Maternal and Child Health Services
Title V Block Grant

State Narrative for ARIZONA

Application for 2007
Annual Report for 2005

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Table of Contents

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.

II. Needs Assessment

In application year 2007, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

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 liason among partners, staff the Governor's Women's Commission, oversee implementation of the plan, and provide technical assistance. //2007//

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//.

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).

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.

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//***

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.

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.

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).

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//***

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//***

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//***

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).

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//***

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 and who meet financial eligibility requirements. 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.

Traumatic Brain Injury Program. Children and teenagers with traumatic brain injuries (TBI), their families, and the 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//

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//***

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.

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.

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 were there 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 CardSM, 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//***

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.

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//***

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.az.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.

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 oversite 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.

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//***

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//***

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//***

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.

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.

Governor's Office for Children Youth and Families: OWCH funds the Women's Health Policy Advisor position.

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. ***/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//***

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.

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.

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.

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 consulation 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.

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.

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 funded 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 statwide 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 woks 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

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	23.3	23.3	26.5	35.6	35.6
Numerator	920		1324	1533	
Denominator	395605		499721	430549	
Is the Data Provisional or Final?				Final	Provisional

Notes - 2005
Problems with tabulating hospital discharge data prevented reporting on this measure for 2002. Data for 2005 not yet available. The estimate for 2005 is provisionally set at the 2004 rate until data becomes available in the Fall of 2005.

Narrative:
The Office of Women's and Children's Health 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.

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	87.6	89.2	84.3	95.0	96.1
Numerator	38911	42854	43509	51326	54373
Denominator	44403	48046	51598	54047	56587
Is the Data Provisional or Final?				Final	Final

Narrative:
Information for HSCI #02 is obtained from the HCFA 416 provided by Arizona's Medicaid program (AHCCCS). The Title V agency contacted AHCCCS to obtain information on what has influenced this measure. The AHCCCS representative indicated that the HCFA 416 reporting methodology was modified. The new methodology began in the 2003-2004 contract year and may have influenced the percent of enrollees reported as receiving at least one periodic screen.

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	70.7	76.3	71.8	79.7	82.1
Numerator	649	646	549	484	517
Denominator	918	847	765	607	630
Is the Data Provisional or Final?				Final	Final

Narrative:
Information for HSCI #03 is obtained from the HCFA 416 provided by Arizona's Medicaid program (AHCCCS). The Title V agency contacted AHCCCS to obtain information on what has influenced this measure. The AHCCCS representative indicated that the HCFA 416 reporting methodology was modified. The new methodology began in the 2003-2004 contract year.

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	69.3	69.9	67.9	69.3	69.3
Numerator	59036	61112	61674	64499	
Denominator	85213	87379	90783	93093	
Is the Data Provisional or Final?				Final	Provisional

Notes - 2005
Data for 2005 not yet available. The estimate for 2005 is provisionally set at the 2004 rate until data becomes available in the Fall of 2006.

Narrative:
The maternal and child health program utilizes 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.

Arizona Vital Records data shows that entry into prenatal care varies widely by geographic location from a low of 58% of women in Yuma County entering prenatal care in their first trimester to a high of 80% in Maricopa County. Possible explanations for these disparities include women crossing the border to deliver and lack of providers in rural communities.

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.

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	69.3	73.6	72.0	72.6	73.7
Numerator	246830	317629	366273	402079	424014
Denominator	356179	431697	508776	553763	575577
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%.

Notes - 2004
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:
The maternal and child health program 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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Indicator	33.8	41.3	44.0	49.2	45.5
Numerator	26392	37768	47484	56991	54909
Denominator	78053	91453	108018	115746	120763
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.

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Indicator	55.8	56.5	55.2	58.1	58.9
Numerator	6527	6940	7514	8849	8945
Denominator	11700	12280	13618	15230	15189
Is the Data Provisional or Final?				Final	Final

Narrative:
This denominator for Health Systems Capacity Indicator 8 is estimated based on data obtained from the U.S. Social Security Administration, Office of Policy

(http://www.ssa.gov/policy/docs/statcomps/ssi_sc/2005/az.html). The numerator is the number of children less than 16 years old reported to have received services in the Children's Rehabilitative Services database.

For previous measures, OCSHCN reported in the numerator all SSI eligible members who were also eligible for CRS services. This year, we are reporting only those with at least one claim or encounter, which indicates that they were not only eligible, but actually received some service from CRS.

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

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2004	payment source from birth certificate	7.5	6.8	7.2

Narrative:
The percent of low birth weight infants born by pay source is obtained through an analysis of birth certificate data. The maternal and child health program has direct access to birth certificate data. As seen in previous block grant applications, a higher proportion of infants whose deliveries were paid for by Medicaid were born at a low birth weight.

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

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2004	other	0	0	6.7

Notes - 2007
Mortality data is not available by payer. Data source is death certificates.

Narrative:
Infant death statistics in Arizona are not available by payer.

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

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

non-Medicaid, and all MCH populations in the State					
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2004	payment source from birth certificate	65.8	87.4	76.3

Narrative:
The data source for HSCI 05C is birth certificate data. The maternal and child health program has direct access to birth certificate data. Data for this measure illustrates that women whose births are paid for by Medicaid are less likely to enter prenatal care during their first trimester than women whose births are not paid for by Medicaid.

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 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**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])	2004	payment source from birth certificate	59.7	79.2	69.3

Narrative:
The data source for HSCI 05D is birth certificate data. The maternal and child health program has direct access to this data. As with other Health Systems Capacity Indicators in this section, results were more favorable for the non-Medicaid population than the Medicaid population in 2004.

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 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2005	140
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2005	200

Narrative:

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. OWCH 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 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2005	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2005	 200

Narrative:
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. OWCH 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*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2005	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2005	200

Narrative:
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. OWCH 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.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES 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	2	No
REGISTRIES AND SURVEYS 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 - 2007

Narrative:
The maternal and child health program 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.

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

DATA SOURCES	Does your state	Does your MCH program have direct

	participate in the YRBS survey? (Select 1 - 3)	access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2007
The Arizona Department of Education administers the YRBS and makes the data available by request to the Office of Women's and Children's Health.

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

OWCH 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 OWCH 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 OWCH strategic plan, which is available at the OWCH 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//

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//

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//

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//

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 flouride 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//.

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//.

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.

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.

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective		100	100	100	100
Annual Indicator		100.0	100.0	100.0	100.0
Numerator		59	69	75	80
Denominator		59	69	75	80
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

The High Risk Perinatal Program/Health Start Program's (HRPP) Lay Health Workers and Community Health Nurses educated families about the need for a second newborn screen and facilitated referrals to medical homes. Community Health Nurses and Lay Health Workers are bilingual or have bilingual staff available.

The Medical Director for Public Health Prevention Services (PHPS) provided medical direction to the Newborn Screening Program, collaborated with staff to administer the program, and served

as a liaison with the medical community to help the passage of legislation expanding the number of conditions screened. The Medical Director also assisted with the development of rules for the program.

The Special License/ Midwifery Program reviewed licensed midwives report forms to ensure that metabolic screening was completed for each newborn, and provided information to the midwives regarding metabolic screening of newborns.

The Newborn Screening Program (NBS) reported 92,573 initial bloodspot screens and 82,572 second screens. 83 were diagnosed with clinically significant disorders: 48 cases of primary congenital hypothyroidism, 1 of secondary hypothyroidism, 2 of other thyroid disorders, and 8 of thyroid binding globulin deficiency; 6 cases of salt-wasting congenital adrenal hyperplasia (CAH), and 3 of simple virilizingl CAH; 4 cases of phenylketonuria (PKU) and 2 of hyperphenylalaninemia; 1 case of biotinidase deficiency; 1 classic galactosemia, and 2 galactosemia variants; 1 case of sickle cell anemia and 7 other hemoglobin diseases. The rates are within the expected range for Arizona. NBS located 100% of affected infants. All received services. All but 2 accessed services within timeframe determined as optimal by Arizona Department of Health Services (ADHS) NBS. Legislation passed authorizing ADHS to determine and expand the panel of disorders screened. Tandem Mass Spectrometry (MS/MS) was introduced. Pilot testing of three additional disorders was completed. MS/MS provides capacity to test for the panel of disorders recommended by the American College of Medical Geneticists, Health Resources and Services Administration, American Academy of Pediatrics, and March of Dimes.

CRS received information from the Birth Defects registry on all spina bifida and cleft lip/cleft palate births in Arizona. After such information is shared, the CRS social worker would make contact with the family to inform them of services offered through CRS and would assist them in making contact with the appropriate CRS regional contractor. In 2005 there were 64 births with cleft lip/cleft palate and 16 births with spina bifida that received a referral to CRS.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The High Risk Perinatal Program educates families about importance of second newborn screen.	X			
2. The High Risk Perinatal Program facilitates referral to medical home.		X		
3. The High Risk Perinatal Program incorporates cultural sensitivity into explanation of need for screening and medical home through use of bilingual staff.	X			X
4. The Medical Director for Public Health Prevention Services provides medical direction for Newborn Screening Program.				X
5. The Newborn Screening Program provides follow-up services to newborns identified with abnormal screening results to ensure they recieve diagnostic testing.			X	
6. The Newborn Screening Program will install Newborn Screening database upgrade. The upgraded database will facilitate follow-up.				X
7. Provide education on disorders added to the screening panel to providers, parents, and public.			X	
8.				

9.				
10.				

b. Current Activities
The HRPP's Health Start Program Lay Health Workers and Community Health Nurses continue to educate families on second newborn screens and facilitate referrals to medical homes. The Program continues to ensure that Community Health Nurses and Lay Health Workers have bilingual staff available.

The Medical Director for PHPS continues to provide medical direction for Newborn Screening Program (NBS), collaborates with medical specialists in refining screening criteria, and serves as liaison with medical community. The Medical Director continues to provide the medical community with information regarding expansion.

The Special License/ Midwifery Program attends Arizona Midwife Association meetings and shares metabolic screening requirements. Program information is available to the mothers both in English and Spanish.

The NBS will increase the panel of disorders from 8 to 27 in 2006. The additional disorders will be Amino Acid Disorders. Screening will expand to include Fatty Acid Oxidation Disorders and Organic Acid Disorders. Follow-up services continue to be provided to newborns and infants affected, including those whose specimens were unsatisfactory for testing. Follow up specialists read, write, and speak Spanish. The central database used to record screening information and results, to report results to providers, to record follow up services, and clinical outcomes will be updated. Education about the new disorders will be developed and provided to healthcare providers, hospitals, parents, and the general public. Program information will be updated on the website.

Statewide universal screening, referral, and genetic education are provided to infants, children, and adults/couples identified as having sickle cell anemia or trait or that may be at risk for sickle cell anemia or trait. OCSHCN is notified by the Newborn Screening Unit when a child is born with a diagnosis of Sickle Cell Disease or the Sickle Cell trait. OCSHCN contacts the family, provides information on referrals, education, and genetic counseling for up to three months post-referral to ensure they are receiving appropriate services.

OCSHCN and family members from the Sickle Cell Society provided a presentation on Sickle Cell Disease to all ADHS staff in January 2006. This presentation received overwhelming praise from the staff attending and lead to the initiation of a new community action team on Sickle Cell Anemia. As part of the new teams' initiatives, it includes administrative support from the OCSHCN office to assist them in goals they have identified as making an impact in the Sickle Cell Community in Maricopa County. One idea they are moving forward with is to have Sickle Cell Patients carry with them their medical records on a U.S.B flash drive, so that when they are seen in an emergency room, their specific medical history is readily available to the treating physician.

c. Plan for the Coming Year
The HRPP's Health Start Program Lay Health Workers and Community Health Nurses will continue to educate families about newborn screening and facilitate referrals to medical homes. The Program will continue to ensure that Community Health Nurses and Lay Health Workers are bilingual.

The Medical Director for PHPS will continue to provide medical direction, collaborate with program staff in expansion of the program, and serve as a liaison with the medical community.

The Special License/ Midwifery Program will continue to inform the licensed midwives regarding

current law related to metabolic screenings for newborns.

The NBS will increase screening to 28 disorders by adding Cystic Fibrosis, the first DNA testing. The Program will revise and republish brochures and educational materials. The Program will continue follow up services for newborns and infants identified.

CRS will continue to provide referrals and follow up services to families who have children who are identified with cleft lip/cleft palate, spina bifida and sickle cell anemia.

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)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective		51.4	52	53	54
Annual Indicator		51.4	51.4	51.4	51.4
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	55	56	57	58	59

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

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2002 for this performance measure.

a. Last Year's Accomplishments
OCSHCN conducted a satisfaction survey of CRS members less than 21 years of age who had received durable medical equipment from CRS during January 1, 2005 to June 30, 2005. A total of 625 CRS members had received DME during this time. A total of 340 receipts completed a phone survey for a response rate of 54%. Eighty percent of the respondents were currently using the equipment at the time of the survey. The average age of the recipient of services was 9.9 years, the majority were male (56%), and the largest racial/ethnic group was Hispanic (46%). Over 80% of the respondents reported there was no problem getting a referral to a DME supplier. More than 90% of the respondents were either very satisfied or satisfied with the training they received and 85% reported they were treated with courtesy and respect. Of those who had a complaint (12%), 47% reported that the complaint was resolved satisfactorily. The majority of the respondents reported that the equipment was very reliable (81%), they were able to operate the equipment completely (89%), and 93% were very satisfied or satisfied with the equipment. Twenty percent of the respondents had stopped using the equipment at the time of the survey and the most frequently cited reason was that the equipment did not fit (24%).

CRS began to electronically track grievances and complaints that had a quality of care issue associated with them in November 2005. For the calendar year 2005 there were 43 complaints. The largest proportion had to do with availability, accessibility, and adequacy of care. Parents who filed eligibility grievances were looking for other options of care for their cyshcn when they did not qualify for CRS.

OCSHCN conducted a satisfaction survey of every telemedicine event involving a CRS regional contractor. Data was collected from the family, and the provider. In CY 2005 there were 8 telemedicine events involving 25 CRS members. The typical child was 9 years of age, Hispanic (83%), covered by public insurance (96%), and this was the child's first visit (72%). Sixty-four percent of the families reported that the wait time to see the physician was shorter in a telemedicine clinic than in a regular clinic visit. Over one-half of the families reported that they preferred the telemedicine clinic to the in person clinic visit (56%) which was most likely due to the fact that families reported that they only traveled an average of 13 miles for a telemedicine event compared to 145 miles for a face-to-face visit. Almost 90% of the families reported that they would use telemedicine in the future.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Community Development Program provides training and support to parent leaders to enhance their ability to participate at the local, community, state and federal levels.				X
2. The Community Development Program works to increase the percent of families who partner in decision making by supporting community teams that encourage family leadership.				X
3. The Children's Rehabilitative Services contracts mandate that parents are involved program review at regional and state levels.				X
4. The Office for Children with Special Health Care Needs contracts with parents to obtain their input on a wide variety of activities including facilitating meetings, developing curriculum, and participating on interview panels.				X
5. Families receive training and support to participate in community and policy development, program planning implementation and evaluation.				X
6. Parents and family members of child with special health care needs are employed by OCSHCN as staff.				X
7.				
8.				
9.				
10.				

b. Current Activities

OCSHCN provides organizational and administrative support contracts and reimbursement to parent leaders of 11 community action teams serving 27 communities throughout Arizona. These teams determine how to utilize these resources to impact change in their communities that improve the systems of care for cyshcn.

Several communities are adopting the Smart Card Program initiated by the TriCity Partnership and supported by funding from Southwest Institute for Families and Children with Special Needs, Building Community Health Across AZ grant. The Smart Card Initiative combines the resources of first responders in local communities and families of cyshcn. The families have a card that outlines any special needs that require attention during an emergency and this card is registered with the emergency personnel. The card allows first responders to be prepared when responding to an emergency involving an individual with special needs. The Smart Card has been trademarked and is active in 7 communities in Arizona; 48 families and providers are registered and 305 first responders have been trained. The Smart Card Program has the written endorsement of the Governor and the AZ Peace Officer Standards & Training Director.

Family members and yshcn participate on the community teams that formulate decisions at the local level, on the statewide Community Development Initiative which reinforces family members as decision makers at the state agency level. Parent leaders participate in national committees and attend national conferences including the annual AMCHP conference.

Family members participate at both the state level and at the individual CRS contracted provider sites through the Parent Action Councils. The statewide council is required to participate in any process that changes the law, rules, policies and procedures that influence the delivery the CRS services to children and families. Each CRS regional contractor has two PAC representatives that participate in administrative meetings at the regional sites and in joint meetings with ADHS and the regional contractors. A PAC parent participated in the OCSHCN/SWI Summit in December 2005. PAC members at the regional CRS clinics developed newsletters, conducted health fairs, assisted with the review of the New Member Orientation Book, and reviewed an OCSHCN telemedicine survey content and translation. In addition, they added a Parent Room in one of the regional clinics that included a computer and a private phone line.

CYSHCN and their families participate and lead committees supporting the activities of Integrated Services Grant. Through this participation, committees directly benefit from the experiences families and youth have had related to satisfaction in service delivery systems, and gain insightful and practical ways to improve and integrate services.

c. Plan for the Coming Year

All parents and youth partnering with OCSHCN will be required to participate in Parent Youth Leadership Training. Specific training will be required based on program responsibility and need to enable parents and youth to function in a formal decision-making capacity for all OCSHCN programs. OCSHCN will conduct formal evaluations with parent and youth and used to identify additional training/mentoring needs and activities. In collboration with OCSHCN, parents and youth are preparing ancedotal stories to promote family-centered care to families, partners, and providers.

As CRS began to electronically track grievances and complaints, OCSHCN has been able to intervene and provide better customer service on eligibility. OCSHCN is also able to provide intervention/assistance for situations that were scheduled for grievance hearings. As this practice continues, OCHCN plans to conduct more analysis of complaints in order to see if the issues are can be generalized to other cyshcn populations, outside CRS.

The community teams are becoming more self-sustaining. There have been inquires from 11 communities in Arizona and 10 states for information on the Smart Card Program. The community teams will be following up these communities. OCSHCN contracts with a community action team to mentor new and existing teams, further developing the leadership capabilities of families and youth to partner in decision making at all levels.

OWCH/OCSHCN Community Nursing Services has developed a family satisfaction survey and will be given to participants this upcoming year so data can be collected on program improvements and strategies for meeting the needs of the families this program serves.

OCSHCN is requesting technical assistance from national and local centers on cultural competency to conduct self-assessments of the OCSHCN staff and the CRS contracted providers. Based on the results of this self-assessment, management will evaluate strengths, needs and priorities and recommend trainings. Youth, parents, and community partners knowledgeable in cultural diversity will develop the training modules. Staff will be required to participate in the cultural competency training through the eLearning Management System.

The OCSHCN Cultural Competency Committee which includes parents and youth, is in the process of collecting stories of culturally diverse families with cyshcn that will be made available through audio and video media, as well as on the OCSHCN website. The Cultural Competency committee recommends training and resources as well as reviewing websites for culturally sensitive materials for families. They are also developing a process in which public information will be translated and reviewed by OCSHCN and Integrated Services Grant for language and cultural appropriateness.

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective		50.5	50.5	51	51.5
Annual Indicator		50.5	50.5	50.5	50.5
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	52	52.5	53	53.5	54

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

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2002 for this performance measure.

a. Last Year's Accomplishments
Utilizing data from the National Survey of Children's Health Survey it was reported that 34% of the children in Arizona who met the screening criteria for children with special health care needs (cyshcn) received care that met the American Academy of Pediatrics definition of a medical home compared to 37% of children who did not have a special health care need. This compares somewhat unfavorably with the 2001 data reported from the National Survey of Children with Special health care Needs2 where 51% of the cyshcn in Arizona reported that they had a medical home. Eight-eight percent of the cyshcn reported they had one or more persons they considered their personal doctor or nurse compared to 71% of children with no special health care needs. More cyshcn were reported to obtain preventive medicine visits in the last 12 month than were children with no special health care needs, 82% compared to 68%. Despite higher preventative care, cyshcn had more emergency room visits than non-cyshcn, 14 visits compared to 13 visits for non-cyshcn.

Information from the National Survey of Children's Health was used as a foundation for developing the Medical Home component of the Integrated Services Grant

The AHCCCS/CRS Task Force was established to enhance communication and promote problem resolution between the AHCCCS health plans and CRS regional contractors for the purpose of providing appropriate care through a medical home model to their shared members with special healthcare needs. The Task Force is divided into three sub-committees: Care Coordination, Data Sharing and Provider/Family Education. In 2005, the Care Coordination Sub-committee was successful in completing transition policies that were incorporated into the AHCCCS Medical Policy Manual. The Education Sub-Committee developed materials about CRS

for distribution to primary care providers to help them better understand how to connect with the CRS Program. The Data Sharing Sub-Committee developed a process for communicating shared member information and updates between the CRS regional contractors and AHCCCS Plans to enhance coordination of care.

Medical Home resources and training materials were used to promote the concepts of medical home with providers, families, contractors, and community partners.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. OCSHCN provides medical home training to AHCCCS health Plans.				X
2. OCSHCN provides medical home direction for CRS, Community Nursing, Early Intervention, Service Coordination, Traumatic Brain Injury and Spinal Cord Injury Programs.				X
3. OCSHCN promotes medical home concepts at professional conferences, meetings and community activities.			X	
4. OCSHCN integrates medical home concepts into existing OCSHCN programs through contract requirements, training and resources.				X
5. OCSHCN disseminates medical home self-assessment tools for providers and families.				X
6. OCSHCN provides technical assistance to enhance the participation of families in the development of medical home sites throughout Arizona.				X
7. OCSHCN established four medical home sites to collect data on screening, care coordination, and cost to deliver care in a medical home setting.				X
8.				
9.				
10.				

b. Current Activities

Assistance is provided to the community development teams through OCSHCN's administrative contracts to maintain medical home activities. These Medical Home Projects were initially funded by SWI MCHB Medical Home grants and are now being sustained at the local level. The Verde Valley Action Partnership team provides support for their community medical home. The team plans to continue the Medical Home Family Group as a team subcommittee. The group has drawn new families to the Partnership unique to medical needs and interest in working with pediatric practices. The Chino Area Partnership team supports the former SWI initiative of enhancing the Medical Home Project in their community. The Mesa Partnership works with the Az School of Dentistry and Oral Health to ensure that the training includes learning about the dental care of cyshcn. This work will ensure the development of dental medical homes for cyshcn in the future. OCSHCN also contracts with Raising Special Kids, the state Parent Training and Information Center and Parent-to-Parent program, to provide dental students from the school and medical residents the opportunity to do joint home visits with families to help promote dental care as part of the medical home. Five of the community development teams are applying to the Governor's Council on Developmental Disabilities for funds to sustain medical home activities in their local communities.

The CRS Regional contractors submit annual Medical Home Plans to OCSHCN for review, approval and evaluation. As part of these plans, the contractors are developing a mechanism to automatically load the AHCCCCS PCP information into the CRS clinic databases to facilitate

communication between the CRS specialty providers and the AHCCCS PCPs. Until this system is completed, the CRS contractors are loading the electronic list of physicians from the AZ Board of Medical Examiners so they will have the address and phone numbers readily available. When known, the PCP will be invited to the multidisciplinary planning clinics or to provide input into the process. OCSHCN continues to offer technical assistance to the professional and administrative staff of the four CRS regional contractors on Medical Home. Each of the Contractors must submit annual Medical Home Plan and an evaluation of the previous years plan. These plans, activities, and evaluations are evaluated during the site visits conducted by OCSHCN staff.

OCSHCN Community Nursing staff participated in an annual conference with High Risk Perinatal contractors involving nurses, developmental specialists, transportation staff, discharge staff and physicians. As of July 1, 2006 the CM staff will administer the Edinburgh Post-Natal Depression Scale on the initial visit to the mother of the referred child to evaluate potential post-partum depression.

c. Plan for the Coming Year
Based on the findings of the Family Satisfaction Survey, OCSHCN will

OCSHCN has decided to evaluate the CRS program on Medical Home through more defined methods than the previous annual plans. The sites are being encouraged to utilize web-based tools to implement medical home care coordination at each of the regional sites. Combined with the activities of the AHCCCS/CRS care coordination meeting, specific plans on improving communication are being developed. OCSHCN is also providing Medical Home training to the AHCCCS plans to facilitate better coordination of care between the PCP and the CRS specialty providers. Targeted site visits and medical record reviews will be used to assess members access to a medical home.

OCSHCN is implementing a performance improvement project designed to identify barriers to care/services that are correlated with poorer quality of life among CRS members including issues related to getting all the services they need and identifying the barriers to having a medical home.

OCSHCN has offered to fiscally support the production of a Communication with Physician's Guide for parents developed by the SWI funded Tucson medical home team.

OCSHCN continues to present to providers and family members of cyshcn through Raising Special Kids, as well as contributing to their newsletter, and by providing medical home and health plan information to RSK staff to include in their resident and nurses training packets.

ADHS/OCSHCN plans to investigate the opportunity for an Inter-Governmental Agreement with the University of Arizona School of Medicine and Arizona State University to have ADHS/OCSHCN educational offerings related to cyshcn available for medical, nursing, and other allied health students to access for credit through the University's electronic curriculum.

The Arizona Early Intervention Program (AzEIP) is going through a system redesign, which will direct emphasis on a team-based model and may include the primary care physician in the development of the Individualized Family Service Plan. This will also include any specialists, social workers, psychologists or other professionals that may be appropriate to work with the family. The plan and approach will be team-based intervention versus agency driven intervention, involving parents as key team participants.

The MCHB Integrated Services grant will fund early and continuous screening and care coordination in four medical home sites. All children and youth will be screened for developmental delays utilizing several screening tools identified through ISG committees. If a patient screens positive, they will be referred to the Care Coordinator for referral and monitoring of compliance. The integration of this specialty care back into the medical home will be the secondary focus of

this study; does the care coordinator integrate all of the care and services the child receives to plan an effective, coordinated course of treatment.

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)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective		60.8	61	61	61
Annual Indicator		60.8	60.8	60.8	60.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	61	61	61	61	61

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

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2002 for this performance measure.

a. Last Year's Accomplishments
The Maternal Child Health (MCH) Nutrition Program coordinated with the Arizona WIC program and the Arizona Health Cost Containment System (AHCCCS) to ensure that Children with Special Health Care Needs are covered in a timely manner and receive medical nutrition therapy as prescribed. The Program has provided training on the approval process with WIC, Hospital Discharge Planners, Special Needs Nutritionist and AHCCCS Maternal Child Health Coordinators.

The National Survey of Children's Health, the most recently released data on insurance coverage among children under the age 0 to 17 reported that 90% of children with special health care needs (cyshcn) in Arizona were insured at the time of the survey compared to 83% of non-cyshcn. Of those children currently covered by health insurance, 30% of cyshcn were covered by public insurance (AHCCCS and KidsCare) compared to 31% without special health care needs. Less than 10% of all the children covered by health insurance at the time of the survey, including cyshcn, had periods during the past 12 months when the child was not covered by insurance. Examining the uninsured population, the survey reported that among uninsured children, 56% of cyshcn were uninsured for part of the year and 44% were uninsured for the entire year somewhat higher than the 39% of non-cyshcn reported being uninsured for part of the year and 61% who reported being uninsured for the entire year. OCSHCN received the ISG has utilized the National Survey of Children's Health data on insurance coverage to establish a committee to address the issues identified, specific to Arizona.

OCSHCN worked to heighten legislative awareness by sending e-mail alerts regarding change in the eligibility requirements for AHCCCS and KidsCare. This past year the Arizona State Legislature made available via the internet, access to legislative staff and the ability to register to testify on behalf of specific bills. OCSHCN took an active role in educating consumers and family members on this direct access line. OCSHCN also advocated against a bill that would have reduced/eliminated coverage for parents of children enrolled in KidsCare.

OCSHCN initiated a series of outreach activities to large self-insured employers about the coverage and services provided to their employees who had cyshcn. The first of these involved several presentations to Raytheon, a large employer in the Tucson area. Presentations were made to the employees that included the third party administrator and the insurance company (MetLife). These presentations consisted of information on the Title V program, educational rights, and long-term health care planning which was done in conjunction with MetLife.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Recruit local self-insured employers to participate in our program designed to educate their employees about evaluating health plans for cyshcn, information on the Title V program, and other private and public programs.				X
2. Continue to inform families and providers about legislative issues that may impact CYSHCN access to insurance coverage.				X
3. Direct eligible SSI applicants to Children's Rehabilitative Services for health services covered by AHCCCS (state Medicaid).		X		
4. The OCSHCN Integrated Services Grant will identify and evaluate potential solutions for the uninsured, under-funded and the issues associated with multiple funding sources for services.				X
5. Children's Rehabilitative Services supports families with enrollment into AHCCCS and KidsCare.				X
6. Information regarding Children's Rehabilitative Services, AHCCCs, KidsCare, and Community Health Centers is provided to community teams, health fair participants, family and community events, and through the OCSHCN website.			X	
7. OCSHCN will develop a survey to identify unmet needs related to barriers regarding coverage				X
8. Work with AHCCCS, ALTCS,DES-AzEIP/DDD on the Revenue Maximization Project to consolidate a program designed to meet the needs of cyshcn.				X
9. Collaborate with AHCCCS (Medicaid) to improve outreach and enrollment approaches.				X
10.				

b. Current Activities

The MCH Nutrition Program is continuing to provide technical assistance to WIC, AHCCCS and Children Rehabilitative Services for coverage of medical nutrition therapy and appealing denied cases.

OCSHCN receives medical information from the Social Security Administration for all applicants for SSI in Arizona. The system is being enhanced to ensure the family receives information on a wide array of services that may be covered, contact information for support/advocacy groups, community team numbers, and a description of potential services with contact information. Information about the Health Information and Education Center will be included to direct the family to more general service options as well.

The regional CRS clinics and the service coordinators help families with enrollment into AHCCCS and KidsCare and forward the information to the Arizona Department of Economic Security. For those children covered by private insurance, the service coordinators and CRS staff at the clinics assist the family in coordinating coverage among potentially multiple payors.

OCSHCN works with families to maximize coverage through multiple systems of care, i.e., DES, DDD, and CRS for specific services that any one payor may not cover.

OCSHCN is working with Raising Special Kids to implement their Family to Family Health Information and Education Center Grant from CMS. This grant which runs from October 2004 through October 2007 identifies how to navigate the state health system including both public and private resources. RSK has developed the curriculum suitable for parents of cyshcn, service coordinators, care coordinators, and other enabling professions. OCSHCN is adapting the curriculum to the eLearning Management system in both English and Spanish and collect data on who accesses the service and how useful they find the system.

The ISG plans to initiate a committee on health care coverage of children and youth with special health care needs in Arizona and the objective of this committee is to look at identifying and evaluating potential solutions to the uninsured, under-funded and the complex variations involved in having multiple funding sources for services.

c. Plan for the Coming Year

The MCH Nutrition Program will continue to provide technical assistance on coverage of medical nutrition therapy, coordinate sharing information with AHCCCS and ADHS, and provide assistance for processing insurance claims for medical foods.

The ISG proposes a strong relationship with both private and public payers to explore alternative funding for cyshcn health care needs. This committee is in its formative stages and will take a lead role in defining the coverage issues during the coming year. The plan is to recruit committee memberships that will consist of families, AHCCCS representatives, members from IHS and the tribal nations that control their own health care dollars, representatives from the Medicaid in the Schools program, school based clinics who provide significant health care services, private insurers such as MetLife, Blue Cross and Blue Shield, and health maintenance plans such as Cigna. Members from third party administration companies, benefit advisory companies, and the Arizona Insurance Commission will also be invited to participate. State agencies, particularly the Division of Developmental Disabilities, that have the ability to pay for uncovered health care services or accommodations, will be included in the discussion of how to maximize health outcomes utilizing all the health care related dollars in the system.

OCSHCN is planning to develop a survey to identify unmet needs related to barriers regarding coverage issues. These results will be used in future systems planning which will impact the recommendations from the ISG.

OCSHCN is targeting two self-insured employers to partner with them to involve employees who have cyshcn in the decision-making process for the purchase of their healthcare coverage. Working with the ISG Insurance committee, other employers will be identified and trainings will be provided to employees with cyshcn on health coverage issues, guardianship, and long-term care options.

OCSHCN is working collaboratively with AHCCCS, ALTCS, DDD and DES/AzEIP (or other child serving state agencies on the Revenue Maximization Project to consolidate a new program designed to meet special needs for children 0-5 under the AHCCCS 1115 waiver. This will allow Arizona to leverage state and federal dollars to enhance service delivery and increase federal support for serving children 0-5.

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective		70.9	71	72	73
Annual Indicator		70.9	70.9	70.9	70.9
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	74	75	76	77	78

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

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2002 for this performance measure.

a. Last Year's Accomplishments
OCSHCN Systems of Care expanded the service coordination for individuals with traumatic brain injury (TBI) to include individuals with a spinal cord injury (SCI) on July 1, 2005. Both the TBI and SCI programs are supported by the Governor's Council on Spinal and Head Injuries (GCHSI).

In CY 2005, 473 children and youth were enrolled in the TBI program receiving 1,936 hours of service coordination and 1,281 hours of therapy services. The TBI service coordinators provided 183 trainings in their local communities to 2,663 individuals in 2005. OCSHCN and the Arizona Department of Education Traumatic Brain Injury Statewide Coordinator developed a comprehensive training on traumatic brain injuries for educational professionals including an overview of traumatic brain injuries, information on prevalence and leading causes, the signs and symptoms of brain injury, the impact of brain injury, and the identification of strategies to promote student success. In August 2005 training was provided, in conjunction with the GCHSI, to service coordinators on serving children and youth that have sustained a spinal cord injury. OCSHCN and representatives of GCHSI conducted focus groups with TBI/SCI service coordinators throughout the state regarding potential program enhancements.

OCSHCN provided early intervention services to 611 children under the age of three, 3,337 units of service coordination and 5,007 units of therapy. OCSHCN provided 684 units of service coordination and 548 units of therapy to 230 children and youth enrolled in the OCSHCN service coordination program in CY 2005.These are children at risk of delay but do not qualify for the other service coordination programs. Community Health Nursing staff provided 947 home visits to 520 high risk infants.

The CRS clinics provided telemedicine services to 110 children in CY 2005; they included orthopedic, cardiac, and neurology clinics. There were 92 telehealth events, 62 telehealth meetings, and 19 Grand Round events. Each CRS site purchased telehealth equipment that enhanced their ability to provide telemedicine; this includes larger screens, router systems that improve pictures, electronic imaging equipment that transfer real-time images, and equipment to measure gait and movement.

The Children and Family Alliance community development team created a Direct Support Professional course, a 4-week 3-college credit course designed to educate and train people

working directly with children and adults with disabilities. The course has been offered by Northland Pioneer College tuition free for three semesters and 25 students have attended. Funding for this project was provided by Southwest Institute for Families and Children (SWI) Integrated Services Project, Building Community Health Across AZ.

OCSHCN co-sponsored with Banner Children's Hospital, the 3rd Annual Caring for Children with Medical Needs at School Conference in November 2005. This is an event OCSHCN sponsors annually.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue advocacy efforts to promote the community development model with major state agencies responsible for services for cyshcn.				X
2. Enhance the abilities of parents of cyshcn to guide the process for systems design within their own communities.				X
3. Assist families and providers to understand the use of telemedicine.		X		
4. Continue to promote the use of telemedicine as a vehicle to provide community based services.		X		
5. Evaluate the potential benefit of telehealth/telemedicine services.				X
6. Continue to expand service coordination for individuals with TBI and SCI.	X			
7. Conduct a family satisfaction survey with families from the Children's Rehabilitative Services.				X
8.				
9.				
10.				

b. Current Activities

Telemedicine outreach continues to expand to include connections with out of state hospitals such as Stanford Medical Center for children with rare cardiac conditions. Flagstaff continues to partner with Shriner's Hospital in Utah for children and youth with orthopedic needs from Northern Arizona including many children from the reservations. OCSHCN presented a workshop on the telemedicine program at the 32nd Annual Arizona Rural Health Conference. OCSHCN also participated in the Telemedicine for CSHCN: A State-by-State Comparison of Medicaid Reimbursement Policies and Title V Activities conducted by Institute for Child Health Policy at the University of Florida.

The Community Development Initiative formed a strong partnership with the DES as they moved forward in implementing an integrated service delivery model that incorporates families at the community level. CSHCN staff and contracted parent leaders participated in the development and training of staff and community members in 22 different communities utilizing the Annie Casey Breakthrough Collaborative on system integration. This was the kick-off of DES's system integration designed to improve service delivery by integrating DES service providers, communities, and families.

The Comunidades Asistiendo A Niños con Necesidades Especiales de Salud in San Luis collaborated with the Regional Center for Border Health to install the first special needs T-swings at a local park. The Bullhead Area Community Partnership for Special Needs Children partnered with the city to facilitate the purchase of park equipment that is accessible to all children.

Two new teams were formed this year, the Turtle Nation Collaborative on the Hopi Nation has approximately 20 members and rotates among the villages on Hopi to ensure the maximum participation. The team's first initiative is to address with the tribal council the need for local services, including long-term care. A second team has been formed around the Sickle Cell organization called Quest for a Cure. Rather than being locally based, this team will reach out to all individuals throughout the state.

c. Plan for the Coming Year

As a result of the focus groups with the TBI/SCI service coordinators, several programmatic changes are being implemented: expanding the eligibility requirements, billing changes that are more flexible for the coordination of services for these populations, additional allocation of funds for community education to encourage service coordinators to increase awareness of the program in their communities, policy revisions, and Spanish translation of program materials. These changes will be implemented in CY 2007.

The Direct Support Professional curriculum has been purchased by Northern Arizona Regional Behavioral Health Authority and by a local provider for use in their clinics. As interest in the curriculum is growning, the Children and Family Alliance community action team is expanding the training statewide. In collaboration with the Governor's Long Term Care Task Force, a Core Curriculum is being formed to meet the needs of a more diverse group of direct support professionals. It will include a core curriculum common to all areas of direct care, with additional modules in developmental disabilities, elderly and aging, Alzheimer's, and the seriously mentally ill. The Children and Family Alliance curriculum will be used as the model for the developmental disability module. The Division of Developmental Disabilities also is forming a Compensation Workgroup that is exploring the feasibility of a rate increase for those direct support professionals that have received the higher level of training developed by the Core Curriculum Workgroup.

The community development model is gaining local and national attention. MCHB has asked the Parent Community Development Leaders to present the community development model at an international conference in Washington DC. OCSHCN community development staff and parent leaders have also been invited to participate as a best practice example within the newly created National Center for Community Development at Utah State University. Two Parent Community Development Leaders have been asked to participate with DES as Expert Faculty for the Breakthrough Series Collaborative on system integration.

Stories will be gathered from culturally diverse families of cyshcn from around the state for use in the development of multi media products to share with families and the professionals who provide care for cyshcn. Development of DVDs, CDs, books, website, and "shorts" from the stories will be used as a resource for presentations, training modules, and product development for our office and to share with other community and state agencies that work with cyshcn.

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)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective		5.8	6	6	6
Annual Indicator		5.8	5.8	5.8	5.8
Numerator					
Denominator					

Is the Data Provisional or Final?				Provisional	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	6	6	6	6	6

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

Notes - 2004
Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted. The data reported in 2004 are pre-populated with the data from 2002 for this performance measure.

a. Last Year's Accomplishments
OCSHCN provided funding for Patti Hackett from the National HRTW Center to be the keynote speaker at the Department of Education's Annual Transition Conference. During the same visit she provided training to the clinicians at the CRS on transition related issues to assist in the development of transition plans for adolescents in CRS. OCSHCN also conducted two workshops for the CRS sites on transition. One of the trainings reviewed the different programs youth might be eligible for after exiting high school, emphasizing that programs providing scholarships for youth may make youth eligible for health care. The other assisted the CRS regional contractors in the development of transition-related resources within their clinics and offered some tips on how to use national resources. Guidance was also provided on the use of advanced directives.

CRS sites identified methods for communicating with families and youth regarding the transition process. All CRS sites mailed letters to the youth/parents starting at age 14 to inform youth/parents about the requirement for a transition plan; letters at age 17 to inform parents of the importance of establishing guardianship (where applicable) and the need to complete advanced directives prior to the 18th birthday; and letters at age 20 informing youth/family that CRS services will end and services must be completed by the 21st birthday. All of the CRS sites included a discussion of care coordination of the transition plan at age 20, the need for connecting families/youth with information regarding community resources for educational, vocational, and futures planning. Copies of the letters were sent to the PCP to inform them of their patients' participation in the program. The PCP's were encouraged to participate in the process and discuss medical transition information with the family.

OCSHCN represented the health perspective as a member of the Arizona Transition Leadership Team at the second NCSET-hosted National Leadership Summit on Improving Results for Youth in Washington DC in June 2005. There were over 500 state leaders and policy makers representing secondary education, transition, workforce development, vocational rehabilitation, youth, and families. Arizona was one of the few teams with a health representative.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Include transition goals related to self-determination in training and curriculum for all OCSHCN contractors and providers.				X
2. Continue to participate on the Arizona Department of Education Secondary Education Leadership Team.				X
3. Provide training on transition topics such as advanced directives, guardianship, transition services, and transition to adult providers to contractors and providers				X

4. Young adults and youth provide feedback on OCSHCN programs, policies, and operations.				X
5. Youth/Young adults from Juvenile Corrections, OCSCHN, DES, Behavioral Health and Governor's Council on DDD will partner with OCSHCN to design, plan, and evaluate an annual transition conference.				X
6. Monitor and assess Children's Rehabilitative Services program for compliance with transition contract requirement to develop a transition plan by the age of 14 for each cyshcn during the annual review.				X
7. Maintain and support youth and Young Adult focused committees on Integrated Services Grant to assist in the design of integrated systems of care for cyshcn		X		
8. Develop and implement a survey, in partnership with a community transition program at Phoenix Children's Hospital, to collect information on primary care providers for cyshcn in our state.				X
9.				
10.				

b. Current Activities

Youth have presented at four conferences this year as representatives of ADHS-OCSHCN including the Arizona Public Heatlh Association (AzPHA) conference, the Rural Health Conference, the Community Development Summer Conference, Arizona Department of Education Transition Conference.

St. Joseph's CRS program has implemented the transition to adult healthcare services process for Sickle Cell patients from 14-21 years of age who are enrolled in the CRS program. The nurse, social worker, child life specialist, and psychologist work together to have the youth complete a questionnaire. They then work individually with the youth and their family to educate them on the issues they identify. The process for transitioning youth includes restructuring the clinic visit from parent focused to youth focused as the youth matures and gains skills, educating the youth related to their disease, developing a potential plan for transition of care when they age out of CRS, and referring the youth to community agencies that provide educational and support services relevant to youth in transition.

The Tri-City Partnership launched the Pathways Program that connects individuals with disabilities to opportunities for job shadowing, volunteering, and employment. They partner with local businesses that can provide training, volunteer and employment opportunities to individuals with disabilities, creating pathways to independence.

In conjunction with the Governor's Council on Head and Spinal Injuries, the Governor's Council on Developmental Disabilities, the Arizona Department of Education, the Arizona Department of Health Services Division of Behavioral Health Services, the Arizona Department of Juvenile Corrections, ValueOptions (the Regional Behavioral Health Provider for Maricopa County), and youth associated with each of these agencies as well as youth from the Youth Action Council of Arizona (YAC-AZ) representing Southwest Institute for Children and Families are meeting to discuss the format of a Youth Transition Summit. Additional groups are being identified for inclusion in this planning process. This Summit will be planned by youth, for youth and the youth will be paid to participate in all phases of the development and scholarships will be offered to youth to attend the conference. Funding will be provided by the lead agencies.

OCSHCN participates throughout the year with the Arizona Department of Education in the Adolescent Transition Leadership Team, providing perspectives on health issues related to cyshcn, data analysis, and educational modules. Meetings are occurring to determine how the Youth Summit can fulfill the needs of both OCSHCN and the Department of Education in reaching

and involving youth.

c. Plan for the Coming Year

The Arizona Medical Association (ArMA), Committee on Maternal and Child Health Care, Adolescent Subcommittee had received a small grant to develop a plan for improving adolescent access to appropriate health care in Arizona. An Adolescent Health Community Advisory Group was formed to create the plan. The grant funding ended with the completion of the plan. The group will become a subcommittee of the ISG in order to implement the plan and work with the other subcommittees as appropriate to move integrated services for adolescents forward. In the next year there will be a specific section of the ISG website devoted to this plan and further defining resources for practitioners involved in adolescent health issues.

The ISG Clinical Committee, Adolescent Health Committee, and the Parent Action Council will be reviewing and selecting instruments appropriate for screening for transition related issues in the ISG medical homes. A final review will be a pre-test and debriefing with the youth participating in the Transition Summit.

The Youth Transition Summit is planned for the Fall 2007.OCSHCN is working with the Arizona Department of Juvenile Corrections to explore possible ways of including incarcerated youth in planning the Transition Summit. The conference will be videotaped and made available through the eLearning Management System.

OCSHCN is investigating a partnership with Tressia Shaw, MD of Phoenix Children's Hospital (PCH) to survey family practice and internal medicine physicians to assess how many of the physicians are currently seeing yshcn, the barriers to seeing them, and what would encourage them to include yshcn needs in their patient census. This will allow PCH to explore ways to expand the Transition Clinic and for OCSHCN to establish the real issues with providers for transitioning youth. The results will allow for the design of a curriculum that will encourage participation of physicians in the care of yshcn.

OCSHCN will continue to participate with the Arizona Department of Education, the Adolescent Transition Leadership Team in planning and contributing to their next Transition Conference.

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	70	70	70	71	78
Annual Indicator	65.7	69	75	78	78.6
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	79	79	80	80	80

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.

Notes - 2004
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
The 2004 estimate reflects the immunization status of children by age two for children who were 19-35 months of age, born between August 2000 and November 2002. The estimate tolerates 3.8% error at a 95% confidence level.

a. Last Year's Accomplishments
The County Prenatal Block Grant provided 279 infants and children under the age of 2 with age-appropriate immunizations.

Health Start and HRPP Community Health Nurses monitored the immunization status of the children enrolled and continued to promote and facilitate immunization. Many HRPP Community Health Nurses are bilingual. The Health Start Lay Health Workers are hired from and reflect the ethnic and socioeconomic makeup of the communities they serve.

The Arizona Partnership for Immunization (TAPI) home web page, www.whyimmunize.org allowing parents to ask medical experts questions about vaccines and immunizations was updated. The web site receives visitors looking for school requirements and immunization clinics. The TAPI quarterly newsletter, "Upshots" was printed and distributed to 1,800 + organizations and individuals. English and Spanish parent education flyers, "Is Your Child Protected?" and provider flyers, "Welcome to Our Office," were revised and distributed. Reminder/recall postcards were printed and distributed to providers throughout the state. All materials produced and available through TAPI can be ordered from the TAPI resource catalog and from the web site. Materials updated in 2005 included: an immunization record card overlay allowing parents and providers to determine which vaccines are needed at different ages, a parent education flyer designed to help parents overcome immunization concerns, and the "Cloud Award" brochures nomination form given to providers who have achieved a 90%+ immunization coverage level of

their two year old patients. A post card was developed to guide parents and providers to the web site for information and a clinical guide on giving shots was developed.

50,000 educational pieces were distributed to schools, child care facilities, private providers, county health departments, community health centers, managed care organizations and WIC sites. Additional material was distributed at conferences, health fairs and community education events. TAPI participated in corporate/community health/wellness fairs, eight professional conferences or seminars, and supplied and distributed materials for several rural health fairs, including border health fairs.

TAPI organized and conducted 17 regional immunization programs with the Vaccines for Children Program. 365 individuals from provider offices and health departments participated in the trainings. TAPI emphasized the importance of using resources such as reminder/recall cards and parent education flyers. The Arizona Immunization Program Office (AIPO) initiated an incentive program to increase completion of the 4th DTaP by 24 months of age.

In November health plans operating in Arizona convened for a meeting on vaccine reimbursement. Immunization reimbursement topics included: how the county handles insured children and the need for counties to begin billing health plans.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The County Prenatal Block Grant program supports home visits provided by Public Health Nurses to assess needs, including immunization schedules.			X	
2. The Arizona Partnership for Immunization conducted regional immunization education programs with the Vaccines For Children Program for providers statewide.				X
3. The High Risk Perinatal Program and Health Start both monitor the immunization status of children enrolled in these programs.	X			X
4. The High Risk Perinatal Program and Health Start both provide transportation to medical home for immunization when needed.		X		
5. The High Risk Perinatal Program and Health Start both provide translation services at the medical home to facililate and promote immunizations.		X		
6. Through the Office of Chronic Disease Prevention Services, Arizona WIC participants are screened and referred for proper timing of the DtaP.	X			
7. The Arizona Partnership for Immunization distributes awards to providers who acheive a 90%+ immunization coverage level for 2 year olds.				X
8. The Arizona Partnership for Immunization distributes parent education flyers designed to help parents overcome immunization concerns.			X	
9. The Arizona Partnership for Immunization distributes a clinical guide on giving shots with easy to follow picture instructions for providers.				X
10.				

b. Current Activities

Health Start and HRPP Community Health Nurses monitor the immunization status of children enrolled in their programs and promote and facilitate immunization.

The Office of Chronic Disease and Nutrition Services coordinates statewide immunization record screening and referral by WIC staff to ensure proper timing of the DtaP shots in WIC children.

TAPI will continue to print and distribute immunization materials, print and mail quarterly newsletters, plan and conduct ten immunization workshops for public and private clinics, medical offices, schools and other enrolled sites, meet and confer with managed care plans to ensure local health departments are reimbursed vaccine administration costs for AHCCCS enrolled children, work with immunization service providers to ensure they are available in underserved areas, and revise and update web site and print materials.

c. Plan for the Coming Year
The County Prenatal Block Grant will continue to provide immunizations and will improve tracking and documentation activities.

The Health Start and the HRPP Community Health Nurses will continue to monitor the immunization status of children enrolled and promote and facilitate immunization.

The Office of Chronic Disease Prevention Services will continue to train WIC staff to screen and refer participants to receive the proper timing of the DtaP shots. WIC will continue to assess screening and referral services and implement new strategies as needed.

TAPI will continue and expand immunization promotion and education activities. TAPI will continue to explore AHCCCS reimbursement for county health departments. Health plans will be encouraged to become more involved with TAPI.

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	44	43	42	41	35
Annual Indicator	37.8	35.5	35.9	35.8	35.8
Numerator	4080	3952	4110	4227	
Denominator	107846	111218	114368	118082	
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	35	34	33	32	32

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 Abstinence Education Program funded 11 contractors to provide abstinence education and positive youth development services in seven counties. 23,977 youth and 402 parents were reached. Four quarterly trainings were provided, three teen maze events were funded, and all contractors received one annual site visit in which education services were observed. An abstinence until marriage media campaign was begun, featuring radio and television spots,

theatre advertising, and outdoor billboards. Funds were added to 8 county health departments to conduct Teen Maze events. Five events were conducted in 2005, reaching over 2,000 youth. The Teen Pregnancy Prevention Program initiated and funded intergovernmental agreements (IGA's) with four county health departments to plan and implement a teen pregnancy prevention program in areas with high rates of pregnancy and births. These programs are finalizing their community plans and will begin implementation in 2006.

11 of 15 County Health Departments received IGA's to provide Reproductive Health/Family planning services. 4 of the 11 contractors also received Title X funds. 5,954 clients received initial/annual family planning visits, education, and referrals. 656 (22%) were adolescents. The program was represented on the Governor's Commission on the Health Status of Women and Families in Arizona's sub-committee on Reproductive Health, Family Planning, and Teen Pregnancy Prevention.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to fund contractors who provide Abstinence Education Program Services and Youth Development.			X	
2. The Reproductive Health/Family Planning Program provides information on effective community based abstinence,teen pregnancy/std prevention progams.			X	
3. The Abstinence Eduction Program developed, implemented and maintained the abstinence until marriage/sex can wait media campaign.			X	
4. The Abstinence Eduction Program continue to fund teen maze educational events in communities.			X	
5. The Reproductive Health/Family Planning Program will increase the number of teens receiving services in the reproductive health/family planning clinics.	X			
6. The Women's Health Policy Advisor/Coordinator coordinates teen pregnancy prevention activites among all Offices within ADHS Public Health Prevention Services.				X
7. The Women's Health Policy Advisor/Coordinator staffs the Governor's Commission on the Health Status of Women and Families. This commission works on issues related to teen pregnancy prevention.				X
8. The Women's Health Policy Advisor/Coordinator implements Commission recommendations and provides technical support for issues related to teen pregnancy prevention.				X
9.				
10.				

b. Current Activities

The Abstinence Education Program received a $1 million allocation July 1, 2005 relieving current program contractors of their match obligation for FY06. Funds were added to current budgets to provide parent education and youth development activities. A Request for Grant Application (RFGA) was released in 2005 with four projects awarded in 2006 serving unserved areas of the state. The Program participates on the Arizona Department of Education (ADE) Materials Review Committee and collaborates with local and national abstinence education and teen pregnancy stakeholders such as the Arizona Partners for Abstinence Education, the Arizona Coalition on Adolescent Pregnancy and Parenting and the National Campaign to Prevent Teen Pregnancy. OWCH continues to provide information on effective community-based and research

based best practice approaches for teen pregnancy prevention and sexually transmitted disease (STD) prevention. Quarterly training is provided to programs, including training on STD's and HIV, contraception information, and approved abstinence curricula. The Abstinence Education Program participates on the Arizona Adolescent Health Care Coalition, provides support and program information and attends quarterly meetings. The Teen Pregnancy Prevention Program implemented a media campaign which focused on abstinence and condom use. Two television spots for teens, one parent spot, and one radio spot were developed in English and Spanish and placed on local cable and radio stations. Posters, billboards and signage for mall kiosks were printed and placed in targeted communities. An evaluation plan for the Abstinence Education Programs and Comprehensive Sexuality Education Programs will be designed.

Two Reproductive Health/Family Planning Program contractors are to increase teen services by 5% to address high teen pregnancy rates. Contractors are to meet these goals by working collaboratively with schools, counselors and community organizations. The program will provide technical support and resources. The Program will work with other healthcare agencies and funding entities to ensure teens receive education on prevention of STDs, STD screening and follow-up. The contractors will also work with other agencies to offer teen's alternatives. The Program will hold a contractors' meeting for collaboration and partner building focusing on sharing initiatives and strategies in getting teens into the clinics.

The Women's Health Coordinator will continue to work with partners to reduce the rate of teen pregnancy.

The Special License/ Midwifery Program will refer for consultation all pregnant mothers who are under age 16.

c. Plan for the Coming Year

The Abstinence Education Program will continue to identify unserved areas in the state and encourage programming in those areas. The Program will examine the results from program evaluation reports to improve and update program content, implement and deliver models of educational and youth development services. Data on teen births and sexually transmitted diseases by county, age and ethnicity will be analyzed and distributed to ensure that programs are targeting those populations and geographic areas with high rates of teen births. New research on innovative approaches regarding abstinence education services and teen pregnancy prevention will continue to be distributed to community providers. The Abstinence Education Program will serve additional numbers of teens and parents through expansion of existing projects and 4 new projects. Staff will continue to participate on the ADE HIVAIDS Materials Review Committee, the Arizona Adolescent Health Care Coalition and other local and national groups.

The Reproductive Health/Family Planning program will continue to provide outreach to teens and increase teen access to services. The program will evaluate if an increase in teen services occurred in the contractors targeted to increase services to teens.

Beginning July 2006 the abstinence program will be allocated an additional $500,000 in state funds. Additional funds will be used to enhance the evaluation and media components of the program, as well as to increase educational services in currently unserved/underserved areas.

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)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	12.5	13	30	30	25
Annual Indicator	29	29	36.2	24	36.2
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	36.5	36.5	36.5	36.5	37

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.

Notes - 2004
The data source for this measure has been changed. Figures for previous years were from a statewide oral health survey of over 80 communities. The measure for 2004 is based on children in schools from five of the 15 counties in Arizona where at least 65% of the student population in the school are on the Free and Reduced Lunch program. Data is collected on second grade children because physiologically, their average age is the optimum time for sealant placement on first permanent molars. Presence of existing dental sealants is determined at the time of the screening for sealant need, and before any additional sealants are placed. Data reported for 2004 were collected during the 2003-2004 school year and 24% of students were found to have sealants. The same surveillance method on the previous academic year yielded an estimate of 20%.

a. Last Year's Accomplishments
The Oral Health Arizona Dental Sealant Program operated in 5 counties, in schools with 65% or greater participation in the Free and Reduced Lunch Program, and provided 10,205 children in 136 schools with a dental screening and referral for dental care. 8,476 high-risk children with no dental insurance or on Medicaid received dental sealants. The total number of dental sealants placed was 31,263.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Oral Health Office provides dental sealants to high risk children.	X			
2. The Dental Sealant Program is being evaluated.				X
3. Collaborations between the Office of Oral Health and other interested entities are taking place to expand services.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Oral Health Program provides dental sealants to at least 8,000 high-risk children, and provides dental examinations and referrals to at least 7,000 high-risk children. The program will continue to seek alternative delivery models that promotes quality of care and expands the number of children served; continue to collect data on children in 2nd and 6th grades; collaborate

with other agencies and organizations to increase the number of children receiving dental sealants; educate schools and the public on the benefits of dental sealants and promote that it is an evidenced based program; educate the dental profession about the Office of Oral Health and Dental Sealant Program; and expand sealant program to Navajo and Mohave Counties.

c. Plan for the Coming Year
The Oral Health Program will provide dental sealants to at least 8,000 high-risk children, and will provide dental examinations and referrals to at least 7,000 high-risk children. The program will continue to seek alternative delivery models that promote quality of care and expand the number of children served, and will continue to collect data on children in 2nd and 6th grades. The program will collaborate with other agencies and organizations to increase the number of children receiving dental sealants, and will educate schools and the public on the benefits of dental sealants. The program will educate the dental profession about the Office of Oral Health and Dental Sealant Program. The sealant program will be expanded to Cochise County.

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	6.7	6.3	5.9	5.9	5
Annual Indicator	5.5	4.8	5.3	4.5	4.5
Numerator	65	59	67	58	
Denominator	1189772	1226721	1261764	1300444	
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	4.2	4	4	3.8	3.5

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. 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 - 2004
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
Child Fatality Review Program (CFR) provided reports and presentations on preventing deaths due to motor vehicle crashes (MVCs) which included factors such as demographics, types of motorized vehicles involved, use of passenger restraints, substance abuse, age of driver, and position of child in the vehicle. The CFR Data Form was revised, enhancing accuracy of data and identification of factors contributing to deaths. The 12th Annual CFR Report was used to support legislation related to reduction of MVC deaths including primary seat belt laws, graduated driver's license laws, and increased accessibility of substance abuse treatment programs.

Community Health Services funded 8 car seat safety projects. 6,066 child car safety seats were installed and education was provided to parents/caregivers. 50 child car safety seat events were held, 55 new Child Passenger Safety Technicians were certified, and two technicians were certified as trainers. 736 bicycle helmets were distributed with helmet safety education. 4th, 5th & 6th graders were targeted for motor vehicle safety education. Pregnant women were educated on correct seat belt usage. Thousands of brochures were distributed across the state on child car

seat and motor vehicle safety for pregnant women.

20 newspaper ads on child car seat safety and motor vehicle safety for pregnant women were published in Native American media using photographs of local tribal members. Radio PSA's were aired in tribal communities, reaching thousands of tribal members across the state. A survey of low-income families living on reservations showed that 91% of families have a car seat for their infant, an increase of 7% from 2004. Another survey showed that 85% of tribal families had a car seat for their child, an increase of 6% compared to year 2004. 290 cable television spots were aired on child car seat safety and bicycle helmet safety reaching an estimated 13,000 of the target population.

Click-It-Or-Ticket campaigns were used to educate on car seat safety. Some programs are training case managers at rural Child Protective Services Offices on child car seat safety.

40 physician residents at Maricopa Integrated Health System Hospital went through car seat safety training during their Pediatric Emergency Department rotation.

Motor vehicle safety programs were presented to 1,256 high school students in rural areas. These programs include the practical application of motor vehicle safety through the use of impaired goggles while driving through a computerized driving simulation.

2 County Prenatal Block Grant counties obtained car seat safety technician training and accessed sources for car seats. 436 car seats were distributed.

Health Start provided families with car seat education. Parents must complete car seat training before their infant is discharged from the hospital. Community Health Nurses and Lay Health Workers, many of whom are certified car seat safety technicians, monitor car seat usage at each home visit.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Community Health Services Program conducts car seat safety education for parents in their native language.		X		
2. The Community Health Services Program sponsors car seat technician training.				X
3. Health Start and the High Risk Perinatal Program assist families in obtaining car seats.		X		
4. The Community Health Services Program distributes bicycle helmets with safety education for children.		X		
5. The Injury Prevention Program provides information on pedestrian and child passenger safety.			X	
6. Health Start and the High Risk Perinatal Program monitor car seat usage at home visits for those enrolled in High Risk Perinatal Program.		X		
7. The Child Fatality Review Program produces reports upon request for research related to motor vehicle crashes resulting in child deaths from Child Fatality Reviews.				X
8. The Community Health Services Program provides motor vehicle safety education with appropriate seat belt application for pregnant women.		X		
9. The Community Health Services Program provides motor vehicle safety education with practical for high school students.		X		

10. The Child Fatality Review Program produces an annual report of findings and recommendations to reduce fatal motor vehicle crashes.				X

b. Current Activities

Child Fatality Review (CFR) Teams will continue to review circumstances surrounding motor vehicle crashes, and make recommendations for reduction of child deaths. In November the CFR program will produce an annual report for the public, the Governor and the Legislature on statistical trends and recommendations for prevention of child fatalities due to motor vehicle crashes. CFR staff will continue to provide technical assistance to the local child fatality teams in developing and implementing local culturally sensitive teams, and will identify and promote campaigns to educate the public on preventing fatal motor vehicle crashes. The CFR website will be enhanced to promote prevention strategies related to MVC deaths of children and other preventable deaths.

Community Health Services contractors will continue with current programs. One contractor will educate foster parents on car seat education and correct installation and the biological or adoptive parent when the child is placed. More effective ways of obtaining follow-up information are being developed to evaluate the long-term effects of car seat education and correct installation of the seat. Contractors continue to seek car safety seat donations. Currently there are 6 contractors who install car seats and provide car seat education through community events, 3 contractors who provide motor vehicle safety information to adolescents, and 7 contractors who provide bilingual and bicultural car seat and motor vehicle safety information.

County Prenatal Block Grant Program staff will attend car seat technician training. The program holds car seat "Rodeos" throughout the state, in which trained staff provide free inspection and installation of car seats to the public. Some programs provide free training and car seats as incentives to attend prenatal classes.

The Health Start Program has provided families with education on car seat safety and training has been offered to all participants. Prior to taking an infant home from hospital, the program trains parents on car seat safety. The program assists parents in obtaining car seats. Community Health Nurses and Lay Health Workers, many of whom are certified car seat safety technicians, monitor car seat usage at each home visit.

The Safe Kids Arizona program will establish a Safe Kids Board, and will continue to provide technical assistance to Safe Kids Coalitions. The program will provide public education on pedestrian and child passenger safety, and will assist with two child passenger safety certification trainings in tribal communities. The Safe Kids Arizona program will participate in the Governor's Traffic Safety Advisory Council.

c. Plan for the Coming Year

The Child Fatality Review Program (CFR) will review circumstances surrounding deaths of children due to motor vehicle crashes. CFR will include information in the 2007 annual report on factors contributing to motor vehicle crash deaths and recommendations addressing these factors. CFR will provide data reports upon request regarding motor vehicle crashes for purposes of research, public education, and to promote public policy on reducing motor vehicle crashes. The CFR website will be enhanced to promote prevention strategies related to MVC deaths of children and other preventable deaths.

A new Community Health Services Request for Grant Application (RFGA) will be released in the fall of 2006 and will include a focus on injury prevention. The anticipated start date for the new grants awarded under the RFGA is January 1, 2007.

The Health Start program will continue to provide families with education on car seat safety and user training will be offered to all participants. Parents will continue to complete car seat training before discharge. Parents will continue to be assisted in obtaining car seats. Community Health Nurses and Lay Health Workers, many of whom are certified car seat safety technicians, will continue to monitor car seat usage at each home visit. This education is done in Spanish or English.

The Safe Kids Arizona Program will geomap location of certified technicians to determine certification training needs. Efforts will focus on restraint needs of "tweens" ages 8-14.

The state injury prevention plan has been updated for 2006-2010. The plan will be used to help partners and communities identify and implement appropriate strategies.

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator					37.6
Numerator					
Denominator					
Is the Data Provisional or Final?					Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	38	38.5	38.5	39	39

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 County Prenatal Block Grant reports 269 women statewide have received information and supportive services from certified lactation counselors in the hospital and follow-up after discharge.

The High Risk Perinatal Program (HRPP) contracts with all Neonatal Intensive Care Units (NICU) throughout the state. Each NICU has a lactation consultant available. Discharged mothers can contact the NICU with concerns about breastfeeding. During follow-up home visits the HRPP Community Health Nurses (CHN) support the mother with breastfeeding. Health Start Lay Health Workers teach breastfeeding classes before delivery and follow mothers' breastfeeding progress after delivery. Many of the CHNs and Lay Health Workers are Certified Lactation Consultants. Two of the OWCH Hot Line staff are Certified Lactation Consultants and the third will be trained. All three Hot Line staff are bilingual in Spanish and English.

The Special License Midwifery program midwives provide education to pregnant mothers regarding importance of breast-feeding. They provide information pamphlets regarding the breast-feeding and follow up at postpartum evaluation for all mothers. All 341 midwife deliveries were provided with breast-feeding information.

The Arizona Department of Health Services (ADHS), Office of Chronic Disease Prevention and Nutrition Services (OCDPNS) created a statewide coalition called LATCH-AZ, which serves as an umbrella coalition to bring together breastfeeding advocates and provide educational and networking opportunities. ADHS provided training and technical assistance to Hotline staff to

enhance services provided. Breastfeeding pump loan program continued through WIC. A one-day training on breastfeeding the Neonatal Intensive Care Unit (NICU) infant was held for healthcare professionals. Scholarships to lactation courses were offered to WIC staff and selected community partners. Advanced certification in lactation (IBCLC) was awarded to eight WIC and ADHS staff. A social marketing campaign was conducted to promote breastfeeding in the workplace. Funding was awarded to four WIC agencies to begin breastfeeding peer counseling programs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The County Prenatal Block Grant provides in hospital and home breastfeeding education.		X		
2. Bilingual Certified Lactation Consultants from the High Risk Perinatal Program and Health Start provide support through the OWCH Pregnancy and Breastfeeding Hot Line.	X			
3. WIC participants were able to use the pump loan program.	X			
4. High Risk Perinatal Program Community Health Nurses assist with breastfeeding concerns.		X		
5. The WIC program conducted free lactation education and networking events and provide scholarship for training.				X
6. The Special License Midwifery Program educates midwives on current information regarding screening, breast feeding, and complications.		X		X
7. The County Prenatal Block Grant encourages business and local agencies to develop policies for breastfeeding in workplace.				X
8. The County Prenatal Block Grant incorporates breastfeeding information and education in prenatal and childbirth education programs.		X		
9. Health Start Lay Health Workers teach breastfeeding classes and assist mothers with breastfeeding post partum.		X		
10. WIC provided breast pumps through the breast pump loan program	X			

b. Current Activities

The County Prenatal Block Grant funds training of health workers to be Certified Lactation Counselors. County programs include breastfeeding information and education in prenatal and childbirth education classes. Some counties are working with local business to encourage breastfeeding in the workplace.

The High Risk Perinatal Program (HRPP) has a lactation consultant available to the NICU to encourage and support breastfeeding. Discharged mothers can contact the NICU with concerns about breastfeeding. During follow-up home visits the HRPP Community Health Nurses support the mothers with breastfeeding. Health Start Lay Health Workers teach breastfeeding classes before delivery and follow mothers' breastfeeding progress after delivery.

The Special License/ Midwifery program continues to provide education to all women who choose delivery by midwives. The midwives provide handout information in English and Spanish and childbirth education classes for the mothers. Education opportunities for newborn screening, breast feeding, and hearing screening is provided to the midwives.

The Office of Chronic Disease Prevention and Nutrition Services activities through the statewide coalition LATCH-AZ continue, with quarterly free lactation education events planned.

Scholarships to WIC staff and community partners to attend lactation education courses continue, providing opportunities for WIC staff to achieve advanced certification in lactation (IBCLC). Additional breast pumps have been purchased for the breast pump loan program through WIC. Promotion of worksite lactation policies are supported by the Breastfeeding Coordinator and the website developed during the social marketing campaign. The Health Start program receives breastfeeding training at their annual meeting.

c. Plan for the Coming Year

The County Prenatal Block Grant will continue to provide breastfeeding information and education in prenatal classes, and will continue to provide breastfeeding support by Certified Lactation Counselors. The program will continue to focus on breastfeeding as a priority, and will provide all county programs with information on train the trainer programs and educational opportunities for breastfeeding education.

The High Risk Perinatal Program (HRPP) will continue to contract with all Neonatal Intensive Care Units (NICU) throughout the state. Each NICU will have at least one lactation consultant available to help encourage and support breastfeeding. Discharged mothers will be able contact the NICU with concerns about breastfeeding. During follow-up home visits the HRPP Community Health Nurses will continue to support the mother with breastfeeding. Health Start Lay Health Workers will continue to teach breastfeeding classes before delivery and follow mothers' breastfeeding progress after delivery. A third OWCH Hot Line Human Services Specialists will be trained as a Certified Lactation Consultant.

The Special License/ Midwifery program will continue to provide breastfeeding education to all women who choose delivery by midwives.

The Office of Chronic Disease Prevention and Nutrition Services Breastfeeding Coordinator will provide support and materials to Breastfeeding Hotline staff, continue to assess and recommend training for WIC and MCH breastfeeding counselors, and coordinate training opportunities for internal and external partners on breastfeeding. The breast pump loan program will continue to be a service through WIC local agencies. Social marketing efforts will promote breastfeeding duration and will also target community healthcare providers. Funding for an additional breastfeeding peer counseling program will be released, and peer counseling services will be provided through selected local WIC agencies. Employee breastfeeding policies will continue to be promoted to Arizona businesses, with the ADHS breastfeeding policy serving as a model. Scholarships for WIC employees to attend lactation education courses will be provided. High Risk Breastfeeding guidelines will be developed for the hospital neonatal units. Breastfeeding training will be regionally offered for Health Start. An International Board Certified Breastfeeding Consultant will be added, as well as 24-hour service to the breastfeeding hotline. The program will review and revise the job classifications for the breastfeeding hotline staff.

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)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	85	85	98	98	98.5
Annual Indicator	93.3	97.9	98.0	98.3	98.2
Numerator	79470	85368	89233	96876	94750
Denominator	85213	87200	91054	98551	96487
Is the Data Provisional or Final?				Final	Final

	2006	2007	2008	2009	2010
Annual Performance Objective	98.8	99	99	99	99

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.

Notes - 2004
The data reported are estimated based on 41 out of 45 birthing hospitals. While all 45 birthing hospitals have universal screening programs, reporting to the ADHS is voluntary, and not all report. Among the 78,139 births at these 41 hospitals, 76,774, or 98.3% were screened. The best estimate of the numerator for this measure on a statewide basis is 98% of all births: 98,551 x .983 = 96,876.

a. Last Year's Accomplishments
All 48 hospitals in Arizona admitting newborns (all birthing or pediatric hospitals) now voluntarily perform Universal Newborn Hearing Screening (UNHS). All but two voluntarily report the results to the Arizona Department of Health Services (ADHS) Newborn Screening Program. One of the two non-reporting hospitals has recently completed installation of software to facilitate reporting and is expected to begin reporting April 2006. The remaining non-reporting hospital is not under the jurisdiction of Arizona law but its regulators have expressed an interest in requiring the hospital to report in 2006. The number of hearing screenings reported to ADHS reflects 91% of all hospital births recorded by Arizona Vital Statistics. ADHS estimates 94 to 95% of all newborns admitted to screening hospitals receive an initial hearing screening.

Several key hospitals transitioned from screening with only Automated Auditory Brainstem Response (AABR) to equipment that is capable of conducting both AABR and Otoacoustic Emissions (OAE's), improving the quality and reliability of hearing screening.

Rule writing for the amended newborn screening legislation was to be completed in April 2006. The new legislation and rules require mandatory reporting of newborn and infant hearing screening, creation of a database to monitor hearing screening results, and follow up services for newborns and infants who do not pass hearing screening.

Hearing screening follow up has been piloted in Yuma, Arizona since January 2006. Hearing screening follow up protocols were developed and will be used for state-wide follow up services.

The Newborn Screening Program contracted with University of Arizona to provide a workshop on the newest research on audiologic neuroplasiticity. The workshop was attended by audiologists and other healthcare providers in Arizona in March, 2006.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Newborn Screening Program provides follow up services to newborns and infants with possible hearing loss.		X		
2. The Newborn Screening Program established a central database for hearing screening results and follow up services.				X
3. The Newborn Screening Program develop standardized reports through data integration identifying newborns not passing				X

screen.				
4. The Newborn Screening Program develop educational materials and provide education to providers, parents, and public.				X
5. The Newborn Screening Program provided technical assistance to hospitals and providers in newborn hearing screening and reporting.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Through the Newborn Screening Program, follow up services for all newborns and infants in Arizona who do not pass the newborn hearing-screening test will be initiated. An assessment of availability of audiology and otology services in Arizona will be completed as well as creation of referral tools and education for providers and families as part of the preparation for delivery of follow up services.

The ADHS will establish a central database of newborn and infant hearing screening results and subsequent follow up services. The database will be linked to the Newborn Bloodspot Screening upgraded database in order to facilitate follow up services.

The Newborn Screening Program will provide education to hospitals, healthcare providers, consumers, and the public about newborn hearing screening and the benefits of early intervention. The Newborn Hearing Screening web page will be updated. The Newborn Hearing Screening Program will contract with the University of Arizona to provide a workshop for pediatric audiologists on an emerging topic in newborn screening.

The Office of Women's and Children's Health will develop standardized reports to identify all infants who have not passed a newborn hearing screen. The reports will allow a closer look into demographic data to evaluate possible trends and potential patterns.

The ADHS will continue to provide technical assistance to hospitals and providers for newborn hearing screening and reporting of results to audiologists for the reporting of evaluations.

The ADHS will provide mini grant offerings to community health centers to increase the availability of outpatient newborn and infant hearing screening.

The Newborn Hearing Screening Program is participating in an 18-month multi-disciplinary Learning Collaborative facilitated by the National Initiative for Children's Healthcare Quality and MCHB/HRSA. The Learning Collaborative goal is to reduce loss to follow up of infants who have not passed the newborn hearing screen by 50% by working through the Medical Home. A rapid-cycle, small-test performance improvement model will be used by the collaborative.

c. Plan for the Coming Year

The Arizona Department of Health Services Newborn Screening Program will continue to provide technical assistance to hospitals and providers in newborn hearing screening and results reporting.

An assessment of newborn populations not receiving newborn screening will be performed including analysis of unscreened newborns, analysis of barriers to screening, and plan to

increase percentage of newborns screened.

An assessment will be done of newborns and infants identified as not passing the newborn hearing screen and not accessing follow up services of re-screening, audiologic evaluation, and early intervention. An analysis of barriers to follow up and plan to decrease loss to follow up will be prepared.

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	15	14	14	14	14
Annual Indicator	17.8	14.7	14.6	14.7	14.7
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	14.5	14.4	14.3	14.2	14

Notes - 2005
Data source is http://www.census.gov/hhes/hlthins/historic/hihistt5.html. Data for 2005 not yet available. The estimate for 2005 is provisionally set at the 2004 rate until data become available in the Fall of 2006.

Notes - 2004
Data source is http://www.census.gov/hhes/hlthins/historic/hihistt5.html.

a. Last Year's Accomplishments
The Community Health Services Program assessed and referred 104 children who did not have medical insurance to providers for medical and/or dental care. The children's parents were assisted with filling out forms to obtain medical insurance. In Mohave County the program coordinator educates school nurses on services and programs available for children without health insurance, and contacts physicians and dentists who provide services for a reduced or no cost.

The County Prenatal Block Grant assisted 665 families with AHCCCS enrollment and other medical assistance programs.

The High Risk Perinatal Program and Health Start programs assessed the health insurance status of each client. Families were educated on the importance of establishing and maintaining a medical home and were assisted with overcoming barriers to access to care. The OWCH Hotline staff assisted callers to find health care in their communities.

The Medical Home Project (MHP) continued to link uninsured children who do not qualify for AHCCCS with medical providers. The MHP is available in 7 counties. School age and younger children were provided 1,251 acute care services and a true medical home was provided to 26 children. Services provided included 51 eyeglasses, 111 diagnostic laboratory services, and 398 prescription medications. MHP has 81 primary care physicians providing acute care services, 7 physicians providing a medical home, 59 specialty physicians, and 847 entities providing referral. The MHP has bilingual and bicultural staff. When possible, Spanish-speaking families are referred to bilingual physician's offices. All print materials about MHP are available in English and Spanish.

The Office of Oral Health (OOH) published The Oral Health of Arizona's Children, Current Status, Trends and Disparities, November 2005 report. This report notes that 25% of children in 3rd grade are without dental insurance.

The OOH continued to work with AHCCCS, and multiple community coalitions. The collaboration with the AHCCCS Dental Director to expand and improve services is on going. OOH continues to disseminate oral health messages through community dental clinics, WIC programs, Head Starts and other community based organizations.

OOH continues to expand outreach efforts to increase utilization of services by current AHCCCS enrollees. The % of enrollees receiving dental treatment was 30% in Federal Fiscal Year 2004 and 31% in 2005. AHCCCS clarified services to include dental care for those under age 3. The percentage of children through age 5 who received dental care annually increased from 21% in 2004 to 23% in 2005.

The Arizona Committed to Improving Oral Health Needs (ACTION) Program provides dental referrals to help establish a dental home for children and recruits dentists to serve as a safety net for the uninsured by providing free or reduced cost dental treatment.

OOH awarded a grant for a mobile dental van in rural Cochise County to improve access to dental care.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Community Health Services Program finds children in the school system that do not have medical/dental insurance, and assist parents of these children in filling out the appropriate forms to obtain medical insurance.		X		
2. The County Prental Block Grant coordinates Health Fairs for purpose of public education on available services.		X		
3. The High Risk Perinatal Program and Health Start provide training and updates on available public insurance plans.			X	
4. The Medical Home Project screens children for AHCCCS eligibility and refer as appropriate.			X	
5. County Prental Block Grant staff attend fairs and other public events to identify and assist families.		X		
6. The Office of Oral Health continues support of community based programs to improve access to care issues.		X		X
7. The County Prental Block Grant links with agencies to identify and assess qualified families.		X		
8.				
9.				
10.				

b. Current Activities

Community Health Services contractors will continue to facilitate enrollment of children into a health insurance program.

The County Prenatal Block Grant continues to promote insurance options. The program also will continue home visits, referrals, and follow-ups to assess needs and assist in application processes.

The High Risk Perinatal (HRPP) /Health Start Program educated families on the importance of establishing and maintaining a medical home and assisted them in overcoming barriers to health care. Training and updates on available public insurance plans are provided for specific populations. The HRPP and Health Start programs continue to assess the status of each client through enrollment. The OWCH Hotline staff assist callers with finding health care in their communities.

The Medical Home Project (MHP) continues to link uninsured children who do not qualify for AHCCCS with medical providers. The MHP continues to provide acute care services to children. In 2006, our goal is to increase the number of families who receive services through a true medical home to 20 and increase to 8 the number of counties served. The MHP continues to seek additional providers and school nurses and public health nurses to refer children to the Project. The MHP continues to have bilingual and bicultural staff available. Spanish-speaking families are referred to bilingual physician's offices. All written materials about this program are available in both English and Spanish.

The Office of Oral Health (OOH) will complete a report on dental workforce in Arizona. OOH will continue to work with AHCCCS Dental Director on improving dental care services in Arizona to support measures to increase access to dental care issues. OOH is expanding duties for dental hygienist in the dental practice act, and will support additional funding for dental clinics in rural areas. OOH will provide Oral Health 'train the trainer' workshops to childcare centers and WIC programs. OOH will develop and print fact sheets on the need and disparities in Arizona children for oral health, and will present information to key partners in improving access to care issues. OOH will complete the State Oral Health Plan. OOH will provide trainings to pediatricians on oral health care and use of fluoride varnish, and will provide technical support for conducting a varnish program. OOH will promote new Affiliated Practice rules in underserved children populations. OOH will provide educational opportunities for dental hygienists. All information will be available online.

c. Plan for the Coming Year

The Community Health Services contracts will be ending on December 31, 2006. A new Community Health Services Request for Grant Application (RFGA) will be offered in the fall of 2006. The anticipated start date for the new grants awarded under the RFGA is January 1, 2007.

The County Prenatal Block Grant will continue to promote insurance options and continue home visits, referrals, and follow-ups to assess needs and assist in application processes.

The High Risk Perinatal Program (HRPP)/Health Start Program will continue to educate families on the importance of establishing and maintaining a medical home and will assist them in overcoming barriers to health care. Training and updates on available public insurance plans will be provided for specific populations. The HRPP and Health Start programs continue to assess the status of each client through enrollment. The OWCH Hotline staff will continue to assist callers with finding health care in their communities.

The Medical Home Project will continue to link uninsured children who do not qualify for AHCCCS with medical providers. The Project 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 Project. The goal will also be to continue to increase the number of children who receive a true medical home from the Medical Home Project.

The Office of Oral Health (OOH) will continue to support ACTION program and evaluate its effectiveness and investigate alternatives. OOH will promote the coordination of dental care between physicians and dentists. OOH will improve access to dental care for children with special health care needs. OOH will provide dental continuing education and expanding the availability

of dental professionals accepting patients with special health care needs. OOH will investigate strategies for workforce shortage areas, and will continue working with AHCCCS Dental Director to improve access to dental care issues.

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)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					35.1
Numerator					31345
Denominator					89325
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	35	35	34.5	34.5	34.5

a. Last Year's Accomplishments

The Arizona Health Care Cost Containment System (AHCCCS/Medicaid) Childhood Obesity Prevention Model incorporates behavioral, nutritional, and physical activity components into their interventions. Interventions are divided into three tiers based upon BMI. The Office of Chronic Disease Prevention and Nutrition Services Maternal Child Health Program provided prevention messages for the managed care newsletters and developed guidelines for nutrition intervention. A promising practice of this model is the referral for nutrition intervention and behavioral modification above the 75th percentile for BMI. The Nutrition And Physical Activity Self Assessment for Child Care (NAP SACC) project promotes healthy eating and physical activity in young children by assessing and implementing changes in policy, environment, and communication in child care settings. Childcare centers do an assessment and highlight changes it will make to prevent obesity and encourage healthy eating and physical activity. Centers receive training. Steps To A Healthier Arizona Initiative, Maternal and Child Health Nutrition, Nutrition and Physical Activity Program, Epidemiology, Child Care Licensing, Governor's Council of School Readiness, and Oral Health have established a committee to coordinate planning, pilot-testing, implementation and evaluation activities related to NAP-SACC on an ongoing basis.

The goal of the Fit WIC program for children is to increase their physical activity through caregiver education; introduce children to good nutrition; and stress the importance of physical activity through activities in WIC.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Office of Chronic Disease Prevention and Nutrition Serivces provides technical assistance to childcare centers for the Nutrition and Pysical Activity Self Assessment for Child Care Program.				X
2. The Office of Chronic Disease Prevention and Nutrition Serivces provides training for the communities participating in the CDC funded STEPS program.				X
3. The Office of Chronic Disease Prevention and Nutrition Serivces continues to incorporate Nutrition and Pysical Activity Self Assessment for Child Care into the licensure rating system.				X

4. The Office of Chronic Disease Prevention and Nutrition Serivces continues Fit WIC programs.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Office of Chronic Disease Prevention and Nutrition Services Maternal Child Health Program provided prevention messages for the AHCCCS managed care newsletters and developed the guidelines for nutrition intervention. Nutrition and Physical Activity Programs five sites in Tucson, Flagstaff, Mesa, Phoenix and Chino Valley are piloting NAP SACC. The pilot began in May 2005 and will conclude in June 2006. ADHS Nutrition and Physical Activity Program and MCH Nutrition Staff train as Child Care Health Consultants and can provide training and technical assistance on NAP-SACC and other health-related child care, day care and preschool interventions.

Mariposa Community Health Center and Maricopa County WIC programs have started their second year of Fit WIC classes. The Arizona State WIC program has added 13 agencies to the program. Arizona Nutrition Network and State WIC collaborated to provide Fit WIC Activity Bags. The bags contained incentive items to encourage play, such as beach balls, bubbles, etc.

c. Plan for the Coming Year
The Office of Chronic Disease Prevention and Nutrition Services Maternal Child Health Program will continue to provide technical assistance for the AHCCCS Childhood Obesity Prevention Program. Tohono O'odham Nation will pilot test Nutrition and Physical Activity Self Assessment in Child Care Centers (NAP-SACC) with Head Start Cochise and Santa Cruz Counties will initiate NAP-SACC. MCH Nutrition will work with the Office of Child Care Licensure to include NAP SACC in the childcare rating system. Arizona State WIC program will develop lesson plans for FIT WIC and begin evaluation of success of the program.

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator					5.4
Numerator					5128
Denominator					95798
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	5	5	4.5	4.2	4

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
The High Risk Perinatal Program's Health Start Lay Health Workers advise pregnant women of the dangers of smoking to their unborn baby. If a woman is interested in quitting the LHW will refer the mother for smoking cessation classes. Bilingual OWCH Hotline staff refers pregnant women who are seeking smoking information to the ADHS Tobacco Education and Prevention Program.

The County Prenatal Block Grant (CPBG) coordinators have successfully integrated smoking cessation and tobacco education and prevention programs into their prenatal classes. They have also developed preconception health programs, targeting teenage girls, to educate them on the importance of a woman's health status prior to pregnancy and the effects nicotine have on birth outcomes. The prenatal classes included information on smoking cessation provided by the ADHS Tobacco Education and Prevention Program while education on the effects of smoking on the unborn child was provided by the CPBG coordinators. To date, no documentation has been collected regarding the effects of this educational component, but counties are developing goals, objectives and evaluations regarding the impact of this program that should be available next year.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Bilingual Lay Health Workers from the Health Start Program inform pregnant women of smoking effects on baby.		X		
2. Bilingual Lay Health Workers from the Health Start Program refer to smoking cessation classe.		X		
3. Bilingual OWCH Hot Line staff refer interested mothers to ADHS Tobacco Education.		X		
4. The County Prenatal Block Grants provide information on the inpact of nicotine on the unborn fetus in prenatal classes.			X	
5. The County Prenatal Block Grants provide clients with opportunities to reduce/quit smoking through support and education.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The High Risk Perinatal Program's Health Start Lay Health Workers advised pregnant women of the dangers of smoking to their unborn baby. Interested mothers are referred to smoking cessation classes. Bilingual OWCH Hot Line staff referred pregnant women to the ADHS Tobacco Education and Prevention Program.

The County Prenatal Block Grant coordinators, throughout the state, have developed preconception health education programs and prenatal programs that have a tobacco cessation component to them. In areas where the ADHS Tobacco Education and Prevention Program is active, the coordinators work closely with them to provide the education related to the effects of smoking and the information on smoking cessation. The coordinators provide education to pregnant women on the impact tobacco has on the unborn fetus, and educates women and teens on the effect of tobacco on the health status of women prior to pregnancy.

c. Plan for the Coming Year
The High Risk Perinatal Program's Health Start Lay Health Workers will continue to advise pregnant women of the dangers of smoking to their unborn baby. Women interested in quitting will be referred for smoking cessation classes. Bilingual OWCH Hot Line staff will continue to refer pregnant women seeking smoking information to the ADHS Tobacco Education and Prevention Program.

CPBG will develop and implement goals, objectives and evaluations that demonstrate their efforts to reduce the number of low birth weight babies as a result of education regarding the relationship between smoking and birth outcomes. The target populations will be pregnant women and any women of childbearing age.

CPBG will continue to work closely with the ADHS Tobacco Prevention and Education Program to include them in any event, prenatal class, teen maze, health fair, and all activities related to perinatal services.

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	17	16.7	16.4	16.4	9.5
Annual Indicator	10.5	9.9	9.7	11.8	11.8
Numerator	40	39	39	49	
Denominator	380103	391964	403088	417019	
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	11.5	11	10	10	9.8

Notes - 2005
Data for 2005 are not yet available. The estimate for 2005 is provisionally set at the 2004 rate until data becomes available in the Fall of 2006.

a. Last Year's Accomplishments
In 2005, the 12th Annual Child Fatality Report was produced, summarizing reviews of childhood deaths that occurred in Arizona in 2004. The Child Fatality Review Program reviewed 98% of childhood deaths, which is a significant increase over the 89% of 2003 deaths that were reviewed. During 2005, Child Fatality Review Teams reviewed circumstances surrounding suicides of 27 children that occurred in 2004. Three of the 27 children who committed suicide were between eight and 14 years. 24 suicides were in the 15 through 17 age group. Through improvement in the data forms, the program was able to identify factors that contributed to suicides among children Leading factors included failure to recognize depressive symptoms (20), lack of public awareness of suicide (13), access to guns (13), and drug or alcohol use (7). The most frequent method of suicide was gunshot wound (13), followed by hanging (10), poisoning (3), and suffocation (1). The Arizona Child Fatality Review Program provided data reports for research and presentations on preventing child deaths due to suicide.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. The Child Fatality Review Program conducts reviews of child fatalities due to suicide.				X
2. The Child Fatality Review Program produces reports upon request for research related to incidence of suicide.				X
3. The Child Fatality Review Program produces an annual report that includes findings and recommendations on suicide by children.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In 2006 Child Fatality Review (CFR) will continue to review deaths of children due to all causes, including suicide. Reviews will continue to identify circumstances surrounding each death and factors contributing to the death. The program will continue 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 13th Annual Child Fatality Review Report in November 2006. The report will include recommendations to reduce preventable deaths of children and data compiled through reviews of child fatalities that occurred in 2005. The Child Fatality Review annual report and the Citizen Review Panel annual report is available to the public on the Department's website.

The ADHS Suicide Prevention Program participates in the Internal Injury Prevention Workgroup and worked on the suicide chapter of the state injury prevention plan.

c. Plan for the Coming Year

CFR will review circumstances surrounding deaths of children due to suicide. CFR will include information in the 2007 annual report on factors contributing to childhood suicide and recommendations addressing these risk factors. CFR will provide data reports upon request regarding childhood suicides for purposes of research, public education, and to promote public policy on addressing risks for suicide. The CFR website will be enhanced to include information on the availability of data for research and public health campaigns. The website will also identify links to organizations regarding reduction of childhood deaths due to suicide and other causes.

The ADHS Suicide Prevention Program will give a presentation to the ADHS Injury Prevention Advisory Council and will continue to promote the strategies set forth in the suicide chapter of the state injury prevention plan.

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)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	80	80.5	81	81.5	82
Annual Indicator	78.7	77.6	80.1	81.6	81.6
Numerator	657	678	741	805	
Denominator	835	874	925	986	
Is the Data Provisional or Final?				Final	Provisional

	2006	2007	2008	2009	2010
Annual Performance Objective	82	82.5	83	83.5	84

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. Data for 2004 are not yet available. The estimate for 2005 is provisionally set at the 2004 rate until data become available in the Fall of 2006.

Notes - 2004
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 2 Enhanced Qualification or Level 3 centers. 1,404 women received maternal transports to an appropriate level of care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The High Risk Perinatal Program transports at risk pregnant women to appropriate level of care regardless of financial ability to pay.	X	X		
2. The High Risk Perinatal Program provides education on availability of transport.	X			
3. The High Risk Perinatal Program distributes High Risk Perinatal Nutrition Guidelines.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The maternal transport component of the High-Risk Perinatal Program (HRPP) continues to fund a centralized Information and Referral Service. The program continued to fund all uncompensated care associated with the transport of high-risk pregnant women to Level 2 Enhanced Qualification or Level 3 centers.

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

The Office of Nutrition Services provides consultation and education to the Perinatal Nutrition Network and continues to distribute the Perinatal Nutrition Guidelines to Arizona Perinatal Trust certified hospital units. Technical assistance is provided to OWCH and to county prenatal block grant coordinators. The WIC program will continue to screen pregnant women and refer them to prenatal services.

c. Plan for the Coming Year

The maternal transport component of the High-Risk Perinatal Program (HRPP) will continue to fund the centralized Information and Referral Service to offer toll free consultation services by board certified perinatologists throughout Arizona to providers caring for pregnant women who present with high-risk factors. The program will continue to fund all uncompensated care associated with the transport of high-risk pregnant women to Level 2 Enhanced Qualification or Level 3 centers. The Program will educate Level 2 and lower hospitals about the availability of the toll free consultation line.

Office of Chronic Disease Prevention and Nutrition Services will provide technical assistance and training to county prenatal block grant coordinators. The WIC program will continue to screen pregnant women and refer them to prenatal services.

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	77	78	79	80	78
Annual Indicator	75.5	75.7	75.6	76.3	76.3
Numerator	64377	66146	68632	71268	
Denominator	85213	87379	90783	93396	
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	78	79	79	80	80

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

The County Prenatal Block Grant (CPBG) Program used pregnancy tests to identify women early and refer them to prenatal care. The Program provided services to 2,640 women: early assessment, education and direct services to pregnant women. In general 85% of the women served were identified and began receiving prenatal care in their first trimester.

ADHS continued a partnership with Maricopa County Department of Public Health to conduct a survey to assess satisfaction with prenatal and birth care, barriers to access to prenatal care, and psychosocial predictors of positive prenatal care experiences and infant health outcomes. 2 communities with the highest indicators of inadequate prenatal care utilization were selected. 4 birthing hospitals were chosen to participate. Arizona State University Resilience Solutions group

served as a consultant in survey implementation, statistical analysis, and interpretation of the survey. The Friendly Access Baseline survey was modified to include psychosocial factors and indicators of individual resilience. Cultural identity, religious beliefs, acculturation, and well being were resiliency factors given emphasis.11 interviewers were hired and trained in human subjects protection, interviewing skills, confidentiality, cultural sensitivity, data collection, and protocol. 9 of the interviewers were bilingual English/Spanish. 560 postpartum bedside interviews were completed.

Health Start program utilizes Lay Health Workers identify pregnant women within their community and facilitate early entry into prenatal care. Program data is collected and analyzed to determine the Program's success in addressing this measure.

The OWCH Pregnancy and Breastfeeding Hotline prescreens pregnant women for eligibility into Baby Arizona (AHCCCS). Baby Arizona is a program of participating obstetricians willing to enroll pregnant women into AHCCCS in their office and agreeing to develop a payment plan if the woman does not qualify for AHCCCS. If prescreening shows a woman will not be eligible the Hotline can refer them to other providers in their area who offer sliding scale fees.

The Office of Oral Health (OOH) developed marketing brochures on pregnancy and oral care and oral care of your infant. OOH developed radio spots to promote reduction in bacterial causing dental decay. Marketing materials have been piloted in Paige, Flagstaff, Prescott and Yuma and distributed to all WIC programs, Head Start programs, and Community Health Clinics. They are also available for downloading from ADHS web site. OOH continued to work with professional associations to provide continuing education on issues related to caring for pregnant women and infants and toddlers. The Robert Wood Johnson Foundation supported pilot programs with Early Head Start and Cochise County Perinatal Program include an oral health education and prevention component for pregnant women.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Health Start Lay Health Workers identify pregnant women in the community and facilitate entry into care.	X			
2. The County Prenatal Block Grant Program provides subsidized funding for prenatal care for low-income women .		X		
3. The Office of Chronic Disease and Nutrition Services train WIC staff to refer pregnant women for early prenatal care.		X		
4. Bilingual Hotline prescreens for Baby Arizona and makes referals so that women can access prenatal care in timely manner.		X		
5. The Office of Women's and Children's Health continues to meet with AHCCCS MCH Coordinators to work towards getting women into early prenatal care.				X
6. Bilingual Hotline referrs to other providers offering sliding scale if not eligible for Baby Arizona.		X		
7. Health Start and the County Prenatal Block Grant provide pregnancy testing in order to early identify pregnant women.	X			
8. The Office of Women's and Children's Health utilize results from the Friendly Access Survey to gain an understanding of barriers to early entry into prenatal care.				X
9.				
10.				

b. Current Activities

The goal of the 15 counties within the CPBG Program is to improve birth outcomes with the objective of increasing the number of women who receive prenatal care in the first trimester. Counties are partnering with providers and using other available resources to meet this goal. CPBG also funded the full time position of the Director of the Alliance for Innovations in Health Care. This program is responsible for the Friendly Access survey that is the result of a collaboration between ADHS, Maricopa County, and Arizona State University Resilience Solutions.

The Friendly Access baseline survey results were reported, and a community plan was developed. Follow up surveys at 3 and 6 months have begun. The program will expand outreach on WIC, pregnancy and contraceptive education, and will hold focus groups to examine how experiences with discrimination and cultural beliefs related to pregnancy and prenatal care affected prenatal care utilization.

The Women's Health Policy Advisor will work with partners to implement women's commission goals of increasing access to health care; improving the health and well being of women, and increasing prenatal and preconceptional care. The Advisor will also work with the Governor's Office for Children, Youth and Families to increase minority participation on the Commission.

Representatives from the Arizona Department of Economic Security (DES), AHCCCS and ADHS convened to look at ways to strengthen Baby Arizona. An Intergovernmental Agreement was written to define roles, quarterly meetings for exchange of ideas/status/reports/etc., bi-annual newsletter to Baby AZ providers to talk about training opportunities/program successes/etc, purchase some social marketing materials increase visibility by attending more health fairs etc., Baby AZ website test site up by June 2006, increase/improve provider training, increase/improve provider network-establish more providers in the traditionally underserved areas.

The Office of Chronic Disease Prevention and Nutrition Services 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. WIC staff regularly meet with AHCCCS MCH coordinators.

Marketing materials developed in 2005 by the Office of Oral Health (OOH) will be more widely disseminated and utilized with train the trainer programs in child care centers, WIC programs, Head Start Programs and Community Health Centers. OOH continued collaborations with community partners in developing new programs and continuing programs to improve oral health during pregnancy. OOH will work with professional associations to increase awareness (provide continuing education) on issues related to caring for pregnant women and infants and toddlers. OOH will continue to support pilot programs through mini grants that include an oral health education and prevention component for pregnant women.

c. Plan for the Coming Year

The County Prenatal Block Grant will network with other agencies - WIC, family planning, pregnancy clinics, Health Start. The Program will provide services to pregnant women who were not eligible for other programs and do not have insurance. The Program will develop prenatal classes, trainings, brochures and other educational opportunities in bilingual format and with bilingual staff. The Program will also increase service base to include screening for perinatal mood disorders

The Health Start Lay Health Workers will continue to identify women within their communities who are at risk for a low birth weight baby. They expand on ways to assist clients in obtaining medical insurance and prenatal care throughout the women's pregnancy. They will continue to provide education on various topics that can impact the birth of the child as well as providing family

follow-up visits and education during the postpartum period. The Health Start Program will continue to network with other agencies like WIC, family planning, AHCCCS, and behavioral health services.

The Friendly Access Program will hold focus groups to examine how experiences with discrimination and cultural beliefs related to pregnancy and prenatal care affected prenatal care utilization. The Program will conduct asset based community development in two targeted communities. The Program will increase access to health care by promoting the AHCCCS program through Spanish language media outlets. The Program will expand outreach on WIC, pregnancy and contraceptive education, and will expand partnerships in the targeted communities.

The Women's Health Policy Advisor will work with partners to implement women's commission goals of increasing access to health care, improving the health and well being of women, and increasing prenatal and preconceptional care.

The OWCH Pregnancy and Breastfeeding Hotline will continue to prescreen pregnant women for eligibility into Baby Arizona. 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.

The Special License Midwifery program continue to review when women entered prenatal care and provide information about the importance of early care.

The Office of Chronic Disease Prevention and Nutrition Services will continue to train WIC staff to refer pregnant women for early prenatal care.

The Office of Oral Health (OOH) will expand efforts to educate health professionals on oral health before, during and after pregnancy, to improve birth outcomes and improve oral health of infants and toddlers. OOH will promote low cost clinics for oral care and receiving oral care during pregnancy. OOH will support the AHCCCS Dental Director and Health plans to develop policies regarding oral care during pregnancy. OOH will continue to provide technical assistance to community-based organizations on the relationship of oral health and pregnancy outcomes.

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	17.9	17.9	17.9	17.9	11
Annual Indicator	17.2	14.1	9.3	49.2	49.2
Numerator	50260	41231	29610	126442	
Denominator	291862	291862	319289	256879	
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	50	50	51	51	51

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.

Notes - 2004
Both the numerator and the denominator for this measure changed as of the 2004 reporting year. In the past, Arizona reported just those women receiving family planning services through Title V funded clinics in the numerator. The denominator, was women below 150% FPL.

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.

a. Last Year's Accomplishments
Through the Reproductive Health/Family Planning Program, 11 of the 15 County Health Departments received Intergovernmental Agreements to provide Reproductive Health/Family Planning services. 4,132 women received initial/annual visits. 99.5% of those women served were at or below 150% of the Federal Poverty Level and received services free of charge. By race and ethnicity, women served were: 54% White, 44% Hispanic, .5% Native American, .7% African American, and .3% Asian. 10,354 screenings were provided for either pregnancy, cervical or breast cancer, or HIV/STD testing. 5,012 referrals were made to receive follow-up medical care, nutritional services (WIC), domestic violence, behavioral health, prenatal care, or other community services.

All Reproductive Health/Family Planning Program contractors received one site monitoring visit with no contractual issues identified. The Reproductive Health/Family Planning Program worked collaboratively with Title X, Arizona Family Planning Council (AFPC), sharing information and data for trending purposes and outcome studies.

The Reproductive Health/ Family Planning Program supports community education and received funds from ADHS to co-sponsor the Arizona Family Planning Conference "Focus on Family Planning - Increasing Access".

The Reproductive Health/Family Planning Program has given ongoing technical assistance regarding policy changes, best practices and funding to all contractors. In response to a request from the contractors for increased funding to meet the increasing medical costs, the program completed a cost analysis and determined that an increase was needed. Technical assistance has been provided as needed with an average request for assistance being 3 per contractor.

The Women's Health Policy Advisor coordinated learning activities around women's health issues, including access to health care, reducing teen pregnancy and increasing preconceptional care.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Family Planning Program will maintain or increase number of women receiving initial or annual exam.	X			
2. The Family Plannign Program is woking to increase African American access to services.	X			
3. Friendly Access developed a community plan.				X
4. Friendly Access will conduct follow up surveys to gain an understanding of barriers to obtaining reproductive health/family planning services.				X
5. The Friendly Access Coalition will expand outreach efforts for reproductive health/family planning services.		X		
6. Friendly Access will hold focus groups to gain an				X

understanding of barriers to obtaining reproductive health/family planning services.				
7. The Women's Health Policy Advisor/Coordinator coordinates reproductive health/family planning activities at ADHS Public Health Prevention Services.				X
8. One goal of the Governors's Commission on the Health Status of Women and Families is to increase access to reproductive health/family planning services. The Women's Health Policy Advisor/Coordinator staffs the Women's Commission.				X
9. Implement Commission recommendations related to reproductive health/family planning and provide technical support.				X
10.				

b. Current Activities

The Reproductive Health/Family Planning Program contractors will receive level funding in the unit reimbursement for providing the required services of the program. The Reproductive Health/Family Planning program will monitor the outcome of this level funding to assess if the costs are covered and the number of individuals served is maintained. All contractors will have at least one site monitoring visit. The Reproductive Health Family Planning Program will continue projects to focus on increasing African Americans and teen access to services. The Reproductive Health/Family Planning Program will continue to work collaboratively with other agencies, organizations, and coalitions regarding the provision of reproductive health and family planning education, counseling, clinical care services, and referral services. The Program anticipates co-sponsoring the Annual Arizona Family Planning Coalition Conference. The Reproductive Health/Family Planning Program will continue to provide technical support, and resources for infrastructure building, continued education, and funding. The contractors will continue to build collaborative relationships and partners with the other contractors by attending an annual contractor's meeting.

The OWCH programs are reviewing their current policies and practices and identifying ways to better integrate information and referrals to family planning services. The Reproductive Health/Family Planning Program is using data that has been geomapped to identify areas of highest need for family planning services for African Americans. The program expects to identify and provide funding to a new provider in Maricopa County that will target this population.

The Women's Health Policy Advisor will work with partners to implement women's commission goals of increasing access to health care; improving the health and well being of women, reducing the rate of teen pregnancy, increasing preconceptional care.

c. Plan for the Coming Year

The Reproductive Health/Family Planning Program will continue to contract with the county health departments serving the underserved populations, and providing services in many of the rural areas of the state. The Program will provide services to the uninsured and underinsured focusing on women at or below the 150% of the federal poverty level. The Program will evaluate the outcome of focusing on African Americans and Teen access to services. The Reproductive Health/Family Planning Program will evaluate the outcome of increasing the unit rate of 9 of the 11 contractors that received an increase focusing on services provided and numbers served. The Program will have an annual contractors' meeting for collaboration and partnership building, and will work collaboratively with Title X. The Reproductive Health/Family Planning Program Manager will continue to participate on the Arizona Family Planning Coalition, and will continue to provide technical support as needed by each contractor.

Beginning in 2007, the Reproductive Health/Family Planning Program expects to fund new

providers in Maricopa County. The Program will work with the Title X agency to coordinate the identification of a new provider(s).

The Women's Health Policy Advisor will coordinate learning activities around women's health issues. The position will staff the Governor's Commission on Women, coordinate women's health activities within Public Health Prevention Services, and work with partners to implement women's commission goals of increasing access to health care; improve the health and well being of women, reduce the rate of teen pregnancy, and increase prenatal and preconceptional care.

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)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					25.5
Numerator					
Denominator					
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	25	25	24.5	24.5	24

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 Community Health Services Program funded three Women's Health Programs throughout the state. These programs were established to improve the health of women of child bearing age by reducing the percentage of women who experience "a lot" of stress, increasing physical activity, maintaining a healthy weight, improving diet by consuming at least 5 fruits and vegetables a day, reducing substance use/abuse, reducing the number of women injured or killed in motor vehicle accidents, and reducing the number of women who smoke.

1,124 women (unduplicated number) attended women's health series of classes and over 550 hour-long classes were conducted. There was a considerable increase in the women's knowledge of what contributes to a healthy lifestyle, which was demonstrated by the results of the pre and posttests. There was also a significant increase in physical activity. An example of one improvement in physical activity was demonstrated by an increase in daily steps, measured by pedometers, of more than 2,000 steps. Body Mass Indices (BMI's) also had evidence of reducing. One Contractor had a beginning BMI average of 31.7 and an ending BMI average of 30.3. The goal is not so much to lose weight, but to change behavior that will have the ultimate effect of weight loss. Healthy lifestyle is the primary goal.

Programs included ethnic food items and eating preferences of the participants helps with the long-term success of behavioral change and interventions that build on the strengths of a community are more likely to be successful.

Through the Office of Chronic Disease Prevention and Nutrition Services, the Steps Across Arizona Initiative developed a Steps School Health Index (SHI) Plan of Action to streamline and advance the SHI implementation process across the participating Steps communities. The Plan of Action includes strategies for getting buy-in and support from schools to participate in the SHI; regional Training of Trainers for local Steps staff and partners; community-based orientation and

training for assigned liaisons (school personnel and/or students from Health Careers Club or School Health Councils/Committees); and ongoing technical assistance to support all phases of implementation. The ADE Steps School Coordinator in the Office of Chronic Disease Prevention and Nutrition Services conducted a train-the-trainer session to the contractors, subcontractors and relevant affiliated partners from the four Steps communities. 74 participants from various STEPS communities have attended SHI workshops. School Health Mini-Grant Program incorporated the Arizona Healthy School Environment Model Policy Mini-Grants into schools. Four schools in Steps communities (Carmichael Elementary and Apache Middle School in Cochise County and the San Cayetano Elementary and Pena Blanca Elementary in Santa Cruz County) received an Arizona Healthy School Environment Model Policy mini grant in Winter 2005 and have begun implementation.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Community Health Services Program funds culturally sensitive programs that provide health education to women in child bearing years, including high school aged women.		X		
2. The Community Health Services Program funds culturally sensitive programs to increase physical activity of women in child bearing years, including high school aged women..		X		
3. The Community Health Serivces Program provides education and activities for women to help maintain a healthy weight and eat 5-a-day.		X		
4. The Office of Chronic Disease Prevention and Nutrition Services increased the number of high schools districts that create & implement a local school wellness policy.				X
5. The Office of Chronic Disease Prevention and Nutrition Services increased the number of high schools that adopt the Arizona healthy School Environment Model Policy.				X
6. The Office of Chronic Disease Prevention and Nutrition Services increased the number of schools in Steps communities that are utilizing the School Health Index.				X
7.				
8.				
9.				
10.				

b. Current Activities

The Community Health Services Program's three women's health programs will be continuing through 2006 and addressing the same chosen outcomes with minor adjustments made as their clientele changes. Contractors are always evaluating their programs and continuously refine their programs based on client input and results achieved.

The School Wellness Policy Mini-Grants will provide four Local Educational Agency (LEAs) $10,000 each to create and implement a local school wellness policy. Grant funds will be used to create school health councils in each school to include a team of members such as principals, food service directors, teachers, school nurse, and students. Tools for Healthy Schools training and technical assistance to create their wellness policy will be provided.

c. Plan for the Coming Year

The Community Health Services contract ends on December 31, 2006. A new Community Health Services Request For Grant Application (RFGA) will be released in the fall of 2006 using Title V funds. It is expected that the new grant will also address overweight/obesity. The anticipated start date for the new grants awarded is January 1, 2007.

Through the Office of Chronic Disease Prevention and Nutrition Services, additional SHI workshops are being planned for 2007 for STEPS partners. The Steps School Health Coordinator continues to promote school health councils / committees and remains a resource for partners, providing information and technical assistance. Existing School Health Councils will be offering ongoing technical assistance and coordination, and following up on the individual SHI School Health Improvement Plan implementation process. SHI promotion to the schools will be linked to key national and state efforts such as, the new USDA mandate for every school on the National School Lunch Program (NSLP) to have a school wellness policy in place by the 2006-2007 academic year, current state nutrition and physical activity standards, and the ADHS Nutrition and Physical Activity State Plan released in February 2005.

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)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					33.2
Numerator					251
Denominator					756
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	33	32.5	32	31.5	31

Notes - 2005
Data provided is for the 2003 birth cohort, which is the most recent data available.

a. Last Year's Accomplishments
The Arizona Birth Defects Monitoring Program (ABDMP) is continuing to build infrastructure for its Rapid-Reporting System (RRS) for active statewide surveillance of neural tube defects (NTDs). Pre and post national mandatory folic acid fortification data was analyzed and presented to State Genetic Services Advisory Committee. The ABDMP has completed data collection for 1998-2000 births and is currently analyzing data to be published in a report in the spring of 2006.

Governor Napolitano issued a proclamation for National Folic Acid Awareness Week. The ABDMP shared data and folic acid prevention information health fairs and events. This information was also shared with the Dean of the Arizona State University College of Nursing and printed in a front-page story of the WellNews.

The ABDMP promoted prevention of birth defects and secondary complications by passing $44,000 of CDC Cooperative Agreement funding through to the Arizona Teratology Information Program (ATIP) at the University of Arizona to operate a free national call center providing teratogen information services. The ATIP responded to 2,141 calls in 2005. Of these requests, 1,424 (45%) were from Arizona residents.

The ABDMP developed a protocol and electronic reports and implemented the 1st referral of children with spina bifida or cleft lip and/or palate to the Office for Children with Special Health Care Needs for follow-up. 91 children were referred. These families were contacted with

information about recurrence prevention and about community medical and support services. Families were also offered assistance with enrollment in government programs.

The Child Fatality Review (CFR) program provided copies of the Infant Death Checklist for investigations of unexplained infant deaths and a protocol for investigations to law enforcement agencies. The completed checklists were provided to the Medical Examiner's office and to the CFR program. CFR reviewed deaths of all children in Arizona. Reviews determined the circumstances surrounding these deaths and identify preventable factors. Data reports were provided to the public for research, media reports, and public health campaigns, public policy and prevention campaigns.

The Unexplained Infant Death Council advises the department, legislature and governor on issues related to unexplained infant deaths and fetal deaths. In 2005 the first annual report on Incidence and Reported Causes of Stillbirths was produced.

The Citizen Review Panel reviewed 6 Child Protective Service's cases 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 State Legislature funded a Folic Acid Vitamin Distribution Program, which provides a year supply of multivitamins with 400 micrograms of folic acid at no charge. Over 28,000 low-income women of childbearing age in Arizona have received multiple vitamins and education from the program.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Arizona Birth Defects Monitoring Program conducts active birth defect surveillance.			X	
2. The Child Fatality Review Program conducts reviews of child fatalities including infant deaths and include findings to promote prevention activities.				X
3. The Office of Chronic Disease Prevention and Nutrition Services continues to distribute folic acid.		X		
4. The High Risk Perinatal Program provides transport for premature infants to appropriate level of care.	X			
5. Office of Chronic Disease Prevention and Nutrition Services implemented a health marketing program regarding the benefits of folic acid.	X			
6. The High Risk Perinatal Program transports gravid woman in imminent risk of preterm delivery.	X			
7. The Arizona Birth Defects Monitoring Program Referral of children with NTDs or clefts to OCSHCN for resource lists and assistance.		X		
8. The Child Fatality Review Program provides staffing support to the Unexplained Infant Death Advisory Council.				X
9. The Child Fatality Review Program distributes the Infant Death Checklist and unexplained infant death protocols to law enforcement.				X
10.				

b. Current Activities

The ABDMP will visit all reporting hospitals to complete RRS data collection for NTDs, cleft lip and/or palate, gastroschisis, and omphalocele for 2001-2005. NTD data will be reported to the CDC on a quarterly basis. A report with 2001-2005 data on NTDs will be published in the summer. ABDMP will focus on statewide data collection for 44 categories of birth defects for 2003-2005. The ABDMP is continuing to participate in community health fairs to promote awareness of birth defects and prevention strategies and will participate in Folic Acid Awareness Week.

The CFR will continue to promote use of the Infant Death Checklist by first responders. The data from checklists will be included in the child fatality reviews. CFR will review deaths of all children in Arizona. Data reports will continue to be provided to the public for research, media reports, and public health campaigns. In 2006 the second annual report on Incidence and Reported Causes of Stillbirths will be produced by the Unexplained Infant Death council. and posted on the department website. The CFR website will provide information on prevention of childhood and infant deaths, including information on how the review data will be made available for research and will identify links to organizations regarding reduction of and responding to infant deaths. The Citizen Review Panel will continue to review Child Protective Service's cases, policies, and procedures and prepare an annual report of review findings and recommendations to improve the state's child protection system.

The Office of Chronic Disease Prevention and Nutrition Services continued to implement a statewide Folic Acid Vitamin Distribution program for low-income women of childbearing age. Over, 35,000 women have been served since the initiation of this program. In 2005, 7,020 low-income women were served and received a year's supply of vitamins with folic acid. 1650 women received ADHS's brochure "Baby In Your Future". Folic Acid Education and Vitamin Distribution program served 13 County Health Departments and 7 Community Health Centers throughout the state.

The Arizona Department of Health Services, Office of Women's and Children's Health (OWCH), is supportive of the Arizona Safe Haven Legislation enacted in August 2001. The legislation allows for infants less than 72 hours old to be physically handed over to a safe haven provider with no questions asked. In an effort to increase awareness of this legislation, OWCH is working with the community to develop materials that will be used to educate women about the law. The marketing campaign will supplement and support local community and state efforts to reduce the incidents of newborn babies being left alone in unsafe locations in Arizona.

c. Plan for the Coming Year

The Arizona Birth Defects Monitoring Program (ABDMP) will visit all reporting hospitals in Arizona to complete Rapid Reporting System (RRS) data collection. Regional data collection visits will be scheduled for the spring. NTD data will be reported to the CDC on a quarterly basis. ABDMP will collect data for the 44 major categories of birth defects for 2003-2006. ABDMP will participate in Folic Acid Awareness Week and continue to participate in community health fairs to promote awareness of birth defects and birth defect prevention strategies.

The Child Fatality Review Program (CFR) will continue to review deaths of all children in Arizona, including infant deaths. The Citizen Review Panel will continue to review Child Protective Service's cases, policies, and procedures and prepare an annual report of review findings and recommendations to improve the state's child protection system. CFR will continue to promote use of the Infant Death Checklist. The data from checklists received will be included in the child fatality reviews. CFR will continue to staff the Unexplained Infant Death Council. In 2007 the second annual report on Incidence and Reported Causes of Stillbirths will be produced and posted on the department website. The CFR website will be enhanced, providing information on prevention of childhood and infant deaths, including information on how the review data will be made available for research, and will identify links to organizations regarding reduction of and

responding to infant deaths.

As a part of the APHA Leadership Institute, the OWCH has begun a project aimed at addressing infant mortality in the African American community by collaborating with the Black Nurses Association (BNA). The BNA will address groups already meeting at churches and begin to educate appropriate audiences about the relationship between preconception health and fetal mortality. The education sessions will also include increasing awareness among African Americans of the Arizona Perinatal Periods of Risk (PPOR) results and the appropriate intervention strategies.

The Office of Chronic Disease Prevention and Nutrition Services will implement a health marketing campaign, including media placement, community outreach and promotional items, to promote the Folic Acid Program and encourage women to take a daily folic acid supplement of 400 micrograms. The primary target audience includes women 18 - 40 years old that are of lower education and income levels. The Office will continue to distribute multivitamins through existing programs. The Office will recruit new partners for folic acid distribution program. The Office will begin referring pregnancy and breastfeeding hotline callers to folic acid distribution sites.

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator				7,478.6	7478.6
Numerator				90739	
Denominator				1213314	
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	7478	7477	7477	7476	7476

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
The High Risk Perinatal /Health Start Program's Community Health Nurses conduct environmental risk assessments on every home visit and Lay Health Workers conduct Safe Home/Safe Child assessments in the home. These assessments help to identify potentially hazardous situations in the home. Once identified, the Community Health Nurse and Lay Health Worker works with the family to correct the situation, reducing risks and ER visits.

The Emergency Medical Services for Children Program funded development and delivery of pediatric education for pre-hospital providers in rural Arizona. The Program funded distance-learning curriculum for pediatric education for pre-hospital providers. The Program funded evaluation screening tool to identify children at high risk of inappropriate use of child restraint. The Program provided basic life support pediatric education for pre-hospital providers. The Program applied and received continued funding for EMSC.

The Injury Prevention Program strengthened participation of community in the Injury Prevention Advisory Council. The Program also hired a full time Injury Epidemiologist.

Through the County Prenatal Block Grant, some Maternal Child Health programs in counties use this service to provide home safety programs to women at risk of getting pregnant.

Community Health Services funded 8 car seat safety projects. 6,066 child car safety seats were installed and education was provided to parents/caregivers. 50 child car safety seat events were held, 55 new Child Passenger Safety Technicians were certified, and two technicians were certified as trainers. 736 bicycle helmets were distributed with helmet safety education. 4th, 5th & 6th graders were targeted for motor vehicle safety education.

20 newspaper ads on child car seat safety were published in Native American media using photographs of local tribal members. Radio PSA's were aired in tribal communities, reaching thousands of tribal members across the state. A survey of low-income families living on reservations showed that 91% of families have a car seat for their infant, an increase of 7% from 2004. Another survey showed that 85% of tribal families had a car seat for their child, an increase of 6% compared to year 2004. 290 cable television spots were aired on child car seat safety and bicycle helmet safety reaching an estimated 13,000 of the target population.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Lay Health Workers from the Health Start Program conduct safe home/safe child assessments.	X			
2. Community Health Nurses from the High Risk Perinatal Progrom conduct environmental assessments.	X			
3. The Emergency Medical Services for Children Program funded emergency medical services providers to collect pre-hospital data.				X
4. The Emergency Medical Services for Children Program funded a Needs Assessment to determine Arizona's operational capacity to provide emergency medical services.				X
5. The Emergency Medical Services for Children Program established an advisory council.				X
6. The Injury Prevention Progam revised the state injury prevention plan to inform injury prevention efforts.				X
7. The Injury Prevention Program promoted education to Level I & II hospital injury prevention coordinators.				X
8.				
9.				
10.				

b. Current Activities

The High Risk Perinatal Program/Health Start's Community Health Nurses conduct environmental risk assessments on every home visit and Lay Health Workers conduct Safe Home/Safe Child assessments in the home. The Community Health Nurse and Lay Health Worker works with the family to correct the situation, thereby reducing risks and ER visits.

The Emergency Medical Services for Children (ESMC) program funded a needs assessment to determine Arizona's operational capacity to provide emergency medical services. The Program established an ESMC Advisory council. The Program also funded Emergency Medical Services (EMS) Providers to collect EMS pre-hospital data.

The First Annual Injury Prevention Symposium was held in June 2006 and focused on policy

development. The OWCH led the 2006-2010 update to the state injury prevention plan. The plan reviews data from emergency department visits.

c. Plan for the Coming Year
The High Risk Perinatal Program/Health Start's Community Health Nurses will continue to conduct environmental risk assessments on every home visit and Lay Health Workers will continue to conduct Safe Home/Safe Child assessments in the home. These assessments will continue to help to identify potentially hazardous situations in the home. Once identified, the Community Health Nurse and Lay Health Worker will continue to work with the family to correct the situation, thereby reducing risks and ER visits.

The Emergency Medical Services for Children Program will continue to add EMS data collection sites. The Program will determine what the emergency medical services for children needs are for AZ and offer technical assistance.

The Injury Prevention Program will market /disseminate state injury plan to communities. The Program will promote basic injury prevention training for injury prevention coordinators with Level I & II hospitals. The Program will place injury prevention resources and injury prevention calendar of events on ADHS website. The Program will create injury specific fact sheets. The Program will conduct an annual symposium on injury.

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	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator				49.6	49.6
Numerator				62	
Denominator				125	
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	48	48	47	47	46

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.

Notes - 2004
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
The Health Start Program contracts with 16 agencies throughout the state to provide community outreach for pregnant women who are considered to be at risk for premature delivery or a low birth weight baby. These services are provided by women who are recruited from within the community, with the ideal that these women will offer culturally appropriate serves to clients. 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.

The County Prenatal Block Grant (CPBG) Program utilizes pregnancy testing and/or immunizations as means of early identification and referral to prenatal care and programs. Over 200 women entered into prenatal care in the first trimester.

Within the CPBG Program, the rural counties have attempted to address the needs of women who live in what has been traditionally called primary care areas that are medically underserved. However, their needs and approaches vary from one county to another. The approaches involve mobile clinics for women who have no or minimal transportation; immunization clinics that attract women who are at risk of getting pregnant; "diplomatically" approaching high schools and developing teen pregnancy programs and teen mazes; providing BootCamp for Dads as a module in prenatal classes; providing gifts as incentives to complete prenatal classes (i.e., car seats, gift certificates, gift bags, etc.); collaboration with schools, private providers, agencies such as WIC, AHCCCS, Baby Arizona, police and fire departments; and any other agency, interested private business and community members and groups. The CPBG's basic objective is to link services, build infrastructure that will insure accessibility to services. This is a major challenge and accomplishment for rural areas to market CPBG programs and services and meet the needs of the target populations.

By the end of 2004, rural/medically underserved areas provided prenatal services to over 4,800 women.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Health Start Lay Health Workers provide outreach to high risk pregnant women and children in underserved areas.	X			
2. Health Start Lay Health Workers offer services in appropriate languages.	X			
3. The County Prenatal Block Grant Program assists women in accessing services including doctors, AHCCCS, social services, transportation, etc.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Health Start Program contracts with agencies that provide services 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.

Within the County Prenatal Block Grant (CPBG) Program, some of the rural counties have attended Identification and Assessment training by the Postpartum Depression Support International. CPBG programs have received childbirth education and/or lactation counseling training for themselves or their staff. These services are particularly important in the rural areas, as some counties do not have a doctor or a hospital. In these areas, the CPBG program is the only prenatal care they may receive until the third trimester or until they deliver. CPBG coordinators feel they can provide minimal services and education for the pregnant women as an alternative to their receiving no prenatal care. CPBG programs provide prenatal education,

prenatal vitamins, education on preconception health, smoking cessation, folic acid, nutrition, exercise, and home safety. The programs also do pregnancy testing (to identify women early into the pregnancy) and assist them in accessing services such as Health Start, AHCCCS, Baby Arizona, WIC, etc.

c. Plan for the Coming Year
The Health Start Program will continue to contract with agencies to provide services to pregnant women who are considered at high risk for having a low birth weight baby in communities designated as primary care areas and categorized as medically underserved.

The County Prenatal Block Grant (CPBG) Program will increase service base to include screening for perinatal mood disorders. Many of the rural counties have or are planning to acquire the Identification and Assessment training by the Postpartum Depression Support International. CPBG coordinators have expressed an interest in receiving childbirth education and/or lactation counseling training for themselves and/or their staff.
Due to level funding, counties are not able to expand much more than current level of service provision.

The OWCH Assessment and Evaluation Section will work to identify medically underserved areas using geomapping. OWCH will work with partners to begin planning to improve access to care. OWCH will also research nontraditional methods of identifying pregnant women and linking them to services.

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator					42.6
Numerator					255983
Denominator					600379
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	43	43.5	44	44.5	44.5

a. Last Year's Accomplishments
The percent of high-risk children who receive dental care annually are: FY 2003- 28%, FY 2004- 30%, FY 2005- 31%. The percent of high-risk children through age 5 years who received dental care annually: FY 2003-20%, FY 2004-21%, FY 2005-23%.
The percent of high-risk children who receive preventive dental care annually: FY 2003- 23%, FY 2004- 25%, FY 2005- 25%.

OOH developed and presented presentations to educate about the impact of preventive dental care called 'Watch Your Mouth', developed fact sheets on the problem. OOH finalized The Oral Health of Arizona's Children report. Some of the findings are: Arizona has one of the highest prevalence of decay in the nation. Promotion of early childhood dental care to prevent dental disease before it happens is the strategy. Only 57% of children in kindergarten through third grade visited the dentist in the last year. And almost 39% of Arizona's third graders have untreated tooth decay. OOH moved two dental trailers from communities that finished dental clinics to serve the underserved. OOH organized and sponsored a second annual Dental Public

Health Institute to promote our partners successes and to share best practices.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Office of Oral Health tracks AHCCCS utilization.				X
2. The Office of Oral Health provides trailers for communities to provide services to underserved populations including medicaid enrollees.	X	X		X
3. Policy makers are educated at Dental Public Health Institutes to improve the infrastucture for services including services provided to medicaid enrolles.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Office of Oral Health (OOH) will disseminate The Oral Health of Arizona's Children report and fact sheets. OOH will continue presentations and promote access to dental care issues. OOH will expand utilization of the Affiliated Practice concept. OOH will provide trainings to childcare centers, WIC programs, Head Start Programs and Community Health Centers on the importance of early intervention. OOH will monitor AHCCCS Health Plans on policies for dental care and case management issues. OOH will collaborate with school based dental clinics. OOH will partner with private organizations and foundations to enhance preventive efforts. OOH will promote dental trailer program in underserved areas. OOH will refurbish dental trailers. OOH will organize and sponsor third annual Dental Public Health Institute.

c. Plan for the Coming Year

The Office of Oral Health (OOH) will continue to track AHCCCS utilization for dental care. OOH will collaborate with other agencies and organizations to promote oral health education and early dental professional interventions. OOH will expand utilization of the Affiliated Practice concept to improve access to care issues and other new dental practice act initiatives. OOH will continue to evaluate the best utilization of dental trailer program. OOH will evaluate continuation of Dental Public Health Institutes.

State Performance Measure 7: *Percent of parents and youth participating with state agencies in community development initiatives who completed the Parent Youth Leadership Training.*

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					12.0
Numerator					12
Denominator					100
Is the Data Provisional or Final?					Final

	2006	2007	2008	2009	2010
Annual Performance Objective	24	50	65	75	90

a. Last Year's Accomplishments

The Parent and Youth Leadership (PYL) curriculum is being utilized by other Community Development Initiative state agency partners in their efforts to offer training that supports parents and family members as leaders and partners. Parents and Youth from other agencies reviewed the curriculum and made modifications to meet the needs of their programs and projects. The curriculum was highlighted at the Champions for Progress multi-state meeting in August 2005. Over 100 CD's of the curriculum were disseminated to state participants in the August and September Champions meetings. Parent representatives from the Children's Rehabilitative Services Program were provided mandatory training from the PYL curriculum prior to their participation in quarterly medical director and administrator meetings.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Register OCSHCN parents and youth partners in Learning Management System.				X
2. Parent and Youth Leadership modules are offered through the ADHS-OCSHCN e-Learning program, Raising Special Kids, Pilot Parents of Southern Arizona, and through the OCSHCN community teams.				X
3. OCSHCN compensated parents and youth will be monitored on a quarterly basis to assess their participation in required training activities.				X
4. OCSHCN produces quarterly reports regarding parent and youth participation in on-line training activities.				X
5. The OCSHCN Cultural Competence Committee, the ISG Cultural Competence Committee, and the ISG Parent and Young Adult Councils will review the translated curriculum for appropriateness of materials.				X
6. OCSHCN promotes the use of the Parent and Youth Leadership curriculum with community partners including the graduates of the Arizona Partners in Policymaking program.				X
7.				
8.				
9.				
10.				

b. Current Activities

The Parent Youth Leadership Training Curriculum was presented to over 50 participants at the Arizona Public Health Association Spring Conference in April 2006 by a parent and a youth. OCSHCN is currently developing policy and processes for compensated parents and youth to participate in PYL training as required by specific programs. OCSHCN is in the process of converting these modules in preparation for hosting them on our Learning Management System.

c. Plan for the Coming Year

OCSHCN staff will continue to convert PYL modules to be hosted on the ADHS-OCHSN Learning Management System. This will afford easy access to the curriculum and allow us to track the participation of OCSHCN compensated parents and youth in the training.

The leadership modules adapted by other state agencies or programs will be added to the curriculum and included in the on-line training catalog.

Other e-Learning required courses will include modules on cultural competency; transition, medical home, school health and a complete guide to systems of care in Arizona developed by Raising Special Kids through their CMS funded Family-to-Family Health Information Center.

The Parent Youth Leadership training modules will be reviewed by the Integrated Services Grant (ISG) Cultural Competency committee to evaluate the cultural appropriateness of the material. As the modules are translated the OCSHCN Cultural Competence Committee, the ISG Cultural Competency Committee and the Parent Council of the Integrated Services Grant will verify the quality of the translation. Both the English and Spanish versions will be posted on the ADHS eLearning Management System. Future data will be obtained from the eLearning Management System in addition to more traditional educational venues.

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.

#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).

#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).

#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).

#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.

#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.

#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.

#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.

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.

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//

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//***

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//***

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//***

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//***

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//***

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

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 Office of Birth Defects; $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/Core Public Health Infrastructure: $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//

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/Population-Based Services: $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//

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/Enabling and Non-Health Support: $386,304

$386,304 will support planning, education and partnership initiatives that include the Medical Home Project and Community grants.//2007//

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/Direct Health Care Service: $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//

Indirect Administrative Costs: $776,985
/2007/Indirect Administrative Costs: $751,229//2007//

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.