

STATE TITLE V BLOCK GRANT NARRATIVE

STATE: **AL**

APPLICATION YEAR: **2005**

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I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

/2005/Assurances and certifications are included in Appendix A. Appendices are not submitted electronically but are on file in the Bureau of Family Health Services, Alabama Department of Public Health. Any appendix, including Appendix A, can be obtained upon request by calling, e-mailing, or faxing the Bureau of Family Health Services' Epidemiology and Data Management Branch (phone: 334.206.2005; e-mail: christinelong@adph.state.al.us; fax: 334.206.2914)./2005//

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

The Bureau of Family Health Services (BFHS, or Bureau), Alabama Department of Public Health (ADPH, or Department), usually makes pre-submission and post-submission drafts of Maternal and Child Health (MCH) Services Block Grant Annual Reports/Applications available to the State Perinatal Advisory Committee (SPAC) and invites comments. In fiscal year (FY) 2001 the Bureau prepared a report of the FY 2000 needs assessment---focusing on pregnant women, mothers, potential mothers, and infants---that is appropriate for general audiences. The report has been distributed to various stakeholders, invites readers' input, and is available on ADPH's website (<http://www.adph.org/mch/maternal.pdf>).

Children's Rehabilitation Service (CRS), Alabama Department of Rehabilitation Services (ADRS), administers services to children with special health care needs (CSHCN) and seeks input on this population. For example, CRS presented the FY 2003 draft State plan for CSHCN at a meeting of Local Parent Consultants in April 2002. The Parent Consultants rated CRS on the 6 characteristics listed on what is now Form 13.

/2005/Through e-mail and postal mail, BFHS sought input from SPAC and regional perinatal advisory committees in June 2004. For more input BFHS will rely heavily on the FY 2004-05 MCH needs assessment process (already-conducted community discussion groups and mailed surveys, an advisory group to be convened, etc.). CRS continues seeking input on CSHCN. In early FY 2004 CRS presented the FY 2005 draft State plan for CSHCN at a meeting of the State Parent Advisory Committee, who rated CRS on the characteristics listed on Form 13./2005//

II. NEEDS ASSESSMENT

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

//2005/Acronyms or shortened terms are listed in Appendix B, obtainable by calling 334.206.2005 or e-mailing christinelong@adph.state.al.us. Further, Appendix B is included on pages 1-3 of the attachment to III.A. Other appendices are not included in this web-based submission but are obtainable through the above phone number and e-mail address.//2005//

In the State of Alabama (State), the Title V Program is administered by ADPH through BFHS. BFHS does not directly administer aspects focusing on CSHCN but contracts with CRS, within 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.

Changes in the Health Care Environment

The State's MCH Services Block Grant annual reports for FYs 1997 and 1998 described changes that had been occurring in Alabama's health care environment. Initiatives (described below) involving the Alabama Medicaid Agency's (Medicaid's) Managed Care programs and Alabama's State Children's Health Insurance Program (SCHIP) have continued to evolve since the Alabama MCH Services Block Grant FY 1998 Annual Report/FY 2000 Application (1998 report/2000 application) was submitted. Specifically, 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 concerning the roles of CHDs---toward a greater emphasis on the core public health functions of assessment, policy development, and assurance.

Medicaid Managed Care Programs

Medicaid Maternity Care Program

Medicaid has received approval for the Medicaid Maternity Care Program to replace the Alabama Maternity Waiver Program. Under the latter, begun in 1988, ADPH had been the primary provider of prenatal care for 23 of the State's 67 counties and a subcontractor for such care in many other counties. The new State Plan for maternity care began in June 1999, was fully implemented by October 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 subcontractor for case management in 54 counties and a subcontractor for prenatal care in 14 counties. Under this plan, there has been a substantial decline in the number of patients receiving prenatal care in ADPH clinics. A primary concern continues to be access to care for uninsured patients (see "Selected Changes in Alabama's Population").

//2003/Compared to FY 2001, ADPH is a subcontractor for case management and prenatal care in fewer counties. ADPH is the subcontractor for case management in 39 counties (versus 54 counties about 1 year ago) and a subcontractor for prenatal care in 11 counties (versus 14 counties about 1 year ago). The Intent to Bid for Medicaid's State Maternity Plan that is to begin in June 2002 was disseminated in December 2001, and Mobile County will become part of the June 2002 plan. Minor changes in the plan have been made. For example, 4 care coordination visits (instead of 3), including 2 face-to-face visits (instead of 1) per year are now required.//2003//

//2004/With the decline in opportunities for direct patient care, CHD staff are shifting their focus from services provided in the CHD to services provided in the community. This shift has given rise to increased emphasis on provision of case management/care coordination services by licensed public health social workers and nurses. Case managers/care coordinators work in several clinical programs, including family planning, child health, Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), and maternity. All of these programs take public health staff into the community and allow them to work with private providers as well as other government and

community agencies. The teen family planning program has provided a vehicle for staff to network with the State Department of Education (SDE) to provide abstinence-based classes in local schools.//2004//

/2005/In FY 2003 ADPH provided prenatal care, as a subcontractor, in 10 counties (versus 14 circa 2001 and 11 in FY 2002). In July 2004 prenatal care provided by the Jefferson County Department of Health (JCDH) will be transferred to the University of Alabama at Birmingham (UAB), leaving ADPH a subcontractor for prenatal care in 9 counties.//2005//

Medicaid Patient 1st Program and Related Issues

As stated in the 1998 report/2000 application, Medicaid completed implementation of Patient 1st, its primary care case management (PCCM) program, with initiation of services in Jefferson County in November 1998. In FY 1999 all of Alabama's counties except Mobile continued to use 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 referrals for specialty care and pre-authorization of specified Medicaid services. PCCM has increased access to primary care for Medicaid recipients, including CSHCN, throughout the State. Though 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 41% in FY 2000 relative to FY 1997. 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.

/2005/In early FY 2004 the State's governor (Governor) appointed a new Medicaid Commissioner, who has a strong interest in and ties with MCH. Medicaid discontinued Patient 1st, the managed care program for Medicaid patients, effective March 1, 2004 because of financial constraints. Medicaid patients are no longer assigned to a doctor and can go to any Medicaid provider, including a CHD, for services. The discontinuation of Patient 1st brought concerns from providers of health and related services to children due to the program's effectiveness in assuring the assignment of children to a medical home. However, Medicaid, ADPH, and CRS continue to support the concept of a medical home for patients, and patients will only be seen for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) in CHDs when there are no private providers available to perform these screenings. Medicaid has established a task force to plan a new waiver that also promotes medical homes and hopes to have a new waiver in place by October 2004.

The Medically at Risk Case Management Program (MAR Case Management) was closely tied to Patient 1st, so MAR Case Management also ended effective March 1, 2004. However, children and youth through 20 years of age who have full Medicaid coverage can now receive care coordination services under the newly implemented EPSDT Care Coordination Program, discussed under National Performance Measure (NPM) #14 and State Performance Measures (SPMs) #3-4. About 18% of persons receiving services under MAR Case Management just prior to its termination were 21 years of age or older, and are being referred to other resources for services.//2005//

Medicaid Family Planning Waiver and Related Issues

In March 1999 Medicaid and ADPH staff submitted an 1115(a) Family Planning Waiver Proposal to the Health Care Financing Administration (HCFA). This waiver proposal was implemented in October 2000. The Waiver expanded Medicaid eligibility for family planning services for women aged 19-44 years to 133% of the federal poverty level (FPL). (The previous eligibility cut-off was about 16% of FPL.) Family planning services for adolescents less than 19 years old are now covered by the Alabama Child Health Insurance Program, which provides 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.

/2005/In June 2001 the Alabama Department of Human Resources (DHR) had funded a Teen Family Planning Care Coordination program at ADPH, with the goal of reducing teen

pregnancies and decreasing abortions among teens in Alabama. Under this program, all teens 18 years old and younger who presented at any CHD for family planning services were eligible for care coordination. Because of the cuts in federal Temporary Assistance to Needy Families funds to the State, this program is being phased out and will end by September 30, 2004. However, half of these teens are enrolled in Medicaid so will be eligible to receive the same services via the newly implemented EPSDT Care Coordination Program, discussed under NPM #14 and SPMs #3-4.//2005//

The State Children's Health Insurance Program

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 workgroup, formed in September 1997, to research and recommend how services for the uninsured could best be developed. The workgroup included other State agencies (Medicaid, DHR, ADRS, Alabama Department of Mental Health and Mental Retardation [MHMR], SDE, State Employees' Insurance Board), advocacy groups (Alabama Arise, Family Voices, and VOICES for Alabama's Children), hospitals, community health centers, and various professional associations. Phase 1, a limited Medicaid expansion, was begun in February 1998. Phase 2 (the ALL Kids Program), a private insurance package for children between 100% and 200% of the FPL, began on October 1, 1998. As of September 30, 2000, 37,012 (down from 42,909 on that date in 1999) children were enrolled in Alabama's SCHIP (7,948 in Phase 1 and 29,064 in Phase 2). Due to SCHIP outreach, an additional 43,500 children have been added to the Sixth Omnibus Budget Reconciliation Act (SOBRA) Medicaid rolls (up from 30,000 having been added by 1 year earlier). FY 1999 appropriations were also \$5 million; \$9 million were appropriated for FY 2000 and \$16.2 million for FY 2002. 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, administered through ADPH's Office of Children's Health Insurance, has experienced many distinctive achievements. Alabama was the 1st state in the nation to have a federally approved SCHIP State Plan as well as the 1st to have a major plan expansion. Because Alabama is on the forefront of SCHIP, the State was chosen as 1 of 7 states to pilot a federal communications outreach project, implemented in the fall of 1999. Alabama was also 1 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 1 of 6 states chosen by the national Association of MCH 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 1 of 6 states upon which to conduct an in-depth case study, published in July 1999, on the early implementation of SCHIP. Alabama is also part of a National Academy for State Health Policy team examining the complex issue of retention at renewal. Specific activities of SCHIP staff are described under National Performance Measure (NPM) #13, in Section IV.C.

/2003/As of May 2002 at least an additional 60,000 children have been added to SOBRA Medicaid rolls (up from 43,500 when the 2000 report/2002 application was being prepared).//2003//

/2004/As of May 5, 2003, over 80,000 children have been added to the SOBRA Medicaid rolls.//2004//

/2005/SOBRA Medicaid and SCHIP utilize a joint application form, making applying for these programs much simpler and referrals between these programs more automated and streamlined. Because of the joint form and extensive outreach for SCHIP, at least an additional 16,412 children were added to the Medicaid SOBRA rolls in FY 2003. As discussed under SPM #13, ALL Kids is now the sole component of SCHIP.

Due to State fiscal issues discussed in Section III.B, SCHIP established a waiting list in October 2004. Because of cost-saving measures that the program has instituted in FY 2004, the waiting list has been opened several times. As of late June 2004, SCHIP is aggressively

conducting outreach and enrolling eligible applicants without delay.//2005//

Department of Children's Affairs

The Department of Children's Affairs (DCA), created through legislation endorsed by the Governor in 1999, has continued to expand its role. Its mission is to coordinate the activities of State and local agencies to ensure that services are maximized for the benefit of Alabama's children and adolescents. DCA was instrumental in convening the Children's Summit meeting in November 2000, which led to the creation of Alabama's 5-Year Strategic Plan for Children. The primary functions of DCA are 1) establishing coordination and communication channels with State and local agencies and advocacy groups concerning children, 2) developing additional resources to invest in the welfare of children and families, and 3) creating a database to link Alabama families with appropriate service providers. Further, DCA oversees the Children's Policy Councils (CPCs), which address needs of children at both the State and county levels.

County CPCs are charged to assess the local needs of children and families and assess available resources; develop local resource guides; seek funding for local initiatives; articulate locally the identified needs; and submit an annual report on services provided, local needs, and recommendations to the State CPC. The State CPC is responsible for reviewing these reports and making recommendations for action to the Governor and the State Legislature, including recommendations about the Children First budget, which distributes the tobacco settlement money in the State. ADRS has been active at both the State and local levels with the CPCs, as a voice for children and adolescents with disabilities, and has conveyed information on services provided to these children and youth via ADRS's 4 service programs. The preceding information about DCA was excerpted from its informational brochure, "Because Every Child Deserves to Succeed."

/2004/CRS continues its collaborative activities with DCA through the State and local CPCs. The Commissioner and Assistant Commissioner participated in DCA's Children's Summit in November 2000. The State Parent Consultant and 3 local CRS staff members attended the CPC's Capitol Planning Conference in March 2002. Training was provided on needs assessment and strategic planning at the county level, grant writing, resource directory development, and creating children's advocacy in communities. A new governor was sworn in, in January 2003, and has appointed a new DCA commissioner. CRS continues its collaborative activities with DCA through both the State and local CPCs. Several local staff members attended training provided by DCA in February 2003. CRS continues to be the voice for CSHCN in all these activities.//2004//

/2005/Alabama's governor has been a strong supporter and advocate for children's issues, including education, health insurance coverage, and health care provision. During this legislative session, the possibility of relocating DCA to a division in DHR has been suggested. The former Commissioner of DCA is now the Commissioner of DHR. This potential shift illustrates the Governor's initiative toward greater accountability and more consolidated service systems in government. The Governor continues his support for the DCA and CPCs. ADRS, including CRS, the Alabama Early Intervention System (EIS), and ADRS's Adult Vocational Rehabilitation Service (AVRS), continues to collaborate with DCA as the voice for Children and Youth with Special Health Care Needs (CYSHCN) in both State and local CPCs. A staff member from ADRS sits on local CPCs in all counties. CRS staff and local parent consultants attended the CPC's statewide conferences in February 2003 and 2004, which concerned children's issues, information-sharing, and best practices. Training was again provided on needs assessment and strategic planning at the county level, grant writing, resource directory development, and creation of children's advocacy in communities.//2005//

Governor's Task Force on Children's Health Insurance

One issue of great concern to the Governor and DCA is that of uninsured children. The Governor, through the State Health Officer, convened the Governor's Task Force on Children's Health Insurance (CHI Task Force) in July 2000. The Governor designated a local pediatrician as the chair of this group. The DCA Commissioner served as the vice-chair and the DCA Deputy Commissioner served as the secretary. The Task Force membership, appointed by the Governor, included State agency

directors, child health advocates, and pediatric health care providers, including the chief executive officer of The Children's Hospital of Alabama (TCHA).

The CHI Task Force was charged with coordinating existing funds to determine how to provide health insurance to children not otherwise eligible for Medicaid, developing a comprehensive strategy to expand Medicaid eligibility, and developing a comprehensive strategy to reduce the percentage of Alabama's children without health insurance. Four working committees were formed to advise the Task Force on the following: outreach and enrollment, eligibility, financing, and provider/reimbursement issues. The group met monthly for 6 months, and the committees met at least biweekly over the same period.

The final report contained 29 recommendations and was presented to the Governor in January 2001. Recommendations on outreach included 1) simplifying and coordinating the enrollment process for the 4 children's health insurance programs (Medicaid for Low-Income Families, SOBRA Medicaid, ALL Kids, and the Alabama Caring Foundation); and 2) developing public awareness strategies about eligibility for the 4 programs, with the strategies targeted to hospital staff, primary care physicians, child care providers, and public school staff. Recommendations about enrollment and eligibility included assurance of an efficient, adequately staffed enrollment system for both ALL Kids and Medicaid, and streamlining of the annual renewal processes. Further, establishment of an adjunct "eligibility" for Medicaid based on income eligibility for other means-based programs, such as Food Stamps and subsidized child care, was suggested. Recommendations concerning providers, reimbursement, and financing included: 1) increasing Medicaid reimbursement rates to match Medicare rates for physician office visits and to match Blue Cross and Blue Shield of Alabama (BCBS) rates for dental procedures, 2) creating a fully automated, web-enabled enrollment system for ALL Kids and Medicaid, 3) describing the demographics for uninsured children at the county level, and 4) addressing long-term financing strategies for Medicaid. The CHI Task Force further recommended that an ADPH and Medicaid joint committee be formed to monitor progress on implementing recommendations.

Several interesting developments occurred while the CHI Task Force was active. Medicaid convened a dental task force to look at issues affecting access to dental services for children who are Medicaid recipients, and collaborated with the Alabama Dental Association to survey dentists on what might encourage them to become Medicaid providers. CRS worked with the dental task force to address special challenges that dentists might encounter when providing services to CSHCN. With the Governor's approval, Medicaid increased its rates for dental procedures effective October 1, 2000. CRS also increased rates to at least match the new Medicaid rates. Further, Medicaid is developing a plan for a functional assessment of orthodontic needs in order to expand its coverage of orthodontic treatment beyond children with craniofacial conditions to include other children with severe disabilities.

Although many systems improvements were anticipated as a result of the CHI Task Force, the State is now facing a major funding shortfall. The Governor has declared proration in the Education Trust Fund, which provides all of the ADRS State funding and some funding to ADPH. By court order, funding for teachers' salaries for kindergarten through 12th grade local educational agencies cannot be prorated. This order has increased the percentage of proration (now 11.8%) for higher education institutions and for State and local agencies funded through the Education Trust Fund. With decreased funding available for FY 2001 and anticipated for FY 2002, implementing insurance reform for children will be challenging.

/2004/CRS joined the Alabama Dental Health Coalition (renamed the Oral Health Coalition) and participated in the Dental Summit meeting held in Montgomery in December 2001. CRS staff members serve on 2 subcommittees of the Oral Health Coalition: Patient Education and Dental Surveillance. CRS continues to look for ways to integrate dental health initiatives for CSHCN into the program. Medicaid provided training to CRS Cleft Lip/Palate Clinic and Craniofacial Clinic Coordinators and other relevant staff in May 2001 concerning the new criteria for establishing medical necessity for Medicaid-sponsored orthodontic treatment. In January 2002 the Oral Health Branch

(OHB) at ADPH and CRS participated in an assessment conducted by the Association of State and Territorial Dental Directors on ways to improve the oral health of CSHCN.

CRS continued participating in the Oral Health Coalition to, among other things, highlight access to care issues for CSHCN whose disability may be a barrier to receiving routine and specialized dental care. This organization consists of some 31 public and private agencies and groups, with its stated purpose "to ensure every child in Alabama enjoys optimal health by providing equal and timely access to quality, comprehensive oral health care, where prevention is emphasized, promoting the total well-being of the child." CRS advocated for consumer representation on the Oral Health Coalition and successfully nominated 2 parents of CSHCN to the coalition. In addition, the CRS representative served on the Public Awareness subcommittee for the Oral Health Coalition to help develop outreach materials about prevention and intervention for lawmakers and policy-makers as well as the general public.//2004//

/2005/In FY 2003 CRS continued participating in the Oral Health Coalition, with CRS staff members and parents of CYSHCN serving on 3 subcommittees: Availability and Access, Surveillance and Monitoring, and Education and Awareness. A CRS staff member attended a 2nd Dental Summit, held in Montgomery in January 2003. With the completion of the initial Robert Wood Johnson grant funding, the Oral Health Coalition is seeking to continue project activities and disseminate dental awareness kits through alternative methods and funding sources. CRS is planning to convene a subcommittee, to include a pedodontist and an orthodontist, to promote improved dental outcomes for CYSHCN. CRS continues to integrate dental health initiatives for CYSHCN into the program.

Following completion of the CHI Task Force's work, the United States (U.S.) Health Resources and Services Administration (HRSA) awarded Alabama a State planning grant, "Insurance Directions for Every Alabamian" (IDEA), to identify the uninsured, under-insured, and unstably insured in the State. Through this project, efforts are ongoing to study options to reduce the proportion of persons who are uninsured, potentially by piloting the CHI Task Force's recommendations. A CRS staff member sits on 2 subcommittees of IDEA--Statutes and Publicly-Funded Programs--to serve as an advisor and as a voice for CYSHCN.//2005//

Medicaid Reorganization

Another initiative of Medicaid, which facilitated its collaboration with CRS, was a reorganization of staff duties effective January 2001. Medicaid returned to a programmatic focus after several years of being organized by a functional focus. Due to this change, CRS once again has specific Medicaid staff members assigned to work with its programs. This change has already helped resolve many programmatic issues and has led to greater coordination and communication between the agencies. Monthly meetings were instituted to address many of the challenges that had developed over the years without a specific point of contact for CRS issues. This enhanced partnership efficiently developed procedures enabling CRS to begin billing for therapy services provided by vendors in April 2001, thus increasing access of Medicaid-covered CSHCN to small therapy-provider groups. Further, CRS staff are working with Medicaid to identify concerns regarding interagency data sharing that need to be addressed due to implementation of the new privacy regulations in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. These regular meetings are so productive that they will be continued indefinitely on a bimonthly basis.

/2004/Bimonthly meetings between Medicaid and CRS have continued. Due to new regulations under HIPAA, the agencies have revised codes for clinics and related services. Also, Medicaid and CRS have entered into a new contract. At CRS's request, Neuromotor Clinic, Teen Transition Clinic, and Seating Clinic were added to the list of approved multidisciplinary clinics in August 2002. Medicaid implemented new guidelines for the provision of nutritional supplementation products, and CRS has worked closely with them to ensure that Alabama's CSHCN who are Medicaid recipients continue to have access to supplementation as needed. Additionally, at CRS's request, Medicaid revised its Administrative Code to simplify the procedures for physical and occupational therapists to document their credentials.//2004//

//2005/Medicaid has undergone another reorganization. The newly appointed commissioner, who has strong ties to MCH, has emphasized children's issues as an agency priority. Meetings between Medicaid and CRS are now conducted on a quarterly basis. CRS continues to collaborate with Medicaid to meet HIPAA standards for privacy and billing and to provide access for Medicaid-enrolled children to community-based medical specialty clinics. CRS continues to credential its staff and vendor physical, occupational, and speech therapists according to the Medicaid Administrative Code in order to provide services to clients in CRS-sponsored early-intervention programs and/or the CRS program. Further, CRS has developed a policy with Medicaid to credential licensed physical therapy assistants and certified occupational therapy assistants to provide services within the CRS program or CRS-sponsored early-intervention programs. CRS has piloted a new initiative of billing Medicaid for targeted case management within 1 sponsored EIS program. Plans are in place to expand this to all 16 CRS-sponsored early-intervention programs in order to provide reimbursement monies to EIS. Negotiations are ongoing for CRS to become a provider with Medicaid for audiological services, hearing aids, and related supplies, thereby providing better coordination of these services for Medicaid-eligible CRS clients. With the expiration of the waiver for Medicaid's PCCM model, Patient 1st, Medicaid has established a task force to plan a similar program for application for a new demonstration waiver. Two members of the CRS State office staff sit on this task force. Though children's medical services are protected by EPSDT requirements, providers and advocates for children are supportive of a model of care similar to PCCM for the perceived benefits of medical home provision.//2005//

Medicare Expansion

The Medicare Program has expanded its health plan options program to urban and contiguous counties in Alabama. This program allows Medicare recipients to choose a benefit package that best meets their individual needs. CRS serves about 70 clients with Medicare benefits, a small number of whom are adults with bleeding disorders. The changes from the fee-for-service Medicare benefits in the various option plans for clients with certain disabilities are often unclear, which has challenged CRS clients in the selection of the most appropriate plan. Enrolling in the most beneficial option initially is preferable due to dis-enrollment penalties. CRS is gathering contact information to share with clients concerning the insurance resource persons affiliated with various plans, so that clients can investigate and select plans that address their needs.

//2003/Efforts continue to assist CRS clients with Medicare coverage to select plans that address their needs.//2003//

//2005/CRS continues efforts to assist clients with Medicare coverage to select plans that address their needs.//2005//

Selected Changes in Alabama's Population

Increase in Hispanic/Latino Births

As described in the 1998 report/2000 application, an increase in Hispanic/Latino 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/Latino individuals have continued to increase in number. Based on birth certificate data, the number of live births to Hispanic/Latino Alabama residents has increased more than 4-fold in 10 years: from 344 in 1990 to 1,595 in 1999. As shown in the 2001 report/2003 application (see Table 1, page 4 of attachment), the largest absolute increase in numbers occurred in 1998 and the 2nd largest in 1999.

Statewide in 1999, 2.6% (1,595/62,070) of live births to Alabama residents were to Hispanic/Latino mothers (up from 2.2% in 1998 and 1.7% in 1997). Most (72%) of these 1,595 births were to Mexican women, 7% to Central or South American women, 6% to Puerto-Rican women, 1.3% to Cuban women, and 14% to other Hispanic/Latino women. Ten percent or more of residential live births in 4 counties were to Hispanic/Latino mothers, and 5%-9% of such births in 5 other counties were to Hispanic/Latino mothers. The percentages of live births in these 9 counties that were to

Hispanic/Latino mothers in 1997 and 1999 are shown in Table 2, page 4 of the attachment. In 8 of the 9 counties in 1999, most (54%-100%) of these Hispanic/Latino mothers were of Mexican origin. As was true in 1998, the exception was Dale County, where not quite half (49%) of Hispanic/Latino women having live births were Mexican. As shown in the 2001 report/2003 application (see Table 2 of attachment), comparing 1999 to 1997, Morgan County had the largest absolute increase in numbers of Hispanic/Latino live births (61 additional births). DeKalb, Marshall, and Blount Counties each had more than 30 additional live births to Latino women in 1999 relative to 1997.

Deliveries of nearly 1/3 (31%) of the Hispanic/Latino live births in 1999 were uncompensated, and about 1/3 (34%) of all uncompensated deliveries of live births involved Hispanic/Latino mothers (using the "Self Pay" response to the 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). Further, many immigrants may be unwilling to apply for Medicaid out of concern that doing so would 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 Latinos, 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 effect is especially exacerbated in counties not having other reimbursable maternity clinic activities to subsidize services to uninsured clients, such as Hispanic/Latino residents illegally residing in the U.S. 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 of local CHDs to continue providing uncompensated prenatal services (lacking the cost-shifting resources from compensated care) in Marshall County has been compromised, and the consequences have been dramatic. Marshall County, like most other CHDs, has discontinued its prenatal care services, with the result that no one in Marshall County is seeing the Hispanic/Latino immigrant population for prenatal care. While Marshall and other CHDs are pursuing local alternatives to prenatal care, the Bureau initiated the Uncompensated Maternity Care Project to study and respond to the challenge of uncompensated maternity care throughout the State. With about 1/3 of individuals receiving uncompensated maternity care being Hispanic/Latino, the Project is developing a response tailored to the Hispanic/Latino population---for example, local coalition building, local and statewide networking strategies with Hispanic/Latino communities and organizations, a Hispanic/Latino-interest website, etc.

/2003/As previously stated, the number of live births to Hispanic/Latino Alabama residents increased by more than 4-fold during the 1990s. The increase continued in calendar year (CY) 2000, when 1,931 infants (comprising 3.1% of all live births) were born alive to Hispanic/Latino Alabama residents. This is a marked increase from 1999, when 1,595 such births occurred: That is (i.e.), the number of live births to Hispanic/Latino women increased by 336 infants, or by 21.1%, in 2000. In absolute terms (i.e., number of infants), this is the largest increase during the surveillance period (1990-2000); in relative terms (i.e., percent change in number of infants), it is the 4th largest increase during that period. The 1,931 live births to Hispanic/Latino Alabama residents in 2000 represents a 5.6-fold increase over the number in 1990 and a 2.5-fold increase over the number in 1995. As was true in previous years, most (74.9%) of the Hispanic/Latino live births in 2000 were to Mexican women.

In 2000, births to Hispanic/Latino residents again comprised 5% or more of live births in all but 1 of the 9 counties shown in the attached Table 2. (The exception was Dale County, where 4.3% of live births in 2000 were to Hispanic/Latino women.) Moreover, in that year Hispanic/Latino births comprised 5% or more of residential live births in 2 additional counties: Limestone (69 births, or 7.3%) and Etowah (71 births, or 5.1%).

As previously stated, ADPH now provides prenatal care (as a subcontractor) in only 11 counties, rather than 14. The Division of Women's and Children's Health implemented the Uncompensated

Maternity Care Project in CY 2000, to better understand the needs of and serve pregnant women without private insurance or Medicaid coverage. Annual data show that roughly 1,400 mothers of live-born Alabama infants receive maternity care for which the provider is uncompensated. Because a growing proportion of these women are Hispanic/Latino, counties with relatively high proportions of Hispanic/Latino births were targeted. In FY 2001 MCH Block Grant funds supported uncompensated maternity care in 20 counties, with about 170 patients being served in this manner.//2003//

/2004/In FY 2002 ADPH served as a subcontractor for case management in 28 counties (down from 39 counties circa 2001, and from 54 counties circa 2000) and for prenatal care in 10 counties (down from 11 counties circa 2001, and from 14 counties circa 2000). In FY 2002, however, MCH Block Grant funds supported uncompensated maternity care in 21 counties, with over 250 patients receiving services. Per provisional numbers, there were 2,630 live births to Hispanic/Latino Alabama residents in CY 2002: a 14.7% increase over the number (2,293) in CY 2001.//2004//

/2005/Due to funding reductions discussed in Section III.B, the Uncompensated Maternity Care Project was discontinued in early FY 2004. As a new initiative, in early FY 2004 the Bureau collaborated with 3 other entities to implement the Family Planning Special Initiative Project for Illiterate Latinas in the Montgomery area. The 3 other entities were UAB, Frazier Memorial United Methodist Church, and ADPH's Minority Health Section.

Demographics (including ethnicity) pertaining to women of childbearing age, newborns, and children and youth will be updated as part of the FY 2004-05 needs assessment.//2005//

Total Numbers of Children and Children Living in Poverty

The proportion of the State's population comprised of children has continued to gradually decline: Children/youth 19 years of age or younger comprised 28.8%, 28.7%, 28.6%, and 28.5% of Alabama's population in 1996, 1997, 1998, and 1999 respectively, versus 29.0% in 1994. Absolute numbers of children/youth have also declined. That is, there were 1,187,245 children/youth in this age group in 1999---3,317 fewer than in 1994.

External factors affecting infant mortality include poverty and characteristics linked with poverty. As described in 2 previous MCH Services Block Grant reports/applications, the percentage of the State's children living in poverty had steadily declined from 31% in 1986 to 23% in 1992 (1999 Kids Count Data Book. The Annie E. Casey Foundation). The rate then remained fairly stable (23%-24%) through 1995, but rose slightly in 1996, when 25% of Alabama children were living in poverty (2000 Kids Count Data Book. The Annie E. Casey Foundation). 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, down to 44.7% in 1996-98, then stable at 44.6% in 1997-99. In absolute terms, the number (rounded to 1,000s) of State children at or below 200% of poverty declined from 597,000 in 1993-95 to 489,000 in 1996-98, then increased slightly to 499,000 in 1997-99. (In other words, there were about 98,000 fewer children at or below 200% of poverty in 1997-99 than in 1993-95, a decline of about 16%.) This decline in the numbers of low-income children could contribute to a small degree to the decline in numbers of ADPH child health patients, but changes in the health care environment are the major factors in the decline in numbers of patients.

/2003/The proportion of the State's population comprised of children continued to gradually decline, with children comprising 28.2% of Alabama's population in CY 2000 (versus 28.5% in 1999). The Bureau has no updated numbers for this indicator. The proportion of Alabama children at or below 200% of poverty remained stable, at 44.6% in 1998-2000. As implied in the preceding discussion, we are not aware of very current estimates pertaining to the proportion of children living in low-income households. The overall economic environment presumably affects households with children and the environment in which the Department functions, however, and indicators of the economic environment are available for 2001. For this reason, a brief discussion of unemployment indicators, which we consider to reflect the overall economic environment, follows. In CY 2001 total jobs declined statewide for the 1st time in a decade. Comparing December 2001 to December 2000, the State lost 33,300 non-agricultural jobs, with all sectors of the economy except services and government losing jobs.

Comparing those same months, statewide unemployment rose from 4.5% to 5.9%. Job losses affected almost every area of the State. Various statewide and local technical training programs were initiated or expanded in 2001, however, and notably fewer jobs were lost in December than in November (reference #1). (References are listed in Appendix C, obtainable as described earlier.)//2003//

/2004/In 2001 children comprised 28.1% of Alabama's population (similar to the figure of 28.2% in 2000). In 1999-2001, an estimated 46.0% of Alabama's children were from households with incomes at or below 200% of FPL (slightly higher than the estimate of 44.6% for 1997-99).//2004//

/2005/Demographic indicators pertaining to the proportion of Alabama's population comprised of children, as well as the proportion of the State's children living in poverty, will be updated during the FY 2004-05 MCH needs assessment.//2005//

ADPH's Strategic Direction Project and Workgroup

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 Workgroup. The Workgroup had representation from the State, area, and local levels, as well as many public health disciplines. As described in the 1998 report/2000 application, the Workgroup was initially 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 Workgroup's report was distributed to key State and area staff in February 1999. Five overarching themes emerging from the Workgroup's deliberations follow:

- 1) 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.
- 2) 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.
- 3) The need for combining certain programs and services into a chronic disease administrative unit in the Department.
- 4) The importance of maintaining a close association between the Department's mission and its programs, services, and grant pursuits.
- 5) 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 Strategic Direction Workgroup met in March 2000 to review the above plan. Although the total Workgroup has not met together since then, several workgroups functioned as an adjunct to the Strategic Direction Work Group in FY 2000, by doing strategic operations planning to accomplish the directions recommended in the original strategic plan. Three of the areas on which these workgroups focused pertain directly to Title V populations: 1) uncompensated care (with a focus on maternity) for non-English-speaking people, 2) the Family Planning Waiver, and 3) WIC.

BFHS' Mission and Vision

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 3 core public health functions---assessment, policy development, and assurance---the Bureau continues seeking 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 CHDs 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.

/2004/Title V-Served Children, Pregnant Women

The aforesaid paradigm shift is reflected in the marked decline, over a period of several years, in the numbers of children and pregnant women receiving Title V-funded services in CHDs---as captured by clinic encounter-form data. These declines can be quantified by comparing Form 7 from the 2002 report/2004 application to Form 7 from previous MCH Services Block Grant reports/applications.

Per Form 7, 34,154 children and youth (1-21 years of age) received Title V-funded services in CHDs in FY 2002---slightly (1.2%) more than in FY 2001, but 55% fewer than in FY 1997. Further, 6,883 pregnant women received Title V-funded care in CHDs in FY 2002--29% fewer than in FY 2001, and 76% fewer than in FY 1997. The question has arisen, however, as to whether the decline in the number of Title V-served pregnant women is partly due to a reporting artifact. That is, social workers providing case management services to pregnant women under subcontracts with primary contractors with the Medicaid Maternity Care Program have been billing the primary contractors, rather than coding their time to MCH programs as they did before. This reporting issue has not been fully explored by Bureau staff, but is not expected to account for all of the reported decline in the number of Title V-served pregnant women.//2004//

/2005/Certain Categories of Title V-Served Individuals

The number of children and youth receiving Title V-funded services in CHDs has declined by almost half over a 5-year period. That is, per Form 7, 32,174 children and youth received Title V-funded services in CHDs in FY 2003--somewhat (5.8%) less than in FY 2002, 29.1% less than in FY 2000, and markedly (47.9%) less than in FY 1998. The estimated number of pregnant women receiving Title V-funded care in CHDs has declined strikingly (by 72.8%) over 5 years, from 26,850 in FY 1998 to 7,295 in FY 2003. However, the number served in FY 2003 (7,295) is 6.0% higher than the number served in FY 2002 (6,883).//2005//

/2004/Delivery of Title V Services for CSHCN

Addressing the service delivery needs of Alabama's CSHCN presents special challenges. The State is mainly rural. Rural areas, compared to non-rural areas, tend to have higher prevalences of risk markers for having special health care needs: such as higher levels of poverty and lower educational attainment. Thus, rural areas may have higher proportions of CSHCN than non-rural areas. Alabama pediatric subspecialists and allied health professionals with pediatric experience are mainly located in the State's 2 largest urban areas (Birmingham and Mobile), however, and the State has poor public transportation systems. Therefore, 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 CRS's 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 communities than would otherwise be the case. Via CRS's MOUs with the 2 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, and thereby help address the health, social, and educational needs of Alabama's CSHCN, including Supplemental Security Income (SSI) beneficiaries under age 16 years. Through its intradepartmental collaboration with AVRS, CRS promotes the transition of adolescents with special health care needs, including SSI

beneficiaries, from school to work to independence.//2004//

/2005/Title V service delivery for CYSHCN basically continued in FY 2003 per the preceding paragraph.//2005//

B. AGENCY CAPACITY

ADPH Program Capacity

The Title V Program has maintained its capacity to provide services to, and promote and protect the health of, the 3 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 Coordinator positions, were eliminated in January 1999, and the Area Nursing Directors assumed many of the Family Health Services Coordinator responsibilities. At that time, many employees in State-funded positions were placed in vacant federal positions where feasible.

In FY 2000 the WIC Program experienced a notable drop in caseload due to implementation of the income verification documentation policy of July 1999 and, to some degree, implementation of the Public Health of Alabama County Operations Network (PHALCON) system. Also, State WIC Nutrition staff was understaffed by 2 key positions during most of FY 2000 and through the 1st quarter of FY 2001; 1 of the unfilled positions was that of Nutrition Services Administrator.

Though not at previous levels, ADPH funding stabilized in FY 1999, and further massive layoffs are not anticipated. Moreover, an entry-level epidemiologist and a mid-level research analyst were added to the Bureau's staff in FY 2000, strengthening 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 than it had been in FY 1999.

/2003/BFHS added staff again in FY 2001. Key positions added or filled are described under the update to "ADPH's Other Capacity." The Alabama WIC Program increased its caseload by 6.8% in FY 2001 over those served in FY 2000. All key staff positions in WIC were filled in early FY 2001.//2003//

/2004/ADPH Program Capacity

The Department has maintained its capacity to promote and protect the health of pregnant women, mothers, infants, and children. ADPH's capacity to provide culturally competent care that is appropriate to specific populations is addressed in appropriate places throughout this document. For instance, the Bureau has developed the Uncompensated Maternity Care Project in counties with the highest prevalence of uncompensated maternity care and, through activities such as a Hispanic/Latino-interest website and participation in Hispanic/Latino-interest organizations, brought special attention and resources to these counties (mentioned in Section III.A). Other examples are the collaboration of the Bureau's Newborn Screening Program with community-based sickle cell organizations (mentioned in Section IV.C), and involvement of public health areas (PHAs) in community activities (see Appendix D for 1 Area Director's perspective). Not mentioned elsewhere (due to space constraints) is OHB's partnership, in FY 2001, with WIC, the University of Alabama School of Dentistry in Birmingham (School of Dentistry), and the UAB School of Public Health to develop a culturally sensitive educational model for the prevention of early childhood caries in WIC children. The State Nutrition Plan now includes a model to prevent early childhood caries in WIC-enrolled children. Also not mentioned elsewhere, in areas often traveled by minorities, the Department distributes culturally sensitive educational materials about the importance of early and continuing

/2005/ADPH Program Capacity

As stated in Section III.A and below, the Uncompensated Maternity Care Project was discontinued in FY 2004. The Bureau then collaborated with 3 other entities to implement the Family Planning Special Initiative Project for Illiterate Latinas in the Montgomery area. The entities were UAB, Frazier Memorial United Methodist Church, and ADPH's Minority Health Section.

Late in FY 2003, projected shortfalls in State revenue for FY 2004 caused the Department to critically review all funding sources, prioritize budget expenditures, and aggressively cut expenditures. As part of this process, the State Health Officer asked the Bureau to reduce FY 2004 projected expenditures of MCH Services Block Grant funds (MCH Title V funds) on Bureau programs by \$1,600,000, compared to FY 2003. One purpose of these reductions was to increase MCH Title V support of CHDs, who face inadequate local support and decreased availability of State funds. Such use of MCH Title V dollars supports local infrastructure, so that CHDs can continue serving the State's low-income maternal and child population. Another, albeit overlapping, purpose was to set aside funds to sustain MCH services provided by central-office, PHA, and CHD staff--should State funds available to ADPH be further reduced. Such further reductions were quite conceivable, given the State's acute financial shortfall and marked, ongoing uncertainty over measures that might be taken by the State Legislature. In addition to being asked to reduce projected expenditures of MCH Title V funds allocated for Bureau programs, the Bureau was informed that State dollars previously available to support the State Perinatal Program and the Dental Program would no longer be available.

Accordingly, the Bureau Director and Division Directors closely scrutinized projected expenditures for contracts, purchase orders, then-vacant Bureau positions, recently funded projects, and grants to other entities. Though the resultant decisions regarding cuts in projected expenditures were necessary and appropriate, the capacity of certain Bureau programs was unavoidably diminished to varying degrees. What follows is a list of Bureau programs and contracts affected by this \$1,600,000 reduction in FY 2004 projected expenditures of MCH Title V funds on Bureau programs:

1) Community Development Specialist Program--The Bureau had embarked on this program in FY 2003 in order to support further involvement of county-level staff in promotion of community-based MCH initiatives. This support was provided through cooperative agreements between ADPH and selected PHAs, in which MCH Title V dollars funded 8 positions for the purpose of conducting community health initiatives. The cooperative agreements were not renewed in FY 2004, ending this focused effort.

2) Abolishment of certain positions in 2 programs--The Bureau abolished the following 3 positions--the OHB's position for a fluoridation specialist and the Women's and Children's Health Division's 2 positions for nurses to perform quality assurance functions. (The persons who had filled these positions were transferred to positions, for which funds were available from other sources, outside the Bureau.) Abolishing the fluoridation specialist position has greatly diminished OHB's ability to promote water fluoridation and monitor existing water systems. The quality assurance function has been absorbed by existing Bureau staff.

3) Programs with unfilled vacant positions--Due to resignations or promotions to positions outside the Bureau, the following positions became vacant before or during the FY 2004 budget reductions: 1 epidemiologist and 1 public health research analyst in the Epidemiology and Data Management Branch (Epi/Data Branch), 1 account clerk in the Administration Division, and 1 nurse in the Women's and Children's Health Division. Because funds previously allocated for these positions in FY 2004 were needed to sustain other programs, the Bureau decided not to fill these positions. Consequently, directors of the involved units

must clearly prioritize tasks.

4) Uncompensated Maternity Care Project--Through this program, MCH Title V funds had been used to help local communities design and maintain systems of care for maternity patients who could not pay for services. These patients were mainly Hispanic/Latino clients. The program was discontinued in FY 2004, in order to set aside funds for other MCH services. The termination of this program diminishes the Department's ability to promote systems of care for maternity patients who cannot pay for services.

5) Contract with ADRS--Through the Bureau, ADPH continues to contract with ADRS to administer services to CSHCN, through CRS. As part of this contract, ADPH has historically transferred about 35% of MCH Title V funds to ADRS. Fiscal constraints have necessitated that, effective FY 2004, we transfer only about 30% of MCH Title V funds to ADRS, the amount required by federal statute.

6) Contract with Monsky Developmental Clinic--The Monsky Developmental Clinic serves CSHCN in Montgomery, Alabama and the surrounding area. In FY 2003 the Bureau channeled \$173,000 in MCH Title V funds to this clinic. This amount is being reduced by half, greatly diminishing the capacity of Monsky Clinic to serve CSHCN.

7) Contract with the Alabama Chapter of the American Academy of Pediatrics (AAP)--\$20,000 of MCH Title V funds had been directed to this contract in FY 2003, providing for direct input by pediatricians into the Bureau's endeavors. This contract was terminated in FY 2004. By leaving no funds to reimburse private-sector pediatricians for consultation, this termination has adversely affected collaboration between the Bureau and the private pediatric community.

Some of the above savings were redirected to sustain the State Perinatal Program and the State Dental Program, the latter of which is administered through the Bureau's OHB. Even with this redirection, these programs could not be sustained at previous levels. For instance, with the exception of the Monsky Developmental Clinic, the Bureau no longer channels funds toward clinics that follow infants discharged from neonatal intensive care units. (The consequences of discontinuing support for such clinics, from the viewpoint of a neonatologist, are described at the end of this update.) Additionally, as previously mentioned, OHB's ability to promote water fluoridation and monitor existing water systems has been greatly diminished. However, The State Perinatal Program and State Dental Program continue to provide crucial MCH services described elsewhere in this document. As previously explained, some of the savings in projected FY 2004 MCH Title V expenditures have been reserved to cover unforeseen changes in the State's very uncertain fiscal situation. Accordingly, as of early May 2004, senior-level Bureau administrators are consulting with the State Health Officer and ADPH's Public Health Administrative Officer regarding potential uses of unspent FY 2004 MCH Title V funds.

Additionally, fiscal constraints have led to abolishment of 5 WIC positions: 3 for health services administrators and 2 for administrative support assistants. Also due to fiscal constraints, WIC will not seek to fill a recently vacated (in April 2004) position for a health services administrator until FY 2005.

As stated in Section I.E, in June 2004 BFHS sought input from SPAC and regional perinatal advisory committees. This process entailed distribution of a summary of key activities pertaining to the national and State performance measures to members of these groups, an offer to provide the entire pre-submission draft of the 2003 report/2005 application upon request, and an invitation to provide comments. A neonatologist (subsequently termed "respondent") from the northwest part of the State expressed serious concerns, via a telephone call and a follow-up letter, about the impact of budget cuts on "High Risk Clinics," which follow high-risk graduates of neonatal intensive care units. (In this context, "high risk" refers to an infant who is discharged from a neonatal intensive care unit, whose birth weight

was less than 1,500 grams, and/or who is at risk of physical, social, or neurodevelopmental problems.) Since budget cuts, most of these clinics have closed their doors. From the perspective of the respondent (who is neither employed by nor receiving financial benefit from such clinics), the closure of High Risk Clinics entails a high cost in terms of dollars and in terms of medical homes. In the environment in which the respondent works, a graduate of a neonatal intensive care unit who was referred to a High Risk Clinic could be seen by at least 6 specialists during a single visit. Without such clinics, such an infant now requires from 3 to 8 appointments to receive the same evaluations that could have been done in a single appointment at a High Risk Clinic. Further, families "have to visit many offices and hospitals and radiology centers to continue the care of these fragile infants." Moreover, the respondent expects that the lack of a medical home, which would have been provided by a High Risk Clinic, will increase use of emergency rooms by the affected population. In sum, he anticipates that the closure of these clinics will increase the cost incurred by Medicaid in funding care for some of these infants and, as well, deprive many infants of a medical home. //2005//

/2004/CRS Program Capacity
System Constructs

As discussed in Section III.A., CRS has taken an active role in ensuring a statewide system of services that is comprehensive, community-based, coordinated, and family-centered. A discussion of these efforts at both the State and community levels follows.

CRS has several ongoing State-level collaborative initiatives to address systems development for Alabama's CSHCN. CRS, functioning as a voice for the State's CSHCN, works with DCA through the State CPC to review information concerning children's services statewide. The mission and activities of DCA are fully discussed in Section III.A. CRS also partners with an interagency group to implement an enhanced benefits package for CSHCN through ALL Kids Plus, which is provided through SCHIP. Further, CRS is actively involved in EIS's Governor's Interagency Coordinating Council (ICC), which has developed coordinated policies and monitoring standards for service delivery, developed joint legislative budget requests, and shared data on infants and toddlers with disabilities. CRS continues its interagency agreement with Medicaid to provide Children's Specialty Clinic Services and shares eligibility data to facilitate service planning.

CRS staff support community systems building through EIS's District ICCs and their involvement with the network of county-level CPCs facilitated by DCA. These councils are charged with assessing the local needs of children and families, identifying available resources, articulating local needs, and seeking funding to address needs.

Several mechanisms exist to coordinate health services for CSHCN within community-based systems. CRS district offices function as powerful resource networks within their local communities, responding to numerous requests for information regarding CSHCN. CRS has MOUs with the 2 tertiary-level pediatric hospitals in the State to provide community-based care coordination, family support activities, and financial assistance to CRS-eligible children and their families receiving subspecialty care at these institutions. These agreements ensure that children are referred and receive appropriate services from both providers. Medicaid's Patient 1st Waiver has also enhanced the flow of information between primary and specialty care at the community level.

The coordination of health services with other services at the community level is facilitated in several ways. CRS offices are co-located with EIS and AVRS in most locations, facilitating more coordinated services and smoother transitions for CSHCN. Special education, social services, and family support services are brought together by the ICCs at the community level; this mechanism has increased collaboration regarding service coordination for other age groups as well. County-level CPCs address the coordination of a wide array of children's services, including primary, specialty, home health, and mental health services at the community level. CRS is the voice for CSHCN on these councils.

Through these various mechanisms, it is clear that CRS has a far-reaching scope of influence on the State's service system at both State and community levels. As new challenges and opportunities

present, CRS's mission and infrastructure, as detailed below, support a ready response.//2004//

/2005/The overall CRS program capacity is virtually the same as described in previous submissions. With the expiration of Medicaid's Patient 1st Program, CRS is seeking to continue assuring access for CYSHCN to medical homes and continue facilitating communication between primary and specialty care providers at the community level. CRS engages in ongoing collaboration with Medicaid and has taken an advisory role related to the unique needs of CYSHCN and their families. Through active participation on a task force to create a new Medicaid waiver, CRS continues to provide leadership in policy-making and service provision for CYSHCN in the State. Additionally, ADRS, including all divisions, continues to play a vital role in local and State CPCs. As CPCs are charged with assessing broad categories (health, safety, education, economic security, early care, and education) related to all children, CRS provides the voice for CYSHCN and their families on recommendations specific to this subset of the population.//2005//

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 3 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 with public and private agencies occurs at the State level to develop and enhance systems of services for CSHCN and their families. 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 7 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. Specialty medical staff are recruited from the public and private sector and are 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 with community groups on planning issues concerning CSHCN. 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. 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 are 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 CRS services. 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 5th, 9th, and 14th 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).

CRS operates 6 service programs to serve CSHCN and their families. Services provided in each of these programs are paid for in full or in part by Title V funds. The 6 programs are:

1) Information and Referral--provision of information on resources available in the community, in the form of educational materials related to pediatric specialty health care, community resources, etc.

2) Specialty Clinical Services/Clinical Medical--clinics directed by physicians and staffed by multidisciplinary teams for provision of diagnosis, evaluation, treatment, and related services.

3) Specialty Clinical Services/Clinical Evaluation--physician-supervised clinics to provide functional evaluation and planning services by multidisciplinary teams.

4) 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.

5) Care Coordination--arrangement of services to assist clients and families in identifying, accessing, and utilizing health and related resources to effectively meet their needs.

6) 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.

/2005/The CRS program is basically organized as previously described with the following changes: In FY 2003 CRS began redirecting methods of service provision for the portion of early intervention services for which the agency is fiscally responsible. Prior to this time, the 7 CRS districts provided case management services directly to eligible infants and toddlers and purchased related services (physical therapy, occupational therapy, speech therapy) via a vendor system. In order to better provide a more coordinated, team approach to early intervention, CRS began transitioning eligible infants and toddlers away from the more piecemeal system into 1 of 16 CRS-sponsored EIS programs statewide. CRS State Office staff participate in the annual Provider Appraisal Review for these programs to ensure consistent quality and fiscal responsibility, provide technical assistance, and provide information to program coordinators on the benefits of referral to CRS for eligible infants and toddlers with special health care needs.

Also in FY 2003, the public website for ADRS was updated to include the newly designed look and tag line for CRS. This new look not only matches other public awareness materials for the program, but also serves to increase the visibility of the State CSHCN program to the general public. This website includes information about the program and services offered and, as well, provides consumers access to a directory of ancillary care providers (of services pertaining to physical therapy, occupational therapy, speech therapy, nutrition, and audiology) in each CRS district.

Due to newly imposed HIPAA regulations, Medicaid is no longer providing CRS with a list of SSI beneficiaries. Therefore, CRS is no longer able to contact recipients that are not active with CRS on their 5th, 9th, and 14th birthdays to offer any additional assistance with unmet needs.

CRS now operates 7 service programs to serve CYSHCN and their families. The newly added Youth Connection Program facilitates youth-to-youth connections, supports youth

involvement in policy development and decision-making, and promotes appropriate transition services for youth with special health care needs to all aspects of adult life. The Youth Connection Program consists of a Youth Advisory Committee (YAC), a Youth Consultant, Teen Transition clinics, linkages to AVRS, and a Youth News insert in the quarterly Parent Connection newsletter.//2005//

Some Statutes Relevant to the Title V Program

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

1) CRS Statutory Authority--The State statutory authority for the CRS program is in Code of Alabama 1975 SS 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 SS 21-8-1 et seq. and placed within CRS administratively. Code of Alabama 1975 SS 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.

2) 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 (SPP) and the mechanism for its operation under the direction of the State Board of Health and 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 SPP. SPP 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.

3) Child Death Review--Legislation creating the Alabama Child Death Review System (ACDRS) 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, suicide, suffocation etc. Deaths from prematurity or birth defects, as well as deaths 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 comes from the national settlement with the tobacco industry and will be disbursed through the Children First legislation described later in this section.

4) 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.

5) School Nurse Law Act 98-672--This act, passed by the Alabama Legislature in 1998, mandated a school nurse for each school district in FY 1999 and a school nurse for every 2,000 students by 2010.

6) SCHIP--See "Changes in the Health Care Environment," in Section III.A.

7) Children First--A major legislative event was the passage by the Alabama Legislature of the Children First Bill (in April 1999), which allocated 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.

8) DCA--Legislation created this new State department, discussed in Section III.A, in 1999. In 2000

legislation was passed that expanded the powers and duties of DCA 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 EIS, were specifically included in this legislation.

/2003/Statutes

With respect to relevant statutes, legislation calling for graduated vehicle licensure was reintroduced in January 2002 and passed by both State legislative bodies by early April 2002. As of this writing (April 12, 2002), enactment of the bill into law is pending the Governor's signature. This legislation is fully discussed under NPM #10 in Section IV.C.//2003//

/2004/Statutes

The Alabama Graduated Driver's License Bill was signed by the Governor in September 2002 and became effective in October 2002.

The Alabama Legislature passed the Woman's Right to Know Act in 2002, and the law went into effect October 14, 2002. Its purpose is "to ensure that every woman considering an abortion receives complete information on the procedure, risks and her alternatives." The act requires that ADPH create a printed informational booklet as well as an informational video tape. In accordance, ADPH's Bureau of Health Provider Standards drafted a pamphlet for distribution to abortion centers. A group of health care facilities and physicians who provide abortion services in the State challenged the constitutionality of the act and sought "a preliminary injunction or a temporary restraining order against its enforcement." As of March 13, 2003, final ruling from the District Federal Court has not been received.//2004//

/2005/The preliminary injunction or temporary restraining order requested in the aforesaid challenge was not granted, and the Woman's Right to Know Act remains in effect.//2005//

/2004/The State's Office of Women's Health was created with passage of legislation in 2002 to educate the public regarding women's health; to assist the State Health Officer with identification and prioritization of women's health issues and concerns relating to the reproductive, menopausal, and postmenopausal phases of a woman's life; to assist the State Health Officer in coordination of services to address these issues and concerns; to serve as a clearinghouse and resource for information regarding women's health data, strategies, services, and programs; and to collect, classify, and analyze relevant research information and data concerning women's health. This office is located in ADPH's Office of Professional Services.//2004//

C. ORGANIZATIONAL STRUCTURE

DCA, DHR, MHMR, and Medicaid are all cabinet-level agencies, and the Governor directly appoints their commissioners. ADPH, SDE (which includes the State's 2 disability determination units), and ADRS are not cabinet-level agencies. As their respective boards appoint the heads of these 3 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 2 levels for ADRS and ADPH. The State Health Officer and the ADRS Commissioner work together on matters of mutual concern, as do the CRS and BFHS Directors. Staff members from CRS and BFHS meet quarterly to discuss programmatic and administrative issues pertinent to MCH services. 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 and underwent a less extensive reorganization in June 2001. A description of these reorganizations follows.

ADPH's Organizational Structure

The purpose of the Bureau's reorganization in September 1999 was to better integrate related

functions into existing units and add several branches, which particularly enhanced the Bureau's capacity for community systems development and data analysis. Three of the Bureau's 4 major divisions retained the same name during that reorganization: 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. Changes within divisions in September 1999 included the following:

1) The Administration Division's Planning and Evaluation/Data/Contract Management Branch became 2 branches: the Contract Management Branch and the Epi/Data Branch, with a mid-level research analyst position and an entry-level epidemiologist position added to the latter branch. (Positions were filled in December 1999.)

2) The Community Development and Professional Support Division was created, incorporating the previous Clinical Support Branch and adding 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 to address MCH problems at the local level. The Community Development Branch (previously the Community and Systems Development Branch), which is in this division, added a position for a community development specialist, which was filled in March 2000.

3) 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 or Reduction in Pregnancy Treatment (SCRIPT), teen pregnancy, and the Office of Adolescent Pregnancy Prevention, 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 (AUPPP) 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 purpose of the more recent (June 1, 2001) changes in the Bureau's organization was to respond to staffing changes, accommodate new programs, and further integrate related functions. These changes consisted of the following:

1) Following the resignation of the Staff Assistant to the Bureau's Director, this position was replaced with the position of Deputy Director of the Bureau.

2) Within the WIC Division, 2 branches (Nutrition Education and Breastfeeding) were incorporated into the Nutrition Services Branch; and the Financial Management Branch was created. The discontinuation of the Outreach Branch reflects the fact that outreach is a valued opportunity shared by all branches of WIC, rather than being mainly the responsibility of a single branch.

3) A Case Management Training position was added to the Professional Support Branch of the Community Development/Professional Support Division.

4) Within the Women's and Children's Health Division, the Special Projects Branch was discontinued; and AUPPP, SPP, and SCRIPT were incorporated into the Women's Health Branch. The Family Planning Program and Maternity Program continue to be housed in the Women's Health Branch. The Child Health Branch added the Newborn Hearing Screening Program and renamed the Childcare Program as the Healthy Childcare Alabama Project.

/2003/ADPH's Organizational Structure

Certain changes occurred in the Bureau's structure in May 2002. The major structural changes consisted of relocating the Epi/Data Branch to the Community Development/Professional Support Division, discontinuing WIC's Financial Management Branch, and assigning the Director of WIC's Financial Management Branch to the Administration Division's Financial Management Branch. The purpose of these changes was to further integrate related functions into existing units. Specifically, the Epi/Data Branch is deemed to be functionally related to professional support, and the consolidation of

the Administration Division's Financial Management Branch and WIC's Financial Management Branch better integrates the Bureau's financial functions.//2003//

/2004/In June 2003 the Community Development/Professional Support Division was renamed the Professional Support Division and streamlined into 2 branches: the Consultant Branch and the Epi/Data Branch. The Consultant Branch includes 3 programs: Social Work, Nursing, and Community Development.//2004//

/2005/Current organizational charts for ADPH and BFHS are in Appendix E, which is obtainable as described in Section III.A. WIC's financial functions continue to be performed by the Bureau's Administration Division, and WIC pays for 2.18 FTEs in that division. Several changes have occurred in the Bureau's organization, most of them due to funding reductions discussed in the 2005 update to Section III.B. These changes mainly affected 2 of the Bureau's 4 divisions: Women's and Children's Health, and Professional Support. Key changes in these 2 divisions are described below.

The Women's and Children's Health Division's Quality Assurance Branch was discontinued in early FY 2004, and its functions were absorbed by the Children's Health Branch. In the Women's Health Branch, AUPPP is being phased out to be effective June 30, 2004. Accordingly, the position pertaining to this program has been removed from the organizational chart. Further, since the Uncompensated Maternity Care Project was phased out in early FY 2004, the position for this program has been removed, and responsibility for the maternity program has been assumed by the Director of SPP. In the Children's Health Branch, a position for an additional Newborn Screening Coordinator, to focus on expanding the newborn screening profile as discussed in Section IV.C (under NPM #1), has been added to the Newborn Screening Program. Responsibility for infant death review has been removed from the Child Death Review Program, since responsibility for fetal and infant mortality review (FIMR) had previously (in FY 2002) been transferred to SPP.

The OHB, which previously had been located as an adjunct to the Bureau Director, is now located in the Professional Support Division. As discussed in Section III.B, cooperative agreements with several PHAs to support MCH community health initiatives were not renewed in FY 2004. Consequently, the Professional Support Division's Community Development Program no longer exists as a separate entity and has been removed from the Bureau's Organizational Chart. Because the State Systems Development Initiative (SSDI) Project has been located in the Epi/Data Branch for several years, the position for the SSDI Coordinator has been added within the Epi/Data Branch.

(Note: In the narrative for this document, most corresponding subtitles show the current, sequentially based number identifying the SPM, followed by the previously used identification number for that measure. However, the Title V Information System web-based reporting package continues to use the previous identification number for SPMs in Form 11, the detail sheets, and the table listing the detail sheets. Unless stated otherwise, when cross-referencing an SPM in the narrative we use the CURRENT, sequentially based identification number for the measure.)//2005//

CRS's Organizational Structure

ADPH contracts with CRS, a division of ADRS, for services to CSHCN. CRS has administrative responsibility for the State Title V CSHCN Program as well as the Alabama Hemophilia Program. The Alabama Board of Rehabilitation Services, whose members are appointed by the Governor, oversees ADRS, which consists of 4 major divisions: EIS, CRS, AVRS, and the State of Alabama Independent Living Program. The current chairperson of the Board is a parent of a child with special needs.

The ADRS Commissioner re-configured the leadership for ADRS's children's services in June 2000, following the resignation of the coordinator of EIS, Ouida Holder. Christine Kendall, CRS Director, was named the Assistant Commissioner for Children's Programs and given administrative responsibility for

both CRS and EIS. This modification to the organizational structure is expected to enhance coordination between the 2 programs. Elizabeth Prince, formerly the CRS Field Services Supervisor, was named as the new coordinator of EIS. In an unrelated reporting change, the Hemophilia Program Coordinator is now organizationally under the Grants Management Specialist rather than the CRS Director.

/2003/CRS's Organizational Structure

Christine Kendall, ADRS Assistant Commissioner for Children's Programs, retired on January 1, 2002. Cary F. Boswell, EdD, was appointed as the ADRS Assistant Commissioner for CRS. Dr. Boswell is not administratively responsible for the Division of Early Intervention, although a strong collaborative relationship continues between CRS and the Division of Early Intervention. Additionally, a new position of CRS Assistant Director was created in place of the State Supervisor of Field Services and was filled by Dawn Ellis. Supervision of the 7 CRS district supervisors is now directly under the CRS Assistant Commissioner, although the Assistant Director continues to oversee the day-to-day operations in Field Services. The Administrative Analyst position was changed to a Patient Accounts Manager position without any change in personnel. A Quality Assurance/Quality Improvement Coordinator was hired and is supervised by the State Supervisor for Professional Services. Active recruitment continues for the vacancy in the Grants Management Specialist position.//2003//

/2004/CRS's Organizational Structure

A full-time Program Specialist for Audiology was hired as well as a full-time Program Specialist for Social Work. The Program Specialist for Speech Language Pathology, who formerly spent 40% of his time on clinical duties, is now focusing full-time on administrative duties. An additional 0.5 full-time-equivalent (FTE) Patient Accounts Manager was hired to assist with 3rd party billing. The Program Specialists for Social Work and Nursing as well as the State Pediatric Traumatic Brain Injury (TBI) Coordinator were moved under the supervision of the CRS Assistant Director to facilitate an agency initiative to enhance the CRS Care Coordination Program. The positions for the Program Specialist for Occupational Therapy and the Grants Management Specialist remain vacant.//2004//

/2005/Due to fiscal constraints, the Quality Assurance/Quality Improvement Coordinator position was eliminated and all previously assigned duties were resumed by the State Supervisor for Professional Services. Also due to budget constraints, the Grants Management Specialist position was reclassified as MCH Program Specialist and duties were combined with the Occupational Therapy Program Specialist position. As discussed in a 2005 update to Section III.D, this new, combined position was filled in September 2003. The Nutrition Program Specialist position remains vacant. Current organizational charts for ADRS and CRS are in Appendix E, which is obtainable as described in Section III.A.//2005//

D. OTHER MCH CAPACITY

ADPH's Other Capacity

/2004/For reasons described in the 2001 report/2003 application but omitted from this report due to space constraints, the Bureau is seeking to capture a wider array of cost centers in order to better describe the number of FTEs performing Title V-related work. Based on this wider array, in FY 2002, 219.2 total FTEs were devoted to Title V-related work: 15.8 at the State level, 5.7 at the area level, and 197.8 at the county level. The 219.2 total FTEs included 92.9 social worker, 60.9 nurse, 32.4 clerical, 7.2 physician, 7.1 aide, and 4.8 nurse practitioner/midwife FTEs, with various other positions accounting for the remaining 13.9 FTEs. This FTE breakdown does not capture all Bureau FTEs devoted to MCH issues, such as administration, nurse, nutritionist, and research FTEs.//2004//

/2005/To better describe the number of FTEs performing Title V-related work, the Bureau has further expanded the array of cost centers captured, even beyond the array used in the preceding 2004 update. Based on this newly expanded array, in FY 2003, 251.6 total FTEs were devoted to Title V-related work: 41.5 at the State level, 4.9 at the area level, and 205.2 at the county level. The 251.6 total FTEs include the following, which collectively account for 92.3%

of the total: 97.9 social worker, 79.0 nurse (excluding nurse practitioners and midwives), 36.0 clerk, 7.2 physician or epidemiologist (which are often combined in ADPH's cost center databases), 6.2 aide, and 5.8 nurse practitioner/midwife FTEs.

Even this expanded array of cost centers does not include WIC or SSDI FTEs. As a corollary, the total FTEs reported in the preceding paragraph do not capture FTEs for several key positions that serve the maternal and child population. For example, in FY 2003 WIC included 71.8 nutrition specialist and 45.1 nurse FTEs; and SSDI, which helps the Bureau perform MCH needs assessment and meet Title V reporting requirements, funded portions of the salaries for 2 research analysts and 1 epidemiologist.

The expanded array of cost centers explains the increased number of Title V-related FTEs reported for FY 2003, compared to those reported for FY 2002 earlier in this section. Comparing FY 2003 to FY 2002 requires the use of the same cost centers used in the 2004 update at the beginning of this section. Using the same cost centers used in the 2004 update yields the following FTEs for FY 2003: 212.4 total FTEs (versus 219.2 in FY 2002), 12.8 State-level FTEs (versus 15.8 in FY 2002), 4.5 area-level FTEs (versus 5.7 in FY 2002), and 195.1 county-level FTEs (versus 197.8 in FY 2002).//2005//

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, Deputy Director of the Bureau and Director of the Professional Support Division, worked in the Madison CHD 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, including Director of the Administration Division. Academic credentials include studies in education and public health.

Sherry K. George, BS, MPA, Director of the Bureau's Division of Women's and Children's Health, has been with the Bureau since 1975. During this time she has become familiar with issues concerning 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.

Dianne M. Sims, BSN, RN, who became Assistant Director of the Women's and Children's Division in March 2000, has been with ADPH since 1981 and joined BFHS in 1999. Her experience includes serving as a public health nurse and administrator at the county, area, and State levels. 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.

Charlena M. Freeman, LCSW, Assistant Director of the Professional Support Division, brought 20 years of medical social work experience when she joined the Bureau in 1996. Academic credentials include advanced degrees in social work and counseling.

/2003/Brief biographies of key, recently hired personnel and an update on the status of certain

positions follows. Stuart A. Lockwood, DMD, MPH, Director of OHB, joined the Bureau in 2001. Dr. Lockwood practiced dentistry in Alabama for 4 years before earning an MPH with a double major in dental public health and oral epidemiology. Prior to joining the Bureau, he worked for 12 years with the U.S. Centers for Disease Control and Prevention (CDC) in the Division of Oral Health. A diplomate of the American Board of Dental Public Health, Dr. Lockwood was also the director of the Dental Public Health residency program at CDC.

Layton E. Williams, BS, Director of the Administration Division, joined the Bureau in July 2001, after being with ADPH since 1995. Prior to joining BFHS, Mr. Williams performed production analysis and special studies in clinical and home health activities for the Director of the Department's Bureau of Financial Services. In addition, as Director of the Third Party Operations Branch, Mr. Williams managed the Department's billing operations, distribution of funds to budget units, and reconciliation of receipts with electronic data interchange records and/or paper remittance advices. In 1999 Mr. Williams transferred to the Bureau of Health Care Standards, where he maintained the federally mandated Minimum Dataset and Outcome Assessment Information Set data management systems for 1 year before returning to the Bureau of Financial Services until he joined BFHS.

The Bureau created a new full-time position, Director of SPP, which strengthens the SPP and enables us to better address Alabama's high infant mortality rate. This position was filled in January 2001 by Gene Hamrick, RN, EdD. Dr. Hamrick came to the Bureau with 9 years of experience as a State-level health education administrator. Additionally, she has 12 years experience in nursing education, including 5 years as university-level faculty. In collaboration with the Bureau Director, other Bureau staff, and SPAC, Dr. Hamrick plays a key role in developing strategies to improve public awareness of the causes and prevention of infant deaths, revitalizing the State's regionalized system of perinatal care, and improving women's health through the perinatal continuum.//2003//

CRS's Other Capacity

/2005/CRS maintains a strong multidisciplinary emphasis at both district and State office levels. Currently, there are 230.9 FTEs in the field: 7 district supervisors, 8 physical therapists, 7 nutritionists, 6 speech-language pathologists, 7 audiologists, 8.9 parent consultants, 32 nurses, 53 social workers, 1 rehabilitation counselor, and 102 clerical support staff members. Additionally, there are 7 budgeted vacancies for which personnel are being sought: 3 physical therapists, 2 nurses, 1 speech-language pathologist, and 1 clerical support staff member. Staff in the State Office consists of 15.5 FTEs with administrative responsibilities and 4.75 FTE clerical support staff members. The following disciplines are represented in the State Office administrative staff: 1 special educator, 3 social workers, 2 nurses, 2 speech-language pathologists, 1 nutritionist, 1 rehabilitation counselor, 1 patient accounts manager, 1 parent consultant, 1 audiologist, 1 physical therapist, 1 occupational therapist, and a .5 FTE youth consultant. Additionally, there remain State Office vacancies for 2 clerical support staff members and a nutrition program specialist.//2005//

Key senior administrative staff of CRS include the Assistant Commissioner, the CRS Assistant Director, the State Supervisor for Professional Services, and the Grants Management Specialist (vacant). Planning, evaluation, and data analysis are in the purview of the Grants Management Specialist. Biographical information on persons in these positions follows.

Cary F. Boswell, EdD is the Assistant Commissioner of ADRS and Director of CRS. He brought to this position 27 years of professional experience in special education, supported employment, and transition initiatives. Prior to joining CRS, he was the ADRS State Coordinator of Transition from School to Work Programs. He serves on Alabama's Special Education Action Committee Board of Directors, the Alabama Council for Developmental Disabilities, the SDE's Special Education Steering Committee, the SDE's Special Education State Transition Task Force, and the Alabama Higher Education and Disability Board of Directors. Academic credentials include an undergraduate degree in business administration and graduate degrees in special education with emphasis in mental retardation and program administration.

Dawn E. Ellis, RN, MPH is the CRS Assistant Director and Acting Grants Management Specialist. She brought to this position, which she assumed in January 2002, 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, 4 years as a CRS district supervisor, and 4 years as the grants management specialist. She is a member of the American Public Health Association and the National Rehabilitation Association. Academic credentials include an undergraduate degree in nursing and graduate studies in MCH.

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.

/2005/This paragraph from previous submissions has been shortened due to space limitations. CRS employs 12 parents of CYSHCN as Local Parent Consultants. CRS partners with United Cerebral Palsy (UCP) of Mobile for employment and supervision of the Local Parent Consultants and support of the State and Local Advisory Committee activities. UCP provides access to insurance coverage as well as leave, holiday, and retirement benefits. A State Parent Consultant is based in the State Office and her role includes advising in collaborative inter-agency efforts, recruiting/supporting additional parent participation, facilitating the State Parent Advisory Committee, coordinating the parent-to-parent network, and publishing the Parent Connection Newsletter.

There were 2 changes in CRS senior administrative personnel in FY 2003. Dawn Ellis is no longer the Acting Grants Management Specialist, but continues her duties as the CRS Assistant Director. Also, the Grants Management Specialist position has been reclassified to the MCH Program Specialist and combined with the Occupational Therapy Program Specialist position. Planning, evaluation, data analysis, and technical assistance related to occupational therapy are all in the purview of this position, which was filled in September 2003. Biographical information for the person filling this position follows.

Julie Preskitt, MS, OT, MPH is the MCH/Occupational Therapy Program Specialist for CRS. Her professional experience includes 7 years of high-risk follow-up, overlapping with 5 years of occupational therapy service provision to CYSHCN in a pediatric hospital and in early intervention settings. She is a member of the American Occupational Therapy Association, the Alabama Occupational Therapy Association, and AMCHP. Academic credentials include undergraduate degrees in biology and occupational therapy and graduate degrees in occupational therapy and public health./2005//

E. STATE AGENCY COORDINATION

BFHS and CRS have collaborated via attending quarterly interagency meetings and collaborating in such tasks as preparing the Title V annual reports/applications and planning the 5-year MCH needs assessment. A description of some of the collaborations in which each agency is involved follows.

/2004/Coordination of the Title V Program with programs or entities specifically mentioned in the Guidance (reference #2) for this section occurs in the context of BFHS and CRS seeking to accomplish their respective missions and meet priority MCH needs, rather than a particular plan to coordinate with specific programs. Since BFHS administers the Title X Family Planning Grant and WIC, coordination with these 2 entities is built into the Bureau's organizational structure and internal collaborative mechanisms. Similarly, CRS and AVRS are major divisions of ADRS, facilitating collaboration between the Title V Program and AVRS. With respect to identification of Medicaid-eligible infants and pregnant women--through SCHIP, discussed in Sections III.A and under NPM

#14, ADPH and Medicaid collaborate to identify Medicaid-eligible infants and pregnant women and help with their applications for Medicaid coverage. With respect to SSA, as discussed in Section III.B, SSI beneficiaries less than 16 years old are eligible for CRS services; several ways that CRS coordinates with SSA are also discussed in Section III.B. CRS's collaboration with SSA through the Disability Determination Units (DDUs) and CRS's involvement with families are discussed later in this section.//2004//

ADPH Coordinations/Collaborations

A requirement for area/county staff for the FY 2000 Cooperative Agreement (between ADPH and the 11 PHAs) was the development of area-specific MCH performance measures. UAB School of Public Health's MCH Department and the Bureau collaborated, therefore, to train area- or county-level staff on developing and analyzing area-specific performance measures. BFHS collaborates with numerous other groups, including several institutions of higher learning. For example, staff from the Bureau, CRS, Medicaid, UAB School of Public Health's MCH Department, UAB's Civitan Center, and TCHA's Pediatric Pulmonary Center 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) collaboration with UAB to sponsor Basic Tobacco Cessation Intervention Skills training to CHD maternity staff; 3) continuation of administrative and programmatic support to CHDs; and 4) participation in monthly meetings of ADPH Area Nursing Directors, Area Social Work Directors, and Area Administrators to share information and offer technical assistance.

Other collaborations (some of which are discussed elsewhere in this document) include the following: OHB and ADPH's Bureau of Health Promotion and Chronic Disease's (HPCD's) Tobacco Use Prevention and Control Branch jointly conducted a statewide Survey of Alabama Dentists in November 1999. Data collected ranged from opinions about access to services for low-income populations to tobacco cessation counseling activities for dental patients. OHB developed the tool, conducted the mailing/compiling phase, and entered data, and HPCD analyzed the data (findings are in Section II).

BFHS continues its commitment to ensuring that children and women of childbearing age receive adequate treatment for phenylketonuria (PKU). Persons who cannot afford to purchase the necessary food items for managing the condition can choose from 9 medical foods for treatment of PKU.

BFHS Family Planning Program staff collaborate with many statewide and community groups and governmental and private organizations to address various issues, such as with: the Alabama Chapter of the March of Dimes (AMOD) on a folic acid campaign; UAB to assess smoking prevention methods in selected CHDs; DHR to purchase Depo-Provera and implement an Office of Unwed Pregnancy Prevention; Medicaid on an 1115(a) Family Planning Waiver; 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 Medicaid, Auburn University at Montgomery (AUM) School of Nursing, and the Pharmacia/Upjohn Company on the PT+3 Educational Model for family planning. Further, Family Planning staff are partnering with DHR to implement a new Family Planning teen coordination project to provide care coordination services for all teens in family planning clinics who are age 18 years and under.

Staff from the Epi/Data Branch 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 FY 2001 the paper was accepted for publication in a peer-reviewed journal.

In conducting the 5-year MCH needs assessment in FY 2000, the Bureau collaborated with many persons from other agencies and organizations, as well as with several members of other ADPH units. Additionally, the Bureau's Needs Assessment Coordinator collaborated extensively with other Bureau members throughout the needs assessment process, described in Section II.

In addition to external collaborations already mentioned, many collaborations occur within the Bureau and among Bureau staff and staff from other ADPH units. For example, Family Planning staff collaborate with many ADPH units/programs at the State and local level to coordinate projects and provide input/technical assistance on family planning. For example, they collaborate with the Bureau of Disease Control's Sexually Transmitted Diseases Division and the Bureau of Clinical Laboratories (BCL) on the Title X Infertility Prevention Project; with the Department's Center for Health Statistics (CHS) on the Title X Regional Network for Data Management and Utilization Project; and the Public Health Nursing Section on Title X Training activities. Moreover, Epi/Data Branch staff collaborate with many persons from the Bureau and other Department units when preparing the Title V annual reports/applications. Multiple other collaborations, too numerous to mention here, are described throughout this document.

/2003/ADPH Coordinations/Collaborations

The Bureau continues to develop cooperative agreements with the 11 PHAs. For example, per the agreement for FY 2002, the Bureau's responsibilities are to provide level funding for MCH activities, technical assistance, area-level estimates for selected vital-statistics-based performance and outcome measures, and funding for community systems development projects that have potential for replication and continuation with alternative funding sources--as well as to develop new policies, programs, and strategies to address identified MCH needs. Responsibilities of each PHA team are to appraise the capacity of CHDs to plan, implement, and sustain community-based initiatives; submit an area MCH annual report to the Bureau; monitor the production of MCH services; submit a quarterly progress report of county-level community activities to the Bureau; and make an annual oral presentation of county-specific services to Bureau staff. Counties are to participate in local community partnerships, participate in local fetal/infant and maternal death reviews, make at least 4 MCH-focused oral presentations, and participate in health education programs on MCH topics. Several counties are now participating in fetal/infant death review, discussed under State Performance Measure (SPM) #2 in Section IV.D.

Findings from the statewide Survey of Alabama Dentists, jointly conducted in 1999 by OHB and HPCD, were reported in the February 2001 issue of the "Alabama Dental Association Newsletter." The purposes of this report were to inform Alabama dentists of the survey results and advise them that their responses would impact future planning for oral health initiatives in the State. Survey respondents said that they desired more training to provide tobacco cessation and prevention counseling for their patients. As a follow-up to this request, OHB hosted a workshop addressing these strategies at the April 2001 State Tobacco Prevention and Control Conference.

In January 2002 OHB and CRS participated in an assessment conducted by the Association of State and Territorial Dental Directors on ways to improve the oral health status of CSHCN. OHB is interested in developing educational materials for CSHCN and their families, as well as conducting oral health training sessions emphasizing CSHCN for CRS staff, parents, and teachers.

WIC staff collaborate with several groups and organizations, such as the Alabama Chapter of the AAP to share nutrition education resources with pediatricians and promote communication with them about WIC policies and procedures; the Alabama Breastfeeding Coalition and other stakeholders to address issues regarding breastfeeding promotion and support; the U.S. Department of Agriculture (USDA), DHR, the Alabama Cooperative Extension System, and SDE to develop the Alabama Integrated Nutrition Education Partnership Plan (being developed by a subcommittee of the Healthy Alabama Nutrition and Physical Fitness Coalition); Head Start to serve on the Advisory Board and to develop an MOU between the 2 organizations; and other ADPH staff and USDA, DHR, and SDE on the Food Security Partnership Committee to address food security issues. Additionally, WIC staff hold bimonthly meetings with the Nutrition Area Coordinators to provide updates on policies and procedures and provide information about technical assistance.

Other collaborations or collaborative programs newly initiated circa FY 2001 or thus far in FY 2002 include: 1) a Care Management Program for CSHCN, initiated by SCHIP and BCBS; 2) Bureau participation in the Alabama State Suicide Prevention Planning Group (discussed under NPM #16); 3)

Bureau participation in the Title X Regional Best Practices Project; 4) the Family Planning Teen Care Coordination Program, which Family Planning staff and DHR partnered to implement; 5) the FYs 2002-03 SSDI Project, which focuses on enhancing data capacity; and 5) membership of 2 Bureau staff members (respective Directors of the Child Health and the Epi/Data Branches) on the UAB Pediatric Pulmonary Center's Advisory Committee. Some of these collaborations are discussed elsewhere in this document.

The Epi/Data Branch collaborated with AMOD to prepare a reader-friendly report of the needs assessment, discussed in Section II, which was distributed in January 2002. Although a formal survey evaluating the report has not been conducted, several very positive verbal comments have been volunteered (including comments by a SPAC member and staff members from various organizations, including UAB, a CHD, and AMOD). AMOD staff distribute the report to a variety of individuals, including medical staff at UAB, and have found the report to be very well received.

With respect to discontinued collaborations, AUM School of Nursing and the Pharmacia/Upjohn Company are no longer active in implementing the PT+3 Educational Model for family planning, but Family Planning and Medicaid staff continue partnering to implement this model.//2003//

/2004/ADPH Coordinations/Collaborations

In October 2002 SPP began a partnership with AMOD to implement the new 5-year March of Dimes campaign on prematurity. The planning phase of the partnership continued through December 2002. In January 2003 press conferences were simultaneously held in the State's 5 perinatal regions to announce the prematurity campaign. RPAC members and AMOD volunteers presented the 2 campaign goals: to 1) increase public awareness of the problems of prematurity to at least 60%, and 2) decrease the rate of preterm birth in the U.S. by at least 15%. Target audiences for the campaign are the general public, pregnant women, and health care providers. The partnership will continue in FY 2003.

In FYs 2002-03 the Bureau continued development of the Alabama Health Resources Directory, contracting with UAB to collect information for the Directory. The Directory will provide a comprehensive community health services profile of providers and services whose mission is to promote the health and well-being of the MCH population, with a special focus on reproductive health. Plans for FY 2004 are to establish a contract for an external entity to develop and maintain a website on which the directory will be posted. The website would then be promoted through appropriate media.

The Bureau collaborates with 2 of the 5 major perinatal referral hospitals and 1 High Risk Follow-up and Tracking Clinic to address the need for family planning services for a targeted high risk population. Linkages to services are provided for mothers of infants who are admitted to the 2 hospitals' neonatal intensive care units and/or receive services from the follow-up clinic. These women are at high risk for repeated poor outcomes of pregnancy. ADPH contracts with these hospitals and the clinic for their staff to provide family planning counseling and referral to Plan First providers and care coordinators. The intent of the project is to reduce the occurrence of unintended pregnancies and of infant deaths in the targeted population.

In FY 2002 the Bureau Director served on the Domestic Violence Task Force, which included other ADPH staff and the Alabama Coalition Against Domestic Violence, to develop an updated resource guide for ADPH. This draft guide, entitled "Treating Victims of Domestic Violence," will provide ADPH employees with new tools for responding to victims of domestic violence who are seeking services in CHDs. He also collaborated with other ADPH staff and the Council on Violence Against Women, the Coalition Against Rape, and the Coalition Against Domestic Violence to develop an Alabama State Plan and Resource Directory of Violence Prevention and Intervention Services to address violence against women.//2004//

/2005/ADPH Coordinations/Collaborations

Unless indicated otherwise previously or in this update, previous collaborations basically

continue. Newly initiated collaborations include the following: 1) In FY 2004 a contract was established with a website consultant to begin developing a website to host the database for the aforesaid Alabama Health Resources Directory. The website is to be available statewide by FY 2005, when it will be promoted through appropriate media. 2) As part of an ongoing collaboration between HPCD's Injury Prevention unit and the Alabama Coalition Against Rape to combat sexual violence, ADPH and the coalition provided a statewide news release in April 2004. The Alabama Coalition Against Rape, which has 15 rape crisis centers throughout the State, conducts activities designed to prevent rape and enable crisis centers to facilitate consistent and compassionate care of victims of sexual violence and their families.

SPP staff continue partnering with AMOD in the 5-year March of Dimes campaign to reduce the prevalence of prematurity. The Bureau Director, the SPP Director, and several other Bureau staff attended the "Advocacy Day at the State Capitol" press conference--convened by AMOD in partnership with VOICES for Alabama Children, the Gift of Life Foundation, and the Alabama Hospital Association--to support the conveners' call for full funding of Medicaid.

As respectively mentioned in Sections III.A and III.C, the Department's Teen Care Coordination Program and AUPPP are being phased out in FY 2004. Further, due to fiscal issues discussed in Section III.B, cooperative agreements between ADPH and PHAs ended with expiration of the FY 2003 agreement, under which some PHAs designated certain staff (totaling 10 persons) as community development specialists. Although there are no such formal agreements in FY 2004, certain area- and county-level staff, as well as out-stationed State-level staff, have helped with the ongoing FY 2004-05 MCH needs assessment. For example, Social Work Directors or their designees from each PHA provided a list of potential recipients for the MCH Organizations Survey conducted in early calendar year (CY) 2004. Further, 14 county-level, area-level, or State-level staff located at the area level facilitated or helped facilitate 1 or more community discussion groups in early CY 2004. The process and findings for the FY 2004-05 MCH needs assessment will be reported in an attachment to the 2004 report/2006 application, to be submitted to HRSA's Maternal and Child Health Bureau (MCHB) in July 2005./2005//

CRS Coordinations/Collaborations

CRS has ongoing coordination with State and federal programs that strengthen the overall Title V program. The placement of CRS as a division within ADRS facilitates coordination of program planning and service delivery with other divisions, including EIS, the State of Alabama Independent Living Program, and AVRS. EIS and AVRS staff members are co-located with CRS staff in most locations throughout the State. CRS is an Early Intervention service provider and continues active participation on the Governor's ICC and subcommittees and District Coordinating Councils (DCCs). Implementation of the transition plan for clients from CRS to AVRS for vocational guidance is a priority focus. AVRS staff continue to collaborate with CRS in the ongoing development of a comprehensive statewide system of services for children with TBI. Interagency agreements are in place for planning service delivery between ADRS and the Alabama Institute for Deaf and Blind, Head Start, the Department of Youth Services, and local education agencies for transition services.

CRS partners with Medicaid in various ways. Although 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 CSHCN served by the program. CRS continues its interagency agreement with Medicaid to provide Children's Specialty Clinic Services throughout the State, which enhances access to services for Medicaid recipients. CRS serves as the reviewer of all requests for Medicaid funding for augmentative communication devices.

CRS remains committed to participation in many State-level collaborative planning efforts affecting CSHCN. CRS serves on the State Head Start Disability Advisory Committee to provide guidance in accessing health, education, and welfare service systems, as well as on the State and local CPCs. Other key State-level councils in which CRS participates that focus on systems development include SPAC, the State Multi-Needs Child Task Force, and the State Child Death Review Team. Other key

agencies involved with most of these councils include Medicaid, SDE, and MHMR. CRS has a long history of collaboration with the Alabama Easter Seal Society to enhance services for CSHCN through community rehabilitation centers and Alabama's Special Camp for Children and Adults (Camp ASCCA), a year-round camp facility for children and adults with disabilities. A CRS district supervisor with a child with special needs serves on the Camp ASCCA Board of Directors. Other CRS staff members hold ex-officio positions on statewide and local boards, coordinate service delivery through the Easter Seal Centers, and support Camp ASCCA through recruitment and funding assistance. CRS continues its collaboration with SSA through the DDUs in Birmingham and Mobile for serving SSI beneficiaries below age 16 years.

CRS remains committed to supporting Family Voices and VOICES for Alabama's Children. The CRS State Parent Consultant and the parent of a child enrolled in CRS together function as the State Family Voices Co-coordinators and the Region IV Family Voices Co-coordinators.

/2005/CRS collaboration and coordination activities basically continued in FY 2003 with the following additions. CRS has restructured its provision of early intervention services away from a direct service and vendor model to a team approach of linking eligible infants and toddlers with 1 of 16 CRS-sponsored programs statewide. This method allows for more comprehensive care coordination and better family-centered care.

CRS continues partnering with Medicaid to assure coordination of services with the medical home and provide access to specialty care and related services through Medicaid funding for all CYSHCN served by the program. CRS continues its interagency agreement with Medicaid to provide Children's Specialty Clinic Services throughout the State, which enhances access to services for Medicaid recipients. CRS continues to serve as the reviewer of all requests throughout the State for Medicaid funding for augmentative communication devices. CRS serves in an advisory role to Medicaid for program and policy decisions likely to affect CYSHCN and serves as a voice for this population in the planning for a new waiver addressing PCCM for recipients. Two CRS staff members sit on a task force created following the expiration of the previous PCCM model, Patient 1st, to offer expert input concerning specific needs of CYSHCN.

CRS continues participating in the many State-level collaborative planning efforts described above. The agency maintains support of the Alabama Easter Seal Society and Camp ASCCA through leadership, recruiting, and funding assistance. CRS continues to serve SSI beneficiaries under age 16 years and maintains collaboration with SSA through 2 DDUs in Birmingham and Mobile.

In FY 2003 CRS renewed its commitment as lead agency in planning to meet Healthy People 2010 objectives for CYSHCN. During meetings over the summer, an action plan was created to form 6 workgroups around the objectives, each chaired by a colleague from outside the agency. CRS State Office staff members serve as liaisons to these groups and assist in the facilitation of quarterly meetings addressing planning and implementation of activities and strategies to meet the objectives. Families of CYSHCN, youth, and representatives from other agencies are active participants in these workgroups. Activities will be ongoing over the next several years.

CRS strongly supports Family Voices, VOICES for Alabama's Children, and the Alabama Governor's Youth Leadership Forum. This forum is an annual leadership and career skills training opportunity for high school youth with disabilities in Alabama.//2005//

F. HEALTH SYSTEMS CAPACITY INDICATORS

/2005/The most recent estimates for health systems capacity indicators at this writing, May 24, 2004, are reported in the narrative. Currently unavailable estimates for 2003 will be reported on forms as they become available, but not discussed in this narrative. (In this document,

comparison of estimates over time is based on a multiplicative model unless stated otherwise.)/2005//

Health Systems Capacity Indicator (HSC) #1: The rate of children hospitalized for asthma (ICD-9 Codes:493.0-493.9), per 10,000 children less than 5 years of age.

/2004/The State still does not have a representative, centralized hospital discharge database nor firm plans to develop one in the near future. Discussion of the Bureau's previous efforts to estimate this indicator by contacting certain hospitals, along with the serious methodological limitations of these efforts, is in the corresponding note to Form 17. This year, however, BCBS and Medicaid have provided numbers for estimating the asthma hospitalization rate in preschool children enrolled in their respective plans. We believe that numbers provided by these 2 organizations collectively represent most Alabama children under 5 years of age. Using the total number of discharges for hospitalizations due to asthma among children 0-4 years of age enrolled in either of these 2 plans as the numerator, and the estimated population of 0-4 year-old Alabama children as the denominator, we estimate the CY 2002 asthma hospitalization rate in Alabama children less than 5 years of age to be 67.3 hospitalizations per 10,000 such children. In spite of the problematic denominator for this estimate (see corresponding note to Form 17), we have more confidence in the estimate for CY 2002 than in those for previous years. Because of the different methods employed for obtaining estimates for previous years and for CY 2002, trends in this indicator cannot be assessed.//2004//

/2005/The estimated CY 2003 asthma hospitalization rate in Alabama children less than 5 years of age is 90.6 hospitalizations per 10,000 such children. This estimate is notably higher (by 34.5%) than the corresponding estimate (67.3/10,000) for CY 2002. Respective numerators for CY 2002-2003 estimates are the total numbers of discharges for inpatient hospitalizations due to asthma among 0-4 year-old enrollees in either BCBS or Medicaid. Denominators are the estimated population of 0-4 year-old Alabama children for those respective years, reported by the Center for Business and Economic Research, the University of Alabama. Because the current method of estimating the State's asthma hospitalization rate for preschool children has been used for only 2 years, we cannot confidently describe trends in this indicator.

The absolute number of reported discharges for inpatient hospitalizations due to asthma for Medicaid enrollees aged 0-4 years increased by about half (51.7%): from 1,488 in CY 2002 to 2,258 in CY 2003. The corresponding number of reported discharges for BCBS enrollees aged 0-4 years was relatively stable, declining by 10.2% (from 532 in CY 2002 to 478 in CY 2003).

The reason for using a population-based denominator, rather than the total reported number of 0-4 year-old enrollees in BCBS and Medicaid, is that for CYs 2002-2003 the total reported number of BCBS and Medicaid enrollees in this age group exceeds the estimated population for this age group. This apparently inflated denominator, coupled with failure to capture hospitalizations among children who are enrolled in other plans or have no insurance, would markedly underestimate the rate. Population estimates provide a relatively stable denominator, and most children in the State are presumably insured by BCBS or Medicaid. Further, the number of reported 0-4 year-old children enrolled in Medicaid has declined by nearly one-third (32.2%): from 296,328 in FY 2002 to 200,997 in FY 2003. Two implications of this decline are: 1) The estimated number of Medicaid enrollees may continue to be unstable, and 2) the observed increase in numbers of Medicaid-funded hospitalizations for asthma in 0-4 year-old children was NOT accompanied by increased enrollment. Taking all the preceding issues into account, we consider the estimated population to be the preferable denominator. Nevertheless, we recognize that the reported estimate is likely to be somewhat lower than the actual hospitalization rate of 0-4 year-old children for asthma, since hospitalizations of children who are uninsured or enrolled in other insurance plans are not counted.

To our knowledge, the State still has neither a representative, centralized hospital discharge database nor firm plans to develop one. As part of the SSDI Project, by early FY 2006 the Bureau will further assess whether the State environment is more conducive to development

of a centralized hospital discharge database. However, partly due to fiscal constraints and the consequent reduction in the Bureau's analytic FTEs (discussed in Section III.B), the Bureau's capacity to facilitate the development of a centralized hospital discharge database is very limited.//2005//

HSC #2: The percent of Medicaid enrollees whose age is less than 1 year during the reporting year who received at least 1 initial periodic screen.

We assume that 90% or more of Medicaid enrollees under 1 year of age received at least 1 periodic screen in FY 1999 and FY 2000 (former core health status indicator #02A). Due to limitations of the pertinent databases, estimates for this measure often notably exceed 100%.

/2004/Estimates for this measure continue to far exceed 100%. We continue to assume, for practical purposes, that 90% or more of Medicaid enrollees under 1 year of age receive at least 1 initial periodic screen. See corresponding note to Form 17 for data-related issues.//2004//

/2005/Estimates for this measure continue to far exceed 100% but have been quite consistent (ranging from 122%-126%) throughout 2001-2003. We continue to assume, for practical purposes, that 90% or more of Medicaid enrollees under 1 year of age receive at least 1 initial periodic screen. See corresponding note to Form 17 for data-related issues.//2005//

HSC #3: The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than 1 year during the reporting year who received at least 1 periodic screen.

/2004/Again due to database limitations estimates for this measure have far exceeded 100% for the past 2 years. We assume that 90% or more of SCHIP enrollees under 1 year of age receive at least 1 periodic screen. See corresponding note to Form 17 for data-related issues.//2004//

/2005/SCHIP, BCBS, and Epi/Data Branch staff have consulted extensively regarding potential ways to better estimate the proportion of SCHIP enrollees whose age is less than 1 year during the reporting year who received at least 1 initial or periodic screen. Based on these consultations, the previous computation of "percents" that exceeded 100 was mainly for 2 reasons. First, at the time that those reports/applications were submitted, SCHIP could not report unduplicated counts of individuals, so was instead reporting numbers of screens, which inflated the numerator. Secondly, the current enrollment at the end of a given FY was apparently reported as the denominator, making the denominator spuriously low.

Based on the aforesaid consultations, we are developing new methods for estimating the numerator and denominator for this indicator. Per the current stage of these in-progress methods, we estimate that, in FY 2003, 64.6% of SCHIP enrollees under 1 year of age received at least 1 periodic screen before their 1st birthday. Clearly, this estimate does not support our previous assumption that 90% or more of SCHIP enrollees under 1 year of age receive at least 1 periodic screen. However, in stark contrast to earlier methods, our current methods most likely underestimate the proportion of SCHIP infants who receive age-appropriate screens, perhaps markedly. To elaborate, the denominator is the number of children who were less than 1 year of age at any time during the reporting year and were enrolled in SCHIP at any time during the reporting year; and the numerator is the number of such children who had 1 or more initial or periodic screens WHILE LESS THAN 1 YEAR OF AGE at any time during the reporting year. Consequently, an infant who reached 1 year of age before the end of the FY may not have been due for a screen until on or after his or her 1st birthday--and that screen would not have been counted.

SCHIP and BCBS will continue seeking feasible methods to better estimate this indicator. For instance, including children in the numerator who were 1 year of age at some time during the reporting year and were screened in that year after their 1st birthday would probably provide a better estimate. Further, SCHIP and BCBS may consider adapting methods being used for any

measures derived from the Health Plan Employer Data and Information Set (HEDIS) that involve similar data management or analytic issues. Accordingly, the reported estimate of 64.6% is considered provisional. Nevertheless, since it data-based, we consider it to be the preferable estimate for any recent year for which the earlier estimate exceeded 100%. Accordingly, we have replaced previous estimates that had exceeded 100% with this provisional estimate.//2005//

HSC #4: The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

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 each year during the surveillance period, from 74.6% in 1996 to 78.7% in 1999.

/2004/In CYs 2000 and 2001, respectively 77.6% and 78.1% of such women had an observed to expected prenatal visit ratio of 80% or greater, per the Kotelchuck Index. Thus, this measure did not consistently improve.//2004//

/2005/In CYs 2002 and 2003, respectively 78.9% and 79.9% of women 15-44 years of age had an observed to expected prenatal visit ratio of 80% or greater, per the Kotelchuck Index. Thus, this measure has improved slightly in 3 consecutive years. The 2003 estimate of 79.9% is 1.2% higher (better) than in 2002, and 1.5% higher than in 1999. Activities to encourage early and adequate prenatal care are described under NPM #18.//2005//

HSC #5: Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State.

/2004/All numbers reported here pertain to live births and are for CY 2001. Mothers of 71% of Medicaid infants and 91% of non-Medicaid infants had received prenatal care in the 1st trimester; mothers of 68.5% of Medicaid infants and 86% of non-Medicaid infants had received adequate or more than adequate prenatal care. With respect to birth weight, 11.6% of Medicaid infants versus 8.1% of non-Medicaid infants weighed less than 2,500 grams. Infant mortality rates for Medicaid and non-Medicaid infants, respectively, were 11.2 and 7.9 deaths per 1,000 live births. The worse experience of Medicaid, versus non-Medicaid, infants is presumably linked to socioeconomic status or factors associated with socioeconomic status.//2004//

/2005/All numbers reported here pertain to live births and are for CY 2002. Mothers of 73% of Medicaid infants and 91% of non-Medicaid infants had received prenatal care in the 1st trimester; mothers of 71% of Medicaid infants and 85% of non-Medicaid infants had received adequate or more than adequate prenatal care. With respect to birthweight, 11.7% of Medicaid infants versus 8.5% of non-Medicaid infants weighed less than 2,500 grams. Infant mortality rates for Medicaid and non-Medicaid infants, respectively, were 11.5 and 7.0 deaths per 1,000 live births. Again, the worse experience of Medicaid, versus non-Medicaid, infants is presumably linked to socioeconomic status or factors linked with socioeconomic status.

Roughly comparing 2002 to 2001, estimates for only 2 of the indicators included in HSC #5 differed notably. Both of these estimates pertained to the non-Medicaid population. That is, in the non-Medicaid population, the reported prevalence of low birth weight increased by roughly 5%, from 8.1% in 2001 to 8.5% in 2002. On the other hand, the infant mortality rate in the non-Medicaid population declined by roughly 11%, from 7.9 deaths per 1,000 live births in 2001 to 7.0 deaths per 1,000 births in 2002. These 2 points in time are insufficient for describing trends however, especially for the infant mortality rate, which is based on small numbers in the statistical sense. Respective trends in these indicators for Medicaid-insured, privately insured, and remaining populations will be assessed during the FY 2004-05 MCH needs assessment.//2005//

HSC #6: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children, and pregnant women.

/2004/The upper percent of poverty level parameter for Medicaid eligibility is 133% for infants, children aged 1-5 years, and pregnant women; and 100% for children aged 6-19 years. The ALL Kids component of SCHIP serves eligible infants/children/youth from birth through age 18 years whose household income exceeds the Medicaid criterion for their age group but does not exceed 200% of poverty. These criteria have not changed for several years. Alabama's SCHIP covers pregnant females only if they are less than 19 years of age and eligible for the ALL Kids component of SCHIP, with household incomes exceeding the Medicaid criterion but not exceeding 200% of poverty.//2004//

/2005/Respective criteria, pertaining to poverty levels, for eligibility in the State's Medicaid and SCHIP programs for infants, children, and pregnant women remain the same as they have been for several years.//2005//

HSC# 7: The percent of EPSDT-eligible children aged 6 through 9 years who have received any dental services during the year.

Thirty-two percent of EPSDT-eligible children aged 6-9 years were estimated to have received dental services in FY 2000 (down slightly from 34% in FY 1999).

/2004/Forty-two percent of such children received a dental service in FY 2002.//2004//

/2005/Forty-seven (46.5) percent of EPSDT-eligible children aged 6 through 9 years received a dental service in FY 2003. Over the surveillance period (1999-2003), this indicator improved in every year except 2000, when it was at its lowest level (32.3%) for these years. Overall, this indicator has improved notably (by 37.5%) over the past 4 years: from 33.8% in FY 1999 to 46.5% in FY 2003. Activities pertaining to assurance of dental services to low-income children are described under SPMs #05 and #08.//2005//

HSC #8: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program.

/2004/This indicator declined for the 2nd year. There were 4,352 CRS enrollees less than 16 years old who were SSI beneficiaries in FY 2002 as well as in FY 2001. However, the number of State SSI beneficiaries less than 16 years old increased from 21,360 in FY 2001 to 22,670. Over the past 2 years, the denominator has increased by 12.8%. Thus, the increasing denominator in FY 2002 caused the overall decrease in this indicator. (See Section IV.C for pertinent activities.)//2004//

/2005/Again, this indicator has declined. There were 4,327 CRS enrollees less than 16 years old who received SSI benefits in FY 2003. Again, the number of State SSI beneficiaries less than 16 years old increased to 23,635, representing a 4% increase over numbers for FY 2002. This consistent increase in the denominator results in the decrease noted for this indicator. (See Section IV.C for pertinent activities).//2005//

HSC #9A: The ability of states to assure that the Maternal and Child Health Program and Title V agency have access to policy and program relevant information and data.

/2004/Issues pertaining to HSC #9A are extensively described in the State's SSDI Competing Renewal Proposal for FY 2003, discussed in Section IV.F and located in Appendix F, which is obtainable as described in Section III.A. Through SSDI, the Bureau continues to make progress on linking live birth records to newborn screening billing records and WIC files. Of the criteria listed for HSC #9A, the Bureau has the ability to routinely obtain data (both per hard copy reports and direct access to electronic databases) from linked birth and infant death files, linked birth records and newborn screening billing records, and the Pregnancy Risk Assessment and Monitoring System (PRAMS). However, other reporting responsibilities have kept the Epi/Data Branch from mastering the

PRAMS database layout and the statistical techniques necessary to analyze a database with its complex sampling design. Under SSDI, the Epi/Data Branch is developing methodology for linking live birth records to WIC registration files for prenatal patients. We do not currently link birth records and Medicaid files but, as part of SSDI, Medicaid and Bureau staff are tentatively planning to link birth records with Medicaid eligibility or paid claims files by FY 2006. The Bureau can sometimes obtain limited reports from a regional (in South Alabama) birth defects surveillance system, but has no access to that system's electronic database. The State has neither a centralized, representative hospital discharge database nor, to our knowledge, plans to develop one in the near future. Under SSDI, the Bureau will renew exploration of the feasibility of developing a statewide birth defects surveillance system and/or a statewide hospital discharge database.//2004//

/2005/Two responses to HSC #9a differ from what they were in the 2002 report/2004 application. The 1st of these responses pertains to annual linkage of birth certificates and WIC eligibility files. The Bureau now has the capacity to link live birth records with WIC prenatal registration records, and has direct access to the linked database. Such capacity did not exist in early FY 2003, so the score for this indicator has improved from 1 to 3. Epi/Data Branch staff have presented key findings from preliminary analysis of the initially, though incompletely, linked live birth records/WIC prenatal registration records database to the Director of the WIC Division. She has a keen interest in findings from the linked database and suggested an approach that might achieve a higher proportion of valid links. Based on her advice and other identified measures, SSDI staff are now refining the program to link live birth records with WIC prenatal registration records.

On the other hand, the score for "annual linkage of birth certificates and newborn screening files" is now 2, down from 3 in the 2002 report/2004 application. This score was reduced for several reasons, 1 of which pertains to increased capacity to monitor in a more timely manner whether infants are being screened. With respect to more timely monitoring, as discussed under NPM #1, concern over possible reasons for the apparent non-linkage of a few live birth records with newborn screening billing records has led to ongoing development of reports to show, by hospital, the number of newborns and the number of these newborns who receive initial screens. Based on these reports, Newborn Screening Program (NSP) staff will be able to follow up on individual infants in hospitals that do not seem to be screening all their newborns. In light of these increased capabilities, the need for annual electronic linkage of live birth records to newborn screening billing records has diminished. Specifically, we consider more timely ascertainment of whether all infants recently born in hospitals have been screened, which the Bureau is now focusing on, to be more important than routine electronic linkages that do not identify recently delivered infants who may not have been screened.

Other reasons for reassessing the feasibility of annual electronic linkage of live birth records to newborn screening records include: 1) the loss of 2 analytic FTEs in the Epi/Data Branch (discussed in Section III.B), and 2) the Branch's lack of access to the Neometrics, Inc. Case Management System (CMS) database, which is preferable to billing records. Though such access might be granted in the future, other priorities, as well as the diminished FTEs, may keep the Epi/Data Branch from pursuing such access and/or developing computer programs to annually link live birth records with the database. The initial linkage of live birth records to newborn screening billing records has accomplished its main purposes: 1) estimation of the proportion of live birth records that could not be linked to newborn screening billing records; 2) description of certain characteristics of infants whose records could not be linked; and 3) action by key Bureau staff to increase the Bureau's capacity to monitor in a more timely manner whether infants are being screened. The Epi/Data Branch will consider performing periodic (for instance, every 3 years) linkage of live birth records to the Neometrics, Inc. CMS database if 1) analysis of the linked database would be deemed to have program or policy implications for the NSP, and 2) the Branch is granted access to the database.

The Bureau continues to address high priority electronic data linkages through SSDI. Appendix F, obtainable as described in Section III.A, now includes the State's SSDI FY 2004

Summary Progress Report, as well as the Competing Renewal Proposal for FY 2003./2005//

HSC #9B: The ability of states to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month.

/2004/SDE participates in the Youth Risk Behavior Survey (YRBS). Though the Bureau does not have access to the database, we have been able to obtain information on this indicator from SDE in the past. Additionally, HPCD conducts the Alabama Youth Tobacco Survey during alternate years, when YRBS is not conducted./2004//

/2005/The Bureau can now query CDC's on-line YRBS database, for both national and State-specific findings, via a CDC web page. Accordingly, Form 19 now indicates "yes" to the question, "Does your MCH program have direct access to the state YRBS database for analysis?" Due to the ability to query the national YRBS database, the Bureau no longer needs to contact SDE for YRBS findings. Further, HPCD continues to conduct the Alabama Youth Tobacco Survey in years that the YRBS is not conducted and shares findings with the Bureau upon request. Because CDC's on-line YRBS database can be queried and HPCD shares findings with us, the Bureau does not consider it necessary to request direct access to either the YRBS database or the HPCD database--especially in light of the Epi/Data Branch's broad analytic and reporting responsibilities and the Branch's recently vacated positions. As part of the FY 2004-05 MCH needs assessment, the Bureau will track findings pertaining to tobacco consumption by youth--using findings from the YRBS database and HPCD's database. Further, we will seek input from staff in HPCD's Tobacco Prevention and Control Division concerning activities and developments affecting tobacco consumption among youth./2005//

HSC #9C: The ability of states to determine the percent of children who are obese or overweight.

/2004/Presumably, SDE would provide us with available information on this indicator upon request. PHALCON collects data on nutritional indicators that are included in CDC's Pediatric Nutrition Surveillance System (PedNSS). However, ADPH's Computer Systems Center has not yet completed PHALCON-compatible programs to submit data to PedNSS. For that reason, ADPH has not submitted data to PedNSS since 1999. (PHALCON replaced the Department's previous encounter-form data management system in FY 2000). ADPH's Computer Systems Center and WIC jointly manage and access the WIC database./2004//

/2005/As described under HSC #9b, the Bureau can now query CDC's on-line YRBS database, which includes data about the percentage of high school students who are obese. PHALCON-compatible programs for submitting data to PedNSS are nearly complete, and WIC expects to begin submitting data to PedNSS by early FY 2005.

WIC's FYs 2005-06 Nutrition Education Plan for all ADPH WIC clinics focuses on childhood obesity. WIC will periodically compute the number and percentage of WIC-enrolled children who were initially certified or were recertified for enrollment in WIC because of being, respectively, overweight or at risk of being overweight. CDC's criteria, which are based on body mass index percentiles, are used to identify children who are respectively overweight (95th percentile or above) or at risk of being so (85th through 94th percentiles)./2005//

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

/2004/Determination of the State's priorities, performance measures, and program activities occurs in the context of the Government Performance and Results Act (GPRA, Public Law 103-62). This act requires each federal agency to establish performance measures that can be reported as part of the budgetary process that links funding with pertinent performance and outcome measures. Figure 3 of the guidance for the MCH Services Block Grant reports/applications (reference #2, Appendix C) depicts the Title V Block Grant Performance Measurement System. This system is to begin with needs assessment and identification of priorities and culminate in improved outcomes for the Title V population. As shown in Figure 2 of the aforesaid guidance, assessing needs is part of a circular process including the following components: assessing needs, examining capacity, selecting priorities, setting targets, identifying activities, allocating resources, and monitoring progress. Each component of this process receives input from a preceding component and feeds into the next component. As also shown in Figure 2 of the guidance, monitoring progress addresses the question of whether an outcome has improved, and the answer to this question feeds into the "identifying activities" component.

When designing, allocating resources to, and implementing programs, key ADPH and CRS staff consider the priority MCH needs identified through the FY 2000 MCH needs assessment. That is, ADPH or CRS supports or directly administers programs to directly address 9 of the 10 priority MCH needs (discussed in Section IV.B) identified through the FY 2000 MCH needs assessment. Neither ADPH nor CRS administers a program mainly designed to address the remaining priority need, "Reduce deaths of children and youth due to homicides." ADPH staff have, however, monitored homicide deaths in youth and have ascertained that at least 2 external organizations specifically address violence in youth, sometimes through interventions designed to help youth manage anger. Accordingly, the Department's current role regarding this priority need pertains to the core public health function of assessment, rather than policy development or assurance. Section IV.B describes the relationship of the priority needs, the National and State performance measures, and the capacity and resource capability of the State's Title V program.

Per federal guidance, accountability for MCH Services Block Grant funds is determined in 3 ways. The 3 ways consist of 1) measuring progress toward achievement of each performance measure; 2) having budgeted and expended dollars spread over all 4 of the service levels shown in the MCH Pyramid (Figure 1 of the aforesaid guidance), which are direct health care, enabling services, population-based services, and infrastructure-building services; and 3) having a positive impact on the outcome measures. Sections IV.C and IV.D pertain to the 1st of the 3 aforesaid elements (performance measures), Section V to the 2nd (dollars), and Form 12 to the 3rd (outcome measures).

The State Title V Program's role in actions to address each performance measure varies, but falls within 1 or more of the 3 core public health functions of assessment, policy development, and assurance. As a corollary, the State Title V Program's role concerning a given performance measure may pertain to 1 or more of the 10 essential public health services, especially the following: 1) monitoring health status; 2) informing and educating people about health issues; 3) mobilizing community partnerships to identify and solve health problems; 4) developing policies and plans that support individual and community health efforts; 5) linking people to needed personal health services and assuring the provision of health care when otherwise unavailable; 6) assuring a competent public health work force; and 7) evaluating accessibility of personal and population-based health services. Accordingly, the Bureau's Executive Committee and the Director of the Epi/Data Branch are currently reviewing the 10 essential public health services, using the Capacity Assessment for State Title V (Cast-5) model (reference #3, Appendix C).

Services provided by the State Title V Program are intended to promote health and well-being, as well as to collectively achieve the long-term goal of having a positive effect on the 6 National Outcome Measures in this report/application. Effects of MCH programs are often incremental, rather than dramatic, however. Moreover, outcome measures and some "performance measures" (such as very

low birth weight, or VLBW) are often influenced by forces beyond the control of the Title V Program. Indeed, various studies have found that programs initiated to prevent preterm delivery and low birth weight--including social support of pregnant women, early prenatal care, and education to increase awareness of signs of preterm labor--have been largely unsuccessful (reference #4, Appendix C). VLBW, of which prematurity is the major component, is further discussed in Section IV.C.//2004//

/2005/Sections IV.C and IV.D respectively discuss the 18 National Performance Measures and the 8 State Performance Measures. Performance measures are discussed in numerical order, with a focus on MCH populations served and activities by level of the MCH Pyramid. The following are described for each performance measure: key activities in FY 2003; key activities initiated in early FY 2004; and plans for FY 2005. Further, where indicated and permitted by space constraints, key activities prior to FY 2003 are reported as a context for FYs 2003-2005. Specific activities are described and categorized by the 4 service levels in the MCH Pyramid.

The State's applications/reports for previous years have typically included a description of the status and trends for each performance measure in the narrative, though such discussion is not required by the guidance referenced in Appendix C. In the current application/report, however, status and trends for most measures are reported in an attachment to the "Last Year's Accomplishments" narrative for that measure, rather than in the narrative itself. These attachments on trends include graphic depictions, brief discussions and, where indicated, checklists.

Due to the need to focus on specific adaptations to fiscal constraints discussed in Section III.B, the formal Cast-5 process has been interrupted, but some of the concerns expressed during the process are being addressed.//2005//

B. STATE PRIORITIES

Priority Needs

Through the FY 2000 MCH needs assessment initially reported in July 2000, ADPH and CRS respectively identified 7 and 3 priority MCH needs. A review of the needs assessment process, detailed in Section II, follows and is itself followed by a discussion of each identified priority need, including pertinent needs assessment findings. (The specific year[s] to which cited findings pertain is not always mentioned and varies according to the data source. That is, the most recent pertinent data sources available during the FY 2000 MCH needs assessment were used, and the years for which data were available varied by source. Findings, including the years to which they pertain, are detailed in Section II.)

ADPH gathered information mainly through community forums and focus groups, vital statistics data, 3 mailed surveys (primary care medical practices, non-medical MCH organizations, and dentists), and a telephone survey of households with children. BFHS organized the MCH Needs Assessment Advisory Committee, which was convened on 3 occasions, to provide input into the needs assessment process and selection of priority needs. During the final meeting of this committee, then-available findings from the needs assessment were presented. Following presentation of these findings, the Bureau Director presented 12 potential priority needs that had been identified by the Bureau's Needs Assessment Coordinator, based on findings from the needs assessment and in consultation with the Bureau Management Team. Attendees at this 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 5 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 7 priority MCH needs, which were approved by the Bureau's Executive Committee.

CRS convened the CRS Needs Assessment Advisory Committee on 4 occasions, and pursued 3 methodologies in gathering qualitative and quantitative data: 8 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 7 areas as priorities for improvement. A core planning team within the CRS State Office then selected the 3 priority MCH needs pertaining to CSHCN that CRS has the mission to address.

//2005/Certain BFHS actions concerning the FY 2004-05 MCH needs assessment have been referenced in several places in this document. For example, as mentioned under SPM #2, mailed surveys of 2 Alabama groups serving maternal and child populations have been initiated: 1 of primary health care providers, and 1 of non-medical organizations. Further, as alluded to in Section III.E, more than 12 community discussion groups have been convened by ADPH staff. The Bureau plans to convene an MCH Needs Assessment Advisory Committee in early FY 2005--in order to present then-available findings and seek input on priority needs, as well as input on data to consider collecting in subsequent, ongoing needs assessment. The Bureau's Epi/Data Branch is assuming the lead for ADPH's component of the needs assessment.

CRS has begun planning activities related to CYSHCN for the FY 2004-05 MCH needs assessment. The CRS Needs Assessment Advisory Committee has been convened on 2 occasions. Activities will be ongoing over the next year and will include county-level surveys, statewide Family Forums, a Youth Forum, and a youth survey.

The Bureau's MCH Needs Assessment Coordinator is a member of the CRS Needs Assessment Advisory Committee, and 1 or more members of CRS's staff will be invited to join the Bureau's MCH Needs Assessment Advisory Committee. Section II has not been updated to reflect the emerging FY 2004-05 needs assessment process, but a full report of this ongoing assessment will be attached to the 2004/2006 report application.//2005//

With 2 exceptions, the priority needs are organized below by level of the MCH Pyramid where they were first mentioned in previous MCH Services Block Grant reports/applications. Most needs, however, pertain to more than 1 level. Terminology used in subsequent sections to refer to each need is shown parenthetically. Key findings on which the selection of priority MCH needs were based are summarized. 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 included those from the Medical Practices Survey suggesting that limited health education was being provided to patients, that improvement was needed with respect to tracking of immunizations and provision of counseling about appropriate sleep position for infants, and that the proportion of adolescents who used tobacco was unacceptably high.

//2004/Many performance measures pertain to this need: NPMs #1 (newborn metabolic screening), #7 (immunizations), #8 (teen birth rate), #10 (motor vehicle crash death rate for children), #11 (breastfeeding), #12 (screening newborns for hearing impairment), #13 (uninsured children), #14 (Medicaid-paid service for eligible children), #16 (suicide deaths among youth); and SPMs #1 (folic acid intake), #2 (development and analysis of key MCH databases), #3 (assuring access to case management), #4 (children receiving case management), and #5 (promoting use of dental care). (Note: As explained in a 2005 update to Section III.C, the current, sequentially based numbers identifying SPMs are used in narrative cross-references with SPMs unless stated otherwise.)//2004//

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-building levels. Multiple findings from the needs assessment supported the designation of this issue as a priority need. Several of these findings suggested that utilization of and/or access to dental care was 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 were children with private insurance. Per the Dental Survey, only 11% of dentists said that they accepted new Medicaid clients. Moreover, only about 1/3 of EPSDT-eligible children aged 6-9 years were estimated to have received dental services in FY 1999. Additionally, several findings suggested that access to dental care was a problem, without reference to insurance status. For example, per the Telephone Survey, dental care was delayed more often for children than other types of care were. Also per the Telephone Survey, about 1/4 of the referent children had not been checked by a dentist within 1 year--with lower income (household income under \$25,000 per year), African American, and uninsured children being less likely than their respective referent groups to have had a dental checkup. Moreover, per the Medical Practices Survey, dental care was among the types of services for which access was reported to be most problematic.

/2004/NPM #9 (protective dental sealants), SPM #3 (assuring access to case management), SPM #4 (children enrolled in case management), SPM #5 (promoting use of dental care), and SPM #8 (dentists serving Medicaid-enrolled children) pertain to this need.//2004//

Population-based Services

Improve health status of CSHCN through increased access to primary, specialty, and subspecialty care (improve health status of CSHCN): This need pertains to all 4 levels of service, but especially to population-based, since it concerns outreach/public education. Needs assessment findings through the family forums and county provider surveys indicated that inadequate access to care for CSHCN continued in the State, as evidenced by the reported lack of transportation, limited knowledge of resources, inadequate financing, and limited availability of providers.

/2004/NPM #3 (coordinated care for CSHCN), NPM #4 (health insurance for CSHCN), NPM #5 (easily used community-based service system for CSHCN), and SPM #7 (public awareness of Title V CSHCN programs) pertain to this need. This need has been re-designated as a population-based service because of its relationship to outreach and public education.//2004//

Further reduce the adolescent pregnancy rate (reduce adolescent pregnancy): Needs assessment findings supporting this issue as a priority need included the following. First, teen pregnancy was ranked 2nd by adolescents (behind early sexual activity) when asked what the greatest problems teens face today were, and early sexual activity was ranked by participants in Women's Health Focus Groups as being of greatest concern. Second, though the live birth rate for adolescents aged 15-17 years had notably declined, further improvement was needed, and repeat adolescent pregnancies continued to occur.

/2004/NPM #8 (teen birth rate) and SPM #6 (programs to prevent adolescent pregnancy) pertain to this need.//2004//

Infrastructure Building

Reduce infant mortality in the African American population (reduce African American infant mortality): The racial gap in infant mortality had long been identified as a major concern in Alabama, as well as the Nation. In Alabama, African American infants had been about twice as likely to die before their 1st birthday as were white infants. 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 did not entirely explain the racial infant mortality gap.

/2004/NPM #17 (delivery of VLBW infants at appropriate facilities) pertains to this need.//2004//

Reduce the prevalence of VLBW in the African American population (African American VLBW): VLBW infants were 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. During the study period, the proportion of singleton infants who were VLBW had stayed about the same for white infants but increased markedly for African American infants. Although the racial disparity in VLBW did not entirely explain the racial infant mortality gap, it accounted for much of the gap, and notably reducing the prevalence of VLBW in African American babies would notably reduce their infant mortality rate.

/2004/NPM #15 (VLBW) pertains to this need.//2004//

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/Latino immigrants. The number of live births to Hispanic/Latino Alabama residents had increased more than 4-fold in the study period and, in 1998, 10% or more of residential live births in 4 counties were to Hispanic/Latino mothers. With respect to source of payment for birth, deliveries of nearly 1/3 of Hispanic/Latino live births in 1999 were uncompensated. Moreover, the rate of improvement in the percentage of live births to pregnant women who received early prenatal care had slowed in the late 1990s, and this slower improvement was not largely explained by the increase in numbers of uninsured Hispanic/Latino women. Further, racial and economic disparities in the proportion of women receiving inadequate or no prenatal care existed. Bureau staff believed that managed care for Medicaid-eligible pregnant women had improved access to private medical providers throughout the State, but that uninsured women had difficulty accessing care. /2004/NPM #18 (early prenatal care) pertains to this need.//2004//

Increase family participation in CSHCN policy making and in family-to-family support services (increase family participation). Through 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 specifically mentioned by families. These inadequacies 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. /2004/NPM #2 (families partnering in decision making) pertains to this need.//2004//

Improve the capacity of CSHCN to be fully integrated into their communities to live, learn, work, and play (integrate CSHCN): Through public forums, families reported their frustration with the inadequate integration of their children with special needs into communities. They noted inadequacies in educational and health-related services from public education, accessibility of facilities, community recreational opportunities, and transitions from school to work and independence. /2004/NPM #6 (transition of youth with special health care needs to adult life) and SPM #16 (referral of CSHCN to AVRS, using the previous numbering system for SPMs) pertain to this need. SPM #16 is being discontinued, however, for 2 reasons: 1) Related activities are now addressed under NPM #6, and 2) our experience has shown that an individualized transition plan is more effective than a rigid procedure of referral to AVRS at 16 years of age.//2004//

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) had declined sharply during the study period, a wide racial disparity persisted. This disparity supported the priority need to reduce deaths of children and youth due to homicides, particularly for African American male adolescents. /2004/State Outcome Measure #2 (homicide death rate for African American male adolescents) pertains to this need.//2004//

Relationship of Priority Needs, Performance Measures, and Capacity/Resource Capability of the State Title V Program

The preceding discussion lists the most relevant performance measures (and, in 1 case, outcome measure) for each priority need. The Bureau's and CRS's plans are based on their overall missions, recent developments, findings from studies conducted as part of the FY 2000 MCH needs assessment, and input from each agency's Needs Assessment Advisory Committee. Further, the Bureau's plans are based on input from SPAC.

As described in the State's 1998 report/2000 application, 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 stabilized in FY 1999 and has remained reasonably stable since then, and further massive layoffs are not expected. Moreover, personnel have been added to the Bureau's staff in recent years, enhancing the capacity of the Bureau's infrastructure. Thus, the Title V Program is now better equipped to

accomplish its mission and effect strategy described in the 1998 report/2000 application. 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 was on the Management Team of the Department's Strategic Direction Workgroup, and this paradigm shift undergirded the Workgroup'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. Activities discussed in Sections IV.C and IV.D address specific performance measures and occur in the context of the Bureau's mission, vision, and consequent paradigm shift--described in Section III.A.

/2005/Fiscal issues are updated in Section III.B./2005//

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

a. Last Year's Accomplishments

MCH Population Served: Pregnant women, mothers, and infants

/2005/Status and trends: See attachment./2005//

/2004/Cross-cutting:

The Bureau's NSP staff, together with ADPH's BCL, continued screening for conditions shown on Form 6 and tracking infants as indicated by results of screening or diagnostic tests. The numbers of presumptive positives, confirmed cases, and infants needing treatment who received treatment are listed on Form 6 for classical PKU, primary congenital hypothyroidism, classical galactosemia, sickle cell disease, and congenital adrenal hyperplasia. In FY 2002 over 57,000 infants were screened for the conditions on Form 6, and infants screening positive were referred for follow-up by private providers of diagnostic services.

Infrastructure-building:

The Bureau continued maintaining files on confirmed cases identified by networking with private providers of diagnostic services. The Automated Voice Response System, which provides authorized health care providers prompt access to screening results, had more than 2,214 physicians registered. Other services included: 1) monitoring and evaluating services to infants with sickle cell disease or trait whose families were provided sickle cell counseling and education and support services by the 7 contracted Community-Based Sickle Cell Organizations (CBSCOs); 2) providing monthly reports to hospitals, CHDs, CBSCOs, and other entities; and 3) through BCL's County Assistance Section, providing laboratory consultation and training to CHDs.

BFHS began developing infrastructure to electronically link live birth records to newborn screening billing records.

The Alabama Sickle Cell Disease Client Registry ended in March 2003 because certain barriers, such as long distances to services, limited its usefulness.*//2004//*

/2005/NSP activities occurring at the end of FY 2002 basically continued in FY 2003. Recaps and updates follow.

Cross-cutting:

Over 58,000 newborns were screened for the conditions on Form 6.

Infrastructure-building:

The Bureau continued maintaining files of confirmed cases, and 2,198 physicians were registered in the Automated Voice Response System. Provision of previously described services pertaining to sickle cell disease (except for the registry that ended in March 2003), monthly reports to certain entities, and laboratory-related consultation to CHDs continued.

In September 2003 the State Newborn Screening Advisory Committee recommended use of Tandem Mass Spectrometry (MS/MS). The State Health Officer presented the proposed Rules and Regulations Regarding the Care and Treatment of Infants Identified Through the Newborn Screening Program to the State Committee of Public Health.//2005//

b. Current Activities

/2005/FY 2003 activities basically continue in FY 2004. Updates follow.

Infrastructure-building:

The Epi/Data Branch met with NSP staff to discuss possible reasons for the estimate that about 3%-4% of live birth records do not link to newborn screening billing records. Consequently, a monthly report is being developed by the Computer Systems Center that will show, by hospital, the number of newborns and the number of these newborns who are screened. This issue is further discussed under "Plan for the Coming Year."

NSP, UAB, and the University of South Alabama (USA) collaborated to initiate research on hemoglobinopathies.

Consistent with the September 2003 recommendations of the State Newborn Screening Advisory Committee, MS/MS is being implemented. Alabama is 1 of 21 states using MS/MS, making it possible to screen for about 30 metabolic and inheritable disorders. Disorders detected by MS/MS include amino, fatty, and organic acid disorders. With the added tests, Alabama will comply with the March of Dimes recommendation that all newborns be screened for at least 9 metabolic and/or inheritable disorders and for hearing loss. Reporting on disorders screened for via MS/MS will begin as pilot studies are completed. A more detailed timeline (as of mid-April 2004) of MS/MS-related activities in FY 2004 follows:

In December 2003 the State Committee of Public Health adopted the proposed revision to newborn screening rules and regulations, mentioned under "Last Year's Accomplishments."

In March 2004 the Bureau staffed the newly created position of Newborn Screening Follow-up Coordinator for MS/MS.

As of mid-April 2004, existing newborn screening literature is being revised. The Bureau provides staff support to a UAB metabolic specialist, who is to provide consultation to families of newborns identified as having metabolic disorders and serve as a resource for providing educational counseling and materials to parents, practitioners, and consumers. Neometrics, Inc. CMS has been upgraded to CMS III, which allows follow-up of newborns screened via MS/MS.

By the end of April the following will have occurred. NSP will add screening for biotinidase deficiency to the existing newborn screening panel. The short test panel will be chosen for MS/MS under the guidance of the UAB metabolic specialist. The Newborn Screening Follow-Up Coordinator for MS/MS will begin developing disorder-specific fact

sheets for professionals and parents, for review by a subcommittee of the State Newborn Screening Advisory Team. Stakeholders from the Alabama Hospital Association, Alabama Chapter of AAP, and ADPH will be notified of the expanded testing via newsletters and the ADPH Newborn Screening website.

In May the Newborn Screening Follow-up Coordinators will attend the Newborn Screening and Genetic Testing Symposium, a national conference. A statewide 6-month pilot study of MS/MS will begin in April or May, and reporting of the 1st panel is to begin by September.//2005//

c. Plan for the Coming Year

/2005/FY 2004 activities, including incremental implementation of MS/MS, will continue in FY 2005. Recaps and updates follow.

Cross-cutting:

Screening of all newborns for biotinidase deficiency and for conditions shown on Form 6, with appropriate follow-up, will continue.

Direct:

Provision by private providers of diagnostic services for infants screening positive will continue.

Infrastructure-building:

Operation of the Automated Voice Response System, which provides authorized health care providers prompt access to screening results; provision of monthly reports to hospitals, CHDs, and other appropriate entities; and provision of laboratory-related consultation to CHDs will continue.

By FY 2005 NSP will explore the possibility of changing the galactosemia screens to measure transferase and galactose metabolites. Further, NSP staff will collaborate with a TCHA pediatric endocrinologist to improve testing, reporting, and follow-up on tests for hypothyroidism and congenital adrenal hyperplasia.

The statewide pilot of MS/MS will be completed, and test panels will be incrementally added to the current screening panel.

The Bureau will continue educating providers, parents, and consumers on newborn screening practices. Activities will include development and distribution of a newborn screening practitioner's manual. Further, the Newborn Screening Follow-up Coordinator for MS/MS will continue developing disorder-specific fact sheets.

NSP staff will work with the State Genetic Centers, located at UAB and USA, to assure that a system of follow-up for infants who screen or test as presumptively positive or confirmed positive is in place.

The Newborn Screening Follow-up Coordinators will attend the 2005 Newborn Screening and Genetic Testing Symposium.

As discussed under "Current Activities," NSP staff are taking measures to address the apparent non-linkage of a few live birth records with newborn screening billing records. That is, a monthly report is being developed (in FY 2004) by ADPH's Computer Systems Center, which will show, by hospital, the number of newborns and the number of these newborns who receive initial screens. This report will be derived from Neometrics records, which are preferable to newborn screening billing records but were previously

unavailable to Epi/Data staff for electronic linkage to live birth files. Further, if the hospital-specific report suggests that a particular hospital may not be screening all newborns, NSP staff will be able to print the names of infants born in that hospital, in order to promptly follow up on each infant to determine if he or she was screened. Also, NSP staff will be able to run annual summaries of total numbers of newborns and numbers who were screened, by hospital. In light of these increased capabilities, the need for continued electronic linkage of live birth records to newborn screening billing records will be reassessed.//2005//

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

a. Last Year's Accomplishments

MCH Population Served: CSHCN

/2005/Using data from the Summary Tables from the National CSHCN Survey, 2001 (U.S. Department of Health and Human Services [DHHS], April 28, 2003), 66.1% of families with CSHCN age 0-18 years in Alabama reported that they partner in decision-making at all levels and are satisfied with the services they receive, compared to 57.5% nationally. Of the Alabama families, 91.0% reported that the physician usually or always made them feel like a partner in contrast to 84.3% of families nationally. Regarding satisfaction with care, 66.2% of Alabama families reported that they were very satisfied with the services they received as compared to 60.1% of families nationally.

Enabling:

CRS continues to expand its commitment to family participation within the program. Employment of the State Parent Consultant (SPC) and 12 Local Parent Consultants (LPCs) continued. The State Parent Advisory Committee held 2 meetings in FY 2003, and Local Parent Advisory Committees were active in all CRS districts, hosting speakers on a variety of topics of interest to families. The CRS Parent Connection, the parent-to-parent support network, has grown to include over 375 families statewide and sponsored 2 "family gatherings" offering information and support. CRS continued to publish the Parent Connection Newsletter. The SPC, along with another CRS parent, serves as 1 of the Family Voices of Alabama State Coordinators and as 1 of the Region IV coordinators. A grant was completed and refunded through the Alabama Council for Developmental Disabilities to study barriers to health care for people with disabilities in Alabama and develop an advocacy plan to address these barriers. Work will continue on this project for an additional 3 years. A task force to develop a Family Guide was established and work is ongoing.

Population-based:

LPCs presented trainings throughout the year at a variety of locations. Presentations to promote awareness of people with disabilities occurred through LPC participation in community Health Fairs and a local university's Disability Awareness Day.

Infrastructure-building:

LPCs attended many training programs both nationally and throughout the State. Family members were included on all CRS committees and task forces. LPCs were active participants in a number of interagency task forces and committees, including local CPCs in their areas and 2010 Action Plan workgroups. A Family/Professional Partnership workgroup was established to address the 2010 goal of parent satisfaction and partnering in decision-making. The SPC was involved in a variety of training, both as a

presenter and a participant. She also served as a member of the AMCHP Best Practices Committee, provided training to Pediatric Pulmonary Center trainees, and co-presented at the First International Conference on Family Centered Care . She is a member of several interagency planning groups and collaborated with the Early Intervention system in a number of efforts.//2005//

b. Current Activities

/2005/Enabling:

LPCs will continue to be supported in CRS district offices. The SPC and the parent of a CRS-enrolled child will continue as the Regional Co-coordinators for Family Voices. (The parent is involved in CRS State and Local Parent Advisory Committees.) The State Parent Advisory Committee rated the agency for FY 2003 on the 6 characteristics documenting family participation in CSHCN programs on Form 13, utilizing a checklist format developed by the State of Wisconsin in December 2001. The scored checklist is attached to this subsection.

Infrastructure-building:

Work continues on the renewed grant through the Alabama Council for Developmental Disabilities to study barriers to health care for people with disabilities in Alabama and develop an advocacy plan to address these barriers. The Family Guide Task Force continues to meet to develop a Family Guide for families of CYSHCN. A new data collection system has been implemented, in partnership with Family Voices, which will provide information on types of services and information requested by families and professionals. Families of CYSHCN, LPCs, and the SPC continue participation in all 2010 workgroups, including the Family/Professional Partnership workgroup specifically addressing the 2010 goal of parent satisfaction and partnering in decision-making. Due to fiscal constraints, the Quality Assurance/Quality Improvement Coordinator position was eliminated. Therefore, activities toward the development and utilization of a family/client satisfaction survey are not being pursued at this time, but may be resumed by the State Coordinator for Professional Services in the future.//2005//

c. Plan for the Coming Year

/2005/Enabling:

Family/professional collaboration in program and policy activities will be facilitated through support of families for CRS State/local parent advisory committees, training activities, publication of a newsletter, and employment of at least 1 Parent Consultant in each office. The utilization of the parent-to-parent list serve will increase as evidenced by at least a 10% annual increase in the number of monthly postings. CRS will have parents of CYSHCN as co-presenters at all staff and community trainings. CRS will publish a Family Guide to assist families in understanding the CRS Program and making informed choices regarding services, as well as develop and provide training on utilizing the Family Guide.

Infrastructure-building:

During FY 2005, CRS will work with its partners and stakeholders to implement a State plan to ensure that by 2010 families of CYSHCN will partner in decision-making at all levels and will be satisfied with the services they receive. CRS will support, financially and philosophically, the growth of Family Voices within the State through the provision of leadership, the dissemination of information, and the continued utilization and analysis of data gathered through the CRS/Family Voices database. Additionally, CRS will partner with families to insure that the principles of family-centered care will be incorporated into an enhanced Care Coordination Program and that families will be active participants in the development of the training process and related

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

a. Last Year's Accomplishments

MCH Population Served: CSHCN

/2005/Using data from the Summary Tables from the National CSHCN Survey, 2001 (DHHS, April 28, 2003), 53.9% of CSHCN have a medical home in Alabama as compared with 52.6% of CSHCN nationally. Regarding a usual source of care, 93.2% of the Alabama families reported having one as compared to 90.5% of families nationally. Within the CRS Program, 98.5% (14,373) of the enrollees reported in FY 2003 that they had a usual source of care as compared to 97.4% in FY 2001 and 98% in FY 2002. This indicator has shown great improvement from its baseline of 62%, established in FY 1996, the 1st year for which complete data were available.

Activities/Accomplishments in FY 2003 follow.

Enabling:

CRS staff continues to identify community-based primary care physicians willing to accept CYSHCN 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. Medicaid now includes a roster of available primary care providers by county as a link from their web page. The 60.9% of CRS enrollees with Medicaid coverage were provided a medical home through the Patient 1st Program, according to programmatic procedures. However, with the expiration of Patient 1st, CRS will be closely assessing the impact on medical home provision in the coming year. CRS works closely with Medicaid providers to receive appropriate referrals for these children to facilitate comprehensive EPSDT services.

Population-based:

CRS exhibited at the annual meeting of the Alabama Chapter of AAP. One physician newsletter, "MD Connect," was published in August and mailed to all physicians listed as primary care providers through Medicaid and all State pediatricians.

Infrastructure-building:

The CRS Medical Advisory Committee, including primary care physicians and specialists across the State, met in Mobile in mid-October 2002. Meeting topics included local CRS clinic issues and birth defects prevention.

CRS provided grant funding to a private pediatrician who received a Community Access to Child Health (CATCH) grant in FY 2001 to continue its activities for another year; however, this activity is now completed. Positive collaboration occurred between CRS and this local pediatrician for coordination of services for CYSHCN and families./2005//

b. Current Activities

/2005/Population-based:

Medical home information was mailed to CRS courtesy staff physicians and a newsletter article is being developed. The Family Voices fact sheet related to medical home was

included in the fall edition of the CRS Parent Connection. CRS continues to collaborate with SCHIP to establish a protocol to include information about medical home and the CRS program, for families who indicate when applying that they have a child with special health care needs.

Infrastructure-building:

CRS partnered with the Alabama Chapter of AAP and the UAB School of Public Health in Birmingham to plan and compose a grant submission for statewide implementation of medical home for CYSHCN. However, federal funding was rescinded due to budget constraints. CRS continues to facilitate and support a workgroup addressing activities and planning to meet the 2010 objective of medical home provision for CYSHCN. Further, CRS collaborated with colleagues through the medical home 2010 task force to bring a medical home training session to the State. A training was provided by a mentor physician and family representative at the winter meeting of the Alabama Chapter of AAP. Medicaid is developing continuing medical educational materials on medical homes, to be distributed in CD-ROM (Compact Disc-Read Only Memory) format to Medicaid's primary care providers in the spring of 2004. CRS was invited to contribute to this information and is listed among the reference materials as a resource for CYSHCN.//2005//

c. Plan for the Coming Year

/2005/Enabling:

CRS staff will continue to meet with new community medical providers to identify primary care physicians willing to accept CYSHCN as patients. CRS will continue to recruit physicians to become CRS courtesy physicians in order to provide more comprehensive, streamlined access to related services. Partnerships between CRS and these courtesy physicians will be enhanced through the provision of ongoing educational and agency-related public-policy awareness materials. Families of CSHCN without medical homes will continue to be assisted at the local level with linkage to appropriate, community-based primary care providers.

Population-based:

The exchange of information will be enhanced among CRS, its medical staff, and Alabama primary care physicians, including medical home providers, by the publication of at least 1 physician newsletter. CRS will develop a plan to share client-specific service plan information with medical home physicians.

Infrastructure-building:

In FY 2005 CRS will work with its partners and stakeholders to implement a State plan to ensure that by 2010 all CSHCN will receive ongoing comprehensive care through a medical home. CRS will also work with its partners and stakeholders to implement a State plan to ensure that by 2010 all children will be screened early and continuously for special health care needs. Further, CRS will partner with Medicaid to continue promoting the inclusion of the medical home concept into their revised model for Primary Case Management.//2005//

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

a. Last Year's Accomplishments

MCH Population Served: CSHCN

/2005/Using data from the Summary Tables from the National CSHCN Survey, 2001 (DHHS, April 28, 2003), 59.7% of families with CSHCN age 0-18 years in Alabama have adequate private and/or public insurance to pay for the services they need, as compared with 59.6% of families with CSHCN nationally. The percentage of CRS enrollees with 3rd party coverage increased from 81.5% in FY 2002 to 83.2% in FY 2003. This figure, however, continues to lag behind a high of 84.4% in FY 2000. The number of uninsured children in the program has declined by 37% from the 1st reporting period, from 3,885 in FY 1997 to 2,446 in FY 2003, and represents an 8.5% decline compared to FY 2002 (2,673). Due to CRS's safety net provider role and recent uncertainty regarding the general economy and the State's budget, it is anticipated that more uninsured children may be enrolled in CRS.

FY 2003 activities included the following.

Direct:

CRS continued to participate as an ALL Kids Plus provider through Alabama's SCHIP, ALL Kids. The Plus package enhances the ALL Kids benefit package for CYSHCN receiving services through a State-funded entity. Additional services provided in FY 2003 included analog and digital hearing aids, audiology services, therapy visits beyond the scope of the usual benefit package, and orthodontia, for which CRS receives additional reimbursement from ALL Kids. For FY 2003, CRS received \$59,340.81 from ALL Kids for basic covered benefits and the enhanced Plus services.

Enabling:

CRS continued to identify children at enrollment with no health insurance who may have been eligible for Medicaid, SCHIP, or SSI, and assisted with the application process. CRS actively monitored children with ALL Kids coverage to assist them with annual re-enrollment and paid the annual premium for 1 family upon request. There were about 316 CRS enrollees with ALL Kids coverage in FY 2003. Additionally, CRS paid premiums for 12 clients whose families were unable to afford the premiums for insurance coverage accessible through employment, Consolidated Omnibus Budget Reconciliation Act (COBRA), or the Alabama Health Insurance Plan.

Infrastructure-building:

CRS has successfully collaborated with ALL Kids to create ALL Kids Plus, an enhanced service package for CYSHCN, and continues to advocate for the incorporation of additional covered services for CYSHCN in the basic ALL Kids benefit package as well as for recognition of all 16 Alabama EIS services as Plus-covered services. CRS staff attended regional ALL Kids training and provided quarterly updates to staff.

CRS has collaborated with ADPH on IDEA, a grant-funded project designed to advocate for adequate/improved insurance coverage for CYSHCN (discussed in Section III.A). Pilot recommendations will be implemented.

CRS continues to facilitate a workgroup to ensure that by 2010 all families of CYSHCN will have adequate insurance to pay for services they need.//2005//

b. Current Activities

/2005/Direct:

Work on coverage for Early Intervention services through ALL Kids Plus continues, as does advocacy for the inclusion of enhanced coverage for CYSHCN through the basic ALL Kids package.

Enabling:

CRS continues to pay health insurance premiums for families who are unable to afford them. Given recent uncertainty regarding the State's general economy and the State's fiscal situation, it is anticipated that additional requests for this service may be forthcoming. Additionally, for the 1st time, SCHIP has implemented a waiting list and has increased co-pays and family contributions due to the State's fiscal constraints. It is possible that, due to this development, additional families of CYSHCN will report a lack of insurance coverage and require CRS safety net coverage. (Editor's note: As discussed in a 2005 update to Section III.A, as of late June 2004, SCHIP has opened the waiting list and is enrolling eligible applicants without delay.)

Infrastructure-building:

Through the State Policy Specialist and Computer Information Systems, CRS has trained all staff members on HIPAA regulations and visits were made to all local ADRS offices to ensure HIPAA compliance. Privacy notices are provided to all active clients and families and are posted in all field offices/clinics.

As previously stated, CRS has partnered with ADPH on IDEA, to advocate for adequate/improved insurance coverage for CYSHCN who are under-insured, uninsured, or unstably insured. This grant initiative, which includes key stakeholders from many public- and private-sector organizations, has the overarching goal of improving the insurance status of all Alabamians to ensure access to health care. Collaborations are underway to pilot a strategy developed during the planning phase of this grant.

CRS has initiated a pharmacy review effort to develop a plan for better utilization of Title V funds to meet the rising cost of prescription drugs for CYSHCN in the program. Another initiative explores options to increase the cost-effectiveness and efficiency of the CRS Diaper Program. This program covers part of the cost of diapers for eligible CRS enrollees, when the diapers are purchased through authorized vendors.

Modifications and updates continue to the CRS information management system to facilitate data collection and enhance 3rd party reimbursements for services provided to CYSHCN.

Two staff members sit on a Task Force of Medicaid as a new waiver for PCCM is drafted. These members serve as advocates and key informants on unique needs and service coverage requirements of CYSHCN.

Training on enhanced services and beneficial programs provided to CYSHCN through CRS was provided to staff from the 16 EIS programs for which the agency is the fiscal agent.

Support continues for the implementation of activities of the workgroup addressing the 2010 objective of adequate insurance coverage for families of CYSHCN to pay for needed services.//2005//

c. Plan for the Coming Year

/2005/Direct:

CRS will continue to be an ALL Kids Plus provider to enhance the ALL Kids benefit package for Alabama's CYSHCN who are eligible for the CRS Program.

Enabling:

During FY 2005, 100% of CYSHCN enrolled with CRS who have no health insurance will be referred for SSI, Medicaid, or ALL Kids consideration and will receive assistance with

the application. One hundred percent of the CRS clients for whom it would be appropriate for CRS to pay for insurance premiums will be identified and afforded this service.

Population-based:

The grant-funded IDEA Project administered by ADPH--designed to address insurance coverage for all Alabamians who are under-insured, uninsured, or unstably insured--has completed its funding cycle and will begin a pilot strategy to address these issues. CRS will continue to collaborate with ADPH to advocate for the inclusion of the special service needs and coverage requirements of CYSHCN.

Infrastructure-building:

In FY 2005 CRS will work with its partners and stakeholders to implement a State plan to ensure that by 2010 all families of CYSHCN will have adequate public and/or private insurance to pay for the services they need. CRS will continue to collaborate with ADPH to support expanded services for CYSHCN to be provided through ALL Kids Plus and the basic ALL Kids plan. CRS will collaborate with ALL Kids and the Alabama EIS in the development of a Plus benefit package that includes all mandated early intervention services and a functional billing system. CRS will continue implementation of its work plan to address client privacy, security, and transaction issues mandated by HIPAA and will develop a plan to provide ongoing training related to HIPAA requirements to current and new staff members. CRS will modify and update an information management system that will facilitate 3rd party billing and data collection.//2005//

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

a. Last Year's Accomplishments

MCH Population Served: CSHCN

//2005/Using data from the Summary Tables from the National CSHCN Survey, 2001 (DHHS, April 28, 2003), 73.7% of Alabama families with CSHCN age 0-18 years reported the community-based service systems are organized so they can use them easily, compared with 74.3% of such families nationally.

FY 2003 activities included the following.

Direct:

In FY 2003 CRS provided 14,189 clinic visits, responded to 8,471 requests for information and referral, and furnished 69,601 encounters by physicians, dentists, and CRS staff. CRS served 23,633 children, slightly more than the 23,051 children served in FY 2002. Of these, 380 were CYSHCN with TBI.

CRS continued to upgrade its facilities and expand access to specialized services. The Jackson District Office was renovated and remodeling began on the Dothan District Office. Audiology was added in the Gadsden District, with new equipment purchased for the Gadsden and Selma District Offices. A physical therapist was hired as a new discipline in the Tuscaloosa District Office and a 2nd physical therapist was hired in the Mobile District Office.

Several new clinic initiatives began in FY 2003. Seating and Positioning Clinics began in the Huntsville, Montgomery, and Anniston Districts. Neuromotor Clinic, staffed by a

Birmingham pediatric physiatrist, began in the Mobile District. Medication administration is offered, including monitoring/refilling intrathecal baclofen pumps and giving intramuscular botox injections. Direct involvement in these clinical procedures is new for CRS. Through its work on the Alabama Arthritis Prevention and Treatment Coalition, CRS recruited a rheumatologist to the Mobile Juvenile Rheumatoid Arthritis Clinic. The clinic has resumed after several years of shortage of rheumatologists willing to see pediatric patients.

Population-based:

CRS staff made presentations at 20 of the 21 State SSA offices, increasing SSA staff's awareness of CRS services to facilitate referrals and enhance usability of the system for families. Local contacts were made with all children newly awarded SSI within the State to offer assistance with service needs.

Infrastructure-building:

CRS continued to provide funding to 4 multidisciplinary specialty service centers in the State. The medical genetics programs at UAB and University of South Alabama (USA) provided services to CYSHCN in satellite clinics at local CRS offices and on-site. In FY 2003 USA held 25 clinics and UAB held 11. Sparks Clinics and Monsky Developmental Clinics (Birmingham and Montgomery) were funded to provide multidisciplinary developmental evaluations for CYSHCN. In FY 2003 Sparks Clinics served 2,423 CYSHCN under 21 years, including 1,184 new clients. Ninety-six CYSHCN were referred by CRS for interdisciplinary services at Sparks Clinics, a 33% increase over FY 2002.

CRS continued partnership with NHSP, and developed procedures to report to ADPH on 2nd-level hearing screening activities for newborns.//2005//

b. Current Activities

/2005/Direct:

As part of the overall implementation of its new HIPAA-compliant billing software, CRS developed a new form that is utilized during each clinic visit to provide the clinic physician with a comprehensive picture of the client's medical history and current health status.

Enabling:

CRS continues the development and implementation of a Medicaid targeted case management program to secure funding for case management services for children and youth with TBI who are not involved in the agency's Children's Specialty Clinic Program. Despite numerous setbacks related to computer software issues, the agency has persevered to make progress on this project.

Infrastructure-building:

CRS is partnering with Alabama's EIS to increase access to early intervention services for eligible infants and toddlers with disabilities through the provision of grant funding to community-based projects throughout the state. CRS sponsors 16 projects, which may serve up to 578 children each year.

CRS continues work on the development of its new data management system, the Children's Health and Resource Management System (CHARMS). The new system will allow the agency to have a single database, rather than the current distributed database, and will create over time an electronic medical record for each client that can be accessed by each CRS clinic site. The automated service plan and anticipatory guidance educational program in CHARMS will be enhancements to the agency's care coordination program.

CRS continues its active partnership with AMOD, Family Voices, and the Alabama Chapter of AAP to develop Alabama's 2010 Action Plan for CYSHCN to address the 6 new national performance measures for this population. The UAB School of Public Health continues to consult with CRS on this project. Six workgroups were convened during Summer 2003 to develop an action plan for each measure, and the consolidated State plan was disseminated at a joint meeting of all the workgroups held in Montgomery on November 12, 2003. The plan document is dynamic, evolving as the workgroups continue to meet, complete action steps, and envision new activities and strategies over the next several years.//2005//

c. Plan for the Coming Year

/2005/Direct:

In FY 2005 at least 23,000 CYSHCN, including SSI recipients, will receive information and referral services, health and rehabilitative services, care coordination services, and enabling services arranged through local CRS offices, including assistance with referrals/applications to other agencies. CRS will also work cooperatively with other public and private agencies in Alabama, including the SSA's Disability Determination Unit, to ensure access to appropriate diagnostic procedures and intervention services for all children identified with hearing impairments through universal newborn hearing screening.

Enabling:

CRS will implement a targeted case management program to create additional funding for eligible children and youth with TBI who are also Medicaid recipients.

Population-based:

A CRS representative will present every SSA office in Alabama with information about rehabilitation services, including care coordination, available to CYSHCN through CRS. A CRS representative will provide information to the regional perinatal high-risk follow-up programs about services available to CYSHCN through CRS.

Infrastructure-building:

During FY 2005, CRS will work with its partners and stakeholders to implement a State plan to ensure that by 2010 community-based service systems will be organized so that families can use them easily. CRS will support the Alabama EIS by increasing access to early intervention services for eligible infants and toddlers with special health care needs by the provision of grant funding to community-based projects throughout the State. CRS will implement a new management and information system to support care coordination and to build an electronic record for clients served. CRS will also complete the development of an enhanced Care Coordination Program and provide training to staff, youth, and families on the new system.//2005//

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

a. Last Year's Accomplishments

MCH Population Served: CSHCN

/2005/Using data from Summary Tables from the National CSHCN Survey, 2001 (DHHS, April 28, 2003), 5.8% of youth with special health care needs nationally received the services necessary to make transitions to all aspects of adult life. Alabama rates for this

measure were deemed unreliable by the National Center for Health Statistics.

Activities in FY 2003 included the following.

Direct:

CRS staff worked individually with CRS youth turning 21 years of age to ensure linkage with adult health care providers and community service systems. The referral system between CRS and AVRS has been problematic as the age-specific referral point is arbitrary and not responsive to the individual needs of youth and families. Staff training and the development of enhanced referral procedures is ongoing. See discussions below.

Enabling:

YAC continued to advise CRS on policy related to services for youth, inform CRS on the needs of youth, and promote development of a service system that facilitates transition to all aspects of adult life. A meeting was held in November 2002 and a retreat was held in August 2003. Members of YAC include CRS youth who participated in leadership training through the Alabama Governor's Youth Leadership Forum, which CRS supports annually.

The CRS Youth Consultant continued to serve in an advisory capacity to CRS on issues affecting youth with disabilities. The Youth Consultant provides leadership to the YAC, provides articles and information specific to youth for the Youth News insert in each edition of the CRS Parent Connection, and supports and participates in the national board of Kids As Self Advocates (KASA, a Family Voices project).

The ADRS website continues featuring a link to information related to the Youth Connection Program.

For FY 2003, 595 CRS youth turned 16 years of age. Of these, 14.5% became AVRS clients.

Population-based:

The CRS Youth Consultant and 4 YAC members presented at Alabama's Transition Conference and co-presented with the State Adolescent Coordinator and the SPC at the International Family Centered Care Conference.

Infrastructure-building:

The CRS State Adolescent Coordinator and State Youth Consultant collaborated on several grants to provide input into development of materials for youth with special health care needs. Efforts to develop materials and trainings related to successful transitions remain under the purview of the CRS State Adolescent Coordinator and the AVRS State Transition Coordinator. However, further training and program development on this topic will be accomplished through the CRS/AVRS Steering Committee, the ADRS State Transition Team, and the workgroup addressing the 2010 objective on transition. Youth have been supported in participation on 2010 workgroup activities.//2005//

b. Current Activities

/2005/Direct:

CRS's Teen Transition Clinic has been expanded to an additional site, Mobile. Along with the clinic in Birmingham, the Mobile clinic provides a setting for transition planning.

Enabling:

YAC continues to play an integral role in providing input to CRS on specific issues related to youth with special health care needs. YAC held a meeting in January 2004 in which 4 new members were present and training was provided on resume-building. CRS continues to support the Alabama Governor's Youth Leadership Forum, including participation by the State Adolescent Coordinator and the CRS Youth Consultant in the Forum and on the steering committee.

Population-based:

Youth have been identified who are willing to be co-presenters as needed for staff and community trainings. The CRS Youth Consultant co-presented with the CRS Occupational Therapy Program Specialist in a statewide staff videoconference.

Infrastructure-building:

The CRS State Adolescent Coordinator and the AVRS State Transition Coordinator have established a State Transition Team and continue to lead efforts to identify obstacles and challenges in the referral and transition process as well as to develop plans to address these issues. In an effort to strengthen the ADRS continuum of services by increasing the number of youth with special health care needs receiving services from CRS that are referred to, determined eligible for, and successfully placed into employment by AVRS, the Transition Team visited each CRS and AVRS office in the State. Information was solicited regarding the strengths and weaknesses of the referral system presently in place. In addition to this discussion, surveys were completed by staff to identify perceived needs and barriers. A steering committee has been developed and workgroups will be organized around the identified weaknesses.

The CRS Youth Consultant was selected to serve on the National KASA Board. Her efforts related to this prestigious honor will be supported by CRS.

The Adolescent Coordinator and the Youth Consultant participate in ongoing efforts of a workgroup to develop an enhanced Care Coordination Program. Anticipatory guidance and exit plans will be included as part of the program.

CRS continues to collaborate with the Children's Advisory Council for the MHMR, the ADRS Deaf Services Transition Committee, the MCH-UAB grant (the Leadership Education in Adolescent Health [LEAH] and Leadership Education in Neurodevelopmental and Related Disabilities [LEND] programs), and with a Developmental Disabilities Council grant through Easter Seal Rehabilitation Services. This latter grant created a Personal Care Attendant Services task force and developed a handbook and CD training module on accessing and utilizing this service.

Members of YAC and the State Youth Consultant continue to participate in various 2010 workgroups, including the one specifically addressing the objective of successful youth transitions to all aspects of adult life.//2005//

c. Plan for the Coming Year

/2005/Direct:

In FY 2005 CRS will select at least 1 site for the expansion of Teen Transition Clinic. A manual will be developed on the operation of the clinic.

Enabling:

Youth/professional collaboration in program and policy activities will be facilitated in FY 2005 through the employment and support of a State Youth Consultant, support of youth on the CRS State YAC, involvement in the National KASA Board, training activities, and articles in the Parent Connection newsletter. Opportunities for participation in leadership

activities will be offered to youth with disabilities enrolled in the CRS Program. CRS will have youth with special health care needs as co-presenters at all staff and community training related to transition issues. Youth Advisory Committee activities will be increased to include conference calls and at least 2 face-to-face meetings. Trainings will be planned and implemented for youth on self-determination.

Infrastructure-building:

In FY 2005 CRS will work with its partners and stakeholders to implement a State plan to ensure that by 2010 all youth with special health care needs will receive the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence. Additionally, youth will be supported in participation in planning and activities related to the 5-year needs assessment, including a Youth Forum and a Youth Survey. CRS will continue collaboration with AVRS and the CRS/AVRS Steering Committee to develop transition training and resources for staff.//2005//

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

a. Last Year's Accomplishments

MCH Populations Served: Pregnant Women, Mothers, and Infants; Children

/2005/Status and trends: See attachment.//2005//

FY 2001 activities follow.

Direct:

CHDs immunized infants and children seen in clinics.

Enabling:

Reminders to parents and follow-up for hepatitis B occurred as described in the 2005 update.

Infrastructure-building:

The Immunization Division continued work on an immunization registry, to make childhood vaccine histories available to all the State's vaccine providers. Enhanced user interface screens and reports were developed, and many federally qualified health centers (FQHCs) in Alabama are using the system, known as IMMPrint (Immunization Provider Registry with Internet Technology). ADPH provided immunization education and vaccine-completion-level audits in FQHCs and private physician offices; provided satellite down-link sites for programs presented by CDC; and administered the Vaccines for Children (VFC) Program for the State. In FY 2001 there were 525 public and private providers of VFC vaccine in the State.

/2004/FY 2001 activities basically continued in FY 2002. Additionally, the Division began developing enrollment and training activities in cooperation with BCBS and with Medicaid.//2004//

/2005/Previous activities basically continued in FY 2003. Recaps and updates follow.

Direct:

CHDs immunized infants and children seen in clinics.

Enabling:

ADPH sent postcards to parents of 11-month-old CHD patients to remind them of

vaccines that will become due after the 1st birthday. The Department tracked all infants known to be born to mothers with chronic hepatitis B, as well as household and sexual contacts of the mothers.

Population-based:

The Immunization Division sent vaccine pamphlets to parents of all 4-month-old infants born in the State to remind them of the importance of vaccines.

Infrastructure-building:

Via PHALCON, educational materials required for the Immunization Program were made available in English and Spanish for on-site printing by CHDs. Making these and other materials (mentioned under SPM #2) available in this way has decreased storage needs at the central-office and county levels.

In FY 2003 the Immunization Division retooled a computer program, run from IMMPrint, to identify CHD Child Health patients who are 4 months of age or older and have not been vaccinated. CHDs are then to track this group of children, who are considered to be least likely to complete the vaccine series. In June 2003 immunization records in IMMPrint were linked directly to PHALCON, allowing staff to access patient vaccination history, including vaccines provided through the private sector.

ADPH continued providing immunization audits and satellite down-link sites, administering VFC, and collaborating with BCBS and with Medicaid. The Immunization Division provided vaccine and support for 543 public and private VFC providers.//2005//

b. Current Activities

/2005/Basically, all FY 2003 activities are ongoing in FY 2004. The Immunization Division now provides vaccine and support for 540 public and private VFC providers.//2005//

c. Plan for the Coming Year

/2005/FY 2003 and 2004 activities, recapped below, will basically continue in FY 2005.

Direct:

CHDs will continue providing immunizations to infants and children seen in clinics.

Enabling:

The Immunization Division will continue sending reminders to parents regarding immunizations that are due and the importance of vaccines.

Infrastructure-building:

The Immunization Division will continue maintaining IMMPrint; providing immunization education and vaccine-completion-level audits; providing satellite down-link sites for programs presented by CDC; administering the State's VFC Program; and collaborating with BCBS and Medicaid.//2005//

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

a. Last Year's Accomplishments

MCH Population Served: Children

/2005/Status and trends: See attachment.//2005//

/2004/Cross-cutting:

By FY 2002, most of the Bureau's non-clinical adolescent-pregnancy-prevention activities were occurring under 1 of the following programs: 1) the Alabama Unwed Pregnancy Prevention Program (AUPPP), 2) the Alabama Abstinence-Only Education Program (AAEP), and 3) the Alabama Community-Based Abstinence-Only Education Program (ACAEP, begun in FY 2002).//2004//

/2005/The above non-clinical programs for preventing adolescent pregnancy continued through FY 2003. Selected updates follow.

Direct:

CHD family planning clinics served 29,524 persons under 20 years of age in FY 2003 (down from 31,415 in FY 2002). ADPH continued providing Depo-Provera for CHD family planning clinics.

Enabling:

The Bureau and DHR continued partnering to provide the Family Planning Teen Care Coordination Program, which offered care coordination for all teens in CHD family planning clinics who were 18 years of age or younger and not eligible for the Plan First Program.

Population-based:

Under AUPPP, public service announcements on prevention of adolescent pregnancy were provided. AUPPP continued operating a toll-free hotline for parents and teens about pregnancy prevention and other health issues, distributing pamphlets about unwed pregnancy, and distributing the publication "Births to Unwed Mothers in Alabama" (collaboratively prepared in FY 2002) to legislators, educators, counselors, teachers, and others.

Abstinence-based sex education classes were conducted in selected local school systems by Teen Family Planning Care Coordinators.

AAEP continued its statewide media campaign targeting adolescents to promote abstinence-only until marriage.

Infrastructure-building:

AUPPP continued funding for 30 unwed pregnancy prevention projects (up from 26 originally, down from 36 in FY 2002). An economic impact study funded through AUPPP was completed. The Director of AUPPP continued collaborating with external groups and providing technical support as feasible.

In FY 2003, due to several U.S. Congressional continuing resolutions to extend funding through September 2003, AAEP continued funding for 10 projects, down from 13 in FY 2002. Of the 10 AAEP grants, 9 were to community-based agencies/organizations and 1 to a city/county school system. These projects provided abstinence-only education to about 35,000 participants aged 10-18 years in 34 of Alabama's 67 counties. AAEP continued its longitudinal evaluation component.

ACAEP's 12 community-based projects conducted Adult/Peer Mentor Leadership Training in 12 locations. These trainings were mainly for adult role models and adolescents aged 12-18 years. Additionally, ACAEP provided abstinence-only education for adult role models and adolescents aged 12-18 years in 48 cities/communities around the State. Data collection to monitor ACAEP's progress toward achieving objectives continued.//2005//

b. Current Activities

/2005/Crosscutting:

Two major programs designed to address adolescent pregnancy are being phased out in FY 2004. As discussed under SPM #6, AUPPP and activities conducted under that program are being phased out in FY 2004. The timeframe for discontinuation of specific AUPPP activities is discussed under SPM #6. Additionally, the Family Planning Teen Care Coordination Program is being phased out in FY 2004. The direct reason for phasing out these programs is that DHR funds that had been provided to ADPH for these programs are now being reserved by the Bureau for purchase of Depo-Provera. The context for the decision to reserve these funds is discussed in Section III.B.

In FY 2004 the U.S. Congress did not reauthorize abstinence education funding for AAEP. However, a U.S. Congressional continuing resolution extended funding through June 30, 2004. Subsequent funding for AAEP is contingent upon a U.S. Congressional continuing resolution extending funding through September 2004.

In FY 2004, 6 ACAEP community-based projects were funded to monitor and document the activities of adults certified to: 1) teach abstinence-only education; collect, compile, and submit pre-tests and post-tests for use in assessing progress toward program goals; and continue providing abstinence-only education, mainly for adult role models and adolescents aged 12-18 years in 48 cities/communities. As part of this program, a statewide media campaign targeting adolescents to promote abstinence-only until marriage continued, as well as advertisement of project activities. ACAEP's federal funding to provide abstinence-only education for FYs 2002-04 ends on June 30, 2004. The Bureau submitted a competitive application in February 2004 for grant funds for FYs 2005-07 to provide abstinence-only education mainly for adult role models, as well as adolescents aged 12-18 years.

Direct:

CHD family planning clinics continue serving teens and providing Depo-Provera.//2005//

c. Plan for the Coming Year

/2005/Crosscutting:

As mentioned under "Current Activities," AUPPP and the Family Planning Teen Care Coordination Program will no longer be operating in FY 2005.

If Congress reauthorizes abstinence education in FY 2005, AAEP will submit an application for funds to continue being channeled to 9 projects--8 to community-based organizations and 1 to a city/county school system.

ACAEP will continue if the application described under "Current Activities" is approved and funded.

Direct:

CHD family planning clinics will continue serving teens and providing Depo-Provera.//2005//

on at least one permanent molar tooth.

a. Last Year's Accomplishments

MCH Population Served: Children

//2005/Status and trends: See attachment.//2005//

FY 2001 activities included the following.

Direct:

Through CHD dental clinic programs and 2 school-based dental clinics, well over 40,000 protective dental sealants were applied to children's permanent teeth.

Population-based:

OHB distributed educational materials about sealants through schools, health fairs, CHDs, community health centers, dental clinics, and other entities.

Infrastructure-building:

As elaborated on in the 2005 update, OHB made certain dental-related materials, supplies, and equipment available to selected entities. With respect to research, anecdotal reports from hospital staff indicated that notable numbers of uninsured children and adults present at emergency rooms with urgent dental needs.

//2004/FY 2001 activities basically continued in FY 2002. Updates follow.

Direct:

Dental sealants were provided to 29,052 children in Jefferson, Tuscaloosa, and Coffee CHDs.

Infrastructure-building:

Planning and sampling for the direct-observation, oral health survey of pre-kindergarten and selected kindergarten through 12th grade students for dental sealants continued. Per these plans, a dental team from OHB, the School of Dentistry, CHD dental staff, and volunteer dentists from throughout the State were to implement the survey. Technical assistance was to be provided at no charge by the Association of State and Territorial Dental Directors.***//2004//***

//2005/FY 2003 activities included the following.

Direct:

Staff in 4 CHD or FQHC dental clinic programs and 2 school-based clinics applied dental sealants to the permanent teeth of 27,669 children.

Population-based:

During National Children's Dental Health Month, the Bureau began what is to be an annual media focus including a statewide press release, with dental sealants being part of each media message.

OHB continued distributing educational materials about dental sealants through schools, health fairs, CHDs, community health centers, dental clinics, and other entities.

Infrastructure-building:

OHB continued donating disposable sealant supplies, instruments, and small equipment for school-based dental clinics that provide services for qualifying children on free and reduced lunch programs; and maintained availability of portable dental equipment for CHD dental staff and private dental teams to implement community-based sealant projects.

The above mentioned direct-observation oral health survey was conducted in 25 public schools, on a representative sample of Alabama public school children. In this survey, 1,692 3rd grade children were screened.

The Bureau began collaborative efforts with national and state dental associations to provide free dental care, including sealants, in the "Give Kids a Smile" national campaign. Additionally, the Bureau renewed efforts to promote provision of more comprehensive instruction on dental sealant placement as part of the training of dental hygiene students.//2005//

b. Current Activities

/2005/With the exception of the direct-observation survey of oral health in public school students, which will not be repeated until around FY 2006, activities described for FY 2003 are basically ongoing. Additionally, direct-observation assessment of oral health in school children in selected areas of the State occurs on an ongoing basis.//2005//

c. Plan for the Coming Year

/2005/Except for the statewide direct-observation survey of oral health in a representative sample of Alabama public school children, FYs 2003-04 activities will basically continue in FY 2005. Recaps follow.

Direct:

Several CHD, FQHC, or school-based dental clinics will continue applying dental sealants.

Population-based:

The Bureau will continue promoting an annual media focus on oral health, including the need for dental sealants. As well, OHB will continue distributing educational materials about dental sealants through various entities.

Infrastructure-building:

Direct-observation assessment of oral health in school children in selected areas of the State will continue. However, as previously stated, the statewide direct-observation survey of oral health in school children will not be repeated until FY 2006.

OHB will continue collaborative participation in the "Give Kids a Smile" national campaign. Additionally, OHB will continue seeking to assure that more comprehensive instruction on dental sealant placement will be provided to dental hygiene students.

As described under "Current Activities," OHB will continue donating or loaning certain dental supplies and equipment as feasible.//2005//

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

a. Last Year's Accomplishments

MCH Population Served: Children

/2005/Status and trends: See attachment.//2005//

FY 2001 activities, which provide a backdrop for FYs 2002 and 2003, included the following.

Infrastructure-building:

FY 2000 review of child deaths from motor vehicle crashes by the Local Child Death Review Teams identified the 1st year driver to be at higher risk for a fatal traffic accident. Any 1 variable, such as rain, darkness, drinking, horseplay etc., added to their driving inexperience, was found in cases reviewed. These findings led to introduction of legislation calling for graduated vehicle licensure, though the legislation did not initially pass. Regarding another issue related to motor vehicle crash deaths--use of passenger safety restraints--HPCD's Injury Prevention Division conducted the 2001 Alabama Observational Survey of Occupant Restraint Use. This annual survey follows guidelines created by the National Highway Traffic Safety Administration, and 345 sites were surveyed. Of the 40,611 individuals observed, 79.4% were using seatbelts. This seatbelt usage rate exceeded the national average and was the highest that had been achieved in Alabama. A presumed reason for the increased usage is that the survey was conducted within 2 weeks following Alabama's "Click-It-or-Ticket" campaign.

/2004/Infrastructure-building:

The Alabama Graduated Driver's License Bill was reintroduced, passed by both State legislatures, and signed by the Governor in September 2002. In FY 2002 the Alabama Observational Survey of Occupant and Child Restraint Use was conducted, with 54,977 front seat occupants and 2,190 children 5 years of age and younger being surveyed. Findings were that 78.7% of front seat occupants and 89.4% of children were in restraints.//2004//

/2005/Infrastructure-building:

In FY 2003 ADRS continued reviewing child deaths per the mandating legislation, described in Section III.B. In FY 2003, in their 2nd set of recommendations to the Governor, ACDRS recommended that increased attention be given to safety concerns regarding operation of all-terrain vehicles by children and the transport of children on public roads in pickup truck beds. Additionally, ACDRS supported proposed legislation that would require children and youth up to the age of 16 years to use approved safety restraints regardless of seat position.

The Graduated Driver's License legislation, mentioned above and described in the 2004 update to "Current Activities," took effect in October 2002.

In FY 2003 HPCD again conducted the Alabama Observational Survey of Occupant and Child Restraint Use, with 52,489 front seat occupants and 2,523 children 5 years of age and younger being surveyed. Findings were that 77.4% of front seat occupants and 86.5% of children were in restraints. These usage rates are slightly below, though within 4% of, corresponding FY 2002 usage rates. The national usage rate for 2003 is not available.//2005//

b. Current Activities

/2004/Infrastructure-building:

The Graduated Driver's License legislation took effect in October 2002. For licenses issued on or after that date, restrictions apply to 16-year-old drivers and to 17-year-old drivers who have been licensed for less than 6 months. Under the legislation, restricted drivers cannot have more than 4 passengers, not counting their parents, in the car. Additionally, except under certain circumstances, they cannot drive between midnight and 6 A.M. unless accompanied by a parent, guardian or, with the consent of the parent/guardian, a licensed adult driver. The circumstances in which they do not need to have a parent/guardian or licensed adult designee of the parent/guardian with them are when the teenager is driving to or from work or a school or church event or driving due to an emergency.//2004//

/2005/Infrastructure-building:

ACDRS continues monitoring infant and child deaths, including those caused by motor vehicle crashes. The Graduated Driver's License legislation remains in effect. To our knowledge, no action has been taken by the Governor or State Legislature pertaining to ACDRS's recommendations regarding operation of all-terrain vehicles by children and the transport of children on public roads in pickup truck beds. The previously mentioned legislation proposed in FY 2003 to require children and youth up to the age of 16 years to use approved safety restraints regardless of seat position has not passed. In FY 2004, in their 3rd set of recommendations to the Governor, ACDRS repeated recommendations regarding children and all-terrain vehicles, children in the rear of pickup trucks, and the need for improved auto safety restraint laws for vehicular passengers 16 years of age and younger.

HPCD's Injury Prevention Division continues conducting annual observational surveys of occupant restraint use.//2005//

c. Plan for the Coming Year

/2005/Infrastructure-building:

In FY 2005 ACDRS will continue reviewing child deaths per mandating legislation and following up on previously described recommendations to the Governor. HPCD's Injury Prevention Division will continue conducting annual observational surveys of occupant restraint use.//2005//

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

a. Last Year's Accomplishments

MCH Population Served: Pregnant Women, Mothers, Infants

/2005/Status and Trends: See attachment.//2005//

FY 2001 activities included the following.

Population-based:

A television ad promoting breastfeeding was aired.

Infrastructure-building:

WIC conducted the 2001 Hospital Breastfeeding Survey. Every Alabama hospital providing obstetrical services was surveyed; 47 returned the survey, for a response rate of 70%.

WIC 1) initiated the PHALCON Infant Breastfeeding Report; 2) helped the Alabama Breastfeeding Coalition plan a statewide breastfeeding conference to be held in 2002; 3) promoted Breastfeeding Awareness Month; and 4) distributed the "2002 Alabama Breastfeeding Resource Guide," an annual publication to facilitate networking among private- and public-sector health care professionals, to all WIC clinics and all Alabama hospitals providing obstetrical services.

In collaboration with CDC, CHS administered Alabama PRAMS, which collects information about breastfeeding.

/2004/FY 2002 activities included the following.

Population-based:

Via public relation and outreach efforts, WIC staff sought to increase public awareness of the importance of breastfeeding.

Infrastructure-building:

The previously mentioned statewide breastfeeding conference was held in March 2002. Additionally, 1) the WIC Breastfeeding Coordinator continued working closely with the Alabama Breastfeeding Coalition, of which she is a board member; 2) the "2003 Alabama Breastfeeding Resource Guide" was published; and 3) the Breastfeeding Coordinator provided training for WIC staff and offered breastfeeding education to staff from Alabama hospitals. With respect to the latter, 11 breastfeeding education presentations were made at CHDs or local hospitals, with staff from 19 hospitals attending 1 of the presentations. The PHALCON Infant Breastfeeding Report was revised to reflect all breastfed infants enrolled in Alabama WIC.//2004//

/2005/FY 2003 activities included the following.

Population-based:

WIC continued action to increase public awareness of the importance of breastfeeding. For instance, radio ads to promote breastfeeding, targeting working mothers and emphasizing family support, were aired statewide in Breastfeeding Awareness Month.

Infrastructure-building:

The WIC Breastfeeding Coordinator continued working closely with the Alabama Breastfeeding Coalition, which held the (now annual) statewide breastfeeding conference, and serving as a board member.

The Breastfeeding Coordinator continued training WIC staff and offering breastfeeding education to staff from Alabama hospitals. Eleven breastfeeding education presentations were made at CHDs or local hospitals, with staff from various hospitals and physicians' offices attending.

The PHALCON Infant Breastfeeding Report was generated quarterly and sent to PHA Nutrition Coordinators. The report lists breastfeeding incidence and duration rates for each clinic and PHA.

The annual Hospital Breastfeeding Survey was conducted.//2005//

b. Current Activities

/2005/Activities described for FY 2003 are basically ongoing in FY 2004. The annual statewide breastfeeding conference was held in March 2004.//2005//

c. Plan for the Coming Year

/2005/FYs 2003-04 activities will basically continue in FY 2005. Recaps follow.

Population-based:

The WIC Breastfeeding Coordinator will continue collaborating with external groups to promote public awareness about the importance of breastfeeding. For instance, she will participate in the National Breastfeeding Campaign, a 3-year project that is expected to begin by early FY 2005.

Infrastructure-building:

The WIC Breastfeeding Coordinator will continue collaborating with the Alabama Breastfeeding Coalition and providing breastfeeding education for WIC staff and, if

requested, hospital staff.

Convening of the annual statewide breastfeeding conference, implementation of the annual Hospital Breastfeeding Survey, and production of the quarterly PHALCON Infant Breastfeeding Report will continue.

CHS will continue implementing PRAMS.//2005//

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

a. Last Year's Accomplishments

MCH Population Served: Pregnant Women, Mothers, and Infants

//2005/Status and trends: See attachment.//2005//

Activities in FY 2001 included the following.

Cross-cutting:

ADPH continued contracting with the Alabama Ear Institute (AEI) to have on staff a Newborn Hearing Screening (NHS) Coordinator--who provided technical assistance to health care providers and coordinated family-oriented support programs like the Parent-2-Parent Network (P2P), formed in August 2000. P2P was established in each perinatal region and provided support to families who have children found to have hearing loss.

Infrastructure-building:

An NHS workgroup was formed to recommend guidelines for implementing universal NHS. It included representatives from organizations like AMOD, the Alabama Institute of Deaf and Blind, CRS, and AEI--as well as consumers--and established the NHS Advisory Board. ADPH provided equipment and supplies, totaling over \$600,000 in value, to 50 hospitals to either start or enhance NHS programs. Further, the Bureau and AEI jointly submitted a proposal that was funded in March 2001 by HRSA, through MCHB, to facilitate full implementation of a statewide universal NHS program. As part of the program, the Alabama Early Hearing Detection and Intervention Project was integrated with the NSP located in the Bureau. To coordinate data collection, an item pertaining to hearing screening was added to the Metabolic Collection Form.

//2004/FY 2002 activities included the following.

Infrastructure-building:

ADPH established the position of NHS Coordinator, which was filled for several months before the coordinator's resignation. The NHS Advisory Board formed subcommittees to address education, marketing, and reimbursement. By FY 2002 grants for equipment and supplies were being provided to 55 hospitals. As of February 2002, 59 of 60 hospitals with birthing facilities were participating in the State's Universal NHS Program. Additionally, CRS bought hearing screening equipment for each of their 7 districts, so that each district can provide follow-up screening and diagnostic services to newborns.//2004//

//2005/FY 2003 activities included the following.

Enabling/Infrastructure-Building:

In October 2002 ADPH began tracking hearing results for all newborns born in the State, using the Metabolic Collection Form, and 59 birthing facilities continued participating in the Universal NHS Program. The newly hired, in December 2002, NHS Coordinator

followed all newborns who either missed or did not pass their hearing screening, to assure that each newborn was tested and that those who tested positively received appropriate follow-up and intervention. In May 2003 the Bureau completed the "Qualified Provider Directory," a directory of audiologists qualified to perform NHS, and distributed it to all birthing hospitals. The NHS Advisory Board met in July 2003 to review the Universal NHS Program. The P2P family support group continued.//2005//

b. Current Activities

/2005/FY 2003 activities basically continue in FY 2004, with the addition of an EPSDT Care Coordination component. This addition and other updates follow.

Enabling:

For the 1st time, through collaboration between the NHS Program and the EPSDT Care Coordination Program (discussed under NPM #14 and SPMs #3-4), care coordinators are following infants who fail a newborn hearing screen test. The Bureau's NHS Coordinator refers newborns failing their 1st hospital screening test to Area Social Work Directors. These directors then refer the infants to county-level EPSDT Care Coordinators, who assure that the infant receives a 2nd hearing screening test. If the infant fails the 2nd test and that test was not performed by an audiologist, the EPSDT Care Coordinator refers the infant to an audiologist for further testing and obtains the results of the testing. If the infant is diagnosed as having hearing loss, the Care Coordinator refers him or her to CRS for early intervention to address the hearing impairment. Throughout the process, the EPSDT Care Coordinator electronically reports all findings and referrals to the NHS Coordinator.

Infrastructure-building:

All of the State's remaining 58 birthing facilities have universal NHS programs in place. The NHS Coordinator monitors the status of these programs and is available to offer assistance and training when necessary. The NHS Coordinator sends monthly hospital reports to all birthing hospitals to assist in program monitoring. This report includes the respective numbers for infants who were born, were screened, did not pass screening, passed screening, and were not screened. Each birthing hospital is provided with its individual results and with statewide results. The NHS Program is distributing the "Qualified Provider Directory" to all pediatricians in the State, so that pediatricians can identify appropriate entities to which children with diagnosed or suspected hearing loss can be referred.//2005//

c. Plan for the Coming Year

/2005/Services described for FYs 2003-04, recapped below, will basically continue in FY 2005.

Cross-cutting:

P2P, the support group for families of children found to have hearing loss, will continue.

Direct:

CRS district offices will continue providing follow-up hearing screening and diagnostic services to newborns.

Enabling:

The NHS Coordinator and EPSDT Care Coordinators will continue collaborating to assure that all live-born infants delivered in birthing hospitals are screened and receive appropriate follow-up and intervention.

Infrastructure-building:

The Bureau will continue contracting with AEI to have on staff a Universal NHS Coordinator. Under the Coordinator's leadership, the Bureau will continue collaborating with the NHS Board; tracking newborn hearing screens and follow-up; providing training on NHS; supporting (in the form of grants, supplies, and technical assistance as indicated and feasible) the 58 hospitals providing universal NHS; and providing monthly data reports to each of these hospitals.//2005//

Performance Measure 13: *Percent of children without health insurance.*

a. Last Year's Accomplishments

MCH Population Served: Children

/2005/Status and trends: See attachment.//2005//

/2004/FY 2002 activities follow.

Cross-cutting:

SCHIP's Regional Directors facilitated local efforts to enroll children. A Statewide Coordinator was hired to serve the Latino population.

Enabling:

Regional Directors and the Statewide Coordinator for Latino outreach liaised between ADPH central-office staff and families, and a social worker assisted the families. Applications and brochures were available in Spanish, and Spanish-speaking enrollment workers were generally available.

Population-based:

Combined applications for ALL Kids/SOBRA Medicaid were available from CHDs and other places, a toll-free number, and the ALL Kids website. School outreach continued.

Regionalization of SCHIP staff, increased marketing and outreach to providers, and statewide radio and television ads spurred enrollment to over 52,000 persons. SCHIP focused on outreach to daycare providers serving children from birth to age 5 years.

Infrastructure-building:

Medicaid placed a SOBRA Medicaid eligibility determination unit in the ALL Kids Enrollment Unit. These Medicaid staff process some applications that had traditionally been processed by SOBRA Medicaid workers around the State.

SCHIP received a 2-year Robert Wood Johnson Supporting Families After Welfare Reform (RWJ Welfare Reform Support) Grant for FYs 2003-04, designed to improve data flow between SCHIP and Medicaid. Working with a local technology consulting firm, SCHIP completed an initial assessment of the Medicaid and SCHIP eligibility and enrollment systems and developed an RWJ Welfare Reform Support Project 12-month plan. The plan focuses on aligning SOBRA Medicaid and SCHIP data systems so that application information and eligibility determination information can more easily be shared between the Medicaid and ALL Kids components of SCHIP. One major goal of this project is to develop a web application for use by SOBRA Medicaid, ALL Kids, and the Alabama Child Caring Foundation. The latter is a non-governmental, privately supported program for eligible persons under age 19 years who are not eligible for Medicaid or ALL Kids.//2004//

/2005/Unless stated otherwise, FY 2002 activities basically continued in FY 2003. Certain

updates follow.

Enabling:

In FY 2003, 78,554 persons were enrolled in SCHIP.

Population-based:

SCHIP increased outreach toward children from birth to age 5 years.

Infrastructure-building:

Due to incremental, federally mandated Medicaid coverage of persons from 6-19 years of age with household incomes below 100% of FPL, SCHIP ceased funding Medicaid enrollees.

As part of the RWJ Welfare Reform Support Project, SCHIP and Medicaid implemented the Automated Data Integration system, which greatly simplified referrals between the 2 entities and is estimated to have reduced FTE requirements by about 1.5 FTEs.

SCHIP began implementing a State Planning Grant, discussed under "Current Activities."/2005//

b. Current Activities

/2005/FY 2003 activities basically continue in FY 2004. Certain updates follow.

Population-based:

Through the 9 SCHIP Regional Coordinators, SCHIP continues to implement outreach targeted toward children from birth to 5 years of age. Because of anticipated fiscal constraints, in FY 2003 SCHIP developed plans for limiting enrollment and instituting a waiting list. As of May 2004, the waiting list has been opened 4 times and over 13,000 children have been enrolled in SCHIP from these lists. (Editor's Note: As discussed in Section III.A, as of late June 2004, SCHIP is aggressively conducting outreach and enrolling eligible applicants without delay.)

Infrastructure-building:

In FYs 2003 and 2004, SCHIP has been implementing a federal State Planning Grant, which identified the magnitude of Alabama's uninsured population along with their demographics. Further, under this grant, SCHIP researched possible health insurance plans that might reduce the prevalence of being uninsured. Analysis of data continues, and SCHIP will develop a communication strategy to inform the public about identified issues.

Implementation of the RWJ Welfare Reform Support Project continues. Under this project, in FY 2004 staff have developed and will pilot an Internet-based, joint application for SCHIP, SOBRA Medicaid, Medicaid for Low-Income Families, and the Alabama Caring Foundation. Funding for this project will end at the close of FY 2004.

SCHIP was granted another Robert Wood Johnson (RWJ) project, Covering Alabama Kids and Families. This project will build on previous work to support SCHIP and Medicaid programs by providing outreach to the public, coordinating enrollment, and simplifying the application process.

As mentioned under "Last Year's Accomplishments," Alabama children and youth from 6-19 years of age with household incomes below 100% of FPL are now covered by Medicaid. Accordingly, SCHIP no longer pays for Medicaid coverage, and ALL Kids is now the sole component of SCHIP. However, SCHIP and Medicaid continue to

collaborate as described for FY 2003./2005//

c. Plan for the Coming Year

/2005/Unless stated otherwise, SCHIP will basically continue FYs 2003-04 activities in FY 2005. To recap, certain plans for FY 2005 follow.

Cross-cutting:

SCHIP's 9 Regional Coordinators will continue facilitating local efforts to identify and enroll eligible children. Additionally, the Coordinators will engage in health education activities directed toward the SCHIP population, with the aim of improving health status and decreasing health expenditures.

The RWJ project, Covering Alabama Kids and Families (discussed under "Current Activities"), will continue.

Enabling:

SCHIP Regional Coordinators will continue serving as liaisons among ADPH central-office staff, health care providers, employers, and families. Provision of assistance to families by a social worker and provision of information in Spanish will continue.

Population-based:

SCHIP will continue providing joint application forms through CHDs, private health care facilities, other locations, a toll-free number, and the ALL Kids website. School outreach and other appropriate marketing and outreach will continue. It is expected that SCHIP and Medicaid will plan for implementation of a joint renewal form for their programs.

Infrastructure-building:

Out-stationing of a SOBRA Medicaid eligibility determination unit in the SCHIP office is expected to continue.

As stated under "Current Activities," funding for the RWJ Welfare Reform Support Project will have ended at the close of FY 2004. However, SCHIP and Medicaid will continue seeking ways to fund continuation of the work of this project./2005//

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

a. Last Year's Accomplishments

MCH Population Served: Children

/2005/Status and trends: See attachment./2005//

Note: FY 2001 activities and issues provide a backdrop for later years and included the following.

Cross-cutting:

CHDs were not providing direct patient services as extensively as in the past. Though most patients had moved into the managed care environment, ADPH continued to promote activities to ensure that Medicaid-eligible children would have the opportunity to enroll and then receive regular checkups. SCHIP, discussed under NPM #13, includes a Medicaid component and

therefore identified potentially Medicaid-eligible children. Outreach and referral activities of SCHIP promoted enrollment in Medicaid of children meeting appropriate criteria and, as a corollary, presumably promoted access to Medicaid-paid services.

Direct:

Subcontracts were in place with Medicaid Maternity Care Primary Providers in selected counties to provide home visits to infants and postpartum patients by nurses and social workers. Public health nurses from 9 counties, each in a different PHA, provided 1,441 off-site, school-based EPSDT comprehensive screening assessments in FY 2001.

Enabling:

Social workers were available in every CHD to work with children and families to assist in the removal of barriers to health care. Under the Medically at Risk (MAR) Program, discussed under SPM #3, case management was provided to certain medically-at-risk children. Further, case management was provided statewide to children with severe disabling health conditions (for instance, sickle cell disease, HIV, and elevated lead levels) requiring extensive medical and habilitative or rehabilitative services. WIC made referrals to internal and external systems of care such as Medicaid, Temporary Assistance to Needy Families (TANF), and SCHIP.

/2004/The preceding activities, which collectively involve direct, enabling, population-based, and infrastructure-building services, basically continued in FY 2002. In FY 2002 PHA nurses provided 1,219 off-site EPSDT comprehensive screening assessments.//2004//

/2005/The preceding activities, which collectively involve direct, enabling, population-based, and infrastructure-building services, basically continued in FY 2003, when 2 CHDs were involved in school-based EPSDT assessment (down from 9 in FY 2001). In FY 2003 staff from Wilcox and Butler CHDs collectively performed 968 school-based comprehensive EPSDT assessments on students.//2005//

b. Current Activities

/2005/MAR Case Management ended on March 1, 2004. Children and adolescents under the age of 21 years with full Medicaid coverage are now being followed for care coordination through the EPSDT Screening Program (also discussed under SPMs #3-4). Care coordination will continue to be available for children with various health problems--including dental problems and other conditions identified through screenings--and for teenagers at high risk of pregnancy, HIV infection, or other STDs. Further, EPSDT care coordination will focus on children with severe health problems requiring multiple hospitalizations, outpatient visits, or emergency room visits. Care coordination is also available for newborns who failed their hearing screening tests in the hospital (discussed under NPM #12), children with elevated blood lead levels, and infants identified through the NSP as having metabolic disorders. Referrals are made to CHD care coordinators by ADPH central-office staff.

Under the statewide Targeted Case Management Program, ADPH continues providing case management for children with certain disabling health conditions and persons with HIV. However, this is a small program because most children were being seen under MAR Case Management and will be transitioned into the EPSDT Care Coordination Program. Additionally, ADPH case managers/care coordinators make referrals to community-based organizations, which provide case management to the majority of HIV-positive patients in the State. Many of these community-based organizations receive both State funds and federal Ryan White funds.

ADPH is working to develop a Centralized Referral System for care coordination referrals. This system will be implemented in FY 2004. A website is being designed for

Medicaid doctors and dentists with access to the Internet, but the system will also have a fax component for medical providers without Internet access. All faxed referrals will come to ADPH's central office and will be sent to CHDs via the website.//2005//

c. Plan for the Coming Year

/2005/Per the discussion under "Current Activities," MAR Case Management will not be provided in FY 2005. Unless time framed in previous discussion, other FYs 2003-04 activities will basically continue in FY 2005. Certain activities are recapped below.

Cross-cutting:

ADPH will continue promoting activities, including SCHIP outreach, to ensure that Medicaid-eligible children have the opportunity to enroll and to receive regular checkups.

Direct:

As feasible, ADPH will continue subcontracts with Medicaid Maternity Care Primary Providers in selected counties to provide home visits to infants and postpartum patients. Additionally, the Department will continue providing school-based services where needed and feasible.

Enabling:

Under the statewide Targeted Case Management Program, ADPH will continue providing case management for children with certain disabling health conditions and persons with HIV. Further, ADPH will implement the Centralized Referral System for care coordination referrals, which is currently being developed as described under "Current Activities."//2005//

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

a. Last Year's Accomplishments

MCH Population Served: Pregnant women, mothers, and infants

/2005/Status and trends: See attachment.//2005//

FY 2001 activities included the following.

Direct:

CHDs provided family planning services to teens and, per agreement with some Medicaid Primary Contractors, prenatal care in 11 counties.

Enabling:

WIC provided food vouchers to eligible pregnant women. ADPH continued to coordinate with UAB to implement SCRIPT (see Section IV.E). All family planning clients were provided information on the importance of early and continuous prenatal care and were assessed for risk and referred if appropriate. WIC provided nutritional counseling to eligible pregnant women and made referrals when indicated.

Population-based:

Outreach services designed to prevent teen pregnancy were provided as described under NPM #8.

Infrastructure-building:

In the past several years the Bureau's overall strategy for addressing VLBW has been to maintain and develop the infrastructure for regionalized health care; seek to ascertain what interventions are most likely to reduce the frequency of VLBW; and develop strategies based on information so gathered. In FY 2001 SPAC continued quarterly meetings.

//2004/Previous activities basically continued in FY 2002. Specific updates follow.

Direct:

Ten CHDs served as subcontractors for Medicaid Primary Contractors to provide prenatal care, and 6,883 pregnant women received Title V-funded services from CHDs (down 29% from FY 2001).

Infrastructure-building:

By August 2002, 5 Regional Perinatal Coordinator positions were created and filled with nurses (1 in each region). The 5 hospitals designated as regional perinatal referral centers provided office space for the coordinators, who acted as executive directors for the RPACs, to help the RPACs address regional perinatal issues. Reducing the prevalence of VLBW was identified as a priority for each RPAC. Activities of the perinatal coordinators included recruiting RPAC members and completing regional needs assessment.//2004//

//2005/Previous activities basically continued in FY 2003. Recaps and updates follow.

Direct:

Ten CHDs served as subcontractors for Medicaid Primary Contractors to provide prenatal care. See Form 7 for number of pregnant women receiving Title-V funded services in FY 2003.

Enabling:

Provision of food vouchers and nutritional counseling by WIC, coordination with UAB to implement SCRIPT, and education of family planning clients about prenatal care continued.

Population-based:

Outreach services designed to prevent teen pregnancy, described under NPM #8, continued.

Infrastructure-building:

The SPP continued partnering with SPAC, which continued meeting quarterly. Via the 5 Regional Perinatal Coordinators, SPP continued working with RPACs to revitalize the State's system of regionalized perinatal care. The general approach to this revitalization, described in the 2004 update to "Plans for the Coming Year," was adapted based on resources and regional needs.//2005/

b. Current Activities

//2004/FY 2002 activities are basically continuing in FY 2003. With respect to infrastructure, in FY 2003 the Regional Perinatal Coordinators helped each RPAC develop a regional plan to address VLBW. Specific strategies to be used by the RPACs include efforts to reduce the adolescent pregnancy rate and to reduce the prevalence of cigarette smoking among pregnant women.//2004//

//2005/Two of the Bureau's programs to address adolescent pregnancy (referenced below) are being phased out in FY 2004. Unless previously time framed or stated otherwise below, remaining FY 2003 activities basically continue in FY 2004. Certain

updates follow.

Crosscutting:

Two major programs designed to address adolescent pregnancy are being phased out in FY 2004. As discussed under SPM #6, AUPPP and activities conducted under that program are being phased out in FY 2004. Additionally, the Family Planning Teen Care Coordination Program is being phased out in FY 2004. Budgetary constraints, discussed under NPM #8 and SPM #6, account for the termination of these programs. AAEP and ACAEP (described under NPM #8), the Bureau's 2 remaining community-based programs designed to prevent adolescent pregnancy, continue.

Enabling:

Although the SCRIPT model will continue being delivered to pregnant smokers in ADPH clinics, SCRIPT funding for training ADPH personnel may end in June 2004. As of this writing (April 2004), a possible extension until June 2005 is pending.

Infrastructure-building:

The SPP's collaboration with SPAC and AMOD continues. In FY 2004 AMOD began providing educational resources for each perinatal coordinator to offer programs for physicians' office staff, perinatal nurse managers, and new perinatal staff nurses. As discussed in Section III.E, Bureau staff attended a press conference convened by AMOD and 3 other organizations, to support their call for full funding of Medicaid.

The SPP used its FY 2003 regional perinatal needs assessments to develop strategies for FY 2004. Based on these strategies, activities were implemented to promote smoking cessation, reduce the prevalence of unintended pregnancy, and reduce the prevalence of short inter-pregnancy interval (pregnancies in which the birth occurs less than 2 years after the end of the preceding pregnancy.)

Further, in consultation with the Epi/Data Branch, the 5 Regional Perinatal Coordinators are each conducting a regional FIMR, with each RPAC subcommittee forming a case review team. These reviews focus on CY 2002 deaths of VLBW infants who were not born at a perinatal center.//2005//

c. Plan for the Coming Year

/2004/FYs 2002-03 activities will basically continue in FY 2004. Further, newly initiated strategies will be undertaken as feasible by the RPACs, with support by SPAC and the Bureau. These strategies are described below.

Infrastructure-building:

Strategies to be undertaken by RPACs will include revitalization of the State's system of regionalized perinatal care; public awareness campaigns on infant mortality, breastfeeding, and the impact of sleep position on SIDS; regional FIMR teams; smoking cessation programs; evidence-based medicine; and other strategies based on the specific region's needs. Outreach education for each region will be planned by its RPAC and Perinatal Coordinator, based on an annual needs assessment, and coordinated by its Perinatal Coordinator. Quarterly meetings of SPAC will continue, and the Regional Perinatal Coordinators will act as liaisons between SPAC and RPACs to implement initiatives developed by SPAC. SPAC and RPACs will be used to develop resource faculty to ensure that evidence-based medicine becomes the foundation for outreach education. SPAC will continue developing plans to address SPAC recommendations that grew from the 2000 Governor's Infant Mortality Task Force (discussed in Section II). Strengthening the leadership capabilities of the 5 RPACs and developing new advocacy partners across the State will be vehicles for implementing SPAC recommendations.//2004//

/2005/Unless stated otherwise previously or below, FY 2003-04 activities will basically continue in FY 2005. Recaps and updates follow.

Cross-cutting:

As previously noted, AUPPP and the Family Planning Teen Care Coordination Program will no longer be operating. AAEP and ACAEP will continue if federal funds for these programs are made available.

Direct:

CHDs will continue providing family planning services and WIC vouchers for pregnant women. Some CHDs will continue providing prenatal care.

Enabling:

As mentioned previously, the SCRIPT model will continue being delivered to pregnant smokers in ADPH clinics, but SCRIPT funding for training ADPH personnel may not be available. WIC will continue providing nutritional counseling and, as indicated, referrals of WIC-enrolled pregnant women for other types of care. CHD staff will continue educating family planning clients about the importance of prenatal care.

Infrastructure-building:

The SPP will initiate additional educational activities to increase awareness of the relationship between preconceptional and interconceptional health status and perinatal outcomes. Education will include how the following issues relate to perinatal outcomes: folic acid supplementation, hypertension, diabetes, obesity, and breastfeeding.

The 5 Regional Perinatal Coordinators will continue conducting regional FIMRs, focusing on CY 2003 deaths and studying a larger number of cases than in FY 2004. Criteria for selecting these cases remain to be determined and may be influenced by findings from ongoing (in FY 2004) FIMR.//2005//

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

a. Last Year's Accomplishments

MCH Population Served: Children

/2005/Status and trends: See attachment.//2005//

/2004/Activities in FY 2002, which were infrastructure-building in nature, are described below.

ACDRS, which has been operating for several years, is designed to collect data on unexpected deaths, including any suicide deaths of children or youth.

In March 2002 HPCD convened the 1st meeting of the Alabama State Suicide Prevention Task Force, in which certain BFHS staff participated. The purpose of the meeting was to begin forming a plan for Alabama's involvement in the national Call to Action, by the U.S. Surgeon General, to prevent suicide. The meeting was the 1st of 6 monthly meetings, all hosted by ADPH and MHMR. The Suicide Prevention Task Force consisted of persons from various specialties, organizations, or groups: including community mental health, rehabilitation, education, youth services, law enforcement, UAB School of Public Health, the Domestic Violence Coalition, faith-based organizations, and survivors of suicide attempts. As an introduction to the problem of suicide in Alabama, numbers were presented comparing Alabama to the Nation. (Neither the task force nor the numbers focused on a particular age

range.) Task force development strategies from several other states were presented, and ideas on issues to address were put forward. At the end of 6 months, the group had developed a directory of resources for the prevention of suicide. This directory lists various organizations in Alabama and elsewhere that provide services to persons who have attempted or are contemplating suicide, as well as families and friends of persons who have contemplated suicide, attempted suicide, and/or carried out their suicide plan.//2004//

/2005/Activities in FY 2003, which were again infrastructure-building in nature, included the following.

ACDRS, more fully described under NPM #10, continued in FY 2003. In FY 2003 ACDRS created the Infant and Child Death Investigation Task Force, in accordance with the mandating legislation's (discussed in Section III.B) charge to develop a standardized infant/child death investigation curriculum for investigators.

ADPH and MHMR began convening the State Suicide Prevention Task Force on a quarterly basis. The task force developed a website, hosted by ADPH and MHMR, providing information about suicide and resources available in Alabama and outside the State. Since the resignation in May 2003 of an epidemiologist in the Epi/Data Branch, who had previously attended Suicide Prevention Task Force meetings, no Bureau staff have participated on this task force.//2005//

b. Current Activities

/2005/The previously described infrastructure-building activities continue in FY 2004. Recaps and updates follow.

ACDRS, as well as the Infant and Child Death Investigation Task Force, continues. The Infant and Child Death Investigation Task Force has developed a training course for all infant and child death investigators, which will help standardize and improve death investigation techniques involving infant and child victims. The course will be taught at all Alabama Police Academies and is scheduled to commence as in-service training for all experienced investigators in July and August 2004. ACDRS's 3rd set of recommendations to the Governor, made in FY 2004, included an emphasis on the need for death investigators to participate in this course.

The "State Suicide Prevention Plan" has been finalized, and ADPH's Injury Prevention Division will fund printing of the document. The aforesaid plan will be distributed at a September 2004 media event, Alabama's Suicide Prevention Day. The Governor, MHMR Commissioner, and the State Health Officer will participate in this event. The Suicide Prevention Task Force is currently meeting monthly to finalize plans for this event. Further, this task force is pursuing funding for other projects: an ongoing media campaign to educate individuals about suicide-related issues and sources of help, training for mental health staff concerning suicide, educational programs in schools, etc. Although (as of May 2004) the Bureau has not participated on the Suicide Prevention Task Force for over a year, the ACDRS Director will begin representing the Bureau on this task force.//2005//

c. Plan for the Coming Year

/2005/Unless stated otherwise, the previously described infrastructure-building activities will basically continue in FY 2005. Recaps and updates follow.

ACDRS will continue studying unexpected deaths, including suicides, of Alabama youth under the age of 18 years. The training course developed by the Infant and Child Death

Investigation Task Force will continue being taught at Alabama Police Academies. The ACDRS Director will represent the Bureau on the Suicide Prevention Task Force, discussed below.

The Suicide Prevention Task Force will return to meeting on a quarterly basis. This task force will continue to seek funding for educational projects and to network with support groups for persons affected by suicide. Further, the Suicide Prevention Task Force will begin a Speakers' Bureau and encourage the development of regional activities around the needs of suicide crisis lines and the community mental health centers.//2005//

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

a. Last Year's Accomplishments

MCH Population Served: Pregnant women, mothers, and infants

//2005/Status and trends: See attachment.//2005//

Data issues: The reported numbers pertain to live-born infants delivered at perinatal centers, defined as any teaching or non-teaching hospital with 1 or more full-time neonatologists, a neonatal intensive care unit, and 2 or more obstetricians.

FY 2001 activities included the following infrastructure-building services: SPP, including its Director and SPAC, continued to review findings provided by CHS concerning this indicator. Efforts to strengthen regionalization, including addition of a full-time staff position for an SPP Director, were undertaken by the Bureau. The SPP Director then worked with the Epi/Data Branch to identify additional analyses that would contribute to better understanding of how well the State's system of regionalized perinatal care is working. These findings were presented to SPAC, who continued to meet quarterly and make recommendations to ADPH about regionalization and perinatal care in Alabama. Further, the Bureau submitted a proposal to Medicaid for strengthening the statewide perinatal system by providing leadership and coordination within each of the 5 perinatal regions. Under the proposed plan, new ADPH positions would be created for 5 Regional Perinatal Coordinators, and Medicaid would contract with ADPH for each Regional Perinatal Coordinator to complete a needs assessment for the region to which she was assigned and develop and implement an annual perinatal plan for that region. Matching Medicaid dollars for new funding were not available, however, so the Bureau devised a plan to use existing funds for the Regional Perinatal Coordinator positions.

//2004/Previous activities basically continued in FY 2002. Certain updates follow.

Infrastructure-building:

As described under NPM #15, the Bureau added 5 Regional Perinatal Coordinator staff positions to coordinate RPAC activities and liaise among all perinatal providers within a region. The Perinatal Outreach Education Program was incorporated into the job responsibilities of these positions. The coordinators helped coordinate an annual State Perinatal Conference and plan and coordinate continuing education activities in the perinatal regions. Four of the State's 5 perinatal regions had functioning FIMR projects.//2004//

//2005/Unless stated otherwise in previous discussion, most FY 2002 activities basically continued in FY 2003. An exception is that, due to fiscal constraints, the Bureau did not fund, and does not expect to fund in the foreseeable future, a State Perinatal Conference.

Infrastructure-building:

As described under NPM #15, SPP continued collaborating with SPAC and, through the Regional Perinatal Coordinators, with RPACs to maintain and develop the system of regionalized perinatal care. Regional profiles discussed in the FY 2004 update to "Current Activities" were used when developing a strategic plan for each perinatal region.//2005//

b. Current Activities

/2004/Previous activities are basically ongoing in FY 2003. Certain updates pertaining to infrastructure-building services follow. The Epi/Data Branch is not currently performing data analyses focusing on regionalization of perinatal care. However, at the request of the SPP Director, in June 2003 the Branch produced maternal and infant profiles for each perinatal region in draft form, for use by the Regional Perinatal Coordinators. (These are located in Appendix G, which can be obtained as described in Section III.A.) The leadership potential of each RPAC has begun to be realized, and stronger regionalization of perinatal care has been identified as a goal to pursue.//2004//

/2005/FY 2003 activities are basically ongoing in FY 2004. Certain updates follow.

Infrastructure-building:

As discussed under NPM #15, in consultation with the Epi/Data Branch, who helped plan the study design and who randomly selected deaths to be reviewed, the SPP is performing regional FIMRs. That is, each Regional Perinatal Coordinator is implementing FIMR in her region, with the RPAC subcommittee forming the case review team. In an effort to identify barriers that might prevent VLBW babies from being born at a perinatal center, the FY 2004 FIMRs are focusing on CY 2002 infant deaths of VLBW babies who were not born at a perinatal center.

Due to Medicaid's financial constraints, Medicaid remained unable to provide matching dollars for SPP.

Due to the resignation of an epidemiologist in May 2003 and the promotion, to a position in another bureau, of a public health research analyst in September 2003, the Epi/Data Branch has been unable to thoroughly proof and, consequently, to finalize the draft maternal and infant profiles for each perinatal region.//2005//

c. Plan for the Coming Year

/2005/FYs 2003-04 activities pertaining to regionalization of perinatal care, which are generally infrastructure-building services, will basically continue in FY 2005. One exception is that, due to Medicaid's financial constraints, the Bureau will no longer pursue matching Medicaid dollars for SPP. Certain other recaps and updates follow.

Infrastructure-building:

With the support of SPAC and the Bureau's SPP, the RPACs will continue seeking to maintain and strengthen the State's system of regionalized perinatal care. Quarterly meetings of SPAC will continue, and the Regional Perinatal Coordinators will continue liaising between SPAC and the RPACs to implement initiatives developed by SPAC.

Additionally, the Epi/Data Branch and the SPP Director will continue collaborating regarding what types of data-based reports would be most helpful to the Regional Perinatal Coordinators and RPACs. As part of the FY 2004-05 MCH needs assessment, the Epi/Data Branch will produce and finalize updated maternal and infant profiles for

each perinatal region. Subsequently, SPP staff will use these profiles when reassessing their regional strategic plans.

As stated under NPM #15, the 5 Regional Perinatal Coordinators will continue conducting regional FIMRs, focusing on CY 2003 deaths and studying a larger number of cases than in FY 2004. Criteria for selecting these cases remain to be determined, and may be influenced by findings from ongoing FY 2004 FIMRs. Available findings from FY 2004 FIMRs will be included in the FY 2004-05 MCH needs assessment.//2005//

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

a. Last Year's Accomplishments

MCH Population Served: Pregnant women, mothers, and infants

/2005/Status and trends: See attachment.//2005//

Discussion: Managed care for Medicaid-eligible pregnant women is generally thought to have improved access to private medical providers throughout the State. Whether access is timely merits ongoing consideration, however. For women who are uninsured, access to care is especially difficult since many Medicaid providers do not provide services for uninsured women, and CHDs are only providing prenatal care in 11 of Alabama's counties, through agreement with some of the Medicaid Maternity Care Primary Providers. As discussed in Section III.A, the increase in numbers of births to apparently uninsured Hispanic/Latino 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/Latino 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 over the last several years. Other reasons for the slower rate of improvement are unclear. BFHS is addressing the issue of uninsured pregnant women through the Uncompensated Maternity Care Project by using Title V funds to pay limited costs for prenatal care (private provider or CHD), as long as a system of care is in place and the system is supported by a community-based coalition. Implementation of this effort began in July 2000, and it now (circa March 2001) has maternity care systems for the uninsured either in place or under development in 20 counties (up from 15 counties about 1 year ago).

/2005/FY 2003 activities included the following:

Direct:

See Form 7 for the number of pregnant women receiving Title-V-funded services in CHDs in FY 2003. (At this writing [June 2, 2004], this number is pending receipt of numbers served by Mobile CHD.) Ten CHDs served as subcontractors for Medicaid Primary Contractors to provide prenatal care.

Enabling:

All CHD family planning clients were provided information about the importance of early and continuous prenatal care. Maternity care coordination was provided in 30 counties.

Population-based:

The Bureau operated a toll-free hotline that helps pregnant women access providers and provides educational materials about pregnancy.

Infrastructure-building:

The Medicaid Maternity Care Program was in place statewide; this system addressed the issues of early entry into care, compliance with care, referral patterns, and delivery services. Twenty counties participated in the Uncompensated Maternity Care Project.//2005//

b. Current Activities

//2005/As discussed in Section III.A, the Uncompensated Maternity Care Project was discontinued early in FY 2004 due to funding reductions discussed in Section III.B. Additionally, in July 2004 JCDH, which has 1 of the larger CHD maternity programs, will discontinue providing maternity care coordination and prenatal care.

Unless time framed in previous discussion, remaining FY 2003 activities are basically ongoing in FY 2004. With JCDH no longer providing maternity care coordination effective July 2004, several PHAs will be providing the bulk of CHD maternity care coordination services: PHA 1 in northeast Alabama, PHA 8 in south-central Alabama, PHA 10 in southeast Alabama, and PHA 11 in southwest Alabama. Mobile County, which comprises PHA 11 and is the State's 2nd most populated county, continues providing both prenatal care and care coordination services.//2005//

c. Plan for the Coming Year

//2005/The Uncompensated Maternity Care Project was discontinued for FY 2004, as previously mentioned, so will not be implemented in FY 2005. Remaining FYs 2003-04 activities will basically continue, unless stated otherwise in previous discussion. Certain recaps follow.

Direct:

Some CHDs will continue providing care to pregnant women, but the number of pregnant women served may continue to decline.

Enabling:

CHD staff will continue educating family planning clients about the importance of early and continuous prenatal care. As previously stated, JCDH will no longer be providing maternity care coordination. Twenty-four counties will continue providing this service.

Population-based:

Operation of a toll-free hotline that informs pregnant women and helps them access providers will continue.

Infrastructure-building:

The Medicaid Maternity Care Program will continue.//2005//

FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

General Instructions/Notes:

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

Pyramid Level of Service

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				
1. Provide biochemical screening of newborns for mandated conditions	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Through use of Tandem Mass Spectrometry, incrementally add tests for other disorders to the screening panel	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Refer infants testing positive, per any of the screening tests performed, for diagnostic follow-up	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Maintain files on confirmed cases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Operate an automated voice response system providing results to authorized health care providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Provide monthly reports on screening to key organizational stakeholders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Provide lab-related consultation to county health departments (CHDs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)				
1. Implement Alabama's 2010 Action Plan for Children and Youth with Special Health Care Needs (CYSHCN)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Facilitate collaboration/partnerships through Children's Rehabilitation Service (CRS) State/local parent advisory committees	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Facilitate collaboration/partnerships through training activities	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Facilitate collaboration/partnerships through publication of a newsletter	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Facilitate collaboration/partnerships through employment of Parent Consultants	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Increase utilization of the parent-to-parent list serve	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7. Support the growth of Family Voices, financially and philosophically, including utilization of CRS/Family Voices database	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
8. Include parents of CYSHCN as co-presenters at all training events	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Publish a Family Guide to the CRS Program and develop training for staff and families on its use	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
10. Partner with families to include family-centered care in the enhanced Care Coordination Program and insure family participation in development of training process and materials	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

3) The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)				
1. Implement Alabama's 2010 Action Plan for CYSHCN	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Publish at least 1 physician newsletter	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Feature medical home concept in newsletters and the CRS Family Guide	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Distribute information through the State Child Health Insurance Program (SCHIP) about medical home and the CRS Program to families	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Advocate with the Alabama Medicaid Agency (Medicaid) to incorporate the medical home concept in its revised Primary Care Case Management model	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Provide ongoing educational and agency-related materials to enhance partnerships with primary care physicians recognized as CRS courtesy staff	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7. Develop plan to share client-specific service plan information with medical home providers	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)				
1. Implement Alabama's 2010 Action Plan for CYSHCN	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Refer 100% of children with no health insurance enrolled with CRS to Supplemental Security Income (SSI), Medicaid, or SCHIP	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Continue collaboration with SCHIP and Alabama's Early Intervention System (EIS) to implement a Plus benefit package for EIS services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue implementation of the CRS work plan for the Health Insurance Portability and Accountability Act, and develop plan to provide training to new and current staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Modify/update a management information system to facilitate billing and data collection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Identify 100% of CRS clients for whom it is appropriate to pay insurance premiums and provide this service	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Continue collaboration between CRS and the Alabama Department of Public Health for support of expanded services for CYSHCN through the basic SCHIP and SCHIP-Plus packages	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

	DHC	ES	PBS	IB
5) Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)				
1. Implement Alabama's 2010 Action Plan for CYSHCN	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Serve at least 23,000 CYSHCN through the local CRS offices	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Support Alabama's EIS by increasing access to EIS services for eligible individuals	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Implement a targeted case management program to create additional funding for Traumatic Brain Injury services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Work cooperatively with other agencies to implement a universal newborn hearing screening program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Give a presentation on CRS to the staff in every Social Security Administration office in Alabama	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Implement new management system to support care coordination and build electronic client record	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Complete development of an enhanced Care Coordination Program and provide training to staff, youth, and families	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. Implement Alabama's 2010 Action Plan for CYSHCN	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Facilitate collaboration/partnerships through support of youth on the CRS Youth Advisory Committee and National Kids As Self Advocates (KASA) Board	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Facilitate collaboration/partnerships through training activities	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Facilitate collaboration/partnerships articles in the family newsletter	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Facilitate collaboration/partnerships via employment of a State Youth Consultant	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Include youth as co-presenters at all agency training related to transition issues	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Support the involvement of youth in 5-year needs assessment activities	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Collaborate with Adult Vocational Rehabilitation Services through a steering committee to develop transition training and resources for staff	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
9. Develop a clinic manual for Teen Transition Clinic and select at least 1 potential site for expansion	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Provide 2 trainings to youth on self determination and support the Youth Advisory Committee through conference calls and 2 meetings per year	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

7) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.				
1. Provide immunizations to infants or children seen in CHD clinics	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Via postcards, remind parents of 11-month-old CHD patients of vaccines that will be due soon	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Mail vaccine pamphlets to parents of all 4-month-old infants (with available addresses) in the State	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Maintain an immunization registry, to make childhood vaccine histories available to all providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Provide vaccine-level audits in federally qualified health centers and for some private providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Administer the Vaccines for Children (VFC) Program for the State	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Provide vaccine and support for public and private providers of VFC vaccine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. If receipt of federal funds continues, administer the Alabama Abstinence-Only Education Program to prevent teen pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. If receipt of federal funds continues, administer the Community-Based Abstinence-Only Education Program to prevent teen pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Through the above programs, channel federal funds to eligible community groups seeking to prevent adolescent pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provide family planning services to teens coming to CHDs for such services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Through several CHDs and school-based dental clinics, apply protective sealants to children's teeth	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Along with others, provide oral health exams for school children in selected schools in certain areas of the State	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Participate in an annual media focus on oral health, including the importance of dental sealants	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. In a national campaign, collaborate with others to provide free dental care, including sealants	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Distribute educational materials about dental sealants via schools, health fairs, and other organizations or events	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Donate dental sealant supplies, instruments, and small equipment to 2 school dental clinics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Promote fuller instruction on dental sealant placement during training of dental hygiene students	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Administer the Alabama Child Death Review System (ACDRS), to review unexpected deaths of children and youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. [Appropriate State authorities] enforce the graduated driver's license law	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Through ACDRS, monitor deaths of infants, children, and youth due to motor vehicle crashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. As indicated, provide recommendations to governing entities regarding road safety issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Implement an annual survey of occupant restraint use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Collaborate with the Alabama Breastfeeding Coalition and, when indicated, other groups to promote breastfeeding	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Promote public awareness of the importance of breastfeeding, through radio or other appropriate media	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Present breastfeeding education programs for CHD staff and, upon request, hospitals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Using the Alabama Department of Public Health's clinic-encounter-form	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

database, monitor breastfeeding of infants seen at CHDs				
5. Annually conduct the Alabama Hospital Breastfeeding Survey	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Implement the Pregnancy Risk Assessment Monitoring System, which includes items on breastfeeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. Implement the State's Newborn Hearing Screening Program (NHSP)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Through NHSP, provide equipment and supplies for newborn hearing screening to participating hospitals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. [Participating hospitals] provide hearing screening for all newborns who are delivered in their facilities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Track newborn hearing screening results, per a metabolic/hematologic/hearing screening data tool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Refer newborns who fail a hearing screen and/or are confirmed to have hearing loss for follow-up	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Coordinate the Parent-2-Parent Network, for families of children found to have hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Convene the Newborn Hearing Screening Advisory Board	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Along with others, address education, marketing, and reimbursement issues concerning newborn hearing screening	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. Administer SCHIP	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Include supplemental insurance in SCHIP for enrolled CYSHCN	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. [SCHIP and Blue Cross/Blue Shield of Alabama] implement a Care Management Program for certain children	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Through SCHIP, Medicaid, and CHDs, implement a streamlined application process for uninsured qualifying children to obtain health insurance	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Outreach to the Hispanic/Latino community by providing information about SCHIP in Spanish	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Particularly outreach to families with children from birth to 5 years of age to identify uninsured children	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7. Research issues concerning health insurance coverage and promote				

public awareness of these issues	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
8. Administer "Covering Alabama Kids and Families," a project funded by the Robert Wood Johnson Foundation	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. Provide services to Medicaid-enrolled children coming to CHDs for care	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provide social workers in every CHD, to work with children and families in removing barriers to care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provide care coordination for Medicaid-covered children and youth who are CHD patients or are referred for the service (see State Performance Measure #3)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Collaborate to implement a streamlined application process for coverage through SCHIP or Medicaid	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.				
1. Offer family planning services to CHD clients, including teens, needing the services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Implement measures to encourage early and adequate prenatal care (see National Performance Measure [NPM] #18)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), provide food vouchers and nutritional counseling to pregnant women	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Along with a university group, implement the Smoking Cessation or Reduction in Pregnancy Program	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Administer the State Perinatal Program (see NPM #17), for which the State is divided into 5 regions	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. At State and local levels, prioritize need to reduce the prevalence of very low birth weight (VLBW)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. Administer ACDRS to review unexpected deaths, including suicide, of Alabama children and youth	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. With the Alabama Department of Mental Health and Mental Retardation, host periodic meetings of the Alabama Suicide Prevention Task Force	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Through the Infant and Child Death Task Force formed by ACDRS, provide curriculum for a training course for child death investigators, to be taught at Alabama Police Academies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. Administer the State Perinatal Program, to strengthen the regionalized system of perinatal care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue quarterly meetings of the State Perinatal Advisory Committee (SPAC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Through Regional Perinatal Coordinators, support SPAC and Regional Perinatal Advisory Committees	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provide statewide and region-specific reports on indicators concerning regionalization of perinatal care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Through the Bureau of Family Health Services' 5 Nurse Perinatal Coordinators and the 5 Regional Perinatal Advisory Committees, conduct infant mortality reviews	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Via fetal and infant mortality reviews, ascertain whether any deaths of VLBW babies might have been averted by birth at a perinatal center	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal				

care beginning in the first trimester.				
1. Through some CHDs, provide prenatal care per agreement with Medicaid Maternity Care Primary Provider	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Educate CHD family planning clients on the importance of early and continuous prenatal care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Operate a toll-free hotline that helps pregnant women access providers and educational materials	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Collaborate with Medicaid, who administers a statewide maternity care program for Medicaid enrollees	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *The degree to which the Bureau of Family Health Services addresses the folic acid intake of women of childbearing age.*

a. Last Year's Accomplishments

MCH Population Served: Pregnant women, mothers, infants

/2005/Status, trends, and checklist: See attachment./2005//

Rationale for measure:

Addressing folic acid intake of childbearing-aged women can reduce occurrence of serious, lifelong morbidity and prevent a few infant and childhood deaths. The measure concerns the priority need "promote education/outreach."

/2004/FY 2002 activities included the following.

Enabling:

WIC and Family Planning staff continued giving WIC folic acid pamphlets to family planning clients during initial and annual visits.

Population-based:

Bureau staff and partners continued educating health care providers and women of childbearing age on the need for adequate folic acid intake by women who can become pregnant. This education was accomplished via education of individual ADPH clients and collaboration with other entities. The Bureau Director, the Bureau's Nutrition Education Director, and several Nutrition Area Coordinators were members of the Alabama Folic Acid Council (AFAC), and collaborated with AFAC to promote folic acid intake by women of childbearing age.

An ad on the need for adequate folic acid intake by women of childbearing age, sponsored by the March of Dimes, was aired on television.

Infrastructure-building:

The Bureau continued requiring preconceptional counseling in family planning clinics.

At the request of AMOD, the Bureau assumed the lead for AFAC, which had been initiated and led by AMOD. Leadership was assumed through the Bureau's SPP, and AFAC continued meeting quarterly. ADPH partnered with USA's CDC-funded Birth Defects Surveillance and Prevention Program in a statewide campaign to prevent occurrence and recurrence of neural tube defects (NTDs). The SPP Director coordinated action (begun in December 2001) to supply folic acid tablets to private providers and CHDs who prescribe 4 milligrams of folic acid daily to women who are contemplating pregnancy and are considered to be at high risk of an NTD-affected pregnancy. Further, she developed protocols for CHD family planning nurses to provide preconceptional counseling to at-risk women.//2004//

/2005/FY 2003 activities included the following.

Enabling:

WIC and Family Planning staff continued efforts to educate family planning clients.

Population-based:

Through RPACs, SPP staff continued educating health care providers and women of childbearing age about the need for adequate folic acid intake by women who can become pregnant. AMOD's ads on preconceptional folic acid consumption were not repeated.

Infrastructure-building:

The Bureau continued requiring preconceptional counseling in family planning clinics. AFAC met in February 2003 but did not meet again. Through SPP, however, the Bureau continued promoting folic acid consumption by women who may become pregnant. The SPP Director continued coordinating action to prevent recurrence of NTDs. Activities supported by the March of Dimes occurred per the 2004 update to "Current Activities."//2005//

b. Current Activities

/2004/Infrastructure-building:

The National March of Dimes earmarked funds for folic acid education activities for FY 2003, and these funds supported regional perinatal education targeting physicians and their clinic nurses who provide preconceptional counseling for women. The Regional Perinatal Coordinators distributed training materials to physicians' clinics and presented information to each RPAC. Additionally, folic acid exhibits have been displayed at conferences around the State. In March 2003 AFAC celebrated "Folic Acid Day" with a news release and press conference regarding the need for folic acid among childbearing-age women. This day was celebrated with peanut butter and jelly sandwiches, peanut butter cookies, and peanuts for the State Legislature and other attendees. Alabama's First Lady, Patsy Riley, presented and served as honorary chair for AFAC.//2004//

/2005/Updates and recaps for FY 2004 are below.

Enabling:

WIC and Family Planning staff continue collaborating to give WIC folic acid pamphlets to family planning clients during initial and annual visits.

Infrastructure-building:

The Bureau continues requiring preconceptional counseling in family planning clinics.

Due to ADPH's fiscal constraints and the re-direction by AMOD of funds, previously set

aside for AFAC, to the March of Dime's campaign to prevent prematurity, AFAC has been disbanded. Further, AMOD's media and legislative efforts now focus on preventing prematurity, rather than on encouraging folic acid consumption.

A plan, developed in June 2003, for continuing folic activities was presented to SPAC in November 2003. Under the plan, which SPAC approved, SPAC became the State's leadership body for continuing folic acid education activities. Also under the plan, each RPAC created a folic acid subcommittee that included former AFAC members. These subcommittees continue the work of AFAC at a regional level, with emphasis on education of health care providers about the need to address folic acid consumption by women capable of becoming pregnant. The Bureau's SPP continues to arrange SPAC meetings and liaise among SPAC and the RPACs. Further, the SPP Director and a member of USA Genetics Center's staff represent Alabama on the National Folic Acid Council.

The Bureau continues to deem implementation of a survey regarding knowledge about, consumption of, or biochemical status of folic acid (a checklist criterion for this performance measure) to be unfeasible. Other analytic and reporting responsibilities of the Epi/Data Branch--most of which pertain to Title V reporting requirements, ongoing MCH needs assessment, and administration of SSDI--are deemed of higher priority than the folic acid survey and preclude dedication of resources to such a survey. Accordingly, the target for this measure, which was revised downward in FY 2003, remains at 13 for the years 2004-2007.//2005//

c. Plan for the Coming Year

/2005/Unless stated otherwise in previous discussion, all FYs 2003-04 activities will basically continue in FY 2005. Recaps and updates follow.

Enabling:

Family Planning and WIC staff will continue providing folic acid pamphlets to ADPH family planning clients.

Infrastructure-building:

The Bureau will continue requiring preconceptional counseling in ADPH family planning clinics. The Bureau will also continue participating in the National Folic Acid Council and, through RPACs, encouraging health care providers to educate their female patients of childbearing age about the need for adequate consumption of folic acid. The SPP Director will continue collaborating with other groups to promote folic acid consumption by women who can become pregnant, and coordinating action to provide folic acid tablets to CHDs and certain private providers. The Epi/Data Branch will seek to ascertain whether information about folic acid consumption by nonpregnant women of childbearing age in Alabama is available from sources external to the Bureau.//2005//

State Performance Measure 2: The degree to which key maternal and child health databases are developed and analyzed, with pertinent findings reported to and utilized by the Bureau of Family Health Services (formerly SPM #7).

a. Last Year's Accomplishments

MCH Populations Served: Pregnant women, mothers, and infants; children; CSHCN

/2005/Status, trends, and checklist: See attachment.//2005//

Rationale for Measure:

This indicator concerns ADPH's designated priority need to promote education/outreach, since data analysis should help identify issues to address. Though not directly related to an outcome measure, the indicator pertains to surveillance and better understanding of risk markers for infant and child morbidity and mortality.

/2004/Selected FY 2002 activities follow.

Cross-cutting:

ACDRS, described in the 2005 update, continued.

Infrastructure-building:

The SPP Director liaised with local FIMR teams, previously the role of ACDRS staff. Four of the State's 5 perinatal regions had functioning FIMR projects, including ones respectively operated by JCDH and Mobile CHD.

PHALCON, the ADPH computer system, remained the lifeline for communication between ADPH State and county offices. High speed lines were established and personal computers in CHDs were upgraded. Infant/child growth charts were automated statewide by PHALCON. Mobile and Jefferson CHDs remained on different systems.//2004//

/2005/FY 2003 activities included the following.

Crosscutting:

Concerning ACDRS, all 41 Judicial Circuits had a Child Death Review Chairperson, and there were nearly 60 Child Death Review teams in the State. (The proportion of assigned child death cases for which reviews were reported by local teams had increased to 82% in FY 2001, up from 64% circa FY 1998.) ACDRS upgraded its website to include all data collection forms, which local child death review teams can complete online. This website provides information on underlying legislation, the child death review process, causes of child death, and summary recommendations of the State Child Death Review Team. ACDRS submitted a 2nd set of recommendations to the governor, which covered such issues as the dangers of co-sleeping with infants, the absence of smoke detectors in many homes, especially mobile homes, and insufficient use of floatation devices when swimming in open-water areas.

Infrastructure-building:

FIMR continued.

Rather than focusing on analysis of indicators by category of perinatal care, the Epi/Data Branch prepared statewide and PHA-specific maternal and infant profiles. These profiles included several items pertaining to criteria for SPM #2 and were distributed to PHA staff. Further, as discussed under NPM #17, the Branch drafted maternal and infant profiles for the 5 perinatal regions. The Branch continued performing data-related tasks to meet MCH Services Block Grant reporting requirements, and continued administering SSDI (see current activities, and plans).

PHALCON was updated to accommodate more of the billable conditions that require referral during a Child Health Inter-periodic Visit. WIC implemented computer-calculated growth percentiles for children, replacing the previous growth charts.//2005//

b. Current Activities

/2005/FY 2003 activities basically continue in FY 2004. Updates follow.

Crosscutting:

All appointments have been made to the State Child Death Review Team.

Infrastructure building:

FIMR is being conducted as described under NPMs #15 and #17. Additionally, Mobile CHD and JCDH continue their FIMR projects.

In addition to performing its usual activities, the Epi/Data Branch is coordinating the FY 2004-05 MCH needs assessment. Pertinent activities, done in consultation with key BFHS staff, have included the following: planning methods; revising tools; writing a manual for conducting community discussion groups; serving as Bureau liaison with facilitators of these groups; initiating 2 mailed surveys (further discussed under "Plan for the Coming Year"); developing electronic tools for entering and checking data; and serving on the CRS Needs Assessment Advisory Committee. Because the FY 2004-05 MCH needs assessment is in its early stage, Section II has not been updated to describe this ongoing process. A detailed description of methods and findings will be included in the comprehensive report of this needs assessment, which will be attached to the 2004 report/2006 application to be submitted to MCHB in July 2005.

As part of the SSDI Project, the Epi/Data Branch completed its electronic linkage of CY 2000 live birth records to newborn screening billing records--1 of the 3 major linkage tasks to be accomplished under SSDI. As discussed in the 2005 update to HSC #9a, the Branch presented major findings from this linkage to key Bureau staff. These staff then took steps to develop hospital-specific reports of the number of live births and the number of newborn screens (further described under NPM #1). If the hospital-specific report suggests that a particular hospital may not be screening all newborns, NSP staff will be able to promptly follow up on each infant to determine if he or she was screened. This increased capability of NSP staff to monitor newborn screening in a timely manner diminishes the need for annual electronic linkage of live birth records and newborn screening billing records. For this and other reasons discussed under HSC #9a, the Epi/Data Branch may not continue linking live birth records and newborn screening billing records.

A system to print pharmacy labels from PHALCON is being tested in 1 CHD. Further, current MCH reports from PHALCON will be revised to accommodate multi-race data entry. See NPM #7 for discussion of PHALCON and immunization records.

The new laboratory software, Sysware, is nearly developed and will be implemented in FY 2004. This system is expected to allow CHDs to receive lab reports directly through PHALCON and provide many reports that are difficult to extract from the current system. BCL and ADPH's Computer Systems Center staff are working with BFHS staff to meet laboratory-related reporting needs.//2005//

c. Plan for the Coming Year

/2005/Unless stated otherwise in previous discussion, FYs 2003-04 activities will basically continue in FY 2005. Certain updates follow.

Cross-cutting:

ACDRS, whose activities have been described under NPM #10, NPM #16, and earlier under this performance measure, will continue.

Infrastructure-building:

FIMR will occur as described under NPMs #15 and #17.

The Epi/Data Branch will continue coordinating the FY 2004-05 MCH needs assessment. The needs assessment will include 3 projects involving collection of new data (the 2 mailed surveys were alluded to under "Current Activities"): 1) "Survey of Alabama Primary Health Care Providers Serving Women of Childbearing Age, Children, or Youth," a statewide mailed survey; 2) "Survey of Organizations Serving Women of Childbearing Age, Children and Youth, and/or Families," a statewide mailed survey of non-medical organizations; and 3) several MCH community discussion groups that were held around the State in early FY 2004, according to Bureau-specified procedures. Also included will be multivariate analysis of vital records, focusing on stratified analysis pertaining to key MCH Services Block Grant indicators and on indicators for inclusion in statewide and perinatal-region-specific maternal and infant profiles. Item 5 on the checklist for this measure (birthweight- and age-specific infant mortality according to PHA) will probably be performed according to perinatal region, rather than PHA. Additionally, accessible, pertinent reports prepared by external groups, such as CDC's web-based report of YRBS indicators, will be utilized.

The FYs 2004-06 SSDI Project (described in Appendix F, which is obtainable as described in Section III.A) is expected to continue. Basically, this federally funded project is designed to better access, manage, link where appropriate, and utilize certain key MCH databases, with a particular focus on 3 of the electronic linkages specified on Form 19. One of these linkages, concerning birth and newborn screening records, is discussed under "Current Activities." In FY 2005 the Epi/Data Branch will continue developing computer programs for linking live birth records and WIC prenatal registration records, which is an in-progress task. Another SSDI linkage task, that of electronically linking live birth records and Medicaid records, will not be accomplished until FY 2006.

WIC will modify PHALCON to capture the type of proof shown by the client to document income. Currently, verification of income is documented in the medical record. Capturing the information in PHALCON will streamline the intake process for the clerk, while still meeting federal reporting requirements.//2005//

State Performance Measure 3: *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 1st Program (formerly SPM #10).*

a. Last Year's Accomplishments

MCH Population Served: Children

//2005/Status, trends, and checklist: See attachment.//2005//

Rationale for Measure: This measure pertains to 2 priority needs: to assure dental care and to promote education/outreach. It was chosen because case managers can best assure that individuals have access to health and dental care and get maximum benefit from those services. Though provision of case management might help prevent a few infant and childhood deaths, it will probably affect access, morbidity, and well-being more than mortality.

//2004/Case management services on a 1-to-1 basis, as provided by CHDs, are enabling services. However, since assurance of the availability of case management largely rests on infrastructure-building, activities are described under the latter level.//2004//

The following historical information, which pertains to FYs 1999-2001, is the backdrop for FY 2002 and subsequent years.

Infrastructure-building:

Targeted Case Management for the MAR was approved by Medicaid to provide case management services under Title XIX, effective January 1999. This program became the main means of providing case management to children enrolled in the Patient 1st Program. A referral from the primary provider or dentist was required. Case management services help patients access medical, social, and educational services and other community resources. In FY 2000, after getting off to a slow start the program steadily increased and prospered as dedicated staff were hired in key locations. By the end of FY 2000 the program had been successfully implemented in most key locations--with the exception of JCDH, which is in 1 of the most populated counties in the State. The program continued to prosper in FY 2001, when case managers maintained previously developed working relationships with local physicians and dentists, the referral source for the program. In FY 2001, 23 full-time licensed social workers employed by ADPH provided services to MAR children and their families in 66 Alabama counties. Training was conducted quarterly for new case managers, with 41 licensed social workers and nurses being trained in that year. As of early CY 2001, most MAR referrals were for immunizations, dental care, EPSDT, missed appointments, social systems issues, specialty referral coordination, and problems with a medical regimen.

/2004/This performance measure and SPM #4 are complementary and involve the same activities. See SPM #4 for FY 2002 activities pertaining to this measure, as well as to SPM #4./2004//

/2005/In FY 2003 most MAR referrals were for dental care, missed appointments, EPSDT screenings, social system issues, and problems with the medical regimen--all of which had been frequent cause for referral in FY 2002 as well. This performance measure and SPM #4 continue to involve the same activities. See SPM #4 for a description of FY 2003 activities pertaining to this measure, as well as to SPM #4./2005//

b. Current Activities

/2005/Notable changes in Medicaid policies affected case management in FY 2004. Discussion of these changes, the EPSDT Care Coordination Program developed in response to the changes, and care coordination training events in FY 2004 follows. Discussion of enhancements in the electronic system for documenting case management and care coordination are located under "Current Activities" for SPM #4, which involves the same activities as SPM #3.

Infrastructure-building:

Under Patient 1st, Medicaid assigned patients to a primary medical provider, and other providers could be reimbursed by Medicaid for care coordination only if the client had been referred by the primary medical provider for this service. With Patient 1st no longer in effect, ADPH developed the EPSDT Care Coordination Program in collaboration with Medicaid. (This program is also discussed under NPM #14.) Under the EPSDT Care Coordination Program, which is coordinated through the Bureau's Professional Support Division, ADPH Care Coordinators can be reimbursed by Medicaid for Medicaid-enrolled children referred by anyone in the community for care coordination. This expanded source of referrals, which includes but is not limited to the medical and dental communities, for reimbursable care coordination services allows ADPH Care Coordinators to provide services to more children and youth.

Concurrent with the expanded referral system, ADPH ended MAR Case Management in March 2004, as discussed in Section III.A. Further, as also discussed in Section III.A, ADPH will terminate the Teen Family Planning Care Coordination Program in September 2004 due to reduction in funds from DHR. These programs require the same credentials

(social work license, bachelor of science in nursing, or master of science in nursing) for workers. Workers in both these programs (in FY 2003, 37 FTEs in MAR Case Management and 45 FTEs in the Teen Family Planning Care Coordination Program) will transition into the EPSDT Care Coordination Program before September 30, 2004. Additionally, JCDH now provides services to children and youth under the EPSDT Care Coordination Program.

Training will continue being conducted quarterly for new EPSDT Care Coordinators. A 2-hour satellite training was done in February 2004 for all MAR-Certified Case Managers. Those who watched the satellite program and completed a test were certified as EPSDT Care Coordinators.//2005//

c. Plan for the Coming Year

//2005/The EPSDT Care Coordination Program, discussed under "Current Activities" for this performance measure, will continue in FY 2005. To recap, these services include the provision of case management for eligible children (an enabling service) and provision by Bureau staff of quarterly training events for EPSDT Care Coordinators (an infrastructure-building service). As previously discussed, the Teen Family Planning Care Coordination Program is being phased out in FY 2004, and workers from this program, along with those from MAR Case Management, are being transitioned into the EPSDT Care Coordination Program. As a consequence, workers that were previously limited to family-planning related care coordination will be available for other types of care coordination--increasing the total number of Care Coordinator FTEs available for a broad range of care coordination. This increased number of FTEs should alleviate some of the previous limitations experienced under MAR Case Management and allow for expansion of the EPSDT Care Coordination Program.//2005//

State Performance Measure 4: *The percent of children, 0-9 years of age, enrolled in the Patient 1st Program who received case management services during the reporting year (formerly SPM #11).*

a. Last Year's Accomplishments

MCH Population Served: Children

//2005/Status and trends: See attachment.//2005//

Rationale for Measure: This indicator concerns the priority needs to assure dental care and promote education/outreach. It is complementary to and has the same rationale as SPM #3.

Note: See SPM #3 for historical backdrop to FY 2002 activities.

//2004/FY 2002 activities included the following.

Infrastructure-building:

Five of JCDH's social workers attended the MAR training event held in April, but JCDH continued to lag behind other areas of the State in implementing MAR Case Management. In April the Bureau hired and trained a case manager and placed her in JCDH, where she

developed a substantial caseload and good rapport with private providers. However, she resigned in August 2002 and has not been replaced with a JCDH employee as the Bureau had expected. Accordingly, JCDH can provide only limited case management services to patients referred by private providers. Medicaid has informed ADPH that there are private providers in Jefferson County who need case management services for patients, and JCDH is aware of this need.

In FY 2002 MAR Case Management did not grow as rapidly as expected--even in counties with staff dedicated to the program--largely due to financial constraints in hiring and to Medicaid-reimbursement problems with certain infants and children. Concerning infants, case managers sometimes served Medicaid-covered infants referred by physicians but were not reimbursed since the infants had not been assigned to a primary medical provider. (Assignment takes up to 5 months.) Concerning children, case managers sometimes served but were not reimbursed for children who were temporarily ineligible for Medicaid coverage because parents/guardians had not submitted paperwork in time. Even so, the program's case managers provided services in all 67 counties, though services in Jefferson County were limited. Certification training was provided quarterly for MAR case managers, with 74 licensed social workers or nurses attending.

Discussion:

The slight decline in this indicator in FY 2002, shown in the attachment, may be related to 2 of the above issues: 1) lack of a social worker assigned mainly to case management in JCDH and 2) slower than expected growth of MAR Case Management in FY 2002. BFHS will continue seeking to address issues that have limited the growth of MAR Case Management.//2004//

/2005/Activities in FY 2003 included the following.

Enabling:

ADPH provided case management services to 9,607 MAR Patient-1st-enrolled children.

Infrastructure-building:

Quarterly training for MAR case management continued and was received by 34 licensed social workers and nurses. Bureau staff discussed the aforesaid (see FY 2002) reimbursement problems with Medicaid.

Continued enhancements in the electronic system for documenting care coordination, described in the 2004 update to "Current Activities," have allowed better oversight of care coordination activities.//2005//

b. Current Activities

/2004/Unless stated otherwise in previous discussion, all FY 2002 activities are basically ongoing in FY 2003. Certain updates follow:

Infrastructure-building:

All ADPH case managers/care coordinators in the State now (in FY 2003) have their own personal computers, and all documentation is done electronically. The transition from hard-copy records to electronic records was implemented gradually in FY 2002 and finalized in January 2003, when all 11 PHAs went online. This transition should increase efficiency and accuracy in all case management/care coordination programs. Case managers initially used a MAR referral form developed by ADPH, but since January 2003 have been using a referral form developed by Medicaid. Supervisors continued using the standardized MAR audit tool that was developed in FY 2000.//2004//

/2005/Changes in Medicaid policies affecting case management, the EPSDT Care Coordination Program (also discussed under NPM #14) developed in response to these changes, and training events in FY 2004 are described under "Current Activities" for SPM #3. Further enhancements of the electronic system for tracking care coordination activities are discussed below.

Infrastructure-building:

The electronic system for documenting and reporting on care coordination and case management has been further enhanced. In February 2004 the EPSDT Care Coordination Program's staff redesigned the referral form and the form for reporting back to the referral source. The system now captures information on referral sources, types of referrals, and reasons for referrals. Further, the system can be used to send electronic reports of findings to the referral source. All Care Coordinators have computers and can document their work electronically. However, as has been true in the past, JCDH has their own electronic system and does not use the State's system--making it difficult to track JCDH care coordination activity and integrate their numbers with those for the rest of the State.//2005//

c. Plan for the Coming Year

/2005/As stated in the 2005 update to "Plan for the Coming Year" for SPM #3, the EPSDT Care Coordination Program will continue in FY 2005. To recap, these services include the provision of case management to eligible children (an enabling service) and provision by Bureau staff of quarterly training events for EPSDT Care Coordinators (an infrastructure-building service). As more fully discussed in the update to plans concerning SPM #3, the increased number of FTEs available for a broad range of care coordination should alleviate some of the staffing-related limitations previously experienced under MAR Case Management.//2005//

State Performance Measure 5: *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 (formerly SPM #12).*

a. Last Year's Accomplishments

MCH Population Served: Children

/2005/Status, trends, and checklist: See attachment.//2005//

Rationale for Measure:

This indicator mainly flows from the priority need to assure dental care, but also relates to promoting education/outreach. It was chosen because appropriate and timely use of dental services, as well as access to care, is crucial to good oral health. The measure directly relates to well-being, though it does not appreciably affect mortality rates.

/2004/The Governor's initiative in October 2000 to increase Medicaid reimbursement for dental services to 100% of BCBS fees has had far reaching benefits. Statewide, use of dental services by Medicaid-enrolled children increased by 26% in FY 2002. The increase occurred in 64 of the State's 67 counties. Most remarkable was the increased use in 12 especially poverty-ridden counties. These counties previously had poor utilization rates relative to the rest of the State, but in FY 2002, 34% of Medicaid-enrolled children in these counties received dental care, versus 24% in the rest of the State.

FY 2002 activities included the following.

Direct:

Coffee CHD opened a dental clinic that has experienced tremendous demand for services. Through CHDs, dental sealants were provided to 29,052 children. Also, through school-based clinics in 2 locations, dental care was provided to 1,371 students, 193 of whom received sealants.

The number of Medicaid-enrolled children who received dental care increased markedly (see 2005 update below for details). This gain occurred due to a marked increase in the number of dentists enrolled as active Medicaid providers: from 360 in FY 2001 to 455 in FY 2002 (a 26.4% increase, and nearly twice the number for FY 2000).

Population-based:

A school-based fluoride mouth rinse program was provided in over 30 schools.

The Alabama Oral Health Coalition developed the State's 1st Oral Health Fact Sheet, which has been disseminated to health care professionals, MCH advocates, and State legislators.//2004//

/2005/FY 2002 activities basically continued in FY 2003. Recaps/updates follow.

Direct:

Two CHDs and 2 school-based clinics provided dental care to 40,006 children.

In FY 2003, 150,939 (34.6% of) Medicaid-enrolled children received dental care, compared to 103,630 in FY 2001 and 130,897 in FY 2002. Further, as mentioned in the 2004 update, statewide in FY 2002, 24% of Medicaid-enrolled children received dental care. Thus, this indicator has improved markedly, both in terms of absolute numbers and the proportion served.

Population-based:

The school-based fluoride mouth rinse program continued in over 30 schools.

The Alabama Oral Health Coalition continued disseminating information on oral health, and educational activities described under NPM #9 occurred.

Infrastructure-building:

Four CHDs each received MCH grants of \$40,000-\$60,000 to replace or upgrade old dental equipment or to buy equipment for dental clinics under construction.

Also see "Current Activities" and SPM #8.//2005//

b. Current Activities

/2005/The Bureau continues involvement in activities pertaining to the 5 criteria on which this performance measure is scored. Further, though fluoridation of water systems does not affect direct (1-on-1) provision of dental services, this issue affects dental health statewide. For this reason, recent grants pertaining to water fluoridation, not discussed under "Last Year's Accomplishments," are discussed below. As discussed in Section III.B, OHB's position for a fluoridation specialist has been abolished due to fiscal constraints. Thus, the receipt of these grants to strengthen the infrastructure for providing fluoridated water is especially critical.

Infrastructure-building:

In FY 2003, 6 public water systems received CDC grants to begin fluoridating for the 1st time. As well, 8 previously fluoridating systems received CDC funds to upgrade old fluoridation equipment. The 6 new fluoridating systems serve 70,041 persons, and the 8 upgraded systems serve 162,487 persons. Through these and other fluoridating systems, about 82% of the State's citizens drink fluoridated water.

Further, in FY 2003 OHB submitted to HRSA a "State Oral Health Collaborative Systems Grant" application. The proposal was approved and will be implemented in FY 2004. The primary focus of the proposed activities is to promote oral health among women of childbearing age, infants, and children and youth in underserved communities.//2005//

c. Plan for the Coming Year

/2005/In FY 2005 the Bureau will continue involvement in activities pertaining to the 5 criteria on which this performance measure is scored, adapting plans as necessary to accommodate emerging needs or opportunities. (See attachment to "Last Year's Accomplishments" for checklist of criteria.) To recap, these activities include the following.

Direct:

Certain CHDs and school-based clinics will continue applying dental sealants.

Population-based:

The school-based fluoride mouth rinse program will continue if sufficient funds are available to provide supplies. The Bureau will continue participating in the Alabama Oral Health Coalition and promoting oral health awareness in the State.

Infrastructure-building:

Efforts to recruit more dentists to become Medicaid dental providers, described under SPM #8, will continue.

Efforts to promote fluoridation of drinking water will continue though, due to the abolishment of OHB's fluoridation specialist position, that branch's capacity to personally interact with community groups and providers of water systems on this issue has been diminished.//2005//

State Performance Measure 6: *The degree to which programs and policies designed to prevent adolescent pregnancy are implemented and evaluated (formerly SPM #13).*

a. Last Year's Accomplishments

MCH Populations Served: Pregnant women, mothers, and infants; children

/2005/Status, trends, and checklist: See attachment.//2005//

Rationale for Measure:

This indicator flows from the priority need to reduce adolescent pregnancy. Prevention of adolescent pregnancy may only marginally reduce overall infant mortality and may not reduce mortality of African American infants in the short term. However, 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.

Activities as of FY 2001, which provide a backdrop for subsequent years, follow. The main non-clinical programs administered by the Bureau to address adolescent pregnancy are the Alabama Unwed Pregnancy Prevention Program (AUPPP), the Alabama Abstinence-Only Education Program (AAEP), and the toll-free hotline providing abstinence-based and abstinence-only education. (All are discussed under NPM #8.) Additionally, a new federal grant award resulted in initiation in FY 2001 of the Alabama Community-Based Abstinence-Only Education Program (ACAEP), also discussed under NPM #8. Each of the above-mentioned programs has an evaluation or data-collection component, but the degree to which evaluations are reported varies.

Of the aforesaid non-clinical programs, as of FY 2001, AAEP had demonstrated the strongest evaluation component, in that the university group AAEP contracts with produces periodic, extensive evaluative reports. The Bureau has contracted with Alabama State University to evaluate the community-based, abstinence-based projects conducted under AUPPP. However, none of the periodic reports provided by that university have been systematically evaluative in nature. Packets mailed to adults calling the telephone hotline to request materials about pregnancy prevention and other health issues include a survey form, but data from returned forms have not been computerized or systematically analyzed. With respect to previously conducted teen focus groups, a report distributed in January 2000 includes a description of methodology and findings from the evaluation forms distributed to participants. With respect to services to teens in ADPH family planning clinics, no comprehensive evaluation reports have been distributed. The final criterion for this measure pertains to annual monitoring of adolescent pregnancy rates, which the Department performs.

/2004/Infrastructure-building:

Except for the January 2000 distribution of the report on teen focus groups, preceding activities basically continued in FY 2002. The availability of evaluative reports continued to vary by program.*//2004//*

/2005/Infrastructure-building:

FY 2001 activities described above, as well as the variable availability of evaluative reports, basically continued in FY 2003.*//2005//*

b. Current Activities

/2005/FY 2004 activities follow.

Cross-cutting:

AUPPP, which has been supported by funds received from DHR, is being phased out in FY 2004. Projects within AUPPP, including the community-based projects and the media campaign discussed under NPM #8 in Section IV.C, were terminated effective March 30, 2004. The evaluation of AUPPP, being conducted by Alabama State University in collaboration with UAB, will be completed by mid-2004. AUPPP Bureau staff will be reassigned effective June 30, 2004, but the Alabama Campaign to prevent Teen Pregnancy will be funded through September 30, 2004. The phasing out of AUPPP is ultimately due to the State's ongoing financial shortfall, discussed in Section III.B. In the context of this shortfall, DHR decided to discontinue providing ADPH with TANF dollars to support AUPPP, effective at the end of FY 2004. Further, due to the budget cutbacks also discussed in Section III.B, the Bureau has needed to prioritize activities and allocate resources accordingly. Thus, the Bureau Director requested and received DHR's permission to re-channel TANF dollars received by the Bureau in FY 2004 toward the purchase of Depo-Provera, which directly led to phasing out AUPPP in FY 2004.

As mentioned under NPM #8, the U.S. Congress did not reauthorize abstinence education funding for AAEP, but a Congressional continuing resolution extended

funding through June 2004. Subsequent funding for AAEP is contingent on a Congressional continuing resolution extending funding through September 2004. If Congress reauthorizes abstinence education for FY 2005, AAEP will submit an application for funds to continue being channeled to the 9 community-based organizations discussed under NPM #8.

As fully discussed under NPM #8, funding continued in FY 2004 for 6 ACAEP community-based projects to monitor and document the activities of adults certified to perform certain ACAEP tasks (abstinence-only education, and pre- and post-tests to monitor progress toward ACAEP goals). Further, ACAEP's statewide media campaign targeting adolescents to promote abstinence-only until marriage continued. ACAEP's federal funding to provide abstinence-only education for FYs 2002-04 ends on June 30, 2004, and the Bureau submitted a competitive application in February 2004 for funds to continue ACAEP.//2005//

**c. Plan for the Coming Year
/2005/Plans for FY 2005 follow.**

Cross-cutting:

For reasons described under "Current Activities" for this performance measure, AUPPP will be no longer be operative in FY 2005.

If the U.S. Congress reauthorizes abstinence education funding for FY 2005, AAEP will submit an application for funds to continue supporting 9 of the 10 community-based projects described under NPM #8 in Section IV.C. Eight of the continued projects would be operated by community-based organizations and 1 by a city school system. Longitudinal evaluation of these projects would also continue.

ACAEP will continue if the Bureau's competitive application, submitted in February 2004, for federal funds to continue this project is funded.

Direct:

CHD family planning clinics will continue serving teens and providing Depo-Provera.//2005//

State Performance Measure 7: The degree to which the State CSHCN Program assures public awareness of the Title V CSHCN programs and activities among families and public/private service providers (formerly SPM #14)

a. Last Year's Accomplishments

MCH Population Served: CSHCN

This measure relates to the priority need to improve health status of CSHCN. It was placed under population-based services due to its relationship to outreach and public education. The FY 2001 target of 5 (scale 0-15, per attached checklist) was met.

/2004/The FY 2002 target was 8, and the agency's actual performance was 9.//2004//

/2005/The FY 2003 target of 10 was met.

The following activities occurred in FY 2003.

Population-based:

CRS developed a unique look and tag line to use in all its public awareness materials. The following educational/public awareness materials were updated to include the new look: CRS overview of services brochure (English and Spanish), "Services for Children" (English and Spanish), CRS Office Locations State Map, CRS Parent Connection newsletter, CRS Non-Medical Vendor Directory, CRS/ADRS website, the CRS PowerPoint presentation, CRS's large and small exhibit display boards, and CRS signage for workshops, meetings, and facilities. Further updates to clinic brochures etc. are ongoing.

CRS has developed the format and content for its informational video. A draft script has been written and videotaping has been completed. Final narrative recording will be completed in FY 2004, with videographic editing and completion anticipated by the end of FY 2004.

Revised CRS web pages have been loaded onto the ADRS website. Collaborations are ongoing among CRS, ADRS Office of Communication and Information, and the ADRS Division of Computer Services to maintain useful, updated content.

CRS conducts public awareness/education exhibits throughout the State at conferences, health fairs, professional meetings, consumer meetings etc. For FY 2003, CRS has record in the State office of 16 exhibits, potentially impacting 18,535 persons. This number is lower than the 20 reported in FY 2001 and the over 36 reported in FY 2002. Due to the fact that 8 small exhibit settings have now been placed in local offices, the FY 2003 number may be an underestimate of actual public awareness exhibits conducted as local office staff may have failed to report local exhibitions to the State office.

CRS maintains an Access database to track its statewide public awareness efforts. The database enables the agency to analyze its efforts by numerous data elements. In FY 2003 there were 258 reported public awareness contacts made by local office staff. This figure demonstrates the CRS staff's consistent commitment to public awareness when compared to 208 contacts in FY 2001 and 259 in FY 2002.

Infrastructure-building:

The CRS Public Awareness Task Force continued bi-annual meetings in FY 2003. Planning is ongoing for a training to each CRS district regarding public awareness strategies utilizing video-conferencing technology to ensure a uniform, consistent statewide message regarding the agency and its services. However this activity was not pursued in FY 2003 due to fiscal constraints.//2005//

b. Current Activities

/2005/Population-based:

CRS has completed revision of 2 public awareness/family education brochures to include the new, more visible look and tag line and be produced in Spanish and in alternative formats (Braille, large print, and electronic). The agency anticipates the completion of 2 additional materials by the end of FY 2004. Work continues on the public awareness videotape that highlights CRS services and the scope of its activities. Videotaping has been completed and voice-over work for the video narrative is ongoing. The agency is partnering with the videographers at ADPH in the final assimilation of the video, and the finished videotape is expected to be available for use by the end of FY 2004. CRS maintains and updates web pages at the ADRS web site that feature information about the agency's services, enrollment procedures, the Parent Connection

Program, the Youth Connection Program, and links to other State and national resources.

Infrastructure-building:

The CRS Public Awareness Task Force has met several times. Tentative plans include the expansion of the task force and the provision of statewide training to staff on public awareness strategies. Activities in this area will be ongoing throughout FY 2004 and FY 2005.//2005//

c. Plan for the Coming Year

/2005/Population-based:

In FY 2005 the CRS program will complete the revision of at least 2 more of its public awareness materials, including incorporation of its new look and tag line reflecting its message and the scope of its activities. The CRS program will have at least 2 more of its informational brochures made available to the public in Spanish and in alternative formats (large print, electronic file, audiotape, and Braille) to increase accessibility for individuals with disabilities. CRS will expand its Public Awareness Task Force to include representatives from field offices (1 from each district) and consumers.

Infrastructure-building:

CRS will provide statewide staff training that focuses on public awareness strategies to insure a consistent statewide message. CRS will insure the inclusion of a youth perspective in the revision and development of public awareness materials.//2005//

State Performance Measure 8: *The percent of Alabama dentists who actively provide dental services for Medicaid-enrolled children (formerly SPM #15).*

a. Last Year's Accomplishments

MCH Population Served: Children

/2005/Status and trends: See attachment.//2005//

Rationale for Measure:

This indicator flows from the priority need to assure dental care. 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. The measure would not appreciably reduce mortality but concerns well-being.

As a backdrop to later years, FY 2001 information about infrastructure-building follows.

Though some improvement had occurred, in FY 2001 Alabama continued to have a critical shortage in access to oral health care for low-income persons. Some areas, especially rural counties, continued to be under served, with 11 rural counties having 1 or fewer Medicaid dental providers. The number of such counties was fewer (better) than in FY 2000, with the improvement attributed to the "Smile Alabama!" initiative that recruited dentists into the Medicaid network. For counties with no providers, transportation continued to be an issue, with some families having to travel notable distances to access dental services. In FY 2001 BFHS continued partnering with Medicaid, the School of Dentistry, the Alabama Board of Dental Examiners, the Alabama Dental Association, the Academy of Pediatric Dentistry, the Academy of General Dentistry, the Department's Office of Primary Care and Rural Health, and other entities to promote access to dental care, especially for low-income children. See SPM #5 for discussion of the Governor's October 2000 initiative to increase Medicaid reimbursement for

dental fees.

/2004/FY 2002 activities follow.

Infrastructure-building:

The "Smile Alabama!" initiative continued, especially targeting senior dental students as potential Medicaid providers. Other activities of Bureau staff included: 1) Serving on the Medicaid Dental Task Force, the Oral Health Policy Council, and the Oral Health Coalition to address barriers to recruiting and retaining Medicaid dental providers; 2) collaborating with the School of Dentistry to place dental residents/faculty, as part of a community-based rotation, in facilities that serve low-income populations, and lecturing annually to dental students and dental hygiene students; 3) sharing data with the Alabama Board of Dental Examiners and using their database to measure progress in performance; and 4) partnering with the Office of Primary Care and Rural Health Development to recruit dentists into the National Health Service Corps Program.//2004//

/2005/FY 2002 activities basically continued in FY 2003. Recaps/updates follow.

Infrastructure-building:

BFHS continued collaborations mentioned in the above 2004 update.

Efforts to recruit more dentists to become Medicaid dental providers continued, with 649 (34.0% of) dentists being active medical providers (compared to 579, or 30.4% of, dentists in FY 2002).//2005//

b. Current Activities

/2005/The "Smile Alabama" initiative, which was funded through an RWJ grant, ended in January 2004. Otherwise, FY 2003 activities are basically ongoing in FY 2004.//2005//

c. Plan for the Coming Year

/2005/FYs 2003-04 activities will basically continue in FY 2005. Recaps follow.

Infrastructure-building:

Previously described services that will continue include the following: service by Bureau staff on various groups addressing oral health, collaboration with the School of Dentistry, tracking of progress on this performance measure, and partnership with the Department's Office of Primary Care and Rural Health Development to address dental health manpower issues.//2005//

FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The degree to which the Bureau of Family Health Services addresses the folic acid intake of women of childbearing age.				
1. Provide folic acid pamphlets to county health department (CHD) family planning clients	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

2. Designate the State Perinatal Advisory Committee (SPAC) as the State's lead for education on preconceptional folic acid consumption	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Promote such education regionally through Folic Acid Subcommittees formed by the 5 Regional Perinatal Advisory Committees (RPACs)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Through RPACs, promote health care providers' awareness of the need to address folic acid consumption by women who may become pregnant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Coordinate action to provide folic acid tablets to CHDs and to certain private providers of health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Participate in the National Folic Acid Council	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The degree to which key maternal and child health databases are developed and analyzed, with pertinent findings reported to and utilized by the Bureau of Family Health Services (formerly SPM #7).				
1. Through the Bureau of Family Health Services' 5 Nurse Perinatal Coordinators and the 5 RPACs, conduct infant mortality reviews	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Administer the Alabama Child Death Review System (ACDRS), to review unexpected deaths in children and youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Maintain the ACDRS website, which provides information about a variety of topics	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Based on death reviews, collaborate with other entities regarding potential legislative initiatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Administer the State's System Development Initiative Project, a federally funded project designed to increase data capacity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Conduct a comprehensive maternal and child health needs assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Maintain the Public Health of Alabama County Operations Network (PHALCON) data system on patient-care encounters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) 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 1st Program (formerly SPM #10).				
1. Administer the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Care Coordination Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Through the above program, provide care coordination to eligible				

Medicaid-enrolled CHD Child Health patients	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Also through the above program, provide care coordination to eligible Medicaid-enrolled children who are referred to CHDs specifically for care coordination	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Through this care coordination, help eligible children access medical, social, and educational services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Provide quarterly training events for EPSDT Care Coordinators	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Maintain the Alabama Department of Public Health's Care Coordination/Case Management database	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The percent of children, 0-9 years of age, enrolled in the Patient 1st Program who received case management services during the reporting year (formerly SPM #11).				
1. Administer the EPSDT Care Coordination Program (see State Performance Measure [SPM] #3)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) 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 (formerly SPM #12).				
1. Operate several CHD-based dental clinics	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Collaborate with the Alabama Medicaid Agency to promote provision and utilization of dental services for low-income children	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Collaborate with others to implement a statewide oral health awareness campaign	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Participate in the Alabama Oral Health Coalition, to promote the State Oral Health Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

5. Beginning in FY 2005, administer the federally funded Alabama Oral Health Collaborative Systems Project	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Through the above project, promote oral health among women of childbearing age, children, and youth in underserved areas	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7. Engage in activities described under National Performance Measure (NPM) #9 and SPM #8	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The degree to which programs and policies designed to prevent adolescent pregnancy are implemented and evaluated (formerly SPM #13).				
1. If receipt of federal funds continues, administer the Alabama Abstinence-Only Education Program to prevent teen pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. If receipt of federal funds continues, administer the Community-Based Abstinence-Only Education Program to prevent teen pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Through the above programs, channel federal funds to eligible community groups seeking to prevent adolescent pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Assure evaluation of community-based adolescent pregnancy prevention projects funded through the above programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Provide family planning services to teens coming to CHDs for such services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) The degree to which the State CSHCN Program assures public awareness of the Title V CSHCN programs and activities among families and public/private service providers (formerly SPM #14)				
1. Incorporate the new look and tag line into all Children's Rehabilitation Service (CRS) public awareness materials	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Complete and utilize an informational video on CRS to disseminate its message and the scope of its services	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Maintain a website with resource information for families	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Expand the Public Awareness Task Force to include field office staff and consumer representatives	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Develop and implement staff training on public awareness	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

6. Continue to make informational brochures available in alternative formats (Spanish, Braille, audiotape, electronic file)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Insure the inclusion of a youth perspective in the revision and development of public awareness materials	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Pyramid Level of Service			
STATE PERFORMANCE MEASURE	DHC	ES	PBS	IB
8) The percent of Alabama dentists who actively provide dental services for Medicaid-enrolled children (formerly SPM #15).				
1. Serve on the Oral Health Policy Council, State Oral Health Council, and Medicaid Dental Task Force	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Through the above groups, address barriers to recruiting and retaining dentists in the Medicaid network	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Collaborate with the University of Alabama School of Dentistry in Birmingham	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Via such collaboration, rotate dental residents and faculty through settings serving low-income children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Seek to recruit dentists into the National Health Service Corps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E. OTHER PROGRAM ACTIVITIES

Cross-Cutting:

Family planning:

To promote access to family planning services among uninsured mothers, the Bureau and Medicaid implemented an 1115(a) Medicaid Family Planning Waiver (Plan First) in October 2000. The waiver expanded Medicaid eligibility to include women aged 19-44 years who were at or below 133% of FPL. In addition to CHDs, about 399 private providers and 74 FQHCs enrolled as Medicaid Plan First providers. In FY 2001 ADPH, through BFHS, was responsible for Plan First outreach and marketing, care coordination for clients of ADPH and for clients referred by other providers, a toll-free Plan First Hotline, provision of oral contraceptives for all clients, and State Medicaid match. The Bureau's Family Planning staff partnered with the ADPH Division of Sexually Transmitted Diseases and BCL on the Region IV Title X Infertility Prevention Project.

//2004/Since implementation of Plan First, about 97,308 women have been enrolled by Medicaid as being eligible for family planning services. In the 1st year of the waiver, an estimated 5,980 births were averted through Plan First. In FY 2003 a grant proposal was submitted for federal Title X funds to expand services to Latino women with low literacy levels. If the proposal is funded, the program will begin in July 2003. The goal of the expansion is to increase knowledge of and participation in family planning services among Latino women with limited reading skills. The program would initially be targeted to 3 counties in south-central Alabama.//2004//

/2005/The Bureau continues administering the Plan First Waiver, which accounted for 64% of Family Planning patients served in FY 2003. About 114,000 women have enrolled in Plan First since its implementation, and enrollment is 9% higher than had been expected when the waiver was developed. ADPH's Family Planning Program provided direct services to 96,355 clients in FY 2003. The above proposal for funds to serve Latino women was funded in October 2003./2005//

Direct:

Alabama Childhood Lead Poisoning Prevention Project (ACLPPP):

The goal of this project, funded through CDC, is to eliminate childhood lead poisoning by 2011. Environmental case management is provided for all lead-poisoned children in the State with a blood lead level greater than or equal to 15 ug/dl. In FY 2001, 17,881 blood lead screenings were completed among children aged 6 months through 5 years. Of these screenings, 4.4% were elevated (10 ug/dl or higher). Universal screening is carried out in 7 counties, while remaining counties follow the targeted screening protocol, under which only children meeting certain social/medical criteria are screened. In FY 2001, 199 environmental inspections for exposure to lead were completed. Lead hazards were identified in 89% of the homes inspected. Efforts to increase awareness of lead-safe practices among parents, property owners, renovators and child health providers were addressed statewide through the ACLPPP Primary Prevention Program.

/2004/In FY 2002, 21,277 blood lead screenings were completed among children aged 6 months through 5 years; 9% of these showed elevated lead (10 ug/dl or higher). Screening guidelines previously approved by the Lead Advisory Committee were reevaluated and clarified./2004//

/2005/ACLPPP continued in FY 2003, when 22,252 blood lead screenings were completed, 7.3% of which showed elevated lead levels./2005//

Enabling:

Care Coordination and Case Management:

/2005/As discussed in Section III.A, changes in Medicaid policy and reductions in DHR funds led to FY 2004 organizational changes in how care coordination or case management is provided. The Bureau's care coordination/case management services now include the following 4 categories: 1) Maternity care coordination, (2) Targeted Case Management, an umbrella term encompassing provision of services to children with certain disabling health conditions, patients with HIV, and pregnant patients who exempt out of the Medicaid State Maternity Program because of high-risk status, 3) family-planning-related care coordination for women aged 19-44 years, and the new EPSDT Care Coordination Program discussed under SPMs #3-4./2005//

WIC:

In FY 2001 WIC's caseload increased to 111,049 per month (from 103,930 per month in FY 2000). The increase may be attributed to several factors--including a greater understanding of the Year 2000-compliant computer system, the use of MCH money for bonuses for increased WIC caseload, and television ads to increase public awareness of WIC.

/2005/WIC's average caseload was 118,614 cases per month in FY 2002, and 120,377 cases per month in FY 2003./2005//

Population-based:

Toll-free MCH Hotlines (Form 9)--There were 1,741 calls to the Bureau's MCH Hotline (Healthy Beginnings) in FY 2001, more than twice the number received in FY 2000. This increase was mainly due to FY 2001 WIC public service announcements listing the Healthy Beginnings' toll-free number. CRS maintains toll-free lines, in operation during normal business hours, in the CRS State Office and

15 district offices. There were 42,414 calls to CRS's toll-free lines in FY 2001 (versus 42,087 in FY 2000), up 30% from the FY 1997 baseline of 32,640 calls.

/2005/FY 2003 brought 992 calls to the Healthy Beginnings Hotline, down from 1,579 in FY 2002, with most callers seeking information about WIC. Calls about maternity care and child health continued to fall, presumably due to ADPH's decreased involvement in direct care of children and pregnant women, discussed in Section III.A. There were 44,863 toll-free calls to CRS, up from 40,556 in FY 2002, when CRS had their 1st and only decline in the annual number of calls./2005//

Infrastructure-building:

Smoking Cessation During Pregnancy:

In FY 2001 ADPH and UAB implemented Phase 3 of SCRIPT, funded by the National Institutes of Health. Initiated in 1986 and now in 8 Alabama counties, SCRIPT is a randomized clinical trial to evaluate the effectiveness of patient education methods that can be delivered to pregnant smokers by ADPH maternity staff during a regularly scheduled prenatal visit. All pregnant smokers at the study sites began receiving the SCRIPT treatment model by October 2000.

/2004/Federal funding for SCRIPT ended in December 2001, but the model will continue being used./2004//

/2005/The State's first Basic Tobacco Intervention Training for SCRIPT trainers was held in May 2002. SCRIPT became part of ADPH's clinical protocol in October 2002, but funds to continue SCRIPT training are uncertain./2005//

F. TECHNICAL ASSISTANCE

Further technical assistance is requested by CRS in 1 area during FY 2003. The agency would like to use technical assistance monies for further consultation in the implementation of the new privacy regulations for HIPAA. The new procedures related to client confidentiality and the release of medical information will have significant impact on programmatic operation.

The Bureau's main needs for technical assistance are being met through SSDI funds provided through MCHB. The principal goal of Alabama's SSDI Project for FYs 2000 and 2001 was to further develop State and regional infrastructure: in order to 1) strengthen the State's capacity to provide valid estimates for performance and outcome measures, 2) identify true priority needs, and 3) translate results of analyses to policies and programs that address those needs. Specific objectives, as well as progress on those objectives, have been described in the SSDI Project Interim Final Report for FYs 2000-2001, submitted to MCHB in December 2001. In FY 1999 and early in FY 2000, the Community Development Branch's Director, who then served as SSDI Project Coordinator, consulted closely with the Bureau's Needs Assessment Coordinator (the Director of the Epi/Data Branch) and spearheaded the community forums and focus groups held throughout the State as part of the needs assessment. Later in FY 2000 the SSDI Project Director and Project Epidemiologist worked together to report findings from the community forums and focus groups, and these findings were incorporated into the needs assessment component of the 1999 report/2001 application. SSDI funded 70% of the salary of the SSDI Project Epidemiologist, who joined the Bureau's Epi/Data Branch in December 2000 and resigned, in order to pursue her PhD in Epidemiology, in August 2001. This epidemiologist was essential to analysis of data from the community forums, completion of the needs assessment, and compilation of some core and many developmental health status indicators.

/2004/In FY 2003 the Epi/Data Branch assumed responsibility for coordinating the State's SSDI Project. Largely using resources funded by the SSDI grant, the Branch is developing infrastructure to electronically link live birth records to newborn screening billing records. Using a 2-stage electronic program linking CY 2000 occurrent live births to newborn screening billing records, supplemented by visual inspection of random samples of linked pairs, the Branch roughly estimates that 96.7% of live

births could be correctly linked to newborn screening billing records. In the next several months, we will explore potential reasons (for instance, incomplete, incorrect, or unclear data; data entry errors; and the potential for actual failure to screen a child) for apparent non-linkage of about 3%-4% of birth records to newborn screening billing records.

With respect to potential national or regional training events, the Bureau unreservedly supports a proposal made to AMCHP by Dr. Russell S. Kirby (School of Public Health, UAB), Dr. Craig A. Mason (College of Education and Human Development, University of Maine), and Dr. Philip K. Cross (New York State Congenital Malformations Registry). We believe that such a seminar would be of great benefit to the Bureau's SSDI staff, and would help all states who do not routinely perform all linkages specified in HSC #9A make notable progress on this indicator. We therefore suggest that MCHB and AMCHP jointly support the provision by Dr. Kirby and associates of the proposed seminar on MCH epidemiology record linkage methods, to persons representing each interested State Title V Program.//2004//

/2005/In December 2003 the Director of the Epi/Data Branch attended a seminar on electronic linkage of databases, provided by Dr. Kirby and associates.//2005//

/2004/In addition to strongly agreeing with the need for the aforesaid training event concerning electronic linkage methods, to be provided on a national or regional basis, the Bureau requests resources for several technical assistance activities that are tailored to particular current or emerging issues in our state. The 1st such request is one by CRS, who requests technical assistance monies during FY 2004 for further consultation in the ongoing implementation of HIPAA, specifically on issues related to utilizing standardized code sets for unique public health services and evolving case law.

The next 2 requests, made by BFHS, pertain to aspects of the upcoming FY 2004-05 MCH needs assessment (to be reported in the 2004 report/2006 application). The requested monies would be in addition to those requested through SSDI, which is expected to continue as a major source of technical assistance for the Bureau. However, since the technical assistance funds requested here would complement the technical assistance provided through SSDI funds, a description of plans for SSDI in FYs 2004-2006 follows as background. (These plans for continuing and expanding SSDI linkage activities are fully described in the State's SSDI Competing Renewal Proposal for FY 2003, located in Appendix F and obtainable as described in Section III.A.) The primary goal of the proposed SSDI Project is to enable BFHS to further develop its capacity to manage, analyze, and report information from MCH databases listed in HSC #9A, with continued focus on "annual linkage of birth records and WIC eligibility files" and "annual linkage of birth records and newborn screening files." Secondary foci of the primary goal are 1) renewed exploration of the feasibility of linking birth records and Medicaid files, developing a statewide hospital discharge database, and/or developing a statewide birth defects registry; and 2) enhancement of the Bureau's capacity to analyze PRAMS data. The proposed project has 3 secondary goals: to maintain and further develop the Bureau's capacity to 1) report valid estimates for the performance/outcome measures and health systems capacity indicators (in addition to HSC #9A) in the MCH Services Block Grant; 2) conduct ongoing MCH needs assessment, including a comprehensive assessment in FY 2004-05; and 3) prepare and disseminate various reports of needs assessment findings, with the reports being tailored to particular readerships.

Because the SSDI budget does not fully cover the cost of activities necessary for meeting the above goals, Epi/Data Branch staff make substantial in-kind contributions of their time to SSDI. Furthermore, supplementary monies are necessary for conducting the FY 2004-05 MCH needs assessment. Accordingly, the Bureau requests additional technical assistance monies in early FY 2004 for 2 components of the upcoming needs assessment, both of which involve collection of new data and pertain to the proposed SSDI Project's secondary goals.

The 1st component pertains to seeking public input, i.e., qualitative data, through community forums and/or focus groups. The Bureau proposes that we convene from 6-10 community forums, discussion groups, and/or focus groups early in FY 2004 (by no later than March 2004). These groups should

collectively represent parents and children/youth from low-income and middle-income households and from 4 types of counties (rural northern, urban northern, rural southern, urban southern). Tentative plans are that 3 of the groups will consist of CHD patients and 3 of middle-income consumers of health care. If feasible, 2-4 other groups may be convened, some of which may consist of professionals (for instance, PHA nurses and a medical group including private practitioners). One of the Epi/Data Branch's research analysts (who will serve as the upcoming SSDI Project's Research Analyst) will coordinate the logistics for these groups, and the Bureau will encourage each of ADPH's 10 community development specialists, who are employed by PHAs or CHDs, to convene 1 or more groups. However, neither Epi/Data Branch staff nor the community development specialists have been adequately trained in the selection, recruitment, or facilitation of such groups. Additionally, the Epi/Data Branch has very limited experience in analyzing qualitative data. For this reason, we request monies for use in contracting with a university-based group: preferably certain nationally recognized staff from the UAB School of Public Health's MCH Department, who collectively have extensive experience in needs assessment and in training others on needs assessment. Responsibilities of the university-based group would include provision of: 1) formal, didactic instruction on such groups (for instance, the definition of and criteria for a focus group versus other types of groups; selection, recruitment, and facilitation of groups; and analysis of data from the groups); 2) a manual for use in the didactic instruction; 3) on-site oversight of 4-6 groups facilitated by ADPH staff; 4) feedback regarding the groups overseen on site; and 5) consultation to Epi/Data Branch staff during the Branch's analysis of data from the gatherings.//2004//

/2005/The Bureau used SSDI funds to provide a training workshop on community forums. Specifically, through a contract with the University of Alabama, Donna J. Petersen, MHS, ScD, Professor, UAB School of Public Health, presented a 1-day workshop, "Public Forums on Public Health," in Montgomery in September 2003. The workshop was attended by 29 persons, most of whom were area- or county-level ADPH staff or State-level staff located in a PHA office. The Epi/Data Branch prepared and distributed, in October 2003, "Maternal and Child Health Community Discussion Groups: A Manual in Progress." Subsequently, as stated in Section III.E, 14 county-level, area-level, or State-level staff located at the area level facilitated or helped facilitate one or more community discussion groups in early CY 2004. Because of fiscal constraints described in Section III.B, the Bureau did not contract with UAB to prepare a manual on community discussion groups, provide oversight of several community discussion groups, or provide ongoing consultation to the Epi/Data Branch concerning analysis of qualitative data.//2005//

/2004/The 2nd proposed component of the upcoming FY 2004-05 MCH needs assessment for which the Bureau requests additional monies is a telephone survey of Alabama households with children. Methodology would be similar to that used in the FY 2000 MCH needs assessment, during which the Bureau contracted with UAB's Survey Research Unit (SRU) to conduct the telephone survey. (Methods for and preliminary findings from the FY 2000 survey are described in Section II.) The tool for this survey was designed by the Director of the Epi/Data Branch, in consultation with several other Bureau members, the Bureau's MCH Needs Assessment Advisory Committee for the FY 2000 needs assessment, and SRU. The 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). The surveyed households were identified by SRU staff from a random-digit-dialing sample. The focal child in each participating eligible household was randomly selected through the use of computer-assisted telephone interviewing (CATI), using a rigorous protocol. The Bureau requests additional technical assistance monies to contract with SRU--or another university-based group that has clearly demonstrated experience and performance of comparable extent and quality--to provide consultation as the Bureau refines the data collection tool; to conduct the telephone phase of the survey, using procedures comparable to those for the Behavioral Risk Factor Survey; and to provide the Bureau with a SAS(TM) database and full documentation of the database. Data would then be analyzed by Epi/Data Branch staff. We are aware that the National Center for Health Statistics is expected to conduct a random-digit-dial National Survey of Child Health during the coming year. However, we have no assurance that the database will be available to us in time for the

Bureau to adequately analyze the data and integrate findings into the FY 2004-05 MCH needs assessment. That is, for findings to be fully integrated into the 5-year MCH needs assessment that is to be reported in the 2004 report/2006 application, the SAS(TM) database and full documentation should be available to the Bureau by no later than July 2004. Assurance of the availability of a random-digit-dialing-based database within this time frame, as well as assurance that information of interest to the Bureau is obtained, will require a contract between ADPH and the University of Alabama or a university housing a survey team comparable to SRU.//2004//

/2005/The Bureau is no longer actively seeking funds to conduct a random-digit-dial survey of Alabama Households with Children. A combination of circumstances have accounted for the decision not to seek funds at this time. First, based on communication in FY 2003, we expect the National Center for Health Statistics to provide access by early CY 2005 to a national telephone survey of households with children database (from which state-level estimates can be made). Secondly, fiscal constraints discussed in Section III.B have limited the amount of Title V dollars that the Bureau can spend on new initiatives. Thirdly, the loss of 2 analytic FTEs in the Epi/Data Branch, also discussed in Section III.B, left no personnel hours that could be devoted to refining the survey tool and methods.//2005//

/2004/A final request for technical assistance comes from the Bureau's WIC Division, which requests assistance in refining methodology used to compute in-need numbers for WIC. Epi/Data Branch staff have provided in-need estimates for WIC that were based on previously developed methodology. (Who initially developed the methodology is not clear.) Due to other responsibilities, however, most of which pertain to Title V or SSDI, Branch staff neither have had nor anticipate having time to evaluate or refine the methodology. One issue is the lack of sufficiently accurate information on the number of Hispanic/Latino persons in the State. Perhaps due to underestimates of this population, some counties are reported to provide WIC services to over 100% of persons in need of WIC. Although the availability of Year 2000 Census-based estimates of the numbers of Hispanic/Latino persons may somewhat alleviate the problem with WIC in-need estimates, the need for replacing or refining current methods for making these estimates continues. For this reason, provision of training and written materials on appropriate methodology for estimating WIC in-need numbers, and the application of that methodology to Alabama-specific numbers, would be much appreciated. Optimally, such training and materials should include provision of specific formulas and their application, using Alabama-specific numbers.//2004//

/2005/WIC is no longer requesting technical assistance from MCHB regarding computation of in-need numbers.

The Bureau's main needs for technical assistance continue to be met through SSDI: which is discussed in 2005 updates to HSC #1, HSC #9a, and SPM #2 (under "Current Activities" and "Plans for the Coming Year"). Appendix F, obtainable as described in Section III.A, now includes the State's SSDI FY 2004 Summary Progress Report, as well as the Competing Renewal Proposal for FY 2003.

With respect to regional or national training events, the Bureau's Epi/Data Branch suggests that AMCHP and/or MCHB consider sponsoring a workshop on analysis of qualitative data. The workshop should include such topics as the following: 1) special-purpose software proven to be of value in analysis of qualitative data; 2) utilization of software for general use, such as Microsoft(TM) Access, to develop and analyze a qualitative database; 3) and classification of qualitative material into issues, sub-issues, and corresponding views expressed by discussants. The mode of instruction should include lecture, hands-on experience with pertinent software, exercises for classifying and analyzing qualitative data, handouts (preferably manuals) that clearly present key information being covered in the lectures, and contacts for follow-up consultation.//2005//

V. BUDGET NARRATIVE

A. EXPENDITURES

ADPH

/2003/Form 3: State MCH Funding Profile

Line 1 (Federal Allocation)--This line indicates that, in FY 2001, ADPH expended \$9,027,236 of the federal award of \$12,487,088, leaving a carryover of about \$3,459,852. A portion of this carryover amount was due to payments of some of the earned incentives as well as purchase order and contract payments made in September 2001. Additionally, there was a turnover of personnel in the Office of Financial Services, which included key supervisory positions, as well as the replacement during the 4th quarter of Chris Haag, the Bureau Financial Officer, with Layton Williams.

Line 6--Program income in FY 2001 declined from \$13,431,846 in FY 2000 to \$11,415,109. This declining program income is as expected and supports a decline in the numbers of children and pregnant women served by CHDs. As stated in the 2000 report/2002 application, the decline in program income is consequent to the sharp decline in numbers of children and pregnant women served by CHDs. This decline is discussed in Section III.A of this submission of the 2002 report/2004 application. This decline in numbers of individuals served is largely due to changes in the health care environment, also discussed in Section III.A. Specifically, Medicaid's recently (during the last several years) implemented Patient 1st Program and Maternity Care Program have respectively led to declines in the numbers of children and pregnant women served at CHDs. As a corollary to the decline in program income, only \$13,431,846 in program income was expected in FY 2000, compared to over \$31 million that had been budgeted for that year and over \$30 million that had been expended in FY 1999. A comparison of FY 2001 costs associated with these services with the same FY 2002 program costs indicates that the trend in services is still declining. That is, only \$11,415,109 in program income were expended in FY 2001.

Form 4: Budget Details by Types of Individuals Served and Sources of Other Federal Funds

As shown in Line I.a, expenditures for pregnant women in FY 2001 were only \$11,099,874, compared to over \$33 million that had been budgeted for that year and over \$18 million expended in FY 2000. This discrepancy between budgeted and expended funds, as well as the decline in expenditures, is also due to the decline in the number of pregnant women served by CHDs that is described in Section III.A of this 2001 report/2003 application.

Expenditures for infants increased by 18% from FY 2000 (Line I.b): from \$4,124,245 in FY 2000 to \$4,880,156 in FY 2001. As in FY 2000, expenditures for infants in FY 2001 totaled half of what had been budgeted. The number of infants served in CHDs presumably declined as the number of children served declined. (The number of infants served in CHDs is not reported on Form 7, since that form estimates the number of newborns undergoing metabolic screening, rather than the number served at CHDs.)

Expenditures for children more than tripled (from the 1999 baseline) from just over \$4 million in FY 1999, to \$16,675,302 in FY 2001 (Line I.c). As stated in the 2000 report/2002 application, as explained in the discussion of Line I.A on Form 2, this increase reflects the initiation of case management for teens and non-clinic programs for children.

Form 5: State Title V Program Budget and Expenditures by Types of Services

Overall expenditures for FY 2001 (Line V) were within 24% of the projected budget for that year as compared to 14% for FY 2000. Although expenditures for direct health care services and population-based services were within 28% of their projected budget, the FY 2001 budget for direct health care services decreased by 4% over FY 2000, while the FY 2001 budget for population-based services increased by 41%. Additionally, FY 2001 expenditures for enabling services and infrastructure-building services were within 34% and 48% of their respective budgets (with infrastructure-building expenditures being 48% higher than the budgeted amount for this level).

Form 5 continues to reflect movement away from direct health care services in FY 2001, toward

services at the lower levels of the public health services pyramid (shown in Figure 1 of the current guidance for the MCH Services Block Grant reports/applications). That is, expenditures for direct health care services comprised only 72% of the Federal-State Title V Block Grant Partnership total expended funds (Line V) in FY 2001--down from 85.5% of this total during FY 1999 and only slightly higher than FY 2000 with 69.5%. As stated in the 2000 report/2002 application, this movement is consistent with the paradigm shift described elsewhere in this document, as well as the previously discussed declines in numbers of children and pregnant women served at CHDs.

FY 2001 expenditures for enabling services comprised 10.5% of the Federal-State partnership total expended funds (compared to 8.2% - 12.5% in previous years), those for population-based services 6.7% of the total (compared to 1.4% - 5.5% in previous years), and those for infrastructure-building services 11.7% of the total (compared to 3.1% - 12.5% in previous years).//2003//

/2004/Form 3: State MCH Funding Profile

Line 1--In FY 2002, ADPH expended 3.6 million dollars in excess of the federal award for FY 2002. The excess includes expenditures for FY 2001 activity, as is consistent with carryover reported in the 2001 activity as supported by the Budget Narrative in the 2001 report/2003 application.

Line 3--In FY 2002, Total State Funds exceeded budget by 19.1%. This increase is due to the inclusion of MAR Case Management, Teen Care Coordination, and Unwed Pregnancy Prevention programs.

Form 4: Budget Details by Types of Individuals Served and Sources of Other Federal Funds. Line I.a. indicates a continued downward trend in expenditures for pregnant women in FY 2002. This trend is consistent with that identified in the 2000 report/2002 application and again in the 2001 report/2003 application.//2004//

/2003/Updated data since submittal of the 2001 report/2003 application show that expenditures for infants in FY 2001 increased by a greater proportion than that initially reported, increasing from 18% (original submission) to 36.7% over FY 2000.//2003//

/2004/Form 5: State Title V Program Budget and Expenditures by Types of Services

FY 2002 expenditures in population-based services exceed the budget by 20.7% and include the addition of services in the MAR Case Management and Unwed Pregnancy Prevention programs. Included in the infrastructure-building services are expenditures for the Abstinence-Only Education and Community-Based Abstinence Education programs as well as services within the Unwed Pregnancy Prevention Program. FY 2002 infrastructure-building expenditures exceed budget by 71%. As with the previous year, Form 5 continues to reflect movement away from direct services in FY 2002, towards services in the lower levels of the public health pyramid.//2004//

/2005/Form 3: State MCH Funding Profile

Line 1--In FY 2003, ADPH expended 1 million dollars in excess of the federal award for FY 2003. This excess includes approximately 1.8 million dollars of expenditures for FY 2002 activity with approximately 750,000 dollars worth of activity to be paid in FY 2004.

Line 3--In FY 2003, Total State Funds lagged budget by 31%. This decrease in expenditures is partly due to a budget projection based on a template that had an incorrect cell reference that captured Medicaid dollars in error. This error has been corrected with the 2003 report/2005 application.

Line 6--Program Income for FY 2003 exceeded budget by over 120%. This increase is associated with the same template error as explained in the narrative for Line 3 above and resulted in understating the budget for Program Income. Again, this error has been corrected with the 2003 report/2005 application.

Form 4: Budget Details by Types of Individuals Served and Sources of Other Federal Funds Expenditures for pregnant women (Line I.a.), infants under 1 year old (Line I.b.), and children 1 to 22 years old (Line I.c.) were all less than their respective expenditures for FY 2002, which is consistent with the change in health care environment discussed in Section III.A. of the 2002 report/2004 application. (See field-level notes for Form 4 for details.) Although expenditures for children in FY 2002 and FY 2003 have increased markedly when compared with expenditures in previous years, due to the initiation of case management for teens and non-clinic programs for children as stated in the 2002 report/2004 application, expenditures for children were lower in FY 2003 than in FY 2002.

**Form 5: State Title V Program Budget and Expenditures by Types of Services
See field-level notes for Form 5./2005//**

CRS

/2003/See Forms 2-5. The only significant variation in expenditures for CRS in FY 2001 was in Program Income (Form 3, Line 6). Expenditures to date for FY 2001 under Program Income are approximately 2.2 million dollars less than the budgeted amount. The budgeted funds reported each year in Program Income are only an estimate. Therefore, actual expenditures more accurately reflect the funds received./2003//

/2004/The only significant variation in expenditures for CRS in FY 2002 was in Program Income (Form 3, Line 6). Expenditures to date for FY 2002 under Program Income are approximately 9 hundred thousand dollars less than the budgeted amount for the same reason as indicated in FY 2001. CRS has no unobligated balance of Federal Title V funds from FY 2002. CRS completed its 3-year MCHB-funded Genetics Demonstration Grant (which had a 1-year no-cost extension) in May 2003. It also completed its 1-year MCHB-funded post-demonstration TBI grant in March 2003./2004//

/2005/The only significant variation in expenditures for CRS in FY 2003 was in Program Income (Line 6, Form 3). Expenditures for FY 2003 under Program Income are approximately 1.6 million dollars less than budgeted amount. The budgeted funds reported each year in Program Income are only an estimate. Therefore, actual expenditures more accurately reflect the funds received./2005//

B. BUDGET

/2003/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.

ADPH

A description of notable variations in ADPH's budget (FY 2003) follows.

Form 2: MCH Budget Details for FY 2003

Line 8.a--ADPH initiated a Community-Based Abstinence Education program focusing on providing abstinence education in a community setting primarily to a target audience of adolescents 12-18 years of age and adults. Federal funds in the amount of \$661,902 were budgeted for this start-up year./2003//

/2004/ADPH's budget in MCH cost centers represents approximately 22 million dollars and is composed of the following programs: Maternity (6.5 million dollars), Child Health Assessments (4.2 million dollars), Child Primary Care (7 million dollars), School Health (3 million dollars), Perinatal (1.2 million dollars), Child Death Review (300 thousand dollars), and Dental (400 thousand dollars) with a major focus on services to children. The Title V allocation is approximately 12.9 million dollars. Of the federal allocation, 4.6 million dollars is provided to CRS under contract for services to CSHCN. Additionally, ADPH partners with DHR to provide Teen Family Planning Care Coordination services

for approximately 2.8 million dollars. ADPH will continue the Unwed Pregnancy Prevention Program with funds provided by DHR in the sum of approximately 3 million dollars. Through a CDC grant, ADPH expects to spend approximately 700 thousand dollars on the Childhood Lead Prevention Program. An additional 1.5 million dollars is budgeted for Abstinence-Only Education and the Community-Based Abstinence Education programs. Augmenting this effort is approximately 21.4 million dollars in the Family Planning Program, of which 4.3 million dollars is provided by Title X. //2004//

/2005/Although ADPH will have approximately 5.8 million fewer dollars in FY 2005 with the loss of the Teen Family Planning Care Coordination and Unwed Pregnancy Prevention programs, ADPH's budget in MCH cost centers is expected to be fairly level-funded compared to FY 2004, with expenditures expected to be between 22 and 23 million dollars. With the loss of MAR Case Management services brought about by Medicaid's cancellation of the Patient 1st Program, ADPH shifted resources to EPSDT Care Coordination in late FY 2004 and expects to see the same expenditures for FY 2005 (approximately 2.5 to 3 million dollars). Additionally, ADPH expects to see growth in the Family Planning services from approximately 21.4 million dollars in FY 2004 to approximately 25 million dollars in FY 2005, with 4.9 million dollars provided by Title X.//2005//

CRS

/2003/See Forms 2-5. Funds spent on CSHCN will support activities to address NPMs #2-#6 and SPM #7. Under Other Federal Funds, anticipated funding is included for the MCHB Comprehensive Core Hemophilia Grant.//2003//

Anticipated use of the budgeted monies is justified by the level of the pyramid:

I. Direct Health Services

CRS--Includes direct community-based services of specialty medical care, care coordination, and ancillary care through the CRS specialty clinic 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.

II. Enabling Services

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; parent consultant activities to assist families, advocate for their needs, and provide family support services offered through district offices.

III. Population-Based Services

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 awareness mechanisms.

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, in-service 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 a redesigned CRS management information system to collect and analyze data, and use of communication/information technology for public awareness and client/family education as appropriate.

/2004/See Forms 2-5. ADPH contracts with ADRS, Division of CRS, for services to CSHCN and provides 35.46% (approximately 4.68 million dollars) of Title V allocation to CRS for this effort. CRS

does not utilize its Federal Title V allocation to fund any administrative costs. CRS overmatches its federal dollars through its State allocation by over 2 million dollars. For FY 2004, in addition to its State allocation (8 million dollars), the CRS Budget Request includes funds from the Alabama EIS for the provision of early intervention services to Part C-eligible infants and toddlers (2.1 million dollars), a separate State allocation for the Alabama Hemophilia Program (1.3 million dollars), and program income from 3rd party reimbursements (10.6 million dollars). These funds, in conjunction with the Federal Title V allocation, comprise 99.9% of the projected CRS budget for FY 2004. CRS also receives \$28,700 from MCHB to provide comprehensive care to persons with hemophilia as a subgrantee of Hemophilia of Georgia. CRS will receive no other federal funds for special projects/grants in FY 2004.//2004//

/2005/See Forms 2-5. ADPH contracts with ADRS, Division of CRS, for services to CSHCN and allocates Title V dollars to the agency for this effort. Due to budget constraints in the State in FY 2004, ADPH reduced Title V funding to CRS to the required 30% of the federal MCH block grant (approximately 3.7 million dollars) compared to previous funding levels at 35.46% (approximately 4.5 million dollars). Budgeted Federal Allocation (Line 1, Form 3) was therefore reduced by \$777,955, representing this change. CRS continues to overmatch its federal dollars through its State allocation by over 2 million dollars. For FY 2004, budgeted monies for State Funds (Line 3, Form 3) represent an additional \$332,528 allocated by the State legislature. For FY 2005, in addition to its State allocation (7.9 million dollars), the CRS Budget Request includes funds from the Alabama EIS for the provision of early intervention services to Part-C eligible infants and toddlers (2.1 million dollars), a separate State allocation for the Alabama Hemophilia Program (1.1 million dollars), and program income from 3rd party reimbursements (13.6 million dollars). These funds, in conjunction with the Federal Title V allocation, comprise 99.9% of the projected CRS budget for FY 2005. Budgeted monies under Other Federal Funds (Line 10, Form 2) are significantly different from FY 2003 as \$114,401 was represented in a carryover from an MCHB Genetics grant, now completed. CRS continues to receive \$28,700 from MCHB to provide comprehensive care to persons with hemophilia as a subgrantee to Georgia. CRS anticipates no other federal funds for special projects or grants in FY 2005.//2005//

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.