

Section of Women's, Children's, and Family Health (WCFH) Programs
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Alaska Birth Defects Registry (ABDR)/FAS

Established in January 1996, the Birth Defects Registry is a surveillance program to provide information on the prevalence of birth defects among Alaskan infants and children.

- The ABDR is a confidential population-based surveillance system of birth defects as defined by the International Classification of Diseases, 9th edition.
- Eligible children are identified by medical providers who are required to report birth defects to the Division of Public Health.
- The ABDR is a multiple source surveillance system. Reports are cross-linked to insure an unduplicated count of the number of children affected by each reportable congenital anomaly.
- Prevalence estimates are calculated by birth year. Trends, distribution, and factors associated with each condition are monitored in order to assess and evaluate potential etiologies and the effect of preventive interventions.

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Alaska Surveillance of Child Abuse and Neglect (Alaska SCAN)

Alaska SCAN was established in 2008 and gathers data on child maltreatment from a variety of sources, such as vital statistics, police reports, medical examiner reports, hospital records, and child protective services. Individually, these sources provide fragmented data about maltreatment in a narrow context but together they offer a more complete picture of the circumstances surrounding maltreatment.

- Benefits from this system include being able to identify points for interventions, trends or change over time, effectiveness of interventions, risk factors for maltreatment, and an accurate assessment of the actual burden of child maltreatment in Alaska.
- This project will provide the necessary information to guide and support the efforts of all the different agencies in Alaska concerned with reducing child maltreatment.

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Childhood Understanding Behaviors Survey (CUBS)

This is a mail and phone follow-up survey to PRAMS that interviews mothers of three-year-old children who completed the PRAMS survey after their child was born. The CUBS program began sending out surveys in 2006.

- Topics covered on CUBS include child development, nutrition and eating habits, general and specialized health care utilization and access, and child care, as well as items specific to maternal experiences.
- The goal of CUBS is to fill the gap in public health knowledge about the health behavior and early childhood experiences of young Alaskan children before they enter school. By re-interviewing mothers who completed a PRAMS survey, CUBS analysts can evaluate factors present at birth or early life that increase risk for later adverse childhood outcomes.
- If you ever have a client who asks about CUBS, encourage them to fill out the survey.
- For data requests or questions about CUBS, contact the CUBS Coordinator.

Contact: Margaret Young, CUBS Coordinator and Epidemiologist, 269-5657, Margaret.Young@alaska.gov

Maternal-Infant Mortality Review/Child Death Review (MIMR/CDR)

The Maternal-Infant Mortality Review Project was established in 1989. The initial goal of the program was to reduce infant mortality. The goal was later expanded to include maternal and child deaths. The MCH Epi Unit coordinates on-going expert committee reviews of every infant, child (<age 15 years), and maternal death in Alaska. Case files available for reviews include medical records, autopsy reports, death scene investigation reports, and other records as available and appropriate. The committee identifies factors that contributed to the death and makes recommendations about how to prevent future similar deaths.

- The ultimate objective of MIMR-CDR is to reduce maternal, infant and child mortality and morbidity. Other objectives are to
 - Identify preventable causes of death and develop recommendations for public health interventions
 - Educate health care providers regarding preventive, diagnostic and therapeutic contributors to death
 - Educate the public regarding the causes of mortality and the public's role in prevention.

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Maternal and Child Health Indicator Surveillance Project (MCH-ISP)

The goal of the project is to provide data on national and state-specific maternal and child health (MCH) indicators to promote and improve the health and well-being of mothers and children in Alaska.

- The project gathers, analyzes and summarizes epidemiological data on MCH indicators for Alaska. Data are gathered from local, state and federal agencies, including existing surveillance projects within the MCH Epidemiology Unit.
- The project contributes to the Alaska MCH Data Book publications.
- The program is a resource for anyone needing MCH data for grant applications, project planning, program evaluation, and needs assessments.
- For more information on how MCH-ISP can work for you, contact the Coordinator.

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Pregnancy Risk Assessment Monitoring System (PRAMS)

This is a survey of mothers of newborns that has been on-going in Alaska since 1990. It collects all kinds of information about behaviors and circumstances of Alaskan mothers and their infants surrounding the pregnancy and postpartum period.

- Outside of what Vital Records can provide, PRAMS is the only source of population-based data on maternal and infant issues for Alaska. Unintended births, breastfeeding, domestic violence, prenatal substance use, and depression are just some of the topics covered in PRAMS.
- If you ever have a client who asks about PRAMS, encourage them to fill the survey out.
- If you need data on maternal or infant issues, check with the PRAMS Coordinator.

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Adult Health Unit

Kelly Keeter, MPH, Unit Manager 907-269-3461

Breast and Cervical Health

The State of Alaska Breast and Cervical Health Check (BCHC) pays for breast and cervical cancer screening and diagnosis for women 21-64 years old who meet program eligibility requirements.

- BCHC Program Eligibility Guidelines:
 - Women ages 21-64;
 - Who meet income guidelines based on family size and monthly income (250% of federal poverty rates, updated annually in January);
 - Who don't have insurance;
 - Whose insurance will not pay for breast and cervical cancer screening;
 - Who have insurance but can't afford the deductible (after deductible is met, insurance is responsible for payment).
- Women are enrolled through contracted providers, Public Health Centers and by women calling the 1-800-410-6266 in order to determine eligibility. 1-800-410-6266, 907-269-4662 are the phone numbers to BCHC. Fax number is 907-269-3414.
- BCHC pays for breast and cervical cancer screening from the first Pap and Mammogram up until a diagnosis of cancer is determined following USPSTF, ACOG and ASCCP guidelines.

- BCHC can pay for HPV testing when done as a cancer screening tool.
- Women who are eligible for BCHC can be referred to a BCHC Clinical Consultant for follow up of an abnormal Pap and/or CBE results. The initial Pap or Mammogram does not have to be paid for by BCHC in order for the women to be enrolled.
- It is beneficial for Public Health Center clients ages 40 to 64 to be enrolled presumptively to provide coverage for screening mammograms and any subsequent diagnostic follow up. Women younger than 40 who have an abnormal CBE can be referred to a breast consultant on the BCHC Clinical Resource list, once the Enrollment Form has been sent to BCHC.
- For women who are screened through BCHC and who need treatment for breast or cervical cancer, or a pre-cancerous cervical condition requiring treatment, BCHC refers the woman to BC (Breast and Cervical) Medicaid. This allows women who would not normally be eligible for Medicaid access to Medicaid to pay for treatment.
- BCHC works with providers to help improve cancer screening in their offices by distributing evidence based materials to motivate women towards screening.
- BCHC works with partners to increase cancer screening rates statewide by linking resources. Examples would be in linking outreach activities to imaging centers to increase mammography services.

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 Jennifer Roberts, BCHC Program Coordinator, 269-3491, Jennifer.Roberts1@alaska.gov

Family Planning

The Family Planning Program funds comprehensive family planning and related reproductive health services for low income women, men, and teens.

- The federal Title X Family Planning Services Grant funds clinical family planning and related reproductive health services, supplies, counseling and education at the Mat-Su Public Health Center in Wasilla and the non-profit Kachemak Bay Family Planning Clinic in Homer.
- The Federally funded Title V Family Planning Program maintains formal contracts with Nurse Practitioners who offer family planning and related reproductive health services at the Kodiak Public Health Center and at Juneau School Health Centers.

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Reproductive Health Partnership (RHP)

The Division of Public Assistance funds the RHP's evidence-based initiatives which are designed to reduce the number of unintended and non-marital pregnancies in census areas of the state having the highest rates and greatest numbers of those births. RHP activities include:

- Providing tools, technical assistance and skills building trainings for client education and counseling about family planning methods, teen pregnancy prevention, birth spacing strategies and characteristics and benefits of healthy relationships for RHP health care providers.
- Coordination of clinical skills building trainings for provision of reversible, reliable and cost efficient contraceptives that are shown to have the highest level of effectiveness in reducing unintended pregnancies and in assuring optimal pregnancy spacing.
- Periodic provision of a very limited supply of the highly reliable contraceptives for women in need who live in the identified census areas.

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Women's Health Program

The Women's Health Program promotes resources and initiatives designed to improve the health of Alaskan women of all ages. Activities include:

- Providing the public with reliable information about healthful living and its role in reducing the incidence of chronic and preventable conditions.
- Promotion of evidence-based clinical practices based on nationally recognized guidelines, including those published by the U.S. Preventive Services Task Force and the Centers for Disease Control and Prevention, to providers of women's health care through multiple venues, including live webcast, statewide and regional conferences.

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School Age and Adolescent Health Unit

Stephanie Birch, RNC, MPH, MSN, FNP, Section Chief and Unit Manager 907-334-2424

Adolescent Health

The Adolescent Health Program seeks to promote positive youth development and prevent or reduce negative health outcomes, with a focus on:

- Managing community grants on unintended pregnancy and sexually transmitted infection prevention;
- Promoting healthy relationships and a reduction in risky behaviors;
- Implementing primary prevention strategies to reduce the prevalence of sexual assault;
- Encouraging family, school and community involvement in the lives of youth;
- Collaborating with stakeholders throughout the state to promote overall adolescent health and wellbeing;
- Coordinating Youth Alliance for a Healthier Alaska- a statewide youth advisory committee;
- Implementing Alaska Promoting Health Among Teens (AKPHAT) in communities throughout Alaska. AKPHAT is a teenage pregnancy prevention program with trained and supervised peer educators.
- Implementing the Fourth R Curriculum in schools across Alaska. The Fourth R teaches healthy relationship skills and empowers adolescents to make healthier decisions about relationships, sexual behavior, and substance use; and
- Providing technical assistance, trainings, and resources on healthy relationships, peer education, teen pregnancy prevention, youth development, and more for parents, teachers, or adolescent service providers

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School Nursing and School Health

The School Nursing/School Health Program seeks to promote optimal health and safety, educational achievement, and growth/development for all Alaska school children via provision of quality nursing and health services in schools. Key components of the program are:

- Clinical consultation, technical assistance, policy development and analysis, professional education in the areas of school nursing practice and school health
- Research and evaluation of best practices in the provision of school nursing and evaluation of the provision of school nursing services in schools across the state
- Consultation and collaboration with national and state advisory committees including the National Association of State School Nurse Consultants, National School Nurse Association, Alaska Association of School Nurses, American School Health Association
- Consultation and collaboration between the Department of Health and Social Services, the Department of Education and Early Development, the Department of Transportation, All Alaska Pediatric Partnership, Division of Behavioral Health, and the Section of Chronic Disease Prevention and Health Promotion for promotion of a system of Coordinated School Health Programs at the state and local level
- Inter- and intra-agency collaboration and partnering for school based health clinics, oral health screening and sealant programs, school environmental health, disaster preparedness and health services in schools for children with special health care needs
- Leadership of the School Health Nurse Advisory Committee providing best practice guidelines for the development of quality, standardized school nursing and school health policies and procedures statewide as well as education for the role of the school nurse in school health services
- Development and coordination of school nurse professional development
- Promotion of comprehensive well child preventative health visits that include developmental assessments

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MCH-Pediatric Disaster Planning and Emergency Preparedness/Early Childhood

Established in 2011, the goals of this program are to 1) increase community awareness of health care needs and 2) promote access to essential health services for MCH populations that are especially vulnerable during times of disaster: pregnant women, women with infants, and children and youth with special health care needs (CYSCHN).

Research indicates that during disasters, MCH populations experience greater rates of health complications, including increased risk of premature births and infant death. Less is known about the long-term health impact of disasters on these populations. The activities of this program include:

- Collecting, analyzing, and using multiple data sources and Alaska community assessments to better manage maternal, infant, and CYSHN health care programs in the event of a disaster (local, regional, or statewide)

- Providing technical assistance to local and non-profit agencies as they develop more inclusive disaster preparedness plans that address the needs of maternal, infant, and CYSHN populations
- Coordinating disaster preparedness and related workforce training efforts for pediatric health care providers and others who work with maternal, infant, and CYSHN populations
- Leading disaster-preparedness subcommittees, in collaboration with the All-Alaskan Pediatric Partnership and other identified stakeholders

As emergency/disaster preparedness plans are developed and revised, it is imperative that the special needs of maternal, infant, and CYSHN populations are considered and incorporated. During 2011, the program manager will conduct a statewide needs assessment to further identify disaster-related needs of MCH populations across the state. This assessment will further efforts, including development of additional training resources and ongoing program evaluation.

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Oral Health

The Alaska Oral Health Program was funded by the Centers for Disease Control and Prevention in 2003 through a Chronic Disease Prevention and Health Promotion Cooperative Agreement. In FY2014 funding for the program has transitioned to grant funds from the Health Resources and Services Administration and funding within the WCFH Section. Activities include:

- Developing a comprehensive state oral health plan and surveillance system.
- Convening a broad-based oral health coalition to provide an advisory role for the oral health program and improve coordination and collaboration between public and private health systems.
- Developing a state community water fluoridation program.
- Coordinating development of a school-based dental sealant program.

Summary data and the state oral health plan is available at <http://www.hss.state.ak.us/dph/wcfh/Oralhealth/>

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Perinatal and Early Childhood Health Unit

Rebekah Morisse RN, MPH, Unit Manager 269-4762

Perinatal Health

This program provides consultation and technical assistance on perinatal health and birth outcomes to public and private health care providers across Alaska, and leadership to improve health care systems. The focus is on population-based activities and infrastructure building. Activities include:

- Developing and coordinating a statewide perinatal advisory committee to provide a network to communicate and problem-solve among perinatal health care providers.
- Identifying areas for improvement in perinatal standards of care and supporting development of policies and protocols.
- Partnering with health care providers and administrators to improve perinatal outcomes; supporting and collaborating with organizations that promote perinatal health.
- Developing, implementing, and evaluating initiatives to improve perinatal health including:
 - Alaska Infant Safe Sleep Initiative
 - Maternal, Infant, and Early Childhood Home Visiting Program
 - Alaska Healthy Start Program
 - Healthy Weights in Pregnancy
 - Promoting immunizations
 - Alaska Breastfeeding Initiative
- Providing professional education opportunities through participation in conference planning, distribution of materials, and sharing MCH data.
- Preparing information for issues of public or legislative concern.

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Genetic and Other MCH Specialty Clinics

Genetic and Specialty Clinics contracts with medical specialists to bring them to regional centers where there are no local providers with specialty expertise. This makes specialty care more accessible for those who need it. Local health practitioners are invited to facilitate coordination of care.

The Genetic and Metabolic Genetics Clinics offer diagnostic evaluations and genetic counseling for individuals with:

- Birth defects or genetic disorders
- Developmental delays
- Changes in body chemistry or metabolic disorders
- Vision or hearing problems or other sensory problems.

Specialty Clinics provide services through two clinics. Cleft Lip and Palate Clinic provides multidisciplinary, long-term comprehensive, coordinated evaluations, and treatment planning for children with craniofacial abnormalities.

Neurodevelopmental/Autism Clinics offers screenings and consultations for children with neurodevelopmental conditions. Autism screening clinics have been added around the state to reduce the number of children needing to travel to Anchorage for a full diagnostic evaluation.

Process for referral:

- Contact the program manager/coordinator to request a 1-page referral form, if needed.
- Fax the completed referral form with all medical records relevant to the referral reason to the program manager. Complete information will expedite the scheduling process.
- The program manager will then contact the family to schedule the clinic appointment and will follow-up to let you know. It generally takes 3-6 months from the time of referral before a client is seen in Genetics Clinic and for Specialty Clinics it can vary from 1 month to 1 year, depending on the frequency of clinics.

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Newborn Hearing Screening

The State of Alaska Early Hearing Detection and Intervention (EHDI) Program is committed to the National EHDI 1-3-6 Goals: newborn screening before 1 month of age, diagnostic assessment before 3 months, and intervention services before 6 months. The Alaska mandate for universal newborn hearing screening and intervention went into effect in January 2008.

- All birthing hospitals in Alaska are screening newborns. Hearing screening equipment was placed at public health centers in three communities with high out of hospital births and in four midwifery centers in communities experiencing obstacles to screening at their local hospital. Information on where an infant can receive a hearing screening or location of pediatric audiology services can be obtained from the State EHDI Program.
- All newborn hearing screening results, including missed screenings, are reported into a secure web-based data system. Newborn hearing results are reported weekly and audiology (diagnostic) results are reported on a monthly basis.
- If parents or primary care providers do not know if an infant had a hearing screening, or passed their screening, this information can be obtained from the database through the State EHDI Program.
- Parent support is available for children diagnosed with a hearing loss through a parent navigation grant with the Stone Soup Group.
- The EHDI Advisory Committee meets 3x/year to discuss any issues or concerns about the screening program and updating any changes to protocol

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Newborn Metabolic Screening

The Newborn Metabolic Screening program screens for more than 30 metabolic disorders, endocrine disorders, abnormal hemoglobins, and cystic fibrosis. Educational presentations are conducted for the medical community when requested.

- Follow-up includes ensuring abnormal screens are not closed until a diagnosis is made or the case is closed with a normal screen. Additional follow-up is done on improper collections with educational brochures and charts provided on proper collection techniques.
- Children diagnosed with a metabolic disorder through the screening program are seen in the state sponsored Metabolic Clinics and have their diets monitored by a metabolic nutritionist.
- A DVD was produced on one of the conditions when a high prevalence was found in the Alaska Native population. The condition is CPT-1 deficiency and has been identified in more than 300 infants to date. The DVD is sent to each family with an infant diagnosed with this condition to provide education on how to care for their child.
- In 2008, metabolic screening results were successfully integrated into the EHDI database so both programs could be tracked with the same system.
- The NBMS Advisory Committee meets 3x/year to discuss issues, concerns, and proposed changes to the screening panel.

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Autism, Neurodevelopmental Disorders, and Parent Support Services

In 2007, the State of Alaska's Section of Women's Children and Family Health (WCFH) collaborated with programs and agencies statewide in response to the Governor's Council on Disabilities and Special Education five-part autism strategic plan. In partnership, a system of care for children with autism spectrum disorder and other neurodevelopmental conditions was built which includes improved screening, intervention, diagnostic, and treatment services statewide. Highlights of current and on-going program development for children and youth with special healthcare needs (CYSHCN) include:

- Pediatric neurodevelopmental outreach and autism screening clinics are held in 12 rural Alaska communities. In collaboration with tribal health, local health providers, families, and community agencies, patients are referred and seen by a developmental specialist and supported by a parent navigator. Children identified with autism concerns are referred for additional testing; families of children identified with other developmental concerns are supported and given options in their home communities.
- Materials are distributed and educational presentations are conducted statewide to improve the use of early periodic screening diagnosis and treatment (EPSDT) standards and evidence-based treatment options or intervention skill development for medical providers, school or community educators, and community-based direct service staff.
- Special focus is given to program development for 6 national performance measures for CYSHCN from the Title V Maternal Child Health block grant. Working with families, providers, and colleagues, these include an improved service delivery that is organized and accessible; options or adequate insurance to pay for services; CYSHCN transition projects; consistent, quality, and coordinated medical home systems of care; and an improvement and partnering for families and CYSHCN to be involved in all levels of decision making.
- In partnership with families and CYSHCN, ensure meaningful and active participation in Advisory or Action Committees that meet to discuss issues or concerns associated with Alaska's system of care.

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Pediatric Medical Home and Care Coordination Program

The Section of Women's, Children's & Family Health (WCFH) is coordinating a three year Pediatric Patient-Centered Medical Home (PCMH) demonstration project to improve systems of services for Children and Youth with Special Health Care Needs (2011 – 2014). This federally funded project pilots Care Coordination for (CYSHCN) within the context of two pediatric clinical practices within Southcentral Alaska. The project also seeks to expand statewide adoption of "Bright Futures" standards for child and adolescent care as recommended by the American Academy of Pediatrics, and to improve services and increase family supports for CYSHCN as they transition into adulthood. The project addresses systems change through the following goals and activities:

- Promote Medical Home "Model Clinic Sites" through comprehensive care coordination for CYSHCN
- Expand provider access to medical home concepts and tools
- Partner with Medicaid to integrate "Bright Futures" into clinical practice (focus on prevention and screening)
- Integrate and adopt quality measures from related statewide initiatives for sustainability and Continuous Quality Improvement.

Primary Activities:

- Hire two state employed pediatric care coordinators to provide services within two partnering "Model Clinic Sites" (urban subspecialty clinic & rural primary care clinic)
 - Identify children and youth with special health needs and develop plans of care
 - Outreach and referral
 - Health coaching and education
 - Data collection and reporting
- Partner with physician champion and stakeholders to identify barriers to PCMH in primary care practices
- Engage family partnership/leadership to promote PCMH within pediatric practices
- Promote policy changes to support PCMH implementation statewide
- Care Coordination workforce development in partnership with All Alaska Pediatric Partnership and University of Alaska (certificate program new in 2014)
- Provide PCMH related technical assistance to providers (focus on care coordination)
- Continued promotion and dissemination of evidence based developmental screening tools and methods

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