Alabama State Action Plan Table 2024 Application/2022 Annual Report

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
Women/Maternal Health					
Lack of preventive dental visits across all Title V populations, especially for those uninsured.	Educate and reach out to oral health providers to improve understanding of preventive dental visits during pregnancy and through ads utilizing television, streaming, and social media platforms. Promote HPV education, and HPV vaccine education, promotion and referral using the #WATCHYOURMOUTH campaign developed through a partnership with Mitchell Cancer Institute.	By 2025, increase the percentage of dental providers who receive education on the importance of preventive dental visits for expectant mothers by 10 percent. By 2025, increase the percentage of dental providers who are provided education and support on the provision/referral for HPV vaccine by 10 percent. (create a provider Services survey and gather baseline data.)	NPM 13.1: Percent of women who had a preventive dental visit during pregnancy	ESM 13.1.1: Percentage of dental providers receiving information/education regarding importance of preventive dental visits for expectant mothers ESM 13.1.2: Percentage of dental providers that received information/education regarding their perinatal patients about the FDA-approved HPV vaccine in order to reduce the risk of oropharyngeal, cervical, and other HPV-related cancers	NOM 14: Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 19: Percent of children, ages 0 through 17, in excellent or very good health
High levels of maternal mortality.	Offering more classes for women participants in WIC in counties with higher rates of maternal mortality than the state rate or in at least 5 counties.	Provide routine classes, to women participants, that promote health, breastfeeding, safe sleep, and make referrals to other programs that impact maternal mortality.	NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	***Inactive -*** *ESM 1.1: Proportion of women age 15-55 who report receiving a preventive medical visit in the past 12 months by increasing total enrollment percentage*	NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations NOM 3: Maternal mortality rate per 100,000 live births NOM 4: Percent of low birth weight

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
				in the Well Woman Program by 2 points annually. ESM 1.2: Increase the percentage of women receiving both FP services and WW services by 2 percent within active WW counties.	deliveries (<2,500 grams) NOM 5: Percent of preterm births (<37 weeks) NOM 6: Percent of early term births (37, 38 weeks) NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.4: Preterm-related mortality rate per 100,000 live births NOM 10: Percent of women who drink alcohol in the last 3 months of pregnancy NOM 11: Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females NOM 24: Percent of women who experience postpartum depressive symptoms following a recent live birth

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
Perinatal/Infant Health					
High levels of infant mortality (and associated factors of preterm birth and low birth weight).	Convene the delivering hospitals to share data and discuss the Alabama Perinatal Regionalization System Guidelines.	Increase the percent of delivering hospitals convened at a meeting to share data and discuss the Alabama Perinatal Regionalization System Guidelines.	NPM 3: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)	ESM 3.1: Percent of delivering hospitals convened at a meeting to share data and discuss the Alabama Perinatal Regionalization System Guidelines ESM 3.2: Number of steps of the CDC's LOCATe process completed in order to design and align the Alabama Perinatal Regionalization System Guidelines with the national criteria for the maternal levels of care	NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate per 1,000 live births NOM 9.4: Preterm-related mortality rate per 100,000 live births
High levels of infant mortality (and associated factors of preterm birth and low birth weight).	Implement the CDC's Level of Care Assessment Tool (LOCATe) process in order to align and implement the national criteria for the maternal levels of care.	Complete the steps of the CDC's Level of Care Assessment Tool (LOCATe) process in order to design and align the Alabama Perinatal Regionalization System Guidelines with the national criteria for the maternal levels of care.	NPM 3: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)	ESM 3.1: Percent of delivering hospitals convened at a meeting to share data and discuss the Alabama Perinatal Regionalization System Guidelines ESM 3.2: Number of steps of the CDC's LOCATe process completed in order to design and align the Alabama Perinatal	NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate per 1,000 live births NOM 9.4: Preterm-related mortality rate per 100,000 live births

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
				Regionalization System Guidelines with the national criteria for the maternal levels of care	
High levels and worsening trends of sleep-related/SUID deaths.	Provide safe sleep education to WIC prenatal participants in order to increase the percent placing their infants to sleep on their backs.	Increase by 5 percent annually, the percentage of WIC prenatal participants placing their infants to sleep on their backs by providing safe infant sleep education.	NPM 5: A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding	***Inactive -*** *ESM 5.1: Number of sleep-related infant deaths* ESM 5.2: Number of trainings facilitated to assist healthcare professionals and first responders, who interact with expecting and new mothers, with being trained on safe sleep recommendations	NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.5: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births
High levels and worsening trends of sleep-related/SUID deaths.	Implement targeted consistent safe sleep education to caregivers, child health providers, health care providers, and hospital systems.	Decrease by 3 percent annually, the number of sleep-related infant deaths by implementing targeted consistent safe sleep education to caregivers, child health providers, health care providers, and hospital systems.	NPM 5: A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding	***Inactive -*** *ESM 5.1: Number of sleep-related infant deaths* ESM 5.2: Number of trainings facilitated to assist healthcare professionals and first responders, who interact with expecting and new mothers, with being trained on safe sleep recommendations	NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.5: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births
High levels and worsening trends of sleep-	Facilitate trainings to assist healthcare professionals and first responders, who interact with expecting and new mothers, with being trained on safe sleep recommendations.	Increase by 25 percent annually, the number of trainings facilitated to assist healthcare professionals and first responders, who interact	NPM 5: A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a	***Inactive -*** *ESM 5.1: Number of sleep-related infant deaths*	NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
related/SUID deaths.		with expecting and new mothers, with being trained on safe sleep recommendations.	separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding	ESM 5.2: Number of trainings facilitated to assist healthcare professionals and first responders, who interact with expecting and new mothers, with being trained on safe sleep recommendations	rate per 1,000 live births NOM 9.5: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births
Child Health					
Lack of preventive dental visits across all Title V populations, especially for those uninsured.	Provide educational preventive dental materials and oral health kits to patients and providers, and promotion of importance of preventive dental visits via the annual “Share Your Smile with Alabama” smile contest. Promote HPV education, and HPV vaccine education, promotion, and referral using the #WATCHYOURMOUTH campaign developed through a partnership with Mitchell Cancer Institute.	By 2025 increase the number of dental providers who receive education on the importance of preventive dental visits for children ages 1-17 years by 10 percent. By 2025, increase the percentage of dental providers who are provided education and support on the provision/referral for HPV vaccine by 10 percent. (create a provider Services survey and gather baseline data.)	NPM 13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	ESM 13.2.1: Percentage of providers receiving information/education regarding importance of preventive dental visits for children ages 1-17 years of age ESM 13.2.2: Percentage of dental providers that received information/education regarding informing their families of patients at 9 years of age about the FDA-approved HPV vaccine in order to prevent future oropharyngeal, cervical, and other HPV-related cancer	NOM 14: Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 19: Percent of children, ages 0 through 17, in excellent or very good health
Lack of timely,	Increase EPSDT sreenings in the county health departments.	Increase by 1 percent the total	NPM 6: Percent of	***Inactive -*** *ESM 6.1:*	NOM 13: Percent of children

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
appropriate, and consistent health and developmental screenings.		number of EPSDT screenings performed in county health departments annually.	children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	*Proportion of children birth to age 19 that received a well child appointment in the past year* ***Inactive -*** *ESM 6.2: Proportion of children birth to age 19 that received a developmental screening in conjunction with a well-child appointment in the past year* ESM 6.3: Proportion of children aged 12 & 24 months that have a reported blood lead screening in the past year ESM 6.4: Proportion of children birth to age 19 that received a well child appointment in the past year	meeting the criteria developed for school readiness (DEVELOPMENTAL) NOM 19: Percent of children, ages 0 through 17, in excellent or very good health
Lack of timely, appropriate, and consistent health and developmental screenings.	Partner with Alabama Partnership for Children (APC) and Help Me Grow to monitor the number of developmental screenings.	Increase by 1% the total number of children birth to age 5 that receive the ASQ-3.	NPM 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	***Inactive -*** *ESM 6.1: Proportion of children birth to age 19 that received a well child appointment in the past year* ***Inactive -*** *ESM 6.2: Proportion of children birth to age 19 that*	NOM 13: Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) NOM 19: Percent of children, ages 0 through 17, in excellent or very good health

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
				received a developmental screening in conjunction with a well-child appointment in the past year ESM 6.3: Proportion of children aged 12 & 24 months that have a reported blood lead screening in the past year ESM 6.4: Proportion of children birth to age 19 that received a well child appointment in the past year	
Lack of timely, appropriate, and consistent health and developmental screenings.	Consistently referring children in health departments where EPSDT is provided or to their health care provider in countries that do not offer EPSDT.	Ensure that all WIC participants benefit from EPSDT.			
Lack of timely, appropriate, and consistent health and developmental screenings.	Due to the increasing numbers of suicide in children/adolescents and failure to identify mental health concerns in children and adolescents proactively, partner with Suicide Prevention to incorporate questions related to mental health in initial and updated medical history questionnaires in an effort to identify potential mental health concerns.	Intervene/refer patients identified as having mental health concerns/suicidal tendencies to appropriate healthcare professionals.			
Lack of timely, appropriate, and consistent health and developmental screenings.	Increase the percentage of two year old children who were screened for lead poisoning at their 12 and 24 month follow-up visit.	Until more data is available, to maintain the percentage of two year old children who have received two blood lead tests at 12 and 24 months as recommended by the Alabama Childhood Lead Poisoning Prevention Program to	SPM 9: Percent of 2 year old children who have received two blood lead tests at 12 and 24 months as recommended by the ACLPP Program		

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
		at least 20 percent.			
Adolescent Health					
Lack of preventive dental visits across all Title V populations, especially for those uninsured.	Promote HPV education and HPV vaccine education, promotion, and referral using the #WATCHYOURMOUTH campaign developed through a partnership with Mitchell Cancer Institute.	By 2025 increase the number of dental providers who receive education on the importance of preventive dental visits for children ages 1-17 years by 10 percent. By 2025, increase the percentage of dental providers who are provided education and support on the provision/referral for HPV vaccine by 10 percent. (create a provider Services survey and gather baseline data.)	NPM 13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	ESM 13.2.1: Percentage of providers receiving information/education regarding importance of preventive dental visits for children ages 1-17 years of age ESM 13.2.2: Percentage of dental providers that received information/education regarding informing their families of patients at 9 years of age about the FDA-approved HPV vaccine in order to prevent future oropharyngeal, cervical, and other HPV-related cancer	NOM 14: Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 19: Percent of children, ages 0 through 17, in excellent or very good health
Lack of timely, appropriate, and consistent health and developmental screenings.	Increase EPSDT screenings in the county health departments.	Increase by 1 percent the total number of EPSDT screenings performed in county health departments annually.	NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.	***Inactive -*** *ESM 10.1: Proportion of adolescents, aged 12 to 19, that received an adolescent well visit in the past year* ESM 10.2: Proportion of adolescents, aged 12 to 19, that received	NOM 16.1: Adolescent mortality rate ages 10 through 19, per 100,000 NOM 16.2: Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 NOM 16.3: Adolescent suicide rate, ages 15 through 19, per

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
				an adolescent well visit in the past year	100,000 NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling NOM 19: Percent of children, ages 0 through 17, in excellent or very good health NOM 20: Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) NOM 22.2: Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza NOM 22.3: Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine NOM 22.4: Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine NOM 22.5: Percent of adolescents,

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
					ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females
Children with Special Health Care Needs					
Lack of or inadequate access to services necessary for CSHCN to transition to all aspects of adult life.	The state CSHCN program staff, including the Parent Consultant, will conduct a transition readiness assessment at age 14 using a standardized tool, administered periodically, and discuss needed self-care skills and changes in adult-centered care. The state CSHCN program staff, including the Parent Consultant, will incorporate transition planning into their existing plan of care, starting at age 14 partnering with youth and families in developing transition goals and preparing and updating a medical summary and emergency care plan. Provide education to families about Teen Transition clinic and the benefits of attending. Provide education to staff to guide implementation of transition strategies. The state CSHCN program staff will identify adult providers to accept program clients, complete a transfer package for youth leaving the program and follow-up with the provider regarding the YSHCN's transfer status. Obtain feedback on transition experience of young adults.	By 2025, increase the total score on the Six Core Elements of Health Care Transition™ 3.0 Current Assessment of Health Care Transition Activities for Transitioning Youth to an Adult Health Care Clinician from baseline to 90% (Baseline = FY 2020 total score of 68.75%). By 2025, increase the number of attendees at CRS Teen Transition clinic by 25% (Baseline = FY 2020 total attendees of 54).	NPM 12: Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care	ESM 12.1: Percent of YSHCN enrolled in State CSHCN program who report satisfaction with their transition experience to adulthood.	NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
Lack of or inadequate access to health and related services, especially in rural areas and for services identified as difficult to obtain.	Develop and implement a survey for families to assess the comprehensiveness of and satisfaction with CRS Care Coordination services and connection to community resources. Utilize information from the surveys to improve the quality of care coordination for CYSHCN. Educate families on the importance of care coordination and its value in improving health care outcomes for CYSHCN through developing a Care Coordination Program fact sheet. Train CRS care coordinators to use a family and person-centered approach to care plan development. Ensure that families of CYSHCN have access to and are educated about the importance of connection to a medical home. Expand outreach activities to promote public awareness of CRS Care Coordination Services within the medical community and among families of CYSHCN. Develop an internal tracking mechanism for referrals to community resources for CYSHCN not enrolled with CRS.	By 2025, increase by 10 percent the number of families of CYSHCN in the program who report receiving comprehensive care coordination.	SPM 3: Increase the capacity of families to connect CYSHCN to the health and human services they require for optimal behavioral, developmental, health, and wellness outcomes through our Care Coordination Program.		
Increase family and	Administer the FESAT to assess progress on strengthening family/youth engagement within CRS. Incorporate the four domains of Family	By 2025, increase the Engagement Score on the Family Engagement	SPM 2: Strengthen and enhance family/youth		

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
youth involvement and participation in advisory groups, program development, policy-making, and system building activities.	Engagement into staff development activities through the development of a Family Engagement Quality Improvement Initiative action plan within each CRS District. Conduct ongoing monitoring of District action plans to ensure incorporation of the four domains of Family Engagement. Utilize alternative methods to increase parent and youth involvement in advisory groups and program development i.e. Zoom meetings, Facebook Live meetings, and conference calls. Develop and conduct a Family Leadership Training Institute. Develop or modify a Family/Youth Partnership outreach campaign aimed at healthcare providers and related professionals to teach about the importance of engaging families/youth in the decision-making process. Utilize the Family/Youth Partnership outreach campaign materials at professional conferences and other community events.	in Systems Assessment Tool (FESAT) by 10% above the baseline (baseline to be established in FY 2021). By 2025 the first cohort of participants will have completed the Family Leadership Training Institute.	partnerships, involvement and engagement in advisory groups, program development, policymaking, and system-building activities to support shared decision making between families and health-related professionals.		
Cross-Cutting/Systems Building					
Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they live, learn, work, and play.	Increase the proportion of WW preventative visits in all program specific counties for women ages 15-55 and educating the public in all program specific counties of available WW services.	Increase the number of WW visits performed at the local county health departments; Increase public awareness of program via social media & marketing materials.			
Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they	Recruit women ages 15-55 to the WW program for cardiovascular disease risk factor screenings, healthy life/reproductive health planning (interconception and preconception care), health coaching and nutritional counseling.	Each county participating in WW program will establish a particular day of the week to offer WW services at the county health departments; WW staff will continue to assist identified at-risk women in having healthy pregnancies to avoid poor birth outcomes.			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
live, learn, work, and play.					
Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they live, learn, work, and play.	WW program will provide risk reduction counseling to help clients understand their risks, health coaching to set goals for behavioral change, and offer nutritional counseling and support to WW participants to help discover healthy lifestyle behaviors.	Program will continue to offer monthly support group meetings coordinated by social workers; nutritional classes per registered dietitian; and physical activity incentives, such as YMCA memberships, and through partnership with ADPH Nutrition and Physical Activity Division.			
Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they live, learn, work, and play.	Program will recruit all women aged 15-55 residing in counties participating in the WW program via marketing materials and social media.	Continue to partner with community partners in selected counties for referrals into the program; increase the number of community partners in all counties participating in WW program to increase enrollment and broaden ethnicity of participants.			
Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life	WW Program will continue to use Spanish speaking marketing materials to recruit population and offer Spanish literature for education and healthy lifestyle behaviors.	Increase & continue distribution of Spanish marketing materials to recruit Spanish speaking women aged 15-55.			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
where they live, learn, work, and play.					
Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they live, learn, work, and play.	Target underinsured and/or uninsured women, ages 15-55, to enroll in WW program.	Encourage/provide wellness visit to women, ages 15-55, who report not having a preventative visit in the last year regardless of insurance status.			
Lack of or inadequate or inequitable access to opportunities to make choices that allow people to live a long, healthy life where they live, learn, work, and play.	Increase the number of early head start programs that accept children with disabilities.	Increase the number of early head start programs that accept children with disabilities by one provider per year.	SPM 5: Increase the proportion of EHS programs participating in the EHSCCP grant program that maintain 10 percent of their population with children with special needs.		