



**Maternal and Child Health Services  
Title V Block Grant**

**State Narrative for  
Arizona**

**Application for 2009  
Annual Report for 2007**



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## **I. General Requirements**

### **A. Letter of Transmittal**

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

***An attachment is included in this section.***

### **B. Face Sheet**

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

### **C. Assurances and Certifications**

Certification and assurances will be kept on file at the Arizona Department of Health Services.

### **D. Table of Contents**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

### **E. Public Input**

Public input regarding the MCH Block Grant and the associated performance and outcome measures has been incorporated as a continuous process within OWCH and OCSHCN. Program managers and staff who work directly with the public, contractors, and community partners brought the perspective of those stakeholders to the process. The Office of Women's and Children's Health produces quarterly newsletters which are transmitted to partners electronically and posted on the OWCH website. These newsletters keep our partners up to date on our activities and priorities. The Office of Women's and Children's Health and the Office for Children with Special Health Care Needs met with stakeholders independently and jointly.

*/2008/*

In addition to the public input activities listed above, the Bureau of Women's and Children's Health conducted a number of public input meetings during the last two years. In 2006 and 2007, all of the bureau chiefs of Public Health Prevention Services are visiting each county health department in Arizona. The purpose of the visits is to learn about the unique needs of each local area, and gather feedback on how we can better meet those needs. During the spring of 2007, the Bureau of Women's and Children's Health posted their 2006 -- 2010 Strategic Plan and a draft of this application on the internet for public comment and feedback. Additionally, a community advisor read a draft of the application and provided feedback.

OCSHCN's direct service programs now collect survey data on family satisfaction, and OCSHCN has implemented a new telephone inquiry tracking system to identify trends in family's concerns. In addition, the OCSHCN website has a link through which anonymous input can be given. OCSHCN continues to get feedback through its Integrated Services Grant, which brings together partners from state child-serving and community-based agencies, parents and youth, and OCSHCN's community development teams are an ongoing source of feedback. An intensive stakeholder input series designed for CRS identified issues that applied more generally to children with special health care needs.

*//2008//*

***/2009/In addition to the activities outlined above, OCSHCN provided copies of the draft narrative from the 2009 application to contractors, community partners, parents and youth***

*for review and comment.//2009//*

*//2009/ A draft of the 2009 block grant application was placed on the ADHS web and stakeholders were notified and asked to comment. //2009//*

## **II. Needs Assessment**

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

### **C. Needs Assessment Summary**

Needs assessment activities for the Bureau of Women's and Children's Health (BWCH) included many public input activities. In 2006 and 2007, the bureau chief is visiting each county health department in Arizona. The purpose of the visits is to learn about the unique needs of each local area, and gather feedback on how we can better meet those needs. During the spring of 2007, the Bureau of Women's and Children's Health posted their 2006 -- 2010 Strategic Plan and a draft of this application on the internet for public comment and feedback. Additionally, a community advisor read a draft of the application and provided feedback. Feedback obtained during these public input activities supported continuation of the seven priority needs identified for the BWCH in the 2005 Needs Assessment. These priority needs are listed in section IV B of this application.

All of OCSHCN's direct service programs now collect survey data on family satisfaction, and OCSHCN has implemented a new telephone inquiry tracking system to identify trends in family's concerns. In addition, OCSHCN has implemented a website with a link to provide anonymous feedback on OCSHCN programs.

The Integrated Services Grant brought together partners from state child-serving and community-based agencies, parents and youth, to identify barriers to statewide implementation of medical home and care coordination for CYSHCN. The grant's task force and committees represent the Arizona Chapter of the American Academy of Pediatrics, Arizona Medical Association, all of the major child-serving agencies, the three state universities, family organizations, parents and youth, the Governor's office, and many other key stakeholders. A key activity is to evaluate how current systems for serving CYSHCN, including OCSHCN programs, promote Title V performance measures, which encompass family-friendly, community-based care. OCSHCN strategic planning uses results from this evaluation to target scarce Title V resources and align them with identified gaps. A primary evaluation question will be whether OCSHCN is effectively directing its Title V resources to address performance measures.

OCSHCN's 13 community development teams choose projects based on the needs of their own communities. Raising Special Kids and their affiliated family-advocacy groups recruited families for focus groups throughout the state to help inform the design for Children's Rehabilitative Services as the program is scheduled to go out for a new procurement. Stakeholder input also included physicians and other providers, AHCCCS administration and health plan medical directors. Input went beyond the CRS Program and identified issues that applied more generally to children with special health care needs.

Concerns among providers and families alike indicated that the system of care is fragmented and is confusing to navigate, with lengthy and redundant eligibility processes and unpredictable benefits. Children are often split up among several agencies for different aspects of their care. Fragmentation also exists between primary and specialty care, and a need was voiced for a reimbursement system that adequately compensated providers for primary care for C/YSCHN. Provider shortages were identified as contributing to long waiting times for appointments for pediatric sub-specialists. Overall, a need was identified to better educate families, providers, and agencies about the child-serving systems of care and their eligibility processes.

Because of the identified need to clarify systems of care and facilitate linking children and youth with appropriate services, OCSHCN is refocusing two of its priorities.

New Priority #8. Educate families, providers, and child-serving agencies on eligibility rules and processes for accessing services.

OCSHCN will target education efforts within its own agency by training OWCH Hotline staff, Neonatal Intensive Care Program staff and Community Nursing staff on eligibility rules and coverage of programs within OCSHCN and other agencies. OCSHCN will also develop resources to train AHCCCS and other providers, hospital discharge planners, families, and eligibility workers within other agencies. The OCSHCN website and e-learning system will be expanded to include trainings on navigating the systems of care for CSHCN.

New Priority #9. Increase access to available and appropriate services for children and youth with special health care needs.

Through the SSDI grant, OWCH and OCSHCN are defining processes to identify newborns who test positive through the state's Newborn Screening Program and refer them to appropriate staff within both offices and facilitate their enrollment into programs for care coordination and direct medical services. OWCH and OCSHCN are also collaborating to define a new state performance measure, which will track the percent of children identified through the newborn screening process who receive services through an OWCH or OCSHCN program.

### III. State Overview

#### A. Overview

The Governor's Commission on the Health Status of Women and Families was formed in 1999 with key leaders in the public and private sector appointed to serve on it. Title V funds a position in the Governor's office to staff the Commission, and in May of 2005, the Governor approved the Commission's recommendations and empowered them to develop an implementation plan around the following recommendations:

1. Increase access to health care for the women of Arizona through: a) Comprehensive, continuous health insurance coverage throughout the life cycle; b) Integrate dental and behavioral health with physical medicine; c) Increasing access to family planning services for low-income women in Arizona; and d) promoting cultural and linguistic competency among the health care community to achieve appropriate care for diverse populations.
2. Improve the health and well-being of women in Arizona by increasing women's awareness of how they can positively impact their health and well-being.
3. Reduce the teen pregnancy rate in Arizona, with a particular emphasis on reducing the number of second pregnancies to teens.
4. Increase prenatal care and pre-conception care for women in Arizona through: a) Increasing the number of women who access early prenatal care to improve birth outcomes; b) Increasing access to better oral health to improve birth outcomes; and c) Promoting healthy preconception lifestyles to women.

*//2007/ The Governor's staff position moved to ADHS Division of Public Health Prevention Services to coordinate women's health efforts within the Division, act as a liaison among partners, staff the Governor's Women's Commission, oversee implementation of the plan, and provide technical assistance. //2007// **//2009/ The Governor signed an executive order reauthorizing the Commission. The Governor's staff are in the process of appointing members and determining future activities. The Women's Health staff position moved back to the Governor's Office to enhance the visibility of women's health issues as well as to better integrate with various statewide efforts. //2009//***

#### POPULATION

Arizona is the second-fastest growing state in the nation, with an estimated population of 5,832,150 in 2004. The state population grew by nearly 1.9 million people in the period between 1993 and 2004, representing an increase of 48 percent. An estimated 200,000 undocumented immigrants moved to the state during the past five years, and Arizona now has the fifth-largest population of undocumented immigrants in the United States, with an estimated undocumented population of 500,000.

Since the last five-year maternal child health (MCH) needs assessment in the year 2000, there has been a 14 percent increase in Arizona's population, while the population growth within the nation as a whole for the same time period was only 4.3 percent. Over the next 25 years, the U.S. Census projects that Arizona will grow by five million people, doubling by the year 2030. By 2004, the maternal-child population included 2,797,421 women of childbearing age and children under age 21.

There are 15 counties in Arizona; however, 77 percent of the state's population resides in either Maricopa or Pima Counties. Maricopa County alone added 500,000 people since 2000, more than any other county, making it the third largest county in the United States. Overall, three of every four Arizonans lives in an urban area, one in five lives in a rural area; 2 percent live in a

frontier area, and 3 percent live on Indian reservations.

/2007/Arizona is the second-fastest growing state in the nation, with an estimated population of 6,044,985 in 2005. The population grew by over two million people between 1993 and 2005, representing an increase of 53%. Since the year 2000, there has been a 15% increase in Arizona's population, while the population growth in the nation for the same time period was only 5%. By 2005, the MCH population included 2,901,142 women of childbearing age and children under age 21. Maricopa County alone added 576,396 people since 2000.//2007//./2008/During the 12 months ending July 1, 2006 Arizona was the fastest growing state with a population increase of 3.6%. //2008// **/2009/ In 2007, Arizona's population grew to 6,338,755 -- an increase of 1,208,140 persons (23.5%) since 2000, making Arizona the second-fastest growing state in the nation. Fifteen percent of the people living in Arizona in 2006 were foreign born. Eighty-five percent was native, including 36 percent who were born in Arizona. //2009//**

## RACE/ETHNICITY

Twenty-one American Indian tribes reside in Arizona, each representing a sovereign nation with its own language and culture. Tribal lands span the state and even beyond state borders, with the Navajo Reservation crossing into New Mexico and Colorado, and the T'odono Odham Reservation crossing international boundaries into Mexico.

Approximately 18 percent of tribal members reside on tribal lands while 82 percent are considered urban. Some counties have high proportions of American Indians among their population. Seventy-seven percent of Apache County, 48 percent of Navajo County, and 29 percent of Coconino County residents are American Indians.

Four counties border Mexico, and Arizona has an increasing Hispanic population, with a higher proportion of Hispanics (28 percent) compared to the nation (13 percent). An even higher percentage of children are Hispanic (39 percent in Arizona, compared to 19 percent nationally). In 2003, the number of births to Hispanic mothers surpassed Anglos for the first time. Arizona has a smaller percentage of African Americans than the nation (3 percent compared to 13 percent) and a higher proportion of Whites (88 percent compared to 81 percent nationally). **/2009/ For people reporting one race alone in 2006, 79 percent was White; 3 percent was Black or African American; 5 percent was American Indian and Alaska Native; 2 percent was Asian; less than 0.5 percent was Native Hawaiian and Other Pacific Islander, and 11 percent was Some other race. Two percent reported two or more races. Twenty-nine percent of people in Arizona were Hispanic. Fifty-nine percent of the people in Arizona were White non-Hispanic. //2009//**

## LANGUAGE SPOKEN

Arizona residents are more likely to speak a language other than English at home (26 percent in Arizona compared to 18 percent nationally), and more likely to report speaking English "less than very well" (11 percent in Arizona compared to 8 percent nationally). Among Arizona residents who spoke English "less than very well," 85 percent spoke Spanish, while the other 15 percent spoke one of many other languages. **/2009/ Among people at least five years old living in Arizona in 2006, 28 percent spoke a language other than English at home. Of those speaking a language other than English at home, 78 percent spoke Spanish and 22 percent spoke some other language; 44 percent reported that they did not speak English "very well." //2009//**

## ECONOMY

Arizona is second in the nation in generating jobs; however, wages and personal income lag

behind the rest of the nation. Arizona's main economic sectors include services, trade and manufacturing, and most of the fastest growing jobs in Arizona are jobs with relatively low wages and fewer benefits (such as health insurance). The average per capita personal income in Arizona ranked 38th among the 50 states, at \$27,232 in 2003. Although the cost of living in Arizona mirrors national averages, the per-employee compensation tends to be lower. /2007/ The average per capita personal income in Arizona ranked 38th among the 50 states, at \$30,267 in 2005. //2007//**2009/ The median income of Arizona households in 2006 was \$47,265. Seventy-nine percent of households received earnings and 19 percent received retirement income other than Social Security. Twenty-eight percent of the households received Social Security. The average income from Social Security was \$14,582. //2009//**

**/2009/ Arizona is currently facing a billion-dollar shortfall in its \$11 billion budget. This is coupled with the housing crisis, which has seen housing prices in Phoenix drop by double-digit percentages for the past two years. A sharp decline in construction jobs caused the record-low unemployment rate to spike by a full point, to 3.9 percent, from May to December 2007. Population growth has slowed by half in Arizona and retail and office development are also ebbing. In Maricopa County, there are about 13,000 homes in foreclosure, which is a six-fold increase over two years ago. The decline in residential activity is leading to downturns in retail and commercial construction as well. Many business people and economists do not expect things to pick up until the Phoenix-area works through its inventory of about 37,000 unsold homes, which could take three or four years. //2009//**

Based on the 2003 U.S. Census three-year average estimate of 2001-2003, 13.9 percent of Arizona's population earned incomes below the federal poverty line, while the national rate was 12.1 percent. In Arizona, 21 percent of children under the age of 18 years lived in poverty in 2003, relative to 17 percent children in the nation as a whole. Children continue to constitute a large proportion of the poor population (45 percent) while representing only 30 percent of the total population. In 2001, 26 percent of Arizona children lived in families in which no parent had full-time, year round employment, and 29 percent lived in families headed by a single parent. These families bear an increased risk for living in poverty. **/2009/ In 2006, 14 percent of Arizonans were in poverty. Nineteen percent of related children under 18 were below the poverty level, compared with 8 percent of people 65 years old and over. Ten percent of all families and 27 percent of families with a female householder and no husband present had incomes below the poverty level. //2009//**

Hispanic and American Indian children were more likely to live in poverty than other racial and ethnic groups. A study recently released by the Harvard Project on American Indian Economic Development determined that American Indians, who are among the poorest minorities in the United States, made gains during the 1990s in income, educational attainment, housing, poverty and unemployment, and Arizona tribes shared in those gains. The report cautioned that substantial gaps remain between American Indians and the rest of the United States.

## HOMELESSNESS

In Arizona, "homeless" means the individual has no permanent place of residence where a lease or mortgage agreement exists. Determining the number of homeless individuals is a significant challenge because they are difficult to locate and/or identify. The best approximation is from an Urban Institute study, which states that about 3.5 million people nationwide, 1.35 million of them children, are likely to experience homelessness in a given year. Based on actual shelter and street accounts in 2004, approximately 22,000 people are homeless on any given day in Arizona. /2007/ Based on actual shelter and street accounts in 2005, there were approximately 20,000-30,000 homeless people on any given day in Arizona. //2007//

There are many factors that contribute to homelessness, including poverty, domestic violence, gender (the majority of homeless adults are males), substance abuse, mental illness, lack of

affordable housing, decreases in public assistance, low wages and lack of affordable health care. Families, specifically women with children, are the fastest-growing subpopulation of people who are homeless. Twenty-seven percent of homeless women, children, and teens came from a domestic violence situation. In spite of an overall positive economic picture in the state, the large number of households earning less than a livable wage and a disproportionate rise in housing costs versus incomes points to increasing numbers of homeless persons.

## EDUCATION

Arizona has more than 583 school districts, which includes 364 charter holders. Arizona's has 2,270 schools and the largest number of charter schools in the nation. According to the National Educational Association, Arizona per pupil spending is among the lowest in the nation. In a national study of reading proficiency, nearly half of Arizona's 4th graders (46 percent) read below proficiency, compared to 38 percent in the rest of the nation. **//2009/ The total school enrollment in Arizona was 1.6 million in 2006. Nursery school and kindergarten enrollment was 173,000 and elementary or high school enrollment was 1.0 million children. College or graduate school enrollment was 404,000. //2009//**

Among Arizona's population age 25 and older, 84 percent have graduated from high school, and 24 percent have a college degree, similar to the proportions of all United States residents. However, Arizona has one of the highest high-school dropout rates in the nation. During the 2003-2004 school year, the statewide dropout rate was 7.4 percent. For American Indians and Hispanic students, the dropout rates were even higher (12.4 percent and 10.1 percent, respectively). **//2009/ In 2006, 84 percent of people 25 years and over had at least graduated from high school and 26 percent had a bachelor's degree or higher. Sixteen percent were dropouts; they were not enrolled in school and had not graduated from high school. //2009//**

Arizona adopted high stakes testing requiring students to pass proficiency tests in reading, writing, and mathematics in order to earn a high school diploma. The Arizona Instrument to Measure Standards (AIMS) has been administered annually in recent years. Although passing the test has not yet been required to earn a high school diploma, students have been taking AIMS for purposes of evaluating school performance. High proportions of students across the state, and even higher proportions of minority students, have failed to meet AIMS standards for graduation. Implementation of the requirement to pass the AIMS before receiving a diploma was postponed in order to give schools time to align their curriculum to testing standards. The class of 2006 will be the first graduating class required to pass the test in order to graduate. In 2005, legislation was passed to allow students to apply points towards their AIMS scores for some classes in which they earned As, Bs, or Cs. **//2007/ The Arizona Department of Education is currently conducting a survey of all schools with graduating classes in 2006 to study the impact of the AIMS requirement on graduation rates. The study is expected to be completed in September, 2006. //2007// //2009/ In the Fall of 2007, 83 percent of Arizona high school students who took the AIMS test failed to meet state standards in Mathematics; 82 percent fell below standards in reading; and 73 percent failed to meet the standards in the subject of writing. //2009//**

According to the Annie E. Casey Foundation Kids Count 2004 study, a disconnected youth is defined as a teen that is not in school or working. Currently, there are an estimated 3.8 million (15 percent) young adults nationally who are neither in school nor working. In Arizona, 12 percent of teens age 16 to 19 are not in school or working. Referred to as "disconnected youth," they lack the skills, support and education to make a successful transition to adulthood. This study determined that the most disconnected youth were the teens in foster care, youth involved in the juvenile justice system, teens that have children of their own, and those who have never finished high school. These subgroups were determined to need the most urgent attention. **//2007/ During the 2004-2005 school year, the statewide dropout rate was 6.9 percent. For Hispanic and American Indians students, the dropout rates were even higher (10.2 percent and 8**

percent, respectively). //2007//

***/2009/ The 2006-07 school dropout rate for the state was 4.2 percent for all grades. Native American students had the highest dropout rate at 8.9 percent and Asian American students had the lowest dropout rate at 1.7 percent, followed by Whites with a rate of 2.8. African American students had a dropout rate identical to the state average (4.2) and Hispanic or Latino students had a slightly higher than average dropout rate (5.3). //2009//***

## JUVENILE DELINQUENCY

The proportion of violent crimes attributed to juveniles by law enforcement has declined in recent years, while drug and alcohol-related arrests have increased. Between 1993 and 2002, there were substantial declines in juvenile arrests for murder (64 percent), motor vehicle theft (50 percent), and weapons law violations (47 percent) and major increases in juvenile arrests for drug abuse violations (59 percent) and driving under the influence (46 percent). Fourteen percent of all arrests in Arizona were juveniles under age 18, compared to 16 percent nationally, and 71 percent of the arrests were male. Of the arrests of Arizona juveniles ages 8 through 17 in 2003, 16 percent of those offenses were larceny/theft. Runaways, drug violations, and assaults each make up 10 percent of the total number of juvenile offenses, and liquor law violations made up 9 percent of the total violations. //2007/ In 2004, 17% of all arrests in Arizona were juveniles under age 18, compared to 16% nationally, and 76% of the arrests were male. Of the arrests of Arizona juveniles ages 8 through 17 in 2004, 17 percent of those offenses were larceny/theft. Runaways, drug violations, liquor law violations, and assaults each make up 10% of the total number of juvenile offenses. //2007// ***/2009/ In FY 2007 the rate of referrals to Arizona's juvenile justice system declined to 5258 per 100,000 youth aged 8 to 17 years old. The majority of new offenses were related to property crimes (46.2%); 21 percent were for crimes against persons, 15.7% were for drug offenses and 10.8 percent were for public order offenses. As of 6/30/2007, 606 juveniles were in the custody of the Arizona Department of Juvenile Corrections (ADJC) in one of five secure-care facilities. An additional 476 juveniles were on parole. //2009//***

## HEALTH INSURANCE

Eighty-three percent of Arizona residents have some kind of health insurance, according to 2003 United States Census data. Many people have more than one kind of insurance: 64 percent of people have private insurance--either employment-based (55 percent) or direct purchase (9 percent); and 30 percent had some kind of government-sponsored insurance--such as Medicaid, (13 percent), Medicare (14 percent), or military health insurance (6 percent).

***/2009/ Eighty-two percent of Arizona residents have some form of health care coverage, according to CDC's Behavioral Health Risk Factor Surveillance System (2007). There are however major disparities in coverage between the different sexes, age groups and race/ethnicities. For example, 85.0 percent of females in Arizona have health insurance/coverage whereas only 78.7 percent of males are covered. 25-34 year olds have the lowest rate of coverage (72.4%) whereas the vast majority of elderly residents in Arizona are insured/covered (98.7%). And 90.8 percent of Whites in Arizona have some form of health coverage, but the same is true for only 57.1 percent of Hispanics. //2009//***

Ninety-three percent of all businesses in Arizona are small businesses with 50 or fewer employees. There are more than 100,000 small businesses in Arizona, and each year, small businesses add more workers to the workforce than large businesses. One of their top challenges is to offer competitive benefits. Only 28 percent of Arizona small businesses offer employer-sponsored health coverage, and cost is the primary barrier. For many Arizonans, healthcare remains unaffordable.

Recognizing the importance of affordable health care, the Healthcare Group was created in 1985 by the Arizona State Legislature with the support of the Robert Wood Johnson Foundation. It is a

state-sponsored, guaranteed issue health insurance program for small businesses and public servants. AHCCCS, Arizona's Medicaid agency, oversees and administers the program, although it will receive no state subsidies after July of 2005. Over 4,000 businesses participate in Healthcare Group, covering more than 12,000 Arizona residents.

The very concept of health insurance must be redefined as it applies to American Indians, who are entitled to healthcare through treaties with the United States government. However, tribal members face significant barriers to accessing care, including provider shortages and sometimes a confusing array of barriers when accessing services.

## MANAGED CARE

The health care delivery system and its financing has dramatically changed in the last 25 years, and managed care has played a dominant role in its evolution. Approximately 70 percent of the population in the United States under age 65 currently has private health insurance, the majority of which is managed care based, obtained through the workplace. Under the managed care umbrella, health maintenance organizations have become a major source of health care for beneficiaries of both employer-funded care and of the public funded programs, Medicaid and Medicare. 72 million people in the United States had health insurance through a health maintenance organization in 2003. Participation rapidly increased until hitting peak enrollment in 1999; however, it has dropped by 9 million enrollees by 2003.

## ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Arizona was the last state in the nation to implement a Title XIX Medicaid program. After much debate, the legislature rejected traditional fee-for-service financing arrangements in favor of an innovative plan for Medicaid managed care. In October 1982, the nation's first Section 1115 demonstration waiver for a statewide Medicaid managed care program was approved and the Arizona Health Care Cost Containment System (AHCCCS) was created. AHCCCS is a prepaid managed care Medicaid program that has become a national model.

From the beginning the AHCCCS program was envisioned as a partnership, which would use private and public managed health care health plans to mainstream Medicaid recipients into private physician offices. This arrangement opened the private physician network to Medicaid recipients and allowed AHCCCS members to choose a health plan and a primary care provider who can be a physician, nurse practitioner or physician assistant. Primary care providers manage all aspects of medical care for members. There are a limited number of plans available in the rural areas, making fewer choices available to rural beneficiaries.

Fully medically necessary health care services are covered for individuals who qualify for Medicaid, including comprehensive dental coverage for children under the age of 21 and emergency dental care (extractions) for adults 21 years of age and older. For individuals who qualify for the Federal Emergency Service (FES) and State Emergency Services (SES) programs, AHCCCS health care coverage includes only emergency services.

In 1998, KidsCare became Arizona's Title XXI Children's Health Insurance Program (CHIP). It is a federal and state program administered by AHCCCS to provide health care services for children under the age of 19 living in families with a gross income at or below 200 percent of the Federal Poverty Level (FPL). Since KidsCare began, enrollments have steadily risen. The outreach efforts undertaken to identify children eligible for KidsCare have also resulted in identifying additional children who are eligible for Medicaid. The KidsCare application is short, clear, and relatively easy to use, and allows people to apply for health care coverage without having to go through the longer and more detailed application process that is needed for Temporary Assistance for Needy Families (TANF) cash assistance, food stamps, and other family assistance programs.

The passing of Proposition 204 in 2001 expanded eligibility from 34 percent of the federal poverty level to 100 percent. Expanded eligibility, together with Arizona's growing population, increased enrollment in AHCCCS and KidsCare more than 40 percent--from 411,152 enrollees in federal fiscal year 2001 to 579,640 enrollees in federal fiscal year 2003. By May 2005, enrollment in KidsCare increased from 3,710 in December 1998 to 50,682 and AHCCCS was providing health care coverage to 1,054,558 eligible members, approximately 18 percent of Arizona's population.

The state budget passed in 2003 directed AHCCCS to increase the premiums paid by families with children enrolled in KidsCare. The new premiums are based on a sliding scale depending on family income and number of children. Before July of 2003, the scale ranged from \$0 to \$20, depending on income. As of July 2004, the premiums increased to a range of \$10 to \$35. /2007/ By March 2006, enrollment in KidsCare increased from 3,710 in December 1998 to 55,998 and AHCCCS was providing health care coverage to 1,039,433 eligible members, approximately 17% of Arizona's population. With the introduction of premium increases for KidsCare, enrollment dropped by 16.4% in the 6 months following the increase, while the SOBRA kids program (AHCCCS) reported an increase in enrollment by 18.8%, indicating that some children who did not enroll in KidsCare or dropped may have enrolled in Medicaid instead. //2007//

#### GENERAL AND SPECIAL HOSPITALS

According to the Arizona Department of Health Services Division of Licensing Services, there were 59 general acute care hospitals in the State of Arizona in 2004, with 11,235 beds and 25 specialty hospitals with 1,790 beds. There are two children's hospitals, both of which are located in the Phoenix metropolitan area. The state overall has 1.9 inpatient beds per 1,000 population, one-third fewer beds per population than the national average of 2.8 per 1,000. According to the United States Department of Health and Human Services, Arizona ranks 45 in the number of hospital beds per 100,000 population.

#### PROFESSIONAL HEALTH CARE PROVIDERS

Arizona has 12,121 physicians, representing 208 doctors per 100,000 residents. Although the number of doctors practicing medicine in Arizona has grown faster than the population, the physician-to-population ratio in Arizona remains far below the national average of 283. Eighty-six percent of physicians practice in either Maricopa or Pima County, and the physician-to-population ratios range from a high of 277 in Pima County per 100,000 to a low of 48 per 100,000 in Apache County. Arizona has 606 registered nurses per 100,000 population, compared to 784 nationally, and ranks 48 in the number of employed registered nurses per capita.

Federal regulations establish health professional shortage areas based on three criteria: the area must be rational for the delivery of health services, more than 3,500 people per physician or 3,000 people per physician if the area has high need, and healthcare resources in surrounding areas must be unavailable because of distance, over-utilization, or access barriers.

Since 2000, there has been a 25 percent increase in the number of federally designated health professional shortage areas in Arizona. There are 60 areas that are federally designated shortage areas in Arizona. Twelve of these areas are considered frontier, 35 are non-metropolitan, and 13 are in metropolitan areas.

Arizona has developed its own designation system for identifying under-served areas. All federally designated shortage areas are automatically designated as Arizona shortage areas. In addition, Arizona's system involves the application of an index which weights 14 indicators such as providers to population ratios, travel time, percent of population below poverty and adequacy of prenatal care. There are 13 state designated Arizona medically under-served Areas. A recent survey of State Title V Directors on pediatric provider capacity for children with special health care needs pointed out network concerns specific to CSHCN. The most commonly identified significant access barrier in this survey was the uneven distribution of pediatric providers.

Arizona has only one state medical school and a college of Osteopathic Medicine. As a result, Arizona trains fewer of its own providers than do most other states and many Arizona medical graduates leave to practice in other parts of the country. Arizona also has a higher percentage of older physicians than the national average, and more physicians are retiring earlier as well. These factors all affect Arizona's ability to develop and maintain an adequate provider network.

The American Academy of Pediatrics recommends one pediatrician per 10,000 people. Of the 14 counties in Arizona that have a population of at least 10,000, only Coconino, Maricopa and Pima Counties meet this recommendation and 107 of the state's 109 pediatric specialists all practice in these same three counties. The other two specialists practice in Yuma County.

According to the National Center for Vital Statistics, the percentage of midwife-attended births has gradually increased from 1 percent in 1975, to 8 percent in 2002. Arizona reached a high of 10 percent of births being attended by a midwife in 1997. However, since 1997 there has been a gradual decrease in the percentage of midwife- attended births to 7 percent in 2003. However, nearly one in three American Indian births continue to be attended by midwives. As reported by the Arizona Department of Health Services Licensing Division, as of April 2005, there were a total of 34 licensed midwives, and 150 certified nurse midwives.

Although midwifery is a recognized alternative to the medical model of prenatal care, it is faced with a number of challenges. Hospitals that admit women and babies who received midwifery services use the same protocols as if the women had not received any prenatal care and most insurance plans do not cover midwifery services. AHCCCS rules allow coverage for midwife services and most of the AHCCCS-contracted health plans contract with them.

## PERINATAL SYSTEM

Arizona is the home of a unique perinatal regional system. Voluntary participation by the Arizona Department of Health Services, AHCCCS, the Arizona Perinatal Trust, private physicians, hospitals and transport providers result in a statewide comprehensive system that is considered a model nationally.

The Arizona Perinatal Trust endorses a voluntary program that certifies levels of perinatal care provided at hospitals throughout Arizona. Level I perinatal care centers provide services for low risk obstetrical patients and newborns, including caesarean deliveries. Level II facilities provide services for low risk obstetrical patients and newborns, plus selected high-risk maternity and complicated newborn patients. Level II EQ facilities provide expanded services of level II perinatal care centers for defined maternal and neonatal problems through a process of enhanced qualifications. Level III centers provide all levels of perinatal care and treatment or referral of all perinatal and neonatal patients.

The perinatal system reduces neonatal mortality by transporting critically ill newborns from rural hospitals to urban intensive care centers that are equipped to provide higher levels of nursing and medical care during acute phases of illness. Neonatologists provide 24-hour consultation and medical direction for transport, and the Arizona Department of Health Services Newborn Intensive Care Program serves as payer of last resort for families with no insurance for care delivered at Arizona Perinatal Trust certified facilities. The regional system has expanded and changed over the years. Currently services are available to all Arizona residents from the first identification of a high risk condition in pregnancy through post discharge and until the child is three years old.

## ORAL HEALTH

Arizona has 15 counties that have been subdivided into 94 Dental Care Areas, which are geographic areas defined by the state of Arizona based on aggregates of census tracts. These Dental Care Areas are considered rational service areas for dental care by the State and are

used for Federal Dental Health Professions Shortage Area designations. Thirty of the 94 areas are designated by the federal government as Dental Health Professional Shortage Areas. An area may also be designated as a "vulnerable population" if it is in the top quartile of any of the following: percent of the population less than 200% of the federal poverty level, percent of population that is Hispanic, or percent of the population that is American Indian.

The Center for California Health Workforce studies at the University of California, San Francisco in collaboration with the Arizona Department of Health Services Bureau of Health Systems Development analyzed dental workforce data on the distribution of dental providers and the availability of dental care services in Arizona. The project focused on profiling the statewide distribution of dental services in order to inform oral health policy in Arizona. Data were collected by the Arizona Department of Health Services Office of Oral Health through a statewide telephone survey of dentists licensed and practicing in Arizona during the months of July 2000 through September 2001.

According to the survey, 58 percent of dental practices had at least one staff member that could translate for non-English speaking patients, while 63 percent said that they had patients who needed that service. Among office staff who could translate, 80 percent spoke Spanish, and a total of 28 different languages were spoken. Vulnerable populations were more likely to need translation services and were less able to meet the need. While 5 percent of practices overall said that their staff were rarely or never able to meet translation needs, 12 percent of practices in high Hispanic areas rarely or never met the need.

From 2000 to 2004, there was a net increase of 590 dentists and 999 dental hygienists licensed in Arizona. By September 30, 2004, 2,854 dentists and 2,439 dental hygienists had a license and address in Arizona. In 2003 the Governor signed a bill into law that creates a new opportunity for dentists and dental hygienists to expand the traditional walls of a dental practice through the creation of an affiliated practice relationship, expanding the scope of practice for dental assistants. Through an affiliated practice relationship, hygienists can provide preventive oral health services (e.g., fluoride, cleanings, sealants) to children in a variety of community-based health and educational settings without a prior examination by a dentist. It allows underserved children access to preventive services at an earlier age in a convenient setting, such as a Head Start Program or a school. It also provides an opportunity for early referral to dental services.

In 2004, legislation was passed to allow licensure by credentials, which provides a method for dentists and dental hygienists licensed in other states to receive an Arizona license without a clinical examination. Although it is expected that this change will increase the number of licensed dental professionals in the state, the impact on access to care in underserved areas is yet to be realized.

In 2003, the Arizona School of Dentistry and Oral Health opened its doors in Mesa to 54 dental students as Arizona's first dental school. Students will earn the Doctor of Dental Medicine degree and a Certificate in Public Health Management. The school specifically recruits students to work in rural and underserved dental areas. In 2004, Mohave Community College in Bullhead City accepted 18 students into its new Dental Hygiene Program. Students will provide preventive therapies to this rural community as part of their educational experience. Two colleges in Maricopa County are pursuing accreditation for dental hygiene programs.

## BEHAVIORAL HEALTH

The Arizona Department of Health Services Division of Behavioral Health Services has reorganized permanent statutory authority to operate the state's behavioral health system, including planning, administration, and regulation and monitoring of all facets of the state behavioral health system. The division's focus is to promote healthy development and to provide effective prevention, evaluation, treatment, and intervention services to people in need who would otherwise go unserved.

Behavioral health services are delivered through community-based and tribal contractors, known as Regional Behavioral Health Authorities (RBHAs). Contractors are private organizations that function in a similar fashion to a health maintenance organization, managing networks of providers to deliver a full range of behavioral health care supports and services.

At this time there are six active Regional Behavioral Health Authorities: one serving northern Arizona, one serving Yuma, La Paz, Gila, and Pinal Counties, one serving Maricopa County, one serving Graham, Greenlee, Cochise, Santa Cruz, and Pima Counties, one serving the Gila River Indian Community, and one serving the Pascua Yaqui tribe. In addition to other state and federal funds, clinics receive funds from Title XIX and Title XXI. The Division of Behavioral Health Services also has Intergovernmental Agreements with two additional American Indian Tribes to deliver behavioral health services to persons living on the reservation. These tribes are the Colorado River Indian Tribe and Navajo Nation.

The Division of Behavioral Health Services' strategic plan recognizes that the promotion of mental health in infants and toddlers is key to the prevention and mitigation of mental disorders throughout the lifespan. With the involvement of Tribal and Regional Behavioral Health Authorities (T/RBHAs), other child-serving agencies, specialists in infant mental health, and parent advocates, a uniform new approach to assessments and service planning has been developed and will be implemented across Arizona effective October 1, 2005.

The ADHS Birth to Five assessment and service planning process differs from the system's strength-based assessment process for all other persons in two ways: first, it focuses not on any particular attribute of a child, but on the context of the child's life, seeing the child as a product of the environment in which he/she is immersed. Second, service plans must be written to support and reinforce normalized child development; to promote and reinforce health-promoting parenting and child rearing skills; to enhance child/parent attachment and bonding; and to reduce the long-term effects of any trauma. In regards to infants and toddlers, then, behavioral health interventions will include preventive as well as corrective measures, and like the assessment, will target the family, as well as the individual.

#### ARIZONA IMMUNIZATION PROGRAM

The Arizona Department of Health Services Arizona Immunization Program provides funding, vaccines, and training support to public immunization clinics and private providers throughout Arizona. The program works to increase public awareness by providing educational materials to county health departments and community health centers and through partnerships with local and statewide coalitions. The program monitors immunization levels of children in Arizona, performs disease surveillance and outbreak control, provides information and education, and enforces the state's immunization laws. The Arizona State Immunization Information System collects, stores, analyzes and reports immunization data through a central registry maintained at the Department of Health Services.

In 1992 the Arizona Department of Health Services founded the Arizona Partnership for Infant Immunization (TAPI) as part of Arizona's federal Immunization Action Plan. TAPI is a non-profit statewide coalition of more than 400 members. TAPI was formed in response to the alarming fact that in 1993, only 43% of Arizona's two-year-olds were fully immunized against preventable childhood diseases like measles, mumps, polio and whooping cough. Through the efforts of TAPI's partners from public and private sectors, immunization coverage rates in Arizona have dramatically improved, with more than three in four children fully immunized by age two. The goal of TAPI is to deliver age appropriate immunizations by the year 2010 to at least 90 percent of Arizona's two-year-old children before their second birthday and to encourage appropriate immunizations through the lifespan.

#### MEDICAL HOME PROJECT

The Medical Home Project, administered through the Arizona chapter of the American Academy of Pediatrics, was designed to increase access to and utilization of primary care services for Arizona's uninsured children from low-income families. The Medical Home Project provides delivery of medical services in participating physicians' offices to children without health insurance and to those who do not qualify (or are in the process of qualifying) for public assistance. The Medical Home Project creates a system of linkages between medical providers and school nurses to assist with health care provision to the target population. School nurses identify children who are eligible to participate in the Medical Home Project and facilitate their enrollment. To be eligible for the Medical Home Project a child must have no health insurance; must not be eligible for AHCCCS, KidsCare, or Indian Health Services; and must have a household income less than 185 percent of the federal poverty level. For children who appear to be eligible for AHCCCS or KidsCare, the school nurse is encouraged to identify resources to assist families with the application process. A child with an acute illness may be seen through the Medical Home Project while in the qualifying process. The child is provided with a referral form to a participating health care provider and the school nurse makes the appointment.

A network of physicians (pediatricians, family practice physicians and specialists) provides care to children qualifying for the Medical Home Project for a fee of either \$5 or \$10 as payment-in-full for an office visit. The health care providers agree to provide a certain number of appointment slots to Medical Home Project children each month. Development of the provider network has been an ongoing effort since the beginning of the project in 1993. In addition, prescription medications, diagnostic laboratory services, and eyeglasses are provided as necessary to qualifying children.

Funding for the Medical Home Project has been provided by a number of entities. The Arizona Department of Health Services Office of Women's and Children's Health has had a contract with the Arizona chapter of the American Academy of Pediatrics since 1993 to fund the project management. Other sources of funds include the Robert Wood Johnson Foundation, St. Luke's Charitable Health Trust, Arizona Diamondbacks Charities, Diamond Foundation, as well as many others. In addition to the primary care providers, a variety of specialist providers (e.g. cardiology, dermatology, ears nose throat, orthopedics, pulmonology) have donated their services to children in need of care.

The Medical Home Project is currently operating in seven Arizona counties involving school nurses from 834 schools (representing 61 school districts). The primary care provider network consists of 20 pediatric group practices, 38 individual pediatricians, 6 family practice groups, and an additional 17 individual family practitioners.

## COMMUNITY HEALTH CENTERS

Community health centers were established in the 1960s by federal law to treat and provide primary care to all patients regardless of their ability to pay. The Arizona Association of Community Health Centers reports that their membership includes 35 community health centers with more than 100 satellite locations statewide, serving more than 400,000 people in 2002. The Association represents health centers statewide and provides advocacy, professional education programs, financial services, and programs for health centers to improve and ensure clinical excellence. //2007/ 14 of the 35 centers are Federally Qualified Health Centers (FQHC's). In 2005 the FQHC's served 295,966 patients and logged 1,130,149 patient visits. It is estimated that in 2005 patient load and patient visits increased 40 to 60% in the remaining clinics. Eleven of the clinics are tribal or serve significant populations of Indian people. //2007//

## SCHOOL-BASED HEALTH CENTERS

There were 100 school-based or school-linked health care clinics in Arizona, delivering more than 45,000 medical visits to over 14,000 children during the 2002-2003 school year. Most of the children served had no health insurance (79 percent). Thirty-five percent of the centers operate

in rural areas, and six operate on tribal lands. These clinics offer access to health care in communities where there is a significant provider shortage and transportation to health care services may be problematic.

School-based and school-linked health centers allow students to have immediate access to health care providers for problems ranging from minor aches and scrapes to acute illnesses. They are staffed with nurse practitioners and physician assistants who work closely with a medical director. For many students, these centers are the only source of medical care.

Most school-based clinics are affiliated with a hospital-based outpatient department that provides on-call services and after-hours coverage when the school-based clinic is closed. This configuration not only offers a location for the child to go at times when the school clinic is not open, but the affiliated location is also available as a medical home for all family members. All of the clinics encourage parental involvement and parental consent is required before any services are provided. The clinics support the philosophy of the parent participating as a partner in the decision making process.

#### OTHER PROJECTS TO INCREASE ACCESS TO CARE

Health-e-Arizona is a web-based electronic screening and application process for public health insurance. It was initiated by El Rio Community Health Center in Pima County and piloted there beginning in June 2002. It is now used in most federally designated community health centers throughout Arizona as well as in several hospitals. Since its inception, 32,000 people have submitted electronic applications for processing by AHCCCS. The electronic application has many advantages over the paper application. The electronic version requires full and complete information before the application could be submitted, resulting in more complete and accurate applications. As a result, the approval rate of electronic applications is much higher. The electronic application process automatically screens for eligibility for a number of programs thus helping to link patients with health care coverage; a total of 95 percent of those seeking health care coverage through Health-e-Arizona have been linked to some health program.

Another community-based program, the Pima County Access Project (P-CAP) and Healthcare Connect in Maricopa County are offering discounted health care to those not eligible for public health insurance and unable to afford commercial insurance products. With federal grant funding, the project recruited the participation of medical providers who are willing to charge discounted rates to enrolled patients. P-CAP has 8,000 patients enrolled and Maricopa County Healthcare Connect began enrolling patients in June 2004.

#### TELEMEDICINE

Telemedicine is the practice of medicine using a telecommunication system to provide clinical services at a geographically separate site. Service can be delivered "real-time" using interactive video conferencing or through "store and forward" which relies on the transmission of images for review immediately or at a later time.

The University of Arizona Telemedicine Program is a statewide program intended to increase access to healthcare to all residents in Arizona using telemedicine technologies. The use of telemedicine reduces the need for rural patients and their families to travel to urban centers for health services as well as enhances the rural health infrastructure. The program's telecommunications network spans the entire state and serves as a hub for linking all of the telemedicine networks in Arizona. Arizona's telemedicine network serves three functions: health care delivery, education and training, and videoconferencing administrative meetings.

#### CULTURAL COMPETENCE

As racial and ethnic disparities in health outcomes and access to care persist, there has been

much interest in the concept of cultural competence. A recent study evaluated states not on disparities in health outcomes, but on their efforts, leadership, capacity, and infrastructure that would be sensitive to direct policy intervention to create state minority health policy report cards. Four measures were defined: insurance coverage disparity, diversity ratio, offices of minority health, and number of race/ethnicity vital statistics categories (Amal N. Trivedi, et al. "Creating a State Minority Health Policy Report Card." Health Affairs 24.2 (March/April 2005): 388-396).

Since insurance coverage among people whose incomes fell below 200 percent of the federal poverty level is correlated with state Medicaid policy, the authors used data from the 2001 and 2002 Current Population Surveys to find the states' low-income populations. By dividing the state's percentage of low-income non-elderly minorities by its percentage of low-income non-elderly whites, they calculated the insurance ratio. The insurance gap is the relative risk of uninsurance for minorities compared to whites among non-elderly poor, with low scores representing lower relative risk levels for minorities. Arizona's insurance gap was 1.52, meaning that minorities in Arizona were 52 percent more likely to be uninsured than whites. Delaware had the lowest insurance gap, at 0.74, and Idaho had the highest gap, at 2.13.

The diversity ratio is a measure of the degree to which the demographic composition of a state's physicians matches the demographic composition of the state as a whole. The ratio is calculated by first dividing the total state minority population by the number of minority physicians in the state. This number is then divided by the ratio of the total state white population to the number of white physicians in the state. The diversity ratio is the factor by which underrepresented minority physicians must be increased to reach population parity with whites. Arizona scored a 5.70 on this measure. The state with the best ratio was Maine, with a score of 0.94. Illinois was worst, at 11.53.

The office of minority health measure is a simple yes or no field. At the time of the analysis, Arizona had discontinued its office. There were 27 states with minority health offices. Since the time of the study, a Center for Minority Health in the Office of Health Systems Development was reestablished.

The number of race/ethnicity vital statistics categories measures how precisely states record race/ethnicity. For example, a state with two categories may break it down by "white/other" or "black/white," while a state with three may say "black/white/other." Arizona tied with 16 other states that used 5 categories. Three states only used one category.

The Center for Minority Health is currently conducting its own infrastructure assessment within the Arizona Department of Health Services to determine minority health resources existing within the agency, examine the capacity of the agency to identify and address health disparities and barriers to access to care among minority groups and vulnerable populations, and to establish an inventory and directory of minority health resources. //2007// In fall of 2006, OWCH will be conducting a nursing satisfaction survey of the High Risk Perinatal Program clients which will ask a series of questions including if the community health nurse the client saw was aware of their family's values and beliefs, and if the nurse cared about and was sensitive to those beliefs. The OWCH developed and is implementing a new office policy and procedure on utilizing community advisors in programs. Advisors are recruited and paid for a variety of tasks such as assisting in developing programs, evaluations, request for proposals, and providing input on improvements to program grant applications and priority-setting. Community advisors will enhance cultural competence in programs by providing insight from the respective communities. The Center for Minority Health is initiating training on Culturally and Linguistically Appropriate Services (CLAS) with ADHS programs and contractor staff. //2007// ***/2009/ The Director of ADHS hired the Department's first cultural competency advisor. All BWCH program managers attended training on CLAS. The Department will be requiring all new employees to attend CLAS training. The Center for Health Disparities features "brown bag sessions" highlighting different cultures and their health issues and beliefs. //2009//***

/2008/Critical Updates

In 2006, Arizona passed "First Things First", a ballot initiative that funds a voluntary system of early care and education. The mission of the initiative is to increase the quality of, and access to, early childhood programs that will ensure a child entering school the first time comes healthy and ready to be successful. This mission will principally be achieved through regional grants tailored to the specific needs and characteristics of the communities the region serves, and with a focus on demonstrating how improved outcomes will be attained given the challenges the region faces.

In November of 2006 the voters of Arizona passed Proposition 201, The Smoke-Free Arizona Act. The new law became effective May 1, 2007 and prohibits smoking in most indoor public places including restaurants, bars, gaming facilities, bowling centers, public buildings, grocery stores or any food service establishment, lobbies, elevators, restrooms, reception areas, hallways and any other common-use areas in public and private buildings, condominiums and other multiple-unit residential facilities, indoor sports arenas, gymnasiums and auditoriums, health care facilities, hospitals, health care clinics, doctor's offices and child day care facilities, common areas in hotels and motels, and no less than 50% of hotel or motel sleeping quarters rented to guests.//2008//

## **B. Agency Capacity**

The capacity of the state Title V agency to meet all of the needs of the Title V population is limited by both financial and programmatic restrictions. The Office of Women's and Children's Health (OWCH) provides services and facilitates systems development to improve the health of all women of childbearing age, infants, children, and adolescents. OWCH funds programs based upon various criteria of need (financial, risk factors, health status, etc.).

The Office of Children with Special Health Care Needs (OCSHCN) has policy and program development responsibilities for children to age 21 who have any one of a broad range of disabilities or chronic illnesses diagnosed at any time during childhood, including the prenatal period.

The Core Public Health Pyramid is used as a model for program planning and evaluation. This is accomplished by use of needs assessment, technical assistance, and coalition building. Arizona's MCH programs have components in each level of the Core Public Health Services Pyramid. Program capacity is described below for each level of the pyramid.

### **OWCH DIRECT HEALTH CARE SERVICES**

The High Risk Perinatal Program provides direct health care services in two of its three components: the maternal transport component authorizes and funds the transport of high risk pregnant women to appropriate medical centers for delivery and the community nursing component provides in-home nursing consultation to enrolled families. /2007/ Hospital and Inpatient Physician Services has contracts with physician groups to provide care to infants in the Newborn Intensive Care Unit. Developmental Follow-up Service provides developmental assessments after discharge//2007//.

The Reproductive Health/Family Planning Program contracts with county health departments to provide education, counseling, referral, and medical care services to women of childbearing age. Community Health Services contracts for community-based efforts to improve the health of women of childbearing age by developing programs focusing on healthy weight, tobacco cessation, injury prevention, relieving stress, exercise, and nutrition. The Domestic Violence Program provides shelter services and counseling to victims of domestic violence and their children. The Health Start Program provides in-home prenatal outreach services through lay health workers to at-risk women.

## OCSHCN DIRECT HEALTH CARE SERVICES

Children's Rehabilitative Services (CRS). The Arizona Department of Health Service (ADHS), Office for Children with Special Health Care Needs (OCSHCN) transitioned from direct service delivery to administrative oversight of the Children's Rehabilitative Services network of contracted providers in 1985. CRS provides medical treatment, rehabilitation, and related support services to Arizona children, birth to 21 years of age, who have certain medical, handicapping, or potentially handicapping conditions. The objective of CRS is to assure the highest quality comprehensive care through a family-centered, multi-specialty, interdisciplinary team approach in a cost-effective managed care setting. CRS provides these services through four regional Centers of Excellence; each with its own hospital and physician support. In addition to the four regional sites, services are provided through outreach clinics throughout the state. The outreach clinics are designed to provide a limited specific set of services including evaluation, monitoring, and treatments in settings closer to a family's home. The OCSHCN monitors the service delivery system, ensures contractual compliance, initiates quality improvement activities, and provides education, support, and technical consultation.

High Risk Community Nursing. Through contracts with private agencies and county public health departments, public health nurses provided follow-up nursing services to children with special health care needs and infants discharged from newborn intensive care units. This program served approximately 4,000 families each year.

OCSHCN provides Community Home Nursing services to assist families who have children/youth who are medically fragile or are at risk for developmental delays. Specially trained community health nurses are available throughout the state to support the family during a transition from hospital to home, to conduct developmental, physical, and environmental assessments and referral to appropriate community resources. The community health nurse provides support, education, and guidance to family as they develop plans for their child's ongoing care.

## OCSHCN ENABLING SERVICES

Service Coordination. The OCSHCN provides service coordination for Arizona families with children, birth to three years of age, who are eligible for the Arizona Early Intervention Program (AzEIP) and for children/youth with chronic medical problems, developmental delays, or traumatic brain injuries. Service coordination is an enabling function that assists families to access needed services and work toward independence. Through the program, families and community-based providers develop and implement an Individualized Family Service Plan, a Family Service Plan, or an Individualized Service Plan. Program objectives include having families: acquire knowledge and skills to support the development of their child with special needs; communicate and coordinate all services among providers, emphasizing the team approach; and identify their concerns, priorities, and resources.

AzEIP is a collaborative program of the Department of Economic Security, Arizona Health Care Cost Containment System (AHCCCS), Department of Health Services (ADHS), Department of Education, and Arizona Schools for the Deaf and Blind (ASDB). The ADHS' Office for Children with Special Health Care Needs provides developmental screening and referral services to Arizona infants/toddlers, birth to three years of age, who are exhibiting developmental delays and who may benefit from early intervention. ***2009/AzEIP moved to the Arizona Department of Economic Security. OCSHCN will continue involvement as a liaison to provide input regarding CYSHCN.//2009//***

Traumatic Brain Injury Program. Children and teenagers with traumatic brain injuries (TBI), their families, and professionals are provided an array of coordination services to assist in: the determination of priorities and the creation of the Individualized Service Plan; assessment of resources and needs; identification of other/additional resources; navigation of the multiple service delivery systems; completing forms and applications for services; locating service

providers; coordination of services; and supporting the child/family in the Individual Education Plan (IEP) process. Also, as needed, TBI Program service coordinators can advocate for the child/family with providers, services, school and insurance; provide continuity as child moves through stages of recovery and other aspects of service delivery; and assist in transitions (from hospital/rehabilitation/home/school). Additionally, the program provides community education and awareness of TBI and its effects.

#### OWCH ENABLING SERVICES

Enabling services such as outreach, health education, family support services, coordination with Medicaid, and case management are provided through numerous OWCH programs. The Health Start Program is a neighborhood outreach program that works with women who are pregnant, or think they may be pregnant, and their families to help them improve their health and the health of their families.

The Children's Information Center Hotline and the Pregnancy and Breastfeeding Hotline make referrals to AHCCCS, KidsCare, and other community health resources. The Pregnancy and Breastfeeding Hotline serves as the referral source for the Baby Arizona Project that links callers with prenatal care services. The AZAAP Medical Home Project, helps uninsured and underinsured children to find a medical home by linking with a primary care provider.

Community Health Services contracts for community-based efforts addressing specific performance measures related to women and children. Contractors provide a variety of services. One contractor implemented a program to provide health education and activities addressing smoking, physical activity, stress reduction, and proper nutrition for adolescents. Another contractor is targeting efforts directed toward women who are low-income, have a limited education and women of color. They are providing a program that addresses healthy weight management, nutrition, physical activity, stress management, and smoking cessation. Many of the contractors are also focusing on injury prevention by providing child safety seats and bicycle helmets, conducting car safety seat inspections, training in the proper use of car seats, educating pregnant women regarding proper seat belt use, and training car passenger safety technicians. /2007/ The County Prenatal Block Grant (CPBG) funds all 15 County Health Departments to develop programs to encourage entry into early prenatal care. Activities include pregnancy testing, childbirth education, support programs for dads, and health education. //2007//

/2008/The Pregnancy Services Program is a new initiative that was established by the 2006 State Legislature to provide individual grants to non-profit agencies whose primary function is to assist pregnant women seeking alternatives to abortion. The goal of the program is to provide funding for medically accurate services and programs related to pregnancy. The priority service areas focus on positive public health activities for pregnant women and their children. In 2007, 13 contractors were funded to provide one or more of the following pregnancy related services: options counseling; prenatal vitamins; education on folic acid, prenatal care, breastfeeding, infant/child care and development, childhood immunization schedule and the importance of age appropriate immunizations; parenting skills training; and preconception care education and support.//2008//

***/2009/ The Pregnancy Services Program was eliminated as a result of budget cuts in the FY09 state budget. //2009//***

#### OWCH POPULATION-BASED SERVICES

The Newborn Screening Program screens for all newborns for eight conditions prior to hospital discharge. Screening results for all children are reported to the child's physician of record. Follow up is provided to ensure that second screenings are conducted. The Newborn Hearing Screening Program provides hearing screenings of newborns prior to hospital discharge and provides technical assistance, data collection, and collaboration to provide screening equipment

to Arizona hospitals. The Sensory Program facilitates the implementation of hearing and vision screenings in Arizona schools. Schools submit hearing and vision results to the Sensory Program. /2007/ Legislation was enacted to expand screens to 29 conditions and to require reporting initial and subsequent hearing tests performed on a newborn. //2007//

/2008/As a result of state legislation passed in 2006, the Bureau of Women's and Children's Health developed and is distributing educational pamphlets on cord blood banking. Cord blood banking is a relatively new procedure that can save lives, and is completely safe for babies and mothers. It provides a unique biological safeguard, which can come in handy later in life. The pamphlets include information such as banking options, how cord blood is collected, and the costs, benefits, and risks of storing and donating cord blood.//2008//

***/2009/ As a result of state legislation passed in 2008, the NBS program will be moved into the ADHS State Laboratory so that all components of NBS are centralized under one authority. //2009//***

#### OCSHCN POPULATION-BASED SERVICES

Sickle Cell Anemia Program. Statewide screening, referral, and genetic education are provided to infants, children, adults/couples with ancestry from the "world wide malaria belt," (i.e., Africa, Italy, Greece, Spain, India, Pakistan, Mexico, South America, and countries of the Middle East, Asia, Southeast Asia, and the Caribbean) who carry the sickle cell gene. Program goals are: early diagnosis and treatment; education to enable persons with sickle cell disease or trait to make informed decisions regarding child bearing; provision of guidelines and protocols to physicians; and public education about the economic and social impact of sickle cell disease.***/2009/The Sickle Cell Program was integrated into BWCH Newborn Screening(NBS)to facilitate coordination between Sickle Cell and other conditions identified by NBS.//2009//***

#### OWCH INFRASTRUCTURE-BUILDING SERVICES

OWCH facilitates infrastructure development through coalition building to enhance service delivery and addresses issues of the Title V population. The Governor's Commission on the Health Status of Women was established in October 2000 as the result of collaboration between the Arizona Department of Health Services Office of Women's and Children's Health and the Governor's Office. Over the past five years, the commission has brought together public and private parties concerned with women's health to promote women's health activities, educate the public and establish policy that supports women's health. This year, the commission presented their recommendations to the Governor which focused on four areas: 1) increasing access to health care for women, 2) improving health care response and raising awareness about health risks for women, 3) reproductive health and family planning: access to services and 4) prenatal care.

Other examples of OWCH coalition building efforts include: the Adolescent Health Coalition that addresses adolescent health status issues, the Arizona Perinatal Trust that works to improve perinatal outcomes through professional and public education, voluntary hospital certification, and data for participants in the regional certification process, and the Arizona Family Planning Coalition that provides education and supports efforts to improve women's reproductive health and the right to make informed decisions. The Domestic Violence Program administers the federally funded Family Violence Prevention and Services Grant. The funds are used to work with existing Rural Safe Home Networks (RSHN) to ensure continued funding; to establish Rural Safe Home Networks (RSHN) for persons experiencing family and domestic violence in rural communities; to expand and link these RSHN so that they are modeling on "best practice" prevention models; and to develop a set of standards and guidelines for rural safe home/shelters that will ensure the use of "best practices" in service delivery for domestic violence victims.

Many OWCH contractors have been required to conduct comprehensive needs assessments as

a contract deliverable (e.g. the County Prenatal Block Grant requires each of the fifteen counties to develop a needs assessment of the prenatal population). All projects funded by the Community Health Services Grant are required to use the Logic Model to define their program goals, objectives, measurements and program evaluation component. Staff members from the OWCH PEP Section provide training to potential contractors and those awarded contracts in the use of the Logic Model.

The OWCH's organizational structure is based on a functions approach rather than programs for specific populations. The office provides technical assistance to entities serving the Title V population (i.e. communities, contractors, coalitions, schools, county health departments, other state agencies, etc.). The Planning, Education, and Partnerships Section (PEP) provides technical assistance on adolescent growth and development, dealing with adolescents, adolescent risk behaviors, and health and safety in child care settings. The Newborn Hearing Screening Program provides technical assistance to hospitals implementing universal hearing screening. A PEP Section employee sits as a non-voting member of the Arizona School-based Health Care Council board. The OWCH is working with the Governor's School Readiness Board to improve early childhood systems. A statewide plan will be completed by June 2005. /2007/ Emergency Medical Services for Children offers child emergency care training statewide to those who respond to child emergencies. The Arizona Injury Surveillance and Prevention Plan established objectives and proposed strategies to avoid injury. Arizona Safe Kids is a state-wide program to prevent unintentional injury to children under age 15 and provides local coalitions with leadership and technical assistance. //2007//

#### OCSHCN INFRASTRUCTURE-BUILDING SERVICES

OCSHCN has five primary activities associated with infrastructure building; the development and maintenance of coalitions with external constituents; the enhancement and integration of data collection efforts, the development and utilization of the telehealth/telemedicine system throughout Arizona; the development and implementation of a learning management system; and the enhancement of the community action team philosophy.

Asthma Program. This public health program primarily supports local coalitions throughout the state in their efforts to develop and implement community-based programs to address the needs of children who have asthma. Additionally, OCSHCN uses its network of providers, community-based organizations, and those with an interest in asthma to share information on: materials, advances in diagnosis and treatment, grant opportunities, data, and conferences. ***/2009/This program has moved to ADHS Bureau of Chronic Disease Prevention and Control. OCSHCN will provide technical assistance regarding CYSHCN.//2009//***

Beginning in 2004, OCSHCN brought together members of state agencies, community agencies, educational institutions, providers, and families to identify what services were being provided to C/YSHCN in Arizona, who had formed partnerships to conduct these activities, and whether there were missing pieces in the service delivery model. That group will form the Statewide Integrated Services Task Force funded by MCHB. This group will be charged with evaluating the needs of C/YSHCN, the service delivery system, gaps in services, and barriers to services and to draft a white paper to the Governor on recommended changes. There are numerous subcommittees that will enhance the work of the task force; one of these subcommittees will evaluate specialty services which will focus on maximizing the development of the telehealth/telemedicine throughout the state of Arizona, a second committee will focus on establishing standard for cultural competency in the service delivery systems, a third will develop, implement, monitor, and provide reports on various quality improvement methodologies including program evaluation tools

Annual Family Centered CRS Survey. OCSHCN conducts an annual survey of families enrolled in CRS to assess the degree to which family centered care is provided at the regional centers and outreach clinics. This bilingual tool assesses the degree to which family members believe the national performance measures are being achieved in the CRS clinics and how satisfied they are

with the services they receive.

Annual CRS Provider Survey. Beginning in 2005, an annual survey of all CRS contracted providers will be conducted to evaluate the system issues within CRS. Are there barriers to care that are experienced by the providers, how responsive is CRS administration to the needs of the providers, and to determine if they have unmet educational needs.

Quality Improvement Activities. CRS must submit to AHCCCS two Performance Improvement Projects on an annual basis. These PIPs must identify a quality of care issue that will be monitored for improvement against a pre- and post-intervention time frame. Currently the four regional CRS sites are collecting information on the development and implementation of a transition plan for youth when they reach their fourteenth birthday.

Quality of care is monitored through site visits with all contracted providers of their policies and procedures, clinical case records, and financial billing procedures. Any deficiencies are addressed through the completion of a corrective action plan submitted to OCSHCN for review and acceptance.

Consumer satisfaction surveys are conducted with every CRS provider and family participating in telemedicine activities. Additionally annual satisfaction surveys are conducted with contracted service coordinators and the clients they serve.

Development and enhancement of the telehealth/telemedicine system. A statewide network of sites that have the capacity for simultaneous audio and visual communication is used for: the provision of clinical services to patients who live in areas that do not have ready access to specialists; conduct administrative meetings among staff living and working in different parts of the state; provide networking and information sharing opportunities for families and/or providers; and conduct training. OCSHCN has continued to expand its telehealth network. Funding from the Arizona Department of Health Services provided for the purchase of compatible equipment by each of the CRS clinics.

Learning Management System. ADHS has created the infrastructure to develop a learning management system by combining the resources of four office: the Office of Nutrition and chronic Disease, Public Health Preparedness and Response, the Office for Children with Special Health Care Needs, and Emergency Medical Services. This system will allow the electronic tracking and evaluation of all web-based educational modules. These modules are available 24/7 and can be utilized real time or can be stored and reviewed at a later time. In addition to the tracking and educational modules, there will be a list serve available to participants to discuss the information with other e-learners. This system will be available to the four offices to provide training opportunities to their staff, their community partners, and family members. OCSHCN plans to utilize this technology to implement many of its training curriculums.

Community-Based Systems of Services. Through its community development initiative, OCSHCN continues to seek to improve family access to information and understanding of the eligibility and service delivery system through parent leadership and the development of local community action teams in selected communities. Working in partnership with community parent leaders, providers, and citizens, OCSHCN staff provide information, technical assistance and support services to create healthy environments within which organized community initiatives can grow and be nurtured.

Community parent leaders are placed under contract to reimburse them for their time and expertise in facilitating and supporting the work of their local community action teams. In addition, parents are integral members of CFHS and participate in developing budgets, planning and facilitating retreats and conferences, working on teams and developing strategic plans. Partnership with both parents and professionals is one way to ensure that the development of community-based systems of services addresses the needs of the population served.

Family participation in the decision-making process is incorporated in contractual agreements with the Children's Rehabilitative Services (CRS), through the Parent Action Councils (PAC). Each regional PAC provides a parent representative to the quarterly ADHS/OCSHCN/CRS Administrators and the Medical Directors meetings to promote continuous family centered care. PAC meetings are held at least quarterly to provide education, training, and support among PAC members.

### **C. Organizational Structure**

Governor Janet Napolitano was sworn into office in January 2003. Prior to being elected Governor of Arizona, she served one term as Arizona Attorney General and four years as U.S. Attorney for the District of Arizona. A hallmark of Governor Napolitano's administration has been government reform on all levels. She established an efficiency review initiative that has identified hundreds of millions in savings over five years. Her various citizens' commissions have recommended important improvements to Child Protective Services, Department of Corrections, and the Arizona tax code. She erased a billion-dollar state budget deficit without raising taxes or eliminating vital services. She has tackled the spiraling price of prescription drugs by launching what is now the CoppeRx Card<sup>SM</sup>, a discount program that is saving Medicare-eligible Arizonans more than \$100,000 a week. She is a distinguished alumna of Santa Clara University and the University of Virginia Law School.

The Arizona Department of Health Services (ADHS) is one of the executive agencies that report to the Governor. ADHS was established as the state public health agency in 1973 under A.R.S. Title 36 and is designated as Arizona's Title V MCH Block Grant administrator. Eight divisions in ADHS report to one of two deputy directors: Office of the Director, Arizona State Hospital, Division of Assurance and Licensure Services, Division of Behavioral Health Services, Division of Business and Financial Services, Division of Information Technology Services, Organizational and Employee Development, and Division of Public Health Services.

The Division of Public Health Services is organized into two primary service lines; Public Health Preparedness Services and Public Health Prevention Services (PHPS). PHPS administers Title V funds and coordinates activities through the Office of Women's and Children's Health (OWCH) and the Office for Children with Special Health Care Needs (OCSHCN). Included in PHPS are the Office of the Deputy Assistant Director which includes the medical director, business operations, and epidemiology services. Other offices within PHPS are the Office of Chronic Disease Prevention and Nutrition Services, (including WIC), the Office of Oral Health (OOH), the Office of Health Systems Development, and the Office of Tobacco Education and Prevention. Title V funding is used to support many activities throughout the various offices within the Division of Public Health Services as well as other bureaus. /2007/The Center for Minority Health was added to the Office of Health Systems Development. This office is a central source of information and resources on minority health and health disparity. It provides leadership and builds networks and community capacity. //2007//

/2008/To align with other areas within the Division of Public Health, Offices within Public Health Prevention Services were reorganized into Bureaus during the spring of 2007.//2008//

/2008/

In August of 2006, the Office for Children with Special Health Care Needs merged with the Division of Behavioral Health both because of similarities in function and because of overlapping populations. //2008//

***/2009/ The Office of Oral Health was moved into the Bureau of Health Systems Development to enhance infrastructure and capacity. //2009//***

OFFICE OF WOMEN'S AND CHILDREN'S HEALTH

The OWCH office organizational structure is comprised of four sections: Assessment and Evaluation; Community Services; Planning, Education and Partnerships; and the Finance Section. Administrative Assistants are assigned to each section and support staff personnel are assigned to each unit within a section.

The Assessment and Evaluation Section is responsible for supporting research and evaluation related to women's and children's health, including statewide performance, outcome, and health status indicators. The section evaluates OWCH programs' effectiveness through designing studies as well as providing technical assistance to OWCH program managers as they design and implement evaluation strategies. The section also supports data collection, management, analysis and reporting for OWCH programs. Current Assessment and Evaluation programs and projects include: Child Fatality Review Program, Citizens Review Panel, Unexplained Infant Death Title V MCH Block Grant Application, and Five-Year Maternal-Child Health Needs Assessment.

The Community Services Section programs provide services to children and their families who are at risk for developmental delay, metabolic/genetic disorders or hearing impairment. The programs within this section are Newborn Screening, Newborn Hearing Screening, Health Start, the High Risk Perinatal Programs, the Pregnancy and Breast Feeding Hot Line, the Children's Information Center, and the WIC Hot Line. /2008/Two new initiatives were added to the Community Health Services Section. The Blood Cord Pamphlet and Pregnancy Services projects are described in detail in the Agency Capacity section of this application. //2008//

The Planning, Education and Partnerships Section (PEP) provides leadership for statewide priority setting, planning, and policy development, and supports community efforts to assure the health of women, children, and their families. PEP works with a variety of public, private, and non-profit community partners to identify health needs, improve systems of care, and develop public health policies. PEP provides and supports educational activities that advance good health practices and outcomes, including promoting the use of "best practices," providing client and provider education, sponsoring public information campaigns, and developing and distributing education materials. Current Planning Education and Partnership programs include: Abstinence, Sensory, Domestic Violence, Rural Safe Home Network, Rape Prevention and Education, County Prenatal Block Grant, Reproductive Health/Family Planning, the Medical Home Project, and Community Health Services. /2007/Injury Prevention, Emergency Medical Services for Children, and Safe Kids were added to the PEP section. Comprehensive Sexuality Education Program was also added to the PEP section and funded by state lottery dollars. //2007///2008/In 2007, Planning, Education and Partnership hired a full-time health educator. The health educator develops educational materials and assists with office strategies. //2008//

The Finance Section coordinates all budget, fiscal, and operational issues for the office.

OWCH identifies and prioritizes the needs of women and children in Arizona through a participatory process. This results in funding decisions that have the best chance to make an impact on the health of the maternal and child health population. The OWCH strategic plan is available at the OWCH web site [www.azdhs.gov/phs/owch](http://www.azdhs.gov/phs/owch). The plan identifies two priority areas 1) reduce mortality and morbidity of the maternal and child population 2) increase access to health care, and identifies the need to decrease health disparities as an overarching priority. The functions of the various office sections are specified within the plan. The plan is used to make funding decisions and to establish staff priorities.

The OWCH Financial Management Plan was developed to: 1) reduce the amount of year two funds that had historically occurred 2) provide closer management of Title V funds. 3) reduce administrative costs 4) streamlined budget oversight by reducing the number of contracts and cost centers

OWCH funds block grants to communities to address maternal and child health priorities. The

block grants give latitude to local communities in developing strategies but require that the strategies be research based.

The OWCH Partnership Initiative enhances the relationship of OWCH with community partners to better address the needs of women and children. Community partners include a broad group of agencies and organizations. The designated OWCH partner is assigned to serve as the primary office contact for each identified partner agency. The partner is available to answer questions, provide technical assistance and information, serve on committees, and provide updates on the health status of women and children. The OWCH partner presents an overview of current health status data and trends to the partner agency.

***//2009/ The Office of Women's and Children's Health became the Bureau of Women's and Children's Health (BWCH). The Bureau includes an Office of Community Services, Office of Planning, Education, and Partnerships, Office of Assessment and Evaluation, and Finance and Business Section. //2009//***

#### OFFICE OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS

The OCSHCN was restructured in July 2004 to streamline functions and enhance the data analysis and reporting capabilities. OCSHCN is now comprised of five sections: Data, Planning, and Evaluation, Education and Advocacy, Finance and Business Operations, Quality Management, and Systems of Care. The CRS Medical Director and CRS Contract Compliance Officer report to the Office Chief, along with the OCSHCN Office Manager.

The Data, Planning, and Evaluation Section is responsible for developing, publicizing, and updating the strategic plan and the annual action plans; designing, conducting, analyzing, and producing written reports on all needs assessments, surveys, and program evaluations; preparing grant applications; and convening various groups of key partners and stakeholders to provide input on the design, implementation, and evaluation of all OCSHCN activities. This section is also responsible for implementing the use of the Logic Model in the design, implementation, and evaluation of all office activities.

The Education and Advocacy Section provides oversight and technical assistance for all training and educational activities within the office and with external constituents; provides oversight and coordination of all telehealth and telemedicine activities; coordinates activities related to Medical Home, adolescent health including transition, school nurses, asthma, web-based education and resources including managing the OCSHCN website, and the publication of the OCSHCN and ADHS Native American Newsletters

The Finance and Business Operations Section coordinates all budget, fiscal, and operational issues for the office. They define and monitor all contracts with external providers and track fiscal compliance with these contractual obligations. In conjunction with AHCCCS, they manage the capitation payment and reporting systems for CRS.

The Systems of Care Section is responsible for the three service coordination programs, Arizona Early Intervention (AzEIP), Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI), and OCSHCN (children not covered under the AzEIP or TBI/SCI programs), as well as the Community Development Program that includes the community action teams and the Community Development Initiative.

The Quality Management Program is responsible for providing administrative oversight to the CRS regional clinics and providing services through quality improvement education and monitoring, utilization review of services including monitoring of the denial and appeals process. The CRS Contract Compliance Officer works closely with this section to ensure all contractual obligations are met.

/2008/

OCSHCN has reorganized into six divisions: Clinical Programs, Quality Management, Utilization Management, Grievance and Appeals, Business and Finance, and Compliance. Division chiefs from each of these areas report directly to the office chief, as do the medical director, a corporate compliance officer, and a cultural competence officer. The business and finance function, as well as the officers for corporate compliance and cultural competence are now shared resources with the Behavioral Health Services. The majority of Title V funded positions and activities are housed in the Division of Clinical Programs, although blended funding from Title V, XIX, and XXI occur in other divisions, and Title V concepts infuse the programmatic activities of the Title XIX and XXI programs.

/2008//

OCSHCN established formal relationships with external stakeholders and partners 2004 and 2005. Beginning in November 2004 when a large group of state and local community agencies, providers, and families of C/YSHCN were brought together to plan the response to the Request for Proposals for the Integrated Services grant and continuing with the Needs Assessment Planning Group, OCSHCN has made a strategic decision to become the repository of information related to activities serving C/YSHCN throughout the state. With the award of the Integrated Services grant, many committees and tasks force were developed that allow for a formal mechanism to include external stakeholders in the planning, development, and evaluation of all activities related to C/YSHCN. The activities of these committees will be made public through the posting of their action plans, agendas, and minutes from their meetings on the OCSHCN website.

Numerous relationships have been established with National committees that will broaden the perspective of OCSHCN and provide an opportunity for the exchange of best practices throughout the US. These include a relationship with the National Center for Cultural Competency, the National Center for Health Care Financing, and the MCHB State Leadership Network.

#### **D. Other MCH Capacity**

Arizona Department of Health Services (ADHS) administrative offices are located in the capitol mall area in the city of Phoenix. This location enhances collaboration between ADHS divisions as well as other state agencies.

#### **ADHS SENIOR LEVEL MANAGEMENT**

Susan Gerard was appointed director of ADHS on April 29, 2005. Ms. Gerard previously served as a member of Governor Janet Napolitano's administration as a policy adviser for health care issues, assisting with crucial decisions involving state and federal budgets. Ms. Gerard served in the state legislature from 1988 to 2002, chairing the health committee for 10 years and earning recognition as a statewide leader on healthcare issues. During her legislative career, Ms. Gerard directed the effort to create the Child Fatality Review Program to reduce preventable child deaths and led a year long study and implemented one of the country's first advance health care directive programs. She led efforts to fund and create intervention and prevention programs such as Healthy Families, Health Start, and Head Start. She was instrumental in obtaining funding for the seriously mentally ill, the Arizona State Hospital, and other mental health programs. Ms. Gerard has served on a variety of boards and service organizations and has received awards for leadership and honors from all the major health organizations in Arizona. Ms. Gerard received a Bachelor of Arts from Drake University in Des Moines, Iowa, and a Masters in Business Administration from Arizona State University.

Rose Conner is the assistant director of the Division of Public Health Services. Ms. Conner is a registered nurse with a Bachelor's of Science degree in Vocational Education and a Master's Degree in Education/Counseling. She has spent the past twenty-nine years in local county and state government service in Arizona, in a variety of positions including direct patient care,

management, executive leadership roles and has an extensive background in licensing and health care regulation. /2007/ In 2005 Rose Conner was appointed Deputy Director of ADHS. Niki O'Keeffe was appointed Assistant Director of Public Health Services. Ms. O'Keeffe is an RN with a BS degree. She has experience in health care recruitment, human resources, developing hospital based community outreach programs in school-based clinics, tele-nursing, parish nursing, and wellness centers. She has served as the Deputy Assistant Director for ADHS Public Health Preparedness that included Epidemiology and Disease Control, State Laboratory, Emergency Medical Services, Public Health Emergency Preparedness and Response. //2007//

/2008/Rose Conner and Nikki Okeefe resigned their positions in 2006. Sarah Allen was appointed Deputy Director for Division of Public Health Services in 2007. Mrs. Allen came to ADHS with over 20 years of experience managing health care organizations and in the training of future health professionals. Previously Mrs. Allen was the CEO for Canyonlands Community Health Care for 14 years. Before coming to CCHC Mrs. Allen ran the Area Health Education Center for Maricopa County in Arizona and taught at the University of New Mexico Medical School. Mrs. Allen completed her M.S. at the University of New Mexico and is in the final stage of her PhD in Health Education and Epidemiology. She is a past president of the Arizona Public Health Association and an Athena Award recipient. Jeanette Shea-Ramirez was appointed Assistant Director for Public Health Prevention Services in 2007.//2008//

Raul V. Munoz Jr., B.S., M.P.H., is the deputy assistant director of Public Health Prevention Services. Mr. Munoz received his Masters of Public Health from the University of Texas Health Science Center at Houston in 1975. He has an extensive background in public health with the State of Texas. Prior to his move to Arizona, Mr. Munoz was an administrator with the Managed Health Care Program at Texas Tech University. He was affiliated with the El Paso City-County Health and Environmental District for twenty-five years, serving in a number of positions, including: associate director, chief of staff services, and chief of environmental health services. In addition to the above, Mr. Munoz was a lecturer at the University of Texas at El Paso, College of Nursing and Allied Health. /2007/In 2005 Raul Munoz retired, Jeanette Shea-Ramirez was appointed Deputy Assistant Director of Public Health Prevention Services. //2007// /2008/The deputy assistant director position was eliminated in 2007.//2008//

#### OFFICE OF WOMEN'S AND CHILDREN'S HEALTH

Jeanette Shea-Ramirez is the office chief for Office of Women's and Children's Health. Ms. Shea-Ramirez has served in many public health leadership positions. A Master's Degree in Social Work with specialization in planning, administration, and community development, combined with professional experience in case management and as a Medicaid policy specialist brought Ms. Shea-Ramirez to public health in 1990 as manager of the Teen Prenatal Express Program. She has served on numerous state and national boards. She has provided consultation to the Association of State and Territorial Health Officers (ASTHO) Policy Committee and serves as a consultant to the Arizona Perinatal Trust Board of Directors. Her presentations at the national conference for the American Public Health Association have included "Team Management in a Public Health Environment", 1995; "Promoting a Family Focus in Public Health Case Management Programs Through Skills Training", 1993; and "Coalition Building with Public Health Social Workers", 1992. A member of the Office of Women's Health Region IX Advisory Council, Ms. Shea-Ramirez received a scholarship to travel to New Zealand to attend the Aotearoa World Indigenous Women and Wellness conference last November. /2007/In 2006 Sheila Sjolander was appointed Chief of the Office of Women's and Children's Health, replacing Jeanette Shea Ramirez. //2007//

Sheila Sjolander has been the section manager for Planning, Education and Partnerships (PEP) since 2001. PEP provides leadership for statewide priority setting, planning, and policy development, and supports community efforts to assure the health of women, children, and their families. Ms. Sjolander oversees a variety of statewide maternal and child health programs, including domestic violence and rape prevention, injury prevention, prenatal block grant to the

counties, community health projects targeting Title V priorities, hearing screening, family planning, and teen pregnancy prevention. For the last twelve years, Ms. Sjolander has used her expertise in strategic planning and policy development in the states of Arizona, Wisconsin, and Oregon, and has had leadership roles in public health for the past eight years. /2007/ In 2006 Catherine Hannen became section manager for the PEP section. Ms. Hannen has a B.A. in Political Science and is an MSW, LCSW. For the past five years she has been a program manager for OWCH. She also has prior experience in acute health care and long-term care. //2007//

Joan Agostinelli joined the Office of Women's and Children's Health as the section manager for Assessment and Evaluation in 2004. The section is responsible for supporting research and evaluation related to women's and children's health. Ms. Agostinelli has over twenty years experience in health care, including ten years as a private consultant providing services to both public agencies and private health care organizations related to research design, needs assessment, performance measurement, program evaluation, and reimbursement system design. /2007/Lisa Anne Schamus became the section manager for Assessment and Evaluation in 2006. Ms. Schamus had been the Research and Statistical Analysis Unit Manager for Assessment and Evaluation since 2004. This unit was responsible for supporting the research needs of the office, collecting data, reporting, providing technical assistance, program evaluation, needs assessment, and performance and outcome measurement. Ms. Schamus has an M.P.H. in Epidemiology and a BA in Spanish with a minor in Latin American studies. //2007//

***/2009/ Paul Holley joined BWCH in October 2007 as Chief of the Office of Assessment and Evaluation. Mr. Holley has more than seven years of experience in the evaluation field and has led evaluations of several federal grant initiatives related to public health prevention and early intervention. He is skilled in research design and implementation, data collection methods, and statistical analysis. Paul received his PhD in Sociology in 2006. //2009//***

#### OFFICE OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Cathryn Echeverria, RN was appointed OCSHCN Office Chief in January 2002. She speaks nationally at conferences and workshops and participates and serves on board of directors and advisory boards. She is known for her leadership in financing healthcare for special needs populations and has recently been asked to serve on a committee for Boston University School of Public Health as the National Center on Health Insurance and Financing for CSHCN. She is a serves as our state liaison with federal, state and local projects related to improving the systems of care for C/YSHCN. Recently, Cathryn was invited by the Child, Adolescent, and Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration and the U.S. Department of Health and Human Services and the Technical Assistance Partnership for Child and Family Mental Health to participate in a working meeting on linking the medical home model with mental health systems. She also participates on the 2010 Leadership States Committee headed by Merle McPherson. /2007/In 2006 Cathryn Echeverria resigned and Joan Agostinelli was appointed Office Chief. Ms. Agostinelli had been the section manager for Assessment and Evaluation in OWCH. //2007//

Jacquilyn Kay Cox, PhD joined the OCSHCN staff in 2004 as the Manager for the Data, Planning and Evaluation Section. This section is responsible for all of the data collection, analysis, and reporting for OCSHCN. Additionally this section is responsible for the MCH Block Grant, the 5-year Needs Assessment, strategic planning, and grant applications. Dr. Cox has 25 years of management experience in the health care industry with a particular focus on Behavioral Health. Prior to coming to OCSHCN, she conducted research utilizing the Centers for Medicare and Medicaid Health Outcomes data which measures changes in the quality of life of Medicare beneficiaries in managed care plans throughout the United States. She has presented the results of original research at numerous national conferences and has published in peer-reviewed journals./2009/Dr. Cox resigned in June 2006. Over the past two years OCSHCN has

***substantially increased capacity around data collection and analysis. Lisa Anne Schamus joined OCSHCN's staff in July 2007./2009//***

#### OTHER PUBLIC HEALTH SERVICE PREVENTION MANAGEMENT

Margaret Tate, M.S., R.D., joined the Arizona Department of Health Services in June 1999 as the chief of the Office of Chronic Disease Prevention and Nutrition Services. Ms. Tate is active in numerous nutrition organizations. She has served as president of the Association of State and Territorial Public Health Nutrition Directors and is active in the American Dietetic Association.

Joyce Fleiger is office chief of the Office of Oral Health Services. She a graduate of the University of Southern California Dental Hygiene Program and received her Masters in Public Health from the University of Michigan in Ann Arbor. She has experience in the clinical practice of dental hygiene, public health and dental hygiene education including Director of Dental Hygiene Program and Department Chair of Dental Studies at Pima Community College in Tucson.

#### ROLE OF PARENTS OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS

The OCSHCN has, since its inception, accepted parents and other caretakers as integral members of the team. Parents are included as partners in all phases of program development, implementation, and policy-making. Block grant funds are used to pay parents for consultant services, travel expenses, and childcare. Children and youth with special health care needs and their families participate in a variety of activities with OCSHCN: the Youth Action Council, the Cultural Competency Team, the training of families and professionals, and they have assisted with data collection, and prioritization of system issues.. The CRS State Parent Action Council includes parents from the four regional CRS sites and advocacy group representatives. Parents also participate n the CRS Quality Improvement Committee and assist with the CRS Biennial Conference.

OCSHCN works to develop parent-led, self-reliant, self-sustaining community organizations that can mobilize local, state, and federal resources to improve the quality of life for C/YSHCN and their families. Each community identifies its unique resources and issues impacting C/YSHCN and their families, and purposefully works to improve the system of care within their community. Building on the success of OCSHCN community development teams, parent leaders proposed an expansion the Community Development model to all agencies serving children and youth in Arizona to the Governor and the Governor's Children's Cabinet. The cabinet endorsed the participation of all state agencies in a summit, "Circles of Success, Communities of Strength." The statewide partnership includes representation from the Office of the Governor, Arizona Department of Economic Security, Arizona Department of Education, Arizona Department of Health Services (OCSHCN and Behavioral Health Services), Arizona Department of Juvenile Corrections, AHCCCS, as well as families working with or being served by these agencies.

#### **E. State Agency Coordination**

The Office of Women's and Children's Health (OWCH) Partnership Initiative enhances the relationship of OWCH with community partners. OWCH staff is assigned as the primary office contact for each partner agency and is available to answer questions, provide technical assistance, serve on committees, and provide updates on the health status of women and children.

#### COORDINATION AMONG STATE HUMAN SERVICES AGENCIES

Governor's Commission on the Health Status of Women and Families in Arizona: The OWCH office chief/Title V director is appointed to the commission. In 2004 and 2005 the Commission met to develop public policy recommendations and strategies to improve the overall health of women focusing on the following areas: access to health care, general health concerns affecting

women, family planning, teen pregnancy prevention, prenatal care. //2008/ The ADHS Assistant Director is appointed to the commission and the Women's Health Coordinator works closely with the BWCH Bureau Chief to ensure BWCH priorities are taken into account in Commission planning. //2008//

Governor's Office for Children Youth and Families: OWCH funds the Women's Health Policy Advisor position. //2007/The Governor's staff position moved to ADHS, PHPS in 2006. Jessica Yanow was hired as Women's Health Coordinator. Ms. Yanow has an MPH with a focus in community health practice. She has experience in domestic violence, reproductive health and family planning, obesity, physical activity, nutrition, chronic disease prevention, and HIV/AIDS. //2007// //2008/ BWCH funds the Women's Health Coordinator, who is responsible for staffing the Governor's Commission on the Health Status of Women and Families in Arizona. //2008//

Governor's School Readiness Board: OWCH uses the State Early Childhood Comprehensive Systems Grant to support a position in the Governor's Office for Children, Youth, and Families to staff the School Readiness Board. OWCH staff participate on the Health Implementation Committee of the board, which focuses on the implementation of the health recommendations of the board.

Governor's Commission to Prevent Violence Against Women: OWCH staff participate on subcommittees of this commission and participated in the development the commission's State Plan on Domestic and Sexual Violence.

Governor's Efficiency Review Board: The Governor's Efficiency Review Report requires the Department of Economic Security, the Arizona Health Care Cost Containment System and the ADHS/OCSHCN to establish procedures that will streamline application processes for children born with severe birth defects.

Governor's Council on Developmental Disabilities: OCSHCN community teams are working with the Council on education regarding self-advocacy and community-based services for children and their families.

Governor's Council on Head and Spinal Cord Injuries: OCSHCN and the Arizona Governor's Council on Spinal and Head Injuries have established a partnership to address the needs of children with brain and spinal cord injuries. The council provides funding to OCSHCN for service coordination of children and youth with head and spinal cord injuries and support two analytic staff within OCSHCN to develop an Arizona traumatic brain and spinal cord injury registry.

//2008/Governor's Interagency Workgroup on Teen Pregnancy and STD Prevention: BWCH actively participates with the Governor's Office and other state agencies to identify policies and strategies to address teen pregnancy and STD prevention among youth in care, i.e. in foster care and the juvenile justice system. The workgroup will also be addressing issues of subsequent pregnancies.//2008//

State Agency Coordination Team (SACT): OWCH staff represent ADHS on this team of various state agencies that meets monthly to work together on domestic violence and sexual assault system issues. The team is organized and led by the Governor's Office for Children, Youth, and Families, Division for Women. Participating agencies include: Department of Economic Security, Department of Public Safety, Attorney General's Office, Department of Housing, Criminal Justice Commission, Arizona Supreme Court, Department of Corrections, and Arizona Health Care Cost Containment System (AHCCCS).

Interagency Coordinating Council: The Governor established the State Interagency Coordinating Council to advise and assist the lead agency, DES, in the development and implementation of policies that constitute the statewide system of early intervention services, Part C of the IDEA. OCSHCN serves on the Council by appointment of the Governor.

Arizona Department of Economic Security (DES): DES funds support the OWCH Child Fatality Review Program. DES administers state funds for domestic violence shelters, and the OWCH domestic violence program (known as the Rural Safe Home Network) works closely with DES to coordinate services for domestic violence victims. The Arizona Early Intervention Program (AzEIP) is a collaborative program of the Department of Economic Security (DES), Arizona Health Care Cost Containment System (AHCCCS), ADHS/OCSHCN; the Arizona Department of Education; and the Arizona Schools for the Deaf and Blind (ASDB). OCSHCN provides developmental screening and referral services through contracted providers to Arizona's infants and toddlers age birth to three years who are exhibiting developmental delays and may benefit from early intervention.

Arizona Department of Public Safety (DPS): OWCH and DPS work closely on sexual assault and domestic violence issues, and have jointly funded projects in the past. DPS participates on the ADHS Injury Prevention Advisory Council, and provides a source of data for homicide and sexual assault.

Arizona Department of Education (ADE): OWCH staff sits on a committee reviewing HIV/AIDS educational material. ADE works with ADHS on the Youth Risk Behavior Factor Survey and general school health issues. OCSHCN participates on the Arizona Transition Leadership Team (ATLT), developed by the ADE to develop statewide policies to ensure timely access to post-secondary disability resources and to design of research of post school outcomes. OCSHCN partners with ADE on the state transition conferences. /2007/ ADE participates on the ADHS Injury Prevention Advisory Council and has collaborated with OWCH staff to review comprehensive sex education proposals and identify opportunities to coordinate violence prevention efforts. //2007//

Arizona Department of Corrections: OCSHCN develops and provides training and technical assistance to incarcerated and paroled adolescents and those working directly with them.

Children's Cabinet: The Director of the Department of Health Services is on the Governor's Children Cabinet along with other state agencies concerned with children. The cabinet provides an opportunity to work with other state agencies on issues related to children's health.

Arizona Health Care Cost Containment System (AHCCCS): Arizona's Title XIX agency. OWCH programs collaborate to improve access to health care and increase enrollment. OCSHCN works with AHCCCS to providing administrative oversight to the CRS program; these activities include formal data sharing agreements, the development and implementation of quality improvement activities, and coordination of capitated payment mechanisms to the four regional CRS sites. /2007/ State Agency Survey Coordination Committee: OWCH, ADE, and the Arizona Criminal Justice Commission meet quarterly to coordinate school-based surveys such as Youth Risk Behavior Survey, Youth Tobacco Survey, and Arizona Youth Survey. //2007//

#### COORDINATION WITH PUBLIC HEALTH AGENCIES, FEDERALLY QUALIFIED HEALTH CENTERS, OTHER ORGANIZATIONS, ASSOCIATIONS, UNIVERSITIES

Northern Arizona University/Institute for Human Development: OCSHCN provides financial support for parents of children with special health care needs and OCSHCN staff to provide training twice a year to this group of students. The Flagstaff CRS clinic also arranges for home visits with families. Students will acquire knowledge and skills through the 12-hour program of courses and practicum.

University of Arizona (UofA): OCSHCN works with the UofA to implement the Telemedicine Program. /2009/ ***BWCH and the University of Arizona College of Public Health coordinated an all-day orientation to MCH programs for interested MPH students. //2009//***

Arizona State University (ASU): OCSHCN works with ASU on implementing the LMS system and the ADHS Leadership Academy

Residency Programs: OCSHCN provides financial support for training physicians in pediatric and family practice residency programs. The residents complete a one-hour orientation at Raising Special Kids that focuses on the importance of family-centered care and a two-hour Home Visit with the Family Faculty who are trained volunteer parents who are raising a child with special needs.

Arizona Local Health Officers Association (ALHOA): Includes health officers from all county health departments and tribal health agencies. OWCH provides funds to county health departments and tribal agencies for services to women, infants, and children.

Association of Community Health Centers: OWCH provides funds to the health centers for immunizations through The Arizona Partnership for Immunization (TAPI). OWCH also has contracts with some community health centers for the Health Start program. As a result of HRSA's Strategic Partnership Session for Arizona grantees, the BWCH continues to work with the Arizona Association of Community Health Centers on the issue of improving integration of behavioral health. Other partners involved in this collaboration include the State Office of Rural Health and the Bureau of Health Systems Development. Also as a result of HRSA's Partnership Session, the BWCH invited the Office of Rural Health to join its advisory committee for the HRSA EMSC grant.

Arizona Department of Health Services (ADHS): ADHS has created the infrastructure to develop a learning management system by combining the resources of four offices: the Office of Nutrition and Chronic Disease, Public Health Preparedness and Response, OCSHCN, and Emergency Medical Services. This system will allow the electronic tracking and evaluation of all web-based educational modules.

Arizona Chapter of American Academy of Pediatrics: OWCH provides funds to support the Medical Home Project, and works with them on development of a statewide child care health and safety consultation system. OCSHCN/CRS Medical Director is a member of the AzAAP and has been appointed as the Arizona liaison for the National AAP Council on Children with Disabilities. OCSHCN staff assist AzAAP in policy revisions regarding the role of the school nurse in providing school health services.

Arizona Perinatal Trust partners with OWCH to maintain and improve the regionalized perinatal system of care in Arizona. OWCH acts as a technical advisor to the Trust, participates on site visits that the Trust conducts to certify birthing hospitals, and assists with data analysis and dissemination to Level I, II, and III birthing hospitals.

March of Dimes (MOD): Ongoing partnership. MOD provided technical support for the expansion of screening tests provided by the OWCH Newborn Screening program./2008/BWCH participates on the MOD Program Services committee and the assistant director serves on the legislative committee./2008//

Arizona Family Planning Council: the Title X agency shares family planning data and other information with OWCH. Collaborates with OWCH to ensure family planning services are in every county. OWCH participates as a reviewer in the Title X RFP process.

Arizona Family Planning Coalition: OWCH staff sit on the steering committee of this statewide coalition focusing on advocacy, education, and legislation affecting reproductive rights. OWCH is a sponsor of the Coalition's annual conference.

Alliance for Innovations in Health Care: The Alliance is affiliated with the National Friendly Access

Program, a national initiative to bring about changes in the maternal and child health care system. OWCH is funding the implementation of the Friendly Access baseline survey assessment for prenatal clients and the development of a community plan based on findings. OWCH is a member of the Alliance.

Arizona Public Health Association (AZPHA): OWCH staff sit on the board and are association members. OWCH and OCSHCN support AZPHA's two annual conferences. OWCH works with AZPHA to identify maternal and child health issues and policies that the association could help support. OCSHCN staff participate in the monthly AzPHA School Health Section Meetings. ***//2009/ BWCH staff facilitated the creation of an MCH section in the AZPHA. A manager within BWCH will become the President of the AZPHA in September 2008. //2009//***

School Based Health Council: OWCH staff attends board meetings to exchange information.

Arizona Coalition Against Domestic Violence: OWCH Rural Safe Home Network Program provides funding to the coalition for training, advocacy, information and referral services, and technical support of domestic violence community-based programs. OWCH has worked with the coalition to apply for additional federal grants for Arizona, and sought the coalition's input on development of plans related to domestic violence and a variety of other issues.

Arizona Sexual Assault Network: The OWCH Rape Prevention and Education Program works closely with the network in a variety of ways. To enhance collaboration, the network director attends contractor meetings as well as annual CDC grantee meetings with the rape prevention program manager. OWCH provided funding to the Arizona Sexual Assault Network, in partnership with Department of Public Safety, to conduct training on emergency room department response and protocol to sexual assault victims.

ADHS Injury Prevention Advisory Council: The advisory council is appointed by the director of ADHS to make recommendations on policies and actions that the department can take to help prevent injuries in Arizona. The advisory council oversees the development, update, and progress on the Arizona Injury Surveillance and Prevention Plan. OWCH staffs the advisory council and facilitates the meetings. Agencies comprising the council currently include: Inter Tribal Council of Arizona, Indian Health Services, Arizona Local Health Officers Association, Arizona Coalition Against Domestic Violence, Department of Public Safety, Arizonans for Gun Safety, St. Joseph's Medical Center, Desert Samaritan Medical Center, Governor's Office for Highway Safety, EMPACT -- Suicide Prevention Hotline, Poison Control Center, Phoenix Fire Department, Phoenix Children's Hospital, Mothers Against Drunk Driving, Drowning Prevention Coalition, University of Arizona Health Sciences Center, Safe Kids Yuma County, Tucson Fire Department, Arizona Center for Community Pediatrics, Governor's Council on Spinal and Head Injuries, Phoenix Baptist Hospital School Based Clinics, University of Arizona CODES Project.

Arizona Coalition on Adolescent Pregnancy and Parenting (ACAPP): OWCH collaborates with ACAPP to identify and share information regarding best practice strategies to prevent teen pregnancy. OWCH has worked with ACAPP to determine programming for new teen pregnancy funds awarded to ADHS, and to disseminate a parent guide developed by ACAPP.

Arizona Medical Association: A representative from OWCH sits on the Arizona Medical Association Committee on Maternal and Child Health Care as well as the Adolescent Health Community Advisory group. This group has received a grant and is currently working on a statewide action plan for improving adolescent access to appropriate health care. The OCSHCN Medical Director is an appointed member of the ArMA Maternal and Child Health Committee. OCSHCN staff participates on the ArMA, Maternal and Child Health Adolescent Subcommittee's Adolescent Health Community Advisory Group to create a state plan to address how adolescents access appropriate health care. OCSHCN oversees adolescent involvement with the Advisory Group to provide feedback on, and suggestions for the Adolescent Health Plan.

Arizona Adolescent Health Coalition (AAHC): OWCH collaborates with the AAHC to promote healthy adolescents and the reduction of high risk behaviors through the sponsorship of their annual conference, participation at their quarterly meetings and promotion of their training programs. OCSHCN attends bimonthly Board meetings to share information and have issues/concerns of youth with special health care needs included in the AAHC activities. OCSHCN contributes to the Arizona Adolescent Health Coalition's annual publication.

Healthy Start: A representative from OWCH sits on the advisory board and participates in strategic planning activities. OWCH provides maternal and child health data and technical assistance regarding outreach strategies to the Healthy Start Program. Healthy Start staff has been invited to participate in Health Start training workshops and other meetings related to child development and maternal health.

Arizona Asthma Coalition: OCSHCN participates in the Arizona Asthma Coalition and OCSHCN provides funding to develop and implement community-based programs to address the needs of children who have asthma. Through a contract with the American Lung Association, OCSHCN funds the Executive Director of the Coalition. OCSHCN participated and provided funding for the development the Comprehensive Asthma Control Plan for the State of Arizona.

Raising Special Kids (RSK): OCSHCN contracts with the local chapter of Raising Special Kids to facilitate of training sessions for residents from pediatric and family practice programs that include home visits with families with children/youth with special health care needs (C/YSHCN). Both organizations plan, conduct, and evaluate family-centered training and training materials for CRS staff, student nurses, and dental students. RSK participate in bi-annual CRS statewide conference planning and presentations. RSK staff (who are also parents of children with special health care needs) participate in ADHC/OCSHCN planning, program development, training activities, and any activities requiring family perspective.

Pilot Parents of Southern Arizona/Partners in Public Policy Making: Pilot Parents of Southern Arizona promotes the CRS Parent Action Council activities within the regional CRS clinic in Tucson by providing assistance in identifying and supporting parents and youth to participate in CRS activities. OCSHCN is working with Pilot Parents of Southern Arizona to recruit parents, youth, and self-advocate graduates to participate in various advocacy activities within OCSHCN.

Family Voices: Family Voices is a national, grassroots clearinghouse for information and education concerning the health care of children with information and education concerning the health care of children with special health needs. OCSHCN with Family Voices through participation in regularly scheduled regional calls, regional listservs and "FV Talk", and by attending Family Voices meetings.

Children's Action Alliance: Children's Action Alliance (CAA) is a non-profit, nonpartisan research, policy and advocacy organization dedicated to promoting the well-being of all of Arizona's children and families. Recently, CAA participated in an informal School Health Focus group that was facilitated by OCSHCN to discuss how the health needs of children and youth with special health care needs are being addressed in the school setting. /2007/OWCH funded CAA to do a time series analysis to assess the impact premium sharing increases made in the AHCCCS's KidsCare program enrollment. //2007//

BHHS Legacy Foundation: BHHS Legacy Foundation (BHHS Legacy) is an Arizona nonprofit charitable conversion foundation. OCSHCN has a grant from BHHS Legacy to assist children/teens with Traumatic Brain Injuries (TBI) and their families through cross agency intake and referrals for children/teen with TBI. There are additional joint projects to monitor the quality of services through surveys of children with TBI and their families, the development of clinical guidelines, and the development of public listings of resources and services available in Maricopa County related to TBI.

## STATE SUPPORT FOR COMMUNITIES

Community Teams: OCSHCN works to develop parent-led, self-reliant, self-sustaining community organizations that can mobilize local, state, and federal resources to improve the quality of life for C/YSHCN and their families. Each community identifies its unique resources and issues impacting C/YSHCN and their families, and purposefully works to improve the system of care within their community. The community is strengthened by recognizing and building upon local community capacities to care for children. The goal is to provide this program throughout Arizona; currently services are provided in Page, Prescott, Prescott Valley, Chino Valley, Bullhead City, Kingman, Somerton, San Luis, Gadsen, St. Johns, Springerville, Eager, Concho, Mesa, Flagstaff, and the Verde Valley (Cottonwood, Clarksdale, and Sedona).

Building on the success of the OCSHCN community development teams, parent leaders recommended expanding the Community Development model to all agencies serving children and youth in Arizona to the Governor and the Governor's Children's Cabinet. The statewide partnership includes representation from the Office of the Governor, Arizona Department of Economic Security, Arizona Department of Education, Arizona Department of Health Services (OCSHCN and Behavioral Health Services), Arizona Department of Juvenile Corrections, AHCCCS, as well as families working with or being served by these agencies.

## F. Health Systems Capacity Indicators

### Introduction

Over the past four years, the eligibility levels for enrollment in the state's Medicaid program and the State Children's Insurance Program (SCHIP) for children age 1-18 have remained the same.

***//2009/ The eligibility levels for enrollment into AHCCCS decreased for pregnant women, from 140% FPL in 2002, to 133% FPL in 2003. However, eligibility levels for pregnant women increased to 150% FPL in 2007. Eligibility levels for enrollment in SCHIP for pregnant women have remained at 200% FPL from 2002 through 2007. //2009//***

For the Health Systems Capacity Indicators that were broken down by payor, the Medicaid population had worse outcomes than the non-Medicaid populations. Medicaid populations had higher percentages of low birth weight infants, lower percentages of women entering prenatal care in the first trimester, and lower percentages of women receiving adequate prenatal care.

**Health Systems Capacity Indicator 01:** *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	26.5	35.6	29.1	27.4	27.4
Numerator	1324	1533	1299	1323	1323
Denominator	499721	430549	446162	482344	482344
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

**Notes - 2007**

Problems with hospital discharge data prevented reporting on this measure for 2002. Data for 2007 are not yet available. The estimate for 2007 is provisionally set at the 2006 rate until data become available in the Fall of 2008.

**Notes - 2006**

The provisional estimate for 2006 was incorrect. The case population included children 1 to 6 years of age. The revised "final" estimate for 2006 includes only children 1 to 5 years of age. Problems with hospital discharge data prevented reporting on this measure for 2002.

**Notes - 2005**

The estimate for 2005 was incorrect. The 2005 case population included children 1 to 6 years of age. The revised estimate for 2005 includes only children less than 5 years of age.

**Narrative:**

The Bureau of Women's and Children's Health */2009/ (BWCH) //2009//* has direct access to Hospital Discharge data to report on this measure. The Hospital Discharge data does not include Federal or Native American facilities. Over the course of the last two years, the Arizona Department of Health Services has made a concerted effort to improve the quality of the Hospital Discharge data including a series of data audits and enforcement of requirements to submit data. It is unknown what impact these changes in data management have had on asthma hospitalization rates.

Starting with calendar year 2004 data, Arizona also has access to emergency department data for analyses. Analysis of emergency department data will enhance the State's ability to track changes in primary care sensitive conditions such as asthma. */2009/ In previous years the rate for asthma related emergency department admissions per 10,000 children incorrectly included cases 1 to 6 years of age. The revised rates for asthma related emergency department admissions per 10,000 children under age 5 were as follows: 2004: 105.0, 2005: 100.5, 2006: 95.6. //2009//*

**Health Systems Capacity Indicator 02:** *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	84.3	95.0	96.1	97.6	96.4
Numerator	43509	51326	54373	56520	58301
Denominator	51598	54047	56587	57884	60473
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

**Narrative:**

The data source for HSCI 02 is the */2009/ HCFA 416 //2009//* report. Data for the */2009/ HCFA 416 //2009//* report is taken from medicaid encounters and eligibility/enrollment.

The health plans that contract with AHCCCS (Arizona's Medicaid program) conduct various interventions during the course of each year to increase EPSDT participation. Interventions

include outreach to members and providers related to well visits, dental, TB and lead screening, immunizations and other preventive health services. The health plans monitor and evaluate the effectiveness of interventions and report to AHCCCS quarterly. Efforts are under way to work with the health plans to develop new and innovative interventions.

**Health Systems Capacity Indicator 03:** *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	71.8	79.7	82.1	78.4	82.5
Numerator	549	484	517	580	721
Denominator	765	607	630	740	874
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

**Narrative:**

The data source for HSCI 02 is the */2009/ HCFA 416 //2009//*report. Data for the */2009/ HCFA 416 //2009//*report is taken from Medicaid encounters and eligibility/enrollment. The health plans that contract with AHCCCS (Arizona's Medicaid program) conduct various interventions during the course of each year to increase EPSDT participation. Interventions include outreach to members and providers related to well visits, dental, TB and lead screening, immunizations and other preventive health services. The health plans monitor and evaluate the effectiveness of interventions and report to AHCCCS quarterly. Efforts are under way to work with the health plans to develop new and innovative interventions

**Health Systems Capacity Indicator 04:** *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	67.9	69.3	70.1	69.8	69.8
Numerator	61674	64499	66943	70976	
Denominator	90783	93093	95486	101749	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

**Notes - 2007**

Data for 2007 are not yet available. The estimate for 2007 is provisionally set at the 2006 rate until data become available in the Fall of 2008.

**Notes - 2006**

Data for 2006 are not yet available. The estimate for 2006 is provisionally set at the 2005 rate until data become available in the Fall of 2007.

**Narrative:**

*/2009/ BWCH utilized 2006 //2009//* birth certificate data to report on the Kotelchuck index. The fields used to perform a Kotelchuck analysis include month prenatal care began and number of prenatal visits. Both of these fields are self reported and as such may have reliability issues. Kotelchuck index results appear to be similar in Arizona to national figures.

*/2009/ The percent of women with adequate prenatal care utilization on the Kotelchuck index varied widely by county, from a low of 45% of women in Greenlee County to a high of 82% in Cochise County. //2009//*

A survey of low-income postpartum women conducted in an urban area of Maricopa County in 2006 (Friendly Access) revealed that for those women who did not receive adequate prenatal care, lack of money or insurance was the primary reason cited for the delay or lack of care.

An analysis of the 2006 birth certificate file demonstrated that the percentage of women who entered prenatal care in the first trimester varies by county. The percentage of women entering prenatal care in the first trimester by county is as follows: Apache 61%, Cochise 85%, Coconino 80%, Gila 68%, Graham 72%, Greenlee 72%, La Paz 62%, Maricopa 80%, Mohave 79%, Navajo 70%, Pima 73%, Pinal 77%, Santa Cruz 69%, Yavapai 71%, and Yuma 62%. Overall, 78 percent of women delivering a baby in 2006 began prenatal care in the first trimester in Arizona.

**Health Systems Capacity Indicator 07A:** *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	72.0	72.6	73.7	74.5	74.7
Numerator	366273	402079	424014	432605	434205
Denominator	508776	553763	575577	580568	581632
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

**Notes - 2005**

The measure reported is the total number of Medicaid members age 1-20 with at least one paid service during the reporting year divided by the total number of members age 1-20 eligible for Medicaid at any time during the reporting year. A single point-in-time estimate of the potentially eligible population is actually smaller than the number of service recipients yielding a result of over 100%.

**Narrative:**

*/2009/ BWCH //2009//* obtains data for HSCI 07A from AHCCCS. Because we do not know the denominator for potentially Medicaid-eligible children, Arizona reports the

percent of Medicaid enrolled children who have received a Medicaid-eligible service for this measure. The measure reported is the total number of Medicaid members age 1-20 with at least one paid service during the reporting year divided by the total number of members age 1-20 eligible for Medicaid at any time during the reporting year. A single point-in-time estimate of the potentially eligible population is actually smaller than the number of service recipients yielding a result of over 100%.

**Health Systems Capacity Indicator 07B:** *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	44.0	49.2	45.5	54.1	56.6
Numerator	47484	56991	54909	66522	71063
Denominator	108018	115746	120763	122975	125470
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

**Narrative:**

Data for HSCI 07B is obtained through the HCFA 416 form provided to the maternal and child health program by AHCCCS. The Office of Oral Health provides referrals to high-risk children to ensure that they receive dental services.

The percent of EPSDT eligible children aged 6-9 years who have received any dental services during the year has continued to improve. In 2005 the ADHS dental sealant program placed sealants on 1825 EPSDT qualified children aged 6-9 years. In 2006, 1882 eligible children received this dental care.

The program is increasing funding thus supporting the expansion of the dental sealant program. In 2005 the program served 5 counties, in 2006 ADHS was in 6 counties and in 2007 we are expanding to two new counties.

Arizona is tied for the 3rd highest decay rate in K-3rd graders and has a dental workforce shortage in a lot of the same areas. Some of the unmet need is being met by out of state, for profit mobile dental companies who are providing services in underserved, high need areas.

**Health Systems Capacity Indicator 08:** *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	55.2	58.1	58.9	43.1	42.4
Numerator	7514	8849	8945	6627	6732
Denominator	13618	15230	15189	15392	15891
Check this box if you cannot report the numerator					

because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

**Notes - 2007**

The measures for 2004 and 2005 contained duplicate members. The 2006 and 2007 measures are unduplicated.

**Notes - 2006**

The measures for 2004 and 2005 contained duplicate members. The 2006 measure is unduplicated.

**Narrative:**

What appears to be a drop in getting SSI recipients to services in 2006 in part reflects an improvement in reporting capability. Previous numbers contained duplicate members, who may have changed their eligibility status in Children's Rehabilitative Services Program during the contract year.

OCSHCN sends information to SSI applicants and an SSI coordinator enters referral information into a database. Applicants are referred to programs, such as Children's Rehabilitative Services, Community Nursing, OCSHCN care coordination programs, and Arizona Early Intervention Program. A desktop protocol was developed to guide this process. OCSHCN works with the Birth Defects Registry, High Risk Perinatal program and state school nurse organizations to inform families about CRS eligibility, and supports the BWCH Children's Information Services Hotline, providing education to its staff on services and programs for CYSHCN.

OCSHCN has not achieved its objective to link databases across programs for the purpose of tracking progress. To date, BWCH and OCSHCN have not yet developed an automated process through the SSDI initiative to link Newborn Screening Program data to data in the Children's Rehabilitative Services database first because of an inability to identify a qualified job applicant for the position of SSDI epidemiologist, and later due to a statewide agency hiring freeze.

CRS is revising Administrative Rules to simplify the eligibility process. An in-person medical evaluation to verify the presence of a CRS eligible condition is no longer needed if sufficient documentation is provided with the referral. Screening for AHCCCS eligibility no longer requires verification of income and expenses. For applicants already enrolled in AHCCCS, only documentation of a CRS eligible medical condition is required, and only applicants seeking state assistance must apply for AHCCCS.

OCSHCN collaborates with BWCH Community Nursing on children ineligible for other care and at risk for developmental delay and provides care coordination for TBI/SCI in home and community settings. Family Resource Coordination educates contractors, families, providers, and child-serving agencies on eligibility rules and processes to access service. OCSHCN responds to family calls and refers families to community-based services.

**Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)***

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid,</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON- MEDICAID	ALL

<b>non-Medicaid, and all MCH populations in the State</b>					
Percent of low birth weight (< 2,500 grams)	2006	payment source from birth certificate	7.5	6.7	7.1

**Narrative:**

***/2009/ The percent of infants weighing less than 2,500 grams rose slightly from 6.9 percent in 2005 to 7.1 percent in 2006. This increase was seen in both Medicaid (from 7.2 to 7.5) and non-Medicaid births (from 6.6 t 6.7). //2009//***

Results of the PPOR analysis indicate that many of the excess infant deaths occur during the prematurity/maternal care and maternal health periods. Decreasing deliveries of low birth weight infants would improve outcomes in both of these periods. ***/2009/ BWCH //2009//*** has utilized the PPOR results to guide program activities geared towards decreasing low birth weight deliveries and infant deaths.

BWCH has implemented an internal preconception care workgroup to address low birth weight and prematurity. The goals of the workgroup are to develop strategies for increasing awareness of the importance of preconception health among medical providers and the general public and to integrate preconception care into existing BWCH programs. ***/2009/ The monthly internal preconception care meetings have included presentations on training opportunities within the state for various preconception care topics in order to identify resources for contractors as they look at integrating preconception care at the local level. There have been presentations on available training related to smoking cessation, improving nutritional behaviors and mental health resources. The High Risk Perinatal Program (HRPP) Community Nursing component had planned to implement a pilot project in Yavapai County to provide preconception care visits in addition to visits focused on the NICU graduate. Due to a change in senior management at the Yavapai County Health Department, the pilot project was not implemented. The Maricopa County HRPP Community Health Nursing program is working with the Maricopa Integrated Health Systems (MIHS) to identify their role in providing interconceptual care to the mothers of the HRPP enrolled baby. MIHS received a grant from the local March of Dimes chapter to develop and implement an internal care program based on the Grady Memorial model. The grant will work with HRPP mothers who delivered at the Maricopa Medical Center, a public hospital.***

***Efforts are continuing on integrating preconception care into other BWCH programs as appropriate. The County Prenatal Block Grant program added a focus on preconception care in the policy and procedure manual and the program manager is monitoring those activities during site visits. The Family Planning Program has revised the health assessment form to group topics related to preconception care in one area of the form. The revised forms will be distributed during a contractor's meeting in June. The Health Start Program is in the process of revising the home visiting forms to capture education provided to clients on preconception care topics and to capture any referrals made in response to an identified health risk. The Health Start data base will also be revised to allow for the collection and reporting of this information. //2009//***

The workgroup also identified working with the Department of Education as an important strategy for reaching youth with the message of preconception care. A ***/2009/ BWCH //2009//*** Health Educator has a very close working relationship with Department of Education staff and sits on a school health standards committee. This person will also take the lead in identifying or developing educational materials on the importance of preconception care for health care professionals and the general public.

***/2009/ The Bureau has been participating on conference calls with Florida state's Every***

**Woman, Every Time workgroup. The workgroup is revising the original educational packet developed by California and while other states were also reportedly interested in using California's materials there has not been a coordinated effort to share resources on a broad basis. Once Florida has finalized their educational packet, the Bureau will convene an external workgroup to modify it for use in Arizona. //2009//**

**Health Systems Capacity Indicator 05B: Infant deaths per 1,000 live births**

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2006	other	0	0	6.3

**Notes - 2009**

Mortality data is not available by payer. Data source is death certificates.

**Narrative:**

Infant death statistics in Arizona are not available by payer.

To better target interventions that will improve Arizona's ability to reduce preventable infant and fetal deaths, the state has been conducting Perinatal Periods of Risk (PPOR) analysis on an annual basis. PPOR analysis is one of the activities defined in Arizona's State Systems Development Initiative plan. ADHS uses PPOR results better target prevention activities and to guide funding decisions related to reducing preventable infant deaths.

The most recent PPOR analysis of the 2000 to 2003 birth cohort found that overall, 32 percent of fetal and infant deaths in Arizona were found to be preventable. Excess infant deaths are fairly evenly divided among the maternal health/prematurity period, the maternal care period, and the infant health. The conclusion from the state-wide analysis is that, in order to reduce preventable infant mortality, our prevention efforts should be focusing on preconception (and interconception) care, prenatal care, safe sleep, breastfeeding, and other interventions that are proven to be successful during these three periods. However, subgroup analysis showed that some populations have different patterns of excess infant death than the state as a whole. For instance, in the African American population, the period with the highest excess death rate is the maternal health/prematurity period (4.3 per 1,000 fetal deaths and live births) while in the American Indian population, the period with the highest excess death rate is the infant health period (2.5 per 1,000). In addition to being used to guide prevention efforts within the Department, the results of these analyses were shared with stakeholders and partners to encourage them to utilize the information to guide prevention strategies.

**//2009/ BWCH //2009//** is using these results to work with programs to integrate preconception care as appropriate. One example is that the Health Start program is moving towards a stronger emphasis on preconception and interconception care. BWCH will also be working with the Arizona Department of Education to integrate preconception care into health classes/health standards.

**Health Systems Capacity Indicator 05C:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	payment source from birth certificate	71.8	90.2	77.7

**Narrative:**

The percent of women entering prenatal care in the first trimester */2009/ remained at 77.7% for 2006 . Although the percent of women entering prenatal care in the first trimester increased for those women whose births were paid by Medicaid, there was a disparity for prenatal care between the Medicaid (71.8%) and non-Medicaid (90.2%) populations. //2009//*

Eligibility levels for Medicaid and SCHIP remained unchanged in 2005. Changes in poverty level for eligibility in AHCCCS and SCHIP rest with the Medicaid agency (AHCCCS), the legislator and the public. Historically, changes in poverty levels for Medicaid eligibility have been generated as the result of voter propositions. BWCH works with our partners who support increasing poverty levels for Medicaid eligibility and will provide data as appropriate.

The Pregnancy and Breast Feeding Hotline is a statewide, bilingual service that has been sponsored by the Arizona Department of Health Services (ADHS) since April 1988. The Hotline's mission is to ensure the health, safety, and well being of pregnant women and their families through community based, family centered, and culturally sensitive systems of care. One of the many services that the Hotline provides is to assist Arizona's Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS), with pre-screening for the Baby Arizona Program. Baby Arizona is a program that helps pregnant women begin the important prenatal care they need by providing a simple, faster way to get health care before the application process for AHCCCS health insurance is complete.

A woman will call the Hotline at 1-800-833-4642 stating that she thinks she is or knows she is pregnant. Hotline staff will ask if she is interested in completing a pre-screening for Baby Arizona. If she says yes, the Hotline representative will ask a series of questions that will provide potential eligibility. If the woman is potentially eligible she will be given the name and address of three Baby Arizona providers in her community. The woman will select one of the providers and schedule an appointment. At the first appointment the woman will be asked to complete a Baby Arizona application and will have her first prenatal visit. The Provider's office will submit the application paperwork to the Department of Economic Security (DES) and will await notification of eligibility. If the woman is determined eligible she will continue with that provider through delivery and AHCCCS will pay the bills. If she is determined in-eligible she can still continue her visits with the provider but she and the provider will need to work out a reasonable payment plan. If during the pre-screening process the woman appears ineligible, the Hotline representative will provide information on low cost care available in the woman's community. If program eligibility is too difficult to determine, the woman will be encouraged to apply at DES directly.

**Health Systems Capacity Indicator 05D:** *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2006	payment source from birth certificate	61	79.2	69.8

**Narrative:**

The data source for HSCI 05D is birth certificate data. */2009/ BWCH //2009/* has direct access to this data. The percent of women with adequate prenatal care in both the Medicaid and non-Medicaid populations is similar to point estimates reported in the 2005 Medicaid and non-Medicaid populations.

**Health Systems Capacity Indicator 06A:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2007	140
INDICATOR #06 <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Infants (0 to 1)	2007	200

**Narrative:**

Eligibility levels for Medicaid and SCHIP remained unchanged in */2009/ 2007 //2009//*. Changes in poverty level for eligibility in AHCCCS and SCHIP rest with the Medicaid agency (AHCCCS), the legislator and the public. Historically, changes in poverty levels for Medicaid eligibility have been generated as the result of voter propositions. */2009/ BWCH //2009//* works with our partners who support increasing poverty levels for Medicaid eligibility and will provide data as appropriate.

**Health Systems Capacity Indicator 06B:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	YEAR	PERCENT OF POVERTY LEVEL Medicaid
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Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to )	2007	133 100
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Medicaid Children (Age range 1 to 18) (Age range to ) (Age range to )	2007	200

**Narrative:**

Eligibility levels for Medicaid and SCHIP remained unchanged in */2009/ 2007 //2009//*. Changes in poverty level for eligibility in AHCCCS and SCHIP rest with the Medicaid agency (AHCCCS), the legislator and the public. Historically, changes in poverty levels for Medicaid eligibility have been generated as the result of voter propositions. */2009/ BWCH //2009//* works with our partners who support increasing poverty levels for Medicaid eligibility and will provide data as appropriate.

**Health Systems Capacity Indicator 06C:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Pregnant Women	2007	150
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Pregnant Women	2007	200

**Narrative:**

Eligibility levels for SCHIP remained unchanged in 2006. */2009/ Eligibility levels for Medicaid increased from 133% to 150% of the poverty level //2009//*. Changes in poverty level for eligibility in AHCCCS and SCHIP rest with the Medicaid agency (AHCCCS), the legislature and the public. Historically, changes in poverty levels for Medicaid eligibility have been generated as the result of voter propositions. */2009/ BWCH //2009//* works with our partners who support increasing poverty levels for Medicaid eligibility and will provide data as appropriate.

**Health Systems Capacity Indicator 09A:** *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

<b>DATABASES OR SURVEYS</b>	<b>Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)</b>	<b>Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)</b>
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	Yes

Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	1	No
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	3	Yes
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	2	No
Survey of recent mothers at least every two years (like PRAMS)	1	No

**Notes - 2009**

When the SSDI position is filled, annual linkage of birth certificate and WIC eligibility data is a priority.

**Narrative:**

*/2009/ BWCH //2009/* submitted an application for the upcoming State Systems Development Initiative (SSDI) cycle. For the 2006 through 2011 cycle of SSDI, the program proposed using SSDI funding to 1) establish and implement protocols for linking newborn screening data with birth, infant death, and data from the Arizona School for the Deaf and Blind, 2) establish and implement a protocol for linking newborn screening and Children's Rehabilitative Services data, 3) utilize Arizona Births Defects Registry data to enhance stillbirth, infant death and childhood death reports, 4) establish and implement a protocol for linking birth certificate data with data from Women, Infants and Children (WIC), and 5) refine the methodology for linking birth and infant death data. A key element of the upcoming SSDI will be a communication cycle in which reports provided from the linked datasets are reviewed by stakeholders and revised based on their input.

*/2009/ The Arizona Birth Defects Registry will have complete data for 2001-2006 in the fall of 2008. This data will be linked to Birth and Death Certificate data from Vital Statistics in effort to fulfill an objective of the SSDI grant initiative. //2009//* The Hospital Discharge data collection rules are currently being revised. One of the proposed revisions will include the collection of the fourth-digit of the revenue code, which for infants indicates the level of care that an infant receives while in the hospital. This revision will enable */2009/ BWCH //2009//* to be able to identify infants who were admitted to the Neonatal Intensive Care Unit. The ability to identify these infants will greatly enhance the ability to evaluate the Neonatal Intensive Care Program, and to ensure that every infant who spends at least 72 hours in the NICU is enrolled in the NICP program.

**Health Systems Capacity Indicator 09B:** *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

<b>DATA SOURCES</b>	<b>Does your state participate in the YRBS survey? (Select 1 - 3)</b>	<b>Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)</b>
Youth Risk Behavior Survey (YRBS)	3	Yes

**Notes - 2009**

**Narrative:**

The Arizona Department of Education began implementing the Youth Risk Behavior Survey during the 2002/2003 school year, and also participates in the Arizona Youth Tobacco Survey and the Arizona Youth Survey. The maternal and child health program has direct access to the YRBS through a data share agreement. Staff from the maternal and child health program participate in the Inter-Agency Survey Coordination Committee. Members of this committee have worked together to coordinate timing and administration of the Youth Risk Surveillance Survey, the Youth Tobacco Survey and the Arizona Youth Survey to reduce the burden on school districts of responding to multiple surveys.

## **IV. Priorities, Performance and Program Activities**

### **A. Background and Overview**

BWCH continues to follow the method it defined after the year 2000 needs assessment for identifying and prioritizing the needs of women and children in Arizona. The goal of this method is to create a participatory process that is easily articulated and strategic in nature, resulting in funding decisions that have the best chance of making an impact on the health of the maternal and child health population. The BWCH strategic planning process is used to accomplish three goals: 1) identify the health needs of women and children, 2) allocate funding to address the needs and 3) evaluate the effectiveness of those efforts. The BWCH strategic plan, which is available at the BWCH web site, identifies two priority areas: to reduce mortality and morbidity of the maternal and child population; and to increase access to health care. The plan also identifies the need to decrease health disparities as an overarching priority. The functions of the various office sections are specified within the plan. These priorities and related measures are chosen by a multi-step process: 1) reviewing data to identify the most significant issues; 2) excluding those issues already being addressed by another entity within the state; and 3) determining those issues that most likely could improve with a targeted effort. The plan is used to make funding decisions and to establish staff priorities. State priorities resulting from this strategic plan are presented in section IV.B. of this document.

### **B. State Priorities**

Through a series of public meetings and other communications related to the five-year needs assessment process, priorities were established that the community and the Title V agency jointly identified as important and that are within their capability to address.

Many issues were raised during public input sessions that affect the health and well being of the maternal-child health population that are beyond the scope of Title V services. For example, affordable housing, general educational attainment, opportunities for economic and social activities for youth, and parental involvement with their own children were all recognized as important contributing factors to women's and children's health. The themes of home, school, and neighborhood environments may not be specifically reflected in the top priorities identified, however opportunities to work with schools, parents, and the larger community on issues that affect health will continue to permeate programmatic activities and remain top priorities in themselves.

#### **PRIORITY 1: REDUCE TEEN PREGNANCY AND INCREASE WOMEN'S ACCESS TO REPRODUCTIVE HEALTH SERVICES**

A recurrent theme that was heard at each of the public input sessions was that there is a need for enhanced teen pregnancy prevention, sexuality education, and family planning services to prevent unwanted pregnancies and sexually transmitted diseases. Teen pregnancy was seen as important both as an outcome and as a cause. In addition to the consequences that pregnancy has for the teenager's health and life chances, babies born to teenagers are less likely to get a healthy start at life. There was a recognition that services should be aimed both at delaying the onset of sexual activity as well as supporting responsible choices among sexually active teens.

Family planning for women of all ages plays an integral role in bolstering the health and well being of both women and children. In fact, during public input sessions, a WIC director from one of the American Indian tribes stated that spacing of children was the most important nutrition issue they faced. In addition, the ability to plan pregnancies helps women gain flexibility in education and employment opportunities.

\$2 million in lottery funds will be aimed at teen pregnancy, and another \$2 million in state and federal dollars will be directed specifically towards abstinence education. Community-based

programs are being piloted in two communities with the highest teen pregnancy rates. \$1 million of Title V funds are being spent on family planning, and OWCH initiated the Family Planning Coalition, which has been in operation for about 4 years.

/2007/ The state budget for FY07 included a \$500,000 increase for the Abstinence Program resulting in a total of \$1.5 million in state funds dedicated to abstinence beginning July 2006. //2007//

/2008// Lottery dollars are used to fund several comprehensive sexual education projects throughout Arizona. In 2007 BWCH worked with the Navajo Nation and Inter Tribal Council of Arizona to develop new teen pregnancy projects among the tribes. Also in 2007 a parent education campaign is launching as well as pilot projects serving youth in the juvenile justice system. //2008//

***/2009/ Arizona will not apply for federal FY09 abstinence funding, and the state legislature did not include any state funding for abstinence in the state FY09 budgets. Budget cuts also resulted in the loss of some of the lottery-funded comprehensive sexual education projects. //2009//***

## PRIORITY 2: REDUCE OBESITY AND OVERWEIGHT AMONG WOMEN AND CHILDREN

Maintaining a healthy weight through healthy eating patterns and physical activity is a critical component of chronic disease prevention. Over the last decade, strides have been made in increasing the level of physical activity and healthy eating. However, obesity has reached epidemic proportions, affecting all regions and demographic groups.

Being overweight during childhood can carry life-long health consequences. Risk factors for heart disease, such as high cholesterol and high blood pressure, occur with increased frequency in overweight children and adolescents, and type 2 diabetes, which was previously considered to be an adult disease, has increased dramatically in children and adolescents.

OWCH focuses community grants for women's health on healthy weight in women, and partners with the Office of Chronic Disease and Nutrition, including participation in developing a statewide obesity plan and sponsoring Women's Health Week to promote healthy lifestyles. Promoting Lifetime Activity for Youth, or PLAY, promotes 60 minutes of daily independent physical activity in 4th through 8th grade.

## PRIORITY 3: REDUCE PREVENTABLE INFANT MORTALITY

Although infant mortality in Arizona has declined, disparities remain in the rates of death among various subgroups of the population. African American, American Indian, and Hispanic infants die at higher rates than White infants, as do infants born to less educated women and teens. While not all infant mortality can be prevented, disparities suggest that interventions directed at excess mortality within high-risk populations provide an opportunity for further progress.

The Office of Women's and Children's Health used the CDC Periods of Risk Model to analyze infant and fetal deaths in Arizona. Excess deaths were analyzed to estimate the proportion of infant deaths that were preventable, and to associate deaths with periods of risk in order to effectively target interventions within high-risk populations. Resources will be directed towards preconception and maternal health. Good nutrition, physical activity, and reducing risk behaviors such as smoking and alcohol use will be promoted for all women of childbearing age. Because a high proportion of deaths were associated with the postneonatal period (after the first month of life through the first year), interventions will emphasize promoting breastfeeding, proper sleep positions, preventing and diagnosing infection and injury, recognition of birth defects and developmental abnormalities, and prevention of sudden infant death syndrome.

/2007/ OWCH is developing a preconception health initiative and is piloting an educational project with the Black Nurses Association. //2007//

***/2009/ The Bureau of Women's & Children's Health is integrating preconception health into existing programs. //2009//***

#### PRIORITY 4: REDUCE THE RATE OF INJURIES, BOTH INTENTIONAL AND UNINTENTIONAL

For many years, Arizona's injury mortality has exceeded national rates. Injuries, both intentional and unintentional, are among the leading causes of death among children of all ages and women of childbearing years in Arizona. In addition, nonfatal injuries account for a high volume of both inpatient hospitalizations and emergency outpatient visits. The impact of injuries is felt by more than the just the person who is injured. Injuries also affect families, schools and employers. The Arizona Department of Health Services has developed a state injury surveillance and prevention plan.

OWCH has been designated as the agency lead for injury prevention. A new CDC grant was awarded to the office, which will fund a full-time injury epidemiologist and half-time administrative assistant to focus on injury. A statewide injury plan will be updated by the end of December, 2005. In addition, community grants focus on preventing motor vehicle crashes, and other programs will contribute to the reduction of both intentional and unintentional injury (e.g., Safe Kids, Domestic Violence and Rape Education, Child Care Consultation, and participation on the State Agency Coordination Team).

/2007/ The Rural Safe Home Network funds programs to provide temporary, emergency safe shelter and related services to victims of domestic violence.

The Rape Prevention and Education program supports communication, coordination, and collaboration among contractors and with other organizations involved in rape prevention and sexual assault services. Contractors use a variety of methods to convey rape prevention messages including classroom presentations, peer mentoring/education, teen theater productions, long-term/on-going interaction with at-risk youth, workshops and trainings, social marketing, and student coalitions.

The Child Fatality Review Program coordinates the activities of 13 local teams comprised of volunteers with roots in their communities. Team compositions reflect the diversity of the populations they serve.

OWCH is working with Prevent Child Abuse Arizona to conduct a statewide Never Shake a Baby initiative. //2007//

/2008/ BWCH hosts an annual injury prevention symposium. The 2006 symposium was focused on policy, and the focus for ***/2009/ 2007 //2009//*** is burden of injuries on businesses. The Injury prevention program is organizing a challenge among high schools to improve seat belt usage. //2008//

***/2009/ The Sexual Violence Prevention & Education Program launched a strategic planning process to develop a statewide sexual violence prevention plan. //2009//***

#### PRIORITY 5: INCREASE ACCESS TO PRENATAL CARE AMONG MEDICALLY UNDERSERVED WOMEN

Prenatal care is an opportunity to identify risks and mitigate their impact on pregnancy outcomes through medical management. Prenatal visits also offer an opportunity for education and

counseling on proper nutrition and risk factors, such as smoking and alcohol use during pregnancy. Prenatal care is more effective when women enter care early in their pregnancy.

Although there has been an upward trend in the proportion of women receiving prenatal care in their first trimester of pregnancy, Arizona continues to lag behind the rest of the nation. The proportion of women who enter prenatal care early in their pregnancies varies in Arizona by race, ethnicity, education, source of payment for delivery, and geographically. Recommendations at each public meeting were made to increase funding to the Health Start Program, which is a program to identify women early in their pregnancies and get them into prenatal care.

In addition to the Health Start Program, OWCH facilitates entry into prenatal care through its Pregnancy and Breastfeeding Hotlines. OWCH is also participating in the revitalization of Baby Arizona, which is a presumptive eligibility program to encourage physicians to serve pregnant women before their eligibility is confirmed.

*/2007/ The Office of Women's and Children's Health will be geo-mapping Baby Arizona Providers over the Arizona medically underserved areas to identify areas lacking providers. The Health Start Program identifies women early in their pregnancies, facilitates their entry into prenatal care, and supports families throughout the pregnancy and the postpartum period. The program identifies natural community leaders and recruits them as lay health workers who live in and reflect the ethnic and cultural characteristics of their communities. //2007//*

***/2009/ The Bureau of Women's & Children's Health is working with the state Medicaid agency, AHCCCS, and the March of Dimes to enhance promotion of Baby Arizona, the presumptive eligibility program that facilitates pregnant women receiving access to prenatal care prior to the Medicaid application being finalized. //2009//***

#### PRIORITY 6: IMPROVE THE ORAL HEALTH OF CHILDREN, ESPECIALLY AMONG HIGH RISK POPULATIONS

United States Surgeon General David Satcher dubbed dental disease the "silent epidemic," yet it is preventable with early intervention and the promotion of evidence-based prevention efforts like dental sealants. In an effort to improve the health and well being of children, it is imperative that interventions be targeted at preventing dental disease, especially in high-risk children. Concern about oral health was expressed at each public meeting. In fact, oral health was identified as the number one issue for one of the Indian Tribes, according to a review of medical records.

Title V Block Grant funds support the Office of Oral Health in providing sealants, exams, and referrals to high-risk children, as well as the fluoride mouth rinse program. Title V funds also support continuing education courses to WIC educators and other community health providers and Office of Oral Health efforts in working with medical professionals on early recognition, prevention, and referral for dental needs.

*/2007/The Office of Oral Health (OOH) identified communities with below optimal levels of water with fluoride and offered a school based fluoride mouth rinse program. 21,448 children received intervention. OOH provided a conference to targeted communities on water fluoridation//2007//.*

***/2009/ The Bureau of Health Systems Development and Oral Health provides an evidence-based sealant program that is expanding to 9 counties with an emphasis on increasing student participation as well as numbers of participating schools. //2009//***

#### PRIORITY 7: INTEGRATE MENTAL HEALTH WITH GENERAL HEALTH CARE

Widespread concern was expressed at every public input meeting about the need to integrate mental and physical health care. Mental and behavioral health screening of women and children in general, and for postpartum depression in particular were consistent themes. It is important for

primary care providers to be aware of both screening and treatment options.

An initial meeting was held between OWCH and the ADHS Behavioral Health Division to talk about strategies to educate providers on screening and referral for mental and behavioral health issues for both women and children. OWCH provides funds for developmental care in hospitals and participates in an infant mental health interagency work group and in the formation of a new postpartum depression group. OWCH is also supporting an integrated services model grant to integrate mental and physical health screening and services.

/2007/ The Office of Women's and Children's Health continued collaborative efforts with Mountain Park Health Center on the Physical and Behavioral Health Integration Project, which is a planning grant to develop a model to integrate behavioral health care with pediatric care.

OWCH will partner with ADHS Division of Behavioral Health to promote maternal and child mental health, behavioral health, drug and alcohol use screening; promote mental health and behavioral health screening among OWCH partners; increase awareness among partners and the community about mental and behavioral health issues; identify and partner with agencies and organizations involved in maternal and child mental/behavioral health issues. //2007//.

/2008/ In 2006, the BWCH High Risk Perinatal Program began requiring community nurses to conduct post partum depression screening at early home visits. BWCH is working with the Division of Behavioral Health to provide training to MCH programs about the behavioral health system. HRSA conducted a strategic partnership session among the major Arizona HRSA grantees in 2007. The session has resulted in a new collaboration among the grantees regarding the integration of behavioral health. The grantees identified behavioral health as an issue all were concerned about and interested in working on together. //2008//.

***/2009/ BWCH was awarded funding through Northrup Grumman to integrate screening for alcohol use into an existing MCH program, Health Start. The program is using an evidence-based screening tool among pregnant women, providing brief intervention, and making referrals for treatment. //2009//***

#### C/YSHCN PRIORITIES

The data gathered from numerous sources pointed to the fact that C/YSHCN and their families have many unmet or partially met needs. These needs were for specific services and for system changes to allow better access to services. However, there were also more ephemeral needs such as the need to have a provider understand the culture of the family, to speak the language of the family, and to engage the family as a partner in the decision making process. Not all of the needs delineated by the survey data, the focus groups, and other information are incorporated into the priority needs. Many of the needs for specific services will be addressed through the Specialty Care subcommittee of the Integrated Services grant and still other issues will be part of the office's strategic plan for 2005-2010.

The determination of the priority needs for Arizona's C/YSHCN was achieved through a group consensus of the Needs Assessment Planning Group after reviewing the data from the NSCSHCN, the focus groups, and the provider community. While they all agreed there were many specific service and coordination needs, there was very little OCSHCN could do to directly impact those needs. The group decided to address the needs from more of a systems approach that would focus interventions on education of providers as well as the families of C/YSHCN. The following three statements of need are the result of that consensus.

**PRIORITY 8: INCREASE THE ACCESSIBILITY AND AVAILABILITY OF INDIVIDUALIZED HEALTH AND WELLNESS RESOURCES FOR CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS IN ARIZONA.**

PRIORITY 9: INCREASE THE AVAILABILITY OF A COHESIVE AND STABLE CONTINUUM OF RESOURCES WITHIN A MEDICAL HOME THAT INCLUDES AN IMPROVED QUALITY OF LIFE APPROACH.

PRIORITY 10: INCREASE THE RECOGNITION OF FAMILIES AS INTEGRAL PARTNERS IN THE CARE OF THEIR CHILD'S HEALTH AND WELLBEING. ***/2009/This priority is tracked using data from NPM #2./2009//***

The priorities outlined above will be reflected in the Title V agency's strategic plans and block grant applications over the next five years. Progress will be tracked using a combination of national performance measures, which are required by all states, and new state-defined measures, which reflect Arizona priorities. Details on newly defined state performance measures can be found in the 2006 Title V Block Grant Application accompanying this needs assessment. Subsequent applications will report on the actual measures and discuss accomplishments, activities and plans related to them.

*/2008/*

Because of the identified need to clarify systems of care and facilitate linking children and youth with appropriate services, OCSHCN is refocusing two of its priorities.

**NEW PRIORITY 8: EDUCATE FAMILIES, PROVIDERS, AND CHILD-SERVING AGENCIES ON ELIGIBILITY RULES AND PROCESSES FOR ACCESSING SERVICES.**

OCSHCN will target education efforts within its own agency by training OWCH Hotline staff, Neonatal Intensive Care Program staff and Community Nursing staff on eligibility rules and coverage of programs within OCSHCN and other agencies. OCSHCN will also develop resources to train AHCCCS and other providers, hospital discharge planners, families, and eligibility workers within other agencies. The OCSHCN website and e-learning system will be expanded to include trainings on navigating the systems of care for CSHCN.

**NEW PRIORITY #9: INCREASE ACCESS TO AVAILABLE AND APPROPRIATE SERVICES FOR CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS.**

Through the SSDI grant, BWCH and OCSHCN are defining processes to identify newborns who test positive through the state's Newborn Screening Program and refer them to appropriate staff within both offices and facilitate their enrollment into programs for care coordination and direct medical services.

To track progress on new priorities 8 and 9, BWCH and OCSHCN are collaborating to define a new state performance measure, which will track the percent of children identified through the newborn screening process who receive services through an BWCH or OCSHCN program.

*//2008//*

***/2009/BWCH and OCSHCN did not develop a process through the SSDI Initiative to link newborn screening data to the CRS database first because of the inability to identify a qualified job applicant for the SSDI epidemiologist position and later due to a statewide hiring freeze. OCSHCN developed SPM #8 to measure priorities 8 and 9./2009//***

## **C. National Performance Measures**

**Performance Measure 01:** *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	69	75	80	79	85
Denominator	69	75	80	79	85
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	100	100	100	100	100

**a. Last Year's Accomplishments**

Cystic Fibrosis was added to the Arizona Newborn Screening panel in October 2007.

Education about the disorders screened in newborns was developed and provided to healthcare providers, hospitals, parents, and the general public. A new website, [www.aznewborn.com](http://www.aznewborn.com) was developed. It provides information for provider, parents, and the general public. Brochures were revised and distribution tracking improvements made.

The Newborn Screening Program reported 101,977 initial bloodspot screens and 89,346 second screens in 2007. Of those screened, 98 were diagnosed with clinically significant disorders, including 51 cases of primary congenital hypothyroidism; 7 cases of salt-wasting congenital adrenal hyperplasia (CAH); 3 cases of phenylketonuria (PKU); 1 case of biotinidase deficiency; 10 cases of sickle cell anemia, 1 case of Hemoglobin SC and 2 cases of Beta-Thalassemia disease; and 4 cases of cystic fibrosis. These numbers were within the expected range for Arizona's population. The Newborn Screening Program located 100% of affected infants who had screen results suggestive of target diseases. Of those who remained residents of Arizona after birth, all received needed services and accessed needed services within the timeframe determined as optimal by Arizona Department of Health Services Newborn Screening Program. Of those who resided out of state immediately following birth, 100% were notified of need for further services.

The Bureau of Women's and Children's Health (BWCH) referred 11 newborns with positive tests to the Office for Children with Special Health Care Needs' (OCSHCNs) Sickle Cell Program. OCSHCN provided all 11 with further testing, service coordination, information on genetic services, and made follow up calls to assist families with services and referred to Title XIX. The Sickle Cell Program was integrated with the BWCH Newborn Screening Program (NBS) to facilitate coordination between Sickle Cell and other conditions identified by NBS.

The Medical Director provided consultation and technical assistance to all Title V programs that requested assistance and collaborated with several programs, especially the Newborn Screening Program (NBS).

Community Health Nurses (CHN) continued to educate families about the need for a second newborn screen and facilitated referrals to the medical home. To ensure that families understood the importance of the screens, the program ensured that bilingual CHN staff were available.

The Arizona Midwife Licensing Program provided information to all midwives about accessing resources for NBS, especially hearing.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Educate families about the importance of a second newborn screen and facilitate referrals to a medical home.			X	
2. Incorporate cultural sensitivity into the explanation of need for screening and a medical home.				X
3. Refer community members to ADHS for help in obtaining hearing screenings for infants born at home in AZ.			X	
4. Provide follow up services to newborns identified by screening to possibly have disease.			X	
5. Provide education on newly screened disorders to providers, parents, and public.			X	
6. Increase number of staff performing newborn screening case management.				X
7.				
8.				
9.				
10.				

**b. Current Activities**

Through education and continuous feedback to submitters, reduce the number of unsatisfactory newborn screen specimens received.

Determine the predictive values of all newborn screen analytes in order to plan program changes to improve testing specificity.

Secure contractor for lab services per state law to issue a Request for Proposal for these services.

BWCH and OCSHCN work together to identify children who may be eligible for CRS, AzEIP (Arizona Early Intervention Program), and Family Resource Coordination Program (FRCP).

The Medical Director continues to provide consultation and technical assistance to programs upon request (especially the NBS program) apart from acting as a liaison with the medical community. The position also provides technical assistance to facilitate easier access to information relating to NBS to the medical community for efficient and effective follow-ups by the program.

CHN staff continued educating enrolled participants about the importance of second screens and facilitating access to the NBS program.

The Midwife Licensing Program analyzed the opportunities for midwifery community for hearing screening for infants born in the home environment in order to provide information to the midwives about where to obtain the screening information. The program continued to reinforce community education, which included Cord blood pamphlets and hearing screening data apart from informing the midwifery community regarding screening requirements.

**c. Plan for the Coming Year**

Through education and continuous feedback to submitters, continue to reduce the number of unsatisfactory newborn screen specimens received.

Refine the positive and negative predictive values of all newborn screen analytes in order to plan

program changes to improve testing specificity.

Enhance staffing of follow-up through hiring of all vacancies.

Create web-based results retrieval site for providers.

OCSHCN will continue to work with BWCH to identify children who may be eligible for CRS, AzEIP and FRCP.

The Medical Director will continue to provide consultation, technical assistance and identify any bottlenecks in the medical community that can potentially impact the NBS program.

CHN staff will continue to educate families about the need for a second newborn screen and facilitate referrals to the medical home for those screens using culturally appropriate strategies.

The Midwife Licensing Program is in the process of revising the rules to report data in the quarterly reports that relate to hearing screenings for the newborn infants. It will continue to educate the midwifery community about the newborn screening requirements

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	52	53	54	55	56
Annual Indicator	51.4	51.4	51.4	51.4	53.6
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	54	55	56	57	58

**Notes - 2007**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

**Notes - 2005**

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

**a. Last Year's Accomplishments**

From its inception in 1992, OCSHCN has gone beyond MCHB requirements for family involvement by infusing family and youth partnerships throughout its business. In 2007, 55 parents and youth were paid to participate on activities such as reviewing RFPs, developing and reviewing curriculum, presentations, policies and procedures, facilitating meetings, website development and review, and new staff orientation. Family focus group results requesting more access to community based services were incorporated into the CRS RFP. All OCSHCN contracts and the Integrated Services Grant incorporated requirements for family and youth involvement. OCSHCN employs parents of CYSHCN on staff and has a paid parent representative who works in the office one day a week. The parent-staff member participated in staff meetings and promoted the benefits of family centered care principles in her interactions with staff.

OCSHCN supported 13 parent-led community action teams representing 50 communities that developed family-focused, home and community based services such as Action Partnership's Asperger Support Group, Kingman Area Partnership for Children with Special Needs TBI and fetal alcohol syndrome support groups, and Chino Area Partnership's summer library program. Over 900 attended the Hopi Turtle Nation Partnership's Annual Special Needs Day. Six parent-led community action teams established non-profit status as they moved toward becoming self-sustaining organizations.

OCSHCN contracted with Raising Special Kids Family-to-Family Health Information Center (RSK-F2FHIC) to provide training on family centered care to health and dental providers, and to coordinate resident-in-training home visits to help future physicians understand the strengths and needs of families caring for a child with special health care needs. RSK provided support and training for NICU parents, identified family partners for OCSHCN activities, and developed e-learning curricula.

Conducted in English and Spanish, the 2008 CRS Family Satisfaction Survey asked several questions related to decision making. 92% reported usually or always being offered choices about their child's health care. 90% reported usually or always being asked to tell the health care provider what choice they prefer. 99% said they were usually or always involved as much as they wanted when decisions were made, significantly higher than the reported 90% in 2007. Care was rated at a 9.2 on a 10-point scale, with 10 being the highest rating. Families generally felt they were well informed and involved in decision making. 80% reported that clinic staff listens carefully to them and 87% reported that clinic staff always explained things to them in a way they could understand. Of the 32% of respondents that needed an interpreter, 92% reported always receiving translation services when requested. 80% agreed or strongly agreed that staff respected their religious or spiritual beliefs. 81% agreed or strongly agreed that the staff was sensitive to their cultural/ethnic background, significantly higher than in 2007.

The CRS Family Satisfaction Survey also revealed that families were highly satisfied with their services. 92% of respondents gave their child's specialist a score of 8 or higher out of a possible 10. The average rating on a scale from 0 to 10, with 10 being the best specialist possible, was 9.2. Several survey items asked about the way that children and their families were treated by clinic staff, 90% of respondents said they were always treated with courtesy and respect, and 82% felt that the clinic staff was always as helpful as they should be. 86% said that doctors or other health providers always showed respect for what they had to say, 84% said that doctors and other providers always made it easy to discuss their questions and concerns, and 83% said that they always had their questions answered by their provider. 89% of the families receiving care via the CRS telemedicine system rated the telemedicine visit as very good or excellent.

OCSHCN's Family Resource Coordination Program (FRC) provided service coordination for 461 CYSHCN. All families participated in developing Individual Service Plans (ISP's) based on family needs. Families of all 537 children served by ADHS/AzEIP had documentation in their record of direct input in the development of ISP's.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. OCSHCN contracts require family and young adult involvement				X
2. Families and young adults partner in developing resources; such as curriculum, member handbooks, fact sheets, web pages to ensure that they are family-friendly, ADA compliant and culturally competent				X
3. Families and young adult partners serve on OCSHCN committees and task forces				X
4. OCSHCN uses results from the FRC Family Satisfaction Survey CRS Family Satisfaction, Telemedicine and DME surveys to measure how satisfied families are with accessing and using community based services		X		X
5. OCSHCN and other ADHS offices promote and support contracting for family, young adult and consumer partner involvement in all levels of decision making		X		
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

All OCSHCN contracts incorporate requirements for family and youth involvement. Families and youth partner in developing resources such as curriculum, website, handbooks, fact sheets, and brochures to ensure materials are family friendly, culturally competent and ADA compliant. A parent whose children have used multiple systems for CYSHCN works in the office part time to provide a family perspective. Families and youth serve on task forces and committees and are reimbursed for time, travel and accommodations. Parents are on State and Local Parent Action Councils, participate in CRS quarterly administrator and medical director meetings, and on the Quality Management Committee.

The Community Development Initiative has grown to involve parents and youth partners outside of the CYSHCN population. The CDI has a subcommittee made up of parents and agency representatives from several different agencies, who are developing a template for RFP language that can be used by agencies to develop partnerships with youth and families.

Family satisfaction and telemedicine surveys are used to identify strengths and weaknesses in family decision making in CRS and to look for opportunities to improve program design. OCSHCN requires contractors to ensure translation is available if needed, and that forms are available and meetings are conducted in the family's primary language. Families are encouraged to participate and the program supports them in acquiring advocacy skills.

**c. Plan for the Coming Year**

OCSHCN will continue to recruit families and youth for leadership development training, require contractors to include parent and youth leaders on boards and committees, and develop strategies to involve families and youth in all levels of decision-making. OCSHCN will continue to encourage other agencies and offices to include family and youth as decision makers, include family and youth partnership in contracts, and encourage developing mechanisms to reimburse or support parents and youth for their time, leadership, travel and accommodations. CRS will continue to increase participation of parents as decision makers through committees and State

and Local Parent Action Councils.

OCSHCN and BWCH will partner with ADHS Behavioral Health Services to integrate family and youth partners into all levels of decision making. An agency wide RFP will be written to contract with agencies that have better capacity to recruit, train, and support parent and youth partners. Outside agencies will provide reimbursement mechanisms that are less costly and cumbersome to manage than what is required by State agencies. Timely or advance reimbursement will increase the likelihood that a broad range of families reflective of the diversity of Arizona's population will be able to travel to participate in activities. OCSHCN will continue to provide technical assistance on family and youth involvement when requested.

OCSHCN will work with families to develop curricula that promote families as key partners in all levels of decision-making. Presentations will be provided to other agencies, AHCCCS health plans, NICU staff and families, medical residents, physicians, dental students, BWCH Hot Line staff, ADHS licensure, and new OCSHCN staff. E-learning modules on family centered care coordination and an OCSHCN overview will be developed. OCSHCN will work with RSK-F2FHIC to develop e-learning modules to train families on how to navigate the system of care for special health care needs. OCSHCN will also work with RSK-F2FHIC to revamp parent youth leadership training modules to meet training needs for RSK's volunteers. OCSHCN's paid parent advocate will assist with the curriculum review and rewrite. Opportunities will be explored with Raising Special Kids to develop English and Spanish language outreach materials.

OCSHCN will continue with annual family satisfaction surveys. The CRS survey will continue to ask parents to rate satisfaction with involvement in decision-making, choices, and satisfaction with services. The telemedicine program will continue to survey parents to evaluate satisfaction with the telemedicine system. The FRC Program will develop a family-satisfaction survey. Parents and youth will be invited to participate in focus groups held around the state to gather information for the 2010 needs assessment.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	50.5	51	51.5	52	52.5
Annual Indicator	50.5	50.5	50.5	50.5	40.4
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	41	41	42	42	43

**Notes - 2007**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

**Notes - 2005**

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

**a. Last Year's Accomplishments**

Through the Integrated Services Grant (ISG) Medical Home Project four sites were established to participate in a Care Coordination Project. The sites included Chino Valley, Verde Valley, the Hopi Reservation, and the Phoenix CRS Sickle Cell Program. OCSHCN community teams served as contract managers for the care coordinators in each site. The OCSHCN Medical Home Program Manager developed care coordinator job descriptions, provided training, technical support, assisted with communication, and participated in medical home community meetings.

OCSHCN compiled and revised existing documents to develop the Arizona Medical Home Project Care Coordination Manual for use by medical home sites and community action teams. The manual has information to help a medical home site develop an efficient, streamlined, organized, care coordination process. Materials include contacts for state-funded resources, intake forms, instructions on how to complete prescriptions for items commonly used by CYSHCN, guidelines on obtaining durable medical equipment, templates for letters of medical necessity and handouts for local and national resources. The manual was distributed and training was provided to physicians, care coordinators, community action team parent leaders, BWCH, Family Resource Coordination Program contractors, Chiricahua Community Health Center, New Hampshire Title V Program, and OCSHCN's Family Resource Coordination Program (FRC) contractors. The manual was also presented at the 2007 Annual New Freedom Initiative State Implementation grantee meeting.

OCSHCN has integrated the medical home concept into training, presentations, published materials and new staff orientation. Medical home language was integrated into all of OCSHCN's RFPs. Although the Children's Rehabilitative Services Program (CRS) serves a small proportion of Arizona's CYSHCN, the program provides an opportunity to reach the larger population of CYSHCN through provider networks that include most of the pediatric specialty providers. Promotion of best practices, including medical home, required by CRS contracts, reached beyond CRS membership to the larger population of CYSHCN. Administrative site reviews monitored OCSHCN contractors' medical home implementation plans. All 461 children and youth in the OCSHCN FRC Program identified, during the intake process, as having a medical home.

OCSHCN promotes medical home concepts with other ADHS offices, other agencies and community partners. Raising Special Kids has integrated the medical home concept into their resident physician training materials and have offered OCSHCN care coordination resources to residents-in-training. The Arizona Medical Home Project Care Coordination Manual has been provided to the BWCH Community Nursing Program. The 2006 Arizona School Nurse Resource Survey Summary identified that school nurses play an important role in family centered care. OCSHCN partners on an ongoing basis with school nurse organizations and partnered with a local hospital to host 320 school nurses in an annual school nurses conference where best practices, including medical home for CYSHCN, were taught.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. OCSHCN requires contractors to collaborate with primary care physicians		X		X
2. OCSHCN integrates the medical home concepts into training,				X

presentations, published materials and new staff orientation				
3. Medical home language is integrated into OCSHCN's RFP's				X
4. OCSHCN promotes medical home concepts with other ADHS offices, other agencies, and community partners				X
5. The Medical Home Care Coordination manual is available for distribution		X		
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

OCSHCN requires all contractors to collaborate and coordinate with primary care physicians (PCP) and other providers to ensure continuity of care. CRS provides an integrated medical record and care in multi-specialty, interdisciplinary, family-centered clinics. Before a member transitions out of CRS, contractors must identify an adult PCP.

OCSHCN integrates the medical home concept into trainings, presentations, published materials and new staff orientation. Medical home language is integrated into all of OCSHCN's RFPs. OCSHCN promotes medical home concepts with other ADHS offices, other agencies and community partners. The Medical Home Care Coordination Manual continues to be available for distribution to community partners and other ADHS offices, and is required training for FRC contractors serving children in all of Arizona's 15 counties.

OCSHCN acts as a resource to the Mohave County Juvenile Court Children's Action Team on the medical home concept and on accessing services for CYSHCN in the correction system. OCSHCN is an active participant on the Arizona Asthma Coalition's School Health Committee. As a result of OCSHCN's sponsorship of the "Creating Effective and Sustainable Systems for Youth and Families" summit, staff receive and respond to requests for information from parents on how to help their young adult find a medical home as they transition to adult care

**c. Plan for the Coming Year**

A report to the Governor on the Integrated Services Grant (ISG) will include recommendations on how to overcome barriers to implementing medical homes across Arizona. ISG recommendations regarding medical home will also be incorporated into OCSHCN's strategic plan. OCSHCN will offer technical assistance to established medical home sites and provide information to individual medical practices who call to inquire about how to establish a medical home.

OCSHCN will identify ways to expand outreach and increase educational opportunities on medical home for CYSHCN by collaborating with BWCH on their existing programs. These efforts will include working with BWCH through their current prevention education contracts with county health departments to provide resource information to correction staff and to high-risk youth in the juvenile justice system. OCSHCN would also like to reach out to BWCH's Medical Home Project providers to give them information and technical assistance on the MCH Medical Home philosophy.

OCSHCN will explore partnering with organizations such as the Arizona Chapter of the American Academy of Pediatrics to increase the opportunity to distribute the Arizona Medical Home Project Care Coordination Manual to a greater number of physicians. OCSHCN will continue to offer education and training on care coordination and medical home best practices to the Arizona Department of Economic Security as they absorb responsibility for the AzEIP population. Training and resource information supporting the medical home concept, such as the Arizona Medical

Home Project Care Coordination Manual, will be maintained on the OCSHCN website.

OCSHCN will provide training on medical home to school nurses, health educators, health plans, and other child serving agencies. The scope of work for OCSHCN contracts will continue to stipulate that contractors must collaborate with the PCP, the Arizona Long Term Care System, CRS and other providers to facilitate continuity of care and the provision of ongoing services. OCSHCN will monitor contractors for provision of medical home and provide technical assistance.

OCSHCN will continue to partner with the RSK-F2FHIC to develop materials and support medical home activities that empower families to act as their own advocates, develop individual service plans, and connect families to appropriate resources.

SLAITS data will be analyzed through the needs assessment process to identify components of medical home where there are opportunities for improvement. SLAITS data will also be broken down by subgroups, such as age, race/ethnicity, and type of disability, to the degree that it is statistically reliable.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	61	61	61	61	61
Annual Indicator	60.8	60.8	60.8	60.8	58.1
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	59	59	59	59	59

**Notes - 2007**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

**Notes - 2005**

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

**a. Last Year's Accomplishments**

OCSHCN administers the CRS Program, which is a statewide network of inpatient and outpatient services providing medical treatment, rehabilitation, and related support services to Arizona children, birth to 21, who have certain medical, disabling, or potentially disabling conditions. CRS

assures quality comprehensive care through a family-centered, multi-specialty, interdisciplinary team approach in a cost-effective managed care setting. 23,521 children received care through CRS in 2007, representing approximately 11% of CYSHCN in Arizona. These children have conditions that are among the most medically complicated of all CYSHCN.

CRS is funded by a combination of state and federal funds. Families are required to apply for AHCCCS, and contractors assist families with the application process. In 2007, 74% of the members were funded by Title XIX and XXI, and the remaining 26% were funded either by private insurance, self pay or state dollars. According to 2005-2006 SLAITS data, 89.5% of Arizona's CYSHCN had public or private insurance, 88.4% had no gaps in coverage and 88.7% had insurance that usually or always met their child's needs. CRS provides care related to the member's qualifying condition, however the network does not include primary care provider services. Members who are enrolled in AHCCCS have a PCP who delivers primary and preventive care, including EPSDT services. Care related to the member's CRS condition is carved out of the AHCCCS acute-care plans. CRS contractors are required to identify a primary pediatric care provider for all members and an adult care provider for youth aging out of Title XIX services.

OCSHCN has several systems in place to help link families to available services for CYSHCN. OCSHCN developed a letter in collaboration with the ADHS Birth Defects Registry to send to all families of children born with spina bifida and cleft lip/cleft palate to inform them of coverage available through the CRS program. Currently 89 newborns identified with spina bifida or cleft lip/cleft palate are enrolled in CRS. 11 newborns diagnosed with Sickle Cell disorders were referred to the CRS program. 461 children received service through OSCHCN's Family Resource Coordination (FRC) Program. 318 of the children served through FRC had insurance, and 17 children who were without insurance or unable to afford services not covered by their insurance were able to access care through Assistance to Families.

Children and youth with certain rare metabolic disorders must remain on a restricted diet for life. Medical food is very costly, but is the only treatment for the disorders. Neither public nor private insurance covers all of the costs of these foods. CRS pays for formulas for certain disorders, and state funding covers the family copay for medical food for CYSHCN enrolled in CRS. Public insurance covers the cost of enteral feedings as well as oral nutrition supplements when medically necessary. The Bureau of USDA Nutrition Programs has coordinated with WIC and AHCCCS to ensure that CYSHCN are covered in a timely manner and receive medical nutrition therapy as prescribed. The Bureau has also provided training on the approval process with WIC special needs nutritionists and AHCCCS MCH Coordinators. An agreement was made with the formula manufacturer to ship formula directly to members at no cost.

OCSHCN supports the BWCH Children's Information Services Hotline to educate families on AHCCCS and provide other insurance information. Education was provided to staff on services and programs for CYSHCN, including information on CRS eligibility. The SSI project sent 1,987 letters that provided insurance information for families and made referrals to RSK-F2FHIC. Fact sheets were developed on eligibility information and brochures were developed for families with private and public insurance on payer and member responsibility. OCSHCN supported development of brochures that provided education on member rights, responding to denials, how to file grievances and appeals, and how health plans can work together to cover member needs.

The Integrated Services Grant (ISG) Health Benefits subcommittee studied ways to streamline enrollment into ALTCS, CRS, and AHCCCS, and recommended policy and procedure revisions to address barriers to gaining access to care and coverage. The committee also identified a need to require staff training on policy pertaining to eligibility.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service
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	DHC	ES	PBS	IB
1. CRS is revising administrative rules to simplify the eligibility process		X		
2. OCSHCN provides information to families and child serving agencies on eligibility requirements for programs serving children and young adults with special health care needs		X		
3. OCSHCN educates other ADHS offices on services and programs for children and young adults with special health care needs		X		
4. OCSHCN supports development of materials on member rights, responding to denials, filing grievances and appeals and how health plans can cover their healthcare needs.		X		
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

CRS is revising Administrative Rules to simplify the eligibility process. An in-person medical evaluation to verify the presence of a CRS eligible condition is no longer needed if sufficient documentation is provided with the referral. Any child with a qualifying medical condition is eligible for CRS regardless of their financial status. For applicants already enrolled in AHCCCS, only documentation of a CRS eligible medical condition is required, and only applicants seeking state assistance must apply for AHCCCS.

The FRC Program encourages families to apply for health insurance. OCSHCN sends information to SSI applicants, and works with the Birth Defects Registry, AzEIP, High Risk Perinatal program and state school nurse organizations to inform families about CRS eligibility. OCSHCN supports the BWCH Children's Information Services Hotline and provides education to its staff on services and programs for CYSHCN.

OCSHCN supports development of materials on member rights, responding to denials, how to file grievances and appeals, and how health plans can work together to cover their needs. Children who are without insurance or unable to afford services not covered by their insurance can access care through Assistance to Families.

**c. Plan for the Coming Year**

The ISG Health Benefits Committee recommendations on how to streamline eligibility will be submitted as part of a white paper to the Governor from the ISG Task Force. OCSHCN will partner with RSK's F2FHIC grant. OCSHCN will work with RSK to evaluate how CYSHCN are identified within private insurance companies and how services are coordinated. The project will be implemented in partnership with communities and other state agencies to coordinate financing of services. OCSHCN will work with the RSK-F2FHIC to convert their Arizona Health Care Systems Workshop into an on-line interactive class available to families and providers.

OCSHCN will continue to require that contractors assist families in applying for private and public health insurance. OCSHCN will continue to encourage families to apply for AHCCCS and answer general question about the process. OCSHCN will continue to partner with RSK-F2FHIC and BWCH Community Nursing to help families gain access to providers and services. CRS contractors will continue to be required to identify a primary care provider for youth transitioning out of CRS services. OCSHCN will expand services for CRS members to include all medically necessary services related to their CRS eligible condition. The new RFP will require more

services to be community-based, making care more accessible.

OCSHCN will continue to develop resources and offer training and education to providers, families and community partners on public and private health insurance options for CYSHCN. OCSHCN will explore developing, educating and recruiting businesses to participate in training for families on how to evaluate health care plans for CYSHCN. OCSHCN will continue to link children to services, review SSI applications, provide referral information to applicants and track and trend referral outcomes related to disability, age, geographical area and referral sources. OCSHCN will continue to use telephone call log information to track barriers that families identify in gaining access to adequate health insurance. This information will be shared with responsible agencies.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	71	72	73	74	75
Annual Indicator	70.9	70.9	70.9	70.9	86.5
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	87	87	88	88	89

**Notes - 2007**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

**Notes - 2005**

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

**a. Last Year's Accomplishments**

The OCSHCN Community Development Program supported 13 community teams across the state. Four teams sponsored medical home sites funded by the Integrated Services Grant and provided care coordination and training to four practices and families they serve. OCSHCN helped identify resources and provided technical assistance to teams and parent leaders as they move to self-sustaining organizations with a focus on their individual community needs beyond just CYSHCN.

CRS served over 23,521 children in multi-specialty interdisciplinary clinics. The 2008 Family

Satisfaction Survey included questions about the ease of using services. 82% reported it was not a problem to see a specialist when needed. Of the respondents calling the clinic during regular hours, 80% reported usually or always getting the help or advice they needed. 81% always received specific information from their child's provider when needed. When urgent care was needed, 89% reported being satisfied or very satisfied with how long it took to get care. 75% were able to get an appointment within 45 days, higher than the 63% reported in 2007. 88.5% reported that they usually waited 45 minutes or less before being taken to the exam room. An RFP for a new contracting cycle for CRS was released requiring service to be more accessible in local communities, and will include access to visits in local physician's offices, and community-based therapies, pharmacy, and labs.

The CRS telemedicine family satisfaction survey reported families saved an average of \$205.25 per visit. Each telemedicine visit saved families from traveling an average of 109 miles and from missing an average of 10 work hours to receive specialty care that was unavailable in their communities. 89% of families rated telemedicine visits as very good or excellent. Families spent an average of \$20 to travel 15.5 miles to the telemedicine site. Without telemedicine, providers would have had to travel an average of 300 miles to see a patient, and seven providers said they would not have been able to see the patient at all.

OCSHCN worked with RSK-F2FHIC and BWCH Community Nursing to provide resource information to families identified as having a special need. OCSHCN School Health co-sponsored Banner Children's Hospital's annual school nurse conference attended by 365 nurses and focused on best practices. OCSHCN participated in a work group with school nurses, parents, advocates and legislators on the role of school nurses.

OCSHCN responded to over 600 family calls and directed families to services within their community. OCSHCN Family Resource Coordination (FRC) program added contract requirements to ensure that FRC assist families in obtaining services and navigating the systems of care.

AzeIP has transitioned to the Arizona Department of Economic Security (DES), the lead agency for Part C of the Individuals with Disabilities Act (IDEA). The IDEA annual report for 2006 states 95% of families participating in AzeIP believe early intervention services helped their children develop and learn. OCSHCN will continue as a liaison for AzeIP.

OCSHCN practices, policies, and training stress the need for providers to recognize the cultural, racial, ethnic, geographic, social, spiritual, economic diversity and individuality of families. OCSHCN requires contractors to engage families as partners in decision making, including requiring translation services to be available. Education was provided to contractors, providers, and families. OCSHCN staff and contractors complete an annual cultural competence self-assessment.

46 modules of training are offered on-line. The family/youth leadership modules have English and Spanish split screens. OCSHCN's parent advocate worked with RSK-F2FHIC to update the e-learning module, Navigating the System, as changes within the system of care occurred. As of February, RSK-F2FHIC provided Family Centered Care training to 50 medical residents, 38 nursing students, 59 NICU staff and families and provided outreach to 250 nurses at the Arizona School Nurses Conference. RSK-F2FHIC's residency training program focused on family centered care practices and promoted family home visits. 9 faculty families hosted a resident, 8 CYSHCN participated to provide their perspective.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CRS requires pediatric subspecialists be accessible to all		X		X

members via a statewide network of multispecialty, interdisciplinary clinics.				
2. OCSHCN provides education to contractors, families, providers and child serving agencies on eligibility rules and processes to access services		X		X
3. OCSHCN uses results from the FRC Family Satisfaction Survey, CRS Family Satisfaction, Telemedicine and DME surveys to measure how satisfied families are with accessing and using community-based services		X		X
4. OCSHCN partners with community agencies and organizations to provide information about community-based services for children and young adults with special health care needs		X		X
5. OCSHCN and other ADHS offices promote and support contracting for family, young adult and consumer partner involvement in all levels of decision making		X		
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The CRS RFP will require that pediatric subspecialists be accessible to all members via a statewide network of providers in multi-specialty interdisciplinary clinics as well as in community based facilities. Innovative delivery strategies and technology increase members' options for choice and enhance service coordination.

OCSHCN collaborates with BWCH to provide resource information to Community Nursing on children ineligible for other care and at risk for developmental delay, supports the CIS Hotline, and educates staff on available services. OCSHCN trains BWCH hotline staff to help callers access systems of care. Family Resource Coordination (FRC) educates contractors, families, providers, and child-serving agencies on eligibility rules and processes to access service. OCSHCN responds to family calls and refers families to community-based services.

Due to complaints from AZEIP and FRC contractors about providers being slow to authorize services, contractors now send monthly reports identifying providers delaying authorization, which OCSHCN submits to AHCCCS. This system of identification and notification is improving timeliness of service and is now replicated at DES.

OCSHCN sits on the AZEIP Interagency Coordinating Council, participates in committee activities, acts as a liaison to AZEIP and provides information to agencies on CYSHCN. OCSHCN participates on Banner Children's Hospital 2008 School Nurse Conference planning committee to include information on CYSHCN.

**c. Plan for the Coming Year**

CRSA will evaluate the capacity of the new statewide contractor as the RFP is implemented. OCSHCN will provide training, monitor utilization rates, provider network capacity and timeliness of appointments, and provide technical assistance to ensure the care needs of CYSHCN are met. OCSHCN will educate CRS providers, staff and pediatric subspecialists on best practices by introducing these concepts into clinics where they practice. The same subspecialists also serve the larger population of CYSHCN. Consequently, OCSHCN will be able to influence the care of CYSHCN beyond the CRS Program.

OCSHCN will promote best practices with partners and contractors, will provide training on navigating systems of care, continue to educate contractors to recognize families as integral partners, and conduct consumer satisfaction surveys to identify strengths, barriers and strategies for improving services and increasing access to resources. School Health will explore ways to strengthen and promote relationships between school nurses and families.

OCSHCN and RSK-F2FHIC will partner with BWCH Community Nursing to develop a statewide program to support families of babies in the NICU after they leave the hospital. OCSHCN and RSK-F2FHIC will work with the NICU advisory group to develop resources that help families identify needs and access programs and services and will connect families to RSK's parent to parent support.

OCSHCN will educate the Mohave County Juvenile Court Children's Action Team on the medical home concept and accessing services for CYSHCN who are in the correction system. OCSHCN will work with other ADHS offices to identify resources for families regarding child care. OCSHCN will continue to track and trend issues regarding accessing services identified by families receiving SSI letters. OCSHCN will identify opportunities to educate health plans, state agencies and community programs on eligibility for OCSHCN programs.

OCSHCN and other ADHS offices will collaborate to develop an RFP to establish a funding mechanism for family, youth and consumer involvement in ADHS programs. The RFP will create a coordinated agency-wide model of involvement that allows ADHS to maximize resources and eliminate duplication of effort. OCSHCN will actively participate with contract awardees to represent the needs of CYSHCN and provide education on best practices.

OCSHCN will expand the definition of community-based service systems to reach beyond services provided in a geographic area to include services provided to a specific population or constituency. This expanded approach will allow OCSHCN to examine the capacity and ease of use of services provided to the non-English language speaking community, to rural and frontier communities, to low-income families, blended families, and families of CYSHCN with behavioral health issues.

BWCH will work with AHCCCS and the March of Dimes to conduct new promotion of Baby Arizona and outreach to potential Baby Arizona providers.

**Performance Measure 06:** *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	6	6	6	6	6
Annual Indicator	5.8	5.8	5.8	5.8	39.4
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	39	40	41	42	43

**Notes - 2007**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

**Notes - 2005**

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

**a. Last Year's Accomplishments**

Since 2002, OCSHCN has infused youth partnership throughout its business, including youth as decision-makers on committees from the start of any new project or program. Over the past three years, contracts and policies and procedures for all OCSHCN programs were revised to require youth involvement, and these have been implemented across all programs. Several youth leaders have become employed by state and community organizations, and continue to partner with OCSHCN in their new roles. 102 youth in the Family Resource Coordination (FRC) Program received services necessary to make transitions to adult life.

Over the past three years, a total of 31 youth were paid for their expertise on RFP review teams, and to review contract language, help with conference planning, and to develop and improve resources, including curriculum, website, member handbooks, fact sheets and brochures. Youth also reviewed web pages and other materials for ADA compliance. Participating youth were reimbursed for their time and travel, and attendant care and ADA accommodations were provided when requested. OCSHCN partnered with Arizona Department of Education's (ADE) Arizona Transition Leadership Team and planned the ADE Transition Conference to include a Medical/Social Empowerment track to the 2007 conference.

The ISG Adolescent Health Community Advisory Committee promoted the implementation of Get Healthy: Improving Adolescent Access to Appropriate Health Care Plan and the use of a health risk appraisal by primary health care providers working with adolescents and promoting coordination of services through a medical home.

The Committee recommended that: 1) all health plans require providers to use an adolescent health risk screening tool or a systematic method of interviewing patients; 2) all providers use an adolescent health risk screening tool or systematic method of interviewing; and 3) the committee seek funding to develop and maintain a comprehensive adolescent health website that includes health risk screening training opportunities and educational resources.

The Integrated Services Grant (ISG) Young Adult Transition Committee identified service areas impacting young adults transitioning to adulthood for the July 2007 summit: "Creating Effective and Sustainable Systems for Youth and Families." Areas identified were transportation and mobility, employment and financial support, health care and benefits, higher education and vocational education, self-advocacy, social life, peer support and leadership, and housing (independent and assisted living).

The summit was attended by 16 young adults from around the state and 40 representatives from Arizona State University, ADE-Exceptional Student Services, DES Rehabilitation Services Administration and Division of Developmental Disabilities, ADHS-BHS, Arizona Governor's Council on Developmental Disabilities, Southwest Autism Research and Resource Center, and

the Phoenix Mayor's Commission on Disability Issues. Prior to the event the young adults participated in an on-line learning community hosted by an OCSHCN youth leader to discuss participation in the conference and to get acquainted. Participants recommended developing on-line transition planning training for physicians and recommended that Continuing Education Units be available.

OCSHCN educated Children's Rehabilitative Services (CRS) contractors on guardianship, advanced directives, transition resources and identifying adult providers. OCSHCN also mandated contractors to participate in a performance improvement project (PIP) that was developed to promote transition to adult planning. A performance indicator was developed to measure the proportion of members who turned 15 during the contract year that had documentation in their medical record of a transition plan that was initiated by their 15th birthday. The baseline measurement in 2004 had found no documentation of planning in the medical records. Providers were subsequently trained and the measure was repeated for members who turned 15 during FY2007. Overall, 26% of the charts had documentation of transition plans, but the members who turned 15 during the last quarter of the period were twice as likely to have a plan documented than those who turned 15 in the first three quarters. This showed that interventions were beginning to work. The project will continue until the goal of 80% is reached.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. OCSHCN develops and provides training on transition with CME's for physicians on transition based on recommendations from our Young Adult Advisory Council		X		X
2. OCSHCN contracts require documentation of a transition plan before the young adult ages out of all programs		X		X
3. OCSHCN contracts with young adult partners to provide input at all levels of decision making on program, policy, RFP's, and resource information		X		X
4. OCSHCN partners with other agencies and organizations to promote the inclusion of health transition planning in their programs, services and training				X
5. CRS Performance Improvement Project measures contract compliance for having a transition plan in the young adults medical record		X		X
6. Transition planning for young adults in CRS is started by age 15		X		X
7.				
8.				
9.				
10.				

**b. Current Activities**

OCSHCN is working with RSK-F2FHIC to develop an interactive video game to help young adults understand transition issues and the need to develop a transition plan. Youth are participating in the development of the video. OCSHCN is developing on-line transition training for physicians based on Youth Advisory Council (YAC) recommendations.

All FRC contracts require documentation of a transition plan. TBI/SCI contractors collect information on the development and implementation of a plan for youth at age 16. All members are followed up after exiting the program to confirm that the family or young adult followed through on the transition plan.

OCSHCN participates on Banner Children's Hospital annual school nurse conference planning committee targeting transition issues and integrating YSHCN. Youth from OCSHCN programs are sponsored participants in the community development family leadership conference. Youth partners present around the state on health care decision making and transition issues; and review OCSHCN contract language and website.

CRS contractors begin to develop transition plans for members before they reach age 15. The plan must be age appropriate, address member needs and continue until the member exits CRS. Data on documentation in the medical record of a transition plan is being collected for the first three quarters of 2008 to conduct a second re-measurement for the transition PIP. Transition plan training continues to be provided to CRS contractors.

### **c. Plan for the Coming Year**

All OCSHCN contracts will require transition planning. OCSHCN will promote promising practices identified during program audits as models for other ADHS programs and contractors to follow. CRS will continue to train clinic staff on transition issues and continue to require transition planning for all members before they reach age 15. A PIP re-measurement will be done to assess effectiveness of interventions and training related to transition. Utilization and quality management staff will continue to monitor compliance with contractual requirements related to transition. The transition PIP will continue for several more years, until a goal of 80% is reached.

Training will be developed for health care plans to train on best practices related to YSHCN and to raise awareness about the need to develop capacity to care for young adults with conditions that providers are only accustomed to seeing in pediatric populations. OCSHCN will explore the possibility of providing training for adult providers who will take over the care of transitioning young adults and provide CEU's for any transition training curricula.

The FRC Program and the School Health Program will make on-line Parent Youth Leadership Training modules and transition training modules available to contractors, families, youth and family organizations. Youth will work with OCSHCN to develop web based resource information to support youth and families, and will help develop fact sheets and design web-based curriculum.

OCSHCN will continue to co-sponsor and present at the annual ADE Transition Conference for youth, parents and educators. OCSHCN will promote the inclusion of medical and social empowerment tracks. Youth Advisory Council (YAC) activities will move to the RSK-F2FHIC. Unfunded ISG continuation time will be used to complete ISG-YAC recommendations and to recruit and mentor new YAC membership for future activities. The ISG transition committee will develop recommendations around the lack of a transition period between health plans while determining eligibility.

OCSHCN will continue to support youth leadership. Youth leadership including the YAC oversight will be included in the ADHS collaborative parent, youth and consumer RFP. Contractors will be responsible for recruiting, supporting, training, and providing leadership development for youth. Contractors will also be required to identify youth that reflect different disabilities and the cultural and economic diversity of the state. Organizations outside of state agencies may be in a better position to address barriers to participation and support the needs of youth partners including advances for travel and conference expenses, attendant care, mileage and stipends.

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

## Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	70	71	78	79	79.5
Annual Indicator	75	78	78.6	79.2	76.2
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	80	80	80	80	80

### Notes - 2007

The source of immunization data is the CDC National Immunization Survey ([http://www.cdc.gov/vaccines/stats-surv/nis/tables/0607/tab03\\_antigen\\_state.xls](http://www.cdc.gov/vaccines/stats-surv/nis/tables/0607/tab03_antigen_state.xls)). Previously, the reported rate represented the coverage level for 4DPT, 3OPV and 1 MMR only, because data were not reliably available for the full series recommended by the CDC, which also includes 3 doses of Hep B and 3 doses of Hib. No data were available for this measure for 1998, but the data points for 1999 forward have been changed to reflect the full 4:3:1:3:3 series. Performance objectives were also changed to reflect the change in the measure. Estimates for data points are based on reports for the following date ranges:

1999 = July 1998 through Jun 1999

2000 = "2000"

2001 = Jan 01 through Dec 01

2002 = Jul 01 through Jun 02

2003 = Jul 02 through Jun 03

2004= Jul 03 through Jun 04

2005= Jan 04 through Dec 04

2006=Jan 05 through Dec 05

2007= Jul 06 through Jun 07

The 2007 estimate reflects the immunization status of children by age two for children who were 19-35 months of age, born between July 2003 and December 2005. The estimate tolerates 5.4% error at a 95% confidence level.

### Notes - 2006

The source of immunization data is the CDC National Immunization Survey (<http://www.cdc.gov/nip/coverage/NIS/01/toc-01.htm>). Previously, the reported rate represented the coverage level for 4DPT, 3OPV and 1 MMR only, because data were not reliably available for the full series recommended by the CDC, which also includes 3 doses of Hep B and 3 doses of Hib. No data were available for this measure for 1998, but the data points for 1999 forward have been changed to reflect the full 4:3:1:3:3 series. Performance objectives were also changed to reflect the change in the measure. Estimates for data points are based on reports for the following date ranges:

1999 = July 1998 through Jun 1999

2000 = "2000"

2001 = Jan 01 through Dec 01

2002 = Jul 01 through Jun 02

2003 = Jul 02 through Jun 03

2004= Jul 03 through Jun 04

2005= Jan 04 through Dec 04

2006=Jan 05 through Dec 05

The 2006 estimate reflects the immunization status of children by age two for children who were 19-35 months of age, born between February 2002 and July 2004. The estimate tolerates 4.2% error at a 95% confidence level.

#### **Notes - 2005**

The source of immunization data is the CDC National Immunization Survey (<http://www.cdc.gov/nip/coverage/NIS/01/toc-01.htm>). Previously, the reported rate represented the coverage level for 4DPT, 3OPV and 1 MMR only, because data were not reliably available for the full series recommended by the CDC, which also includes 3 doses of Hep B and 3 doses of Hib. No data were available for this measure for 1998, but the data points for 1999 forward have been changed to reflect the full 4:3:1:3:3 series. Performance objectives were also changed to reflect the change in the measure. Estimates for data points are based on reports for the following date ranges:

1999 = July 1998 through Jun 1999

2000 = "2000"

2001 = Jan 01 through Dec 01

2002 = Jul 01 through Jun 02

2003 = Jul 02 through Jun 03

2004= Jul 03 through Jun 04

2005= Jan 04 through Dec 04

The 2005 estimate reflects the immunization status of children by age two for children who were 19-35 months of age, born between February 2001 and May 2003. The estimate tolerates 4.2% error at a 95% confidence level.

#### **a. Last Year's Accomplishments**

The Arizona Partnership for Immunization (TAPI) website, [www.whyimmunize.org](http://www.whyimmunize.org) allowed parents to ask medical experts questions about vaccines and immunizations. The website was updated frequently to include more information and to include information containing pediatric and family practice offices. TAPI supplied articles for the quarterly Immunizations newsletter that was produced and distributed to immunization providers by the ADHS Immunization program. English and Spanish parent education flyers, "Is Your Child Protected?" and vaccine safety concern flyers were revised and distributed, in addition to printing and distributing reminder/recall postcards to immunization providers throughout the state. Several materials were updated and distributed in 2007; some of them included the parent education flyer designed to help overcome parent immunization concerns, "cloud award" brochures nomination form given to providers who have achieved a 90%+ immunization coverage level of their two year old patients, and a clinical guide on how to administer shot.

Over 75,000 educational pieces were distributed to schools, child care facilities, private providers, county health departments, community health centers, managed care organizations and WIC sites in 2007. In the past year TAPI participated in several corporate/community health/wellness fairs, eight professional conferences or seminars, and supplied and distributed materials for several rural health fairs, including border health fairs.

Several partnership and collaborative efforts were formed by TAPI, which not only included partnerships with Maricopa county fire departments, but also the Governor's Office, Arizona Hospital Association (AHA), Arizona Medical Association (AMA) and Arizona State University (ASU) College of Nursing. The partnerships resulted in services such as the provision of educational materials, seminars for graduate level community nursing students, training medics to give shots in fire department sponsored 'Baby Shot clinics,' and flu prevention outreach campaigns. Over 200 medics were trained and were certified to deliver shots to children, which has enabled several baby shot programs to expand their services that has encouraged several other departments to open clinics for kids.

TAPI also organized and conducted 11 regional immunization programs with the Vaccines for Children Program and the Arizona State Immunization Information System (ASIIS) for providers

statewide. 350 individuals from provider offices and health departments participated in the 11 state-wide trainings that emphasized the importance of using resources such as reminder/recall cards and parent education flyers. The new incentive program initiated by the Arizona Immunization Program Office (AIPO) to increase completion of the 4th DTaP by 24 months of age has facilitated new programs.

In cooperation with AIPO, TAPI designed and mailed an ASIIS user satisfaction survey to 2,300 provider sites. 48% of the surveys were completed and returned by the end of the calendar for 2007. Analyses of the survey data indicated that 90% of respondents were very satisfied and/or satisfied with the program; 98 % strongly agreed and/or agreed that ASIIS representatives were knowledgeable and helpful; 78% strongly agreed and/or agreed that using ASIIS decreased missed opportunities; 70% routinely used ASIIS to look up immunization records of their patients.

TAPI developed a curriculum for pediatric offices that fell below the national average for immunization coverage of their patient population. The program was implemented at 6 sites that averaged 60% completion rates for the childhood series. Several sites approached the 90% gold standard of the healthy people 2010 goals, and have applied for consideration of the Daniel T Cloud Outstanding Practice Award.

The Arizona The Midwife Licensing Program also provided training and education to the midwives about the rules and regulations regarding immunization schedules for new born and the resources available to the parents.

The County Prenatal Block Grant (CPBG) program funded assessments for over 1,600 infants/children under the age of two years old to determine if they had completed age-appropriate immunizations.

The High Risk Perinatal Program (HRPP) Community Health Nurses (CHN) monitored the immunization status of the children enrolled in their programs and continued to promote and facilitate immunization.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. TAPI designs, prints and distributes immunization materials for parents and providers on a regular basis.			X	
2. TAPI developed a curriculum for pediatric offices that fell below the national average for immunization coverage of their patient population.				X
3. TAPI conducts client satisfaction surveys to improve their services relating to immunizations.				X
4. TAPI provides trainings throughout the state to increase the outreach efforts for educating parents and to promote on time immunizations for children/adolescents enrolled in managed care plans.			X	X
5. TAPI organized and conducted regional immunization programs with different health providers.		X		
6. TAPI trained medical providers in immunization service delivery to decrease pockets of under immunization.				X
7. The Midwife Licensing Program provides education to midwifery community on the rules and regulations and the importance of immunizations for newborns to parents.		X		
8. The CPBG provides immunizations and grants to identify		X		

potential safety needs for newborns on a regular basis in underserved areas.				
9. Health Start monitors immunization schedules for all their clients' children.		X		
10. HRPP program monitors immunization schedules for all their clients.		X		

**b. Current Activities**

TAPI prints and distributes immunization materials to public and private providers throughout the state, and conducts trainings to certify medics in immunization delivery. It has also planned and is in the process of conducting at least ten immunization workshops for staff of public and private clinics, medical offices, schools and other VFC enrolled sites. TAPI is collaborating with managed care plans to promote and institute methods to ensure local health departments are reimbursed for vaccine administration costs for AHCCCS enrolled children and is currently working with different providers and partners to ensure immunization services are available in underserved areas where children lack access to immunization services. It also frequently revises and updates the web site and print materials as needed to keep current with established immunization recommendations and practices.

The Midwife Licensing Program is reviewing quarterly reports from Arizona mid-wives to ensure compliance to immunization follow-ups.

CPBG has provided immunizations and opened grants to identify potential safety needs for newborns and improve the system to monitor immunization schedules.

The Health Start Program, HRPP, and CHN have been closely monitoring the immunization schedules for their enrolled clients' children apart from educating their clients about the importance of immunizations.

**c. Plan for the Coming Year**

TAPI will continue programs and partnerships that promote childhood immunizations.

The Midwife Licensing Program will continue compliance checks and educate the midwives on the importance of immunizations for newborns to parents.

The County Prenatal Block Grant Program will continue perinatal programs to include immunization clinics, and postpartum home visits to assess needs and monitor immunization schedule.

The Health Start Program and the HRPP community health nursing program will continue to monitor the immunizations for their client's children.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	42	41	35	35	34
Annual Indicator	35.9	35.8	34.1	34.0	34
Numerator	4110	4227	4179	4450	
Denominator	114368	118082	122496	130905	

Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	33	32	32	32	32

**Notes - 2007**

2007 data are not yet available. The rate is provisionally set at the 2006 rate until the data becomes available in Fall 2008.

**Notes - 2006**

2006 data are not yet available. The rate is provisionally set at the 2005 rate until the data becomes available in Fall 2007.

**Notes - 2005**

2005 data are not yet available. The rate is provisionally set at the 2004 rate until the data becomes available in Fall 2006.

**a. Last Year's Accomplishments**

The teen pregnancy rate for 15 to 17 year olds in Arizona remains above the national rate of 22.1 per 1,000 in 2004, nonetheless, it has continued to decrease annually. The Abstinence Education Program (ABEP) funded 11 contractors to provide education to youth which included positive youth development activities and parent education in 14 of 15 Arizona counties. A total of 28,869 youth and 2,350 parents were served under the Abstinence Program. The comprehensive programs were funded in five county health departments, three tribes, and one behavioral health agency, and two community based organizations. 2,249 youth and 263 parents were served. The program assisted with education services to a tribe in Arizona that had a syphilis outbreak that included a large number of youth. Ten "teen mazes" were funded, and all contractors received an annual visit in which education services were observed. Educating youth and parents about the importance of delaying childbearing and the use of contraceptives appears to have had a positive impact. The program hosted two visits from Dr. Douglas Kirby who is a pioneer in the field of teen pregnancy prevention. While the emphasis of the first meeting was to assist BWCH in deciding the future course of evaluation of the Teen Pregnancy Prevention program, the second visit accentuated the need for collaboration with other state agencies. Dr. Kirby's lecture was attended by senior administration of DES, AHCCCS, Superior Courts, and Probation staff to reinforce the goal that administrations need to collaborate and to also provide services to youth who are on probation and in foster care.

The Arizona mid-wife special licensing program reviewed quarterly data reports of births sent to the office for 485 infants born under the care of the Licensed Midwives (LM) in Arizona. The quarterly reviews ensured if adequate services were provided to teenage pregnant mothers and non-compliant LM cases were investigated.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. BWCH awarded grants to programs that targeted abstinence, comprehensive sex education, and parent education programs.			X	

2. BWCH organized seminars for senior administrators to collaborate on teenage pregnancy.				X
3. The Governors Office for Children Youth and Families (GOCYF) facilitates interagency workgroup meetings on teen pregnancy and STD to develop best practices for youth in care and implement comprehensive health education policy for youth in systems				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Four community-based agencies and two county health departments are funded to provide parent education services as of Spring 2008. Twelve county health departments are funded to develop programs for youth in care, young males, the Hispanic population, and the prevention of second teen births. The counties are hiring staff and developing implementation plans. The Governor's Interagency Workgroup on Teen Pregnancy and STD Prevention is a group of state agencies dedicated to supporting the reduction of teen pregnancies in the state. The group has focused their efforts primarily on developing a comprehensive health education policy for youth in systems of care. The workgroup is looking at best practices for youth in care and how to implement an effective curriculum among this population. With the assistance of the interagency workgroup, BWCH is funding county health departments to work with their local counterparts in the juvenile corrections systems to provide teen pregnancy prevention services to young people in the corrections system. Strategies to prevent second pregnancies in teen parents are under discussion.

**c. Plan for the Coming Year**

The Teen Pregnancy Prevention Program will continue funding evidence-based programs that incorporate youth development activities. Should additional funding become available, the program will fund local projects that target prevention of secondary teen births, reduce the Hispanic teen birth rates, and focus on male involvement. The Governor's Interagency Workgroup on Teen Pregnancy and STD Prevention will continue activities such as instituting training and best practices to develop comprehensive health education policy for youth in systems of care.

**Performance Measure 09:** *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	30	30	25	36.5	36.5
Annual Indicator	36.2	24	36.2	36.2	36.2
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	36.5	36.5	37	37	37

**Notes - 2007**

The figure for 2007 is from a statewide oral health survey of over 80 communities, for 1999-2003. This survey will be re-done for each needs assessment year, with the next survey scheduled for 2010.

**Notes - 2006**

The figure for 2006 is from a statewide oral health survey of over 80 communities, for 1999-2003. This survey will be re-done for each needs assessment year, with the next survey scheduled for 2010.

**Notes - 2005**

The figure for 2005 is from a statewide oral health survey of over 80 communities, for 1999-2003. This survey will be re-done for each needs assessment year, with the next survey scheduled for 2010.

**a. Last Year's Accomplishments**

The Office of Oral Health (OOH) used the data for the sealant indicator performance measure from the statewide oral health survey of over 80 communities, from 1999-2003. The new survey is scheduled for the next needs assessment year 2010. During 2007, the Arizona Dental Sealant Program increased their services providing dental screenings, sealants and referrals to children in public schools. Eligible schools included those with at least 65 percent of their students participating in the National School Lunch Program (free/reduced lunch program). Only those 2nd or 6th grade students who had an informed parental consent, along with meeting the 'free or reduced lunch' program eligibility criteria and who did not have private dental insurance were eligible to participate. Uninsured children, Medicaid and SCHIP beneficiaries, and those covered by Indian Health Services or by state-funded tobacco tax health care program were also eligible to receive sealants. The program provided dental screenings and referrals to approximately 10,451 children in 177 schools. In a few remote areas of the state, the '65 percent' free or reduced lunch program criteria was relaxed. Schools that met 50 percent criteria of free or reduced lunch program were included. The total number of dental sealants placed was 30,532.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided dental sealants to high risk children.	X			
2. Evaluated the effectiveness of the dental sealant program.				X
3. Program staff collaborated with key stakeholders to expand services.				X
4. The program is instituting open mouth surveillance for 2008.				X
5. The Program continues to acts as a data warehouse on the sealant program to internal and external partners.				X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

OOH provides an evidenced-based sealant program that is expanding to 9 counties with an emphasis on increasing student participation as well as numbers of participating schools. Collaboration with the Office of Health Systems Development (HSD) will enable expansion to many of their contracted primary care clinics. Efforts also include promotion of establishing a 'dental home' that utilizes Affiliated Practice Dental Hygienists employed by Community Health Centers to provide the sealants to neighboring schools and referring those children to the Center's dental clinic for follow-up care. Strengthening and collaborating with established school-based health clinics and centers is also being emphasized. Additionally, OOH is collaborating with HSD to expand the sealant program to their primary care clinics located throughout the state. A pilot project to increase student participation is being conducted in one county by providing a battery operated power toothbrush to any child who returns a consent form. The consent forms are being revised to make them more reader-friendly and less 'official' in order to encourage greater participation of especially those in the bordering areas of the state. In an effort to increase the number of qualifying schools participating in the program, a colorful 'mailer' brochure was developed to send out the application with the hope that it would draw greater attention from school nurses.

**c. Plan for the Coming Year**

The Arizona Dental Sealant Program will continue to provide and expand the number of dental screenings, referrals and dental sealants to high-risk children. New delivery models for the dental sealant program, such as integrating with community health centers and using the affiliated practice dental hygienist model, will be evaluated for their cost effectiveness, and compared to the traditional delivery model. The sealant indicator survey will take place in 2008 to collect data on the prevalence of dental sealants in 3rd grade children.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	5.9	5.9	5	4.2	4
Annual Indicator	5.3	4.5	4.2	4.0	4
Numerator	67	58	56	55	
Denominator	1261764	1300444	1347557	1390127	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	4	3.8	3.5	3.5	3.5

**Notes - 2007**

Data for 2007 are not yet available. The estimate for 2007 is provisionally set at the 2006 rate until data become available in the Fall of 2008. Estimates for 2001 on reflect motor vehicle death rates for all children ages 0-14. Prior to 2001, estimates were based on ages 1-14.

**Notes - 2006**

Data for 2006 are not yet available. The estimate for 2006 is provisionally set at the 2005 rate until data become available in the Fall of 2007. Estimates for 2001 on reflect motor vehicle death rates for all children ages 0-14. Prior to 2001, estimates were based on ages 1-14.

**Notes - 2005**

Estimates for 2001 on reflect motor vehicle death rates for all children ages 0-14. Prior to 2001, estimates were based on ages 1-14.

**a. Last Year's Accomplishments**

In 2007, the 14th Annual Child Fatality Report was produced, summarizing reviews of childhood deaths that occurred in Arizona in 2006. For the second time since its inception, the Child Fatality Review Program (CFR) reviewed 100% of childhood deaths. In 2006, there were 164 deaths of children in Arizona due to motor vehicle crashes with 49 percent (81) of the victims aged 14 years and/or younger. The most frequent contributing factor to motor vehicle crash deaths were lack of vehicle restraints, excessive driving speeds and reckless driving. Motor vehicle crashes related to drugs and/or alcohol was found in 38 child deaths. The CFR report was used to support legislation introduced in the 2007 session related to reduction of motor vehicle crash deaths including enactment of graduated driver's license laws, which go into effect July 1, 2008.

All HRPP contracted hospitals ensured that parents completed car seat training at each hospital before the discharge of their infant. The community health nurses monitored car seat usage at each home visit.

The Community Health Services Program funded four car sat safety projects throughout the state. Approximately 2,009 car seat safety seats were installed with accompanying education and the self-installation of the child car seat by the caregiver/parent through this program. Child car seat safety events (25) were conducted, 80 new child car seat safety technicians were certified, one technician was certified as a trainer, and another 209 safety technicians were re-certified. Approximately 1,245 infant car seats were randomly checked in local communities for proper installation, wear, damage, or product recalls. Adults (338) were served at community child booster seat campaigns, and another 2,362 received information about preventing vehicle injuries individually, in schools, and at community events. Low income mothers participated in a Nurse Family Partnership program that provided education and support for first time mothers through regular home visits from a public health nurse and the mothers were taught about transportation and home safety for themselves and their children. Topics included the use of car seats and seatbelts, as well as use of substances including alcohol and tobacco while driving.

The County Prenatal Block Grant Program (CPBG) provided 450 car seats and education to low-income families. CPBG staff sponsored car seat rodeos and provided parents with education on car seat safety and proper installation. This program is funded by County Prenatal Block Grant in areas where there is no other funding available.

The Safe Kids Program taught three child passenger safety courses in partnership with Banner Health for the following AZ communities: Hopi, Phoenix and Pinetop. Two short classes were taught to child protective services agencies. The Safe Kids coordinator served as an appointed position with the Governor's Traffic Safety Advisory Council. In addition, the coordinator is a member of the legislative subcommittee and chairs the Restraint Use subcommittee within the Council.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CFR program reviews infant death and produces annual				X

report to support policies, research, and legislation relating to motor vehicle crashes.				
2. CFR program distributes the infant death checklist to law enforcement agencies.				X
3. CFR maintained and updated website containing information on motor vehicle crashes and infant deaths.			X	
4. HRPP educated parents about car seat safety and assisted them in obtaining car seats.		X		
5. HRPP community health nurses monitor car seat usage in every visit.		X		
6. The Community Health Services Program provides car seats, child car seat safety education and correct self-installation guides.		X		
7. Community Health Services Program educates high school and middle school students on motor vehicle safety through public campaigns.			X	
8. Community Health Services Program targeted pregnant women through public events and education for appropriate seat belt application.		X	X	
9. CPBG utilized funding to train, certify and re-certify staff on car seat safety and conducts random car seat safety checks.			X	X
10. Safe Kids Program taught child passenger safety courses				X

**b. Current Activities**

In 2008, the CFR program has distributed 'infant death checklist' to first responders for investigations of unexplained infant deaths. Checklist will also be distributed for investigations of these deaths to law enforcement agencies throughout Arizona. The data from checklists received will be included in the child fatality reviews. Unexplained Infant Death Council continues to advise the department, legislature, and governor on issues related to unexplained infant deaths and fetal deaths. CFR reviews the deaths of all children in Arizona, including infant deaths. The CFR website provides information on prevention of childhood and infant deaths. The Citizen Review Panel prepares an annual report of review findings and recommendations to improve the state's child protection system.

HRPP contracted hospitals ensures that parents complete car seat training at each hospital before the discharge of their infant and CHN monitor car seat usage at each home visit. The Community Health Services Program continues to identify and address community needs to help address the problem of motor vehicle injuries and deaths among children, and is promoting vehicle safety through expanding its services through various outreach methods. CPBG staff provides free inspections and installation of car seats to the public, and free training and car seats as incentives for clients to attend prenatal classes. The program also funds staff training to become certified car seat technicians.

**c. Plan for the Coming Year**

In 2009, CFR program will continue to review infant and fetal deaths, and compile the results in an annual report. CFR will continue to promote the use of the Infant Death Checklist and use the research and data to strengthen ties with local coalitions and organizations, including Safe Kids, Injury Free Coalition for Kids, Governor's Traffic Safety Advisory Council, Never Shake a Baby Arizona, Inter Tribal Council of Arizona, Maricopa Association of Governments, and others. CFR will improve the usefulness of its annual reports by incorporating the different levels of prevention as needed. CFR will improve the usability and applicability of its annual reports by incorporating guidelines for writing effective recommendations. These recommendations will include problem statements, best practices, capacity, accountability, outcomes and impacts.

HRPP will work with contracted hospitals to ensure that parents complete car seat training before the discharge of their infant. CHN will monitor car seat usage at each home visit.

The Community Health Services Program will continue to identify community needs to help address the problem of motor vehicle injuries and deaths among children, and promotes vehicle safety through expansion of services.

CPBG will continue to fund training for car seat technicians for maternal child health staff, provide free car seats and training to pregnant women who attend prenatal classes, and hold public events, inspecting car seats to insure proper installation.

The Safe Kids Program will continue to teach child passenger safety classes in underserved areas, participate in community events, and serve on the Governor's Traffic Safety Advisory Committee.

**Performance Measure 11:** *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures  
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				38	38
Annual Indicator			37.6	46.5	46.5
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	50	50	50	50	50

**Notes - 2007**

Source: The CDC National Immunization Survey ; Table 2. Geographic-specific Breastfeeding Rates among Children born in 2004([http://www.cdc.gov/breastfeeding/data/NIS\\_data/data\\_2004.htm](http://www.cdc.gov/breastfeeding/data/NIS_data/data_2004.htm)). Prior to 2006 the source of this performance measure was the "Mother's Survey", Ross Products Division, Abbott Laboratories, Inc.

**Notes - 2006**

Source: "Mother's Survey", Ross Products Division, Abbott Laboratories, Inc. Data for 2006 is not yet available. The estimate for 2006 is provisionally set at the 2005 rate until data for 2006 become available.

Data for the 2005 datapoint is the percent of mothers breastfeeding at 6 months of age for 2004.

**Notes - 2005**

Source: "Mothers Survey," Ross Products division, Abbott Laboratories, Inc. Data for 2005 not yet available. The estimate for 2005 is provisionally set at the 2004 rate until data become available.

**a. Last Year's Accomplishments**

The Pregnancy Services Program was established by the State Legislature to provide individual grants to non-profit agencies whose primary function is to assist pregnant women seeking alternatives to abortion. The priority areas focus on positive public health activities for pregnant women and their children. Encouraging breast feeding, education on breast feeding, and local resources available for breast feeding mothers are key components of the Pregnancy Services Program. Contractors must provide medically accurate services and programs related to pregnancy and up to twelve months after birth. Pregnancy Services Program contractors ensure that staff/volunteers have been trained or will receive training on current public health practices related to the educational topics discussed with clients. Apart from referring pregnant and post-partum women to several agencies that provide a variety of services, 6297 educational services that directly or indirectly related to breastfeeding, such as benefits of breastfeeding and local resources that support breastfeeding mothers, were provided.

HRPP contracted with all NICUs throughout the state and each NICU had a lactation consultant available to encourage and support breastfeeding. Resources were made available to mothers after discharge to contact the NICU with concerns about breastfeeding. Further, during follow-up home visits the HRPP community health nurses also encouraged the mothers to breastfeed and connected them to available resources. Two of the Hot Line staff members are Certified Lactation Consultants (CLCs) and are bilingual in Spanish and English to assist the large Hispanic population in Arizona.

The Health Start Program provided case management in high risk communities with a focus on improving birth outcomes and the health of children by utilizing the services of community lay health workers (LHWs). LHWs received training on breast feeding and in 2007, the program provided educational services to 2,332 low income high risk women, and the program provided a total of 11,181 home and/or office visits. Approximately 42% of the clients committed to breast feeding their baby.

The CPBG program documented that over 500 women statewide had received education, information and supportive services from certified lactation counselors (CLCs), from staff in the hospital, and during follow-up after discharge. CPBG funded the training of health workers to become CLCs.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Ensured that all contracted NICUs had a lactation consultant available to encourage and support breastfeeding.				X
2. CHNs encouraged and educated mothers during follow-up visits to breastfeed and made available to them different resources.	X			
3. Bilingual Certified Lactation Consultants answer breastfeeding pregnancy Hot Line.	X			
4. Community Lay Health Workers educate pregnant and postpartum women on benefits of breastfeeding.		X		
5. CPBG made additional funds available for training of health workers to obtain certification and emphasize breast feeding in prenatal classes.			X	
6. CPBG is in the process of developing tracking systems for breast feeding mothers.				X
7.				

8.				
9.				
10.				

**b. Current Activities**

The Pregnancy Services Program Manager conducts annual site visits to monitor contractors and provide technical assistance when needed. The Pregnancy Services Program Manager provides information on trainings that relate to pregnant mothers with most updated public health practices, and assists contractors with networking with state and local public health agencies that relate directly or indirectly to breastfeeding.

Additional lottery dollars received for the Health Start program is being used to educate, train, and certify LHWs as lactation consultants. The CLCs provide counseling services to breast feeding clients and encourage breastfeeding among low income high risk women.

CPBG program contractors have been forming coalitions with local businesses to encourage breastfeeding in the workplace. CPBG funds are being used to fund training for CLCs. Several counties are developing a tracking system to determine how many women continue to breastfeed for the first six months. All CPBG program contractors include breastfeeding education and support to pregnant women and postpartum mothers.

**c. Plan for the Coming Year**

The Health Start Program is working to increase the number of clients that breast feed through education of the LHWs. Additional information and training will be provided so that more LHWs are certified breast feeding counselors and/or certified lactation counselors.

The CPBG program will continue to incorporate breastfeeding education in prenatal classes, and will track breastfeeding retention among postpartum women. The program will continue to train and utilize CLCs in program services, and will be tracking postpartum women to determine if they are continuing to breastfeed for at least the first six months after delivery.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	98	98	98.5	98.8	97
Annual Indicator	98.0	98.3	98.2	96.3	95.5
Numerator	89233	96876	94750	98363	97986
Denominator	91054	98551	96487	102095	102587
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	97	98	98	99	99

**Notes - 2007**

The data reported are estimated from 45 of 49 birthing hospitals. There are now 49 reporting hospitals; 48 birthing facilities and 1 children's hospital that provide screens to neonatal intensive care unit infants. All sites voluntarily screen and are mandated to report data weekly. Although 97, 986 infants were screened prior to hospital discharge, another 475 were given an initial screen as part of outpatient services. This occurred because some infants were transferred prior to screening.

**Notes - 2006**

The rates of newborn hearing screening from previous years were based on a combination of reported screen results and inferred rates from non-reporting screening sites. Due to the promulgation of rule this year, requiring providers to report newborn hearing screening results, the newborn hearing screening rate for 2006 is based on actual reported data from all birthing hospitals.

Newborn Screening Rules were approved in April 2006. Two of the 47 birthing hospitals began reporting after the rules had been approved. Two hospitals began birthing services during 2006. Of the 47 hospitals 102,095 babies were born (Vital Records) and 98,363 were screened before discharge (HI\*Track).

**Notes - 2005**

The data reported are estimated based on 44 out of 46 birthing hospitals. While all 46 birthing hospitals have universal screening programs, reporting to the ADHS is voluntary, and not all report. Among the 88,150 births at these 44 hospitals, 86,604, or 98.2% were screened. The best estimate of the numerator for this measure on a statewide basis is 98.2% of all births: 96,487 x .982 = 94,750.

**a. Last Year's Accomplishments**

Hearing Screening is mandated in all private, public, transitional, charter and kindergarten schools in Arizona. In 2007 the Arizona Department of Health Services Sensory Program contracted with University of Arizona Train-the-Trainer Program to provide Vision Screening training, in addition to Hearing Screening. During 2007, 890 Hearing Screeners were trained, 14 new T3 Trainers were trained, and 7 Vision Screening Trainers were trained. In the school year 2006-2007, 563,472 students were screened and 1,418 were identified for the first time with a hearing disorder. The Sensory Program purchases and loans audiometers to schools so that they may provide hearing screening to Arizona children.

Midwives licensed through the Special License Midwifery advise parents where to obtain hearing screening for their newborns.

All 49 hospitals in Arizona admitting newborns (all birthing or pediatric hospitals) voluntarily perform newborn hearing screening. All providers performing newborn hearing screening or subsequent tests are required to report their findings to the Arizona Department of Health Services (Arizona Administrative Code R9-13-201-208). In 2007, the program received 98,275 newborn hearing screening results. This reflects 96% of the total number of births in Arizona and 99% of births that occurred within Arizona hospitals.

The number of newborns referred for further testing remained at 4%. This state average is a nationally accepted referral rate. Of those referred, 116 were diagnosed with a hearing loss.

Loss to follow up at one month of age for the 4% of infants referred for further testing was reduced from 40% to 37%.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service
------------	--------------------------

	DHC	ES	PBS	IB
1. The Sensory Program collaborates with the University of Arizona to train hearing screening trainers.				X
2. The Sensory Program disseminates information about mandatory school hearing screening.			X	
3. The Newborn Hearing Screening Program provides technical assistance to hospitals and providers in newborn hearing screening and reporting.				X
4. The Newborn Hearing Screening Program provides follow up services to newborns and infants with possible hearing loss.			X	
5. Provide follow up services to newborns identified by screening to possibly have disease.			X	
6. Provide education on newly screened disorders to providers, parents, and public.			X	
7. Increase number of staff performing newborn screening case management.				X
8.				
9.				
10.				

**b. Current Activities**

Through education and continuous feedback to submitters, reduce the number of unsatisfactory newborn screen specimens received.

Determine the positive and negative predictive values of all newborn screen analytes in order to plan program changes to improve testing specificity.

Secure contractor for lab services per state law to issue a Request for Proposal for these services.

The Sensory Program monitors the number of children in Arizona schools who receive hearing screening and through a contract with the University of Arizona, funds training of hearing screening trainers. Trainers then train Screeners who are usually school health nurses. Schools submit an annual report documenting number of students screened, number of students referred for further evaluation, and number of students diagnosed with a new hearing loss. ADHS monitors school compliance with the Arizona Hearing Screening Rules. The Program loans hearing screening equipment to schools upon request. The Program also is responsible for this equipment to make sure they have been properly calibrated and repaired if needed. In addition to hearing screening, the Sensory Program has contracted with the University of Arizona to provide Vision Screening Training.

Midwives licensed through the Arizona Midwife Licensing Program are beginning to implement hearing screening for infants born in the home environment. Some of the midwives have obtained the equipment to do the hearing screenings in the home after the births.

**c. Plan for the Coming Year**

Improve percentage of infants with congenital hearing loss meeting national screen, diagnosis, and intervention milestones.

Provide education to providers, families, and the general public related to the importance of infants with congenital hearing loss meeting national screen, diagnosis, and intervention milestones.

Provide tools for providers and families to promote smooth transition between provider groups for screening, diagnosis, and intervention.

Through education and continuous feedback to submitters, the Newborn Screening Program will continue to reduce the number of unsatisfactory newborn screen specimens received, refine the positive and negative predictive values of all newborn screen analytes in order to plan program changes to improve testing specificity, enhance staffing of follow-up through hiring of all vacancies, and create web-based results retrieval site for providers.

The Sensory Program will continue monitoring the contract with the University of Arizona. The program will track the training qualifications of new trainers. The program will maintain the Sensory Database with annual school hearing screening reports and the status of trained trainers. The program will disseminate newsletters to all schools, teach the midwifery community about the newborn hearing screening requirements and continue to provide technical assistance for school health nurses.

Program administration will work on revising the rules to be able to add data to quarterly report forms related to hearing screenings for the newborn infants with data on the referral as needed.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	14	14	14	14.5	16.5
Annual Indicator	14.6	14.7	16.7	17	17
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	16.3	16	15.9	15.7	15.7

**Notes - 2007**

Estimates were revised based adjustments made by the US Census ([www.census.gov/hhes/www/hlthins/historic/hihist5.html](http://www.census.gov/hhes/www/hlthins/historic/hihist5.html)). Data for 2007 not yet available. The estimate for 2007 is provisionally set at the 2006 estimate until the data become available in the Fall of 2008..

**Notes - 2006**

Data for 2006 not yet available. The estimate for 2006 is provisionally set at the 2005 rate until data become available in the Fall of 2007.

**Notes - 2005**

Data source is <http://www.census.gov/hhes/hlthins/historic/hihist5.html>.

**a. Last Year's Accomplishments**

The High Risk Perinatal Program (HRPP) assessed the health insurance status of each client throughout program enrollment. Families were educated on the importance of establishing and maintaining a medical home and assisted in overcoming barriers to accessing health care. The Bureau of Women's and Children's Health (BWCH) Hotline staff assisted callers with finding health care in their communities.

The Medical Home Project (MHP) continued to link uninsured children that did not qualify for AHCCCS with medical providers. The MHP was available in nine out of 15 counties in Arizona. In 2007, the MHP made 259 referrals to primary care physicians and 218 referrals to specialists were made for school age children and younger siblings of school age children. Each year, the number of individuals served through the MHP has reduced, this reflects the higher level of care provided through the MHP. Services provided through the MHP included 57 eyeglasses; 53 diagnostic laboratory services, and 224 prescription medications. The MHP had 72 primary care physicians providing acute care services, five physicians providing a true medical home, 54 specialty physicians and 887 referral sources. Wherever possible, Spanish-speaking families were referred to bilingual physician's offices. All written materials about this program were available in both English and Spanish.

The Pregnancy Services Program was established by the Arizona State Legislature to provide individual grants to non-profit agencies whose primary function is to assist pregnant women seeking alternatives to abortion. The priority areas focus on positive public health activities for pregnant women and their children. Pregnancy Services contractors must provide medically accurate services and programs related to pregnancy and up to twelve months after birth to pregnant women seeking alternatives to abortion. The Pregnancy Services contractors ensure that staff/volunteers have been trained or will receive training on current public health practices related to the educational topics discussed with clients. Pregnancy Services contractors are required to refer pregnant women to appropriate public health services including, Arizona Health Care Cost Containment Services (AHCCCS) for Medicaid eligibility, the Baby Arizona Hotline, and other Arizona Department of Health Services programs that serve pregnant women i.e. (Health Start, County Prenatal Block Grant). The Pregnancy Service contractors inquire about insurance status at their intake sessions. If a client is lacking insurance they will assist them will refer clients to AHCCCS for Medicaid insurance, Baby Arizona, or available services within their community.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The HRPP helps refer clients to a medical home.		X		
2. The HRPP incorporates culturally sensitivity into its explanations of the need for screening and having a medical home.		X		
3. The MHP provides uninsured children with health care services.	X			
4. The MHP screens children for AHCCCS eligibility and refers them as appropriate.		X		
5. Pregnancy Services staff/volunteers provide referrals for state and local resources to clients.		X		
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The HRPP continues to educate families on the importance of establishing and maintaining a medical home and assists families in overcoming barriers to health care. Training and updates on available public insurance plans are provided for specific populations. The HRPP continues to assess the status of each client through enrollment. The BWCH Hotline staff assists callers with finding health care in their communities.

The MHP continues to provide acute care services to school age children and to younger siblings of school age children. The MHP continues to provide a true medical home to a small number of families. The MHP continues to link uninsured children that do not qualify for AHCCCS with medical providers. Bilingual and bicultural individuals are available to address the cultural diversity of the population served in Arizona and to assist Hispanic families in accessing appropriate resources to prevent duplication of services. Spanish speaking families are referred to bilingual physician's offices. All written materials about this program are available in both English and Spanish.

Pregnancy Services contractors assist and encourage their clients to obtain health insurance either through AHCCCS, Baby Arizona, or other services that community health centers that offer free of charge.

**c. Plan for the Coming Year**

Families participating in the HRPP will continue to be educated on the importance of establishing and maintaining a medical home, and will be assisted in overcoming barriers to health care. Training and updates on available public insurance plans will be provided for specific populations. The HRPP will continue to assess the status of each client through enrollment. The BWCH Hotline staff will continue to assist callers with finding health care in their communities.

The MHP will continue to recruit additional physicians to provide services to children and increase the number of participating school nurses, public health nurses, and Head Starts that refer children to the MHP. The MHP will also continue to increase the number of children who receive a true medical home. The MHP will link uninsured children that do not qualify for AHCCCS with medical providers.

**Performance Measure 14:** *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				35	35
Annual Indicator			35.1	35.6	36.9
Numerator			31345	31537	34535
Denominator			89325	88620	93555
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	34.5	34.5	34.5	34	34

**a. Last Year's Accomplishments**

The Maternal and Child Health (MCH) nutrition team continued to work closely with AHCCCS (Medicaid) in promoting early intervention in childhood obesity and appropriate referrals for Arizona WIC children. The AHCCCS Childhood Obesity Prevention Model incorporated behavioral, nutritional, and physical activity components into their interventions. Interventions were divided into three tiers based upon their BMI. A promising practice of this model was the referral for nutrition intervention and behavioral modification above the 75th percentile for BMI. This project is still under evaluation and implementation.

"Fit WIC" group classes and incentives in association with Arizona Nutrition Network (AZNN) were also initiated in 17 Arizona WIC local agencies, including nutrition and physical activity education curriculum for healthy lifestyles after a successful pilot with Mariposa Community Health Center. The goals of the Fit WIC program for children were to increase their physical activity through caregiver education; introduce children to good nutrition; and stress the importance of physical activity through activities in Arizona WIC. Seventeen of twenty-one local WIC agencies across Arizona had Fit WIC classes.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Arizona WIC program will continue "Fit WIC" programs.			X	
2. The Arizona WIC program provides overweight resources to health care providers in Arizona.				X
3. Collaboration between the Arizona WIC program and the AZNN to develop childhood nutrition messages.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Arizona WIC continues to work closely with the AZNN and the "Grow a Healthy Child" campaign. The second series of the Healthy Eating television advertisement began is airing statewide. The integrated marketing campaign includes Arizona WIC, AZNN, and Nutrition and Physical Activity Program (NUPA).

Arizona WIC also continues to work with AZNN on the "Go Low" campaign targeted at skim/low fat milk and dairy choices for children.

Arizona WIC is branding new education brochures and materials that will emphasize emotion-based messages in childhood obesity and health.

"Fit WIC" has been expanded to 17 local agencies.

**c. Plan for the Coming Year**

Arizona WIC will complete branding of new emotion-based education materials for obesity prevention.

Bureau of USDA Nutrition Programs will continue to assist Health Care Providers in Arizona in counseling and referring children to overweight prevention programs. Common statewide prevention messages will be developed and distributed.

"Fit WIC" will be expanded to include all 21 local Arizona WIC agencies.

Nutrition curriculum will be developed for the management of overweight and obesity in children with special healthcare needs with emphasis of coordinated efforts in the management of energy needs in Arizona WIC children on tube feeds or supplemental nutrition products.

**Performance Measure 15:** *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				5	5
Annual Indicator			5.4	5.1	4.7
Numerator			5128	5225	4826
Denominator			95798	102042	102687
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	4.5	4.2	4	4	4

**Notes - 2007**

The State of Arizona does not have a survey like PRAMS that would collect data related to smoking during the last 3 months of pregnancy. The only data available is from the birth certificate, which records whether or not the mother smoked during the pregnancy, but is not specific to the last 3 months of the pregnancy. Therefore, the percent reported is the percent of women giving birth in 2007 who smoked at any time during pregnancy.

**Notes - 2006**

The State of Arizona does not have a survey like PRAMS that would collect data related to smoking during the last 3 months of pregnancy. The only data available is from the birth certificate, which records whether or not the mother smoked during the pregnancy, but is not specific to the last 3 months of the pregnancy. Therefore, the percent reported is the percent of women giving birth in 2006 who smoked at any time during pregnancy.

**Notes - 2005**

The State of Arizona does not have a survey like PRAMS that would collect data related to smoking during the last 3 months of pregnancy. The only data available is from the birth certificate, which records whether or not the mother smoked during pregnancy, but is not specific to the last 3 months of the pregnancy. Therefore, the percent reported is the percent of women giving birth in 2005 who smoked at any time during pregnancy.

**a. Last Year's Accomplishments**

Prenatal classes funded by the County Prenatal Block Grant Program (CPBG) include information, education and referrals to Tobacco Prevention programs. Program contractors conducted assessments when clients presented for pregnancy tests. Clients were provided with information on smoking cessation and the impact of smoking on birth outcomes. Approximately 1,500 women received tobacco education as a segment of the preconception care classes counties offered.

The BWCH Hot Line staff referred pregnant women who were seeking smoking cessation information to the ADHS Tobacco Education and Prevention Program.

The priority areas of Pregnancy Services were to focus on positive public health activities for pregnant women and their children, including cessation of smoking during and after pregnancy. Pregnancy Services contractors must provide medically accurate services and programs related to pregnancy and up to twelve months after birth to pregnant women seeking alternatives to abortion.

The Health Start Program is a preventative health program that provides case management in high risk communities with a focus on improving birth outcomes and the health of children. Referrals were made to smoking cessation programs as needed.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The CPBG asked each county to update their prenatal care curriculum to include more current information on smoking cessation for preconception and prenatal care.			X	
2. The BWCH Hot Line staff refer interested mothers to the Arizona Department of Health Services (ADHS) Tobacco Education Program.		X		
3. Pregnancy Services contractors refer clients to smoking cessation resources in the state.		X		
4. The Health Start Program refer pregnant clients to smoking cessation programs.		X		
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The CPBG collaborates with tobacco cessation programs to develop programs focusing on pregnancy and smoking. The program includes information regarding the impact of smoking on birth outcomes in prenatal care classes as well as for women who test negative on pregnancy tests. Smoking cessation information was provided in both prenatal classes and preconception care classes.

The BWCH Hot Line staff refer pregnant women who are seeking smoking cessation information to the ADHS Tobacco Education and Prevention Program.

The Pregnancy Services contractors discuss the hazards of smoking during pregnancy with clients and encourage them to stop smoking during pregnancy. Clients receive referrals to state

and community smoking cessation programs like the Arizona Smoker Help Line.

**c. Plan for the Coming Year**

The CPBG will work with counties to continue efforts in identifying pregnant women who are smokers. Counties will conduct programs for non-pregnant women to raise awareness of the impact cigarette smoking has on potential birth outcome and to increase knowledge of the importance that a woman's health status has on birth outcomes.

The BWCH Hot Line staff will continue to refer pregnant women who are seeking smoking cessation information to the ADHS Tobacco Education and Prevention Program.

Pregnancy Services contractors will continue to inform clients of the hazards of smoking during pregnancy and encourage clients to stop smoking. They will continue to refer clients to smoking cessation services like the Arizona Smokers Help Line.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	16.4	16.4	9.5	11.5	13.5
Annual Indicator	9.7	11.8	14.1	13.0	13
Numerator	39	49	61	57	
Denominator	403088	417019	431964	439190	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	13	12	11	10	10

**Notes - 2007**

Data for 2007 not yet available. The estimate for 2007 is provisionally set at the 2006 rate until data become available in the Fall of 2008.

**Notes - 2006**

Data for 2006 not yet available. The estimate for 2006 is provisionally set at the 2005 rate until data become available in the Fall of 2007.

**a. Last Year's Accomplishments**

In 2007, the 14th Annual Child Fatality Report was produced, summarizing reviews of childhood deaths that occurred in Arizona in 2006. For the second time since its inception, the Child Fatality Review Program reviewed 100% of childhood deaths that occurred in Arizona. During 2007, Child Fatality Review Teams reviewed circumstances surrounding suicides of 48 children that occurred in 2006. Thirty-six (75 percent) of the suicides were among children 15 through 17 years, and 12 children (25 percent) were younger than 14 years. The most common methods of suicide were hangings and gunshot wounds.

Recommendations in the annual report to reduce suicides among youth included: increase funding for substance abuse treatment programs for both adults and children; increase public awareness of the dangers associated with underage consumption of alcohol and illegal drug use; improve access to mental health services for children and educate parents and teachers on the warning signs of suicide.

The Bureau of Women's and Children's Health provided funding to help support the 2007 Arizona Youth Risk Behavior Survey. This survey provides surveillance data for depression, suicide ideation and suicide attempts for high school students.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Produce an annual report that includes findings and recommendations regarding suicides of children.				X
2. Produce reports requested for research and campaigns to reduce suicides of children.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

In 2008, Child Fatality Review (CFR) continues to review deaths of children due to all causes, including suicide. Reviews continue to identify circumstances surrounding each death and factors contributing to the death. The CFR continues to provide specialty data reports for local, statewide, and national initiatives to reduce preventable child fatalities.

The State Child Fatality Review Team will produce the 15th Annual Child Fatality Review Reporting November, 2008. The report will include recommendations to reduce preventable deaths of children and data compiled through reviews of child fatalities that occurred in 2007. The CFR staff will continue to provide technical assistance to the local child fatality teams in the development and implementation of local culturally sensitive teams, and will identify and promote campaigns to educate the public on preventing child deaths.

**c. Plan for the Coming Year**

The CFR program will continue to review the deaths of all children to identify preventable factors and for surveillance of causes and circumstances surrounding childhood suicides in Arizona. The CFR staff will continue to provide technical assistance to the local child fatality teams in the development and implementation of local culturally sensitive teams, and will identify and promote campaigns to educate the public on preventing suicides of children. The 16th Annual Child Fatality Report will be produced and will include data on suicides and recommendations to prevent suicides among children.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	81	81.5	82	82	82
Annual Indicator	80.1	81.6	77.6	77.5	77.5
Numerator	741	805	868	960	
Denominator	925	986	1119	1238	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	82.5	83	83.5	84	84

**Notes - 2007**

The data source for this measures is birth certificate data for live births. Births in which the birth weight was recorded as being under 450 grams are excluded as a data quality measure, as it is unlikely that these records represent actual birth weights. Only facilities certified by the Arizona Perinatal Trust as level III facilities are included in the numerator. Banner Desert Samaritan became certified as a Level III on 10/1/02. Data for 2007 are not yet available. The estimate for 2007 is provisionally set at the 2006 rate until data become available in the Fall of 2008.

**Notes - 2006**

The data source for this measures is birth certificate data for live births. Births in which the birth weight was recorded as being under 450 grams are excluded as a data quality measure, as it is unlikely that these records represent actual birth weights. Only facilities certified by the Arizona Perinatal Trust as level III facilities are included in the numerator. Banner Desert Samaritan became certified as a Level III on 10/1/02. Data for 2006 are not yet available. The estimate for 2006 is provisionally set at the 2005 rate until data become available in the Fall of 2007.

**Notes - 2005**

The data source for this measures is birth certificate data for live births. Births in which the birth weight was recorded as being under 450 grams are excluded as a data quality measure, as it is unlikely that these records represent actual birth weights. Only facilities certified by the Arizona Perinatal Trust as level III facilities are included in the numerator. Banner Desert Samaritan became certified as a Level III on 10/1/02.

**a. Last Year's Accomplishments**

The maternal transport component of the High-Risk Perinatal Program (HRPP) continued funding for a centralized Information and Referral Service. This line offered toll free consultation services by board certified perinatologists throughout Arizona to providers caring for pregnant women who present with high-risk factors. Providers make one telephone call to be connected with a perinatologist. If a transfer is deemed necessary, the board certified perinatologist determines the availability of a bed and authorizes and provides medical direction for transport to an appropriate level of care regardless of the woman's ability to pay. The program continued to fund all uncompensated care associated with the transport of high-risk pregnant women to Level II Enhanced Qualification or Level III centers. During FY 2007, 1,457 women received maternal transports to an appropriate level of care.

The Health Start Program educated pregnant and postpartum women about prenatal care, nutrition, danger signs of pregnancy, safety, and many other health and behavioral health topics during and between pregnancies. The Program utilized Community Lay Health Workers to identify pregnant and/or parenting women within their community and facilitate early entry into prenatal care. Referrals are made to smoking cessation programs, family planning, WIC, and social services programs as needed. In 2007, the Health Start Program provided educational services to 2,332 unduplicated enrolled clients (SFY2007 data). The Program provided a total of 11,181 home and/or office visits (SFY2007 data). The Program increased outreach in the community to focus new enrollments on the most vulnerable populations. The proportion of very low birth weight infants born to Health Start clients was approximately 1%.

The Special License Midwifery Program reviewed quarterly report forms for 485 deliveries with follow up for any that resulted in need to transfer with a complicated birth, and reviewed medical records to ensure that midwives followed the law related to delivery of low risk mothers in the home environment.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Special License Midwifery program reviews quarterly report forms to ensure that women at risk for delivering a low birth weight infant are referred to the appropriate facility.				X
2. The HRPP transports at risk pregnant women to the appropriate level of care regardless of their ability to pay.		X		
3. The HRPP ensures public awareness of the availability of transport.			X	
4. The Health Start Program assists the client by arranging transportation to medical services.		X		
5. The Health Start Program ensures that pregnant clients attend their medical appointments.		X		
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The maternal transport component of the HRPP continued funding for a centralized Information and Referral Service. This line offered toll free consultation services by board certified perinatologists throughout Arizona to providers caring for pregnant women who present with high-risk factors. Providers make one telephone call to be connected with a perinatologist. If a transfer is deemed necessary, the board certified perinatologist determines the availability of a bed and authorizes and provides medical direction for transport to an appropriate level of care regardless of the woman's ability to pay. The program continued to fund all uncompensated care associated with the transport of high-risk pregnant women to Level II Enhanced Qualification or Level III centers.

BWCH contracts with the Arizona Perinatal Trust to collect, analyze, and distribute annual perinatal data comparing Arizona hospitals to national perinatal data. Staff within the BWCH participate in the APT hospital certification process.

The Health Start Program continues to utilize Community Lay Health Workers to identify pregnant

women within their community and facilitate early entry into prenatal care.

**c. Plan for the Coming Year**

The maternal transport component of the HRPP will continue to fund the centralized Information and Referral Service. This line will continue to offer toll free consultation services by board certified perinatologists throughout Arizona to providers caring for pregnant women who present with high-risk factors. Providers will make one telephone call to be connected with a perinatologist. If a transfer is deemed necessary, the board certified perinatologist will determine the availability of a bed and authorize and provide medical direction for transport to an appropriate level of care regardless of the woman's ability to pay. HRPP will continue to fund all uncompensated care associated with the transport of high-risk pregnant women to Level II Enhanced Qualification or Level III centers. HRPP will educate Level II and lower hospitals about the availability of the toll free consultation line. BWCH is working with key stakeholders to develop an evaluation of the perinatal system of care in Arizona.

The Health Start Program will continue to educate pregnant women about prenatal care, nutrition, and the danger signs during pregnancy. The Community Lay Health Workers will continue to provide education on those topics and assist clients in obtaining prenatal care. The Community Lay Health Workers will continue to follow-up with the clients to verify that they are attending prenatal care medical appointments and are complying with the physician's instructions. They will make referrals to community resources as appropriate, such as smoking cessation programs. They will continue to distribute the Arizona Resource Guides in English and Spanish to enrolled clients.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	79	80	78	78	79
Annual Indicator	75.6	76.3	77.7	77.7	77.7
Numerator	68632	71268	74453	79299	
Denominator	90783	93396	95798	102042	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	79	80	80	80	80

**Notes - 2007**

Data for 2007 are not yet available. The estimate for 2007 is provisionally set at the 2006 rate until data become available in the Fall of 2008.

**Notes - 2006**

Data for 2006 are not yet available. The estimate for 2006 is provisionally set at the 2005 rate until data become available in the Fall of 2007.

**a. Last Year's Accomplishments**

The Health Start Program educated pregnant women about prenatal care, nutrition and danger signs of pregnancy. The Community Lay Health Workers followed-up with clients to verify that they were attending prenatal care medical appointments, and were complying with their physician's instructions. Approximately 64% of the Health Start clients entered the program in their first trimester of pregnancy.

Through the County Prenatal Block Grant Program, 14,250 pregnant women received early assessments, education and direct services. 1,276 women participated in prenatal classes and demonstrated a 54% increase in knowledge regarding prenatal care, breastfeeding, nutrition, childbirth and parenting.

The Special License Midwifery Program reviewed quarterly report forms from the 52 licensed midwives and noted that 445 births were documented in CY 2007. These reports were completed to ensure that prenatal care began at the appropriate time during pregnancy.

The Arizona WIC program continued to screen pregnant women and referred them to prenatal services.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The BWCH Pregnancy and Breastfeeding Hotline staff prescreens women for eligibility for the Baby Arizona program to facilitate obtaining Medicaid coverage and entry into prenatal care.		X		
2. The BWCH Hotline staff refers to other providers offering sliding scales for services if the woman is not eligible for Baby Arizona.		X		
3. The Health Start Program identifies pregnant women in the community and facilitates access to prenatal care.		X		
4. The County Prenatal Block Grant Program staff partner with other agencies and providers to identify and refer pregnant women in need of prenatal care.		X		
5. The Arizona WIC program refers pregnant women to prenatal care.		X		
6. The County Prenatal Block Grant program provides free pregnancy tests to women to identify them early and get them into prenatal care.	X			
7.				
8.				
9.				
10.				

**b. Current Activities**

The BWCH Pregnancy and Breastfeeding Hotline prescreens pregnant women for eligibility into Baby Arizona, thereby expediting the initiation of prenatal care. Baby Arizona is a program of participating obstetricians willing to enroll pregnant women into Arizona Medicaid (AHCCCS) in their office.

The County Prenatal Block Grant Program staff partner with agencies, private providers, family planning programs in order to identify women who are early into their pregnancy. Program staff

provided free pregnancy tests to identify women who are in their first trimester and refer them to appropriate services. County Prenatal Block programs also provide supportive and educational services related to prenatal care. Counties are beginning this year to develop objectives that will better track women to compare birth outcomes with prenatal care.

Arizona WIC promotes the benefits of early entry into prenatal care. WIC participants are referred and tracked, and WIC staff are trained to refer pregnant women for early prenatal care.

The Office of Oral Health (OOH) provided information to educate health professionals on oral health to improve access to oral care during pregnancy. OOH encouraged the AHCCCS Dental Director and Health Plans to develop policies regarding oral care during pregnancy, and provided technical assistance to community-based organizations on the relationship of oral health during pregnancy and early childhood tooth decay.

**c. Plan for the Coming Year**

The BWCH Pregnancy and Breastfeeding Hotline will continue to prescreen pregnant women for eligibility into Baby Arizona, thereby expediting the initiation of prenatal care. If prescreening shows a woman will not be eligible the Hotline will refer them to other providers in their area who offer sliding scale fees. BWCH is working with AHCCCS and the March of Dimes to enhance the promotion of Baby Arizona.

The County Prenatal Block Grant staff will continue to partner with agencies and providers who share the same target populations, such as Women, Infant and Children's (WIC), family planning and private providers in order to identify women who are early into their pregnancy. Program staff will continue to provide free pregnancy tests to identify as many women as possible who were pregnant and in their first trimester. The program will include information about the importance of early prenatal care in preconception health curriculum.

OOH will continue to enhance medical and dental provider knowledge on women's oral health and pregnancy issues to increase referrals for dental care and offer technical assistance regarding dental treatment during pregnancy. OOH will also increase efforts to encourage AHCCCS to develop policies on oral care during pregnancy.

Arizona WIC participants will continue to be referred and tracked for access to prenatal services, and new WIC staff will be trained to refer pregnant women for early prenatal care. WIC staff will continue to regularly meet with AHCCCS coordinators.

**D. State Performance Measures**

**State Performance Measure 1:** *Proportion of low-income women who receive reproductive health/family planning services.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	17.9	17.9	11	50	50
Annual Indicator	9.3	49.2	49.2	49.2	49.2
Numerator	29610	126442			
Denominator	319289	256879			
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>

Annual Performance Objective	51	51	51	51	51
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**Notes - 2007**

Starting with the 2004 data point, the numerator is women at or below 200% FPL who received family planning services through Title V, Title X, Title XIX, or 330/340 Federally Funded Community Health Centers. The denominator is women at or below 200% FPL who are fertile.

Data for this measure is from the Arizona Family Planning Council's Comprehensive Family Planning Report, which is usually conducted annually. However, this report was not produced in 2007. Therefore, the 2005-2007 rates are provisionally set at the 2004 rate the new report is issued in the fall of 2008.

**Notes - 2006**

Starting with the 2004 data point, the numerator is women at or below 200% FPL who received family planning services through Title V, Title X, Title XIX, or 330/340 Federally Funded Community Health Centers. The denominator is women at or below 200% FPL who are fertile.

Data for this measure is from the Arizona Family Planning Council's Comprehensive Family Planning Report, which is usually conducted annually. However, this report was not created for 2005. Therefore, the 2005 and 2006 rate is provisionally set at the 2004 rate the new report is issued in the fall of 2007.

**Notes - 2005**

Starting with the 2004 data point, the numerator is women at or below 200% FPL who received family planning services through Title V, Title X, Title XIX, or 330/340 Federally Funded Community Health Centers. The denominator is women at or below 200% FPL who are fertile.

Data for this measure is from the Arizona Family Planning Council's Comprehensive Family Planning Report, which is usually conducted annually. However, this report was not created for 2005. Therefore, the 2005 and 2006 rate is provisionally set at the 2004 rate the new report is issued in the fall of 2007.

**a. Last Year's Accomplishments**

Through the Reproductive Health/Family Planning Program (RHFP), 10 out of the 15 County Health Departments received intergovernmental agreements to provide reproductive health/family planning services that focused on women at or below 150% of the federal poverty level. In 2007, there was a transition in the provider of family planning services in Maricopa County. In an effort to reach a more diverse population, the program provided funding to Maricopa Integrated Health Systems. Of the 4,073 women who received an initial or annual exam in 2007, 98% were at or below 150% of the federal poverty level and received services at no charge. The RHFP collaborated with the Title X and Arizona Family Planning Council (AFPC) to share data to analyze trends and outcomes of family planning services among this group.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The RHFP program will fund intergovernmental contracts to sustain and/or increase number of low income women receiving family planning and reproductive health services.	X			
2. The RHFP collaborated with other state agencies to share resources and data for trend and outcome analyses				X
3.				

4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The RHFP contractors receive level funding in the unit reimbursement for providing the required services of the program. After monitoring the rates in 2007, the RHFP will increase unit rates to accommodate higher birth control and supply costs. In 2008, the Program will also add two new contractors to increase the availability of Family Planning Services to low income women. Gila County Health Department and Arizona State University's Breaking the Cycle will receive funding from the Program. In addition, the Reproductive Health/Family Planning Program will continue to work with contractors to improve access for low income clients to preconception care. Another focus of the Reproductive Health/Family Planning Program is assisting the Title X, Arizona Family Planning Council (AFPC) with a statewide needs assessment.

**c. Plan for the Coming Year**

The RHFP will continue to provide funding to county health departments and Maricopa Integrated Health Systems to provide services to underserved populations. The program will continue to focus on women at or below 150% of the federal poverty level. The Program will continue to seek out locations where African American clients can be served. The Reproductive Health/Family Planning Program will also focus on making services available to sexually active teens in an effort to reduce teen pregnancy rates.

**State Performance Measure 2:** *The percent of high school students who are overweight or at-risk for overweight.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				25	25
Annual Indicator		25.1	25.5	25.5	25.9
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	24.5	24.5	24	24	24

**Notes - 2007**

The YRBS report already provides the calculated percentage. The percent at risk was added to the percent overweight to get the total at-risk +overweight.

The YRBS report is done every two years. The next report available will be for 2009.

**Notes - 2006**

The YRBS report already provides the calculated percentage. The percent at risk was added to the percent overweight to get the total at-risk +overweight.

The YRBS report is done every two years. Therefore, the 2006 rate is set at the 2005 rate. The next report available will be for 2007.

**Notes - 2005**

The YRBS report already provides the calculated percentage. The percent at risk was added to the percent overweight to get the total at-risk +overweight.

**a. Last Year's Accomplishments**

The Women's and Children's Community Health Grant program funded contractors that served 1,708 children and women of childbearing age, including high school students, with educational programs to address the problem of obesity and overweight for mothers and their families. All classes contained a physical activity component suitable for each local community. 289 obese and/or overweight children were enrolled in a new pediatric weight management program within a medical facility for low-income clients. Using baseline data of perceptions about obesity, one contractor initiated a children's nutrition and physical activity campaign and created a "Healthy Kids" website. One coalition of the community partners was expanded, which worked to promote healthy policy changes within the community and local organizations. Coalition partners attended eight grassroots advocacy trainings, and helped ensure that nine doctors were trained in behavioral counseling to improve adherence to their recommendations about children's dietary and physical activity habits. Several women were educated about the importance of achieving and maintaining a healthy weight through proper nutrition, exercise, and meal portion control through an 8-week course, each segment consisting of one-hour. Culturally appropriate intervention classes for Hispanics were also developed to educate Hispanic women and adolescents about obesity and overweight issues. Low income mothers participated in the Nurse Family Partnership program sponsored through a Women's and Children's Community Health Grant. Each participant received education about reducing obesity and overweight. Topics included nutrition, portion size, reading food labels, and the importance of regular physical activity. Native American elementary school students as well as middle school students participated in a nine month course about nutrition and physical activity on the Navajo reservation. Education and real-life experiences were provided in a culturally appropriate manner about obesity education and weight management.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Women's and Children's Community Health Grant program supported culturally sensitive obesity and/or overweight reduction education for all women of childbearing age and their families.			X	
2. Age-appropriate obesity and overweight reduction education were specifically designed for children of different socio-economic and race and ethnic strata.			X	
3. Coalitions were expanded based on the needs of the community.				X
4. Educational campaigns, presentations, and courses were conducted in different communities along with physical activity exercises.			X	
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The Women's and Children's Community Health Grant program continues nutrition and physical activity education, including healthy lifestyle choices, to reduce obesity and overweight among different strata of women and children.

**c. Plan for the Coming Year**

The Women's and Children's Community Health Grant program will continue nutrition and physical activity education, including healthy lifestyle choices, to reduce obesity and overweight among women and children.

**State Performance Measure 3:** *The percent of preventable fetal and infant deaths out of all fetal and infant deaths.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				33	32.5
Annual Indicator		33.9	33.2	25.8	25.0
Numerator		248	251	191	188
Denominator		732	756	739	753
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	32	31.5	31	31	31

**Notes - 2007**

Data provided is for the 2005 birth cohort, which is the most recent data available.

**Notes - 2006**

Data provided is for the 2004 birth cohort, which is the most recent data available.

**Notes - 2005**

Data provided is for the 2003 birth cohort, which is the most recent data available.

**a. Last Year's Accomplishments**

The Child Fatality Review (CFR) program provided copies of the Infant Death Checklist for investigations of unexplained infant deaths and a protocol for investigations of these deaths to law enforcement agencies throughout Arizona. Law enforcement in turn, submitted completed forms to the Medical Examiner's office and to the CFR program. These forms provide critical information regarding circumstances surrounding unexplained infant deaths. In 2007, CFR teams reviewed 100 percent of deaths for all children in Arizona, including infant deaths to examine and identify the circumstances surrounding the deaths that could be preventable. The data was analyzed for public policy and prevention campaigns and the data reports were provided to the public for research, media reports, and public health campaigns. The Unexplained Infant Death Council is staffed by the CFR Unit that advises the department, legislature and the Governor on issues relating to unexplained infant deaths and fetal deaths. The Office of Assessment and Evaluation produced a report on the incidence and reported causes of stillbirths, which was presented to the Council. Further, in 2007 the Citizen Review Panel (CRP) reviewed 22 Child Protective Service's (CPS) cases, including 12 involving maltreatment and death of infants. The panel prepared an annual report of review findings and recommendations to improve the state's child protection system.

The Arizona Birth Defects Monitoring Program (ABDMP) participated in three health fairs in 2007 to promote adequate intake of folic acid by women of childbearing age. The ABDMP also

conducts statewide, population-based surveillance for 45 major categories of birth defects. The rate of NTDs (spina bifida and anencephaly) for 2004-2006 was 5.06 per 10,000 (preliminary data).

The transport component of the High Risk Perinatal Program (HRPP) ensured the transport of any critically ill neonate or pregnant woman at risk of preterm delivery to the appropriate perinatal level of care. Covering the costs of transports for several high risk women the program was able to facilitate access to immediate transports.

The Women's and Children's Community Health Grant program provided services to 432 women who received classroom instruction on preconception care, with a special focus on consumption of folic acid. Another 148 women were provided with educational materials and information specifically about maternal and infant health at various community events. Approximately 34 women participated in community support groups, and received instruction about post-partum issues, correct infant sleeping position, and Sudden Infant Death Syndrome. Approximately 118 low income first-time mothers were targeted through the Nurse Family Partnership Program to provide education on reducing infant mortality (e.g. preconception care, nutrition, infant care, infant sleeping position, and disciplining practices) and support by public health nurses through home visits.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The CFR program distributes the Infant Death Scene Checklist to law enforcement agencies and promotes its use.				X
2. CFR produces an annual report that includes incidence, causes of fetal deaths and recommendations regarding infant deaths.				X
3. CFR enhanced and updated website to include information and resources on preventing infant deaths.				X
4. Produced an annual report of Citizen Review Panel activities and findings.				X
5. ABDMP conducts state-wide, active, population-based birth defect surveillance for neural tube defects.			X	
6. Women's and Children's Community Health Grant program funded in-home training and support for new mothers about reducing infant mortality.		X		
7. Women's and Children's Community Health Grant program supported the distribution of educational materials that relate to maternal and infant health, and preconception care at community events.		X		
8. HRPP covered the cost of transport to expedite the transfers of critically ill neonates and high risk pregnant women to appropriate levels of care.		X		
9. BWCH worked with partners to promote preconception health.			X	
10. The Governor's Office for Children, Youth, and Families collaborates with ADHS programs working on pre-conception health to integrate pre-conception health in the Arizona women's health calendar and distribute it throughout the state.			X	

**b. Current Activities**

BWCH is integrating promotion of preconception health into existing MCH programs and is working with internal and external partners to promote preconception health.

Child Fatality Review (CFR) program is promoting the use of the Infant Death Checklist by first responders through distribution of the checklist for investigations of unexplained infant deaths and the protocol for investigations of these deaths to law enforcement agencies throughout Arizona. The UIDC is continuing to advise the department, legislature, and governor on issues related to unexplained infant deaths and fetal deaths.

ABDMP programs are currently working with the Bureau of USDA Nutrition Program to encourage all women of childbearing age to consume adequate amounts of folic acid daily for neural tube defect (NTD) prevention.

HRPP continues to cover the costs of transport to transfer neonate and high risk pregnant women to appropriate levels of care, thus facilitating greater access to medical services and reducing the risk of infant death and/or preterm birth.

The Women's and Children's Community Health Grant program continues to educate clients about preventing fetal and infant deaths.

### **c. Plan for the Coming Year**

CFR will continue to review infant and fetal deaths, and compile the results in an annual report. CFR will continue to promote the use of the Infant Death Checklist and expects to further strengthen its ties with local coalitions and organizations, which include: Safe Kids, Injury Free Coalition for Kids, Governor's Traffic Safety Advisory Council, Never Shake a Baby Arizona, Inter Tribal Council of Arizona, Maricopa Association of Governments, and others. CFR will enhance the usability of its annual reports by incorporating the spectrum of prevention, in addition to, incorporating guidelines for writing effective recommendations, which would include problem statements, best practices, capacity, accountability, outcomes, and impacts.

The ABDMP will continue to work with the Bureau of USDA Nutrition Programs to encourage all women of childbearing age to consume adequate amounts of folic acid daily for neural tube defect (NTD) prevention. The ABDMP will continue to participate in three to four health fairs a year where information will be provided to the public about the importance of folic acid for birth defect prevention. The ABDMP will also continue to conduct statewide surveillance on NTDs to provide feedback on the effectiveness of prevention programs in the state. By the end of 2009, the ABDMP expects to have a complete NTD data for 2007 births.

HRPP will continue to cover the costs of transport to transfer neonate and high risk pregnant women to appropriate levels of care, thus facilitating greater access to medical services and reducing the risk of infant death and/or preterm birth.

The Women's and Children's Community Health Grant program will continue to fund programs and grants that will educate clients about preventing fetal and infant deaths.

BWCH is working with WIC and other public health programs to integrate messaging around preconception health, including the use of folic acid.

**State Performance Measure 4:** *Emergency department visits for unintentional injuries per 100,000 children age 1-14.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				7478	7477
Annual Indicator		7,478.6	7,174.4	6,902.9	6902.9
Numerator		90739	90201	89255	
Denominator		1213314	1257269	1293014	
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	7477	7476	7476	7476	7476

**Notes - 2007**

Data for 2007 are not yet available. The estimate for 2007 is provisionally set at the 2006 rate until data become available in the Fall of 2008.

**Notes - 2006**

Data for 2006 are not yet available. The estimate for 2006 is provisionally set at the 2005 rate until data become available in the Fall of 2007.

**Notes - 2005**

Data for 2005 are not yet available. The estimate for 2005 is provisionally set at the 2004 rate until data become available in the Fall of 2006.

**a. Last Year's Accomplishments**

Through the Community Health Grants, 389 bicycle helmets were distributed, along with helmet safety education. 1,611 high school students were provided with education regarding seat belt safety, crash dynamics, and dangers from drugs and alcohol while operating a motor vehicle. 541 pre-adolescents (8-12 years old) were provided with education about appropriate, healthy behaviors regarding vehicle safety. 1,500 elementary school students were provided with presentations about using seat belts and helmets. Approximately 1,000 parents/caregivers attended adult car seat classes.

The Women's and Children's Health Grant Program sponsored "Safe Dates", a co-educational injury prevention course for adolescents 12 to 18 years of age. 783 participants received information about healthy and abusive dating relationships.

The Safe Kids Program taught three child passenger safety courses in partnership with Banner Health for the following AZ communities: Hopi, Phoenix and Pinetop. Two short classes were taught to child protective services agencies. The Safe Kids coordinator served as an appointed position with the Governor's Traffic Safety Advisory Council. In addition, the coordinator is a member of the legislative subcommittee and chairs the Restraint Use subcommittee within the Council.

The High Risk Perinatal Program's Community Health Nurses conducted environmental risk assessments on every home visit. These assessments helped to identify potentially hazardous situations in the home. Once identified, the Community Health Nurse was able to work with the family to understand the risk and correct the situation, thereby reducing risks and ER visits.

**Table 4b, State Performance Measures Summary Sheet**

<b>Activities</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
1. The Safe Kids Program conducts passenger safety training.				X
2. The Safe Kids Program offers continuing education units that will allow current CPS technicians to recertify.				X

3. Community Health Grants Program supports bicycle helmet distribution and bicycle safety education for children.			X	
4. Environmental home assessments performed by the Community Health Nurses.		X		
5. Community Health Nurses educate families about safe environments.			X	
6. The Emergency Medical Services for Children Program established a pediatric designation system for emergency departments.				X
7.				
8.				
9.				
10.				

**b. Current Activities**

The Emergency Medical Services for Children Program will facilitate a pediatric symposium to address paramedic pediatric continuing education. The program will establish guidelines for the care of the injured child for all hospitals, including essential emergency department equipment and pediatric training for providers. In addition, emergency departments will be surveyed to determine pediatric preparedness capacity.

The Safe Kids Program continues to support community child passenger safety trainings and events. Safe Kids will work with Indian Health Services to update the Safe Native American Passengers' curriculum. Safe Kids offers continuing education to CPS technicians. A pediatric symposium will be offered to EMS personnel.

Community Health Nurses conduct environmental risk assessments on every home visit. These assessments help to identify potentially hazardous situations in the home. Once identified, the Community Health Nurse is able to work with the family to understand the risk and correct the situation, thereby reducing risks and ER visits.

**c. Plan for the Coming Year**

Community Health Nurses will continue to conduct environmental risk assessments on every home visit. These assessments will help to identify potentially hazardous situations in the home. Once identified, the Community Health Nurse will be able to work with the family to understand the risk and correct the situation, thereby reducing risks and ER visits.

The Injury Prevention Program will be addressing several initiatives for 2009 including updating the County Injury reports to distribute to County Health Officers, working with Northeastern Arizona to establish a Safe Kids chapter to address unintentional injury to children below age 14, and most importantly continuing current efforts to create a pediatric designation system for hospital emergency departments to improve emergency care to Arizona's children.

**State Performance Measure 5:** *The percent of women entering prenatal care during their first trimester in underserved primary care areas.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				48	48
Annual Indicator		49.6	47.2	50.0	50
Numerator		62	60	62	
Denominator		125	127	124	

Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	47	47	46	46	46

**Notes - 2007**

Data for 2007 are not yet available. The estimate for 2007 is provisionally set at the 2006 rate until data become available in the Fall of 2008. The numerator is the number of Primary Care Area's (PCA's) with less than 74% of women giving birth receiving prenatal care in the first trimester. The denominator is the total number of PCA's in Arizona. For 2006 the percent of women giving birth in a Arizona Medically Underserved Area (AzMUA) who received prenatal care in the first trimester was 73.8%.

**Notes - 2006**

Data for 2006 are not yet available. The estimate for 2006 is provisionally set at the 2005 rate until data become available in the Fall of 2007.

**Notes - 2005**

Numerator is the number of Primary Care Area's (PCA's) with less than 74% of women giving birth receiving prenatal care in the first trimester. Denominator is the total number of PCA's in Arizona.

**a. Last Year's Accomplishments**

Five rural counties reported 366 women entered into prenatal care in the first trimester. Over 1,500 women were provided prenatal services in the rural/medically underserved areas through the County Prenatal Block Grant Program. Rural counties utilized mobile clinics for women who had no or minimal transportation, provided immunization clinics to attract women who were at risk of getting pregnant, and contacted high schools to develop teen pregnancy programs and teen mazes. The County Prenatal Block Program also supported gifts as incentives for women who completed prenatal classes, and provided free pregnancy tests.

The Health Start program educated pregnant women about prenatal care, nutrition and danger signs of pregnancy. The Community Lay Health Workers followed-up with the clients to verify that they were attending prenatal care medical appointments and were complying with the physician's instructions. All contracted agencies serve communities that are designated as primary care areas. Of those categorized as primary care areas a large portion are also designated as medically underserved areas.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Health Start program provides outreach to high risk pregnant women and children in underserved areas.		X		
2. The Health Start program offers services in appropriate languages.		X		
3. The County Prenatal Block Grant program sponsors public events to increase the awareness of services for women of childbearing age.			X	
4. The County Prenatal Block Grant program collaborates with other BWCH programs such as Health Start to identify pregnant women.			X	
5. The County Prenatal Block Grant program supports mobile prenatal care clinics to make services accessible.			X	
6. The County Prenatal Block Grant program utilizes	X			

immunizations and pregnancy tests to identify pregnant women early in their pregnancies.				
7. The Governor's Office for Children, Youth, and Families developed strategies and action steps to examine how to increase prenatal care.				X
8. The Pregnancy and Breast Feeding Hotline will continue to refer women to doctors who provide prenatal care under the Baby Arizona program.			X	
9.				
10.				

**b. Current Activities**

The Health Start Program contracts with agencies that provide service to high risk pregnant women in communities that are designated as primary care areas and are also categorized as medically underserved.

The County Prenatal Block Grant continues to employ multiple strategies to identify women as early as possible who are at risk of getting or being pregnant. The program provides funding for mobile clinics in rural areas where services are limited and/or transportation is a barrier to service.

Baby Arizona allows women to start getting health care before the application process for Arizona Medicaid (AHCCCS) is complete. The Pregnancy and Breast Feeding Hotline provides names of doctors that provide prenatal care and participate in the Baby Arizona Program. Pregnant women receive health care through the Baby Arizona program while their application to AHCCCS is processed.

**c. Plan for the Coming Year**

The Health Start Program will continue to contract with agencies that provide serves to pregnant women who are considered at high risk for having a low birth weight baby in communities that are designated as primary care areas and are also categorized as medically underserved.

County Prenatal Block Grant will include incentive programs to bring low-income and at-risk women into the clinics, identify pregnant women early into the pregnancy and attempt to get them into prenatal care, provide minimal case management services with at-risk women being the priority population, and support contractors who provide mobile prenatal clinics in rural areas.

Baby Arizona will continue to allow women to start getting health care before the application process for Arizona Medicaid (AHCCCS) is complete. The Pregnancy and Breast Feeding Hotline will provide names of doctors that provide prenatal care and participate in the Baby Arizona Program. Pregnant women will receive health care through the Baby Arizona program while their application to AHCCCS is processed.

**State Performance Measure 6:** *Percent of Medicaid enrollees age 1-18 who received at least one preventive dental service within the last year.*

Tracking Performance Measures  
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				43	43.5
Annual Indicator		42.6	42.6	30.9	34.0
Numerator			255983	170018	189423
Denominator			600379	550768	556516
Is the Data Provisional or Final?				Final	Final

	2008	2009	2010	2011	2012
Annual Performance Objective	44	44.5	44.5	44.5	44.5

**a. Last Year's Accomplishments**

The Office of Oral Health (OOH) has continued to support the existing oral health coalitions in Pima, Mohave and Cochise Counties and additionally funded Navajo County to establish a coalition. Continued support for our partners in addressing access to care issues has been a strategy to improve oral health. A grant from State Appropriations was awarded to Coconino County and AT Still School Dentistry and Oral Health (ASDOH) to provide mobile equipment to serve rural areas. OOH continues to maintain dental trailers on loan to communities or non-profit organizations to provide care in underserved areas. In collaboration with ASDOH, Special Health Care training was provided to 8 dentists from underserved areas around the state. Training was provided to approximately 500 staff members of child care facilities, Head Start staff, and WIC programs on early oral health issues and early intervention. The Dental Sealant program reaches children in underserved and low-income areas.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Office of Oral Health provides support to communities in addressing access to care issues.				X
2. The Office of Oral Health provides training for childcare providers and early childhood teachers.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

OOH conducts training for child care professionals and early childhood teachers. The Office continues to monitor AHCCCS (Arizona Medicaid) Health Plans on policies for dental care and case management, collaborates with school based dental clinics, and partners with private organizations and foundations to enhance preventive activities. Through a HRSA Work Force Grant, OOH is initiating tele-dentistry programs in several rural/underserved locations and continues to work with the Arizona Dental Association and Arizona Dental Hygiene Association, all in an effort to improve the number of providers for the underserved. The dental sealant program continues to expand and provides services to underserved children.

**c. Plan for the Coming Year**

OOH will continue to track the utilization of AHCCCS funds for dental care. OOH will collaborate with other agencies and organizations to promote oral health education and early intervention by dental professionals. OOH will again award equipment to serve rural/underserved communities and continue to support the trailer loan program. OOH will support local coalitions to help build oral health infrastructure, and the dental sealant program will continue to expand. The HRSA Work Force Grant will establish one additional site.

**State Performance Measure 8:** *Percent of children and youth with special health care needs who have access to service.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective					
Annual Indicator					0.1
Numerator					32631
Denominator					232545
Is the Data Provisional or Final?					Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	0.1	0.2	0.2	0.3	0.3

**Notes - 2007**

The population estimate for all residents of Arizona under age 21 is 1,860,359. SLAITS estimates that 12.5 percent of children under age 18 have a special health care need. This percentage was applied to the population up to age 21, as the best estimate of the proportion for that population subgroup. The number of children and youth with special health care needs under age 21 living in Arizona is estimated as 1,860,359 X 0.125 = 232,545.

**a. Last Year's Accomplishments**

OCSHCN has several systems in place to help link families to available services for CYSHCN. OCSHCN developed a letter in collaboration with the ADHS Birth Defects Registry to send to all families of children born with spina bifida and cleft lip/cleft palate to inform them of coverage available through the Children's Rehabilitative Services (CRS) program. Currently 89 newborns identified through the Birth Defects Registry in FY07 with spina bifida or cleft lip/cleft palate are enrolled in CRS. 11 newborns diagnosed with Sickle Cell disorders were referred to the CRS program.

461 children received service coordination through OSCHCN's Family Resource Coordination Program (FRC). 318 of the children served through FRC had insurance, and 17 children who were without insurance or unable to afford services not covered by their insurance were able to access care through Assistance to Families (ATF). 208 children and youth received 540 units of ATF services which can include therapy, transportation and equipment. Outreach and training was provided to 2,448 family members, agency and tribal representatives, health care providers, and child serving agencies, Department of Corrections and schools regarding care and services for children and youth with TBI/SCI.

OCSHCN works with the Social Security Administration to review SSI applications and provide referral information to applicants. In 2007, the SSI project sent 1,987 letters that provided insurance information to families, informed families of state and local services and programs, and made referrals to Raising Special Kids-Family to Family Health Information Center (RSK-F2FHIC). 18% of the applicants were referred to the Arizona Department of Education (ADE), 1% to the Arizona School for the Deaf & Blind, 3% to AzEIP; 18% to Childrens Rehabilitative Services (CRS), 40% to the Division of Developmental Disabilities (DDD), 7% to ADE and DDD, 1% OCSHCN FRC and 12% to the ADHS Regional Behavioral Health Authorities and the Navajo and Hopi Behavioral Health Authority. OCSHCN responded to over 600 family calls and directed them to services within their community.

OCSHCN supported the Bureau of Women's and Children's Health (BWCH) Children's Information Services (CIS) Hotline to educate families on AHCCCS, insurance information, and other services for CYSHCN. OCSHCN provided education to the Hot Line staff on services and programs for CYSHCN. OCSHCN worked with Raising Special Kids Family to Family Health Information Center (RSK-F2FHIC) and BWCH Community Nursing to provide resource information to families identified as having a child with special needs.

OCSHCN co-sponsored Banner Children's Hospital's annual school nurse conference attended

by 246 nurses. OCSHCN provided the nurses with information on best practices and with eligibility information for programs providing services to CYSHCN. OCSHCN participated in a work group with school nurses, parents, advocates and legislators on the role of school nurses. The Asthma Program helped fund development of 7000 bi-lingual Patient/Family Asthma Toolkits. The kits were distributed to pediatricians, family physicians, pediatric nurse practitioners and family nurse practitioners. The tool kit is available on the Arizona Asthma Coalition web site at [www.azasthma.org](http://www.azasthma.org). A power point presentation "Asthma in the School Setting" was developed and disseminated to school nurses.

Children and youth with certain rare metabolic disorders must remain on a restricted diet for life. Medical food is very costly, but is the only treatment for the disorders. Public and private insurance do not cover all of the costs of these foods. CRS pays for formulas for certain disorders, and state funding covers the family copay for medical food for CYSHCN enrolled in CRS. Public insurance covers the cost of enteral feedings as well as oral nutrition supplements when medically necessary. The Bureau of USDA Nutrition Programs has coordinated with WIC and AHCCCS to ensure that CYSHCN were covered in a timely manner and received medical nutrition therapy as prescribed. The Bureau has also provided training on the approval process with WIC special needs nutritionists and AHCCCS MCH Coordinators. An agreement was made with the formula manufacturer to ship formula directly to CRS members at no cost.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. OCSHCN programs provide information, referral and education on how to access services to families with children and young adults with special health care needs		X		
2. OCSHCN collaborates with other ADHS offices to provide eligibility information for programs and services for children and young adults with special health care needs		X		X
3. OCSHCN works with Raising Special Kids to develop and distribute information on eligibility determination for programs for children and young adults with special health care needs		X		
4. OCSHCN works with child serving agencies and community partners to draw attention to the needs of children and young adults with special health care needs when program and policy decisions are being made				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

FRC provides information and referral and education on how to access services for CYSHCN to families, providers, child-serving agencies and the community. The Information and Referral Project refers callers to services, provides an overview of systems of care, provides information on eligibility and application processes, and provides information on financial aid and behavioral health services. The SSI Project reviews SSI applications, sends letters to applicants to inform them of insurance options, services and programs, and responds to calls about the letters.

OCSHCN collaborates with BWCH to provide resource information to Community Nursing on

children ineligible for other care and at risk for developmental delay, supports the CIS Hotline, and educates staff on available services. OCSHCN works with RSK to develop and distribute fact sheets on eligibility determination for health care services. OCSHCN and the Birth Defects Registry inform families of children with spina bifida and cleft lip/cleft palate about CRS eligibility.

OCSHCN informs state school nurse organizations about CRS eligibility and provides technical assistance on care and services for CYSHCN. OCSHCN is on Banner Children's Hospital's annual School Nurse Conference planning committee and includes tracts on program eligibility on each agenda. OCSHCN is on AzEIP's Interagency Coordinating Council, actively participates on committees, provides information about CYSHCN, and educates ADHS offices about AzEIP.

### **c. Plan for the Coming Year**

OCSHCN will continue to promote best practices with partners and contractors will provide training on navigating systems of care and conduct consumer satisfaction surveys to identify strengths, barriers and strategies for improving services and increasing access to resources. OCSHCN will remain a liaison to AzEIP, actively participating with this agency and providing education to others about AzEIP service and eligibility. OCSHCN will explore working with The Arizona Partnership for Infant Immunization (TAPII) to develop educational information for families of CYSHCN on adjusting dosages for children and youth who are immunocompromised.

OCSHCN will work with the RSK-F2FHIC to convert their Arizona Health Care Systems Workshop into an on-line interactive class available to families and providers. OCSHCN will continue to collaborate with RSK-F2FHIC and BWCH Community Nursing to help families gain access to providers and services. School Health will explore ways to strengthen and promote relationships between school nurses and families as an avenue to providing information and referral regarding services for CYSHCN.

OCSHCN will continue to develop resources and offer training and education to providers, families and community partners on services available for CYSHCN. Bi-lingual Information and Resource Project staff will assist callers with resource information. Information generated from the call log system will be used to track barriers that families identify in gaining access to the services they need and to track and trend referral outcomes related to disability, age, geographical area and referral sources. The information will be shared with the responsible agencies.

OCSHCN's FRC Program will link children to services and provide referral information. The SSI Project will review SSI applications, provide referral information to applicants and offer training to the agencies receiving referrals as a result of the SSI letters. OCSHCN will continue to work with BWCH to identify children who may be eligible for CRS, AzEIP, and the FRC Program and will provide training to CIS hotline staff. OCSHCN will work with the Birth Defects Registry to send letters to families of children with spina bifida and cleft lip/cleft palate, which provides CRS eligibility information, and will explore adding AzEIP information to the letter.

OCSHCN will educate the Mohave County Juvenile Court Children's Action Team on the medical home concept and accessing services for CYSHCN who are in the correction system. OCSHCN will work with other ADHS offices to identify resources for families regarding child care. OCSHCN will continue to track and trend issues regarding accessing services identified by families receiving SSI letters.

**State Performance Measure 9:** *Percentage of state MCH programs that formally incorporate screening for behavioral health issues.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective					
Annual Indicator					33.3
Numerator					6
Denominator					18
Is the Data Provisional or Final?					Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	40	40	45	45	50

**Notes - 2007**

The programs included in this measure were; the Health Start Program, High Risk Perinatal Program, Teen Pregnancy Prevention program, Family Planning Program, Sexual Violence Prevention and Education Program, County Prenatal Block Grant program, Community Health Services Grant, early childhood health consultation, Rural Safe Home Network, Office of Children with Special Health Care Needs programs, and Dental Sealant and Early Childhood Carries programs (Office of Oral Health).

**a. Last Year's Accomplishments**

The High Risk Perinatal Program (HRPP) community health nurses began screening all mothers of infants enrolled in the Newborn Intensive Care Program in July of 2006 for postpartum depression using the Edinburgh Postnatal Depression Scale.

The Health Start Program has also encouraged contractors to screen for post-partum depression utilizing the Edinburgh Screening Tool.

All 15 counties participated in Perinatal Mood Disorder training that was sponsored by the County Prenatal Block Grant program. Each county conducts depression screening utilizing the Edinburgh Depression Screening Tool, for prenatal and postpartum women who participate in their Maternal Child Health programs.

OCSHCN included requirements related behavioral health screening in contracts for Children's Rehabilitative Services and Family Resource Coordination.

The Family Planning Program monitored women for depression if the need was indicated on the health history screening. Referrals for treatment were made to the appropriate programs.

The early childhood health consultant in Pima County provided training on mental health issues to child care centers and other consultants.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Both the Health Start and High Risk Perinatal programs either encourage or require contractors to use the Edinburgh Postnatal Depression Screening to identify clients with postpartum depression.		X		
2. The County Prenatal Block Grant sponsored Perinatal Mood Disorder training for county health departments in all 15 counties.				X
3. OCSHCN required behavioral health screening in contracts for			X	

Children's Rehabilitation Services and Family Resource Coordination.				
4. The Family Planning Program monitors women for depression and makes appropriate referrals.	X			
5. Early childhood health consultation provided training on mental health issue to child care centers.				X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The High Risk Perinatal Program (HRPP) community health nurses screen all mothers of infants enrolled in the Newborn Intensive Care Program for postpartum depression using the Edinburgh Postnatal Depression Scale.

The Health Start Program encourages contractors to screen for post-partum depression utilizing the Edinburgh Screening Tool.

All 15 counties that receive funding from the County Prenatal Block Grant program conduct depression screening of prenatal and postpartum women in their MCH programs utilizing the Edinburgh Depression Screening Tool.

OCSHCN includes requirements related behavioral health screening in contracts for Children's Rehabilitative Services and Family Resource Coordination.

The Family Planning Program monitors women for depression if the need is indicated on the health history screening. Referrals for treatment are made to the appropriate programs.

The Rural Safe Home Network funds services to children who witness domestic violence.

**c. Plan for the Coming Year**

In State Fiscal Year 2009, the Health Start Program will formally screen pregnant women for alcohol use utilizing the TWEAK Tool during the first prenatal visits. Two contractors will pilot the screening tool for the first year and then other contractors will adopt the screening protocol as required.

The High Risk Perinatal Program (HRPP) community health nurses will screen all mothers of infants enrolled in the Newborn Intensive Care Program for postpartum depression using the Edinburgh Postnatal Depression Scale.

All 15 counties that receive funding from the County Prenatal Block Grant program will conduct depression screening of prenatal and postpartum women in their MCH programs utilizing the Edinburgh Depression Screening Tool.

OCSHCN will include requirements related behavioral health screening in contracts for Children's Rehabilitative Services and Family Resource Coordination.

The Family Planning Program will monitor women for depression if the need is indicated on the health history screening. Referrals for treatment will be made to the appropriate programs.

BWCH will work with the Division of Behavioral Health to identify wellness messaging that can be incorporated into MCH programs.

## **E. Health Status Indicators**

Information summarized through health status indicators provide a foundation for understanding the maternal and child health target population. Many of these indicators are utilized as a starting point of the needs assessment cycle. For the five-year needs assessment, many of these indicators were looked at in greater detail. An analysis was conducted in which the maternal and child health program determined need by comparing subpopulations, comparing Arizona to the rest of the nation, comparing Arizona to standards (such as Health People 2010), and reviewing trends over time. This information was presented to program managers, community partners and other stakeholders to determine the states performance measures and set priorities for program planning. Below is a summary of data presented in the 2007 Block Grant Application.

#01A, #01B, #02A, and #02B: Arizona currently has a higher percentage of infants born at low birth weight and very low birth weight when compared to the Healthy People 2010 goals. In Arizona during 2004, 7.2 percent of live births weighed less than 2,500 grams compared to the Healthy People 2010 goal of 5.0 percent. Additionally, 1.2 percent of live births weighed less than 1,500 grams in Arizona compared to the Healthy People 2010 goal of 0.9 percent. Among singleton births in Arizona, 5.6 percent weighed less than 2,500 grams and 0.9 percent weighed less than 1,500 grams.

***/2009/ The percentage of low and very low birth weight infants remained unchanged in 2006 when compared to 2004. In Arizona during 2006, 7.1 percent of live births that weighed less than 2,500 grams and 1.2 percent of live births weighed less than 1,500 grams. Among singleton births in Arizona, 5.7 percent weighed less than 2,500 grams and 0.9 percent weighed less than 1,500 grams. //2009//***

#03A, #03B, #03C: In Arizona during 2004, the mortality rate of unintentional injuries among children aged 14 years and younger was 9.0 per 100,000. Motor vehicle crashes were the leading cause of unintentional injury deaths among Arizona residents aged 24 years and younger. The mortality rate of unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years (30.6 per 100,000) was 6.8 times higher than for children aged 14 years and younger (4.5 per 100,000).

***/2009/ In Arizona during 2006, the mortality rate of unintentional injuries among children aged 14 years and younger declined slightly to 8.6 per 100,000. //2009//***

#04A, #04B, #04C: In Arizona during 2004, the rate of all nonfatal injuries among children aged 14 years and younger was 263.4 per 100,000. Motor vehicle crashes were the leading cause of nonfatal injuries among Arizona residents aged 24 years and younger. The rate of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years (240.8 per 100,000) was substantially higher than for children aged 14 years and younger (66.6 per 100,000).

***/2009/ In Arizona during 2006, the rate of all nonfatal injuries among children aged 14 years and younger declined to 190.0 per 100,000. The rates of non-fatal injuries in motor crashes also declined for children 14 and younger (50.7 per 100,000) and 15 through 24 years (211.2 per 100,000). //2009//***

#05A and #05B: Teenage women were at higher risk for Chlamydia infection compared to older women. In Arizona during 2004, women aged 15 through 19 years (21.9 per 1,000) were almost three times more likely to be infected with Chlamydia than women aged 20 through 44 years (8.0 per 1,000).

***/2009/ In Arizona during 2006, the rate of Chlamydia infection increased for women aged***

**15 through 19 years (29.0 per 1,000) and 20 through 44 years (11.2 per 1,000). //2009//**

#06A and #06B: The total population by race of infants and children aged 0 through 24 years in Arizona during 2005 was 2,207,011. Within this population, 87.7 percent were White, 6.8 percent were American Indian/Native Alaskan, 3.7 percent were African American, and 1.8 percent were Asian. Among this population, 35.9 percent were Hispanic/Latino and 64.1 percent were non-Hispanic/Latino.

**//2009/ The total population by race of infants and children aged 0 through 24 years in Arizona during 2007 was estimated at 2,301,902. Among children aged 0 through 24, the population of Hispanic/Latino children increased to 37.6 percent. //2009//**

#07A and #07B: The total number of live births to women of all ages in Arizona during 2005 was 95,797. Among these women, 83.6 percent were White, 6.6 percent were American Indian/Native Alaskan, 3.6 percent were African American, 3.2 percent were Other/Unknown, and 2.9 percent were Asian/Native Hawaiian/Other Pacific Islander. When the total number of live births was analyzed by ethnicity, 44.6 percent were Hispanic/Latino, 47.7 percent were non-Hispanic/Latino, and in 7.7 percent of the live births ethnicity was not reported.

**//2009/ The total number of live births to women of all ages in Arizona during 2007 was 102,687. Among these women, 82.6 percent were White, 6.3 percent were American Indian or Native Alaskan, 4.1 percent were Black or African American, 3.7 percent were Other/Unknown, and 3.3 percent were Asian/Native Hawaiian/Other Pacific Islander. When the total number of live births was analyzed by ethnicity 45.1 percent were Hispanic/Latino ethnicity, 48.4 percent were non-Hispanic/Latino, and in 6.5 percent of the live births ethnicity was not reported. //2009//**

#08A and #08B: The total number of deaths of infants and children aged 0 through 24 years in Arizona during 2005 was 1,775. Among these children, 82.1 percent were White, 10.7 percent were American Indian/Native Alaskan, 5.3 percent were African American, 1.6 percent were Asian/Native Hawaiian/Other Pacific Islander, and 0.3 percent were Other/Unknown. Additionally, 42.9 percent were Hispanic/Latino, 37.7 percent were non-Hispanic/Latino, and in 19.3 percent of the deaths ethnicity was not reported.

**//2009/ The total number of deaths of infants and children aged 0 through 24 years in Arizona during 2007 was 1809. Among these children, 80.6 percent were White, 10.5 percent were American Indian/Native Alaskan, 7.5 percent were African American, 1.5 percent were Asian/Native Hawaiian/Other Pacific Islander, and 0.0 percent were Other/Unknown. Additionally, 45.8 percent were Hispanic/Latino, 54.1 percent were non-Hispanic/Latino, and in 0.1 percent of the deaths ethnicity was not reported. //2009//**

#09A and #09B: In Arizona during 2005, there were 502,318 infants and children aged 0 through 19 years enrolled in Medicaid. Among these children, 79.1 percent were White, 12.4 percent were American Indian/Native Alaskan, 6.6 percent were African American, 1.3 percent were Asian/Native Hawaiian/Other Pacific Islander, and 0.6 percent were Other/Unknown. The rate of juvenile crime arrests among African American youth aged 19 years and younger (10,407.1 per 100,000) was almost twice as high as the rate for White children (5,379.1 per 100,000). The percentage of high school drop-outs varied by ethnicity; 10.2 percent were Hispanic/Latino while 5.4 percent were non-Hispanic/Latino.

#10, #11, and #12: In 2005, the majority of Arizona resident children aged 0 through 19 years lived in urban areas (74.5 percent) compared to 18.8 percent in rural areas and 6.6 percent in frontier areas. One third of Arizona's population lived below 200% of the poverty level in 2005 and 14.1 percent lived below 100% of poverty. Children constituted a large proportion of the population in poverty. Among youth aged 0 through 19 years, 41.7 percent were below 200% of the poverty level, 21.0 percent were below 100% of poverty, and 10.7 percent were below 50% of

poverty.

## **F. Other Program Activities**

Toll-Free Hotlines. OWCH operates two toll-free hotlines: the Children's Information Center (CIC) and the Pregnancy and Breastfeeding Hotline. The CIC is a statewide, bilingual/bicultural toll-free number (TDD available for the hearing-impaired in Maricopa County) that provides information, referral, support, education and advocacy to family care givers and health care professionals throughout Arizona. Follow-up is provided to all those who call the number. The Pregnancy and Breastfeeding Hotline is a bilingual/bicultural hotline that facilitates entry of pregnant women into prenatal care services. Although the service is available to any caller, the target population is low-income women and those with culturally diverse needs. It provides advocacy, education, information and support to disadvantaged women and their families. Follow-up calls are provided to all those who use the number. The OWCH Hotline staff has assumed responsibility for the WIC Hotline and WIC provides training and technical assistance for the Hotline staff. A decision was made to reinstitute Baby Arizona, which is a presumptive eligibility process which guarantees physicians who see pregnant women that their first prenatal care visit will be covered by AHCCCS, even before the woman is determined to be eligible for AHCCCS services. Hotline staff will assist in referring women to Baby Arizona.

//2007/The State Systems Development Initiative (SSDI) will convene stakeholders to identify unmet program information needs. SSDI will collect feedback regarding if data is accessible, yields information that identifies and monitors trends, supports strategic planning, coordinates, integrates, and directs resources. SSDI will prioritize needs and will develop a plan based on unmet priority-need areas.//2007//

State Early Childhood Comprehensive Systems Grant (SECCS). The Office of Women's and Children's Health worked in partnership with the Governor's Office to submit the application for the SECCS to work with stakeholders to develop strategies to better integrate early childhood services and to develop a statewide Early Childhood Systems Plan. ADHS was awarded \$100,000 per year for two years beginning July 1, 2003. Funds were used to provide support to the Governor's School Readiness Board. Many people from ADHS, including OWCH staff, participated on subcommittees of the School Readiness Board. Staff will provide support to SECCS planning process as needed. The Board provided its recommendations to the Governor in the fall of 2003, and an implementation plan was released in 2005.

One of the recommendations of the Governor's School Readiness Action Plan recommends developing a health and safety consultation system for childcare providers. The Office of Women's and Children's Health, in conjunction with the Arizona Center for Community Pediatrics, sponsored a telephone survey to evaluate health and safety issues that childcare providers deal with on a regular basis. This survey, which was conducted in 2004, assessed the need for technical support and training in licensed childcare for children five years old and younger. Results of the survey are summarized in the five-year needs assessment document (in the section on Children and Adolescents) accompanying this application.

//2007/Hearing screening is mandated for all Arizona schools. The Program collaborated with the University of Arizona to create a draft curriculum outline for Vision Screening training. The Program monitors the number of children in Arizona schools who receive hearing screening and vision screening. The Program trains hearing screening trainers and monitors the training for hearing screeners to determine their compliance with Arizona Hearing Screening Rules. The Program loans audiometers to schools to provide hearing screening to children. The Program will continue development of a vision-screening curriculum and will begin developing a Train the Trainer Program in Vision Screening.

The Early Childhood Health Consultation Project in Pima County conducted a variety of activities,

some of which are discussed under other sections of this application. In addition to those activities, the program worked closely with the Governor's School Readiness Board on initial steps to develop a statewide health consultation system. This work is being done in conjunction with the State Early Childhood Comprehensive Systems Grant. The Project responds to requests from childcare programs, collaborates with county partners in the development of resources for childcare programs, and promotes best practices related to health and safety of childcare centers. The Project will update the communicable disease flipchart used by childcare providers, will provide training for health professionals utilizing the National Training Institute for Child Care Health Consultants as a guide. The Project will also work with the United Way of Southern Arizona to complete the Quality Rating system for childcare centers that has been developed and piloted.//2007//

Cultural competence:

/2007/Cultural competency will be addressed in other sections of this application for those programs that are discussed under specific performance measures and health systems capacity indicators.//2007// In addition to the information provided in those sections, OWCH programs take measures to ensure that services are linguistically and culturally appropriate, and family centered. The following are just a few examples: Community grants were set up specifically to address cultural competence by putting program design into the hands of the community to ensure that they will reflect the unique circumstances and cultural characteristics of each community. Each year OWCH sponsors the statewide Family Centered Practice Conference which supports family involvement and improves families' ability to access and utilize community services. OWCH is currently working with the Governor's Minority Advisory Council to develop specific strategies to address disparities, including health issues. Meetings focus attention on issues affecting each minority group to examine relationships between the group's social and cultural characteristics and their health status. Health disparity information is shared with community leaders who provide context to statistics, and who can mobilize support.

***/2009/OCSHCN staff and CRS contractors participate in an annual cultural competence self-assessment. Results are used to establish a baseline regarding staff perceptions, develop plans that address changes in policy and procedure, and identify training opportunities. OCSHCN facilitates a monthly cultural competency committee meeting. The committee includes OCSHCN staff, BHS staff, CRS contractors and outside agencies. The committee has discussed information and resources about immigration and has reviewed tools for organizational cultural competency self-assessments. OCSHCN's practices, policies and training stress the need for providers to recognize the cultural, racial, ethnic, geographic, social, spiritual and economic diversity and individuality of families. OCSHCN requires contractors to provide culturally competent service, requires them to use language assistance services and monitors them for compliance. Family satisfaction surveys are conducted in English and Spanish and results are tabulated by race, ethnicity and the need for translation services.//2009//***

E-Learning

***/2009/ OCSHCN's e-learning program added 46 new courses to the learning management system (LMS), expanded registration to 490 external partners, partnered with AHCCCS to include their e-learning domain on the LMS, and partnered with BHS and RSK - F2FHIC to develop courses. OCSHCN's website is used to offer information to families, providers and the community and to seek public input on programs and services. Information on cultural competency is available on the website.//2009//***

## **G. Technical Assistance**

Only one request is being made for technical assistance, and it is related to collecting data for National Performance Measure 15, the percent of women who smoke in the last three months of pregnancy. The State of Arizona does not participate in PRAMS and we are unaware of any

other data source for this measure.

/2008/For the 2008 application year, Arizona is requesting technical assistance to assist with one of our state defined priorities. The Bureau of Women's and Children's Health would like assistance with identifying models for integrating behavioral health with MCH programs. Related to the priority of preventable infant mortality, BWCH also request assistance with identifying a preconception health self assessment tool; strategies for funding preconception care; and framing preconception health message among different populations./2008//

## V. Budget Narrative

### A. Expenditures

The state's match and overmatch continues to exceed the 1989 maintenance of effort.

The budgeted amounts are based on previous year's projections and do not correlate well with the actual budgeted amount because of the unpredictability of the actual award amount and program changes that occur.

/2007/There are no updates for this year//2007//

/2008/There are no updates for this year//2008//

**/2009/There are no updates for this year//2009//**

### B. Budget

In 1998, the Arizona Department of Health made the decision to transition the MCH budgeting cycle from a federal fiscal year to a calendar fiscal year. Consequently, the annual reporting of budgeted, encumbered, and expended monies through September 30th is misleading in that we actually have another three months remaining in our calendar year budget cycle so expenditures will appear less than they should be while remaining money will appear greater.

Arizona state funds (match and overmatch) will be \$13,262,434 in FY2006, surpassing our state's maintenance of effort level in FY89 of \$12,056,360./2007/Arizona state funds (match and overmatch) will be \$13,032,329 in FY2007, surpassing our state's maintenance of effort level in FY89 of \$12,056,360./2007// /2008/Arizona state funds (match and overmatch) will be \$16,879,160 in FY2008, surpassing our state's maintenance of effort level in FY89 of \$12,056,360./2008// **/2009/Arizona state funds (match and overmatch) will be \$17,892,553 in FY2009, surpassing our state's maintenance of effort level in FY89 of \$12,056,360//2009//**

The estimated Title V allocation for Arizona, FY2006, is \$7,769,858. Slightly more than thirty-two percent (\$2,512,683) of the block grant will be allocated for preventative and primary care needs for children and adolescents; thirty percent (\$2,330,957) will be allocated to children with special health care needs; slightly less than twenty-eight percent (\$2,149,233) will be allocated for women, mothers and infants and ten percent (\$776,985) will be budgeted for administrative costs./2007/The estimated Title V allocation for Arizona, FY2007, is \$7,512,293. Slightly more than thirty percent (\$2,286,514) of the block grant will be allocated for preventative and primary care needs for children and adolescents; thirty percent (\$2,253,688) will be allocated to children with special health care needs; slightly less than thirty percent (\$2,220,862) will be allocated for women, mothers and infants and ten percent (\$751,229) will be budgeted for administrative costs./2007// /2008/The estimated Title V allocation for Arizona, FY2008, is \$7,255,120. Slightly more than thirty percent (\$2,242,127) of the block grant will be allocated for preventative and primary care needs for children and adolescents; thirty percent (\$2,176,536) will be allocated to children with special health care needs; slightly less than thirty percent (\$2,110,945) will be allocated for women, mothers and infants and ten percent (\$725,512) will be budgeted for administrative costs./2008// **/2009/The estimated Title V allocation for Arizona, FY2009, is \$7,028,756. Slightly more than thirty percent (\$2,212,595) of the block grant will be allocated for preventative and primary care needs for children and adolescents; thirty percent (\$2,108,627) will be allocated to children with special health care needs; slightly less than thirty percent (\$2,004,659) will be allocated for women, mothers and infants and ten percent (\$702,876) will be budgeted for administrative costs//2009//**

We have another three months remaining in our calendar year budget cycle, so our remaining

money will appear greater. It is projected that there will be \$2,848,328 remaining as carry over from our FY2005 block grant in the following types of service: \$1,170,788 for pregnant women, mothers and infants; \$943,360 for preventative and primary care needs for children and adolescents; and \$734,180 for children with special health care needs./2007/We have another three months remaining in our calendar year budget cycle, so our remaining money will appear greater. It is projected that there will be \$2,861,375 remaining as carry over from our FY2006 block grant in the following types of service: \$517,867 for pregnant women, mothers and infants; \$467,312 for preventative and primary care needs for children and adolescents; and \$1,876,196 for children with special health care needs./2007// /2008/We have another three months remaining in our calendar year budget cycle, so our remaining money will appear greater. It is projected that there will be \$1,618,200 remaining as carry over from our FY2007 block grant in the following types of service: \$341,000 for pregnant women, mothers and infants; \$402,000 for preventative and primary care needs for children and adolescents; and \$875,200 for children with special health care needs./2008// **/2009/It is projected that there will be \$394,791 unobligated funds from our FY2008 block grant. The Office for Children with Special Health Care Needs expends their funds on a state fiscal year (7/1 - 6/30) and does not begin using the funds awarded 10/1 until 7/1 the following year/2009//**

The state's maintenance of effort includes line-item funding for High Risk Perinatal Services, \$3,630,600; a Perinatal block grant to all fifteen counties, \$1,148,500; Children's Rehabilitation Services (CRS), \$3,587,000; Adult Cystic Fibrosis and Sickle Cell Anemia Programs, \$138,200; Child Fatality Review Program, \$100,000; Prenatal Outreach Program (Health Start), \$226,600 and Newborn Screening Program, \$3,205,100. An additional \$1,226,434 in state general funds is allocated to the Public Health Prevention Bureau and, in part, supports half of our personnel located in the Offices of the Bureau Chief, Women's and Children Health, Children With Special Health Care Needs and Oral Health and supplements above-the-line activities. Our state's FY2006 match and overmatch of \$13,262,434 continues to exceed the maintenance of effort amount of FY1989's \$12,056,360./2007/The state's maintenance of effort includes line item funding for High Risk Perinatal Services, \$3,630,600; a Perinatal block grant to all fifteen counties, \$1,148,500; Children's Rehabilitation Services (CRS), \$3,587,000; Adult Cystic Fibrosis and Sickle Cell Anemia Programs, \$138,200; Child Fatality Review Program, \$100,000 and Newborn Screening Program, \$3,727,900. An additional \$700,129 in state general funds is allocated to the Public Health Prevention Bureau and, in part, supports half of our personnel located in the Offices of the Bureau Chief, Women's and Children Health, Children With Special Health Care Needs and Oral Health and supplements above-the-line activities. Our state's FY2007 match and overmatch of \$13,032,329 continues to exceed the maintenance of effort amount of FY1989's \$12,056,360./2007// /2008/The state's maintenance of effort includes line item funding for High Risk Perinatal Services, \$5,430,600; a Perinatal block grant to all fifteen counties, \$1,148,500; Children's Rehabilitation Services (CRS), \$3,587,000; Adult Cystic Fibrosis and Sickle Cell Anemia Programs, \$138,200; Child Fatality Review Program, \$100,000 and Newborn Screening Program, \$5,597,796. An additional \$877,064 in state general funds is allocated to the Public Health Prevention Bureau and, in part, supports half of our personnel located in the Offices of the Bureau Chief, Women's and Children Health, Children with Special Health Care Needs and Oral Health and supplements above-the-line activities. Our state's FY2007 match and overmatch of \$16,879,160 continues to exceed the maintenance of effort amount of FY1989's \$12,056,360./2008// **/2009/The state's maintenance of effort includes funding for High Risk Perinatal Services, \$5,430,600; a Perinatal block grant to all fifteen counties, \$1,148,500; Children's Rehabilitation Services (CRS), \$3,587,000; Adult Cystic Fibrosis and Sickle Cell Anemia Programs, \$138,200; Child Fatality Review Program, \$100,000; and Newborn Screening Program, \$6,351,000. An additional \$1,137,253 in state general funds is allocated to Public Health Prevention Services, in part, supports half of our personnel located in the Offices of the Bureau Chief, Women's and Children Health, Children with Special Health Care Needs and Oral Health and supplements above-the-line activities. Our state's FY2008 match and overmatch of \$17,892,553 continues to exceed the maintenance of effort amount of FY1989's \$12,056,360/2009//**

For fiscal year 2006, we will receive additional state and local funding as a result of our collaboration with other state government agencies and charitable foundations. The total of \$20,187,058 is designated for Children's Rehabilitative Services, Teen Pregnancy Prevention and Abstinence Services, and the Prenatal Outreach Program (Health Start)./2007/For fiscal year 2007, we will receive additional state and local funding as a result of our collaboration with other state government agencies and charitable foundations. The total of \$22,721,775 is designated for Children's Rehabilitative Services, Teen Pregnancy Prevention and Abstinence Services, and the Prenatal Outreach Program (Health Start)./2007// /2008/For fiscal year 2008, we will receive additional state and local funding as a result of our collaboration with other state government agencies and charitable foundations. The total of \$28,991,313 is designated for Children's Rehabilitative Services, Teen Pregnancy Prevention and Abstinence Services, Pregnancy Services and the Prenatal Outreach Program (Health Start)//2008// **/2009/For fiscal year 2009, we will receive additional state and local funding because of our collaboration with other state government agencies and charitable foundations. The total of \$34,243,753 is designated for Children's Rehabilitative Services, Teen Pregnancy Prevention, and the Prenatal Outreach Program (Health Start)//2009//**

Other federal funds in the amount of \$57,926,638 represent matching funds from Title XIX and Title XXI for Children's Rehabilitative Services. Additional federal monies will contribute another \$86,348,660 toward MCH initiatives which include the WIC food grant, \$76,938,417; Universal Newborn Hearing, \$149,970; Rape Prevention and Education, \$753,331; Family Violence Prevention, \$1,685,611; SSDI Primary Care, \$100,000; Abstinence Education, \$1,034,776; Kids Care, \$3,319,509; Arizona Early Intervention, \$500,000; Child Fatality Review, \$148,000; Early Childhood Comprehensive Systems, \$100,000 and \$1,619,046 for the Preventive Health and Health Services Block Grant. /2007/Other federal funds in the amount of \$43,307,910 represent matching funds from Title XIX and Title XXI for Children's Rehabilitative Services. Additional federal monies will contribute another \$84,785,126 toward MCH initiatives which include the WIC food grant, \$74,254,722; Universal Newborn Hearing, \$149,970; Rape Prevention and Education, \$750,932; Family Violence Prevention, \$1,665,286; Core State Injury Surveillance and Program Development, \$120,000; Emergency Medical Service for Children, \$114,999; SSDI Primary Care, \$100,000; Abstinence Education, \$1,034,776; Kids Care, \$4,271,205; Spinal Head Injury, \$237,500; Arizona Early Intervention, \$580,647; Child Fatality Review, \$148,000; Early Childhood Comprehensive Systems, \$140,000 and \$1,217,089 for the Preventive Health and Health Services Block Grant.//2007// /2008/Other federal funds in the amount of \$49,574,056 represent matching funds from Title XIX and Title XXI for Children's Rehabilitative Services. Additional federal monies will contribute another \$76,113,790 toward MCH initiatives which include the WIC food grant, \$65,996,173; Universal Newborn Hearing, \$149,970; Rape Prevention and Education, \$711,008; Family Violence Prevention, \$1,699,821; Core State Injury Surveillance and Program Development, \$116,760; Emergency Medical Service for Children, \$114,702; SSDI Primary Care, \$94,644; Kids Care, \$5,009,499; Spinal Head Injury, \$286,846; Integrated Community Systems implementation, \$429,278; Child Fatality Review, \$148,000; Early Childhood Comprehensive Systems, \$140,000 and \$1,217,089 for the Preventive Health and Health Services Block Grant.//2008// **/2009/Other federal funds in the amount of \$61,143,652 represent matching funds from Title XIX and Title XXI for Children's Rehabilitative Services. Additional federal monies will contribute another \$97,993,807 toward MCH initiatives which include the WIC food grant, \$86,373,163; Universal Newborn Hearing, \$149,931; Rape Prevention and Education, \$671,551; Family Violence Prevention, \$1,730,552; Core State Injury Surveillance and Program Development, \$116,700; Emergency Medical Service for Children, \$115,000; SSDI Primary Care, \$94,644; Kids Care, \$6,717,174; Spinal Head Injury, \$300,000; NGIT Fetal Alcohol Spectrum Disorders, \$252,778; Child Fatality Review, \$148,000; Early Childhood Comprehensive Systems, \$140,000 and \$1,184,314 for the Preventive Health and Health Services Block Grant//2009//**

Core Public Health Infrastructure: \$4,112,928 - Office of Women's and Children's Health (Part A & B): \$12,392 will support the Department's birth defect registry; \$362,796 will support

management service; \$70,165 will support information technology automation; \$160,577 for the Deputy Assistant Director's Office for special projects; \$506,684 for assessment, evaluation and epidemiologic analysis; \$63,896 for Nutrition support; \$100,000 for women's health initiatives; \$667,601 for planning, education & partnership initiatives that include Community Grants, Child Health Primary Care, Healthy Mothers/ Health Babies contract with Banner Health Foundation of Arizona, and the Early Childhood Program; and \$37,860 for Midwife Licensing. Office of Children with Special Health Care Needs (Part C): \$860,226 will support administrative initiatives; \$878,502 for Community Development; and \$347,343 for Quality Assurance and Utilization Review for the Children's Rehabilitation Services program; \$28,998 for epidemiological support; and \$15,888 for

Child Fatality support. /2007/\$3,924,195 - Office of Women's and Children's Health (Part A & B): \$33,520 will support the Department's Office of Birth Defects; \$338,583 will support management service; \$75,039 will support information technology automation; \$86,436 for the Deputy Assistant Director's Office for special projects; \$483,177 for assessment, evaluation and epidemiologic analysis; \$84,154 for Nutrition support; \$100,000 for women's health initiatives; \$613,541 for planning, education & partnership initiatives that include Community Grants and the Early Childhood Program; and \$39,057 for Midwife Licensing. Office of Children with Special Health Care Needs (Part C): \$891,865 will support administrative initiatives; \$713,889 for Community Development; and \$415,890 for Quality Assurance and Utilization Review for the Children's Rehabilitation Services program; \$31,572 for epidemiological support; and \$17,472 for Child Fatality support.//2007// /2008/ \$4,039,754 - Office of Women's and Children's Health (Part A & B): \$32,666 will support the Department's Office of Birth Defects; \$594,781 will support management service; \$62,041 will support information technology automation; \$97,589 for the Assistant Director's Office for special projects; \$493,174 for assessment, evaluation and epidemiologic analysis; \$82,625 for Nutrition support; \$106,170 for women's health initiatives; \$544,455 for planning, education & partnership initiatives that include Community Grants and the Early Childhood Program; and \$37,717 for Midwife Licensing. Office of Children with Special Health Care Needs (Part C): \$871,531 will support administrative initiatives; \$689,350 for Community Development; and \$427,655 for Quality Assurance and Utilization Review for the Children's Rehabilitation Services program.//2008//

***/2009/Core Public Health Infrastructure: \$3,691,251***

***Bureau of Women's and Children's Health (Part A & B): \$42,566 will support the Department's Office of Birth Defects; \$361,845 will support management service; \$79,804 will support information technology automation; \$11,561 for the Assistant Director's Office for special projects; \$427,117 for assessment, evaluation and epidemiologic analysis; \$8,042 for Nutrition support; \$100,000 for women's health initiatives; \$602,092 for planning, education & partnership initiatives that include Community Grants and the Early Childhood Program; \$94,006 for Child Fatality services; and \$42,591 for Midwife Licensing.***

***Office of Children with Special Health Care Needs (Part C): \$1,252,947 will support administrative initiatives; \$26,700 for CRS Direct Services; \$425,000 for Service Coordination and Early Intervention; \$51,745 for Education, Training and Support Services and \$165,235 for Advocacy, Outreach and Member Services//2009//***

Population-Based Services: \$724,252 - \$310,640 is budgeted for planning, education and partnership initiatives that include the Sensory Program and Community grants; \$363,612 for Community development/services that include the Pregnancy and Breastfeeding Hotline Program and the High Risk Perinatal Services; and \$50,000 for Immunizations /2007/\$741,799 - \$299,067 is budgeted for planning, education and partnership initiatives that include the Sensory Program and Community grants; \$394,402 for Community development/services that include the Pregnancy and Breastfeeding Hotline Program and the High Risk Perinatal Services; and \$48,330 for Immunizations//2007// /2008/\$593,128 - \$222,148 is budgeted for planning, education and partnership initiatives that include the Sensory Program and Community grants; \$322,650 for Community development/services that include the Pregnancy and Breastfeeding

Hotline Program and the High Risk Perinatal Services; and \$48,330 for Immunizations//2008//

**/2009/Population-Based Services: \$621,818**

***\$291,873 is budgeted for planning, education and partnership initiatives that include the Sensory Program and Community grants; \$281,615 for Community development/services that include the Pregnancy and Breastfeeding Hotline Program and the High Risk Perinatal Services; and \$48,330 for Immunizations//2009//***

Enabling and Non-Health Support: \$403,391 - \$403,391 will support planning, education and partnership initiatives that include the Child Health Program's contract with Arizona Academy of Pediatrics and Community grants. /2007/\$386,304 - \$386,304 will support planning, education and partnership initiatives that include the Medical Home Project and Community grants//2007// /2008/\$308,150 - \$308,150 will support planning, education and partnership initiatives that include the Medical Home Project and Community grants.//2008//

**/2009/Enabling and Non-Health Support: \$379,095**

***\$379,095 will support planning, education and partnership initiatives that include the Medical Home Project and Community grants//2009//***

Direct Health Care Service: \$1,752,302 - \$200,000 will support community nursing services for high-risk infants; \$523,772 for oral health services for children; and \$1,028,530 for planning, education and partnership initiatives that include Reproductive Health Program's contracts and Community grants. /2007/\$1,708,766 - \$183,000 will support community nursing services for high-risk infants; \$503,196 for oral health services for children; and \$1,022,570 for planning, education, and partnership initiatives that include Reproductive Health Program's contracts and Community grants//2007// /2008/\$1,588,576 - \$188,000 will support community nursing services for high-risk infants; \$500,576 for oral health services for children; and \$900,000 for planning, education, and partnership initiatives that include the Reproductive Health Program//2008//

**/2009/Direct Health Care Service: \$1,633,717**

***\$187,000 will support community nursing services for high-risk infants; \$443,230 for oral health services for children; and \$1,003,487 for planning, education, and partnership initiatives that include the Reproductive Health Program//2009//***

Indirect Administrative Costs: \$776,985 /2007/\$751,229//2007// /2008/\$725,512//2008//  
**/2009/Indirect Administrative Costs: \$7,028,756//2009//**

## **VI. Reporting Forms-General Information**

Please refer to Forms 2-21, completed by the state as part of its online application.

## **VII. Performance and Outcome Measure Detail Sheets**

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## **VIII. Glossary**

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## **IX. Technical Note**

Please refer to Section IX of the Guidance.

## **X. Appendices and State Supporting documents**

### **A. Needs Assessment**

Please refer to Section II attachments, if provided.

### **B. All Reporting Forms**

Please refer to Forms 2-21 completed as part of the online application.

### **C. Organizational Charts and All Other State Supporting Documents**

Please refer to Section III, C "Organizational Structure".

### **D. Annual Report Data**

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.