricians, the ratio is per 10,000 residents under age 20 years.

Concerning services and facilities available to CSHCN, mental health diagnostic services and treatment are available

in every county. However, services through the mental health community centers are available first to individuals who pose a risk to themselves or others and then to the remaining individuals as capacity permits. Although an emergency medical system exists in at least part of every county, there are no routinely available continuing education programs on caring for CSHCN for first responders.

System Linkages

Alabama has two tertiary level hospitals for children: The Children's Hospital of Alabama (TCHA) and the University of South Alabama's (USA) Children's and Women's Hospital. Both institutions provide an extensive array of pediatric subspecialty services and have provider relationships with CRS, ALL Kids, Medicaid, Blue Cross and Blue Shield of Alabama, and most managed care organizations operating in the State. TCHA has developed the Children's Health System consisting of TCHA inpatient services, a primary care provider network in the Birmingham and Anniston areas, and outpatient services for pediatric specialty care in Huntsville, Dothan, Montgomery, and the outskirts of Birmingham. Pediatric subspecialists have relocated to these areas to staff the outpatient satellite clinics on a full-time basis, and other pediatric subspecialists travel to the sites periodically. CRS has opened an office within the TCHA outpatient facility in Birmingham to facilitate referral to community-based care coordination and follow-up. These expansions during the past 5 years have greatly increased access to pediatric subspecialty care for Alabama's CSHCN.

As part of its role to fill system gaps, CRS signed MOUs with the Shriners' Hospitals for Children, TCHA, and the USA Children's and Women's Hospital to address the health, social and educational needs of Alabama's CSHCN. These public/private partnerships were created to (1) identify clients eligible for the services of both but presently served by only one partner, and (2) identify unmet needs of clients served by either partner that could be met through utilization of the other's services/resources. Through these agreements CRS provides community-based care coordination, family support activities, wrap-around services, and financial assistance as needed to CRS-eligible children receiving pediatric subspecialty care at these institutions and their families. CSHCN served by all of the partners are encouraged to have a medical home and assisted with placement as needed. Through the efforts of care coordinators and reports of clinic visits, the medical homes are kept current on the status of the child's specialty care. This system, though in its formative stages, holds great promise for providing the coordinated, comprehensive services so needed by this population of children.

CRS provides funding with Title V monies to four multidisciplinary specialty services centers in the State. The Medical Genetics Programs at both UAB and USA are funded to provide services to CSHCN in satellite genetics clinics held at CRS clinics and other community locations as well as on-site in Birmingham and Mobile, respectively. The northern part of the State is served by UAB and the southern part by USA. Additionally, the Civitan International Research Center/Sparks Clinics and the Monsky Developmental Clinics, in Birmingham and Montgomery respectively,

provide multidisciplinary developmental evaluations for CSHCN and are also partially funded by Title V monies from CRS.

3.1.2.3 Enabling Services

3.1.2.3.A Enabling Services: Pregnant Women, Mothers and Infants

Enabling Services for Pregnant Women, Mothers and Infants: Community Forums and Focus Groups

Many of the responses at the community forums (35%) fell into the enabling level of services. Residents were not appreciably concerned with the existence of direct health care itself; instead, universal access was an issue of greater concern. Repeatedly, concerns about access to direct health care were brought up. However, in most cases the issues continually mentioned dealt with services that enable patients to get the care they need rather than lack of the health care. For example, lack of transportation, language barriers, and lack of insurance coverage were often mentioned as obstacles to healthy communities.

During the focus groups, several different issues pertaining to enabling services were raised. For instance, both the adolescents and the professionals demonstrated concern for transportation problems. In addition, different insurance coverage points were raised. These concerns ranged from the lack of health care coverage altogether to lack of acceptance into health care plans. Also of concern was single parenting. Enabling services may be needed even more by single parents who may need more assistance with caring for themselves and their children. As previously stated, findings from community forums cut across populations and apply to children, as well as to pregnant women, mothers and infants.

Enabling Services for Women of Childbearing Age: Medical Practices Survey

Section C of the Medical Practice Questionnaire (Appendix G) dealt with accessibility, family centeredness, comprehensiveness, coordination, and cultural competence. For each statement in the table comprising that section, respondents were asked to check the column that best described their practice. The column headings were: most or all of the time, some of the time, seldom or never, I don't know, or not applicable. The next table shows the percentage checking "most or all of the time" for the items deemed most relevant to women of childbearing age. To avoid obscuring findings pertaining specifically to pregnant women, findings were analyzed for the 37 practices serving pregnant women, as well as the 107 practices serving non-pregnant women of childbearing age. (Most practices serving pregnant women also served nonpregnant ones, so are also included in the 107 practices. However, as shown in the next table, estimates for the 37 practices serving pregnant women are especially imprecise, due to the small numbers, and confidence intervals for this group greatly overlap with those for the 107 practices. Discussion of the table, therefore, is limited to findings for the 107 practices serving women of childbearing of age.

Characteristics of Practices Serving Women of Childbearing Age: Pertaining to Accessibility, Family Centeredness,

Comprehensiveness, Coordination, and Cultural Competence

<i>Issue*</i>	<i>Characteristic</i>	<i>Percent Providing the Service Most or All of the Time (95% CI)**</i>	
		<i>Practices Serving Women of Childbearing Age (n = 107)</i>	<i>Practices Serving Pregnant Women (n = 37)</i>
Access	Patients in my practice have telephone access to someone 24 hours a day, 7 days a week	90.7 (83.1 - 95.2)	97.3 (84.2 - 99.9)
Access	In an emergency, someone from my practice is available to see a patient in the middle of the night or on weekends.	60.7 (50.8 - 70.0)	81.1 (64.3 - 91.4)
Access	Appointments are available in my practice during extended hours.	16.8 (10.5 - 25.6)	21.6 (10.4 - 38.7)
Family/patient centeredness	Primary provider(s) attempt to explore all health care options with patients and/or their families.	77.6 (68.3 - 84.8)	70.3 (52.8 - 83.6)
Comprehensiveness	Patients or their families are referred to services in the community that meet their specific needs	74.8 (65.3 - 82.4)	67.6 (50.1 - 81.4)
Comprehensiveness	The practice provides written information to patients or their families on a variety of health issues.	64.5 (54.6 - 73.3)	67.6 (50.1 - 81.4)
Coordination	Someone in the practice coordinates care among multiple providers for patients with special health care needs and/or their families.	57.0 (47.1 - 66.4)	59.5 (42.2 - 74.8)
Coordination	Someone in the practice links patients or families who need support groups...to support groups whenever feasible	47.7 (38.0 - 57.5)	45.9 (29.8 - 62.9)
Family/patient centeredness	Extra time is scheduled for office visits when seeing patients with special health care needs.	56.1 (46.2 - 65.5)	59.5 (42.2 - 74.8)
Coordination	After patients have seen a specialist, someone in the practice schedules time with them or their families to discuss the results of the visit to the specialist.	24.3 (16.8 - 33.7)	18.9 (8.6 - 35.7)
Cultural competence	The practice provides a translator or interpreter for patients or families for whom English is a second language that they do not speak fluently.	16.8 (10.5 - 25.6)	24.3 (12.4 - 41.6)
Cultural competence	Materials appropriate to the reading levels of and languages spoken by patients or their families are available for distribution.	32.7 (24.1 - 42.5)	48.6 (32.2 - 65.3)

*Per analyst's judgment

** Fleiss 95% quadratic confidence interval

Discussion of the preceding table is ordered by the issue to which each characteristic pertains:

- With respect to *access*, most (91%) practices were generally accessible by telephone 24 hours a day. Many practices (about 39%), however, were *not* generally available to see patients in the middle of the night or on weekends. Few (17%) practices generally offered appointments during extended hours.
- With respect to *patient centeredness*, about three-fourths of practices generally attempted to explore all health care options with patients, and slightly more than half generally scheduled extra time for office visits for women with special health care needs. As a corollary, nearly half of them did not generally schedule extra time for special health care needs.
- With respect to *comprehensiveness of care*, about three-fourths of the practices generally referred patients to services in the community to meet their specific needs, and over half (but fewer than three-fourths) of them generally provided written information to patients on a variety of health issues. Thus, many practices did *not* generally provide written information on a variety of health issues.
- With respect to *coordination of care*, only slightly more than half of the practices coordinated care among multiple providers for patients with special health care needs, and nearly half of them linked patients who needed support groups to such groups. Only about one-fourth of the practices generally scheduled time with patients to discuss results of previous visits to specialists. Thus, about half of the practices did *not* generally coordinate care for patients with special health needs or link them with support groups, and most of them did *not* generally schedule time with a patient to review previous visits with specialists.
- With respect to *cultural competence*, fewer than one-fifth of the practices generally provided a translator or interpreter for patients for whom English was a second language that they did not speak fluently, and only about one-third of them generally provided materials appropriate to patients' reading levels and languages. Thus, most practices were not well prepared to fully serve persons with poor reading skills or immigrants who had not mastered English well.

None of the above findings are surprising to the Bureau, and indeed they suggest that most practices were forthcoming in acknowledging what services they did not have the resources to provide on a regular basis. The table comprising the accessibility...cultural competence section of the questionnaire also included columns indicating potential barriers to providing the services described: reimbursement, time, staffing, lack of administrative support, or other. For each characteristic listed, respondents were advised to circle any barriers hindering the practice's ability to provide the service. Overall, for the 107 practices serving women of childbearing age, the barriers most often cited (as a percent of all the opportunities for each barrier to be cited) were staffing (7%), time (6%), and other (4%). Reimbursement

and administrative factors respectively cited 2% and 1% of the time. Thus, staffing and time, but also issues not identified by the Bureau, were major impediments to providing the services shown in the preceding table. Though seldom cited, reimbursement may have been an unrecognized factor—conceivably, practices may have hired or contracted with staff to provide some of the services more often had the services been sufficiently reimbursable.

One salient finding from the Medical Practice Survey pertains to *provision of case management*. Respondents were asked, “Does your practice provide case management/service coordination for female patients of childbearing age (activities carried out by a case manager/service coordinator to help patients obtain needed services that are provided elsewhere)?”

- Of the 107 practices serving women of childbearing age, 16% (CI: 10% - 25%) said that they nearly always provided this service, and 13% (8% - 21%) said they often provided it. As a corollary, 69% (CI: 59% - 78%) of the practices said that they provided the service only occasionally, seldom, or never. Thus, most practices serving women of childbearing age do *not* often provide case management services to nonpregnant women. Moreover, in retrospect, the Bureau believes that the question should have more rigorously defined the meaning of case management, and that the number of practices having well qualified case managers might be fewer than these findings would indicate.
- Of the 37 practices serving pregnant women, 43% (CI: 28% - 60%) said that they nearly always provided the service; 16% (CI: 7% - 33%) that they often provided it; and 35% (CI: 20% - 53%) that they provided it only occasionally, seldom, or never. Combining these two categories, accounting for statistical uncertainty, and assuming findings can be validly generalized to non-respondents, probably from about 40% to 75% of obstetrical practices provide case management, as respondents interpreted the survey’s definition (best point estimate is 59%). On the other hand, from about one-fifth to one-half of obstetrical practices do *not* regularly provide case management (best guess is one-third).

Enabling Services for Pregnant Women, Mothers and Infants: MCH Organizations Survey

As discussed in Section 3.1.1.A, Alabama has a variety of organizations that endeavor to serve women, children, and families. These organizations—whether public or private, secular or faith-based—collectively comprise an essential resource to promoting the health of the Title V populations. Accordingly, no needs assessment is complete without a basic description of the services provided by these organizations. The purpose of reporting these findings is to provide a general picture of the many ways that such organizations serve Title V populations and, thereby, provide

information pertinent to discussion in Section 3.1.2.5 of gaps in and barriers to services. No attempt was made to test for significant differences or (with a few exceptions cited in Section 3.1.2.5) estimate confidence intervals, since such analysis was not deemed necessary for the purpose stated above. Because 319 organizations responded, most estimates should be sufficiently precise for a general picture.

Figures 56 and 57 respectively show enabling and other types of services that these organizations provide for pregnant women. (“Other types of services” pertains to services deemed to be important, but not strictly enabling in nature.) The proportion of respondents providing a given enabling service ranged from 5% for translation of health information to 37% for provision of family support services. The proportion of respondents providing other types of services ranged from 5% for treatment/counseling for nicotine dependence to 15% for provision of “other” mental health counseling.

Figure 56. Percent of Surveyed MCH Organizations Providing Enabling Services to Pregnant Women, Alabama, 1999

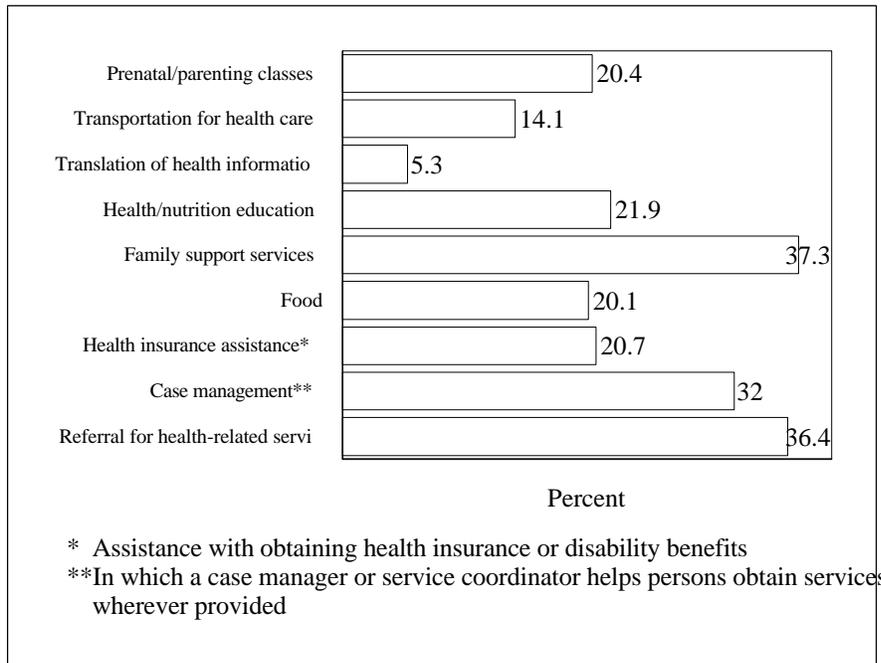
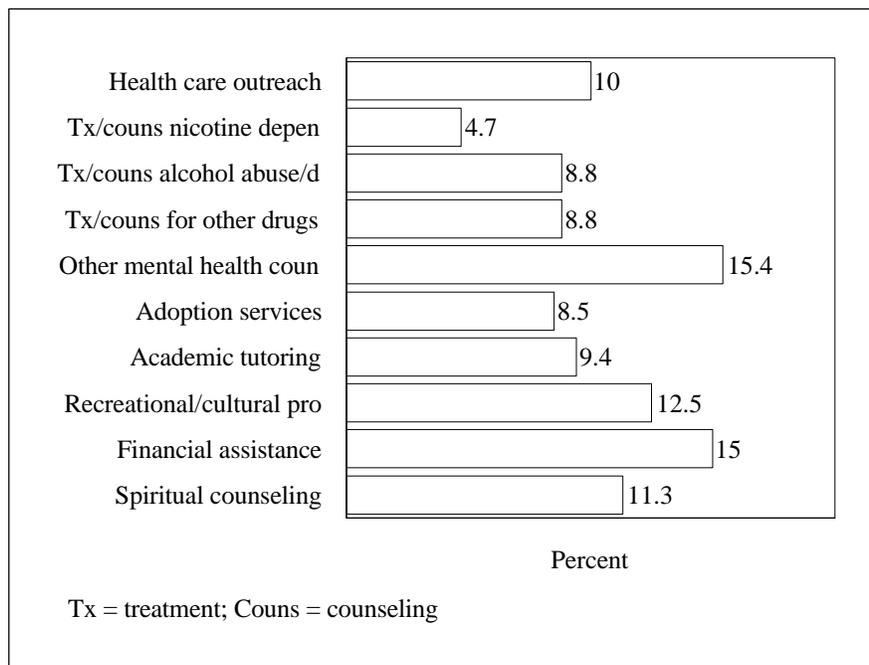


Figure 57. Percent of Surveyed MCH Organizations Providing Other Services to Pregnant Women, Alabama, 1999



A similar variety of services was provided to infants. The proportion of organizations providing a given service of interest ranged from 3% for respite care to 24% for family support services (not graphically depicted). (For the purposes of this survey, examples of family support services are support groups, advocacy, social work, and individual and family counseling.)

Additionally, the organizations promoted a variety of health-related issues via outreach. For example, with respect to women of childbearing age, 28% of the organizations promoted parenting skills (any age or sex), 12% promoted mental health, 10% promoted general nutrition, and 6% promoted folic acid intake. As will be discussed under *Infrastructure: Qualitative Data from Medical Practices Survey and MCH Organizations Survey* in Section 3.1.2.5.B, the parenting skills and mental health issues comprised two of the tentatively identified sub-themes per analysis of qualitative data from the Medical Practice Survey and MCH Organizations Survey. Given the need to promote adequate folic acid intake by women capable of becoming pregnant, ascertaining the proportion (6%) of organizations promoting such intake is of particular interest to the Bureau.

3.1.2.3.B Enabling Services: Children

Enabling Services for Children: Telephone Survey

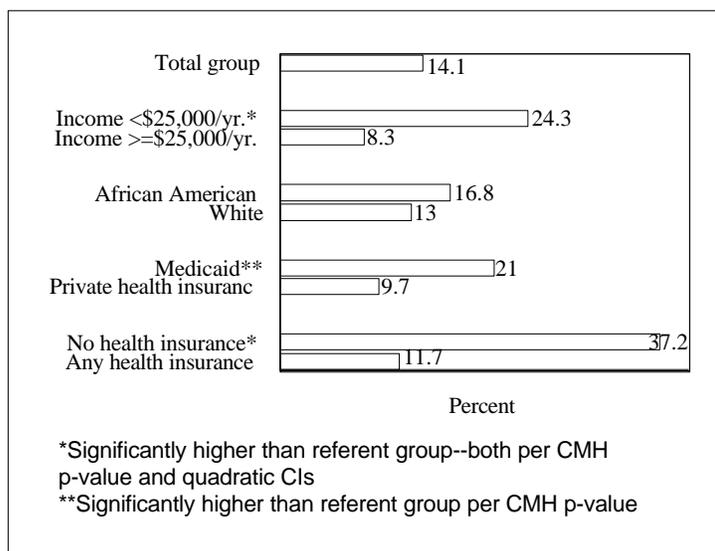
Methods Notes: Methodological notes in Section 3.1.2.1.C apply to the findings below. Again, confidence intervals are included in the narrative when deemed important to allow for statistical imprecision.

Financial Access

The main series of Telephone Survey questions addressing financial access was introduced as follows: “During the past 12 months, was there any time when (he/she) needed any of the following kinds of care, but didn’t get it because you couldn’t afford it?” The “kinds of care” then asked about were (1) prescription medications; (2) mental health care or counseling; (3) dental care, including checkups; (4) eye glasses; and (5) any other kind of care. For all study children (aged 1-17 years) combined, 14% (CI: 11% - 18%) of respondents answered affirmatively (i.e., said they had delayed getting care) for one or more of

the five types of care mentioned. Not surprisingly, low income respondents were more likely than higher income respondents, and respondents for uninsured children more likely than those for insured children, to have delayed care for financial reasons (Figure 58). Moreover, respondents for Medicaid-enrolled children were more likely to have delayed getting care for their child than respondents for children with private insurance. Income differences partly, but not completely, explained the more frequent delay of care for uninsured children and Medicaid-enrolled children.

Figure 58. Percent of Children for Whom Health Care Had Been Delayed, Alabama, 2000

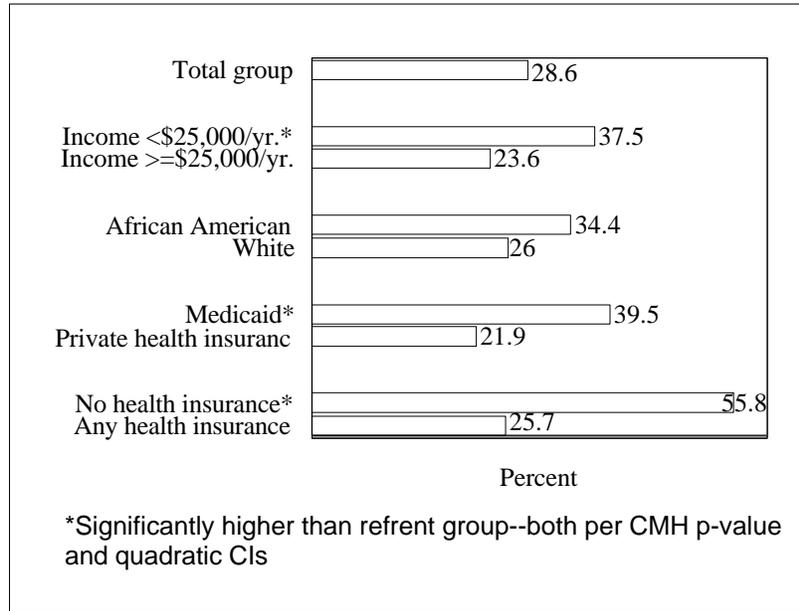


With respect to specific kinds of care, dental care was delayed by the most respondents, with 10% (CI: 8% - 14%) of them having delayed getting dental care for their child. Second in frequency was prescription medications, which 5% (CI: 4% - 8%) of respondents had delayed getting for their child. Third in frequency was eye glasses, which 4% (CI: 2% - 6%) of respondents had delayed getting for their child. Mental health care or counseling and “any other kind” of care were delayed least often, with each delayed by just 2% of respondents. Low income respondents, respondents whose child was enrolled in Medicaid, and respondents for uninsured children were more likely than their respective referent groups to have delayed getting dental care for their child. Comparison of subgroups regarding delay for other kinds of care, though sometimes statistically significant, provides limited information to due to the very small numbers involved so is not reported here.

Barriers to Care

Because financial barriers are not the only barriers to accessing health care, another set of questions addressed an array of potential barriers, including financial ones. This set of questions was introduced as follows: “There are many reasons parents or guardians sometimes delay getting health care for a child. Have you needed to delay getting health care for your (___-year-old) child for any of the following reasons in the past 12 months?” For the 482 study children, 29% (CI: 25% - 33%) of respondents answered affirmatively to one or more of the potential barriers (i.e., said that they had delayed care for one or more of the reasons mentioned). As expected, low income respondents and respondents whose child had no health insurance cited barriers more often than their respective referent groups (higher income respondents and respondents whose child had health insurance of any type).

Figure 59. Percent of Children for Whom Any Barrier Had Delayed Health Care, Alabama, 2000



Additionally, respondents whose child was enrolled in Medicaid cited barriers more often than those whose child was enrolled in private insurance plans (Figure 59).

The potential reasons for delaying health care that were sequentially asked about are listed (not in the order mentioned) in the following table, along with the frequency of their occurrence and confidence intervals. Since the low income population is more likely to experience barriers (and is greater in number than the Medicaid and uninsured populations), the barriers are shown for the low income group as well as for the total population. Delay in getting an appointment, long waiting time in the office, financial considerations, and inconvenient office hours were the barriers most often cited by the total group of respondents (“All Respondents” column). In addition to those four barriers, lack of transportation was a notable barrier for low income respondents (“Low Income Respondents” column). Not surprisingly, being unable to afford the care was an especially prominent barrier for respondents whose child did not have health insurance, with 37% (CI: 23% - 53%) citing this reason for delaying care (not shown in table). Thus, one very important aspect of enabling services is to facilitate enrollment of children in appropriate health insurance plans.

<i>Reason for Delay</i>	<i>Percent of Respondents Answering Affirmatively to Barrier (95% CI)</i>	
	<i>All Respondents</i>	<i>Low Income Respondents</i>
Not being able to get an appointment soon enough	10% (7% - 13%)	13% (8% - 20%)
After arrival, waiting too long to see the doctor	10% (8% - 13%)	16% (11% - 24%)
Not being able to afford the care	10% (7% - 13%)	19% (13% - 26%)
Not being able to get there when the clinic/doctor's office was open	9% (7% - 12%)	9% (5% - 15%)
Not having transportation	3% (2% - 5%)	9% (5% - 14%)
Not being able to get through on the telephone	4% (2% - 6%)	4% (2% - 9%)
"Other" reason	4% (2% - 6%)	7% (3% - 12%)

By administering SCHIP (Section 1.4), ADPH is addressing financial barriers to health care from a population-based perspective. From an individual perspective, moreover, one important enabling service provided by CHDs is the offering of joint SCHIP/Medicaid SOBRA applications. Case managers in CHDs can facilitate enrollment of clients in health insurance plans for which they are eligible. Indeed 28% (19% - 38%) of low income respondents, 21% (14% - 31%) of respondents for African American children, and 44% (33% - 57%) of respondents for Medicaid-enrolled children said that the child's health insurance had been obtained through "Alabama's new Children's Health Insurance Program." (A caveat to these findings is that, to our knowledge, a question about whether insurance was obtained through SCHIP has not been asked in national surveys, and we have not assessed the respondents' understanding of the question or the validity of responses. However, the fact that about one-half of all applications received in the ALL Kids enrollment office are for Medicaid-eligible children suggests that SCHIP promotes enrollment of eligible children in Medicaid.)

Enabling Services for Children: Medical Practices Survey

Notes on Methods #5:

Respondents for the Medical Practices Survey included 109 practices serving children. (Most of these 109 practices also served women of childbearing age.) With respect to ages of children served, 78% of the responding practices

served children 4 years of age and younger, 86% of them served children aged 5-11 years, 94% of them served children aged 12-17 years, and 86% of them served youth aged 18-21 years. (Respondents were advised to check all age categories that applied.) Sixty-eight percent of the practices served CSHCN (defined in the questionnaire as children “with chronic problems requiring more than routine care”).

As discussed under Enabling Services for Pregnant Women, Mothers and Infants in Section 3.1.2.3.A, one section of the Medical Practices Survey dealt with accessibility, family centeredness, comprehensiveness, coordination, and cultural competence. Corresponding findings for the 109 practices serving children are shown below, along with two additional issues that were not deemed pertinent to the adult population. Because findings regarding practices serving children are very similar to those for practices serving women of childbearing age, this discussion mainly addresses only the two added issues and one other issue of particular relevance to children. (The similarities are not surprising, since many of the practices serving children also served women of childbearing age. See the previous discussion for a full explanation of the table and findings.)

As shown in the following table, about three-fourths of practices said that families play a central role in coordination of care for their child, and a similar proportion said that families are involved in decision making around their child. Thus, many practices are family centered, though there is some room for improvement in this area. Barriers cited to providing the services listed were distributed similarly to those cited by practices serving women of childbearing age, with staffing, time, and “other” being cited most often.

Because 68% of the practices served CSHCN, the item pertaining to whether the office provided care coordination services is of particular interest. Per the table below, 60% of practices indicated that someone in the practice coordinated care among multiple providers for patients with special health care needs and/or their families “most or all of the time.” A related question in Section C3 of the questionnaire (the “Children and Youth” section) provides a different perspective, however. The related question asked, “Does someone in your practice serve as the primary coordinator of medical care for children/youth with special health care needs?” Per the four mutually exclusive check box responses regarding how often someone served in this capacity, only 37% of practices said this occurred most of the time, 9% that it occurred often, 13% that it occurred occasionally, and 18% that it occurred seldom or never. The notably different responses to these two questions are puzzling and imply that one or both of the items may not be yielding very valid responses (i.e., are not measuring what we intend to measure). Accordingly, in the future, the clarity of questions in the Medical Practice questionnaire, as well as validity of responses, should be assessed.

Characteristics of Practices Serving Children: Pertaining to Accessibility, Family Centeredness, Comprehensiveness, Coordination, and Cultural Competence

<i>Issue*</i>	<i>Characteristic</i>	<i>Percent Providing the Service Most or All of the Time (95% CI)**</i>
Access	Patients in my practice have telephone access to someone 24 hours a day, 7 days a week.	88.1 (80.1 - 93.2)
Access	In an emergency, someone from my practice is available to see a patient in the middle of the night or on weekends.	59.6 (49.8 - 68.8)
Access	Appointments are available in my practice during extended hours.	17.4 (11.1 - 26.1)
Family/patient centeredness	Primary provider(s) attempt to explore all health care options with patients and/or their families.	76.1 (66.9 - 83.6)
Family centeredness	Families play a central role in coordination of care for their child.	74.3 (64.9 - 82.0)
Family centeredness	In this practice, families are involved in the decision-making around their child.	78.0 (68.8 - 85.1)
Comprehensiveness	Patients or their families are referred to services in the community that meet their specific needs.	76.1 (66.9 - 83.6)
Comprehensiveness	The practice provides written information to patients or their families on a variety of health issues.	63.3 (53.5 - 72.2)
Coordination	Someone in the practice coordinates care among multiple providers for patients with special health care needs and/or their families.	59.6 (49.8 - 68.8)
Coordination	Someone in the practice links patients or families who need support groups...to support groups whenever feasible	48.6 (39.0 - 58.3)
Family/patient centeredness	Extra time is scheduled for office visits when seeing patients with special health care needs.	54.1 (44.3 - 63.6)
Coordination	After patients have seen a specialist, someone in the practice schedules time with them or their families to discuss the results of the visit to the specialist.	22.0 (14.9 - 31.2)
Cultural competence	The practice provides a translator or interpreter for patients or families for whom English is a second language that they do not speak fluently.	12.8 (7.5 - 20.9)
Cultural competence	Materials appropriate to the reading levels of and languages spoken by patients or their families are available for distribution.	32.1 (23.7 - 41.8)

*Per analyst's judgment

**Fleiss 95% quadratic confidence interval

Enabling and Selected Other Services for Children: MCH Organizations Survey

As previously stated, many organizations external to ADPH collectively comprise an essential resource to promoting

the health of Title V populations, and needs assessment should include a basic description of services provided by these entities. Several services are mentioned here as examples, not as a comprehensive description of services provided to an age group. The proportion of organizations providing a given enabling service for children aged 1 through 5 years ranged from 4% providing respite care to 30% providing referral for health-related services. The proportion of organizations providing specified other services for this age group ranged from 3% for sustained treatment or counseling for nicotine dependence to 25% providing recreational or cultural programs. As another example, the proportion of organizations providing a specified service (not classified as enabling) to youth aged 15-19 years ranged from 4% for sustained treatment or counseling for nicotine dependence to 22% for recreational or cultural programs.

***Implications of Findings Pertaining to Enabling Services
for Pregnant Women, Mothers, Infants and Children***

Findings from the Telephone Survey suggest that many parents experience barriers to getting prompt health care for their child, including delayed appointments, financial issues, and for low income parents, lack of transportation. Some of these needs could be addressed through provision of case management services for children, which in turn is addressed through two of the newly developed State-negotiated performance measures. Moreover, several findings from the Medical Practices Survey suggest that limited health education is being provided to patients, especially those with reading or language barriers. For example, many medical practices are apparently not regularly assessing female patients of childbearing age about folic acid consumption and neural tube defects. These findings lead to one of the identified priority MCH needs: to promote health education and outreach regarding high priority topics, per qualitative and quantitative data.

Enabling Services: Impact of Recent Changes in the Health Care Environment on Access to Care

Changes in financial access have been discussed in many places throughout this document but, in response to guidance for the Title V application/Annual Report, are cross-referenced here. Unless stated otherwise, findings discussed here pertain to two of the Title V populations: pregnant women, mothers and infants; and children. In addition to cross-referencing previously discussed issues, selected access-related findings from BFHS-conducted surveys or forums are described. Specifically, the MCH Organizations Survey and the Medical Practice Survey each included the following question: “What effect do you believe the following events are having on delivering health care to, or reducing barriers to health care of, pregnant women, mothers, infants or children?” Three events were listed: (1) expansion of Medicaid coverage to cover more children and pregnant women, (2) the move to managed care delivery systems, and (3) passage

of welfare reform. Four mutually exclusive check box responses were offered as options: beneficial, none, adverse, or don't know.

Shift in Medicaid Coverage Over the Last 5 years

As discussed under *Medicaid Managed Care Programs* in Section 1.4, shifts in Medicaid coverage have reduced financial barriers to family planning services for adolescents. Moreover, as also discussed in that section, expansion of Medicaid eligibility for family planning services for adult women to 133% of FPL is anticipated. This anticipated shift should reduce financial barriers to family planning services for adults.

In the mailed surveys, most of the respondents who expressed an opinion believed that Medicaid expansion was beneficial. That is, of 142 respondents in the Medical Practice survey, 58% rated the effect of expansion of Medicaid coverage as beneficial, 7% rated the expansion as having no effect, 3.5% rated it as having an adverse effect, 10% said they didn't know, and 22% did not answer the question. Of 319 respondents in the MCH Organizations survey, 65% rated the effect of expansion of Medicaid coverage as beneficial, 1.3% rated the expansion as having no effect, 2.8% rated it as having an adverse effect, 9% said they didn't know, and 22% did not answer the question. Further analysis of qualitative data (planned for FY 2001) collected in these surveys may provide additional insight into respondents' views about this issue.

The Move to Managed Care

There is no single, all encompassing view regarding the effects of the move to managed care. Various views pertaining to this issue, discussed in many places in this document, have been expressed:

- Partly due to Medicaid's managed care program, Alabama has seen a continuing shift in the provision of direct medical services from CHDs to private providers (*Changes in the Health Care Environment and Medicaid Managed Care Programs*, in Section 1.4). Partly in response to this shift and to other changes in the health care environment, ADPH has formed a Strategic Direction Project (Section 2.4.E).
- Per some observers, Medicaid's managed care program has increased access to primary care for Medicaid recipients, including CSHCN, throughout the State (*Medicaid Managed Care Programs*, Section 1.4).
- Staff involved with newborn screening for metabolic disorders and hemoglobinopathies believe that Medicaid's managed care program has hampered prompt identification of primary care physicians, but that the Department's working relationships with other entities provide a safety net for early identification and treatment (CP #04, in Section 2.4.C.1).
- There is some speculation, based on unconfirmed verbal reports, that the apparent decline in immunization levels

of children 2 years of age and younger is related to Medicaid's PCCM Program (CP #05, in Section 2.4.C.1).

- With respect to prenatal care, Bureau staff believe that managed care for Medicaid-eligible pregnant women has improved access to private medical providers throughout the State. For uninsured women, however, care is difficult to access. Furthermore, along with the increase in numbers of births to apparently uninsured Hispanic women, the shift from the Medicaid Maternity Waiver to the Medicaid Maternity Care Program has adversely affected the ability of CHDs to provide prenatal care to the uninsured population (CP #18, in Section 2.4.D.1). To better address this issue in the context of the managed care arena, Bureau staff will collaborate with and train CHD staff to empower them to work with their communities and to enlist community support for prenatal funding for the local uninsured (CP #18, in Section 4.1.D.1).

Of respondents expressing an opinion pertaining to this issue in the mailed surveys, many felt that the move to managed care delivery systems was having an adverse effect. Of 142 respondents in the Medical Practice Survey, 14% rated the move to managed care delivery systems as being beneficial, 14% as having no effect, and 30% as having an adverse effect; 20% said they didn't know, and 22% did not answer the question. Of 319 respondents in the MCH Organizations Survey, 14% rated the move to managed care delivery systems as being beneficial, 3.1% as having no effect, and 28% as having an adverse effect; 31% said they didn't know, and 25% did not answer the question. Again, further analysis of qualitative data from these surveys may provide additional insight into views of respondents.

Passage of Welfare Reform

Several data sources, as well as the perspective provided by a local pastor at the last meeting of the MCH Needs Assessment Advisory Committee, provide information pertaining to this issue. Findings regarding welfare reform were similar in the two mailed surveys addressing it, with nearly 25% of respondents rating the passage of welfare reform as being beneficial and about 15% rating it as having an adverse effect (but many did not answer the question). Of 142 respondents to the Medical Practice Survey, 24% rated the passage of welfare reform as being beneficial, 15.5% as having no effect, and 8.5% as having an adverse effect; 28% said they didn't know, and 24% did not answer the question. Of 319 respondents to the MCH Organizations Survey, 24% rated the passage of welfare reform as being beneficial, 5% as having no effect, and 14% as having an adverse effect; 30% said they didn't know, and 27% did not answer the question. Again, further analysis of qualitative data from these surveys may provide additional insight into views of respondents.

Another data source was the Telephone Survey of Households with Children. Of the 22 respondents saying that they had received TANF in the past 4 years but were no longer receiving it, 68% (15/22; 95% CI: 45% - 85%) said that they were better off, 18% (4/22; 95% CI: 6% - 41%) that they were the same as, and 9% (2/22; 95% CI: 1.6% - 31%) that they were worse off than they had been when they were still receiving TANF. The small numbers involved preclude

firm conclusions, however. Moreover, persons who had no telephones are not represented in this survey.

Another source of information regarding the effects of welfare reform is the Welfare Reform Follow-Up Survey conducted for DHR by the University of Alabama School of Social Work and the Institute for Social Science Research. Subjects were 416 Alabamians whose TANF cases were closed between July and November 1998. Thus, the survey described experiences of individuals who had been off TANF from 7 to 12 months. Compared with their status before they had been off TANF, 42% said that they were better off, 45% that they were about the same, and 11% that they were worse off. Thus, per the Bureau's Telephone Survey and DHR's survey, roughly 10% of respondents said that they were worse off than they had been while on TANF, and most respondents said that they were the same as or better off than they had been while on TANF. However, researchers conducting the DHR study said that their survey may have over-represented persons who were employed and/or receiving income from sources that included child support and SSI at the time of the interview. The Bureau's Telephone Survey presumably had a similar limitation—though perhaps to a lesser degree, since random digit dialing excludes persons without telephones but does not exclude persons whose telephone number has changed.

With respect to qualitative information, the pastor addressing the MCH Advisory Committee about welfare reform eloquently reminded the Committee that persons moving off welfare need long-term support and understanding and may be unsuccessful in their first attempts to move beyond welfare. Moreover, such persons often need training in development of “soft” work-related skills that persons who are accustomed to the work environment may take for granted. The pastor commended staff from the local (Montgomery County) DHR office for their excellent work and strong commitment to helping persons succeed as they moved off welfare.

Thus, based on the previously mentioned sources, most former TANF recipients may believe that they are about the same as or better of than they were when receiving TANF. A substantial minority (probably more than indicated in the surveys cited), however, believe that they are worse off. In the health care setting, such women may especially benefit from case management services, which are discussed several places in this document.

Other Financial Access Issues

A major program affecting financial access to health care is SCHIP, which is discussed in many places in this document (e.g, *The Children's Health Insurance Program [SCHIP]*, in Section 1.4; CP #12, in Sections 2.4.D.2 and 4.1.D.2; CP #13, in Section 2.4.D.2 and 4.1.D.2; CP #11, in Section 2.4.D.3; *Barriers to Care*, in Section 3.1.2.3.B; and *Infrastructure Building for Children: Household Telephone Survey*, in Section 3.1.2.5.B). Bureau staff believe that SCHIP, presumably along with improvements in the State's economy, exerts a very positive influence on access to health care.

3.1.2.4 Population-Based Services

3.1.2.4.A Population-Based Services: Pregnant Women, Mothers and Infants

Population-Based Services: Community Forums and Focus Groups

Second to enabling services in quantity, community forum participants offered responses to questions dealing with the population-based (34% of responses) level of service. Community members were interested in strengthening community wide outreach and education. In some instances, residents expressed problems with not knowing what services were available to them. In addition, population-based programs addressing nutrition, substance abuse, and safety were mentioned. Together, enabling services and population-based services made up the majority of issues and concerns raised in the community forums.

In the focus groups' analyses, most of the responses fell into the population-based level of service. Many of the issues that were viewed as problems by all three groups, such as early sexual activity in adolescents and unplanned pregnancy, are addressed mainly through population-based programs. Alcohol and drug use were mentioned in all three groups as well. Other examples among the teenagers included not graduating from high school and teenagers contracting STDs. Most of these issues are also addressed with population-based campaigns. As before, findings from community forums and focus groups also apply to children.

Population-Based Services for Pregnant Women, Mothers and Infants: Medical Practices Survey

The Medical Practices Survey included sets of questions pertaining to the provision of comprehensive preventive and primary care services. Although these services are mainly direct or enabling services from the perspective of the practitioner, their main implications for Bureau programs and policy pertain to potential population-based services and to infrastructure-building activities. Therefore, though involving all levels of the pyramid, findings pertaining to these questions are discussed under *Population-Based Services*.

Though a question addressing assessment of patients for selected issues regarding primary and preventive care during pregnancy was asked, findings were not very informative due to the small number of obstetrical practices in the sample. Accordingly, unless stated otherwise, reported findings pertaining to pregnant, women, mothers and infants are for the 107 practices serving nonpregnant women of childbearing age.

Ninety-two percent (CI: 84% - 96%) of the 107 practices serving non-pregnant women provided pregnancy prevention services. Not surprisingly, oral contraceptives were the most commonly provided method (92% of all 107 practices), followed by Depo-Provera (78% of all practices). Sixty-nine percent of the practices provided counseling about abstinence. The percentage of all practices providing or counseling patients about other types of contraception ranged from 48% for intrauterine devices to 53% for natural methods.

The following table (see next page) shows responses of practices serving women of childbearing age to a question addressing provision of certain preventive and primary care services. The items inquired about are listed in descending order with respect to frequency of assessment. Though (per inspection of confidence intervals), no single issue stands out from all other issues regarding frequency of assessment, more patients were assessed for some issues than for some other issues. That is, notably more patients were assessed regarding tobacco consumption, alcohol consumption, hypertension, and breast cancer than were assessed for “other” nutritional issues, exercise, risk of HIV, folate consumption, blood cholesterol, domestic violence, and genetic issues. One salient finding is that, even accounting for statistical imprecision, it seems that *at least* one-third of primary care practices assess *only half or fewer* of their female patients of childbearing age regarding folic acid consumption. (We think it unlikely that non-respondents provide any of the services described more often than respondents.) This finding is of concern because CDC has recommended that all U.S. women of childbearing age who are capable of becoming pregnant should consume 0.4 mg of folic acid per day in order to reduce their risk of having a pregnancy affected with neural tube defects. The Bureau’s previous and planned activities pertaining to folic acid consumption are respectively described in Sections 2.4.A.1 and 4.1.A.1, under SP #01.

The public health significance of other findings shown in the table under discussion varies from item to item and requires further consideration. For example, it seems that *at least* 15% of primary care practices assess *only half or fewer* of their patients regarding risk of cervical cancer (best point estimate is 22%). Findings for alcohol consumption, hypertension, breast exam, and obesity are roughly similar to those for cervical cancer. As implied above, items listed toward the bottom of the table are probably assessed with less regularity than those listed toward the top of the table. Whether assessments pertaining to such items as genetic issues, domestic violence, blood cholesterol, and HIV infection should be provided more regularly for women of childbearing age merits discussion with other public health professionals and providers of care.

Question: About how many of your female patients of childbearing age does your practice assess (per history and, if indicated lab test) for the following issues and, if needed, counsel/treat or refer?”

<i>Issue</i>	<i>% of Practices Selecting Stated Frequencies (95% CI)*</i>	
	<i>>90% of Patients</i>	<i><50 % of Patients</i>
Tobacco consumption	61.7 (51.7 - 70.8)	17.8 (11.3 - 26.6)
Alcohol consumption	57.9 (48.0 - 67.3)	22.4 (15.2 - 31.7)
Hypertension	57.9 (48.0 - 67.3)	21.5 (14.4 - 30.7)

<i>Issue</i>	<i>% of Practices Selecting Stated Frequencies (95% CI)*</i>	
	<i>>90% of Patients</i>	<i><50 % of Patients</i>
Breast cancer per breast exam	57.9 (48.0 - 67.3)	20.6 (13.6 - 29.7)
Breast cancer per mammogram–baseline at 35-40, every 1-2 yrs after 40	56.1 (46.2 - 65.5)	17.8 (11.3 - 26.6)
Obesity	53.3 (43.4 - 62.9)	25.2 (17.6 - 34.7)
Risk of cervical cancer	52.3 (42.5 - 62.0)	22.4 (15.2 - 31.7)
Other drug use	51.4 (41.6 - 61.1)	34.6 (25.8 -44.5)
Risk of other STDs	36.4 (27.5 - 46.4)	37.4 (28.4 - 47.3)
Other nutritional issues	35.5 (26.7 - 45.4)	39.3 (30.1 - 49.2)
Exercise	33.6 (25.0 -43.5)	28.0 (20.0 - 37.7)
Risk of HIV infection	32.7 (24.1 - 42.5)	42.1 (32.7 - 52.0)
Folate consumption	28.0 (20.0 -37.7)	45.8 (36.2 -55.7)
Cholesterol level per blood test	23.4 (16.0 - 32.7)	46.7 (37.1 - 56.6)
Domestic violence	18.7 (12.1 - 27.6)	63.6 (53.6 - 75.5)
Genetic issues	23.4 (16.0 - 32.7)	55.1 (45.2 - 64.7)

*Fleiss 95% quadratic confidence intervals

3.1.2.4.B Population-Based Services: Children

SCHIP education and outreach activities, which have been discussed in Section 2.4.D.2, are sometimes population based, in that SCHIP has been publicized around the State. Administration of SCHIP is mainly an infrastructure-level activity, however, so SCHIP is discussed in Section 3.1.2.5.B.

Population-Based Services for Children: Medical Practices Survey

With respect to *preventive services*, 75% (CI: 65% - 84%) of the 85 practices serving infants (less than 1 year of age) generally advised parents to place infants on their back or side to sleep “all or most of the time.” Only 61% (CI: 50% -

71%) of these 85 practices tracked immunizations all or most of the time. (Sixty-one percent of the practices serving 1 to 4 year-old children and only 51% of the 109 practices serving children of any age tracked immunizations all or most of the time.) Thus, there is apparently notable room for improvement with respect to tracking of immunizations by private practices and some room for improvement with respect to counseling about appropriate sleep position for infants.

The following table pertains to certain *preventive and primary care services*. Most of the items listed were selected and loosely adapted from *Preventive Evaluation at Specific Ages* suggestions or guidelines in a pediatric medical text¹⁰ (see footnote for exceptions²). Per the text used, the “suggestions or guidelines” were intended to serve as reminders for some of the important preventive and health promotion activities that should be considered at various ages—but the content and time of the activities was to be altered according to special needs and the presence or absence of risk factors. The question introducing these items in the Medical Practices survey tool was intended to ascertain whether practices were assessing the need for such services, not routinely providing the services. Conceivably, however, respondents may have answered based on the frequency that an activity occurred, rather than whether the health care provider assessed the need for the service. Thus, an important caveat is that findings may underestimate the frequency with which providers were assessing the need for specified activities. Taken at face value, however, the proportion of practices assessing more than 90% of their patients for a given issue ranged from 24% for drugs/alcohol/tobacco interview to 62% for a complete physical examination. Even given the caveat above, one issue meriting concern is that only 44% (CI: 35% - 54%) of practices reported assessing nearly all patients regarding the need for counseling about auto safety seats or seat belts. A second issue of potential concern is that only 38% (CI: 29% - 47%) of practices reported assessing nearly all patients regarding the need for oral health screening. These findings reinforce the priority MCH need to promote health education and outreach.

Question: Does your practice assess patients’ needs for the following services and provide the services if needed? (Denominator for all percentages is the 109 practices serving children and youth.)

<i>Issue</i>	<i>% of Practices Selecting Stated Frequencies (95% CI)*</i>			
	<i>>90% of Patients</i>		<i><50 % of Patients</i>	
Complete physical examination	62.4	(52.6 - 71.3)	11.9	(6.8 - 19.9)
Comprehensive interview, with developmental evaluation, anticipatory guidance, hearing/vision	45.0	(35.5 - 54.8)	25.7	(18.0 - 35.1)
Counseling about auto safety seats or belts	44.0	(34.6 - 53.9)	29.4	(21.2 - 39.0)
If sexually active, STD counseling	44.0	(34.6 - 53.9)	23.9	(16.4 - 33.1)

²Items pertaining to auto safety seats or belts, oral health screening, and contraceptives were not included in the medical text’s guidelines. An interview about oral health, however, was suggested.

<i>Issue</i>	<i>% of Practices Selecting Stated Frequencies (95% CI)*</i>			
	<i>>90% of Patients</i>		<i><50 % of Patients</i>	
Dietary counseling	42.2	(32.9 - 52.0)	24.8	(17.2 - 34.1)
Oral health screening, with referral to dentist	37.6	(28.7 - 47.4)	31.2	(22.9 - 40.9)
If sexually active, prescription of contraceptives	34.9	(26.2 - 44.7)	34.9	(26.2 - 44.7)
If 8 years or older, puberty/sexuality counseling	27.5	(19.6 - 37.0)	41.3	(32.1 - 51.1)
If 10 years or older, sexual behavior interview	25.7	(18.0 - 35.1)	40.4	(31.2 - 50.2)
If 8 years or older, drugs/alcohol/tobacco interview	23.9	(16.4 - 33.1)	42.2	(32.9 - 52.0)

*Fleiss 95% quadratic confidence intervals

ADPH Coordination Efforts

Coordination efforts in which the Bureau is involved are discussed extensively throughout this document, most notably in Section 1.5.2. Most of these efforts involve working relationships, rather than written agreements or contracts. Several agreements or contracts in which the Department is involved are located in Appendix H, however. These are (1) an agreement between DHR, ADPH, and ADRS relative to quality child care for infants and toddlers; (2) a contract with the University of Alabama to conduct the Telephone Survey of Households with Children, which is discussed extensively throughout Section 3.1; a collaboration agreement with the Governor, the Children’s Commissioner, the State Superintendent of the Department of Education to work together for the benefit of all Alabama children; and an interagency agreement (among the State Department of Education, MHMR, DHR, the Alabama Institute for Deaf and Blind, Medicaid, ADPH, and the Alabama Insurance Department) pertaining to an early intervention system for infants and toddlers with disabilities and their families.

3.1.2.4.B Population-Based Services: CSHCN

Alabama has been very successful in partially implementing a universal newborn hearing screening program without a State mandate and continues to seek resources to fully support all the components needed to implement a statewide system. Alabama has had an effective intervention system through private providers, the Alabama Institute for Deaf and Blind regional centers and school, the 15 CRS community-based district offices and, more recently, through AEIS. However, the State needs to build its capacity to ensure screening for all newborns, tracking, follow-up, linkage to appropriate services for all infants with a confirmed hearing loss, and monitoring.

The lack of public awareness among families regarding the array of services that are available and the importance of those services was reported by 86.6% of the counties in the county provider survey. The need for easily accessible information on resources was cited as well by families in the family forums. Families find the system of care complex

and difficult to negotiate. Similarly, a lack of information on resources and health needs was mentioned by 56.7% of the counties, particularly by the urban counties (81%) where the availability of multiple providers only increases the complexity of finding appropriate services. Thus, education and outreach programs regarding resources for CSHCN appears to be a significant need in the State.

Further, families of CSHCN reported feeling isolated within their own communities due to a lack of public awareness of disability issues and of the family supports necessary to enable more effective community integration. Recreational activities are often neither inclusive of CSHCN nor physically accessible. Active advocacy within communities through educational efforts to enhance awareness of and sensitivity to CSHCN remains a crucial need in the State as well.

3.1.2.5 Infrastructure Building Services

3.1.2.5.A Infrastructure Building Services: Pregnant Women, Mothers and Infants

Infrastructure Building for Pregnant Women, Mothers and Infants: Community Forums and Focus Groups

During the community forums, infrastructure building activities (11% of all responses) were mentioned much less than enabling and population-based services. However, important issues such as anger management and violence that are dealt with at this level were mentioned by respondents. In addition, residents raised concerns about political leadership and county professionals participating in community activities directed towards improving health.

In the focus group surveys, needs requiring action at the infrastructure-building level of service were identified. Teens perceived a need for teen clinics, as well as clinics testing for STDs and AIDS. The absence of a service (rather than solely lack of access to an existing service) was given as to why some services were unavailable to both teens and women. To reiterate, findings from community forums and focus groups apply to children, as well as to pregnant women, mothers and infants.

Infrastructure Building Services for Pregnant Women, Mothers and Infants: Medical Practice Survey

Several questions in the Medical Practice Survey pertained to infrastructure building services for pregnant women. Since only 37 practices serving pregnant women returned completed questionnaires, however, these findings should be interpreted cautiously.

One question posed to these practices was, “If indicated, ***can your practice arrange for high-risk pregnant women to be promptly assessed at a perinatal center*** (a hospital with one or more full-time neonatologists, a neonatal intensive care unit, and two or more obstetricians)?” Thirty-two of the 37 respondents answered “yes” to this question, and the other five respondents did not answer it. A follow-up question asked, “What have been the ***barriers to arranging for high-risk pregnant women to be assessed at a perinatal center?***” Respondents were then advised to check all of the following items that applied: didn’t know who to contact, patient refused to go, perinatal center

wouldn't accept, no transportation, patient couldn't pay, and other. Lack of transportation was cited as a barrier by 5 respondents; and patient refusal, refusal of the perinatal center to accept the patient, and inability of the patient to pay were each cited once. (Even though respondents checking "yes" to the preceding question were advised to skip the follow-up question, some may have answered it.) The barriers cited in this very small sample suggest that the State's system of regionalized perinatal care should be monitored carefully. A larger sample and/or collection of qualitative data would be necessary to form definitive conclusions, however.

Another infrastructure-related question pertained to *whether the obstetrical practices provided ongoing care for high risk pregnant women*. Of the 37 respondents, 81% (CI: 64% - 91%) said that their practice provided such care.

Yet another infrastructure-related question pertained to needed services that could not be obtained. Specifically, respondents were asked, "Have you sometimes found that the following services were needed by your practice's female patients of childbearing age but could not be obtained?" The services inquired about, as well as the percentages of respondents saying that service was often or occasionally needed but unobtainable, are shown in the next table. Items are ordered in descending order of frequency, based on percentages in the "Often or Occasionally" column.

For the specified services, proportions of respondents saying that a service was often needed but unobtainable varied from 4% for treatment for HIV to 10% for treatment for nicotine dependence or other mental or social problems, with no significant difference in these proportions. Proportions of respondents indicating that a specified service was often or occasionally needed but obtainable (combining positive responses for those two options) ranged from 17% for treatment for HIV to 43% for treatment for alcohol abuse/dependence. The only statistically significant difference was between treatment for alcohol abuse/dependence and treatment for HIV. However, the fact that 17% of respondents had even occasionally had a patient who could not access needed treatment for HIV is a serious matter, given the life-threatening nature of the disease. Allowing for statistical uncertainty, one general observation is that *at least* 18% of the State's practices at least occasionally have patients who are unable to access the first seven services listed, and *at least* 10% of practices at least occasionally have a patient who cannot access treatment for HIV. Perhaps largely due to the small sample size, findings from this study do not clearly show that assuring access to one kind of service merits priority over assuring access to another. Findings do support, however, the need for services in which the Bureau is currently involved, specifically, those pertaining to smoking cessation and to family planning. Moreover, they support the need to expand case management services, since a key role of case managers is to help patients access needed services.

Question: Have you sometimes found that the following services were needed by your practice's female patients of childbearing age but could not be obtained? (Check box options: often, occasionally, seldom or never)
(Number of respondents = 107)

<i>Issue</i>	<i>Percent of Practices Selecting Stated Frequencies (95%)CI*</i>		
	<i>Often</i>	<i>Occasionally</i>	<i>Often or Occasionally**</i>
Treatment for alcohol abuse/dependence	7.5 (3.5 - 14.6)	35.5 (26.7 - 45.4)	43.0 (33.6 - 52.9)
Treatment for “other” mental or social problems	10.3 (5.5 - 18.0)	29.9 (21.6 - 39.6)	40.2 (31.0 - 50.1)
Treatment for nicotine dependence	10.3 (5.5 - 18.0)	28.0 (20.0 - 37.7)	38.3 (29.2 - 48.3)
Treatment for abuse/dependence of/on other drugs	6.5 (2.9 - 13.5)	27.1 (19.2 - 36.7)	33.6 (25.0 - 43.5)
Transportation for health care appointments	9.3 (4.8 - 16.9)	26.2 (18.4 - 35.7)	35.5 (26.7 - 45.4)
Measures to avoid domestic violence	5.6 (2.3 - 12.3)	25.2 (17.6 - 34.7)	30.8 (22.5 - 40.6)
Pregnancy prevention counseling/prescriptions***	7.5 (3.5 - 14.6)	18.7 (12.1 - 27.6)	26.2 (18.4 - 35.7)
Treatment for HIV	3.7 (1.2 - 9.9)	13.1 (7.6 - 21.3)	16.8 (10.5 - 25.6)
Other	0.9 (0.0 - 5.8)	2.8 (0.7 - 8.6)	3.7 (1.2 - 9.9)

*Fleiss 95% quadratic confidence intervals

** “Often” and “Occasionally” combined

***About 90% of the practices provided pregnancy prevention services.

A follow-up question to the question about lack of access inquired about why the services could not be obtained. The check box options and the frequency for selection of those options are shown in the following table, in descending order of frequency. The only item reported as a barrier significantly more often than any other specified barrier was “Patient couldn’t pay,” which occurred significantly more often than “Medicaid not accepted.” Since not being able to pay would often be true when any of the other reasons pertaining to insurance applied, the higher frequency of this, in a sense, composite category is expected. Allowing for statistical uncertainty, it seems that the proportion of the State’s primary medical care practices perceiving a particular barrier as applying *on occasion* probably ranges from at *least* 9% of practices for “Medicaid not accepted” to *at least* 28% of practices for “Patient couldn’t pay.” These findings, along with those shown in the previous table, support the need for expansion of case management services.

Question: Why could the services not be obtained? Check all that apply.
(Denominator for percentages is 107)

<i>Item</i>	<i>Percent of Respondents Selecting Option (95% CI)*</i>	
Patient couldn't pay	37.4	(28.4 - 47.3)
Private insurance doesn't pay	27.1	(19.2 - 36.7)
Not available	29.9	(21.6 - 39.6)
No insurance	21.5	(14.4 - 30.7)
Medicaid doesn't pay	17.8	(11.3 - 26.6)
Medicaid not accepted	15.0	(9.0 - 23.4)
Other	3.7	(1.2 - 9.9)

*Fleiss 95% quadratic confidence interval

A question posed to the 109 practices serving children was, “Can your practice *arrange for a neonate (less than 28 days of age) to be promptly assessed by a neonatologist?*” Sixty-five percent (CI: 55% - 74%) of respondents answered “yes” to this question, 8% (CI: 4% - 16%) answered “no”, 0.9% answered “sometimes,” and 22 % that they had never needed to. A follow-up question asked what had been the *barriers to referring a neonate*. Of the 13 respondents answering the follow-up question, one said they didn't know who to contact, two that the parent refused, two that the referral was not accepted, five that there was no method of payment, five that there was no transportation, and eight that there was an other reason. Although these are not large numbers, they reinforce the need to assure that the State's system of regionalized perinatal care functions well. Additional information, including qualitative data, would be needed to adequately assess this system, however. (Thirteen persons answered the follow-up question, although only the 10 respondents answering “no” or “sometimes” to the initial question had been directed to the follow-up question. Check box items in the follow-up question were not mutually exclusive.)

3.1.2.5.B Infrastructure Building Services: Children

Infrastructure Building Services for Children: Medical Practices Survey

As was true for women of childbearing age, an infrastructure-related question posed to the 109 practices serving children pertained to needed services that could not be obtained. The services inquired about, as well as the percentages of respondents saying that the service was often or occasionally needed but unobtainable are shown in the next table. Items are ordered in descending order of frequency, based on percentages in the “Often or Occasionally” column.

For the specified services, proportions of respondents saying that a specified service was often needed but unobtainable ranged from 2% for treatment for HIV to 17% for dental examination or treatment. Proportions of respondents saying that a specified service was often or occasionally needed but unobtainable ranged from 14% for treatment for HIV to

45% for dental examination or treatment. Access to dental care and transportation for health care appointments, per the “often or occasionally” column, were problematic significantly more often than access to several of the services listed toward the bottom of the table under discussion. As previously mentioned, however, even occasional lack of access to treatment for HIV is a very serious matter, given the life threatening nature of the disease. Allowing for statistical uncertainty, one general observation is that *at least* about one-fourth of the State’s practices probably at least occasionally have children who are unable to access the first six services listed, and at least 8% of the State’s practices probably at least occasionally have children who are unable to access treatment for HIV. As was true for a similar table pertaining to women of reproductive age, with a few exceptions, findings do not clearly show that assuring access to one kind of care clearly merits priority over assuring access to another. Findings do support, however, the need for provision of case management services to children, in order to help children access needed health care.

Question: Have you sometimes found that the following services were needed by your practice’s children/youth but could not be obtained? (Mutually exclusive check box options: often, occasionally, seldom or never)

<i>Issue</i>	<i>Percent of Practices Selecting Stated Frequencies (95% CI*)</i>		
	<i>Often</i>	<i>Occasionally</i>	<i>Often or Occasionally**</i>
Dental examination or treatment	16.5 (10.3 - 25.1)	28.4 (20.4 - 38.0)	45.0 (35.5 - 54.8)
Transportation for health care appointments	10.1 (5.4 - 17.7)	31.2 (22.9 - 40.9)	41.3 (32.1 - 51.1)
Treatment for other mental or social problems	14.7 (8.9 - 23.0)	25.7 (18.0 - 35.1)	40.4 (31.2 - 50.2)
Treatment for abuse/dependence of/on other drugs	6.4 (2.8 - 16.2)	26.6 (18.8 - 36.1)	33.0 (24.5 - 42.8)
Treatment for alcohol abuse/dependence	5.5 (2.3 - 12.1)	27.5 (19.6 - 37.0)	33.0 (24.5 - 42.8)
Measures to avoid domestic violence	6.4 (2.8 - 13.2)	25.7 (18.0 - 35.1)	32.1 (23.7 - 41.8)
Treatment for nicotine dependence	7.3 (3.5 - 14.4)	20.2 (13.3 - 29.2)	27.5 (19.6 - 37.0)
Physical therapy	4.6 (1.7 - 10.9)	20.2 (13.3 - 29.2)	24.8 (17.2 - 34.1)
Speech and language assessment or therapy	4.6 (1.7 - 10.9)	20.2 (13.3 - 29.2)	24.8 (17.2 - 34.1)
Assessment or treatment for hearing loss	2.8 (0.7 - 8.4)	17.4 (11.1 - 21.6)	20.2 (13.3 - 29.2)

<i>Issue</i>	<i>Percent of Practices Selecting Stated Frequencies (95% CI*)</i>		
	<i>Often</i>	<i>Occasionally</i>	<i>Often or Occasionally**</i>
Pregnancy prevention services	4.6 (1.7 - 10.9)	12.8 (7.5 - 20.9)	17.4 (11.1 - 26.1)
Treatment for HIV	1.8 (0.3 - 7.1)	11.9 (6.8 - 19.9)	13.8 (8.2 - 22.0)
Other	1.8 (0.3 - 7.1)	0.9 (0.0 - 5.7)	2.8 (0.7 - 8.4)

*Fleiss 95% quadratic confidence interval

**“Often” and “Occasionally” columns combined.

Again, the question about lack of access was followed by a question about why the services could not be obtained. The check box options and the frequency for selection of those options is shown in the following table, in descending order of frequency. None of the specified items differed significantly from another with respect to frequency of its selection. Allowing for statistical uncertainty, of the State’s primary medical care practices serving children, the proportion perceiving a particular barrier as applying *on occasion* probably ranges from at *least* 18% of practices for Medicaid-related issues to *at least* 31% of practices for “Private insurance doesn’t pay.” These findings reaffirm the need for expansion of case management services to children.

Question: Why could the services not be obtained? Check all that apply.

<i>Item</i>	<i>Percent of Respondents Selecting Option (95% CI)*</i>	
Private insurance doesn’t pay	40.4	(31.2 - 50.2)
No insurance	34.9	(26.2 - 44.7)
Patient couldn’t pay	32.1	(23.7 - 41.8)
Not available	28.4	(20.4 - 38.0)
Medicaid doesn’t pay	25.7	(18.0 - 35.1)
Medicaid not accepted	25.7	(18.0 - 35.1)
Other	7.3	(3.5 - 14.4)

*Fleiss 95% quadratic confidence interval

Infrastructure Building Services for Children: Dental Survey

An infrastructure-related question posed to the to the dentists surveyed was, “At what age do you recommend that new or expectant parents take their child to the dentist for his/her first dental visit?” Of all dentists responding, 45%

indicated an age of 3 years, and 29% indicated an age of 2 years. These practices do not comply with guidelines established by the Academy of Pediatric Dentistry, which recommend that a child visit the dentist by 1 year of age.

A second infrastructure-related question in the Dental Survey was, “Do you currently accept new Medicaid patients within your practice?” Of the responding dentists, 82% answered “no,” and only 11% said that they accept new Medicaid clients.

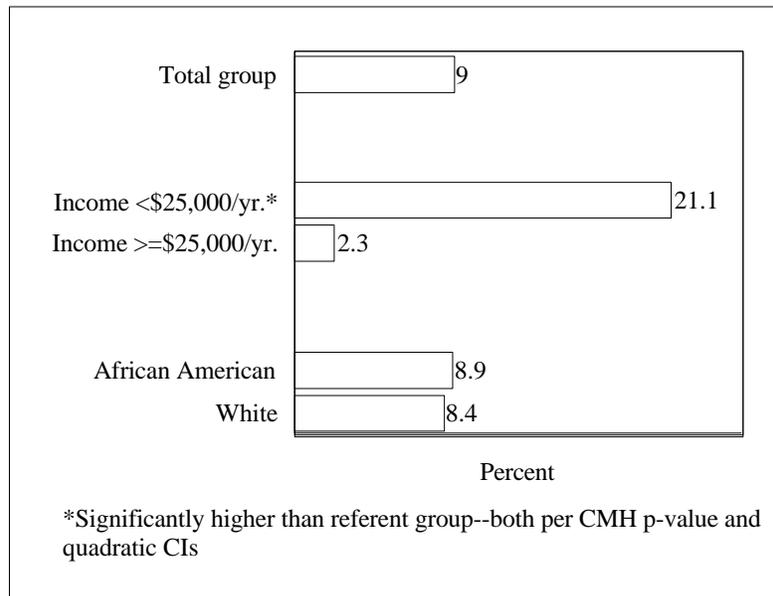
Infrastructure Building for Children: Household Telephone Survey

SCHIP

Although SCHIP involves enabling and population-based activities, its successful implementation requires a strong infrastructure with collaboration among multiple organizations (especially ADPH, Medicaid, and Blue Cross/Blue Shield of Alabama). In our view, the legislation enabling SCHIP and the State’s implementation of SCHIP (discussed in Section 1.4) have been major accomplishments. As previously stated, SCHIP is administered by the ADPH’s Administration Office, but both Bureau and CRS staff collaborate with SCHIP staff. Because the purpose of SCHIP is to promote access to health care insurance for children with household incomes at or below 200% of FPL, insurance-related findings from the Telephone Survey are pertinent to this infrastructure building service. The Telephone Survey had an initial question asking, “Does (he/she) have any health insurance NOW?” For negative responses, a follow-up question was added: “There are different types of health insurance, and I want to be sure we’re not missing something. Does (he/she) have coverage through:...(interviewer sequentially mentioned various health insurance plans)?”. Based on responses of 479 respondents to these two questions, 9% (CI: 7% - 12%) of the study children aged 1-17 years did not have health insurance. (More conservatively, if children identified through the follow-up question as being insured are classified as uninsured, an

estimated 10% [CI: 8% - 14%] of children are now uninsured.). Either way, based on information discussed in Section 2.4.D.3 (which pertains children and infants, i.e., 0-17 years), the State has apparently made notable progress since 1998 in reducing the number of uninsured children. We believe that this progress has indeed occurred and that SCHIP, perhaps along with other factors such as general improvement in the economy, has contributed to it.

Figure 60. Percent of Children Who Were Uninsured, Alabama, 2000



As shown in Figure 60, however, insurance status differed strikingly according to income. That is, 21% of low income children, versus 2% of higher income children, were uninsured. Accordingly, there is much room for progress in providing health insurance coverage for children in low income households. Clearly, SCHIP needs to remain a high priority of ADPH. Bureau and CRS staff should continue collaborating with SCHIP staff and providing outreach and enabling services that help families obtain health insurance for their children. As also shown in Figure 60, the proportion of uninsured children was similar for African American and for white children.

Along with having health insurance, having insurance that adequately covers preventive care is important. A question on the telephone survey addressed this issue, asking respondents for insured children, “Does this health care plan pay for any of the costs of well child care, that is visits when a child is NOT sick, but needs a check-up or immunization?” Sixteen percent (CI: 13% - 20%) of respondents to this question (excluding 44 “don’t know” responses) said that their child’s insurance did not pay for such care. This percentage did not notably differ between income groups or between racial groups, but did differ notably by Medicaid status. In fact, 8% (CI: 3% - 17%) of respondents for Medicaid-enrolled children, versus 19% (CI: 15% - 25%) of respondents for children with private insurance, said that their child’s health insurance would not pay for preventive services. (This difference was significant per the CMH p-value, but not per overlapping quadratic confidence intervals.) The observed difference could be due to one or more of several possible explanations: better coverage for preventive care by Medicaid than by private insurance, higher awareness in the Medicaid group than the private-insurance group that such coverage existed, different understanding by the two groups of the meaning of the question, or statistical chance. Even if the findings were not deemed to be due to statistical chance, coverage of preventive care by “typical” private health insurance plans versus that for Medicaid would need to be reviewed to determine if a disparity in coverage for preventive care actually existed.

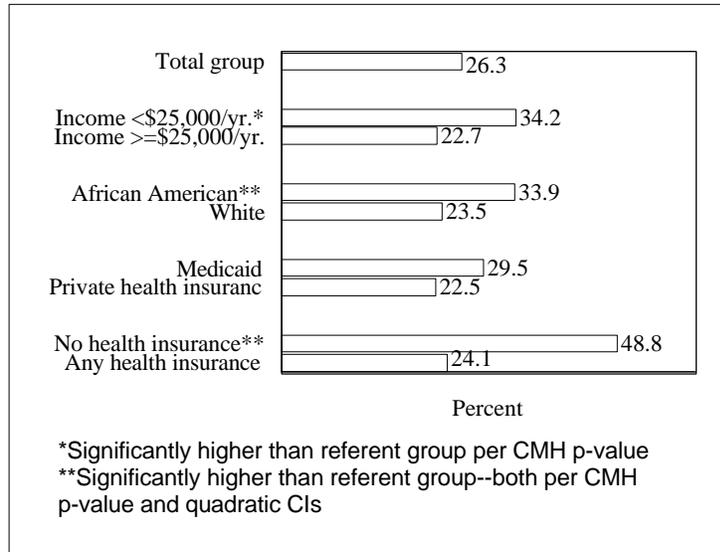
Also pertinent to adequacy of insurance is the satisfaction level of enrollees in insurance plans. When asked if they were very satisfied, somewhat satisfied, or NOT satisfied with the child’s health insurance, 66% (CI: 61% - 70%) of respondents for insured children said that they were very satisfied. Satisfaction levels did not notably differ according to income or race, but did notably differ according to type of insurance. Interestingly, 78% of respondents for children with Medicaid, versus 63% of respondents for children with private insurance, said that they were very satisfied with the child’s health insurance. (Again, this difference was significant per the CMH p-value, but not per overlapping quadratic confidence intervals.)

Dental Care

Because oral health is an important component of overall health, access to dental care is an important component of access to health care in general. Per the telephone survey, 26% (CI: 22% - 31%) of respondents (excluding 10 unknowns) said that their child had not been checked by a dentist or dental specialist within 1 year. Low income children were more likely than higher income children, African American children more likely than white children,

and uninsured children more likely than insured children to have *not* been checked within 1 year (Figure 61). The

Figure 61. Percent of Children Who Had Not Received a Dental Checkup Within 1 Year, Alabama, 2000



racial difference was largely explained by differences in income. Though Medicaid-enrolled children were somewhat more likely than children with private insurance to have not received a dental checkup within 1 year, the difference was not statistically significant.

Another indicator of access to dental care is the percentage of children having dental sealants. Though the core performance measure pertaining to dental sealants is for third grade children only (CP #07 in Section 2.4.C.2), the Bureau deems it relevant for ages 5 through 13 years and especially for ages 8 through 13 years. Accordingly, the Telephone Survey question pertaining to dental sealants has been analyzed for ages 8 through 13 years. Fifty four percent (46% - 62%) of respondents for children in this age group said that their child had not had dental sealants painted on his/her teeth to prevent cavities. Low income children were more likely than higher income children,

Medicaid-enrolled children more likely than children with private insurance, and uninsured children more likely than insured children to have *no* dental sealants. (The difference in uninsured versus insured children was not significant, but numbers in the uninsured group were too small to assume that no difference exists.)

Infrastructure: Qualitative Data from Medical Practices Survey and MCH Organizations Survey (With Review of Corresponding Quantitative Data)

Open-ended questions in the Medical Practices Survey and MCH Organizations Survey elicited responses that promise to collectively comprise a rich source of qualitative information. This information applies to all levels of the service-level pyramid and pregnant women, mothers and infants, as well as to children. It is discussed under infrastructure building services mainly because information garnered from more complete analysis, which is anticipated, should enrich the Bureau’s understanding of salient MCH issues and thereby facilitate infrastructure-building activities. Regrettably but unavoidably—given the several surveys conducted for the needs assessment and, until recently, the Bureau’s very limited analytic resources—qualitative data from the survey have not been fully analyzed. What follows is based on limited review and rough, first-stage analysis of qualitative responses (to open-ended questions) from the Medical Practices Survey and review of only a few qualitative responses from the MCH Organizations Survey. Nevertheless, these responses provide a dimension that quantitative data alone lack, so an overview of very preliminary findings from nascent analyses of these rich data sources follows.

Tentatively identified themes and sub-themes arising from this first-stage review of qualitative responses are shown in the following table. Analyses are not yet complete enough to confidently attribute frequencies of responses within each theme or sub-theme. However, these themes are consistent with findings from quantitative data. Examples of such consistency are cited following the table. The preliminary themes identified roughly apply to two of the open-ended questions (in the Medical Practice Survey and the MCH Organizations Survey) and a general comments section (in the MCH Organizations Survey only). The two questions were:

- List up to 3 maternal and child health **issues** that you believe merit very high priority, with “1” being of highest priority.
- List up to 5 **barriers** to health care for pregnant women, mothers of children or **gaps or weaknesses** in the health care system for this population, with “1” being of the greatest importance.

Tentatively Identified Qualitative Themes and Sub-Themes from Medical Practices and MCH Organizations Surveys

<i>Theme</i>	<i>Sub-themes</i>
Resources	Transportation, manpower, interpretation (language)
Health care	Prenatal care, dental care, general access, outreach, health education
Social	Teen pregnancy, unintended pregnancy

Behavioral	Smoking
Health conditions	Nutrition, STDs
Health insurance	Enrollment, scope
Family characteristics	Negative parenting, parenting skills
Safety	Violence, auto safety

Findings from quantitative data that pertain to the above themes and sub-themes include the following:

- With respect to transportation, per the Household Telephone Survey, 9% of low income respondents said they had delayed getting health care for their child due to not having transportation (Section 3.1.2.3.B). Moreover, 10% of medical practices providing care for children said that they had often found that children could not get needed transportation for health care appointments, and an additional 31% said that they had occasionally noted this barrier.
- With respect to dental care, 17% of respondents for the Medical Practices Survey said that they had often seen children who were unable to access needed dental services, and an additional 28% said that they had occasionally seen such children (Section 3.1.2.5.B). Moreover, 26% of children in the Household Telephone Survey (excluding unknowns) had not received a dental checkup during the previous year. The issue of dental care is further discussed farther on in this report.
- With respect to unintended pregnancy, 8% and 19% of responding practices providing care for women of childbearing age said, respectively, that they often or occasionally had encountered patients who could not access needed pregnancy prevention services.
- With respect to tobacco consumption, 10% of responding practices providing care for women and 7% of practices providing care for children said that they had often seen women/children who needed treatment for nicotine dependence but could not access that care.
- With respect to health insurance, 9% of 1- through 17-year-old children in the Household Telephone Survey did not have insurance (Section 3.1.2.1.C). Moreover, 22% of Medical Practices Survey Respondents caring for women of childbearing age and 35% of those caring for children cited “no insurance” as a reason that needed services could not be accessed (Sections 3.1.2.5.A and 3.1.2.5.B). Furthermore, 27% of respondents caring for women and 40% of those caring for children cited “private insurance doesn’t pay” as a reason that needed services could not be accessed. Additionally, 18% of respondents caring for women and 25% of those caring for children cited “Medicaid doesn’t pay” as a reason for lack of access; and 15% of those caring for women and 26% of those caring for children cited “Medicaid not accepted” as a reason for lack of access.

- With respect to family characteristics (e.g., negative parenting), 10% of practices serving women and 15% of those serving children had often found that treatment for “other mental or social problems” was often needed but inaccessible for a patients. Corresponding proportions for occasionally finding this to be so were 30% and 26%.
- With respect to safety, 6% of practices serving women and 6% of those serving children had found that measures (by implication, services) to avoid domestic violence were often unavailable for patients. Corresponding proportions for occasionally finding this to be so were 25% and 26%. Moreover, as previously discussed, the homicide rate for young African American males is high relative to that for their white counterparts. Also with respect to safety, as has been noted, only 44% of responding practices serving children and youth routinely counseled their patients about auto safety seats or belts.

The actual responses provided to the open-ended questions, however, provide insight that an overview of themes and sub-themes does not provide. Thus, a few excerpts from individual comments are listed below, as written by the respondents, with parenthetical notes explaining the context as needed:

- “Every issue that appears on your survey is of the utmost importance in our County. As Director of the Emergency Management Agency...”
- (Barriers to health care, or gaps or weaknesses in the health care system):
 - T “Lack of public transportation.”
 - T Lack of general knowledge among population re: Health Dept & services offered.”
- (Comments by Safeplace Inc:)-“The Domestic Violence Health Care Initiative has been an excellent way to reach out to battered women to let them know there is help—health depts are doing a good job of routinely asking women patients about their abuse and then referring them to Safeplace for safe refuge, counseling, & court assistance. It has been an effective collaboration.”
- (Comments by a faith-based organization)-“I hope that a greater emphasis toward health issues will include more staffing and training for clients. Coordinating with schools, social agencies are essential for the success of health care for children.”
- (Comments by a family service center)-“Health departments need more funding for community outreach. Their impact on issues such as infant mortality & substance abuse could be astounding. If public funds are not available, health departments should be assisted in locating grant funding. We would love to partner with _____ County Health Department on issues such as teen pregnancy, child & maternal health, substance abuse.

_____ (a rural) County desperately needs children’s dental care (Medicaid). The Health Department would be the perfect place for that.” (Note that this comment praising a CHD was from a family service center, not the CHD itself.)

Implications of Infrastructure-Related Findings

These findings reiterate several previously discussed issues such as the need to continue assuring effectiveness of the State’s regionalized system of perinatal care, the need for health education and outreach, and the need for case management services. Additionally, findings reinforced the need for SCHIP to remain a high priority for ADPH. Two additional priority MCH needs became apparent through infrastructure-related findings:

- To assure access to dental care, especially for low income children.
- To further reduce the adolescent pregnancy rate (based on responses to open-ended questions in the MCH Organizations Survey.

3.1.2.5.C Infrastructure Building Services: CSHCN

Discussion of the constructs of a service system for CSHCN follows. The interagency group that comprised the CRS Needs Assessment Advisory Committee and families of CSHCN, through the advisory committee and family forums, participated in the assessment process.

State Program Collaboration

Many collaborative mechanisms exist at the State level to coordinate State services that could be utilized by CSHCN. CRS represents the Title V CSHCN Program in the following efforts:•

Governor's Interagency Coordinating Council for Early Intervention Services (ICC)–ADRS is the lead agency in Alabama for the Part C initiative for infants and toddlers with developmental delay. The ADRS Commissioner represents CRS on the ICC. Member agencies of the ICC participated in the CSHCN portion of the Title V Needs Assessment. The ICC has developed coordinated policies and procedures, interagency training, monitoring standards for service delivery, joint legislative budgetary requests, and has shared data on infants and toddlers with disabilities. CRS has maintained an active presence in this process, sitting on all ICC subcommittees for funding, personnel preparation and training conferences, public awareness, and program evaluation.

- Juvenile Justice Coordinating Council–CRS staff currently participate on several committees of this council. Unopposed legislation is pending that will change the name of this group to "Alabama's Children's Policy Council" and will broaden the scope of this council's mandate. ADRS is specifically included in this legislation;

the ADRS Commissioner will sit on the council and agency staff will be involved in counties where ADRS has a presence. The legislation also changes the chair of the council to the Commissioner of DCA from the Chief Justice of the Alabama Supreme Court. One mandate for this council is to distribute the funds the State obtains through the tobacco settlement.

- SPAC–CRS staff are appointed to this committee, which has a significant role in the implementation of regionalization for neonatal intensive care in the State to ensure access to appropriate services. This committee is asked by ADPH to comment on the annual MCH Block Grant applications/reports.
- State Head Start Advisory Committee for Children with Disabilities–Representatives from State agencies serving children, including CRS, meet quarterly with Head Start personnel to advise Head Start programs in accessing health, education, and welfare service systems. An interagency agreement between Head Start, including Early Head Start and Migrant Programs, and ADRS was signed this year "to work collaboratively in identifying and serving children with disabilities from birth through age five and their families." Joint public awareness efforts; procedures for identification, referral, assessment and evaluation, and transition of young children with disabilities; procedural safeguards; interagency training; and resource and data sharing are specifically addressed in the agreement.
- Alabama Head Injury Task Force–ADRS is the lead State agency for serving individuals with TBI. This group plans for the development and implementation of a statewide community-based system of services for children and adults with TBI. Data sharing, financing issues, interagency training, and coordinated policies are pursued by this coalition of public and private agencies.
- Children's Health Insurance Program Commission–ADPH is the lead agency for Alabama's SCHIP. The commission oversees the policy development and implementation of SCHIP initiatives in Alabama. CRS has participated both as a provider of ALL Kids Plus Services and as an advocate for the unique needs of CSHCN. Financing issues, data sharing, and evaluation of the current SCHIP programs are within the purview of this group. A resolution is pending to establish CRS as an official member of the commission.
- Medicaid–CRS has an interagency agreement with Medicaid to provide Children's Specialty Clinic Services, including specialty medical and/or evaluation clinics, service coordination, outreach, related therapy services, patient education, orthodontic services, and replacement factor for clients enrolled in the Alabama Hemophilia Program. This has greatly increased access for CSHCN with Medicaid to multidisciplinary team care throughout the State.

- DHR–CRS has an interagency agreement with DHR to jointly fund a CRS nurse consultant housed at DHR to provide consultation and technical assistance to DHR personnel regarding CSHCN in the State's foster care system. An evaluation component is included to demonstrate the effectiveness of this arrangement.

Clearly multiple collaborative initiatives are underway in the State, although most focus on a specific subset of the CSHCN population. The ADRS Commissioner recently initiated formal collaboration with the Department of MHMR around issues of mutual concern, including CSHCN, to address identified needs in the State. Copies of the interagency agreements with AEIS, Head Start, Medicaid and DHR and a grid of CRS interagency collaborative efforts are located in Section 5.3.

State Support for Communities

Support is provided through several planning processes at the local level:

- District Coordinating Councils for Early Intervention Services–The role of the district councils is to conduct local needs assessment, coordinate services, and identify barriers to service for the State council. State support to these councils includes financial support for approved council activities and employment of full-time council coordinators. CRS provides office space to the council coordinators, district service coordinators for children receiving early intervention services who are not yet part of a program, and administrative support personnel. CRS staff participate on all the councils and support at the local level all initiatives of the ICC, such as public awareness campaigns and training activities for service providers and families.
- Juvenile Justice Councils–Each county has a service facilitation team to develop service plans for children at risk for out-of-home placement. CRS participates currently when a service plan includes specialty health services. Following the passage of pending legislation to change these councils to "Children's Policy Councils", CRS will participate regularly in all counties in which it has a presence.
- CRS Local Parent Advisory Committees–Each local office has an advisory committee to address family issues in the CRS community-based service system and advise the office on service needs and family-centered care. Representatives from each committee make up the State Parent Advisory Committee, which advises CRS administrators on program policy issues concerning family-centered care. These committees review the CRS state plan and the status on meeting targets for the CRS performance measures annually.
- CRS local offices–Each district office has the responsibility for supporting local and district/regional health planning initiatives. Staff serve on local councils that address health and/or children's issues. CRS supports their involvement financially and through performance standards, which expect each worker to be active in the assigned county. Additionally, each district office functions as a powerful resource network within its local community,

responding to numerous requests for information regarding CSHCN and available services.

Community initiatives related to CSHCN tend to be child-specific, rather than systems-oriented. The highly centralized nature of Alabama government may contribute to this problem. The development of more mechanisms to support community planning is needed.

Coordination with Other Health Components of Community-based Systems

Coordination within community-based systems is achieved as follows:

- Maternal and Child Health—As mentioned in Section 1.5.2, CRS administrative staff and program specialists meet at least quarterly with staff from BFHS and several other MCH entities to assure coordination of initiatives.
- MOUs with Tertiary Children's Hospitals—CRS' MOUs discussed at length in Section 3.1.2.3 are essential to the coordination of health components of community-based systems. CRS offices have liaison personnel who work with the staff of TCHA satellite offices located in their communities to ensure that children are referred and receive appropriate services from both providers. Copies of these agreements are in Appendix H.
- The Alabama Hemophilia Program (AHP)—AHP is administered by CRS. Persons of any age with bleeding disorders are eligible to participate. Treatment centers in Birmingham and Mobile provide evaluation, treatment, patient education, care coordination, and allied health services. CRS contracts with Hemophilia of Georgia for MCHB funds to promote comprehensive care for this population. Programs collaborating with CRS in this effort include the ADPH AIDS Program, Medicaid, local AIDS treatment clinics and consortia for Ryan White funding, and the two State genetics programs.
- Medical Genetics Programs—The UAB and USA Medical Genetics Programs provide counseling and testing services for CSHCN and their families through a network of community-based clinics throughout the State, often in conjunction with CRS. These programs were discussed in detail in Section 3.1.2.3.

The State has made great advances toward coordinating community-based services for CSHCN within the last 5 years through the agreements with tertiary level providers. The development of further public/private agreements would continue the progress in this area.

Coordination of Health Services at the Community Level

The placement of CRS within ADRS facilitates the coordination of health services with other services at the community level for CSHCN. CRS, as a division of ADRS, is co-located with AEIS, AVRS, and the State's Independent Living Program in most locations throughout the State, which promotes the coordination of program planning and service

delivery at the local level, as well as at the State level. Through a contractual arrangement, CRS provides Early Intervention services to infants and toddlers with disabilities in all of its district offices. Adolescents are referred to AVRS upon their sixteenth birthday for transition services, especially vocational evaluation and counseling. This is accomplished through a formal referral program, sharing of record information, and the Department's school transition program. Special education, social services and family support services are brought together by the Early Intervention DCCs at the community level; this mechanism has increased collaboration regarding service coordination for other age groups as well.

CRS has a long history of collaboration with the Alabama Easter Seal Society to enhance services for CSHCN through community rehabilitation centers and Camp ASCCA, a year-round camp facility for children and adults with disabilities. CRS staff hold ex-officio positions on State and local boards, coordinate service delivery through the Easter Seal Centers, and support the camp through recruitment, funding assistance, and provision of specialty services during hemophilia camp.

Quality Assurance and System Development

Quality assurance and systems development activities by CRS follow:

- A formal monitoring procedure for clinical sites and Quality Care Guidelines for 12 specific diagnostic conditions have been developed and implemented as more fully discussed in Section 2.4.4, SPM # 09.
- Quality Improvement Teams in each district meet regularly to identify service delivery areas that need improvement and to formulate a plan to address that need.
- Standards of care have been implemented for each specialty medical and evaluation clinic.
- Patient satisfaction surveys are mailed monthly to families. Any expressed concerns are forwarded to the appropriate district supervisor for resolution.
- A credentialing process is used for enrolling specialty physicians, dentists, allied health care providers, and DME providers.
- Performance appraisals, based on pre-identified responsibilities and expected results, are conducted annually on all staff.
- Program monitoring for compliance with all Early Intervention provider regulations is conducted annually at each CRS office site providing these services.

CRS actively promotes the development of community-based systems of care through its network of 15 district offices, which work with every county in the State to enhance local services for CSHCN.

3.2 Health Status Indicators

Use and Purpose of the Core and Developmental Health Status Indicators

As described in the guidance provided by MCHB for this application/annual report, the health status indicators “represent practical, highly prevalent, and prevention-oriented data...are broadly focused on the programs, issues, and demographics that have the most impact on mothers and children in each State.” Accordingly, these indicators, when available, are reported on the appropriate forms and discussed below. Where a health status indicator pertains directly to an identified priority need, the relationship is mentioned. Partly because the final draft of the health status indicators did not become available until the needs assessment process was well underway, however, the health status indicators were not the driving force behind identification of priority needs. Instead, the needs assessment process (Section 3.1.1) and findings from the studies planned by the Bureau (comprising most of Section 3.1.2), in consultation with the MCH Needs Assessment Advisory Committee, provided the driving force behind identification of priority MCH needs. This was so because the studies planned by the Bureau were designed to gather information deemed by Bureau staff and the Advisory Committee to be important to well informed decisions regarding policies and programs—as well as to gather information specified in the narrative of the December 1998 guidance provided by MCHB.

Prenatal Care

Per the Kotelchuck Index, the proportion of all live-born infants (without respect to race, plurality, or maternal age) whose mothers received adequate (including adequate plus) prenatal care increased from 74.6% in 1996 to 78.7% in 1999 (Form C1–CHS #03; estimate for 1999 is very preliminary). Prenatal care according to source of payment for delivery is discussed further on in this section under *Selected Other Core Health Status Indicators*.

Chlamydia

Findings pertaining to chlamydia in adult women (DHS #03B) have been described under *Selected Indicators of Morbidity* in Section 3.1.2.1.B. Because screening tests and counseling interventions have been effective in reducing STD burdens in groups that are screened regularly, the Bureau’s Women’s Health Division will continue partnering with the Bureau of Disease Control’s Sexually Transmitted Diseases Division to provide screening and referral for STDs, with a focus on chlamydia. ADPH staff will continue screening for chlamydia in family planning clinics. Patients with positive results are counseled about risk reduction and behavior modification, in addition to receiving treatment. Depending on the county, these services may be provided in the family planning clinic or the STD clinic. Partners of patients are referred to STD Program staff for counseling and treatment.

The chlamydia rate per 100,000 females aged 15 through 19 years is shown on the Developmental Health Status Indicators form (DHS #03A). During the surveillance period (1995-1999), this rate reportedly ranged from 5.9 per 100,000 in FY 1995 to 33.8 per 100,000 in FY 1999. As discussed in Section 3.1.2.1.B, however, whether this reported rise is partly or largely due to more complete reporting, rather than an actual increase, has not been explored. With the recent increased emphasis upon surveillance of chlamydia, much of the rise may well be a reporting artifact. As previously stated, this issue will be discussed with staff from the Department's Division of Sexually Transmitted Diseases.

Asthma

Findings pertaining to asthma from the Telephone Survey are discussed under *Health Status of Children in Telephone Survey* in Section 3.1.2.1.C. As shown on the Core Health Status Indicators form (CHS #01), the estimated hospitalization rate for children in Alabama aged 4 years or younger was 89.2 hospitalizations per 10,000 such children in FY 1999. Because the State does not have a baseline estimate from an earlier year and because Bureau staff have not yet reviewed relevant literature or consulted with others to ascertain corresponding rates for other States, we do not have a context in which to discuss this rough estimate. During FY 2001, however, staff from the Bureau's Epidemiology/Data Management Branch will consult with experts on pediatric asthma, such as staff from Children's Hospital's Pediatric Pulmonary Center, to ascertain their views about this estimate and whether, within existing resources and priorities, the method for making the estimate could be improved. (See footnotes to CHS #01 for a detailed description of the methods used to make the estimate, as well as the method's limitations.)

Selected Other Core Health Status Indicators

All core health status indicators are reported on the appropriate form. Several of these have been discussed elsewhere in this document, depending on whether they pertained to the other information being collected by the Bureau for the 5-year needs assessment. For example, CHS #04A, 04B, 05A, 05B, and 06A are discussed under *Selected Indicators of Morbidity* in Section 3.1.2.1.B. The following core health status indicators have not been discussed elsewhere:

- For practical purposes, we assume that 90% or more of Medicaid enrollees under 1 year of age received at least one periodic screen during FY 1999 (CHS #02A). Similarly, we assume that 90% or more of SCHIP enrollees under 1 year of age received at least one periodic screen during the reporting year (CHS #02B). For reasons described in notes to Forms 1 through 16 (specifically, the notes to Form C1 for CHS #02A and CHS #02B), the number respectively provided by Medicaid and SCHIP yield estimates notably in excess of 100%.
- Comparison of health status indicators for Medicaid, non-Medicaid, and all populations in the State is shown on *Form C2—Medicaid and CHIP Data* (CHS #06A, #06B, #06C, and #06D). Some of these indicators or related indicators were analyzed more precisely, however, as part of the Bureau's 5-year needs assessment. Specifically, based on a birth-certificate item, selected indicators have been analyzed according to whether the source of

payment for delivery was private insurance, Medicaid, or “self pay.” Because the self-pay group is often at higher risk than the Medicaid group, analyzing findings according to these three source-of-payment categories is preferable to making “Medicaid and Non-Medicaid” comparisons. Findings pertaining to infant mortality by source of payment are described under *Mortality* in Section 3.1.2.1.B. Findings pertaining to prenatal care by source of payment are discussed under *Health Care Systems Issues*, also in Section 3.1.2.1.B. As shown on Form C2, per the Kotelchuck Index (not discussed in the previous sections), in CY 1998, 77.2 % of all pregnant women received adequate prenatal care. Only 67.2 % of women whose delivery was paid for by Medicaid, versus 85.1 % of remaining women, received adequate prenatal care, however. These findings are consistent with findings described in Section 3.1.2.1.B.

- Medicaid and SCHIP eligibility levels are shown on Form C2 (CHS #07). For all populations shown on that form, the percent of poverty level for eligibility in the State’s Medicaid Program is 0-133%. For infants and for children aged 0-5 years, the percent of poverty level for eligibility in SCHIP is >133%-200%. For pregnant women, the percent of poverty level for eligibility in SCHIP is >100%-200%.

Data Capacity Information Shown on Form C3

- The State is doing well (i.e., has a score of 3 for 2 or more columns) for the following indicators: annual linkage of infant birth and infant death certificates, survey of recent mothers at least every 2 years, and survey of adolescent health and behaviors at least every 2 years. Bureau staff do not currently have direct access to the PRAMS data base, however. Although such access could probably be arranged in FY 2001, whether Bureau staff will have time to analyze this data base remains to be determined. During FY 2001, staff from the Bureau’s Epidemiology and Data Management Branch will establish priorities for data analysis, thereby determining whether they can devote time to analysis of PRAMS data. Bureau staff anticipate being able to obtain a copy of the Department of Education’s report of the Youth Risk Behavioral Survey, but do not foresee being able to obtain findings not routinely reported by the Department of Education, and do not expect to gain direct access to the electronic data base in the near future.
- Alabama does not have a statewide birth defects surveillance system. USA has a local (2 county) birth defects surveillance system, however. The Bureau has not contacted USA to request regular reports of their findings, but brief reports of selected findings are available on request. The Bureau does not foresee being able to request special analyses in the near future or having direct access to the electronic database. During FY 2001, however, Bureau staff will contact USA to ascertain what reports could be provided on a regular basis.
- The Bureau does not expect annual linkage of birth certificates and Medicaid paid claims or eligibility files to occur in the near future, especially since the birth certificate item pertaining to source of payment for delivery

allows analysis of data by source of payment. Similarly, based on prior experience and on recent communication with staff from the Alabama Hospital Association, the development of a centralized, representative hospital discharge data base does not appear imminent.

- Neither does the Bureau expect annual linkage of birth records and newborn screening files to occur soon. During FY 2001, the feasibility of linking birth certificates and WIC eligibility files will be considered. Because WIC is administratively located within the Bureau and because the Bureau has a close working relationship with the Department's CHS, linkage of WIC files and birth certificates may be more feasible than some of the other linkages listed on Form C3. The cost/benefit ratio for such a linkage has not been determined, however; nor has a time frame for performing the linkage—if the cost/benefit ratio is deemed favorable—been determined.

Developmental Health Status Indicators

Available estimates pertaining to developmental health status indicators are shown on Forms D1 and D2:

- Mortality indicators (DHS #01A, #01B, and #01C) have been discussed under *Health Status of Children: Mortality Data*, in Section 3.1.2.1.C.
- We have no estimates for non-fatal unintentional injuries (DHS #02A, #02B, #02C). Bureau staff will continue seeking to obtain such estimates by obtaining reports from Blue Cross Blue Shield and Medicaid, and/or by requesting reports from selected hospitals.
- Findings pertaining to chlamydia have been cross-referenced or discussed previously in this section (DHS #03A, #03B).
- As shown on Form D1, 34% of EPSDT eligible children aged 6 through 9 years were estimated to have received dental services during FY 1999 (DHS #04). The absence of historical findings precludes description of trends. The fact that only about one-third of such children have received dental services supports the priority need identified from the Telephone Survey and other studies, however—to assure access to dental care, especially for low income children.
- Although adolescent tobacco use will be discussed as a health status indicator in the future, it has been discussed in this document under SP #03 in Section 2.4.B.2. The estimate that 37% of adolescents in grades 9 through 12 reported using tobacco products in the past month (in FY 1999) supports the priority need to promote health education and outreach regarding high priority topics, per qualitative and quantitative data.
- Demographic indicators (Form D2) have been discussed in Section 3.1.2.1.A. The Bureau does not have estimates

for geographic living areas (DHS #10) or poverty levels (DHS #11 and #12). Staff from the Bureau's Epidemiology/Data Management Branch will continue seeking to make these estimates through consultation with staff from CHS and the Census Bureau.

3.2.1 Priority Needs

ADPH and CRS respectively identified seven and three priority MCH needs, with each agency identifying the needs through their components of the needs assessment. A review of the needs assessment process, which is fully described in Section 3.1.1 follows.

ADPH gathered information mainly through community forums and focus groups, vital statistics data, three mailed surveys (primary care medical practices, non-medical MCH organizations, and dentists), and a telephone survey of households with children. BFHS organized an MCH Needs Assessment Advisory Committee, which was convened on three occasions, to provide input into the needs assessment process and selection of priority needs. During the final meeting of the committee, then-available findings from the needs assessment were presented. Following presentation of these findings, the Bureau Director presented twelve potential priority needs that had been identified by the Bureau's Needs Assessment Coordinator, based on findings from the needs assessment and consultation with the Bureau Management Team. Attendees at the Needs Assessment Advisory Committee meeting were asked to individually (anonymously) rate the needs and then to join breakout groups. Each group was asked to collectively identify and rank the top five priority MCH needs and present their selections. Subsequently, based on review of the Advisory Committee's individual ratings and group rankings, the Bureau's Needs Assessment Coordinator recommended seven priority MCH needs, which were approved by the Bureau's Executive Committee (comprised of the Bureau Director and four division directors).

CRS convened the CRS Needs Assessment Advisory Committee on four occasions, and pursued three methodologies in gathering qualitative and quantitative data: eight family forums, county-level surveys of public providers coordinating care for CSHCN, and development of a county profile for CSHCN. Findings from these studies were presented at the final meeting of the CRS Needs Assessment Advisory Committee, and input from participants on suggested priority needs was obtained. Subsequently, The CRS Administrative Team members and CRS family representatives jointly selected seven areas as priorities for improvement. A core planning team within the CRS State Office then selected the three priority MCH needs pertaining to CSHCN that CRS has the mission to address.

With one exception, the priority needs are organized below by level of the pyramid where they are first mentioned in Section 4.1 (*Program Activities Related to Performance Measures*). Most needs, however, pertain to more than one level. Terminology used in Section 4.1 to refer to each need is shown parenthetically. Key findings on which the selection of priority MCH needs were based are summarized and, where appropriate, cross referenced. See Form 14

for a simple listing of the needs.

Direct Services

- *Promote health education and outreach regarding high priority topics, per qualitative and quantitative data (promote education/outreach).* This need also pertains to the population-based and infrastructure levels. Needs assessment findings supporting health education and outreach as a priority need include those from the Medical Practices Survey suggesting that limited health education is being provided to patients (*Implications of Findings Pertaining to Enabling Services for Pregnant Women, Mothers, Infants and Children*, in Section 3.1.2.3.B), the need for improvement with respect to tracking of immunizations and provision of counseling about appropriate sleep position for infants (*Population-Based Services for Children: Medical Practices Survey*, in Section 3.1.2.4.A), and the unacceptably high proportion of adolescents who use tobacco (*Developmental Health Status Indicators*, in Section 3.2).
- *Improve health status of CSHCN through increased access to primary, specialty, and subspecialty care (improve health status of CSHCN).* This need pertains to all four levels of service. Needs assessment findings through the family forums and county provider surveys indicated that inadequate access to care for CSHCN continues in the State, as evidenced by the reported lack of transportation, knowledge of resources, adequate financing, and availability of providers.

Enabling Services

- *Assure access to dental care, especially for low income children (assure dental care).* This need also pertains to the population-based and infrastructure levels. Multiple findings from the needs assessment supported the designation of this issue as a priority need. Several of these findings suggest that utilization of and/or access to dental care is a problem, especially for Medicaid-enrolled children. For example, per the Telephone Survey, Medicaid-enrolled children were more likely to experience delay in getting dental care than children with private insurance were (*Financial Access*, in Section 3.1.2.3.B). Per the Dental Survey, only 11% of dentists said that they accept new Medicaid clients (*Infrastructure Building Services for Children: Dental Survey*, Section 3.1.2.5.B). Moreover, only about one-third of EPSDT eligible children aged 6 through 9 years were estimated to have received dental services during FY 1999 (*Developmental Health Status Indicators*, Section 3.2). Additionally, several findings suggest that access to dental care is a problem, without reference to insurance status. For example, per the Telephone Survey, dental care for children was delayed more often than other types of care (*Financial Access*, in Section 3.1.2.3.B). Also per the Telephone Survey, about one-fourth of the referent children had not been checked by a dentist within 1 year—with lower income, African American, and uninsured children being less likely than their respective referent groups to have had a dental checkup (*Infrastructure Building for Children: Household Telephone Survey*, in Section 3.1.2.5.B). Moreover, per the Medical Practices Survey, dental

care was among the types of services for which access was reported to be most problematic (*Barriers to Care*, in Section 3.1.2.5.B).

Population-based Services

- *Further reduce the adolescent pregnancy rate (reduce adolescent pregnancy)*. Needs assessment findings (unless stated otherwise, parenthetical subheadings are in Section 3.1.2.1.B) supporting this issue as a priority need include the following. First, teen pregnancy was ranked second by adolescents (behind early sexual activity) when asked what the greatest problems teens face today were (*Adolescent Focus Groups*), and early sexual activity was ranked by participants in Women’s Health Focus Groups as being of greatest concern (*Women’s Health Focus Groups* subheading). Second, although the live birth rate for adolescents has notably declined, further improvement is needed, and repeat adolescent pregnancies continue to occur (*Adolescent Pregnancy*). Finally, teen pregnancy was one of the tentatively identified sub-themes per preliminary analysis of some of the qualitative data from the Medical Practices and MCH Organizations Surveys (*Infrastructure: Qualitative Data from Medical Practices Survey & MCH Organizations Survey*, in Section 3.1.2.5.B).

Infrastructure Building

- *Reduce infant mortality in the African American population (reduce African American infant mortality)*. The racial gap in infant mortality has long been identified as a major concern in Alabama, as well as the Nation. In Alabama, African American infants have been about twice as likely to die before their first birthday as are white infants (CO #02, in Section 2.5.A; *Mortality*, in Section 3.1.2.1.B). Normal birth weight African American infants were 1.3 times more likely to die than their white counterparts, so the well known higher prevalence of low birth weight among African American versus white infants does not entirely explain the racial infant mortality gap.
- *Reduce the prevalence of VLBW in the African American population (African American VLBW)*. VLBW infants are much more likely to die than normal birth weight infants, and African American mothers were more than twice as likely to have VLBW babies as white mothers or mothers of other races (*Pregnancy Outcomes*, in Section 3.1.2.1.B). The proportion of singleton infants who were VLBW stayed about the same for white infants in recent years but increased markedly for African American infants (*Low Birth Weight and Multiple Births*, in Section 3.1.2.1.B). Although the racial disparity in VLBW does not entirely explain the racial infant mortality gap, it accounts for much of the gap, and notably reducing the prevalence of VLBW in African American babies would notably reduce their infant mortality rate.
- *Assure access to prenatal care, especially for low income, minority, and immigrant populations (assure prenatal care)*. Several of the findings supporting this issue as a priority MCH need pertain to Alabama’s Hispanic

immigrants. The number of live births to Hispanic Alabama residents has increased more than four-fold in 10 years and, in 1998, 10% or more of residential live births in four counties were to Hispanic mothers. With respect to source of payment for birth, over one-fourth of live births to Hispanic women were uncompensated (*Increase in Hispanic Births*, in Section 1.4). Moreover, the rate of improvement in the percentage of live births to pregnant women who received early prenatal care has slowed in recent years, and this slower improvement is not largely explained by the increase in numbers of uninsured Hispanic women (CP #18, in Section 2.4.D.1). Furthermore, racial and economic disparities in the proportion of women receiving inadequate or no prenatal care existed (*Health Care Systems Issues*, in Section 3.1.2.1.B). Bureau staff believe that managed care for Medicaid-eligible pregnant women has improved access to private medical providers throughout the State, but that uninsured women have difficulty accessing care (*The Move to Managed Care*, in Section 3.1.2.3.B).

- *Increase family participation in CSHCN policy making and in family-to-family support services (increase family participation)*. Through the family forums, families of CSHCN expressed the lack of necessary family supports in the State. Inadequate access to respite care, mental health counseling, and parent support/advocacy networks were areas that were specifically mentioned by families. These needs justify the continuing emphasis on listening to the voices of families in CSHCN policy making and in the development of family-to-family support services.
- *Improve the capacity of CSHCN to be fully integrated into their communities to live, learn, work, and play (integrate CSHCN)*. Through the public forums, families reported their frustration with the inadequate integration of their children with special needs into their communities. They noted inadequate educational and health-related services from public education, accessibility of facilities, community recreational opportunities, and transitions from school to work and independence.
- *Reduce deaths of children and youth due to homicides (reduce homicides)*. Although the homicide/legal intervention death rate for 15-19 year-old African American males (as estimated by the rate for African Americans and other-than-white races) has declined sharply in recent years, a wide racial disparity persists (Section 3.4.3). This disparity supports the priority need to reduce deaths of children and youth due to homicides, particularly for African American male adolescents.

3.3 Annual Budget and Budget Justification

3.3.1 Completion of Budget Forms

See Forms 2-5.

3.3.2 Other Requirements

In FY 2001, 65.24% of the MCH Block Grant allocation will be spent on general MCH services, and 34.76% will be spent on CSHCN. Maintenance of effort from 1989 is shown on Form 2. Anticipated total funding for the MCH Program, as shown on Form 2, is \$182,932,132 and includes the following: MCH funds—\$12,487,088, WIC funds—\$90,000,000, State and local (Program Income) funds—\$62,592,047, and Other funding—\$2,719,368. DHR funds are not included because it is a separate agency and its budget information is not available to ADPH.

Funds were allocated based on previous activity levels, State and federal priorities, and local need, with emphasis on areas with poor health status indicators and high primary care needs. Funds spent on pregnant women, mothers, infants and children will partly support (either directly or indirectly—through consultation, administration, etc.) activities to address core performance measures 04-09, 12-13, and 15-18 and State performance measures 01, 07, 10-13, and 15 (planned activities described in Section 4.1). The degree of support provided by Title V funds for addressing individual performance measures varies widely: from minimal time commitments from Title V personnel to extensive commitment of Title V personnel and resources. (For example, breastfeeding [CP #09] activities are funded by WIC dollars and generally require negligible time from Title V personnel. Promoting access to prenatal care [CP# 18], on the other hand, is expected to heavily utilize Title V resources.) Title V resources have not been committed to CP#10 (newborn hearing screening).

Funds spent on CSHCN will support activities to address the core performance measures 01, 02, 03, 11, and 14 and State performance measures 14 and 16. The FY 2001 budget includes an anticipated increase of \$152,000 in State Funds and an anticipated \$75,000 increase in the State Hemophilia allocation. Under Other Federal Funds, anticipated funding is included for approximately \$100,000 in carry-over funds from the 3-year MCHB Pediatric TBI grant, the MCHB Comprehensive Care Hemophilia Grant, and Year 2 (\$175,000) funding for the MCHB funded genetics demonstration grant. Anticipated use of the budgeted monies justified by the level of the pyramid, follow.

Direct Health Services \$58,348,844

General MCH—Includes services provided at the community or regional level directly to consumers for the improvement of health and/or treatment of disease, such as services provided in CHDs.

CRS—Includes direct community-based services of specialty medical care, care coordination, and ancillary care through the CRS specialty clinical programs and information and referral services for CSHCN who are uninsured or under-insured for needed services and supports, including SSI-eligible children 0-16 years.

Enabling Services \$9,335,815

General MCH—Includes services helping the consumer attain, access or use health services, such as outreach, case management services and the toll-free telephone number.

CRS—Includes transportation reimbursements; translation services; coordination with local educational agencies and with vocational rehabilitation services for adolescent transition services; a toll-free line in every district office; and parent consultant activities to assist families, advocate for their needs, and provide family support services offered through district offices.

Population-Based Services \$5,445,892

General MCH—Includes services provided to the total MCH population in the State, such as newborn screening services, genetics services, and special data support activities.

CRS—Includes State activities to screen/identify CSHCN as early as possible and outreach to families to provide information and assistance in seeking and attaining services through multiple public awareness mechanisms.

Infrastructure Building Services \$4,667,907

General MCH—Includes services provided by the MCH Program to develop, implement, and/or administer efforts to indirectly improve the health status of the maternal, infant, and child population, such as systems development, needs assessment, and quality assurance.

CRS—Includes, at the State level, administrative activities to support the CRS community-based service system and the continuous quality assurance process, including standards of care and outcome measures; interagency collaboration to improve/expand the service delivery system for CSHCN (including those with TBI), demonstration projects, inservice training, health status surveillance and other measurement activities; and at the community level, staff and parent support for local system development activities.

Other expenditures for infrastructure include enhancements of the CRS management information system to collect and analyze data, and use of communication/information technology for public awareness and client/family education as appropriate.

Total Amount Budgeted \$77,130,551

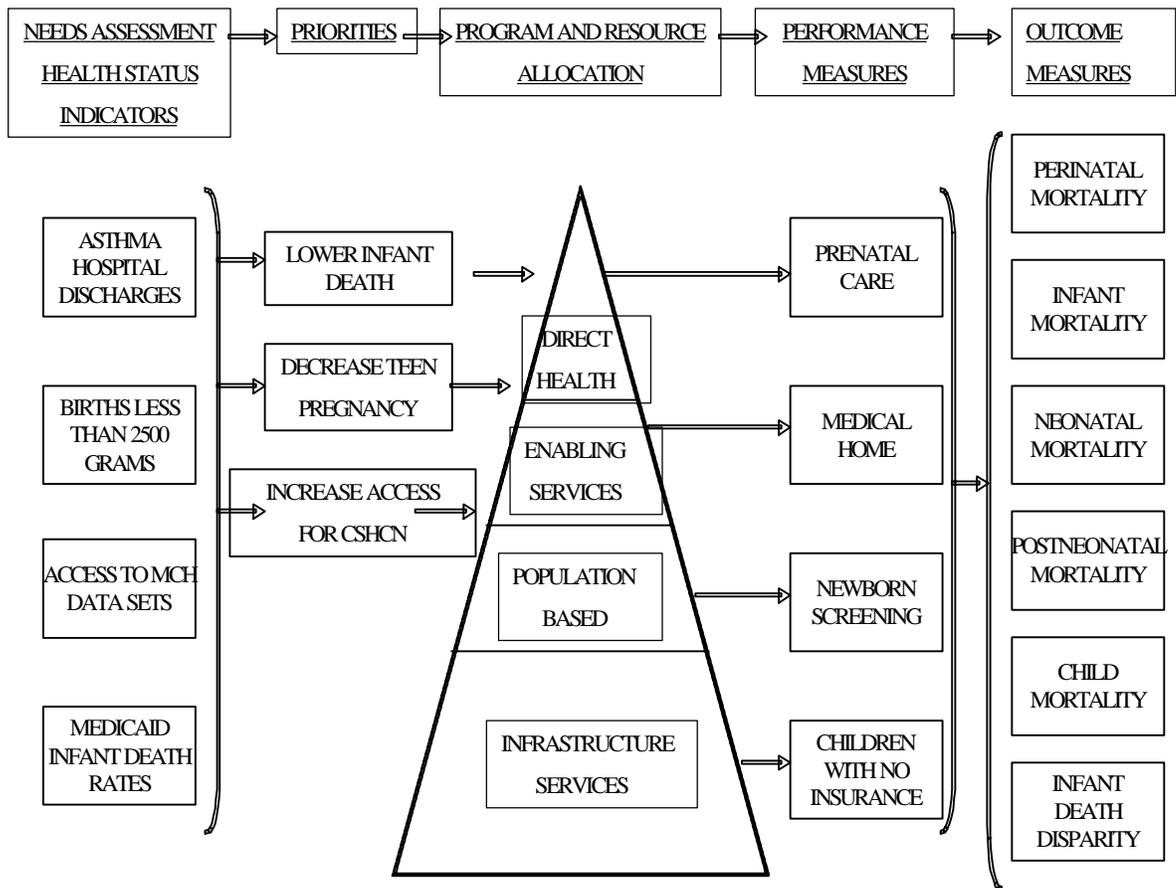
For general MCH—Matching funds for the above allocations are documented and assured through the ADPH cost accounting system, which provides a clear audit trail. This funding has consistently exceeded the legislatively designated amount, as shown on Form 2.

3.4 Performance Measures

The Title V Block Grant Measurement Performance System is shown in Figure 3. Program activities, as measured

by performance measures introduced in Section 2.4, should collectively promote progress toward achieving targets for the outcome measures. Outcome measures and relationships among performance and outcome measures are discussed in Section 4.1.

Figure 3 TITLE V BLOCK GRANT PERFORMANCE MEASUREMENT SYSTEM



3.4.1 National “Core Five Year Performance Measures

The core performance measures are shown in the initial part (under *Performance Measure* subheading) of Figure 4.

See Form 11 for the State’s status regarding these measures.

**FIGURE 4
PERFORMANCE MEASURES SUMMARY SHEET**

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		

Performance Measure	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
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

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
01) The degree to which the Bureau of Family Health Services (BFHS) addresses the folic acid intake of women of childbearing age	X					X	
02) The gonorrhea case rate per 100,000 youths aged 15-19	X						X
03) The proportion of Alabama public high school students who have smoked cigarettes during the past 30 days		X					X
04) The number of women and infants (combined) participating in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC)			X			X	
05) The percentage of blood lead levels exceeding 15 ug/dl among children aged 6 months through 5 years			X				X
06) The degree to which injury in child day care facilities is addressed by the Maternal and Child Health (MCH) Program			X			X	
07) The degree to which key maternal and child health data bases are developed and analyzed, with pertinent findings reported to and utilized by the Bureau of Family Health Services				X		X	
08) The degree to which the State assures a system to coordinate services exists for Children with Special Health Care Needs (CSHCN) who are enrolled in the State CSHCN Program				X		X	
09) The degree to which the State assures a system of quality assurance and evaluation exists to monitor the quality of direct services delivered to Children with Special Health Care Needs (CSHCN) through the State CSHCN Program				X		X	
10) The degree to which the State assures case management to facilitate access to, as well as full benefit from, available health care for children enrolled in the Patient 1 st Program				X	X		
11) The percent of children, 0-9 years of age, enrolled in the Patient 1 st Program who received case management services during the reporting year		X				X	

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
12) The degree to which the State develops and implements a plan to promote utilization of dental services, particularly utilization of preventive services by low income children		X				X	
13) The degree to which programs and policies designed to prevent adolescent pregnancy are implemented and evaluated			X			X	
14) The degree to which the State Children with Special Health Care Needs (CSHCN) Program assures public awareness of Title V CSHCN programs and activities among families and public/private service providers			X		X		
15) The percent of Alabama dentists who actively provide dental services for Medicaid-enrolled children				X		X	
16) Percent of Children with Special Health Care Needs (CSHCN) enrolled in the State CSHCN Program who are referred with family consent to the Adult Vocational Rehabilitation Service for services upon their sixteenth birthday				X	X		

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

3.4.1.1 Five Year Performance Targets

See Form 11.

3.4.2 State "Negotiated" Five Year Performance Measures

See Form 11.

3.4.2.1 Development of State Performance Measures

See Form 16 for detailed description of State measures. State-negotiated measures were developed in FY 2000 in consultation with staff from ADPH and CRS. Wider input into the State's 1998 report/2000 application and the current annual report/application, including the State performance measures, was or is being solicited as discussed in Section 4.3 (*Public Input*).

3.4.2.2 Discussion of State Performance Measures

See Form 16 for detailed description of measures and their significance. The priority need and outcome measures (shown parenthetically) to which each State-negotiated performance measure may be linked are discussed below, using abbreviated terminology. See Figure 4 for a complete statement of each performance measure and its level of placement in the pyramid. Because quality, as well as longevity, of life is important, performance measures that affect well being are clearly relevant to the Bureau's mission of promoting health and safety. Accordingly, as with many of

the core performance measures, meeting targets for State-negotiated measures would reduce morbidity and/or promote well being rather than appreciably reduce mortality.

SP# 01–Folic acid intake of women of childbearing age is related to ADPH’s designated priority need to promote education/outreach. This measure was chosen because adequate folic acid intake by women capable of becoming pregnant can prevent many cases of neural tube defects. Addressing folic acid intake of these women therefore has the potential to notably reduce the occurrence of serious, lifelong morbidity and prevent a few infant and childhood deaths (CO# 01, 03, 04, 05, 06).

SP #07–Utilization of MCH data bases pertains to ADPH’s designated priority need to promote education/outreach. That is, meaningful analysis of data should help Bureau staff to identify issues that should be addressed through education and/or outreach. Though not directly related to any of the outcome measures, this activity is crucial for meaningful surveillance of key MCH indicators and better understanding of risk markers for infant and child morbidity and mortality (CO# 01, 03, 04, 06).

SP #10–The degree to which the State assures access to case management pertains to two priority needs: to assure dental care and to promote education/outreach. This measure was chosen because case managers can best assure that individual patients have access to health and dental care and get the maximum benefit from those services. Though provision of case management might prevent a few infant and childhood deaths (CO# 01, 03, 04, 05, 06) by promoting access to health care, it will probably affect access, morbidity, and well being more than mortality.

SP #11–The percent of children enrolled in case management also pertains to the priority needs to assure dental care and promote education/outreach. This measure is complementary to, and has the same rationale as, SP #10.

SP# 12–Utilization of dental care by low income children mainly flows from the priority need to assure dental care, but also pertains to the need to promote education/outreach. The measure was chosen because appropriate and timely utilization of dental services, as well as access to care, is crucial to good oral health. Though this measure directly relates to well being (eg, good oral health), achievement of its objectives would not appreciably affect the outcome measures, which all pertain to mortality.

SP# 13–Implementation and evaluation of programs and policies to prevent adolescent pregnancy flows from the priority need to reduce adolescent pregnancy. For reasons described in Section 3.1.2, prevention of adolescent pregnancy may only marginally reduce overall infant mortality (CO# 01, 03, 04, 05) and may not reduce mortality of African American infants at all *in the short term*. More importantly, by allowing her time to mature and avail herself of social and economic opportunities, prevention of adolescent pregnancy has the potential to enhance the well being

of the adolescent and her future children. For this potential to be realized, prevention of pregnancy needs to be supplemented by other efforts to help the adolescent mature and provide her with social and economic opportunities.

SP# 14--Assurance of public awareness of CSHCN programs pertains to the priority need to improve health status of CSHCN. The goal of this measure is to increase awareness of the State's resources for CSHCN and, thereby, increase access to care. It is placed under population-based services due to its relationship to outreach/public education. It is linked to outcome measure #06 as increased access to care for CSHCN may decrease childhood mortality and morbidity.

SP#15--The percent of Alabama dentists who provide services for Medicaid-enrolled children flows from the priority need to assure dental care. This measure was chosen because the State is experiencing a critical shortage in access to oral health care for its low income population, including Medicaid clients who are eligible for dental services. SP #12 and this measure are complementary. As is true for SP #12, this measure would not appreciably reduce mortality, but is clearly related to well being.

SP# 16--Referral of CSHCN to Adult Vocational Rehabilitation Service pertains to the priority need to fully integrate CSHCN. The goal of this measure is to increase the percentage of CSHCN enrolled in the CRS program who move from school to work, and, thereby, to independence through referral to AVRS. It is placed under infrastructure building services because planning, policy development, standards development, coordination, monitoring, and evaluation components must be developed to successfully achieve this measure. There is no relevant outcome measure.

3.4.2.3 Five Year Performance Targets

See Form 11.

3.4.2.4 Review of State Performance Measures

BFHS and CRS staff and members of each agency's Needs Assessment Advisory Committee participated in development of these measures.

3.4.3 Outcome Measures

See Form 16 for a detailed description of each outcome measure and its significance, including the State-negotiated measure: the homicide/legal intervention death rate for 15-19 year-old African American males, per 100,000 African American males aged 15-19 years. With the exception of the newly developed State-negotiated outcome measure pertaining to homicide, these measures have been discussed in Section 2.5. Annual targets are shown on Form 12. For reasons discussed in Section 2.5 under SO# 01, the State-negotiated outcome measure pertaining to homicide has

replaced the State outcome measure about adolescent pregnancy. Because of the wide racial gap in deaths due to homicides, the performance measure about homicide specifies African American males. As shown on Form 12, the homicide/legal intervention death rate for 15-19 year-old African American males (as estimated by the rate for African Americans and other-than-white races) increased sharply to 118.2 deaths per 100,000 such males in CY 1994, then declined each year to reach 63.1 deaths per 100,000 in 1998 (the lowest rate during the surveillance period). Although the sharp decline is encouraging (about 47% by 1998, relative to 1994), a wide racial disparity exists and further decline in this death rate is certainly desirable. For example, in 1998 the homicide/legal intervention death rate among 15-19 year-old African American males was 6.3 times the corresponding rate for white males. Of the 42 homicide/legal intervention deaths of 15-19 year-old males in 1998, 32 (76%), were of African Americans.

Bureau staff have not previously been involved in efforts to reduce the number of deaths due to homicide, nor have we reviewed literature or consulted extensively with interested, well informed persons external to the Bureau regarding if and how the Bureau might contribute to efforts to further reduce the homicide/legal intervention mortality rate in African American males. Accordingly, Bureau staff will engage in such literature review and consultation during FY 2001. Based on information compiled, the BMT will discuss what, if any, role the Bureau might play in efforts to reduce this mortality rate. Additionally, Epidemiology/Data Management Branch staff will consult with CHS staff in an effort to report the homicide/legal intervention mortality rate for African American adolescent males, rather than for African American males and other-than-white males combined.

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

4.1. Program Activities Related to Performance Measures

Relationship of Priority Needs, Performance Measures, and Capacity/Resource Capability of the State Title V Program

The most relevant priority need is listed for each performance measure, using previously explained terminology. The Bureau's and CRS' plans are based on their overall missions, recent developments, findings from studies conducted as part of the MCH needs assessment (described in Section 3.1), and input from each agency's Needs Assessment Advisory Committee. Additionally, the Bureau's plans are based on input from SPAC.

As described in the State's 1998 report/2000 application and reiterated in Section 1.5.1.2, reductions in ADPH funding had led to about 1,500 layoffs in CHDs by FY 1998. In general, due to these layoffs, CHDs' potential to provide direct services remains limited relative to previous years. Though not at previous levels, ADPH funding has stabilized in FY 1999, and further massive layoffs are not anticipated. Moreover, as described in Section 1.5.1.3, additional personnel have been added to the Bureau's staff in FY 1999, enhancing the capacity of the Bureau's infrastructure. Thus, the Title V Program is now better equipped to accomplish its mission and effect the strategy described in the State's 1998

report/2000 application.

As described in that report/application and updated in Section 4.1, changes in the health care environment had prompted ADPH to undergo a paradigm shift, envisioned and described by the Bureau Director toward the close of FY 1998. The Bureau Director is on the Management Team of the Department's Strategic Direction Work Group (discussed in Section 2.4.E), and this paradigm shift undergirds the Work Group's recognition of the trend away from the provision of direct patient services in public health clinics toward more of a community focus and the changing assurance role for public health.

Some of the previously discussed activities, for example, child death review (Section 2.4.D), community systems development, SSDI (Section 2.4.D), formalization of relationships with CHDs, convening of the MCH Advisory Committee, and implementation of the MCH needs assessment (Section 3.1.1), were driven by the Bureau's mission and vision and consequent paradigm shift. The following plans to address specific performance measures (beginning with Section 4.1.A) occur in the context of these forces—which provide an overall strategy regarding the future role of ADPH in promoting the health of Title V populations. A description of these three forces—the Bureau's mission, vision and consequent paradigm shift—is therefore provided below.

The Bureau's mission is to protect and promote the health and safety of women, infants, children, youth, and their families through assessment of community status, development of health policy, and assurance that quality health services are available. The Bureau's vision is that Alabama's families and the communities in which they live will be HEALTHY and SAFE. Recognizing that we cannot achieve our mission or bring about our vision alone, the Bureau engages in many collaborative relationships, some of which are described in numerous places in this document. Using the conceptual model of the three core public health functions—assessment, policy development, and assurance—in conjunction with the Department's Strategic Direction Work Group, the Bureau seeks to foster a paradigm shift around family health at all levels (central, area, and county) of ADPH. Simply stated, this shift involves a move from personal health care services to community based or systems development activities where appropriate. While seeking to foster this shift, the Bureau recognizes that some local health departments will need to provide some personal health care services in the future as true "safety net" activities, under the function of assurance. A simple way to conceptualize the shift, however, is to envision the movement of county staff *out* of the building, *across* the threshold of the health department, and *into* the community.

Rationale for Targets

Targets for performance measures reported by BFHS were generally set by the Bureau's Needs Assessment Coordinator, in consultation with appropriate members of Bureau staff and other ADPH staff. The rationale varied with the nature of the performance/outcome measure. For example, targets for performance measures based on check

list criteria were based on activities that the involved Bureau staff purpose to engage in during the respective years. Many other targets (those based on rates or proportions) were set to require a slight or modest improvement over previous trends. If a measure had worsened during recent years, targets that would require the measure to stabilize were generally selected. If a measure had been stable, with no improvement, targets requiring a slight improvement were generally set. If a measure had improved, targets that would require the same or slightly greater rate of improvement to occur were generally set. Targets for performance measures reported by CRS were set by their Grants Management Specialist in consultation with other CRS staff. Three-year baselines were often used for determining objectives, since rates for individual years are often unstable and estimates for 1999, when available, are very preliminary.

4.1.A Direct Services

4.1.A.1 Direct Services: Pregnant Women, Mothers and Infants

SP #01—The degree to which the Bureau of Family Health Services (BFHS) addresses the folic acid intake of women of childbearing age.

Priority need: Promote education/outreach

FY 2001 target: 10

Plan: In FY 2001 BFHS staff will continue

- Through education of individual CHD patients and collaboration with other programs and entities, educating health care providers and women of childbearing age about the need for adequate folic acid intake by women who are capable of becoming pregnant.
- Requiring counseling and distribution of folic acid pamphlets to CHD family planning patients.
- Participating in the MOD initiative, the Alabama Folic Acid Council.

The Bureau Director will continue serving on the Advisory Board of the national collaborative project, Genetics and Your Practice. This initiative originated in Washington State and has been piloted in ten other states, including Alabama. The project, funded in part by MOD and a Special Projects of Regional and National Significance grant administered by MCHB, provides a curriculum to educate health care providers about genetics. The curriculum includes, for example, a section on preconception and prenatal genetic services.

As previously stated, the Bureau has made no progress on two objectives included in the performance measure, both pertaining to planning and implementation of a survey regarding knowledge about, consumption of, or biochemical status regarding folic acid (see relevant checklist in Appendix F). By FY 2001, the Epidemiology/Data Management Branch will consult CDC staff regarding the feasibility of such research.

4.1.A.2 Direct Services: Children

The previous State-negotiated performance measure pertaining to direct services to children (SP #02) is no longer operative, and none of the newly developed State-negotiated measures pertain to direct services to children.

4.1.A.3 Direct Services: CSHCN

CP #01—The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN program.

Priority need: Improve health status of CSHCN FY 2001 Target: 23%

Agency capacity/resource capability: CRS uses about 85% of its funds and 90% of its personnel for direct services for CSHCN, including SSI beneficiaries.

Discussion: Successfully attaining the target depends on transmittal of information on all new SSI beneficiaries less than 16 years of age to the agency from the Disability Determination Units in Mobile and Birmingham for CRS follow-up.

Plan: During FY 2001, 100% of CSCHN enrolled with CRS who are potentially eligible for SSI will be referred to SSA for consideration and will receive assistance with the application. Every SSA office in Alabama will receive information about rehabilitation services, including care coordination, available to CSHCN through CRS. Additionally, over 3,600 SSI beneficiaries less than 16 years old in Alabama will be contacted by CRS during the month of their fifth, ninth, or 14th birthdays to offer assistance with unmet needs.

CP #02—The degree to which the State CSHCN Program provides or pays for specialty and subspecialty clinic services, including care coordination, not otherwise accessible or affordable to its clients.

Priority need: Improve health status of CSHCN FY 2001 Target: 9 (scale 0-9)

Agency capacity/resource capability: The CRS program uses about 85% of its funds and 90% of its personnel for direct services for CSHCN.

Discussion: Successfully meeting this target depends on continuation of adequate State and federal funding to maintain the six CRS programs.

Plan:

During FY 2001 at least 21,000 CSCHN, including SSI recipients, will receive information and referral services, health and rehabilitative services, care coordination services, and enabling services arranged through local CRS offices. CRS

will support AEIS by provision of training, evaluation and assessment, service delivery and service coordination to eligible CSHCN and by participation in 100% of the local and State-level coordinating councils and related activities. CRS will provide intensive care coordination services to at least 10 newborns with genetic conditions and begin baseline data collection to determine effectiveness of services. Through community-based services and intensive care coordination, CRS will develop guidelines for successful community re-integration of children who experience a traumatic brain injury.

4.1.B Enabling Services

4.1.B.1 Enabling Services: Pregnant Women, Mothers, and Infants

No measure

4.1.B.2 Enabling Services: Children

SP #11—The percent of children, 0-9 years of age, enrolled in the Patient 1st Program who received case management services during the reporting year.

Priority needs: Assure dental care; promote education/outreach

Baseline: 0% in FY 1999

FY 2001 Target: 2%

Plan:

This performance measure and SP #10 are complementary and involve the activities described under SP #10, in Section 4.1.D.2.

SP #12—The degree to which the State develops and implements a plan to promote utilization of dental services, particularly utilization of preventive services by low income children.

Priority needs: Assure dental care; promote education/outreach

Baseline: 3 in FY 1999

FY 2001 Target: 9

Plan:

The Bureau's dental staff and the Medicaid Agency's dental staff will plan and implement a promotional campaign that will increase awareness and promote the utilization of dental services, especially among low income children. The initiative will target partnering with school nurses, Head Start staff, WIC and other County Health Department staff, community-based dental clinics/projects, professional dental organizations, pediatricians, the School of Dentistry, advocacy groups, and others to increase awareness regarding the value of good oral health and to encourage early and routine utilization of dental services among this vulnerable population.

4.1.B.3 Enabling Services: CSHCN

CP #03–The percent of CSHCN in the State who have a "medical/health home".

Priority need: Improve health status of CSHCN

FY 2001 Target: 70%

Agency capacity/resource capability: Program personnel at all levels work on issues related to the availability, accessibility, and acceptability of medical homes for CSHCN and are the primary agency resource expended on this measure.

Discussion: The FY 2001 target is an estimate as CRS has no data to draw upon to develop reasonable five year goals. To successfully compile data for this measure, CRS will need cooperation from several public and private agencies. As the agency does not fund primary care, CRS must rely on statewide systems development to increase both physical and financial access to primary care for improvement on this measure.

Plan:

During FY 2001 the roster of primary care physicians, including Patient 1st and ALL Kids providers, willing to accept referral of CSCHN as patients will be updated statewide to facilitate placement of children into a medical home. The primary providers of a medical home to CRS enrollees in each district will be identified and provided with information on services, including care coordination available to CSHCN within the State. Exchange of information will be enhanced between CRS and its medical staff, including medical home providers, by the publication of at least one physician newsletter.

4.1.C Population-based Services

4.1.C.1 Population Based Services: Pregnant Women, Mothers and Infants

CP #04–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).

Priority need: Promote education/outreach

FY 2001 target: 99.95%

Plan:

Although the State continues to remain at or above the target, ADPH will engage in the following activities in order to maintain and preferably increase the proportion of newborns who are screened for the above conditions.

- C Develop and implement an ongoing training and collection procedure to reduce the unsatisfactory specimen rates; and request an inservice program by Neometrics on the software to improve the parameters of specimens. BFHS will continue to work closely with BCL to implement procedures.

- C With BCL, investigate new technology, as well as new approaches with older assays. Statewide Newborn Screening training, which will include assessment of compliance with the NBS Program, is planned.

- C Maintain monitoring and evaluation of all infants identified by the NBS Program with sickle cell disease and trait whose families are provided sickle cell counseling and education services by the seven CBSOs.
- C As part of quality assurance, provide monthly reports, *Children Receiving SCD (sickle cell disease) Tests*, to hospitals.
- C Communicate and collaborate with BCL's County Assistance Section to provide inservice education, upon request, to hospitals regarding the collection, handling, and submission of newborn screening specimens.
- C Maintain the partnership with the Alabama Chapter of AAP's Perinatal Committee, who will continue providing recommendations and serving as advisors to the Bureau regarding newborn screening and giving assistance to the automated voice response system through recruitment of additional physicians.
- C Continue entering information for 100% of all confirmed positive infants into the computerized tracking and follow-up case management system.
- C Continue the Alabama Sickle Cell Disease Registry (described in Section 2.4).
- C Continue universal screening and timely follow-up and treatment for all newborns identified with an abnormal test result until a positive or negative disposition is confirmed. Specifically, maintain progress on and update the recent implementation (January 2000) of the NBS web site and, through BCL's County Assistance Section, continue providing laboratory consultation and training to CHDs.

CP# 05—Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenzae type b, Hepatitis B.

Priority need: Promote education/outreach

2001 targets: 90% for major series; 78.1% for major series plus hepatitis B

Rationale for targets: Previously set targets for achieving a 90% immunization level pertained to the major series, not to the major series plus hepatitis B. ("Major series" is defined in Section 2.4.C.2 under this performance measure.) Since we are now able to report the percentage of children through age 2 years who have completed immunizations for the major series plus hepatitis B, targets have been revised to require progress from the 1998 baseline of 72.7% for the major series plus hepatitis B. That is, the target for 2001 has been revised, and those for 2002 through 2005 set, to achieve a 90% immunization level for the major series plus hepatitis B by 2005.

Plan:

Alabama remains close to the target for completion of the major series, and the State will continue to aggressively seek to promptly meet or exceed the target of 90% for the major series ("major series is defined in Section 2.4.C.2 under this performance measure). Moreover, efforts will be made to achieve by 2005 the target of 90% for the major series

plus hepatitis B. Accordingly, most of the activities described in 2.4.C.1 (under this performance measure) will be continued. These activities include (1) developing the immunization registry, (2) sending reminder pamphlets to parents of 4- and 11-month-old infants, (3) working with the FQHCs throughout the state, (4) proctoring sites where satellite courses from CDC and ADPH can be viewed by vaccine providers, (5) operating a program to locate high-risk babies to ensure that they become fully vaccinated, (6) administering the VCF Program and (7) working with providers of primary care to children to emphasize the importance of assessing vaccine history and vaccinating when appropriate.

CP #09–Percentage of mothers who breastfeed their infants at hospital discharge.

Priority Need: Promote education/outreach

FY 2001 target: 45.9%

Plan: The following activities are planned for FY 2001:

- The PHALCON Breastfeeding Report will reflect all breastfed infants enrolled in the Alabama WIC Program. Data items, which will reflect breastfeeding initiation and breastfeeding duration, will include whether infants were ever breastfed, whether currently breastfed, whether exclusive breastfeeding occurred, and the number of weeks breastfed. Findings will be compared to corresponding findings from PRAMS data.
- The breastfeeding coordinator will continue to work closely with the Alabama Breastfeeding Coalition, which is currently investigating reimbursement issues for lactation consultants across the State, planning a statewide breastfeeding conference and reorganizing membership criteria. Furthermore, the 2000 Alabama Breastfeeding Resource Guide will be published on ADPH's Web Site, and breastfeeding training for Mom's Helper Program assistants will continue.

CP #10–Percentage of newborns who have been screened for hearing impairment before hospital discharge.

Priority need: Promote health education/outreach

FY 2001 target: 74.7%

Plan:

Staffing changes have recently occurred within the Birmingham Ear Institute, and the nature of ADPH's future involvement with BEI is not entirely clear. The Department will therefore reassess its role partnering with BEI.

4.1.C.2 Population-Based Services: Children

CP #06–The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

Priority need: Reduce adolescent pregnancy

2001 target: 38.2%

Plan:

This rate was below (better than) the target rate for 1999, and the Bureau will seek to keep it below target. The overall

plan is to continue providing direct services to teens where needed; providing information about preventing pregnancy to individuals who call; in collaboration with several other agencies, increasing the community's awareness of issues pertaining to adolescent pregnancy and promoting community-based teen pregnancy prevention projects; and educating the community about existing resources for preventing teen pregnancy. Specific plans follow.

- The following services/projects described in Section 2.4 will be continued: (1) family planning services, including preconception care, and counseling to women of childbearing age, including teens, in CHDs statewide; (2) prioritization of appointments for teens in family planning clinics; (3) in addition to provision of family planning services to teens needing them, counseling of these teens about how to resist attempts to influence or coerce them into sexual activities; (4) the PT+3 teaching model, (5) the toll-free hotline to provide abstinence and abstinence-based information to teens and family planning referral services to women of childbearing age; and (6) participation in the Alabama Campaign to Prevent Teen Pregnancy and the Montgomery Campaign to Prevent Teen Pregnancy. A State Teen Pregnancy Prevention Conference will be scheduled in FY 2001, and formation of additional local campaigns to prevent teen pregnancy will be encouraged. The Bureau will continue encouraging CHDs to participate in the Medicaid Teen Pregnancy Prevention Project by offering educational programs such as *Wise Guys*, an educational curriculum addressing male responsibility.
- The Alabama Abstinence Education Project will continue to fund grantees that originally received grant awards in FY 1998. A 5-year evaluation will continue to be a critical component to demonstrate the degree to which the Project achieves its goals/objectives. The project will continue the statewide media campaign. A statewide public forum to address risk elimination education is scheduled for FY 2000.
- ADPH, Medicaid, DHR, and SDE will continue working together, along with the community, to promote teen pregnancy prevention awareness. The results of teen pregnancy prevention focus groups will be distributed to pertinent partners throughout the State.
- BFHS will continue collaborating with DHR in expenditure of TANF funds to provide grants for community-based teen pregnancy prevention efforts, including outreach activities and increased availability of Depo-Provera for teenagers.
- BFHS will submit a request to the Office of Adolescent Pregnancy Prevention for continuation of funds for the Adolescent Family Life abstinence-based pregnancy prevention project.
- BFHS will develop a resource directory that lists local programs/projects involved in teen pregnancy prevention activities.

- A Mobile County Teen Center, established in FY 1998 via a Healthy Start grant, will continue to provide family planning services targeted to both male and female teens.
- BFHS with the help of the ADPH graphics department will establish a web site for listing educational resources and program information pertaining to adolescent pregnancy. BFHS plans to contract with a University to compile a listing of programs geared toward pregnancy prevention. The web site will include county specific resources in addition to statistical data and program contact information.
- The Bureau will encourage CHDs to partner with Primary Medical Providers to refer teens for targeted case management services under the medically-at-risk program.
- The Epidemiology/Data Management Branch will resume efforts to estimate the proportion of ADPH maternity patients who return for family planning services. If feasible, these estimates will be made for adolescents, as well as for other age groups. Success of these efforts is likely to depend largely on whether CST's newly developed PHALCON database becomes fully operational and whether Jefferson and Mobile counties will report pertinent numbers. If the PHALCON and Jefferson and Mobile county data reports are not provided, the Branch will contact selected local site directors for ADPH clinics participating in the Medicaid Maternity Care Program to learn whether they can provide meaningful data about this issue.

CP #07–Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Priority need: Assure dental care

FY 2001 target: 50%

Rationale for targets: Targets for this measure were initially developed in FY 1998, when no current baseline information was available. Targets for 1998 were therefore subjectively selected by the then-director of the Bureau's dental services' unit. Because the target of 36% for FY 1999 appears to have been appropriate, the previously selected targets for FYs 2000 and 2001 are being retained. These targets respectively require about 16% and 19% increases in each of these fiscal years. Assuming that the target for FY 2002 is reached, targets for subsequent FYs require annual increases of about 15%.

Plan:

The much anticipated tool developed by CDC's Division of Oral Health and the Association of State and Territorial Dental Directors is now available. Plans are underway for the Oral Health Branch to conduct a direct observation survey of pre-kindergarten through twelfth grade students using this tool in FY 2001. Examiners will consist of OHB staff, UAB Dental School residents and faculty, CHD dental directors, and private practitioners. This survey project

will provide the most current and accurate sealant data available for the State, as well as provide comparable data for all states using it. SDE enrollment data on public and private third graders will continue as the denominator, and the number of these children with sealants as the numerator for estimating the proportion of third graders with at least one dental sealant. Preliminary findings from a parental-report survey of public school children suggest that interventions to provide appropriate dental care for young children, especially for young children from low income households, are needed (see this performance measure under Section 2.4, *Progress on Annual Performance Measures*). The Bureau's Oral Health Branch staff will continue many of the activities described in Section 2.4, such as promoting placement of dental sealants in children, collaborating with UAB's Department of Pediatric Dentistry to conduct research on early childhood caries, and collaborating with UAB's School of Dentistry to incorporate rotation of dental students and residents to county health departments.

CP #08–The rate of deaths to children aged 0-14 caused by motor vehicle crashes per 100,000 children.

Priority need: Promote education/outreach

2001 target: 8.0 per 100,000

Rationale for targets: Targets require an annual reduction of 2.0% from the 3-year preliminary rate for 1997-1999, counting the 3-year rate as a 1998 baseline.

Plan:

The Bureau's main involvement in addressing motor vehicle crash deaths will be through child death review (described in Section 2.4.E), which has a preventive focus. HPI will continue addressing motor vehicle crash deaths as described in Section 2.4.C.2. Their Injury Prevention Division is in the data collection phase of the 2000 survey and expects the survey to be funded for 2001 as well.

Moreover, the Injury Prevention Division will continue developing the recently initiated Alabama Trauma Registry, which involves collection, storage, and subsequent manipulation of trauma-related data on a statewide level. The Head and Spinal Cord Injury Registry and Traffic Injury Registry, along with additional trauma elements, are incorporated into a centralized database at the Injury Prevention Division. The information gleaned from these data is aimed at serving two purposes: to (1) expedite resource availability to trauma patients—especially patients who have received debilitating injuries, and (2) improve on the current trauma system through data research and analysis. More specifically, the latter focus will be aimed at generating information related to external causes, injury severity, utilization/performance of protective equipment, treatment modalities and outcomes research. The data will further provide statewide information on the magnitude of traffic-related injuries and illustrate the disparity among different segments of Alabama's population. Pilot testing and initial data collection from seven trauma centers began in FY 2000. Data from smaller hospitals will be brought in as the system grows in FY 2001-2002. Collection is supported by Alabama Act 98-611.

SP #13—The degree to which programs and policies designed to prevent adolescent pregnancy are implemented and evaluated.

Priority need: Reduce adolescent pregnancy

Baseline: 9 in FY 1999 (scale 0-18)

FY 2001 target: 11

Plan:

The Bureau will continue a variety of programs designed to prevent adolescent pregnancy: that is, abstinence-based projects, abstinence education projects, a toll-free hotline providing abstinence and abstinence-based information to teens, and prioritization of appointments for teens at ADPH family planning clinics. Additionally, the Bureau will assure that teen focus groups are conducted every 5 years in order to better understand the issues affecting teens. Furthermore, the Bureau will assure that these programs undergo well designed evaluations every 5 years, with interim evaluations about midway through the 5-year periods. The criteria on which this performance measure will be rated are in Appendix F. Plans pertaining to the various programs to prevent adolescent pregnancy are described under CP #06 in this section.

Population-Based Services: CSHCN

SP #14—The degree to which the State CSHCN Program assures public awareness of Title V CSHCN programs and activities among families and public/private service providers.

Priority need: Improve health status of CSHCN

FY 2001 Target: 5 (Scale 0-15)

Agency capacity/resource capability: One administrative staff member will devote 50% of work time to developing and implementing the public awareness program. Other administrative personnel (10% of staff) will commit additional staff time to developing and implementing a statewide public awareness plan.

Discussion: This performance does not depend on other agencies for implementation, but may be affected by any State cutbacks in the purchase of supplies or ability to contract for necessary media services.

Plan: During FY 2001, a public awareness task force will be convened and will develop a statewide public awareness plan that includes dissemination of information through multiple communication channels. The CRS Program will have an informational video that can be utilized to disseminate its message and the scope of its activities statewide. A unique logo and tag line will be developed and approved for all public awareness materials that reflects the message and scope of activities of the agency.

4.1.D Infrastructure Building Services

4.1.D.1 Infrastructure Building: Pregnant Women, Mothers and Infants

CP #15–Percent of very low birth weight live births.

Priority need: Reduce African American VLBW

2001 target: 2.0%

Plan:

The Bureau's overall strategy for addressing VLBW is to maintain and develop the infrastructure for regionalized health care; through analysis of primary data and review of literature, ascertain risk markers for VLBW within the African American population; through review of literature and discussions with professionals familiar with this issue, ascertain what interventions are most likely to reduce the frequency of VLBW in this population; and develop strategies based on the information so gathered.

- The Bureau will continue the following—(1) standardized perinatal educational offerings developed and implemented by perinatal outreach educators, (2) quarterly meetings of the SPAC, (3) maintenance of a system of regionalized health care whereby patients are risk assessed and appropriate referrals are made, and (4) efforts to prevent adolescent pregnancy and unintended pregnancies among all women of childbearing age (SO #01, in Section 2.5.A). Early entry into prenatal care, smoking cessation, and teen pregnancy prevention will be emphasized. Also, the Bureau will continue efforts to increase the number of pregnant women and infants participating in WIC (Section 4.1.C.1).
- ADPH will continue monitoring risk markers for low birth weight through PRAMS and birth/death certificates.
- UAB will continue implementing the SCRIPT Project (described in Section 2.4.B.2 under SP# 03).

CP #17–The percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Priority need: Reduce African American infant mortality

2001 target: 82.9%

Plan:

As described in Section 2.4.D, after worsening during 1994 to 1997, this indicator improved markedly in 1998 and, per very preliminary findings, improved slightly in 1999. The Bureau and SPAC will seek to assure that this improvement continues.

- Perinatal outreach educators will continue providing standardized perinatal educational offerings on such topics as intervention and stabilization, neonatal and maternal assessment, and perinatal emergencies.
- Maintenance of the system of regionalized health care, mentioned in the preceding performance measure, will continue.
- Vital-statistics (birth cohorts linked to infant deaths) data will be used to further study birthweight-specific

neonatal mortality risk by category of perinatal care and further assess where VLBW infants are being born (i.e., at perinatal centers or at other hospitals). These studies are further discussed in Section 3.1.

- In addition, if feasible, transfer patterns of mothers and infants will be studied from birth records, and SPAC will be asked to assess whether appropriate transfers of pregnant women (and critically ill newborns, though these should ideally be born at a perinatal center) are occurring.
- The feasibility of further assessing this issue through FIMR will be considered.

CP #18–Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Priority need: Assure prenatal care

2001 target: 85.2%

Plan:

As discussed in Section 2.4.D.1, although this measure has been improving, the rate of improvement slowed in the mid-1990s. To better address this issue in the context of the managed care arena, Bureau staff will collaborate with and train CHD staff to empower them to work with their communities, to clarify issues to their communities, and to enlist community support for prenatal funding for the local uninsured. In addition, ADPH will continue the following:

- Providing care coordination and other prenatal services such as home visiting, intake etc. where feasible to contract for such services.
- Through outreach and measures to increase public awareness, promoting early entry into prenatal care.
- Through the Healthy Beginnings toll-free hotline, providing educational materials to pregnant women and help in accessing providers.
- In areas often traveled by minorities, distributing culturally sensitive educational materials about the importance of early and continuing prenatal care.

SP #07–The degree to which key maternal and child health data bases are developed and analyzed, with pertinent findings reported to and utilized by the Bureau of Family Health Services (BFHS).

Priority need: Promote education/outreach

2001 target: 15 (scale 0-18)

Plan:

The Bureau's Epidemiology/Data Management Branch will continue addressing the activities described on this measure's checklist in Appendix F. Moreover, Branch staff will further analyze data collected during the FY 2000

needs assessment and, in collaboration with others (including staff from the Bureau, other ADPH units, and external entities), determine how to best report key findings from the needs assessment in a more concise manner. Current plans include preparation of an executive summary of findings reported in this document, analysis of the complete data base for the Telephone Survey (the complete data base was not available in time for analysis and reporting in this document), prioritization of further analyses (both quantitative and qualitative), identification of target audiences for further reports of findings from the needs assessment, and decisions regarding the content and style of reports for these audiences. Additionally, the Branch will consult with the BMT regarding implications of findings for policies and programs, and the Bureau will collaborate with external entities, such as SPAC, regarding implications of findings. Activities carried out as part of the needs assessment pertain to children, as well as to pregnant women, mothers and infants.

Child and fetal/infant death review data collection forms will continue to be changed and streamlined to reflect the input of those collecting the information. The ACDRS has designed scanable data collection tools which reduces the effort to enter data. Software has been designed that will allow for timely data retrieval.

4.1.D.2 Infrastructure-Building Services: Children

CP #12–Percent of children without health insurance.

Priority need: Assure dental care

2001 target: 11.5%

Discussion: Allowing for statistical uncertainty and possible under-reporting of uninsured children (see corresponding footnote to Form 11), the actual percentage of uninsured children might have been as high as about 13% in 2000. Accordingly the previously set target for 2000 may still be appropriate and has therefore been retained. The target for 2001 has been revised, and those for later years set, to have no more than 11.2% of children without health insurance in 2005. If estimates for subsequent years suggest that indeed only 10% or fewer of children are without health insurance, targets will be revised downward accordingly.

Though perhaps appearing trivial by inspection, reducing the targets by 0.2 per year is very aggressive. For example, moving from 11.7% of 0-18 year-old Alabama children being uninsured to 11.5% of such children being uninsured would require that about 2,255 uninsured children obtain health insurance. Achievement of that magnitude over a 1-year period would probably require that other factors, as well as SCHIP, play a role in enabling uninsured children to obtain health insurance.

Plan: SCHIP, which covers dental care as well as other health care, is the Department's main avenue for increasing the proportion of children who have health insurance coverage—thus increasing access to all types of health care, including dental care:

- SCHIP outreach and processing of applications will continue, and the ALL Kids Plus Plan for CSHCN will be maintained. Combined applications for ALL Kids/SOBRA Medicaid can be obtained from CHDs, primary care centers, some doctors' offices, hospitals, and social service agencies or by calling 1-888-373-KIDS (5437). To apply for the program, the combined application can be completed and forwarded to the State Employee Insurance Board (SEIB) with documentation of the child's birth date and a completed pediatric health history. Once approved, SEIB will notify the appropriate insurance vendor of the new enrollee. As previously discussed (Section 2.4.D.2), applications of Medicaid-eligible children are forwarded to Medicaid and the enrollment process is begun.
- Additional plans for FY 2000 and FY 2001 are to implement outreach activities focusing on pre-school children (through day care centers and pediatric providers) and Hispanic children. Application forms and informational brochures are being designed to enhance outreach to Hispanic children.

CP #13—Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.

Priority need: Assure dental care

2001 target: 88.9%

Plan: ADPH will continue to increase the number of Medicaid eligible children who receive a Medicaid-funded service through outreach and the promotion of direct health care services to these children.

- ADPH staff will educate families, local providers, and communities about ALL Kids and ALL Kids Plus and continue promoting enrollment in Medicaid by offering joint SCHIP/Medicaid SOBRA applications in CHDs.
- Out-stationed Medicaid eligibility workers will be located in every CHD and in hospitals, FQHCs, and private physician's office to help families apply for Medicaid.
- ADPH will continue subcontracts that are in place with Maternity Care Primary Providers in selected counties to provide home visits to infants and postpartum patients by nurses and social workers.
- WIC staff will refer patients to other programs as needed, including Medicaid, TANF, and SCHIP.
- CHD staff will continue working with EPSDT and Patient 1st providers to ensure participants receive health screenings within the required time frame.
- Social workers will be available in every CHD to help children and families surmount barriers to health care.

- Serving on the Medicaid Dental Task Force and partnering with Medicaid to address barriers that prevent recruitment of new dentists into the program or cause existing providers to discontinue their participation in the program.
- Collaborating with the School of Dentistry to include dental residents/faculty as part of a community-based rotation training in facilities that serve low income populations.
- Lecturing annually to the junior class of dental students and dental hygiene students to promote their future participation in Medicaid and SCHIP.
- Sharing data with the Alabama Board of Dental Examiners and utilizing their current database of licensed Alabama dentists to measure performance progress.
- Partnering with the Office of Primary Care and Rural Health Development to recruit dentists into the National Health Service Corps Program, to offer dental student loan repayment programs such as SEARCH, and assist rural counties in Health Professional Shortage area designation.
- Increasing awareness of Alabama's dental access shortage by conducting a statewide dental disease prevalence survey and providing the data in a variety of State dental publications.

Infrastructure Building: CSHCN

CP #11—Percent of CSHCN in the State CSHCN Program with a source of insurance for primary and specialty care.

Priority need: Improve health status of CSHCN FY 2001 Target: 86%

Agency capacity/resource capability: Agency personnel at all levels are heavily involved in improving access for CSHCN to third party coverage. Agency funds are budgeted to pay for insurance premiums for CSHCN when appropriate and to fund the State match for SCHIP-Plus services for eligible CSHCN.

Discussion: Other than outreach and educational efforts to families of CSHCN, the agency has primarily advocacy and systems development roles in regard to this measure.

Plan:

During FY 2001, 100% of CRS-enrolled CSHCN having no health insurance will be referred for SSI, Medicaid, or ALL Kids consideration and will receive help with the application. All CRS clients for whom it would be appropriate

for CRS to pay for insurance premiums will be identified and afforded this service. ALL-Kids Plus will provide appropriate Plus services to all CRS enrollees with ALL-Kids coverage. Educational materials will be distributed to ALL Kids primary care providers about the state's system of services to CSHCN and their families, including ALL Kids Plus and care coordination services.

CP #14: The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.

Priority need: Increase family participation

FY 2001 Target: 17 (scale of 0-18)

Agency capacity/resource capability: CRS employs 13 parents of CSHCN and budgets agency funds for salaries, training, travel, and related expenses.

Discussion: This performance measure is not affected by other agencies. CRS continues to seek opportunities to nurture family participation.

Plan:

In FY 2001 CRS will facilitate family/professional collaboration in program and policy activities through support of families for CRS State/Local Parent Advisory Committees, training activities, publication of at least one Parent Connection newsletter, and employment of at least one Local Parent Consultant in each office. The role of the parent consultant will be expanded to include provision of family support in home, school, and other community settings. The Parent Connection statewide (parent-to-parent) network will grow by 10% through technical assistance and training. Opportunities for participation in leadership activities will be offered to adolescents with disabilities enrolled in the CRS program. CRS will support, financially and philosophically, the growth of Family Voices within the State through provision of leadership and dissemination of information.

SP #16–Percent of Children with Special Health Care Needs (CSHCN) enrolled in the State CSHCN Program who are referred with family consent to the Adult Vocational Rehabilitation Service for services upon their sixteenth birthday.

Priority need: Fully integrate CSHCN

FY 2001 Target: 25%

Agency capacity/resource capability: About 50% of CRS field personnel will expend additional staff time to facilitate referral to AVRS for these adolescents. One administrative staff member will be devoted full-time to developing the comprehensive referral system.

Discussion: This performance measure requires the support of AVRS to achieve meaningful outcomes. Relationships

will need to be enhanced at both State and local levels to increase awareness of the benefits of referral to AVRS.

Plan:

During FY 2001 key stakeholders in transition services will be identified, and a task force convened to analyze and evaluate existing policies and procedures and make recommendations for enhancing the present transition system. A statewide plan will be developed for increasing the percentage of CRS enrollees who are referred to AVRS upon their sixteenth birthday. The plan will include recommendations for a data management system, staff training, policies and procedures for program implementation, and outcome measures for monitoring and evaluation.

4.2 Other Program Activities

Pregnant Women, Mothers and Infants; Children

Enabling

No material is included.

Population-Based

Regarding *school-based services*, ADPH will continue to provide technical assistance in writing and updating protocols and procedures for such areas as Standard Precautions, infection control measures, vision screening, spinal screening, and medication administration in the school environment. BFHS plans to continue providing Off-Site EPSDT screenings and being the link between school-age children and their families, and community health and supportive services. To fulfill requirements of the legislation passed mandating the hiring of school nurses by each Local Education Administration, the Department will seek to contract with more school systems to provide these nurses and necessary services. There will be continued efforts involving smoking and tobacco use prevention, conflict resolution training, teen pregnancy prevention and parenting education, immunization, and expanded support for CSHCN.

The *proportion of high school students who smoke* is reported in Section 3.2 under DHS# 05 or the corresponding form.

BFHS activities to address tobacco use by women will include the following:

- Recruitment and randomization of SCRIPT participants will continue until 1,400 eligible women are enrolled in the clinical trial, which is designed to document the effectiveness of smoking cessation and reduction patient education methods for pregnant smokers (further described in Section 2.4.B.2 under SP# 03). Once enrollment is complete, a dissemination phase is being planned for implementation during the final year of this project (FY 2001). Training and practice protocols will be adopted and implemented as "best clinical practice" for pregnant smokers to assure on-going training of new staff to provide SCRIPT methods routinely to all pregnant smokers

at each site, and training will be expanded to other counties providing Medicaid-supported Maternity care across the State as well. As previously stated, though SCRIPT is not targeted solely to adolescents, pregnant adolescent smokers are encouraged to participate.

- Additionally, the National Institutes of Health (NIH) has awarded a \$4.4 million grant to fund the *Alabama Tobacco Free Families Program* (ATOFF). This 4-year program (07/01/00-06/30/04), to be implemented in the original eight SCRIPT sites, will target pregnant women whose maternity care is supported by Medicaid, as well as all females of reproductive age, with the message to remain tobacco-free prior to and during pregnancy. This program extends the collaboration between UAB and ADPH to promote tobacco-free families and continue work to eradicate the use of tobacco among citizens of Alabama.

With the demise of HPI's Tobacco Compliance Branch following the U.S. Supreme Court's decision that the U.S. Food and Drug Administration did not have the authority to regulate tobacco, the ***Bureau of Health Promotion and Information's Tobacco Prevention and Control Branch*** will continue collaborating with the Alcoholic Beverage Control Board to monitor illegal sales of tobacco products to youth and provide merchant education programs and materials. Other activities planned by Tobacco and Prevention Control staff, designed to prevent smoking among persons of all ages, include the following: (1) staffing each public health area with a full-time Tobacco Prevention and Control Coordinator and recruiting two Regional Coordinators, (2) helping these coordinators provide technical assistance for implementing media campaigns, and (3) maintaining and strengthening the Branch's Web page to inform the public about tobacco-related issues and events, and, (4) if funded, implementing the American Legacy Foundation's grant to develop state and local youth-led coalitions.

Plans for ***preventing adolescent pregnancies***, most of which are unintended, have been described in Section 2.4.C under CP# 06. In addition, the Bureau will continue to do the following with respect to prevention of unintended pregnancy:

- Partner with Medicaid to implement an 1115(a) Medicaid Family Planning Waiver, which, if approved by HCFA, will be implemented in the near future. The waiver will increase Medicaid eligibility to 133 percent of the FPL, targeting women aged 19-44 years. Women older than 44 years will be offered services as well.
- Educate the general public and decision makers regarding family planning. These efforts will be expanded significantly with implementation of the Family Planning Waiver. Outreach and education needs assessments will be conducted in each public health area resulting in area outreach plans and social marketing strategies. A family planning outreach coordinator will be employed to develop and implement statewide outreach activities.
- Support clinic staff in their efforts to effectively care for patients from diverse cultures while showing

appreciation for these individuals and their cultural heritage. BFHS will promote the capacity of the health department to serve the needs of the Hispanic population through language training, training on cultural sensitivity, translation of documents, and development of innovative information technology. Technical assistance will also be provided to area and CHD staff on addressing these issues through local resource development.

- Partner with DHR for TANF funding to purchase Depo-Provera for family planning clients and to fund community-based grants for unwed pregnancy prevention.
- Participate on the Women's Health Advisory Group and in the distribution of Alabama's Women's Health Report Card. This report card includes pertinent data related to family planning and reproductive health and is in final draft. It will be distributed to the State Legislature, media, individuals, and multiple entities statewide.
- Participate in the Title X Regional "Best Practices" Project and provide results to other counties throughout the State.

Moreover, the Bureau will initiate the following during the remainder of FY 2000 or in FY 2001:

- Upon implementation of the Family Planning Medicaid Waiver, offer family planning patients care coordination services provided by Health Department licensed and trained social workers and registered nurses. This service will also be offered to Medicaid patients who receive services provided by private providers. Care coordination will greatly enhance and support services for family planning patients such as enhancing their ability to access transportation services and health care providers and assisting them in understanding how to use their contraceptive method correctly.
- Establish the Office of Unwed Pregnancy Prevention. A program director, assistant, and clerk will be hired to carry out the responsibilities of this new program, which include forming an Advisory Committee, developing requests for proposals, providing technical assistance to grantees, and administering day-to-day operations. Funding awards will be provided for community-based projects that implement activities to avoid unwed pregnancies, school-based clinics for comprehensive health care, programs that offer effective methods to reduce the incidence of early sexual activity, projects that promote activities to reduce repeat teen pregnancies, projects that focus on male responsibility to delay sexual activity; and projects that focus on youth development emphasizing future life planning as well as teen pregnancy prevention.
- Formalize relationships with CHDs via MOUs that will bridge the gap between county and State level entities with a new level of accountability secured to Title X program dollars. The methodology for funding counties

will be reviewed to determine if the current production-based method should be continued in FY 2001. For the funding, counties will be expected to conduct needs assessments, develop local outreach plans, and conduct family planning health promotion activities as well as carry out the priorities of the Alabama Family Planning Program in providing direct health care services to family planning clients. In the area of technical assistance, a "canned" speech/presentation regarding reproductive health care and family planning services will be developed for statewide use. Furthermore, the Bureau will encourage local partnerships through the development of contracts and MOUs to enhance the quality of clinical reproductive health services.

- Encourage CHD coordination with school systems and other entities to promote development of school-based clinics.

ADPH will seek to ***prevent lead poisoning***, assure that children at high risk of lead poisoning are screened, and assure appropriate follow-up of children with high lead levels through the following activities:

- C Implement a Statewide Screening Plan that identifies areas for universal screening and areas for targeted lead screening; screen children at highest risk of lead poisoning and avoid unnecessary screening.
- C Screen all children at ages 12 and 24 months, and screen all previously unscreened children 36-72 months of age presenting to ADPH clinics. In addition, screen children who are identified through community outreach activities as being at high risk for lead poisoning. As indicated, make referrals to local physicians and, if necessary, the Children's Hospital in Birmingham for medical management.
- C Conduct environmental investigations in homes of all children identified with elevated blood lead levels of $\geq 15\mu\text{g/dL}$ in an effort to identify and remove the lead hazard. In addition, according to protocol, conduct environmental investigations of residences and other properties thought to contain lead hazards.
- C Conduct public awareness campaigns through collaborative partnerships with local coalitions and communities.

BFHS will seek to ascertain the frequency and type of ***injury in child day care facilities*** and to prevent such injuries through the following activities:

- C The CISS Project Coordinator will (1) continue managing, analyzing, and reporting data from injury reports, (2) serve on DHR's working committee to review and make recommendations on proposed revisions to the Minimum Standards for Day Care/Nighttime Centers and Family/Group Day Care/Nighttime Homes, and (3) use curriculum developed by the National Child Care Consultants Training Institute at the University of North Carolina, continue training public health nurses and other professionals to be child care health and safety consultants. CISS staff will continue to convene community/professional resource groups to act as an advocacy

network for improving the health, safety and quality of child care.

- C BFHS will continue (1) collaborating with providers, parents, civic organizations and public and private agencies to develop strategies to reduce the occurrence of injuries in day care facilities and (2) supporting the work of four Public Health Nurse Child Care Health consultants in 15 targeted counties. Telephone consultation to providers will be provided through the InFo Connection 800 telephone number, and on-site safety assessments will be performed by these consultants. Additionally, the feasibility of having a member of the Bureau's Epidemiology/Data Management Branch assist with analysis of injury data will be considered.

WIC will continue efforts to identify and enroll eligible women and infants. These activities will include many of the previously described activities for FY 1999, e.g. engaging in media outreaches and providing press releases, attending health professional conferences and health fairs, continuing services at Jacksonville State University Health Clinic, promoting *WIC enrollment of eligible mothers and babies* before their discharge from Huntsville Hospital and making postpartum visits in other hospitals, out-stationing two nutritionists in satellite clinics at DHR, and determining and facilitating further out-stationing needs. In addition, WIC will continue many of the activities described in Section 2.4.C.1 for FY 2000, such as obtaining names and addresses of Medicaid and Food Stamp recipients who don't already receive WIC and sending out flyers to the pregnant women, children, and infant households. WIC is also identifying the hospitals throughout the State with the largest number of Medicaid births. This is done in order to potentially out-station more WIC staff to enroll more participants. WIC is also planning to design a new Website that is more interactive. Furthermore, in FY 2001 WIC will continue being an important adjunct to health care through its collaboration and linkage with other BFHS programs. These ongoing collaborations are a very important part of the Bureau's efforts to promote the health of mothers, infants and children and include the following:

- WIC assists SCHIP by providing WIC enrollees information about SCHIP applications and making referrals to SCHIP when appropriate.
- As children are being certified or re-certified for WIC, WIC staff ask whether they live in homes built before 1978 and ask questions about potential exposure to lead particles in paint chips, dust, etc. or through pica. WIC then refers children who appear at risk of high lead levels to their health care providers.
- For infants or children identified during WIC assessment as not having health care providers, WIC staff refer them to the Child Health Program for Well Child or EPSDT visits.
- To support the efforts of the Bureau's Dental Health Services to prevent early childhood caries, WIC staff provide nutrition education about the condition.

- In FY 2000, WIC applied for a WIC Infrastructure Grant, which was awarded. As part of activities under this grant, the Bureau's Oral Health staff will meet with WIC staff and WIC participants to collect information about their needs for education on early childhood caries, as well as information needed to develop culturally sensitive materials.
- WIC staff provide information regarding the potential consequences of alcohol use and illicit drug use during pregnancy to each pregnant or postpartum WIC enrollee. Women identified during a WIC nutritional assessment as having a problem with drugs or alcohol or being at risk of developing a problem are referred to the clinic social worker. Additionally, because any type of alcohol or illicit drug use is considered to be a nutritional risk factor, women having such problems are enrolled in WIC.
- Assessment regarding need for early intervention programs is performed as indicated during WIC assessment visits, and WIC staff encourage postpartum patients to keep appointments for postpartum checkups.

WIC will continue *ongoing collaborations* with other ADPH bureaus or offices and with external organizations, including the following:

- WIC works very closely with other Bureau divisions and with UAB in SCRIPT. All patients participating in this trial are WIC enrollees, and WIC staff assist with data collection and the intervention to prevent or reduce smoking. WIC staff in CHDs assist with getting cotinine levels on the involved patients and provide them with the guide to quitting smoking.
- As described in Section 2.4.C.1 under this indicator, WIC collaborates with the Bureau of Disease Control's Immunization Division to promote full immunization of children and appropriate documentation.

ACDRS will continue to support a statewide network of *child and fetal/infant review teams*. Key findings will be reported to the State Child Death Review Team, SPAC, legislators, and the public. ADPH will continue to support the program until permanent funding occurs. This program has been discussed in Section 2.4.E.

CSHCN

Toll-free lines are maintained in the CRS state office and 15 district offices to enable families and community providers to conveniently interact with State and district level staff as needed. The toll-free lines are in operation Monday through Friday during regular office hours.

EPSDT services are now the responsibility of the primary care provider for all children under Medicaid managed care arrangements. CRS coordinates services with the medical home to ensure access to specialty care and related services

through Medicaid funding for all CSCHN served by the program.

CRS will continue its intradepartmental collaboration with AEIS and AVRS as fully discussed in Section 3.1.2.5 under Coordination of Health Services at the Community Level.

CRS will continue collaborating with SSA through the Disability Determination Units in Birmingham and Mobile for serving SSI beneficiaries below age sixteen years as fully discussed in Section 1.5.1.2.

CRS will continue to support Family Voices and Voices for Alabama's Children. The CRS State Parent Coordinator also functions as the State Family Voices coordinator. The CRS Field Supervisor is the president and membership chairman of Voices for Alabama's Children and has recently been named the chair of the Developmental Disabilities Planning Council.

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

Public input regarding two Title V populations—(1) pregnant women, mothers and infants, and (2) children—was intensively sought by BFHS through the needs assessment process, extensively discussed in Section 3.1.1. To reiterate, widespread public input was obtained via the MCH Needs Assessment Advisory Committee, community forums and focus groups, three mailed surveys, and a telephone survey of households with children. Furthermore, the Bureau presented an overview of selected findings and of the priority MCH needs to SPAC, and provided intermediate drafts of this document to interested members of SPAC. SPAC members actively discussed the presented overview, and two provided written comments to the Bureau's Needs Assessment Coordinator. Although the latter comments could not be fully considered during the time frame for submitting this document, they will be discussed with the BMT and with SPAC during FY 2001.

CRS solicited family participation from its families, as well as the families of other participating agencies, to ensure a broad base of input into the development of the needs assessment activities and input into selection of the State's priority needs for CSCHN. Families were in attendance at all meetings, and family representatives participated in the CRS planning meetings for the final selection of the priority needs and areas for new performance measures. Copies of the report from the CRS Family Forums were made available to the public. CRS presented the needs assessment results, planning meeting information, selected priority needs, and newly developed performance measures to the State Parent Advisory Council at the March 2000 meeting and solicited further input into the development of the State plan activities for FY 2001. The material from this application related to CSCHN will be presented at the summer 2000 meeting of the State Parent Advisory Committee.

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

Technical assistance is requested by BFHS, specifically the Epidemiology/Data Management Branch. The Branch is interested in augmenting its ability to perform different types of data analyses. Some qualitative analyses of community forum and focus groups data were performed for the MCH 5-year needs assessment. The Branch would like to utilize technical assistance monies to further explore training and consultation options from Kay Johnson or another suggested experts in this field to increase its ability to plan, implement, and analyze studies that include qualitative data. Furthermore, monies are requested for further training using the SAS software system and/or other software systems deemed to be especially useful for data management or analysis priorities that may be identified. Such priorities, to be identified in FY 2001, might include, for example, linkage of WIC records and birth certificate records or analysis of data obtained through stratified sampling designs. By increasing the knowledge of the Epidemiology/Data Management Branch in these areas, it will be more equipped to serve the data needs of the Bureau as a whole.

Technical assistance is requested by CRS in one area during FY 2001. The agency would like to use technical assistance monies for consultation in the development of a strategic plan for efficient and effective staff utilization to ensure the quality of services rendered to CSHCN and their families through the CRS Program. Due to limited resource availability in the past, CRS has not been able to address issues about the organization and delivery of its services through contemporary information technology and staffing patterns. Efficient staff utilization will enable the agency to move toward the provision of more community-based supports to CSHCN and their families, including more adolescent transition services and public outreach/education.

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 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.

5.3 Other Supporting Documents

Appendix A: Acronyms and Abbreviated Names

<i>Acronym/Name</i>	<i>Explanation</i>
AAP	American Academy of Pediatrics
AAEP	Alabama Abstinence Education Program
ACOG	American College of Obstetricians and Gynecologists
ADPH	Alabama Department of Public Health
ADRS	Alabama Department of Rehabilitation Services
AFAC	Alabama Folic Acid Council
AEIS	Alabama Early Intervention System
ALPHA	Alabama Public Health Association
AMCHP	Association of Maternal and Child Health Program
APHA	American Public Health Association
AUM	Auburn University of Montgomery
AVRS	Adult Vocational Rehabilitation Service
BCL	Bureau of Clinical Laboratories
BEI	Birmingham Ear Institute
BFHS	Bureau of Family Health Services
Bureau	Bureau of Family Health Services
CATI	Computer-assisted telephone interviewing
CBSSO	Community-based sickle cell organization
CDC	U.S. Centers for Disease Control and Prevention
CDRS	Alabama Child Death Review System
CHD	County Health Department
CHS	Center for Health Statistics
CI	Confidence interval
CISS	Community Integrated Services Systems
CO	Core outcome measure
COBRA	Consolidated Omnibus Budget Reconciliation Act
Cooperative Extension	Alabama Cooperative Extension System
CP	Core performance measure
CRS	Children's Rehabilitation Service
CSHCN	Children with Special Health Care Needs
CY	Calendar year
Department	Alabama Department of Public Health
DCA	Department of Children's Affairs
DG	Duarte galactosemia
DHR	Alabama Department of Human Resources
FIMR	Fetal Infant Mortality Review System
FPL	Federal poverty level
FQHC	Federally qualified community health centers
FY	Fiscal year
g	Grams
HCFA	Health Care Financing Administration
HELP	Hemophilia Evaluation and Learning Program
HPI	Bureau of Health Promotion and Information
HSI	Health Status Indicator
HSR	Health Services Research, Inc.
i.e.	that is
IEP	Individualized Education Plan
LBW	Low birth weight
MCH	Maternal and Child Health

MCH Advisory Committee	MCH Needs Assessment Advisory Committee convened by BFHS
MCHB	Maternal and Child Health Bureau
Medicaid	Alabama Medicaid Agency
MHMR	Alabama Department of Mental Health and Mental Retardation
MLBW	Moderately low birth weight (1,500-2,499 g)
MOD	March of Dimes
MOU	Memorandum of Agreement
NHTSA	National Highway Traffic Safety Administration
NOT	Not on Tobacco Program
OAPP	Office of Adolescent Pregnancy Prevention
OHB	Oral Health Branch
PHA	Public Health Area
PHALCON	Public Health of Alabama County Operations Network
PCCM	Primary Care Case Management
RNDMU	Regional Network for Data Management & Utilization
PRAMS	Pregnancy Risk Assessment Monitoring System
RPACs	Regional Perinatal Advisory Committees
SCD	Sickle cell disease
SCHIP	Children's Health Insurance Program
SCRIPT	Smoking Cessation and Reduction in Pregnancy
SDE	State Department of Education
SEIB	State Employee Insurance Board
SIDS	Sudden infant death syndrome
SOBRA	Sixth Omnibus Budget Reconciliation Act
SPAC	State Perinatal Advisory Committee
SRU	Survey Research Unit, University of Alabama at Birmingham
SSA	Social Security Administration
SSDI	State Systems Development Initiatives
SSI	Supplemental Security Income
SO	State-negotiated outcome measure
SP	State-negotiated performance measure
STD	Sexually transmitted diseases
TANF	Temporary Assistance to Needy Families
TATU	Teens Against Tobacco Use
TBI	Traumatic brain injury
TCHA	The Children's Hospital of Alabama
UAB	University of Alabama at Birmingham
VFC	Vaccines for children
VLBW	Very low birth weight
WHO	World Health Organization
WIC	Special Supplemental Nutrition Program for Women, Infants and Children
1998 report/2000 application	Alabama MCH Services Block Grant 1998 Annual Report/2000 Application

Appendix F: Attachments for State-Negotiated Detail Sheets

Attachment - State-Negotiated Performance Measure #01

SIX CHARACTERISTICS DOCUMENTING THAT FOLIC ACID INTAKE OF WOMEN OF CHILDBEARING AGE IS BEING ADDRESSED

0 1 2 3*

- 999:** 1. Provide pamphlets focusing on folic acid to each health department clinic, along with a letter advising that a pamphlet be given to all WIC and family planning clients and made available to other female clients of childbearing age.
- 999:** 2. Incorporate counseling regarding the importance of folic acid into family planning protocol.
- 999:** 3. Urge both public- and private-sector physicians likely to have contact with women of childbearing age to make pamphlets focusing on folic acid available to their clients, to personally emphasize the value of the nutrient and, if indicated, to refer clients for nutritional counseling.
- 9: 99** 4. Participate in a major media campaign to educate Alabama women of childbearing age about the importance of folic acid intake.
- : 999** 5. In consultation with staff from the Centers for Disease Control and Prevention, plan a survey of women of childbearing age pertaining to one or more one of the following: knowledge regarding the importance of folic acid, consumption of folic acid, biochemical indices of folic acid status.
- : 999** 6. Implement the above survey(s).

*0 - Not Met; 1 - Partially Met; 2 - Mostly Met; 3 - Completely Met

Total the numbers in the boxes (possible 0-18) and enter the number on the appropriate Performance Indicator row on Form 11 "Tracking Performance Measure by Service Levels of the Pyramid."

Attachment - State-Negotiated Performance Measure #06

FIVE CHARACTERISTICS DOCUMENTING THE DEGREE TO WHICH INJURY IN CHILD DAY CARE FACILITIES IS ADDRESSED

0 1 2 3*

- 999:** 1. The State Healthy Alabama Child Care Project has developed and implemented a formal monitoring program to address the number of injuries that occur in child day care facilities and are reported to DHR.
- 999:** 2. An injury reporting system (form and automation of the injury reports) has been developed and implemented for all child care facilities reporting to DHR.
- 999:** 3. Data collection, management and analysis of the injury indicators are underway to identify injuries by type, cause and frequency.
- 99: 9** 4. A statewide process to decrease the incidence of injuries has been developed and implemented through the State's program.
- 9: 99** 5. Quarterly reports have been distributed to appropriate public and private agencies working with the State's program statewide to foster potential preventive measures.

*0 - Not Met; 1 - Partially Met; 2 - Mostly Met; 3 - Completely Met

Total the numbers in the boxes (possible 0-15) and enter the number on the appropriate Performance Indicator row on Form 11 "Tracking Performance Measure by Service Levels of the Pyramid."

Attachment - State-Negotiated Performance Measure #07

SIX CHARACTERISTICS DOCUMENTING DEVELOPMENT, MANAGEMENT, ANALYSIS, REPORTING AND UTILIZATION OF DATA

0 1 2 3*

9: 99

1. At least one functional infant death review team will be established in each of the designated geographic areas (to be determined), and key findings needful for public health planning and/or for engaging the public in preventive measures will be reported to the Alabama Department of Public Health (ADPH), the State Legislature and the public.

9: 99

2. At least one functional child death review team will be established in each judicial circuit, and key findings needful for public health planning and/or for engaging the public in preventive measures will be reported to ADPH, the State Legislature and the public.

9: 99

3. ADPH will develop and distribute a "Women's Health Report."

9: 99

4. ADPH will conduct a stratified (by race or socioeconomic status) analysis of very low birth weight (VLBW) live birth by category of perinatal care (that is, a study of whether VLBW live births are occurring at perinatal centers) and of birthweight-specific neonatal mortality by category of perinatal care, and report results to the State Perinatal Advisory Committee.

: 999

5. ADPH will conduct a study of birthweight-specific neonatal, postneonatal and infant mortality for each of the 11 public health areas, and report results to the State Perinatal Advisory Committee.

9: 99

6. ADPH will utilize findings of above studies, when available, in making decisions pertaining to programs and policy and/or in promoting better understanding of key issues.

*0 - Not Met; 1 - Partially Met; 2 - Mostly Met; 3 - Completely Met

Total the numbers in the boxes (possible 0-18) and enter the number on the appropriate Performance Indicator row on Form 11 "Tracking Performance Measure by Service Levels of the Pyramid."

Attachment - State Negotiated Performance Measure #08

FIVE CHARACTERISTICS DOCUMENTING EXISTENCE OF A SYSTEM TO COORDINATE SERVICES FOR CSHCN

0 1 2 3*

- | | |
|--------------|---|
| 9: 99 | 1. The State CSHCN Program and the State Parent Advisory Committee have developed a statewide plan to define intensity levels for care coordination services. |
| 99: 9 | 2. Quality Care Guidelines for Care Coordination Services are developed for statewide dissemination. |
| 9: 99 | 3. CSHCN staff are trained statewide on the system for coordinating services incorporating the Quality Care Guidelines for Care Coordination Services. |
| 9: 99 | 4. The State CSHCN Program has developed outcome measures for care coordination services and an evaluation plan. |
| 99: 9 | 5. The State CSHCN Program has implemented a pilot intensive care coordination program for children served by the agency who met selected criteria and tracked outcome measures and client satisfaction to assess efficacy. |

0 - Not Met; 1 - Partially Met; 2 - Mostly Met; 3 - Completely Met

Total the numbers in the boxes (possible 0-15) and enter the number on the appropriate Performance Indicator row on Form 11 "Tracking Performance Measure by Service Levels of the Pyramid."

Attachment - State Negotiated Performance Measure #09

FIVE CHARACTERISTICS DOCUMENTING EXISTENCE OF A SYSTEM OF QUALITY ASSURANCE AND EVALUATION TO MONITOR DIRECT SERVICE DELIVERY WITHIN THE STATE CSHCN PROGRAM

0 1 2 3*

- 999:** 1. The State CSHCN Program has developed and implemented a formal monitoring program to address the minimum standards for delivery of direct services to CSHCN within the Program.
- 999:** 2. Standards have been developed and implemented for all medical and specialized evaluation clinics operated by the CSHCN Program.
- 999:** 3. Quality Care Guidelines have been developed and implemented for the major diagnostic categories of children served through the agency programs.
- 99: 9** 4. Outcome measures have been developed and implemented for specialized evaluation services to evaluate efficacy.
- 999:** 5. Quality Care Guidelines have been distributed to appropriate public and private agencies serving CSHCN statewide for endorsement.

0 - Not Met; 1 - Partially Met; 2 - Mostly Met; 3 - Completely Met

Total the numbers in the boxes (possible 0-15) and enter the number on the appropriate Performance Indicator row on Form 11 "Tracking Performance Measure by Service Levels of the Pyramid."

Attachment - Performance Measure #10

FIVE CHARACTERISTICS DOCUMENTING CASE MANAGEMENT FOR PERSONS ENROLLED IN PATIENT 1ST

0 1 2 3*

9: 99

1. The Alabama Department of Public Health (ADPH) and The Alabama Medicaid Agency have developed a statewide program to provide case management services to Patient 1st patients statewide.

0 1 2 3

9: 99

2. An operational protocol manual for the program has been developed and disseminated statewide.

0 1 2 3

9: 99

3. Social workers and nurses have been trained statewide on the system for providing case management services to the Patient 1st population.

0 1 2 3

9: 99

4. Area Social Work Directors in each Public Health Area have assumed supervisory responsibility for this program.

0 1 2 3

: 999

5. The ADPH and Alabama Medicaid Agency have identified outcome measures for management service and have developed as well as implemented an evaluation plan.

* 0 - Not Met, 1 - Partially Met, 2 - Mostly Met, 3 - Completely Met

Total the numbers in the boxes (possible 1-15) and enter the number on the appropriate Performance Indicator row on Form 11 "Tracking Performance Measures by Service Levels".

Attachment - Negotiated Performance Measure #12

FIVE COMPONENTS DOCUMENTING A PLAN TO PROMOTE UTILIZATION OF DENTAL SERVICES BY LOW INCOME CHILDREN

0 1 2 3*
9: 99

1. Partnered with the Medicaid Agency to develop and distribute effective educational materials which promote the early utilization of oral health services to parents of young children through county health departments, WIC clinics, public schools, Head Start centers, day care centers, pediatricians offices, dental offices/clinics, and other appropriate facilities.

0 1 2 3
9: 99

2. Developed oral health materials, sought inclusion in protocol manuals, and as necessary, provided training during periodic educational sessions with social workers, area nursing directors, nutritionists, child health staff, and other suitable health department staff to promote early intervention strategies for low income children and their families.

0 1 2 3
9: 99

3. Collaborated with school nurses, Head Start staff, day care center staff, and other programs that provide services to children to collect data, to increase awareness of oral disease prevention methodology, and to promote access to community dental care programs for children.

0 1 2 3
: 999

4. Planned, developed, and implemented a media campaign that will promote oral health awareness through television, radio, posters, pamphlets, and other material through collaborative efforts with the Alabama Dental Association, the Alabama Dental Alliance, the Alabama Dental Assistants/Hygienists Association, the School of Dentistry, the Academy of Pediatricians, advocacy groups, and other agencies that focus on children's issues.

0 1 2 3
: 999

5. Partnered with the University of Alabama at Birmingham School of Dentistry staff to conduct a survey of hospital emergency rooms to collect data on children's emergency visits for oral health conditions and utilize these facilities and health care professionals in providing appropriate follow-up procedures for these children and their families.

*0 - Not Met, 1 - Partially Met, 2 - Mostly Met, 3 - Completely Met

Total the numbers in the boxes (possible 1-15) and enter the number on the appropriate Performance Indicator row on Form 11 "Tracking Performance Measures by Service Levels".

Attachment - State Negotiated Performance Measure # 13

FIVE CHARACTERISTICS DOCUMENTING IMPLEMENTATION AND EVALUATION OF PROGRAMS AND POLICIES TO PREVENT ADOLESCENT PREGNANCY

0 1 2 3*

- 9: 99** 1. Abstinence-based projects to prevent adolescent pregnancy are provided in appropriate settings—with (1) a comprehensive, well designed evaluation conducted and fully described every 5 years in a written report made available for wide distribution, and (2) an interim evaluative report written and distributed about half way through the 5-year period.**
- 9: 99** 2. Abstinence education projects to prevent adolescent pregnancy are provided in appropriate settings—with (1) a comprehensive, well designed evaluation conducted and fully described every 5 years in a written report made available for wide distribution, and (2) an interim evaluative report written and distributed about half way through the 5-year period.**
- 9: 99** 3. A toll-free hotline providing abstinence and abstinence-based information to teens is provided—with (1) a comprehensive evaluation conducted and fully described every 5 years in a written report for administrative use, and (2) a corresponding evaluative report made available to administrators about half way through the 5-year period.**
- 9: 99** 4. ADPH family planning clinics prioritize appointments for teens statewide and make Depo-Provera available for teens for whom it is appropriate—with a comprehensive evaluation conducted and fully described every 5 years in a written report for administrative use, and (2) a corresponding interim evaluative report made available to administrators half way through the 5-year period.**
- 99: 9** 5. Teen focus groups are conducted every 5 years—using state-of-the-art/science methods to select participants, design questions, and conduct and document the sessions (including demographics of participants). Additionally, a comprehensive report of the methods and findings is made available for wide distribution, and findings are applied to decisions regarding the various adolescent pregnancy prevention programs and policies in place.**
- 999:** 6. Adolescent pregnancy rates are monitored annually.

*0 - Not Met; 1 - Partially Met; 2 - Mostly Met; 3 - Completely Met

**The evaluation should include a description of the acceptability of the program(s) to the communities involved. Annual ratings pertaining to these criteria will consider such as factors as whether a well designed plan for evaluating the program(s) is in place, as well as whether reports are made available during the specified time frames.

Total the numbers in the boxes (possible 0-15) and enter the number on the appropriate Performance Indicator row on Form 11 “Tracking Performance Measure by Service Levels of the Pyramid.”

Attachment - State Negotiated Performance Measure #14

FIVE CHARACTERISTICS THAT DOCUMENT THE DEVELOPMENT AND IMPLEMENTATION OF A PUBLIC AWARENESS PROGRAM

0 1 2 3*

- : 999 1. The State CSHCN Program has developed a unique logo and tag line for all public awareness materials that reflect its message and the scope of its activities and has incorporated it in all its brochures and materials.

- : 999 2. The State CSHCN Program has an informational video that can be utilized statewide to disseminate its message and the scope of its activities and services.

- : 999 3. The State CSHCN Program has a web site for families with resource information about the links to services for CSHCN that is updated regularly.

- : 999 4. The State CSHCN Program has developed and implemented a statewide public awareness plan that disseminates its materials through multiple methods: mail-outs, hand-outs, conference exhibits, articles, presentations, personal contacts, and public service announcements.

- : 999 5. The State CSHCN Program has developed and implemented staff training on public awareness strategies and uses of materials to ensure a consistent message statewide.

0 - Not Met; 1 - Partially Met; 2 - Mostly Met; 3 - Completely Met

Total the numbers in the boxes (possible 0-15) and enter the number on the appropriate Performance Indicator row on Form 11 "Tracking Performance Measure by Service Levels of the Pyramid."

- 5.4 Core Health Status Indicator Forms
- 5.5 Core Health Status Indicator Detail Sheets
- 5.6 Developmental Health Status Indicator Forms
- 5.7 Developmental Health Status Indicator Detail Sheets
- 5.8 All Other Forms
- 5.9 National “Core” Performance Measure Detail Sheets
- 5.10 State "Negotiated" Performance Measure Detail Sheets
- 5.11 Outcome Measure Detail Sheets

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