Alaska Health

Alaska’s National Health Ranking: 50/50

KIDS COUNT

Fall 2018
The Alaska Children’s Trust would like to thank the following people and organizations that helped produce the 2018 Kids Count Alaska report series. Each of these people dedicates themselves to the success of Alaska children every day. We sincerely thank you for your generous contribution of funding, time, data, and advice.

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Rasmuson Foundation

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In a state full of resources, we sometimes forget that our most precious and valuable resource is in homes across Alaska—our children. Alaska’s growth and prosperity is deeply connected to the health and productivity of our children, families, and the communities in which they live. Alaska is home to 187,300 children, and while many of them are thriving, there are just as many who are not.

All families—no matter their education level, economic status, family structure, or where they live—can raise children who thrive. Unfortunately, many of our hard-working Alaskan families are struggling, faced with challenges that prevent them from becoming, and remaining, physically, mentally, and economically self-sufficient.

As a state, we all have a responsibility to ensure our children and families live in safe, stable, and nurturing environments. One of the ways we can ensure we achieve this goal is by allowing data to help tell the story of how we can eliminate the challenges that prevent our families from raising thriving children.

Alaska Children’s Trust (ACT) embraces the belief that all Alaskans have a responsibility to support our children and families, and has adopted a framework that provides the architectural structure Alaska needs to support these families. This framework has six core components:

1. **Foster Data** – data is neutral information that is an essential tool in building the road map to true success.
2. **Advocacy** – ensures implementation of legislation that addresses the root cause of trauma and supports resilience.
3. **Community Investment** – utilizes resources that support efforts to address the social determinants identified by the data.
4. **Strengthen Economic Supports for Families** – lack of resources (i.e. wages, health insurance, transportation) leads to many of the social determinants that create the environment that cultivates unhealthy children. This strategy aims to improve the socioeconomic conditions of families, which tend to have the largest impacts on health.
5. **Education & Life Skills** – increases children’s access to more effective, equitable education, social-emotional learning, and life skills training.
6. **Norms & Values** – aims to strengthen norms and values that support safe, stable, and nurturing environments for children and families.

Kids Count Alaska is an ACT project that supports the first core component of this framework – Foster Data. Kids Count Alaska is part of the national KIDS COUNT program at the Annie E. Casey Foundation (AECF). The mission of KIDS COUNT is to ensure child advocates, policymakers, and the public have access to high-quality, unbiased data about child well-being. AECF gathers and publishes child well-being data from national and state sources online on the KIDS COUNT Data Center. Currently, the data center houses over 4 million data points at national and local levels. To provide an accessible snapshot of child well-being, KIDS COUNT compiles annual Data Books that describe national and state progress towards selected indicators of children’s economic well-being, education, health, and family/community context. KIDS COUNT engages in advocacy at the federal level.
for investments in data collection and provides funding to a network of organizations to gather data and support advocacy at the state level.

ACT has operated as Alaska’s KIDS COUNT partner since 2016. Kids Count Alaska is part of the Voices for Alaska’s Children program (Voices) at ACT. Voices is a grassroots community movement focused on continually raising awareness of the needs and challenges of children, youth, and families throughout Alaska. Voices is an independent voice for children; it aims to provide a sustainable and impactful system that allows every voice to be heard during advocacy for policies and decisions that support children. The goal of Voices is to help create a normative shift that ensures children and families live in safe, stable, and nurturing environments.

Trevor Storrs
President / CEO
Alaska Children’s Trust
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Executive Summary

KIDS COUNT is a project of the Annie E. Casey Foundation (AECF) that ensures child advocates, policymakers, and the public have access to high-quality, unbiased data about child well-being. Kids Count Alaska is part of the Voices for Alaska Children program at the Alaska Children’s Trust (ACT). The following summary, completed by McDowell Group, presents analysis of national and state-level KIDS COUNT data focused on the health of Alaska children.

All data included here can be found at datacenter.kidscount.org/data#AK. Analysis of this data and more is published in the report 2018 Kids Count: Health available at www.alaskachildrenstrust.org.

Alaska Children

187,300
CHILDREN between the ages of 0 and 17 LIVE IN ALASKA

Source: U.S. Census Bureau

- Alaska’s child population will continue to increase modestly through 2045.
- Population changes vary regionally. Over the last 15 years, the child population has increased steadily in the Matanuska-Susitna region, remained about the same in the Interior, Northern, and Southwest regions, and decreased in all other regions.
- Most children live in two-parent households, but approximately 60,000 children live with only one parent. Nearly 40,000 single-parent households are headed by women.
- Alaska’s child population is more racially diverse than the adult population.

Births

- 11,215 babies were born to Alaska families in 2016.
- Nearly 40 percent of women who give birth have less than adequate prenatal care. Statewide, 6 percent of births are to women receiving late or no prenatal care.
- Sixty percent of women who gave birth in 2016 had more than 12 years of education.
- The teen birth rate decreased from 40.3 births per 1,000 females during 2007-2011 to 29.4 during 2012-2016.

Insurance, Access & Preventive Care

- Nine out of 10 Alaska children had insurance coverage in 2016 (90 percent).
- In 2016, about one-half of Alaska children were covered by employer-based insurance (49 percent or 92,000 children).
- Twenty percent of Alaska children did not have a usual source of medical care or visited a hospital emergency room for care when sick in 2016.
Seventy-eight percent of children visited a doctor, nurse, or other health care provider for a preventive check-up within the year (142,060 children).

Seventy-six percent of children saw a dentist at least once for preventive dental care during the year (132,693 children).

Forty-seven percent of children (ages 9 to 35 months) received a developmental screening during the year.

**General Health**

- Nearly all parent/guardians reported their child was in excellent or very good health in 2016 (94 percent).
- In 2016, 79 percent of children had a parent/guardian who reported their child’s teeth were in excellent or very good condition.
- Twenty-six percent of children were overweight or obese in 2016.
- During 2014 to 2016, 20 percent of children lived in a household where there was not enough food.

**Adverse Childhood Experiences**

- Roughly one-fifth of children have experienced one ACE (37,460 children).
- About one-quarter of children have experienced two or more ACEs (43,300 children).

**Risk Behaviors**

- Twenty-seven percent of Alaska high school students reported smoking tobacco, using smokeless tobacco, or using electronic vapor products during the past 30 days in 2017.
- Twenty-two percent of Alaska high school students reported using marijuana at least once in the past month in 2017.
- Twenty-three percent of Alaska high school students reported drinking alcohol during the past month in 2017.
- In 2017, 10 percent of Alaska high school students reported having sexual intercourse with four or more partners during their lifetime.

**Deaths**

- During 2012 to 2016, the Alaska infant mortality rate was 6.0 deaths per 1,000 live births.
- The average annual child death rate in Alaska was 24.1 per 100,000 children (ages 1 to 14) during 2012 to 2016.
- From 2012 to 2016, the average annual teen death rate in Alaska was 77.6 deaths per 100,000 teens (ages 15 to 19).
Introduction

Kids Count Alaska will release a quarterly Kids Count report focused on a core topic. This report, the third of four reports of the 2017-2018 Alaska KIDS COUNT Data Book, focuses on the health of Alaska children and presents analysis of KIDS COUNT data. An executive summary that summarizes the data in this report and an infographic that highlights key findings accompany the report.

Report Structure

Following an introductory letter and the executive summary, this report and all others in the series provide an overview of basic demographic data about Alaska children. Next, this report explores a variety of published indicators that describe the health of Alaska children. The report concludes with a summary of resources to learn more about this topic. A glossary and source notes are included in the Appendices.

Methodology

Information in this report comes from analysis of secondary data publicly available on the KIDS COUNT Data Center. Data denoted by “National KIDS COUNT” are gathered and published by the AECF. Data denoted by “Kids Count Alaska” are compiled from several sources and published by Alaska’s Department of Health and Social Services (DHSS). Detailed citations and the original data sources are included as endnotes in the final section of this report. The glossary defines terms used in the indicators; links connect first-used terms to the glossary. A complete list of health indicators available on the Data Center is provided in the Appendices.

The approach for this report included review of all available health data and documentation from the data center, assessment of the quality and limitations of the data, followed by selection of indicators for analysis and inclusion in the report. The selection process prioritized relevant, stand-alone indicators that explored different dimensions of child health. The ACT Kids Count Advisory Committee provided recommendations for data to highlight in this report, and an outside review team contributed to content and the ‘Finding Solutions’ section.

Data Sources

While all data in this report were gathered from the KIDS COUNT Data Center, the following sources were used by National KIDS COUNT and Kids Count Alaska:

- **U.S. Census Bureau** provides demographic data, including age, race, household characteristics, languages spoken, gender, labor force information, income, etc. All census data are gathered as of April 1 every 10 years, and the income data gathered reflects the previous year.

- **Alaska Department of Labor and Workforce Development (DOLWD)** provides a range of economic data to the public, including population estimates (overall, age and gender, and race), population projections, migration, employment and wages, employers, resident hire, unemployment data, industry and occupational information, workplace safety, cost of living and housing information, workforce training, and local and regional information. The data consider Alaska’s unique patterns, including
seasonal employment, lack of roads, migration, etc., and utilize information only available in Alaska to provide their estimates, such as Permanent Fund enrollment.

- The **American Community Survey (ACS)** collects a wide range of information about demographic, social, economic, and housing characteristics. The ACS produces annual and five-year estimates. It is administered by the U.S. Census Bureau.

- The Alaska **Behavioral Risk Factor Surveillance System (BRFSS) Survey** is a national CDC grant-funded telephone survey of randomly selected adults regarding health-related behaviors. There are national questions and optional modules specific to Alaska. In 2013, Alaska began surveying for Adverse Childhood Experiences (ACEs) among adults ages 18 and older.


- The **Childhood Understanding Behaviors Survey (CUBS)** is a survey sent to mothers with 3-year-old children; about 90 mothers receive the survey each month. It is a follow-up survey to the Pregnancy Risk Assessment Monitoring System (PRAMS). CUBS gathers data related to toddler behavior, health, health care access, parenting, and school readiness. For the purposes of this report, survey responses are described using the terms “mothers of 3-year-olds,” “3-year-olds,” and “mothers.”

- Some program-specific data sources are also consulted, such as Head Start.

- The **National Survey of Children’s Health** is a household survey administered by the U.S. Census Bureau to produce national and state-level data on the physical and emotional health of children 0 - 17 years old. Parents of children ages 0-17 can complete the survey online or in paper form. The survey addresses topics including health and well-being of children, access to and utilization of health care, receipt of care, family interactions, parental health, school experiences, and neighborhood characteristics.

- The **Youth Risk Behavior Survey (YRBS)** surveys high school students (grades 9 through 12) in the classroom regarding behaviors in the following six areas: unintentional and intentional injuries, tobacco use, alcohol and other drug use, interpersonal relationships, diet, and physical activity. The survey collects data every other year and provides population-level information on adolescent and early adulthood behaviors for use in program and policy planning. The survey collects information from traditional, alternative, and correctional high schools. For the purposes of this report, statewide prevalence is calculated using statewide traditional high school results. Regional prevalence is calculated using local results from public traditional, alternative, and correctional high schools.

### Data Notes

#### TIME FRAME

All data reflect the most recent year of available data, usually 2016. Trends were not calculated because statistical variation is not provided for most indicators. When confidence intervals are available on the data center, this is noted in the associated endnote. Occasionally, yearly comparisons are drawn to illustrate relevant changes over time.

#### CHILD POPULATIONS

Interpretation of demographic data can be unwieldy, as data sources categorize and count children in different ways. For example, various sources included in the KIDS COUNT Data Center define children as “under 18," “18
and under,” and “19 and under.” As a result, comparison of indicators is not straightforward. For the purposes of readability, all child populations are children under the age of 18 unless otherwise noted.

**RACE AND ETHNICITY**

The KIDS COUNT Data Center provides several indicators by race and ethnicity. While these were reviewed and do show disparities by race/ethnicity, much of the data is incomplete (often suppressed due to large margins of error) and reflects race/ethnicity categories that are no longer standard in Alaska. Race/ethnicity breakouts are presented only where data are complete. Where race data are presented in “alone” categories (i.e. African American only), populations are typically underestimated and should be interpreted with care.

**CALCULATIONS**

Data included in this report reflects the best available. Calculations with data in this report should be undertaken with care, as data come from multiple sources and reflect different sub-populations and/or total populations of children. For example, some indicators are calculated from the population of children ages 0 to 19, while others begin with a subset of this population, such as children in households or own children (see glossary for population definitions). As a result, counts differ within sections of the report and should be included with each indicator when published elsewhere. Survey data often includes confidence intervals; for ease of readability, confidence intervals are not included in this report.

**REGIONS**

Where presented, regional data are broken into the economic regions used by the Alaska Department of Labor and Workforce Development, except for the Anchorage/Mat-Su region, which is separated. The following map details the census areas included in each region.

*Figure 2. Geographic Regions*

Source: DOLWD.
Approximately 187,300 children between the ages of 0 and 17 lived in Alaska in 2016. Twenty-nine percent were 4 years-old or younger, 39 percent were between the ages of 5 and 11, 16 percent were between the ages of 12 and 14, and 16 percent were between the ages of 15 and 17. Table 1 (next page) provides a detailed breakout of the child population by age.

Data Source: U.S. Census Bureau
Available at: KIDS COUNT Data Center

Alaska’s overall population is projected to increase modestly. Including projected births, deaths, in-migrants and out-migrants, Alaska’s population is projected to be 899,825 in 2045. The growth rate is expected to decline from 0.9 percent during 2015-2020 to 0.5 percent in 2040-2045. The following table details projected child population growth by age.

(See table on the following page.)
Table 1. Current (2016) and Projected (2020-2045) Child Population

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<th>2020</th>
<th>2025</th>
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Source: Kids Count Data Center, Alaska Department of Labor and Workforce Development, and McDowell Group calculations.
Note: Columns may not sum due to rounding.

Children make up about 25 percent of the total population today, compared to 30 percent in 2001. Because the population of adults has increased at a faster rate during the same period, children now make up a smaller percentage of the total population than in 2001. Alaska is the third-youngest state in the country, after Utah and Texas.

When viewed regionally, however, the child population has declined since 2001 in all regions, except for the Mat-Su region and the Interior. The child population has increased steadily in the Mat-Su region and remained about the same in the Interior during the same time period.

(See figure on the following page.)
Over one-third of Alaska children live in Anchorage (39 percent); between 5 and 15 percent of the total child population live in each of the remaining six regions.  

Table 2. Child Population (0-19) by Region, 2016

<table>
<thead>
<tr>
<th>Region</th>
<th># of Children (0-19)</th>
<th>Percentage of Child Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anchorage</td>
<td>81,772</td>
<td>39%</td>
</tr>
<tr>
<td>Gulf Coast Region</td>
<td>21,027</td>
<td>10%</td>
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<tr>
<td>Interior Region</td>
<td>31,041</td>
<td>15%</td>
</tr>
<tr>
<td>Mat-Su</td>
<td>31,704</td>
<td>15%</td>
</tr>
<tr>
<td>Northern Region</td>
<td>9,424</td>
<td>5%</td>
</tr>
<tr>
<td>Southeast Region</td>
<td>18,054</td>
<td>9%</td>
</tr>
<tr>
<td>Southwest Region</td>
<td>14,109</td>
<td>7%</td>
</tr>
<tr>
<td><strong>Alaska</strong></td>
<td>207,131</td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Data Source: Alaska DOLWD
Available at: KIDS COUNT Data Center
Alaska’s child population is more diverse than the adult population; 50 percent of Alaska children are non-white, compared to only 35 percent of Alaskan adults.† 11,12

<table>
<thead>
<tr>
<th>Race</th>
<th>Child Population (0-17)</th>
<th>Adult Population (18+)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic or Latino</td>
<td>10%</td>
<td>6%</td>
</tr>
<tr>
<td>Alaska Native or American Indian alone</td>
<td>18%</td>
<td>13%</td>
</tr>
<tr>
<td>Asian alone</td>
<td>6%</td>
<td>6%</td>
</tr>
<tr>
<td>Black alone</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Native Hawaiian and Other Pacific Islander alone</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Two or More Race Groups</td>
<td>12%</td>
<td>5%</td>
</tr>
<tr>
<td>White alone</td>
<td>50%</td>
<td>65%</td>
</tr>
</tbody>
</table>

Data Source: U.S. Census Bureau
Available at: KIDS COUNT Data Center

Except for the Southwest and Northern regions of Alaska where children are most likely to be Alaska Native or American Indian, the child population is predominantly White. Since 2001, the child populations in Anchorage, Southeast, Mat-Su, and Gulf Coast regions have become more diverse.

(See figure on the following page.)

†When race data are counted in alone categories, populations are typically underestimated. As a result, reporting race data by “All” categories is standard in Alaska, but not available for all indicators on the KIDS COUNT Data Center. Because different categorizations are used, total counts will differ depending on methodology.
Figure 5. Change in Child Population from 2001 to 2015, by Race/Ethnicity and Region

Data Source: U.S. Census Bureau
Available at: KIDS COUNT Data Center


Figure 6. Household Type 2011-2015

Data Source: American Community Survey
Available at: KIDS COUNT Data Center
Health
Births

Data Snapshot

- 11,215 babies were born to Alaska mothers in 2016.
- 60 percent of women who gave birth in 2016 had more than 12 years of education.
- More than one-third of women who give birth have less than adequate prenatal care (39 percent).
- Statewide, 6 percent of births are to women receiving late or no prenatal care.
- The teen birth rate decreased from 40.3 births per 1,000 females (ages 15-19) during 2007-2011 to 29.4 during 2012-2016.

In 2016, Alaska mothers gave birth to 11,215 babies. Births by region closely matched the distribution of the child population by region (see Table 2. Child Population (0-19) by Region, 2016 for reference).

<table>
<thead>
<tr>
<th>Region</th>
<th># of Births</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anchorage</td>
<td>4,509</td>
<td>40%</td>
</tr>
<tr>
<td>Interior</td>
<td>1,870</td>
<td>17%</td>
</tr>
<tr>
<td>Mat-Su</td>
<td>1,506</td>
<td>13%</td>
</tr>
<tr>
<td>Gulf Coast</td>
<td>1,076</td>
<td>10%</td>
</tr>
<tr>
<td>Southwest</td>
<td>913</td>
<td>8%</td>
</tr>
<tr>
<td>Southeast</td>
<td>793</td>
<td>7%</td>
</tr>
<tr>
<td>Northern</td>
<td>538</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11,215</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Data Source: Alaska Section of Health Analytics and Vital Records
Available at: KIDS COUNT Data Center
Notes: Region is determined by maternal residence, not site of delivery. Total includes 10 births for which residence is unknown.

Over one-quarter of babies born in 2016 were Alaska Native (27 percent), and over one-half were White (56 percent).‡

<table>
<thead>
<tr>
<th>Race</th>
<th># of Births</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>6,298</td>
<td>56%</td>
</tr>
<tr>
<td>Alaska Native</td>
<td>3,002</td>
<td>27%</td>
</tr>
<tr>
<td>Asian / Pacific Islander</td>
<td>1,206</td>
<td>11%</td>
</tr>
<tr>
<td>Black / African American</td>
<td>454</td>
<td>4%</td>
</tr>
<tr>
<td>Other / Unknown</td>
<td>255</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11,215</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

‡ The methodology for determining race differs from that used by the American Community Survey in the Alaska Children section of this report. See the KIDS COUNT Data Center for a detailed explanation of the methodology.
Preterm Births

Statewide in 2016, 998 preterm births occurred before 37 weeks of gestation (9 percent of all live births).\textsuperscript{17} Regionally, the percentage of preterm births ranges from 8 percent in the Gulf Coast, Mat-Su, and Southeast to 12 percent in the Southwest.\textsuperscript{18}

<table>
<thead>
<tr>
<th>Region</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anchorage</td>
<td>410</td>
<td>9%</td>
</tr>
<tr>
<td>Gulf Coast</td>
<td>81</td>
<td>8%</td>
</tr>
<tr>
<td>Interior</td>
<td>171</td>
<td>9%</td>
</tr>
<tr>
<td>Mat-Su</td>
<td>116</td>
<td>8%</td>
</tr>
<tr>
<td>Northern</td>
<td>50</td>
<td>9%</td>
</tr>
<tr>
<td>Southeast</td>
<td>60</td>
<td>8%</td>
</tr>
<tr>
<td>Southwest</td>
<td>106</td>
<td>12%</td>
</tr>
<tr>
<td><strong>Alaska</strong></td>
<td><strong>998</strong></td>
<td><strong>9%</strong></td>
</tr>
</tbody>
</table>

Data Source: Alaska Section of Health Analytics and Vital Records
Available at: KIDS COUNT Data Center
Note: Number of preterm births does not sum, because region was unknown for 4 births.

Low Birth-Weight

In 2016, 661 babies were born weighing less than 5.5 pounds.\textsuperscript{19} During 2012-2016, babies weighing less than 5.5 pounds at birth in Alaska represented 5.8 percent of all births. Regionally, the percentage of low birth-weight (LBW) babies ranged from 5.0 percent in the Gulf Coast to 6.3 percent in the Southwest Region.\textsuperscript{20} Variations emerge by race/ethnicity; the percentage of low birth-weight babies ranges from 5 percent among White mothers to 13 percent among Black or African-American mothers.\textsuperscript{21}

Data Source: Population Reference Bureau Analysis of Centers for Disease Control and Prevention, National Center for Health Statistics, CDC Wonder 2016 birth data.
Available at: KIDS COUNT Data Center
Note(s): Race/ethnicity reflects the race/ethnicity of the mother. The categories Black or African American, Alaska Native or American Indian, Asian and Pacific Islander, and Two or more races include both Hispanic and non-Hispanic mothers. Those in the Hispanic or Latino category include those who may have identified as being in one of the non-White race groups.
### Table 7. Low Birth-Weight Babies by Race/Ethnicity, 2016

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Number of LBW Births</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska Native / American Indian</td>
<td>137</td>
</tr>
<tr>
<td>Asian and Pacific Islander</td>
<td>78</td>
</tr>
<tr>
<td>Black or African American</td>
<td>45</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>61</td>
</tr>
<tr>
<td>White</td>
<td>291</td>
</tr>
<tr>
<td>Two or more races</td>
<td>66</td>
</tr>
</tbody>
</table>

Data Source: Population Reference Bureau Analysis of Centers for Disease Control and Prevention, National Center for Health Statistics, CDC Wonder 2016 birth data.
Available at: KIDS COUNT Data Center

Note(s): Race/ethnicity reflects the race/ethnicity of the mother. The categories Black or African American, American Indian, Asian and Pacific Islander, and Two or more races include both Hispanic and non-Hispanic mothers. Those in the Hispanic or Latino category include those who may have identified as being in one of the non-White race groups.

### Births by Mother’s Education

Statewide, 60 percent of women who gave birth in 2016 had more than 12 years of education. This percentage is fairly consistent across Alaska, ranging from 59 to 66 percent in Anchorage, Gulf Coast, Interior, Mat-Su, and Southeast regions. The Northern and Southwest regions showed a much lower percentage at 25 percent.  

![Figure 8. Births by Mother’s Education by Region, 2016](image-url)
Births to Single Parent

From 2012 to 2016, 6 percent of resident births had only one parent listed on the birth certificate. Regionally, this percentage varied from 4 percent of births in the Interior and Mat-Su regions to 19 percent of births in the Northern region.

Figure 9. Births to Single Parent by Region, 2012-2016

Of births with only one parent listed on the birth certificate, the majority are enrolled in Medicaid. This trend has increased over the last 20 years. In 2016, 91 percent of births with only one parent listed on the birth certificate were enrolled in Medicaid.

Figure 10. Trend for Medicaid-Enrollment among Births to Single Parents, 1995-2016
Prenatal Care

Less-than-Adequate Prenatal Care

Over one-third of Alaska women who gave birth between 2012 and 2016 had less-than-adequate prenatal care (39 percent). Regionally, the percentage of women who received less-than-adequate prenatal care in 2016 ranged from 28 percent in Mat-Su to 62 percent in Southwest.

Prenatal care is measured by the Adequacy of Prenatal Care Utilization (APNCU) index which incorporates the month a pregnant woman begins getting care, the number of prenatal visits, and the gestational age of the baby at birth. The index classifies care into four levels: adequate plus, adequate, intermediate, or inadequate. Less than adequate prenatal care refers to intermediate and inadequate care.

Figure 11. Women with Less-than-Adequate Prenatal Care by Region, 2012-2016

Data Source: Alaska Section of Health Analytics and Vital Records
Available at: KIDS COUNT Data Center
Note: Five years of data were combined to minimize the unreliability of measurement due to the small number of actual events.

Photo: Oscar Avellaneda-Cruz
Late or No Prenatal Care

In 2015, 650 women reported receiving prenatal care during the third trimester only or no prenatal care during pregnancy at all, representing 6 percent of statewide births. When viewed by race/ethnicity, the percentage of women receiving late or no prenatal care ranges from 5 percent of White and 6 percent of Hispanic or Latino mothers to 9 percent of Asian and Pacific Islander mothers.

Table 8. Births to Women Receiving Late or No Prenatal Care by Race/Ethnicity, 2015

<table>
<thead>
<tr>
<th>Race</th>
<th>Number of Births</th>
<th>Percent of Births</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska Native / American Indian</td>
<td>184</td>
<td>8%</td>
</tr>
<tr>
<td>Asian and Pacific Islander</td>
<td>94</td>
<td>9%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>29</td>
<td>6%</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>39</td>
<td>5%</td>
</tr>
<tr>
<td>White</td>
<td>312</td>
<td>5%</td>
</tr>
</tbody>
</table>

Pregnancy Spacing

In 2016, about one-third of women with a prior live birth became pregnant less than 18 months after the prior birth (34 percent). This indicator does not include births of multiple children. Nearly two-thirds of women became pregnant 18 or more months after the prior birth (63 percent). In 2016, among live births to women whose pregnancies had been spaced at least 18 months apart, 53 percent were enrolled in Medicaid and 47 percent were not. That same year, 56 percent of the shorter-interval births were enrolled in Medicaid.

Teen Births

The teen birth rate in Alaska decreased from 40.3 births per 1,000 females (ages 15-19) during 2007-2011 to 29.4 during 2012-2016 (see Figure 13). Teen births vary substantially by region. The rate of births per 1,000 females (ages 15-19) ranges from 21.4 in the Gulf Coast to 70.6 in the Northern Region.
When viewed by age, the birth rate for older teens (ages 18 to 19) is substantially higher than the birth rate for younger teens (ages 15 to 17), 56.1 compared to 7.9 births per 1,000 teens.\textsuperscript{36}

\textbf{Figure 13. Trend for Teen Birth Rates, including Younger and Older Teens, 2007-2016}

![Birth Rate Chart](chart.png)

Data source: Alaska Section of Health Analytics and Vital Records

**Subsequent Teen Births**

In 2016, the percent of births to teen mothers (under 20 years) who had previously given birth was 15 percent.\textsuperscript{37}

\textbf{Figure 14. Trend for Subsequent Teen Births, 1990-2016}

![Subsequent Birth Rate Chart](chart.png)

Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics
Available at: [KIDS COUNT Data Center](https://data.kidscount.org)
Insurance and Access

Data Snapshot

- Nine out of 10 Alaska children had insurance coverage in 2016 (90 percent).
- In 2016, about one-half of Alaska children were covered by employer-based insurance (49 percent or 92,000 children).
- Twenty percent of Alaska children did not have a usual source of care or visited a hospital emergency room for care when sick in 2016.

Insurance Coverage

Uninsured children are less likely than insured children to have a regular health care provider, visit a provider for preventive care, and receive care when they need it. They also have a greater risk of hospitalization. Having health insurance can protect families from financial challenges when a member of the family experiences a serious health issue. In 2016, 10 percent of children under age 19 were uninsured. Regionally, this percentage varied from 9 percent in Anchorage to 14 percent in the Gulf Coast region.

Figure 15. Insured and Uninsured Children by Region, 2016

Data Source: U.S. Census Bureau, 2008-2016 Small Area Health Insurance Estimates using the American Community Survey (ACS) Data Available at: KIDS COUNT Data Center
Note(s): Children refers to youth under 19 years-old. Individuals who reported no health coverage, or whose only health coverage was Indian Health Services, were considered uninsured.

Coverage Type

In 2016, the most common type of insurance coverage for children was employer-based insurance. Roughly half of Alaska children were covered, at any point during the year, by employer-based insurance only (49 percent or 92,000 children). Nearly one-third of children were covered, at any point during the year, by public only insurance (29 percent or 54,000 children). Ten percent of children were uninsured or were covered only by Indian
Health Service in 2016 (19,000 children). The remaining children were insured through direct-purchase only, other private coverage, or a combination of public and private coverage.

**Figure 16. Children by Insurance Coverage Type, 2016**

- Employer-based only: 49%
- Public only: 29%
- Both public and private coverage: 6%
- Other private coverage: 3%
- Direct-purchase only: 3%
- Uninsured or Indian Health Service only: 10%

Data Source: Population Reference Bureau Analysis of U.S. Census Bureau, American Community Survey
Available at: [KIDS COUNT Data Center](#)

**Poverty Status of Uninsured Children**

Statewide, of children who are uninsured, 13 percent live at or below 200 percent of the poverty threshold. Regionally, this percentage ranges from a low of 9 percent in the Southwest to a high of 18 percent in the Gulf Coast region.

**Figure 17. Uninsured Children at or below 200% of Poverty Threshold by Region, 2016**

- Anchorage: 13%
- Gulf Coast: 19%
- Interior: 15%
- Mat-Su: 14%
- Northern: 10%
- Southeast: 18%
- Southwest: 9%

Data Source: U.S. Census Bureau. 2008-2016 Small Area Health Insurance Estimates using the American Community Survey (ACS) Data Available at: [KIDS COUNT Data Center](#)
Note: Children refers to youth under 19 years old.

---

\[^1]\footnote{In 2016, 200 percent of the federal poverty threshold for a family of four (two parents and two children) was $48,768. For more information, see https://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-thresholds.html.}
In 2015, the percentage of uninsured children ranged from 8 percent of children living at 100 to 149 percent of the poverty threshold to 13 percent of children living between 200 and 299 percent of the poverty threshold and 13 percent of children living below 100 percent of the poverty threshold.43

Figure 18. Children without Health Insurance by Poverty Level, 2015

<table>
<thead>
<tr>
<th>Poverty Level</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>300% poverty or above</td>
<td>9%</td>
</tr>
<tr>
<td>200 to 299% poverty</td>
<td>13%</td>
</tr>
<tr>
<td>150 to 199% poverty</td>
<td>10%</td>
</tr>
<tr>
<td>100 to 149% poverty</td>
<td>8%</td>
</tr>
<tr>
<td>Below 100% poverty</td>
<td>13%</td>
</tr>
</tbody>
</table>

Data Source: Population Reference Bureau analysis of data from the U.S. Census Bureau
Available at: KIDS COUNT Data Center

Usual Source of Care

In 2016, 80 percent of children had a usual source of medical care when they were sick, such as a doctor’s office, hospital outpatient department, clinic, school, or “Minute clinic.”44 One-fifth of children did not have a usual source of care or resorted to a hospital emergency room for care when sick.45

Figure 19. Usual Source of Care When Child is Sick, 2016

- Has usual source of care
- Does not have usual source of care

Data Source: National Survey of Children’s Health
Personal Care Provider

Roughly two-thirds of Alaska children (67 percent) had at least one personal health care provider—a doctor, pediatrician, nurse practitioner, specialist, or physician’s assistant—who knew the child well and was familiar with his/her medical history in 2016.46 Thirty-three percent of children did not have a personal care provider in 2016 (60,000 children).47

Data Source: National Survey of Children’s Health
Preventive Care

Data Snapshot

- Seventy-eight percent of children visited a doctor, nurse, or other health care provider for a preventive check-up within the year (142,060 children).
- Just over three-quarters of children saw a dentist at least once for preventive dental care during the year (76 percent or 132,693 children).
- Just under one-half of children ages 9 to 35 months received a developmental screening during the year (47 percent).

Check-Ups

Medical

In 2016, 78 percent of children visited a doctor, nurse, or other health care provider for a preventive check-up (142,060 children). Young children were most likely to receive a preventive check-up.49

Table 9. Children who Received 1+ Preventive Check-Ups During the Past 12 Months by Age, 2016

<table>
<thead>
<tr>
<th>Age</th>
<th>Percent</th>
<th>Population Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 years-old</td>
<td>88%</td>
<td>52,770</td>
</tr>
<tr>
<td>6-11 years-old</td>
<td>78%</td>
<td>51,610</td>
</tr>
<tr>
<td>12-17 years-old</td>
<td>67%</td>
<td>37,680</td>
</tr>
<tr>
<td>Total</td>
<td>78%</td>
<td>142,060</td>
</tr>
</tbody>
</table>

Data Source: National Survey of Children’s Health

Dental

During 2016, 76 percent of children ages 1 to 17 years saw a dentist at least once for preventive dental care, including check-ups and cleanings (132,693 children).50

The American Academy of Pediatrics (AAP) recommends that parents establish a dental home for their child by 12 months of age.51 In 2016, 33 percent of mothers reported their 3-year old saw a dentist before the child’s second birthday, and 66 percent of mothers reported their 3-year old had previously seen a dentist, while 34 percent of 3-year-olds had not yet seen a dentist.52 Between 2008 and 2016, the percentage of mothers reporting that their child saw a dentist at an early age increased.

(See figure on following page.)
Screening

Early detection of developmental delays leads to the best outcomes for children. During 2016, 47 percent of children between the ages of nine and 35 months received a developmental screening, according to the National Survey of Children’s Health (12,033 children). According to Alaska Childhood Understanding Behaviors Survey (CUBS), 77 percent of mothers say they completed a checklist or questionnaire about their 3-year-old’s development within the past 12 months. By region, the percentage of mothers who completed a developmental questionnaire about their 3-year-old ranges from a low of 46 percent in the Southwest to a high of 83 percent in the Interior and Southeast.

Immunizations

In 2016, 73 percent of Alaska 2-year-olds were immunized, as measured by receiving a full series of Hib. In 2016, 69 percent of children ages 19 to 35 months received a complete combined 7-vaccine series.
General Health

Data Snapshot

- Nearly all children had a parent/guardian who reported their child was in excellent or very good health in 2016 (94 percent).
- In 2016, 79 percent of children had a parent/guardian who reported their child’s teeth were in excellent or very good condition.
- About one-quarter of children were overweight or obese in 2016 (26 percent).
- During 2014-2016, 20 percent of children lived in households where there was not enough food to eat.

Overall Health

In 2016, 94 percent of children had a parent or guardian who reported their child was in excellent or very good health (172,610 children). During the same time period, 79 percent of children ages 1 to 17 had a parent or guardian who reported their child’s teeth were in excellent or very good condition (139,040 children).

Nutrition and Lifestyle

Of children between the ages of ten and 17, one-quarter were overweight or obese in 2016 (26 percent). In 2016, boys were more likely than girls to be overweight or obese; nearly one-third of boys ages 10 to 17 were overweight or obese compared to one-fifth of girls (31 percent and 21 percent, respectively).

In 2016, over one-third of children ages 6 to 17 exercised less than five days of the past week (36 percent).

During 2014 to 2016, 20 percent of children lived in households where there was not enough food because of insufficient resources (37,000 children).

Mental Health

In 2016, nearly one-fifth of children ages two to 17 had a doctor who said they had autism, developmental delays, depression or anxiety, ADD/ADHD, or behavioral/conduct problems (19 percent or 30,880 children).

Among Alaska high school students in 2017, 36 percent reported feeling sad/hopeless almost every day for two weeks or more in a row during the past 12 months. In the same year, 23 percent of high school students considered suicide, 21 percent planned suicide, and 12 percent attempted suicide.
Special Health Care Needs

In 2016, 16 percent of children had special health care needs (29,860 children). Special health care needs include increased risk of a chronic physical, developmental, behavioral, or emotional condition as well as required services beyond those generally needed by children.

Five percent of children were affected by asthma during 2016.

Between 2012 and 2016, 4 percent of Alaska children had a disability (6,460 children). This includes hearing, vision, cognitive, ambulatory, self-care, and independent living difficulties. During this period, a slightly greater percentage of boys than girls had a reported disability (4.3 percent of boys compared to 2.6 percent of girls). The percentage of children with disabilities is similar throughout all regions of the state.

<table>
<thead>
<tr>
<th>Region</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anchorage</td>
<td>3%</td>
</tr>
<tr>
<td>Gulf Coast</td>
<td>5%</td>
</tr>
<tr>
<td>Interior</td>
<td>4%</td>
</tr>
<tr>
<td>Mat-Su</td>
<td>4%</td>
</tr>
<tr>
<td>Northern</td>
<td>2%</td>
</tr>
<tr>
<td>Southeast</td>
<td>3%</td>
</tr>
<tr>
<td>Southwest</td>
<td>2%</td>
</tr>
</tbody>
</table>

Data Source: American Community Survey 5-year estimates
Available at: KIDS COUNT Data Center

Photo: Laura Norton-Cruz
**Adverse Childhood Experiences**, known as ACEs, are traumatic or highly stressful experiences during childhood that can have a profound effect on a child's developing brain and body. While exposure to some challenges during childhood is normal, sustained or repeated exposure to severe adversity (such as domestic violence or child abuse) without supportive relationships is toxic for children. These early experiences result in biological changes to the human body that can influence the child's physical and mental health throughout his/her lifetime.

ACEs are associated with higher rates of most major health and social problems, from depression and substance abuse to a myriad of physical diseases, including arthritis, liver disease, heart disease, and cancer. In schools, students with ACEs are much more likely to experience academic and behavioral problems, frequent illness, and absenteeism.

**ACE Scores**

A child’s ACE score refers to the number of specific adverse experiences that have occurred during the child’s life. Each experience counts as 1, no matter how often it occurred, and the total number of different adverse experiences is a person’s ACE score. The higher the score, the greater the child’s risk of chronic health and well-being issues.

In 2016, more than half of children ages 0 to 17 had not experienced an ACE (56 percent or 101,500 children).70 Just over one-fifth of children experienced one ACE (21 percent or 37,460 children). Nearly one-quarter of children experienced two or more ACEs (24 percent or 43,300 children).

<table>
<thead>
<tr>
<th>Table 11. ACE Scores of Alaska Children, 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Weighted %</strong></td>
</tr>
<tr>
<td>No ACEs</td>
</tr>
<tr>
<td>1 ACE</td>
</tr>
<tr>
<td>2+ ACEs</td>
</tr>
</tbody>
</table>

Data source: NSCH

Note: The NSCH asks parents/guardians about their child’s exposure to financial hardship, death of a parent or guardian, divorce/separation, domestic assault in the home, incarceration of a parent/guardian, neighborhood violence, unfair judgment or treatment because of race/ethnicity, mental illness in the home, and/or alcohol/drug abuse in the home.

From 2013-2015, 66 percent of adults reported experiencing 1 or more ACEs** before age 18.71

**The National Survey of Children’s Health (NSCH) and Behavioral Risk Factor Surveillance System (BRFSS) questions regarding ACEs differ. The NSCH asks about financial hardship, death of a parent or guardian, neighborhood violence, and unfair treatment/judgment based on race/ethnicity; BRFSS does not ask about these ACEs. BRFSS asks about verbal abuse, sexual abuse, physical abuse, physical and emotional neglect; the NSCH does not. See glossary for more detail.**
Child Maltreatment

Child maltreatment refers to both abuse and neglect of children. Abuse is overt harm committed by others, usually adults, and can be physical, sexual, or verbal/emotional. Neglect means parents and caregivers do not meet a child’s basic physical and/or emotional needs.

Reports of Maltreatment

The Office of Children’s Services (OCS) fields reports of suspected child maltreatment to determine whether child maltreatment occurred and/or if a child is at risk of maltreatment. In 2016, OCS received 27,999 reports of suspected child maltreatment. Multiple reports may be made about a single child. In 2016, 17,749 unique children were identified as potential victims of child maltreatment.  

REGION

Regionally, the number of unique children identified as possible victims of child maltreatment ranged from 1,504 children in the Northern region to 6,416 children in Anchorage. Region is determined by the origin of the report, which may differ from the location of the child’s residence.

<table>
<thead>
<tr>
<th>Region</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anchorage</td>
<td>6,416</td>
</tr>
<tr>
<td>Gulf Coast</td>
<td>1,292</td>
</tr>
<tr>
<td>Interior</td>
<td>2,213</td>
</tr>
<tr>
<td>Mat-Su</td>
<td>2,259</td>
</tr>
<tr>
<td>Northern</td>
<td>1,504</td>
</tr>
<tr>
<td>Southeast</td>
<td>2,114</td>
</tr>
<tr>
<td>Southwest</td>
<td>1,951</td>
</tr>
<tr>
<td><strong>Alaska</strong></td>
<td><strong>17,749</strong></td>
</tr>
</tbody>
</table>

Data Source: Office of Children’s Services (OCS). Data compiled by Alaska Department of Health and Social Services (DHSS), Section of Women’s, Children’s and Family Health, Maternal and Child Health Epidemiology Unit. Available at: KIDS COUNT Data Center

Rates of suspected child maltreatment reports allow comparison between regions with different population sizes. Statewide, the 2016 rate of reported child maltreatment was 94.5 reports per 1,000 children. The rate of reported child maltreatment was highest in the Northern region (174.5 reports per 1,000 children) and lowest in the Interior region (72.6 reports per 1,000 children).  

(See figure on following page.)
Figure 23. Rate of Unique Children with At Least One Report of Maltreatment by Region, 2016

Data Source: OCS, DOLWD. Data compiled by Alaska DHSS, Section of Women's, Children's and Family Health, Maternal and Child Health Epidemiology Unit. Available at: KIDS COUNT Data Center

AGE

Thirty-six percent of children reported for maltreatment in 2016 were five to nine years-old.\textsuperscript{76}

Figure 24. Unique Children with At Least One Report of Maltreatment by Age Group, 2016

Data Source: OCS, DOLWD. Data compiled by Alaska DHSS, Section of Women's, Children's and Family Health, Maternal and Child Health Epidemiology Unit. Available at: KIDS COUNT Data Center
Rates of reports of suspected child maltreatment vary by race, from 42.7 reports per 1,000 children among White children to 161.2 reports per 1,000 children among Alaska Native children.77

<table>
<thead>
<tr>
<th>Race</th>
<th>Rate of Report Children (per 1,000 children)</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska Native</td>
<td>161.2</td>
<td>8,310</td>
</tr>
<tr>
<td>Black</td>
<td>80.3</td>
<td>1,137</td>
</tr>
<tr>
<td>Asian / Pacific Islander</td>
<td>54.4</td>
<td>1,003</td>
</tr>
<tr>
<td>White</td>
<td>42.7</td>
<td>5,425</td>
</tr>
</tbody>
</table>

Data Source: OCS, DOLWD. Data compiled by Alaska DHSS, Section of Women’s, Children’s and Family Health, Maternal and Child Health Epidemiology Unit. Available at: KIDS COUNT Data Center. Note: Race is not exclusive, unique child may be included in more than one race category. Unknown and other race categories not included.

Substantiated Child Maltreatment

A determination of child maltreatment by OCS results in a substantiated report. In 2016, OCS substantiated 3,642 reports of child maltreatment.78 Multiple substantiated reports may involve the same child. In 2016, 2,052 unique children had a substantiated report of child maltreatment.79

Regionally, the number of unique children with substantiated reports of maltreatment ranged from 175 children in Southeast to 626 children in Anchorage.80

<table>
<thead>
<tr>
<th>Region</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anchorage</td>
<td>626</td>
</tr>
<tr>
<td>Gulf Coast</td>
<td>223</td>
</tr>
<tr>
<td>Interior</td>
<td>266</td>
</tr>
<tr>
<td>Mat-Su</td>
<td>199</td>
</tr>
<tr>
<td>Northern</td>
<td>244</td>
</tr>
<tr>
<td>Southeast</td>
<td>175</td>
</tr>
<tr>
<td>Southwest</td>
<td>319</td>
</tr>
<tr>
<td><strong>Alaska</strong></td>
<td><strong>2,052</strong></td>
</tr>
</tbody>
</table>

Data Source: OCS, DOLWD. Data compiled by Alaska DHSS, Section of Women’s, Children’s and Family Health, Maternal and Child Health Epidemiology Unit. Available at: KIDS COUNT Data Center.

Rates of substantiated reports allow comparison between regions with different population sizes. Statewide, the rate of substantiated reports of child maltreatment was 10.9 reports per 1,000 children.81 Rates of reports of child maltreatment are highest in the Northern region (28.3 reports per 1,000 children) and lowest in the Mat-Su region (6.9 reports per 1,000 children).82

(See figure on following page.)
In 2016, most of the children with substantiated maltreatment were less than five years old.\textsuperscript{83}

Data Source: OCS, DOLWD. Data compiled by Alaska DHSS, Section of Women's, Children's and Family Health, Maternal and Child Health Epidemiology Unit. Available at: KIDS COUNT Data Center.

Data Source: OCS. Data compiled by Alaska DHSS, Section of Women's, Children's and Family Health, Maternal and Child Health Epidemiology Unit. Available at: KIDS COUNT Data Center.
**RACE**

Rates of substantiated reports of child maltreatment vary by race, from 5.2 reports per 1,000 children among White children to 24.4 reports per 1,000 children among Alaska Native children.84

<table>
<thead>
<tr>
<th>Race</th>
<th>Rate of Children with Substantiated Reports (per 1,000 children)</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska Native</td>
<td>24.4</td>
<td>1,255</td>
</tr>
<tr>
<td>Black</td>
<td>8.4</td>
<td>119</td>
</tr>
<tr>
<td>Asian / Pacific Islander</td>
<td>5.7</td>
<td>105</td>
</tr>
<tr>
<td>White</td>
<td>5.2</td>
<td>665</td>
</tr>
</tbody>
</table>

Data Source: OCS, DOLWD. Data compiled by Alaska DHSS, Section of Women’s, Children’s and Family Health, Maternal and Child Health Epidemiology Unit. Available at: KIDS COUNT Data Center

Note: Race is not exclusive, unique child may be included in more than one race category. Unknown and other race categories not included.
Data Snapshot

- Twenty-seven percent of Alaska high school students reported smoking tobacco, using smokeless tobacco (including Iqmik), or using electronic vapor products during the past 30 days.
- Just under one-fourth of Alaska high school students reported drinking alcohol during the past month (23 percent) in 2017.
- Twenty-two percent of Alaska high school students reported using marijuana at least once in the past month in 2017.
- In 2017, 10 percent of Alaska high school students reported having sexual intercourse with four or more partners during their lifetime.

Tobacco Use

In 2017, 27 percent of Alaska high school students reported smoking tobacco, using smokeless tobacco (including Iqmik), or using electronic vapor products during the past 30 days. In the same year, 13 percent of Alaska high school students reported smoking tobacco during the past month. Since 2007, the percentage of high school students reporting tobacco smoking during the past month has gradually declined.

Figure 27. Trend for Smoking Tobacco During Past Month Among High School Students, 2007-2017

Data Source: Youth Risk Behavior Surveillance System (YRBSS), Alaska DHSS, Division of Public Health, Section of Chronic Disease Prevention and Health Promotion. Available at: KIDS COUNT Data Center
Regionally, the percentage of high school students who reported smoking during the past month ranged from a low of 11 percent in Anchorage to a high of 24 percent in the Southwest. When smokeless tobacco is included, regional variations in tobacco use become clearer. In all regions of the state, except the Northern and Southwest regions, high school students are more likely to smoke tobacco than use smokeless tobacco.

**Figure 28. Tobacco Use (Smoking and Smokeless) During the Past Month Among High School Students by Region, 2017**

- **Smokeless Tobacco Use**
- **Smoke Tobacco**
- **Tobacco Use**

Data Source: YRBSS
Available at: KIDS COUNT Data Center

**Alcohol Use**

In 2017, 23 percent of Alaska high school students reported drinking alcohol during the past month. Since 2007, the percentage of Alaska high school students who report drinking alcohol during the past month has substantially declined, from 40 percent in 2007 to 23 percent in 2017.

**Figure 29. Trend for Alcohol Use During Past Month Among High School Students, 2007-2017**

Data Source: YRBSS
Available at: KIDS COUNT Data Center
Regionally, the percentage of high school students using alcohol in the past month ranged from 13 percent of students in the Southwest to 30 percent of students in Southeast in 2017.\(^92\)

**Figure 30. Alcohol Use Among High School Students During the Past Month by Region, 2017**

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anchorage</td>
<td>26%</td>
</tr>
<tr>
<td>Gulf Coast</td>
<td>27%</td>
</tr>
<tr>
<td>Interior</td>
<td>19%</td>
</tr>
<tr>
<td>Mat-Su</td>
<td>29%</td>
</tr>
<tr>
<td>Northern</td>
<td>16%</td>
</tr>
<tr>
<td>Southeast</td>
<td>30%</td>
</tr>
<tr>
<td>Southwest</td>
<td>13%</td>
</tr>
</tbody>
</table>

Data Source: YRBSS

Binge drinking is defined as consuming five or more drinks in a row. In 2015, the most recent year for which data is available\(^{93}\), 12 percent of Alaska students reported binge drinking in the past month. Since 2007, the percentage of Alaska high school students who report binge drinking during the past month has substantially declined, from 26 percent in 2007 to 12 percent in 2015. Regionally, this percentage varied from 11 percent in Anchorage to 20 percent in the Gulf Coast region.\(^{94}\)

**Figure 31. Binge Drinking During the Past Month Among High School Students by Region, 2015**

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anchorage</td>
<td>11%</td>
</tr>
<tr>
<td>Gulf Coast</td>
<td>20%</td>
</tr>
<tr>
<td>Interior</td>
<td>12%</td>
</tr>
<tr>
<td>Mat-Su</td>
<td>19%</td>
</tr>
<tr>
<td>Northern</td>
<td>12%</td>
</tr>
<tr>
<td>Southeast</td>
<td>14%</td>
</tr>
<tr>
<td>Southwest</td>
<td>15%</td>
</tr>
</tbody>
</table>

Data Source: YRBSS

\(^{92}\) In 2017, the definition of binge drinking for females changed to four or more drinks in a row.
Marijuana Use

In 2017, 22 percent of Alaska high school students reported using marijuana at least once in the past month.\textsuperscript{95} This percentage has stayed consistently between 19 and 23 percent since 2007.\textsuperscript{96} Legal sale of marijuana began in 2017.

**Figure 32. Trend for Marijuana Use During Past Month Among High School Students, 2007-2017**

[Graph showing trend from 2007 to 2017 with percentages varying between 21% and 23%]

Regionally, marijuana use varies from 20 percent in the Interior to 33 percent in the Northern region.\textsuperscript{97}

**Figure 33. Marijuana Use During the Past Month Among High School Students by Region, 2017**

[Graph showing regional percentages by region]

Sexual Activity

Most high school students reported never having had sexual intercourse in 2017 (63 percent).\textsuperscript{98}

Multiple Partners

In 2017, 10 percent of Alaska high school students reported having sexual intercourse with four or more partners during their lifetime.\textsuperscript{99}
**Unprotected Sex**

Among sexually active high school students, most report using a birth control method (84 percent), about half report using condoms (57 percent), and few report using both condoms and another method of birth control (14 percent) at last intercourse.¹⁰⁰

Photo: Sarah Lewis Photography
Deaths

Data Snapshot

- During 2012 to 2016, the Alaska infant mortality rate was 6.0 deaths per 1,000 live births.
- The average annual child death rate in Alaska was 24.1 per 100,000 children (ages 1 to 14) from 2012 to 2016.
- From 2012 to 2016, the average annual teen death rate in Alaska was 77.6 deaths per 100,000 teens (ages 15 to 19).

Infant (Ages <1)

From 2012 to 2016, the average annual infant mortality rate in Alaska was 6.0 infant deaths per 1,000 live births. The infant mortality rate was lowest in the Gulf Coast region (4.1) and highest in the Northern region (11.2).

![Figure 34. Infant Mortality Rates by Region, 2012-2016](image)

Data source: Alaska Section of Health Analytics and Vital Records
Available at: [KIDS COUNT Data Center](#)
Note: Region is recorded by the infant’s or mother’s residence at time of death, not by place of death.

MEDICAID STATUS

From 2014 to 2016, the percent of infant deaths did not vary substantially by Medicaid status. During this time period, 52 percent of infants who died were eligible for Medicaid and 47 percent were not. Since 2007, the infant mortality rate among Medicaid enrollees has been consistently higher than among those not enrolled in Medicaid. During 2012-2016, the infant mortality rate among Medicaid enrollees was 6.7 infant deaths per 1,000 births compared to 5.2 infant deaths per 1,000 births among those not enrolled in Medicaid.
**Child (Ages 1 to 14)**

From 2012 to 2016, the average annual child death rate in Alaska was 24.1 deaths per 100,000 children ages 1 to 14. Rates varied significantly by region: the child death rate was lowest in Southeast (7.7) and highest in the Southwest region (67.8).

**Figure 35. Child Death Rates by Region, 2012-2016**

![Bar chart showing child death rates by region, 2012-2016.](source)

Data source: Alaska Section of Health Analytics and Records; Alaska DOLWD, Research and Analysis Section. Available at: [KIDS COUNT Data Center](#)

**MEDICAID STATUS**

From 2014 to 2016, 60 percent of children who died were enrolled in Medicaid; the remaining 40 percent of deaths were children who were not enrolled in Medicaid.

**Teen (Ages 15 to 19)**

**All Causes**

From 2012 to 2016, the average annual teen death rate in Alaska was 77.6 deaths per 100,000 teens (ages 15 to 19). Teen deaths vary substantially by region. Mat-Su had the lowest teen death rate (48.1), and the Southwest had the highest rate (202.1).

*(See figure on following page.)*
**MEDICAID STATUS**

During 2014 to 2016, 45 percent of teens who died were enrolled in Medicaid; 55 percent were not enrolled.\textsuperscript{109}

**Violent Deaths**

From 2012 to 2016, the average annual teen violent death rate in Alaska was 69.0 deaths per 100,000 teens; these deaths were from unintentional injuries, homicides, and suicides.\textsuperscript{110} The leading causes of fatal, unintentional injuries among Alaska teens are motor vehicle traffic/ATV/snow machine accidents, overdoses, and drownings. The teen violent death rate varies substantially by region, from 42.4 in the Mat-Su to 196.2 in the Southwest.\textsuperscript{111}
SUICIDE

From 2012-2016, the average annual teen suicide rate was 32.4 deaths per 100,000 teens (ages 15 to 19) by suicide. The teen suicide rate varies substantially by region from 20.4 in the Anchorage region to 136.7 in the Southwest.

**Figure 38. Teen Suicide Rates by Region, 2012-2016**

Data source: Alaska Section of Health Analytics and Records; Alaska DOLWD, Research and Analysis Section. Available at: [KIDS COUNT Data Center](https://www.kidscount.org/alaska)

Note: An ‘*’ indicates fewer than 6 reported events during the time period.
Finding Solutions

ACT recommends the following solutions to support the health of Alaska children. Every child deserves the opportunity to thrive and for that to happen, children and families need access to, and availability of, quality health care. Suitable population health cannot be achieved without the availability of comprehensive and affordable health care for every child in Alaska. It is the responsibility of the State and Federal government to lead an effort to examine options available to achieve stable health care coverage of children and families and to assure the implementation of plans achieve that result. Any reductions in children's coverage would result in fewer children accessing needed care, including preventive services such as well child visits and immunizations. Reductions in children's coverage would have broad long-term negative effects on their health, education, and financial success as adults, and to the long-term success of Alaska.

Prevention – One of the most effective tools to address the health issues identified in this report is prevention. Preventing, or limiting health issues from occurring, minimizes or eliminates overall health and cost impacts.

- **Screening** – Through effective screening, counseling, and support services, we can identify individuals at risk, provide counseling to them on how to change behaviors, and provide the support to access the services they need to be successful. However, screenings, counseling and support services to address serious health risks—tobacco use, physical inactivity, risky drinking, poor nutrition—is often not covered by an employer-sponsored health plan.

- **Birth Control Options and Access** – Most employers’ health care plans cover well-baby care, whereas less than half cover contraceptive devices or drugs to prevent unwanted pregnancies, despite the research showing that about half of all pregnancies and nearly one-third of all births each year are unintended. Unwanted/unplanned pregnancies have a direct relationship with the risk of a child experiencing child abuse and neglect.

- **Prevent ACEs and Build Resilience.** The powerful body of research showing that what a child experiences during the early years (starting in utero) lays the foundation for the rest of their life makes a compelling case for prioritizing investment in this area. Adverse Childhood Experiences (ACE) that occur prior to the age of 18 have been associated with unfavorable future health outcomes (chronic obstructive pulmonary disease, ischemic heart disease, tumor growth, major depressive disorder, post-traumatic stress disorder [PTSD], risky health behaviors [illicit drug abuse, alcohol abuse, and early initiation of sexual activity] and neurodevelopmental deficits). Preventing ACEs and building resilience in children and families will have long-term social, economic, and health benefits.

- **Prevent Future Deaths.** The Alaska Maternal and Child Death Review (MCDR) is a program based on a national evidence-based model to systematically and comprehensively review deaths using a multi-disciplinary consensus decision-making approach. This model specifically aims to identify causes and contributing factors to maternal, infant, and child deaths in Alaska and develop recommendations to prevent future deaths. This goal is accomplished through expert committee reviews of medical records, autopsy reports, death scene investigation reports, and other relevant information that is
compiled for every death. MCDR’s recommendation to ensure the long life of all children should be followed; for more information, their website and the current MCDR report is in the resources section of this report.

Cost Containment

Utilization of high-risk substances like tobacco, alcohol or marijuana has a high-cost impact to states. Increasing the tax on high-risk substances can lead to a significant decrease in utilization and lessen health impacts. In addition, increasing revenue can ensure cost neutrality by generating funds that can be dedicated to prevention, outreach, and education to counteract the industry’s high investment in advertisements. Past research has shown that increases in tobacco and alcohol taxes are a highly effective control strategy and lead to significant improvements in public health. The positive health impact is even greater when some of the revenue generated by tobacco and alcohol tax increases are used to support control, health promotion, and/or other health-related activities and programs. High taxes on high-risk substances have caused minimal to no economic harm and have helped states with cost containment and improving overall health.

Other examples include instituting a tax on sugar-sweetened beverages (sodas, fruit drinks, and others sweetened with sugar, high fructose corn syrup, or similar sweeteners) to dedicate all or a portion of the revenue to health care. Consumption of sugary drinks (which include sodas, soft drinks, fruit drinks, sweetened coffees and teas, sports drinks, energy drinks, and sweetened waters) is associated with a host of adverse health outcomes, including obesity, heart disease, type 2 diabetes, and tooth decay. Studies have shown that the choice to consume soft drinks is influenced by pricing changes, including those driven by taxes. In addition to generating substantial revenue, which can be used to fund health services or other infrastructure, the tax on sugar-sweetened beverages is predicted to greatly reduce the adverse health and cost burdens of obesity, diabetes, and cardiovascular diseases.

Medicaid

State policy makers should explicitly consider and address the full impact (both intended and unintended) of changes in Medicaid policies on the viability of safety net providers and the populations they serve, including children. All federal programs and policies that support the safety net for children and families, and the populations it serves, should be reviewed for effectiveness reducing the number and meeting the needs of uninsured children. Any change that results in lower coverage should be viewed as a cut to children’s health care. Concerted efforts should be directed to improving this state’s capacity and ability to monitor the changing structure, capacity, and financial stability of the safety net to meet the health care needs of the uninsured and other vulnerable populations.

Health Care System

At 11 percent, Alaska has the highest rate of uninsured children in the country. Being uninsured, although not the only barrier to obtaining health care, is by all indications the most significant one. Uninsured children have less access to health care, are less likely to have a regular source of primary care, and use medical and dental care less often compared with children who have insurance. Even when children are covered, sometimes there are gaps in health insurance coverage. These children have worse access to care than those with continuous coverage.
Because insurance status affects access to secure and continuous care, it also affects health. Even when insured, limitations on coverage may still impede people's access to care. Many people who are counted as insured have very limited benefits and are exposed to high out-of-pocket expenses or service restrictions. Three areas in which benefits are frequently circumscribed under both public and private insurance plans are preventive services, behavioral health care (treatment of mental illness, addictive disorders, etc.), and oral health care.

The temptation to cut back on investment in early intervention in times of austerity needs to be resisted, for short-term financial gains can lead to long-term costs. The challenge is not, therefore, deciding whether to maintain spending on early intervention, but working out how to get better value out of the money already being invested. Children's health is mediated by a complex and dynamic social, economic and physical environment that affects every aspect of a child's well-being. The more we learn about the lived experiences of children, the more we have come to understand the influence of a child's environment on the expression of genes and the biochemistry of life. This is as true for children in the urban and rural communities in Alaska.

Delivery system reforms are most effective when they are integrated and ensure real accountability from providers and patients to improve results. Multiple approaches to delivery system reform may be necessary to bend the cost curve and improve care quality. Efforts to coordinate care will be less effective without the use of electronic medical records and more comprehensive decision support for both patient and provider. Alone, sophisticated systems will be ineffective if providers do not have payment and other incentives to promote systematic coordination of care. Providers will not be as successful as they can be over the long term if they do not have access to practical evidence on which clinical practices work best in particular cases or which patients need timely interventions. Evaluations of past efforts to integrate delivery system reforms show promising results. Delivery system reforms must be implemented in concert with other reforms to provide the tools, resources, and incentives (for patients and providers) needed to assure better patient outcomes and move away from perverse financial incentives driving non-evidence-based health care.

Reforming health care payment and delivery and expanding coverage are not only complementary but each is critical to achieving the other. Coverage expansion is critical to fully address the underuse of effective care, a problem that is particularly severe among the uninsured. At the same time, successful payment and delivery reform is needed to increase the value of health care, with better quality care and slower cost growth. These improvements will likely induce more Alaskans to purchase health insurance coverage as it becomes more affordable and valuable. Of course, delivery system reforms alone will not ensure universal coverage; major steps must be taken to explicitly ensure coverage for every Alaskan. Yet substantial progress toward effective delivery system reform is critical to achieving goals with respect to expanded coverage.
The following resources provide additional information regarding Alaska children’s health and well-being.

These resources and more are available at: [http://www.voicesakchildren.org/publications/](http://www.voicesakchildren.org/publications/).
Appendices
**Glossary**

**Adverse Childhood Experiences** or **ACEs** are traumatic or highly stressful experiences during childhood that can have a profound effect on a child’s developing brain and body. The National Survey of Children’s Health asks parents/guardians about their child’s exposure to the following experiences:

- Financial hardship (hard to get by on family’s income);
- Divorce or separation (parent or guardian divorced or separated);
- Death of a parent or guardian;
- Jail-time served by a parent or guardian;
- Domestic assault (saw or heard parents or adults slap, hit, kick, or punch one another in the home);
- Neighborhood violence (victim of violence or witnessed violence in neighborhood);
- Mental illness in the home (lived with anyone who was mentally ill, suicidal, or severely depressed); and
- Alcohol or drug abuse in the home (lived with anyone who had a problem with alcohol or drugs).

In addition to the experiences listed above, **all forms of child maltreatment (physical abuse, sexual abuse, verbal/emotional abuse, and physical or emotional neglect)** are considered ACEs.

The Behavioral Risk Factor Surveillance System (BRFSS) asks adults about their childhood (under age 18) exposure to:

- Physical, emotional, and/or sexual abuse;
- Physical and/or emotional neglect;
- Divorce or separation;
- Substance abuse in the household;
- Mental illness in the household;
- Incarceration among household members; and
- Domestic violence

**Combined 7-vaccine series** includes four or more doses of DTaP (diphtheria, tetanus toxoids, and acellular pertussis vaccine), three or more doses of Polio (poliovirus vaccine), one or more dose of MMR (measles-mumps-rubella vaccine), a Hib full series (haemophilus influenzae type b vaccine), three or more doses of HepB (hepatitis B vaccine), one or more Var (varicella vaccine), and four or more PCV (pneumococcal conjugate vaccine).

**Developmental screening** refers to screener forms filled out by parents of children ages 9 months to 5 years and reviewed by medical providers for concerns related to development, communication or social behavior.

According to the U.S. Census Bureau, anyone who reports any of the following disability types is considered to have a **disability**:

- Hearing difficulty (deaf or having serious difficulty hearing);
- Vision difficulty (blind or having serious difficulty seeing, even when wearing glasses);
- Cognitive difficulty (having difficulty remembering, concentrating, or making decisions because of a physical, mental, or emotional problem);
- Ambulatory difficulty (having serious difficulty walking or climbing stairs);
- Self-care difficulty (having difficulty bathing or dressing); and
- Independent living difficulty (having difficulty doing errands alone such as visiting a doctor’s office or shopping because of a physical, mental, or emotional problem).

**Employee-based only insurance** refers to coverage by one health plan offered through a relative’s current, or former, employer or union, including those covered by TRICARE or other military health coverage offered.
through health care programs for active-duty military and retired members of the uniformed services, their families, and survivors.

**Direct-purchase only insurance** refers to coverage by one health plan that is purchased directly from an insurance company by an individual or an individual’s relative.

**Other private coverage** refers to coverage by more than a private plan and not covered under any public plan.

**Public only insurance** refers to insurance through at least one federal programs—Medicare, Medicaid, and other medical assistance programs, VA Health Care, the Children’s Health Insurance Program (CHIP), or individual state health plans—and no private coverage.

A **family** has two or more members who live in the same home and are related by birth, marriage, or adoption.

A **household** consists of one or more persons living in the same house, condominium or apartment. They may or may not be related.

**Obese** children have a Body Mass Index (BMI) at or above the 95th percentile. BMI is age- and gender-specific.

**Overweight** children have a BMI between the 85th and 95th percentile.

A **primary family** refers to a group of two or more people related by birth, marriage, or adoption residing together and does not include non-relatives.

**Special health care needs** are defined based on the federal Maternal and Child Health Bureau’s definition. As part of the National Survey of Children’s Health, the parent/guardian is asked the following questions:

1. Does the child currently need prescription medications?
2. Does the child need more medical care, mental health care, or educational services than his or her peers?
3. Is the child limited in his or her ability to do things?
4. Does the child need physical, occupational, or speech therapy?
5. Does the child have an emotional, developmental, or behavioral problem?

If the answer to one or more of the questions is yes and the condition(s) is(are) expected to last for 12 months or more, then the child is defined as having special health care needs.114

**Related children** in a family include own children and all other children under 18 years old in the household who are related to the householder by birth, marriage, or adoption.

Children in **single-parent families** are children who live with their own single-parent. Single-parent families may include cohabiting couples but does not include children living with married stepparents. Children who live in group quarters (institutions, dormitories, or group homes) are not included.
Following is a list of health indicators available on the KIDS COUNT Data Center. Occasionally, data for an indicator is suppressed due to small sample sizes or large margins of error.

**Table 16. KIDS COUNT Indicator List**

<table>
<thead>
<tr>
<th><strong>BIRTH OUTCOMES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Teen birth rate ages 15-19 (5-year average)</td>
</tr>
<tr>
<td>Low birth-weight babies (5-year average)</td>
</tr>
<tr>
<td>Births to women with less-than-adequate prenatal care APNCU (5-year average)</td>
</tr>
<tr>
<td>Mothers reported drinking alcohol while pregnant</td>
</tr>
<tr>
<td>Mothers reported smoking while pregnant</td>
</tr>
<tr>
<td>Births to unmarried women</td>
</tr>
<tr>
<td>Births by education level</td>
</tr>
<tr>
<td>Preterm Births (using Obstetrical Estimate)</td>
</tr>
<tr>
<td>Interpregnancy intervals</td>
</tr>
<tr>
<td>Teen births enrolled in Medicaid</td>
</tr>
<tr>
<td>Live births enrolled in Medicaid</td>
</tr>
<tr>
<td>Births with no father named (5-year average)</td>
</tr>
<tr>
<td>Births with no father named enrolled in Medicaid</td>
</tr>
<tr>
<td>Short interpregnancy intervals by Medicaid</td>
</tr>
<tr>
<td>Long interpregnancy intervals by Medicaid</td>
</tr>
<tr>
<td>Total births</td>
</tr>
<tr>
<td>Teen births by age group</td>
</tr>
<tr>
<td>Teen mothers ages 15 to 19 (not updated since 2005)</td>
</tr>
<tr>
<td>Teen births to women who were already mothers</td>
</tr>
<tr>
<td>Births to unmarried women</td>
</tr>
<tr>
<td>Births to foreign-born mothers</td>
</tr>
<tr>
<td>Preterm births (by Last Normal Menses)</td>
</tr>
<tr>
<td>Very low birth-weight babies</td>
</tr>
<tr>
<td>Low birth-weight babies</td>
</tr>
<tr>
<td>Children ages birth to 3 whose parent did not receive a new parent home visit</td>
</tr>
<tr>
<td>Births to women receiving late or no prenatal care</td>
</tr>
<tr>
<td>Births to mothers with less than 12 years of education</td>
</tr>
<tr>
<td>Births to mothers who smoked during pregnancy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>HEALTH INSURANCE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured children under 19 at all income levels</td>
</tr>
<tr>
<td>Uninsured children under 19 at all income levels</td>
</tr>
<tr>
<td>Uninsured children under 19 at or below 200% of poverty threshold</td>
</tr>
<tr>
<td>Children without health insurance</td>
</tr>
<tr>
<td>Children without health insurance by age group</td>
</tr>
<tr>
<td>Children 18 and below without health insurance</td>
</tr>
<tr>
<td>Children without health insurance by poverty level</td>
</tr>
<tr>
<td>Children who have health insurance by health insurance type</td>
</tr>
<tr>
<td>Children who have a parent with no health insurance</td>
</tr>
<tr>
<td>Parents without health insurance</td>
</tr>
<tr>
<td>Insured children under 19 at all income levels</td>
</tr>
</tbody>
</table>
### VITAL STATISTICS

- Infant mortality rate per 1,000 live births (5-year average)
- Child death rate 1-14 per 100,000 children (5-year average)
- Teen violent death rate 15-19 per 100,000 teens (5-year average)
- Teen suicide rate 15-19 per 100,000 teens (5-year average)
- Teen deaths from all causes 15-19 per 100,000 teens (5-year average)
- Infant mortality rate by Medicaid enrollment (5-year average)
- Child deaths ages 1-14 enrolled in Medicaid (5-year average)
- Teen deaths ages 15-19 enrolled in Medicaid (5-year average)
- Infant mortality
- Child and teen death rate
- Child deaths
- Teen deaths from all causes
- Teen deaths by accident, homicide, and suicide

### DENTAL HEALTH

- Early dental visits by age
- Diagnosis of early tooth decay or cavities
- Early dental visits by age and region
- Diagnosis of early tooth decay or cavities by region
- Children who have received preventive dental care in the past year
- Children whose teeth are in excellent or very good condition
- Children who lack access to fluoridated water

### MENTAL HEALTH

- Felt sad or hopeless in past 12 months among high school students
- Considered suicide in past 12 months among high school students
- Planned suicide in past 12 months among high school students
- Attempted suicide in past 12 months among high school students
- Children who have one or more emotional, behavioral, or developmental conditions

### OTHER HEALTH

- Children under 18 with disabilities
- 2-year-olds who were immunized: 3 or more doses of Hib 2002-2008 Full series of Hib 2009-2016
- Combined 7-vaccine series coverage among children (19-35 months)
- Children and teens overweight or obese by gender
- Children and teens not exercising regularly
- Children with special health care needs
- Percent of children with asthma problems
- Children who are not in excellent or very good health

### CHILD ABUSE & NEGLECT

- Rate of unique children with at least one report of maltreatment by region
- Rate of unique children with substantiated child maltreatment by region
- Rate of unique children with at least one report of maltreatment by age group
- Rate of unique children with substantiated child maltreatment by age group
- Children who are confirmed by child protective services as victims of maltreatment
- Children who are confirmed by child protective services as victims of maltreatment by age group
- Children who are confirmed by child protective services as victims of maltreatment by gender
- Children who are confirmed by child protective services as victims of maltreatment by maltreatment type
- Children who are confirmed by child protective services as victims of maltreatment who received post-investigation services
Children who are subject to an investigated report

**OTHER SAFETY & RISK BEHAVIORS**
- Tobacco smoking in past month among high school students
- Alcohol use in past month among high school students
- Binge drinking in past month among high school students
- Marijuana use in past month among high school students
- Sexual intercourse with 4 or more people in lifetime among high school students
- Used birth control method during the past 3 months among sexually active high school students
- Used a condom at last sexual intercourse among high school students
- Used both condom & birth control method at last sexual intercourse among high school students
- Teens ages 12 to 17 who abused alcohol or drugs in the past year
- Illicit drug use other than marijuana by age group
- Binge alcohol drinking among youths by age group
- Cigarette use in the past month by age group
- Marijuana use by age group

**INDICATORS BY RACE/ETHNICITY**
- Total resident births by race
- Children who are not in excellent or very good health by race and ethnicity
- Teen births by race and ethnicity
- Low birth-weight babies by race
- Children without health insurance by race and ethnicity
- Total births by race
- Births to women receiving late or no prenatal care by race and ethnicity
- Infant mortality by race
- Child and teen death rate by race and ethnicity
- Teen deaths from all causes by race
- Child deaths by race
- Children who have health insurance by health insurance type and by race and ethnicity
- Rate of unique children with at least one report of maltreatment by race
- Rate of unique children with substantiated child maltreatment by race

### Table 17. 2017 KIDS COUNT Health Profile, Alaska and United States

<table>
<thead>
<tr>
<th>Health Indicator</th>
<th>Alaska</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Children</td>
<td>Percent of Total Child Population</td>
</tr>
<tr>
<td>Low-Birthweight Babies</td>
<td>653</td>
<td>5.8%</td>
</tr>
<tr>
<td>Children without Health Insurance</td>
<td>20,000</td>
<td>11%</td>
</tr>
<tr>
<td>Child and Teen Deaths per 100,000</td>
<td>78</td>
<td>11.5%</td>
</tr>
<tr>
<td>Teens who Abuse Alcohol or Drugs</td>
<td>3,000</td>
<td>5%</td>
</tr>
</tbody>
</table>

Notes


5. Population projections 2020-2045. (2017). Available at http://datacenter.kidscount.org/data.line/184-population-projections-2020-2045? Data source: Alaska Department of Labor and Workforce Development, Research and Analysis Section. US Bureau of the Census. These estimates were developed using Alaska Permanent Fund Dividend data, information from the Alaska Bureau of Vital Statistics, and survey information as the primary indicators of population change. These population estimates include Armed Forces in Alaska and exclude seasonal populations. The Alaska Department of Labor and Workforce Development provides high, middle, and low scenarios. The data shown here are the middle-level projections.


The SAS code for calculating interpregnancy intervals was developed with the assistance of the National Institute for Children’s Health Quality during Alaska’s participation in the National Infant Mortality Collaborative Improvement and Innovation Network (IM CoIIN) from 2014 to 2017.


53 Children ages 9 to 35 months who have received a developmental screening. Published by National KIDS COUNT. (2018). Available at: http://datacenter.kidscount.org/data/tables/9814-children-ages-9-to-35-months-who-have-received-a-developmental-screening? Data source: Child Trends analysis of data from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, National Survey of Children’s Health (NSCH). The state-level data used here come from the National Survey of Children’s Health (NSCH). The NSCH includes information on approximately 50,000 children under age 18, with representative samples for each state.


63 Children who have one or more emotional, behavioral, or developmental conditions. (2018). Published by National KIDS COUNT. Available at: https://datacenter.kidscount.org/data/talbes/9699-children-who-have-one-or-more-emotional-behavioral-or-developmental-conditions?loc=3&loc2=2&detailed=2/3/false/1539/any/18942,18943. Data source: Child Trends analysis of data from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, National Survey of Children's Health.

64 Youth Risk Behavior Surveillance System (YRBSS) Statewide Query Module: Sad Feelings or Attempted Suicide. Retrieved on June 11, 2018 from Alaska Department of Health and Social Services, Indicator-Based Information System for Public Health (AK-IBIS) website: http://ibis.dhss.alaska.gov/query/Introduction.html. Note: This includes students in public traditional high schools with enrollments of at least 10 students (excluding boarding, correspondence, home study, alternative, and correctional schools). The statewide traditional high school results are weighted by grade, sex, and race/ethnicity.

65 Youth Risk Behavior Surveillance System (YRBSS) Statewide Query Module: Sad Feelings or Attempted Suicide. Retrieved on June 11, 2018 from Alaska Department of Health and Social Services, Indicator-Based Information System for Public Health (AK-IBIS) website: http://ibis.dhss.alaska.gov/query/Introduction.html. Note: This includes students in public traditional high schools with enrollments of at least 10 students (excluding boarding, correspondence, home study, alternative, and correctional schools). The statewide traditional high school results are weighted by grade, sex, and race/ethnicity.


71 Behavioral Risk Factor Surveillance System (BRFSS), Alaska DHSS, Division of Public Health, Section of Chronic Disease Prevention and Health Promotion. data compiled by Alaska Department of Health and Social Services, Section of Women’s, Children’s and Family Health, Maternal and Child Health Epidemiology Unit.


87 State-wide estimates. Alaska Statewide Traditional High School YRBS Dataset. Youth Risk Behavior Surveillance System (YRBSS), Alaska Department of Health and Social Services, Division of Public Health, Section of Chronic Disease Prevention and Health Promotion. http://ibis.dhss.alaska.gov/query/selection/yrbst23/YRBBSelection.html (Accessed June 11, 2018) Note: This includes students in public traditional high schools with enrollments of at least 10 students (excluding boarding, correspondence, home study, alternative, and correctional schools). The statewide traditional high school results are weighted by grade, sex, and race/ethnicity.

88 Regional estimates. Alaska Local YRBS Dataset. Youth Risk Behavior Surveillance System (YRBSS), Alaska Department of Health and Social Services, Division of Public Health, Section of Chronic Disease Prevention and Health Promotion.
http://ibis.dhss.alaska.gov/query/selection/yrbsl23/YRBSSelection.html (Accessed June 11, 2018) Note: This includes students in public traditional, alternative, and correctional high schools (excluding boarding, correspondence, and home study schools). Local results from participating school districts contain both weighted and unweighted data.

Regional estimates. Alaska Local YRBS Dataset. Youth Risk Behavior Surveillance System (YRBSS), Alaska Department of Health and Social Services, Division of Public Health, Section of Chronic Disease Prevention and Health Promotion. http://ibis.dhss.alaska.gov/query/selection/yrbsl23/YRBSSelection.html (Accessed July 2018) Note: This includes students in public traditional, alternative, and correctional high schools (excluding boarding, correspondence, and home study schools). Local results from participating school districts contain both weighted and unweighted data.

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Youth Risk Behavior Surveillance System (YRBSS) Statewide Query Modules: Sexual Behavior. Retrieved on June 11, 2018 from Alaska Department of Health and Social Services, Indicator-Based Information System for Public Health (AK-IBIS) website: http://ibis.dhss.alaska.gov/query/Introduction.html. Note: This includes students in public traditional high schools with enrollments of at least 10 students (excluding boarding, correspondence, home study, alternative, and correctional schools). The statewide traditional high school results are weighted by grade, sex, and race/ethnicity.
99 Youth Risk Behavior Surveillance System (YRBSS) Statewide Query Modules: Sexual Behavior. Retrieved on June 11, 2018 from Alaska Department of Health and Social Services, Indicator-Based Information System for Public Health (AK-IBIS) website: http://ibis.dhss.alaska.gov/query/Introduction.html. Note: This includes students in public traditional high schools with enrollments of at least 10 students (excluding boarding, correspondence, home study, alternative, and correctional schools). The statewide traditional high school results are weighted by grade, sex, and race/ethnicity.

100 Youth Risk Behavior Surveillance System (YRBSS) Statewide Query Modules: Sexual Behavior. Retrieved on June 11, 2018 from Alaska Department of Health and Social Services, Indicator-Based Information System for Public Health (AK-IBIS) website: http://ibis.dhss.alaska.gov/query/Introduction.html. Note: This includes students in public traditional high schools with enrollments of at least 10 students (excluding boarding, correspondence, home study, alternative, and correctional schools). The statewide traditional high school results are weighted by grade, sex, and race/ethnicity.


114 Definition is available at: https://datacenter.kidscount.org/data/tables/9703-children-with-special-health-care-needs?