Maternal and Child Health Services
Title V Block Grant

State Narrative for ARIZONA

Application for 2008
Annual Report for 2006

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I. General Requirements

A. Letter of Transmittal

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

B. Face Sheet

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

C. Assurances and Certifications

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

D. Table of Contents

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

E. Public Input

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

/2008/
In addition to the public input activities listed above, the Bureau of Women's and Children's Health conducted a number of public input meetings during the last two years. In 2006 and 2007, all of the bureau chiefs of Public Health Prevention Services are visiting each county health department in Arizona. The purpose of the visits is to learn about the unique needs of each local area, and gather feedback on how we can better those needs. During the spring of 2007, the Bureau of Women's and Children's Health posted their 2006 -- 2010 Strategic Plan and a draft of this application on the internet for public comment and feedback. Additionally, a community advisor read a draft of the application and provided feedback.

OCSHCN's direct service programs now collect survey data on family satisfaction, and OCSHCN has implemented a new telephone inquiry tracking system to identify trends in family's concerns. In addition, the OCSHCN website has a link through which annonymous input can be given. OCSHCN continues to get feedback through its Integrated Services Grant, which brings together partners from state child-serving and community-based agencies, parents and youth, and OCSHCN's community development teams are an ongoing source of feedback. An intensive stakeholder input series designed for CRS identified issues that applied more generally to children with special health care needs. //2008//

II. Needs Assessment

In application year 2008, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

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

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

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

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

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

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

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

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

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

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

III. State Overview

A. Overview

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

1. Increase access to health care for the women of Arizona through: a) Comprehensive, continuous health insurance coverage throughout the life cycle; b) Integrate dental and behavioral health with physical medicine; c) Increasing access to family planning services for low-income women in Arizona; and d) promoting cultural and linguistic competency among the health care community to achieve appropriate care for diverse populations.

2. Improve the health and well-being of women in Arizona by increasing women's awareness of how they can positively impact their health and well-being.

3. Reduce the teen pregnancy rate in Arizona, with a particular emphasis on reducing the number of second pregnancies to teens.

4. Increase prenatal care and pre-conception care for women in Arizona through: a) Increasing the number of women who access early prenatal care to improve birth outcomes; b) Increasing access to better oral health to improve birth outcomes; and c) Promoting healthy preconception lifestyles to women.

/2007/ The Governor's staff position moved to ADHS Division of Public Health Prevention Services to coordinate women's health efforts within the Division, act as a 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//***/2008/During the 12 months ending July 1, 2006 Arizona was the fastest growing state with a population increase of 3.6%. //2008//***

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//

/2008/Critical Udates

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

In November of 2006 the voters of Arizona passed Proposition 201, The Smoke-Free Arizona Act. The new law became effective May 1, 2007 and prohibits smoking in most indoor public places including restaurants, bars, gaming facilities, bowling centers, public buildings, grocery stores or any food service establishment , lobbies, elevators, restrooms, reception areas, hallways and any other common-use areas in public and private buildings, condominiums and other multiple-unit residential facilities, indoor

sports arenas, gymnasiums and auditoriums, health care facilities, hospitals, health care clinics, doctor's offices and child day care facilities, common areas in hotels and motels, and no less than 50% of hotel or motel sleeping quarters rented to guests.//2008//

B. Agency Capacity

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

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

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

OWCH DIRECT HEALTH CARE SERVICES

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

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

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

OCSHCN DIRECT HEALTH CARE SERVICES

Children's Rehabilitative Services (CRS). The Arizona Department of Health Service (ADHS), Office for Children with Special Health Care Needs (OCSHCN) transitioned from direct service

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

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

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

OCSHCN ENABLING SERVICES

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

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

Traumatic Brain Injury Program. Children and teenagers with traumatic brain injuries (TBI), their families, and professionals are provided an array of coordination services to assist in: the determination of priorities and the creation of the Individualized Service Plan; assessment of resources and needs; identification of other/additional resources; navigation of the multiple service delivery systems; completing forms and applications for services; locating service providers; coordination of services; and supporting the child/family in the Individual Education Plan (IEP) process. Also, as needed, TBI Program service coordinators can advocate for the child/family with providers, services, school and insurance; provide continuity as child moves through stages of recovery and other aspects of service delivery; and assist in transitions (from hospital/rehabilitation/home/school). Additionally, the program provides community education and awareness of TBI and its effects.

OWCH ENABLING SERVICES

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

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

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

OWCH POPULATION-BASED SERVICES

The Newborn Screening Program screens for all newborns for eight conditions prior to hospital discharge. Screening results for all children are reported to the child's physician of record. Follow up is provided to ensure that second screenings are conducted. The Newborn Hearing Screening Program provides hearing screenings of newborns prior to hospital discharge and provides technical assistance, data collection, and collaboration to provide screening equipment to Arizona hospitals. The Sensory Program facilitates the implementation of hearing and vision screenings in Arizona schools. Schools submit hearing and vision results to the Sensory Program. /2007/ Legislation was enacted to expand screens to 29 conditions and to require reporting initial and subsequent hearing tests performed on a newborn. //2007//

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

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

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

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

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

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

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

Development and enhancement of the telehealth/telemedicine system. A statewide network of sites that have the capacity for simultaneous audio and visual communication is used for: the provision of clinical services to patients who live in areas that do not have ready access to specialists; conduct administrative meetings among staff living and working in different parts of the state; provide networking and information sharing opportunities for families and/or providers;

and conduct training. OCSHCN has continued to expand its telehealth network. Funding from the Arizona Department of Health Services provided for the purchase of compatible equipment by each of the CRS clinics.

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

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

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

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

C. Organizational Structure

Governor Janet Napolitano was sworn into office in January 2003. Prior to being elected Governor of Arizona, she served one term as Arizona Attorney General and four years as U.S. Attorney for the District of Arizona. A hallmark of Governor Napolitano's administration has been government reform on all levels. She established an efficiency review initiative that has identified hundreds of millions in savings over five years. Her various citizens' commissions have recommended important improvements to Child Protective Services, Department of Corrections, and the Arizona tax code. She erased a billion-dollar state budget deficit without raising taxes or eliminating vital services. She has tackled the spiraling price of prescription drugs by launching what is now the CoppeRx 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//

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

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

OFFICE OF WOMEN'S AND CHILDREN'S HEALTH

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

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

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

The Planning, Education and Partnerships Section (PEP) provides leadership for statewide priority setting, planning, and policy development, and supports community efforts to assure the health of women, children, and their families. PEP works with a variety of public, private, and non-profit community partners to identify health needs, improve systems of care, and develop public health policies. PEP provides and supports educational activities that advance good health

practices and outcomes, including promoting the use of "best practices," providing client and provider education, sponsoring public information campaigns, and developing and distributing education materials. Current Planning Education and Partnership programs include: Abstinence, Sensory, Domestic Violence, Rural Safe Home Network, Rape Prevention and Education, County Prenatal Block Grant, Reproductive Health/Family Planning, the Medical Home Project, and Community Health Services. /2007/Injury Prevention, Emergency Medical Services for Children, and Safe Kids were added to the PEP section. Comprehensive Sexuality Education Program was also added to the PEP section and funded by state lottery dollars.//2007///***2008/In 2007, Planning, Education and Partnership hired a full-time health educator. The health educator develops educational materials and assists with office strategies.//2008//***

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

OWCH identifies and prioritizes the needs of women and children in Arizona through a participatory process. This results in funding decisions that have the best chance to make an impact on the health of the maternal and child health population. The OWCH strategic plan is available at the OWCH web site www.azdhs.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.

/2008/
OCSHCN has reorganized into six divisions: Clinical Programs, Quality Management, Utilization Management, Grievance and Appeals, Business and Finance, and Compliance. Division chiefs from each of these areas report directly to the office chief, as do the medical director, a corporate compliance officer, and a cultural competence officer. The business and finance function, as well as the officers for corporate compliance and cultural competence are now shared resources with the Behavioral Health Services. The majority of Title V funded positions and activities are housed in the Division of Clinical Programs, although blended funding from Title V, XIX, and XXI occur in other divisions, and Title V concepts infuse the programmatic activities of the Title XIX and XXI programs.
/2008//

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

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

D. Other MCH Capacity

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

well as other state agencies.

ADHS SENIOR LEVEL MANAGEMENT

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

Rose Conner is the assistant director of the Division of Public Health Services. Ms. Conner is a registered nurse with a Bachelor's of Science degree in Vocational Education and a Master's Degree in Education/Counseling. She has spent the past twenty-nine years in local county and state government service in Arizona, in a variety of positions including direct patient care, management, executive leadership roles and has an extensive background in licensing and health care regulation. /2007/ In 2005 Rose Conner was appointed Deputy Director of ADHS. Niki O'Keeffe was appointed Assistant Director of Public Health Services. Ms. O'Keeffe is an RN with a BS degree. She has experience in health care recruitment, human resources, developing hospital based community outreach programs in school-based clinics, tele-nursing, parish nursing, and wellness centers. She has served as the Deputy Assistant Director for ADHS Public Health Preparedness that included Epidemiology and Disease Control, State Laboratory, Emergency Medical Services, Public Health Emergency Preparedness and Response. //2007//

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

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

OFFICE OF WOMEN'S AND CHILDREN'S HEALTH

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

Sheila Sjolander has been the section manager for Planning, Education and Partnerships (PEP) since 2001. PEP provides leadership for statewide priority setting, planning, and policy development, and supports community efforts to assure the health of women, children, and their families. Ms. Sjolander oversees a variety of statewide maternal and child health programs, including domestic violence and rape prevention, injury prevention, prenatal block grant to the counties, community health projects targeting Title V priorities, hearing screening, family planning, and teen pregnancy prevention. For the last twelve years, Ms. Sjolander has used her expertise in strategic planning and policy development in the states of Arizona, Wisconsin, and Oregon, and has had leadership roles in public health for the past eight years. /2007/ In 2006 Catherine Hannen became section manager for the PEP section. Ms. Hannen has a B.A. in Political Science and is an MSW, LCSW. For the past five years she has been a program manager for OWCH. She also has prior experience in acute health care and long-term care. //2007//

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

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.

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

State Agency Coordination Team (SACT): OWCH staff represent ADHS on this team of various state agencies that meets monthly to work together on domestic violence and sexual assault

system issues. The team is organized and led by the Governor's Office for Children, Youth, and Families, Division for Women. Participating agencies include: Department of Economic Security, Department of Public Safety, Attorney General's Office, Department of Housing, Criminal Justice Commission, Arizona Supreme Court, Department of Corrections, and Arizona Health Care Cost Containment System (AHCCCS).

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

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

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

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

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

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

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

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

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

University of Arizona (UofA): OCSHCN works with the UofA to implement the Telemedicine Program.

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.***/2008/BWCH participates on the MOD Program Services committee and the assistant director serves on the legislative committee.//2008//***

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

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

a sponsor of the Coalition's annual conference.

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

Arizona Public Health Association (AZPHA): OWCH staff sit on the board and are association members. OWCH and OCSHCN support AZPHA's two annual conferences. OWCH works with AZPHA to identify maternal and child health issues and policies that the association could help support. OCSHCN staff participate in the monthly AzPHA School Health Section Meetings.

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

Introduction

With the addition of the State Systems Development Initiative grant, the capacity of the MCH program will be enhanced by having access to linked data which will be available for analysis. Analysis of this linked data will help the MCH program to evaluate the health system capacity indicators, which includes tracking the indicators by payor. While the MCH program has the capacity to evaluate the health system capacity incicators, the program does not have any control over the eligibility and access to services provided by the state's medicaid program. This means that for the majority of the health status indicators (HSCI 02, 03, 05A-07B), the program does not expect the rates to change for the medicaid population.

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	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Indicator	23.3	26.5	35.6	30.1	30.1
Numerator		1324	1533	1342	
Denominator		499721	430549	446162	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2006

Problems with hospital discharge data prevented reporting on this measure for 2002. Data for 2006 are not yet available. The estimate for 2006 is provisionally set at the 2005 rate until data become available in the Fall of 2007.

Narrative:
The Bureau 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. The rate for asthma related emergency department admissions per 10,000 children under age 5 were as follows: 2004: 107.7, 2005:107.0, 2006:103.2.

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	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Indicator	89.2	84.3	95.0	96.1	97.6
Numerator	42854	43509	51326	54373	56520
Denominator	48046	51598	54047	56587	57884
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
The data source for HSCI 02 is the CMS 416 report (formerly the HCFA 416 report). Data for the CMS 416 report is taken from medicaid encounters and eligibility/enrollment.

The health plans that contract with AHCCCS (Arizona's Medicaid program) conduct various interventions during the course of each year to increase EPSDT participation. Interventions inlcude outreach to members and providers related to well visits, dental, TB and lead screening, immunizations and other preventive health services. The health plans monitor and evaluate the effectiveness of interventions and report to AHCCCS quarterly. Efforts are under way to work with the health plans to develop new and innovative interventions.

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

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

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Indicator	76.3	71.8	79.7	82.1	78.4
Numerator	646	549	484	517	580
Denominator	847	765	607	630	740

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

Narrative:
The data source for HSCI 03 is the CMS 416 report (formerly the HCFA 416 report). Data for the CMS 416 report is taken from medicaid encounters and eligibility/enrollment.

The health plans that contract with AHCCCS (Arizona's Medicaid program) conduct various interventions during the course of each year to increase EPSDT participation. Interventions inlcude outreach to members and providers related to well visits, dental, TB and lead screening, immunizations and other preventive health services. The health plans monitor and evaluate the effectiveness of interventions and report to AHCCCS quarterly. Efforts are under way to work with the health plans to develop new and innovative interventions.

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

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

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Indicator	69.9	67.9	69.3	70.1	70.1
Numerator	61112	61674	64499	66943	
Denominator	87379	90783	93093	95486	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

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

Narrative:
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.

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

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

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

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Indicator	73.6	72.0	72.6	73.7	74.5
Numerator	317629	366273	402079	424014	432605
Denominator	431697	508776	553763	575577	580568
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2005
The measure reported is the total number of Medicaid members age 1-20 with at least one paid service during the reporting year divided by the total number of members age 1-20 eligible for Medicaid at any time during the reporting year. A single point-in-time estimate of the potentially eligible population is actually smaller than the number of service recipients yielding a result of over 100%.

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	2002	2003	2004	2005	2006
Annual Indicator	41.3	44.0	49.2	45.5	54.1
Numerator	37768	47484	56991	54909	66522
Denominator	91453	108018	115746	120763	122975
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

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

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	2002	2003	2004	2005	2006
Annual Indicator	56.5	55.2	58.1	58.9	30.9
Numerator	6940	7514	8849	8945	4752
Denominator	12280	13618	15230	15189	15392
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2006
The measures for 2004 and 2005 contained duplicate members, as well as any member who was enrolled for a service, whether or not they had actually received one. The 2006 measure is unduplicated, and contains only members with a claim or encounter in the Children's Rehabilitative Services database. Social services and care coordination are provided without resulting in an encounter being filed in the database. Consequently, the number of confirmed encounters is likely to be an undercount.

Narrative:
What appears to be a drop in getting SSI recipients to services may reflect an improvement in reporting capability. Previous numbers contained duplicate members and members who had been determined to be eligible for services and were enrolled, but did not necessarily have a claim or encounter on file with the Children's Rehabilitative Services Program. Still, other programs that provide rehabilitative services, such as occupational and physical therapies, do not have data systems that link to the SSI data and are not included in the capacity indicator.

An SSI coordinator now enters all SSI referrals into a database and refers members to other programs, such as Children's Rehabilitative Services, OCSHCN Community Nursing and care

coordination programs, and Arizona Early Intervention Program. A desktop protocol is being formalized to guide this process. OCSHCN is exploring ways to link databases and develop better performance measures to track and trend progress towards linking children with appropriate services. To date, OWCH and OCSHCN have begun to work through the SSDI initiative on linking newborn screening data to data in the Children's Rehabilitative Services database. Future efforts may include expanding this process to include the SSI database, as well as databases that house information on the rest of OCSHCN's service coordination programs.

An eligibility task force has been established to look at barriers to enrollment, including confusion over overlapping systems of care that are spread out over multiple child-serving agencies.

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)	2005	payment source from birth certificate	7.2	6.6	6.9

Narrative:
The percent of infants weighing less than 2,500 grams declined from 7.2 percent in 2004 to 6.9 percent in 2005. This decline was seen in both medicaid (from 7.5 to 7.2) and non-medicaid births (from 6.8 to 6.6).

As mentioned in other sections of this application, State Systems Development Initiative funds are utilized to conduct Perinatal Periods of Risk analyses. Results of the PPOR analysis indicate that many of the excess infant deaths occur during the prematurity/maternal care and maternal health peroids. Decreasing deliveries of low birth weight infants would improve outcomes in both of these periods. The Bureau of Women's and Children's Health has utilized the PPOR results to guide program activities geared towards decreasing low birth weight deliveries and infant deaths.

BWCH has implemented an internal preconception care workgroup to address low birth weight and prematurity. The goals of the workgroup are to develop strategies for increasing awareness of the importance of preconception health among medical providers and the general public and to integrate preconception care into existing BWCH programs. To date, presentations on preconception care have been made to contractors of the Health Start Program, County Prenatal Block Grant Program, the Abstinence Education Program and the Family Planning Program. In addition, the winter issue of the Bureau newsletter included an article on preconception care and the CDC recommendations. The High Risk Perinatal Program Community Nursing component has implemented a pilot project in Yavapai County to provide preconception care visits in addition to visits focused on the NICU graduate. The pilot will be evaluated on a quarterly basis and will be based on the achievement of individual client driven health goals. The Health Start Program held two meetings with state-wide program coordinators to assess how preconception care home visits could be added to the baby focused visits. Contractors identified additional funding and additional training for lay health workers as key resources needed to accomplish this. The Bureau is developing strategies to provide these resources. Abstinence Education contractors said information on preconception care could be integrated into their presentations as long as they have something scripted. Efforts are continuing on integrating preconception care into other BWCH programs as appropriate.

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

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	2005	other	0	0	0

Notes - 2008
Mortality data is not available by payer. Data source is death certificates.

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

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

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

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

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

INDICATOR #05 ***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 infants born to pregnant women receiving prenatal care beginning in the first trimester	2005	payment source from birth certificate	68.4	88	77.7

Narrative:
The percent of women entering prenatal care in the first trimester increased from 76.3 percent in 2004 to 77.7 percent in 2005. The percent of women who entered prenatal care in the first trimester grew more dramatically for those women whose births were paid for by medicaid. In 2004, 65.8 percent of births paid for by medicaid were to women entering prenatal care during the first trimester compared to 68.4 percent in 2005.

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

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

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

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

INDICATOR #05 ***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])	2005	payment source from birth certificate	61.4	79.7	70.1

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 related to prenatal care, there seems to be an improvement in 2005 over the 2004 statistics. Again, this improvement is seen in both the medicaid and non-medicaid populations.

There is some evidence that programs funded through the Bureau of Women's and Children's Health may be having an impact on the Kotelchuck Index. An evaluation of the Health Start program revealed that, although the percentage of Health Start participants who entered prenatal care in the first trimester was similar to the control group a higher proportion of participants entered prenatal care in the second trimester than the control group, and a smaller percentage of Health Start participants received no prenatal care. In addition to the timing of entry to prenatal care, an analysis of the adequacy of prental care utilizing the Kotelchuck index was conducted. This analysis revealed that a higher proportion of Health Start participants received adequate prenatal care compared to the control group. Sixty-one percent of Health Start participants received adequate prenatal care compared to 56 percent of controls.

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)	2006	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)	2006	200

Narrative:
Eligibility levels for Medicaid and SCHIP remained unchanged in 2006. Changes in poverty level for eligibility in AHCCCS and SCHIP rest with the Medicaid agency (AHCCCS), the legislator and the public. Historically, changes in poverty levels for Medicaid eligibility have been generated as

the result of voter propositions. BWCH works with our partners who support increasing poverty levels for Medicaid eligibility and will provide data as appropriate.

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)	2006	 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)	2006	 200

Narrative:
Eligibility levels for Medicaid and SCHIP remained unchanged in 2006. Changes in poverty level for eligibility in AHCCCS and SCHIP rest with the Medicaid agency (AHCCCS), the legislator and the public. Historically, changes in poverty levels for Medicaid eligibility have been generated as the result of voter propositions. BWCH works with our partners who support increasing poverty levels for Medicaid eligibility and will provide data as appropriate.

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	2006	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	2006	200

Narrative:
Eligibility levels for Medicaid and SCHIP remained unchanged in 2006. Changes in poverty level for eligibility in AHCCCS and SCHIP rest with the Medicaid agency (AHCCCS), the legislator and the public. Historically, changes in poverty levels for Medicaid eligibility have been generated as the result of voter propositions. BWCH works with our partners who support increasing poverty levels for Medicaid eligibility and will provide data as appropriate.

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	**Does your MCH program have**	**Does your MCH program**

SURVEYS	the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	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	3	Yes
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 - 2008

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.

The Bureau of Women's and Children's Health is actively conducting the link between the newborn screening data and birth certificate data. Additionally, the Office annually links the birth and death databases. The Arizona Birth Defects Registry will have complete data for 2001-2005 in the fall of 2007, and will be incorporated into the SSDI. The Bureau constantly utilizes the Hospital Discharge database. The Hospital Discharge data collection rules are currently being revised. One of the proposed revisions will include the collection of the fourth-digit of the revenue code, which for infants indicates the level of care that an infant receives while in the hospital.

This revision will enable the MCH program to be able to identify infants who were admitted to the Neonatal Intensive Care Unit. The ability to identify these infants will greatly enhance the ability to evaluate the Neonatal Intensive Care Program, and to ensure that every infant who spends at least 72 hours in the NICU is enrolled in the NICP program.

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

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

Notes - 2008

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

IV. Priorities, Performance and Program Activities

A. Background and Overview

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

B. State Priorities

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

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

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

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

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

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

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

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

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.

/2008/
Because of the identified need to clarify systems of care and facilitate linking children and youth with appropriate services, OCSHCN is refocusing two of its priorities.

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

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

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

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

To track progress on new priorities 8 and 9, BWCH and OCSHCN are collaborating to define a new state performance measure, which will track the percent of children identified through the newborn screening process who receive services through an BWCH or OCSHCN program.
//2008//

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	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	59	69	75	80	79
Denominator	59	69	75	80	79
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

Disorders being screened for increased from 8 to 27 in calendar year 2006. The added disorders include 3 amino acid, 5 fatty acid oxidation, and 9 organic acid disorders. With the addition of cystic fibrosis in 2007, the Arizona newborn screening panel will be as recommended for all states by the American College of Medical Geneticists, Health Resources and Services Administration, American Academy of Pediatrics, and March of Dimes, among others. Amended rules were promulgated in April 2006, defining the implementation of the newborn screening panel expansion and changes in fees. The Newborn Screening Program reported 100,588 initial bloodspot screens and 89,757 second screens in 2006. Of those screened, 79 were diagnosed with clinically significant disorders, including 45 cases of primary congenital hypothyroidism, 1 of other thyroid disorders; 9 cases of salt-wasting congenital adrenal hyperplasia (CAH), and 2 of simple virilizingl CAH, and 1 other CAH; 4 cases of phenylketonuria (PKU); 3 cases of biotinidase deficiency; 8 cases of sickle cell anemia, 5 cases of Hemoglobin SC, and 1 Beta-Thalasssemia disease. These rates are within the expected range for Arizona's population. The Newborn Screening Program located 100% of affected infants who had screen results suggestive of target diseases. Of those who remained residents of Arizona after birth, all received needed services and accessed needed services within the timeframe determined as optimal by Arizona Department of Health Services Newborn Screening Program. Of those who resided out of state immediately following birth, 100% were notified of need for further services. The central database used to record screening information and results, report results to providers, record follow up services, and clinical outcomes was significantly updated in 2006 to accommodate the increased number of disorder results and case management. Newborn Screening requested and received authorization to add 4.0 FTE's to the case management team providing follow-up services.

High Risk Perinatal Program Community Health Nurses and Health Start Lay Health Workers educated families about the need for a second newborn screen and facilitated referrals to the medical home for those screens. These programs have bilingual staff to ensure that clients receive and understand information regarding newborn screening.

The Newborn Screening Program in BWCH referred 8 newborns who tested positive for the Sickle Cell disease to the Sickle Cell Program in OCSHCN. The Sickle Cell Program provided further testing, service coordination and counseling to 2 of those families. The other 6 children identified through the program were determined to be eligible for Title XIX services through the

Children's Rehabilitative Services Program. The Sickle Cell Program referred 592 children for counseling. In addition, 5,981 families were served through the BWCH Neonatal Intensive Care Program and OCSHCN Community Nursing.

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 identified by screening to possibly have disease.			X	
2. The Newborn Screening Program will add cystic fibrosis to the newborn screening panel.			X	
3. The Newborn Screening Program provides education on disorders recently added to the screening panel to providers, parents and the public.				X
4. The Newborn Screening Program is creating a web-based results retrieval site for providers.			X	
5. The Newborn Screening Program is increasing the number of staff performing newborn screening case management.				X
6. The High Risk Perinatal Program educates families about the importance of a second newborn screen.	X			
7. The High Risk Perinatal Program facilitates referral to a medical home.		X		
8. The High Risk Perinatal Program incorporates cultural sensitivity into the explanation of the need for screening and a medical home.	X			
9. OCSHCN supports Raising Special Kids, who assists families in accessing appropriate services through provider training and peer support.		X		X
10. OCSHCN Community Nursing and service coordination programs assist infants and their families in accessing appropriate services.		X		

b. Current Activities

BWCH provides follow up services to newborns and infants affected by screened disorders, including those whose specimens were unsatisfactory for testing. Health Start Community Health Nurses and Lay Health Workers educate families about the need for a second newborn screen and facilitate referrals to the medical home for those screens. In an effort to ensure comprehension of the urgency of the screens, the Program ensures that Community Health Nurses and Lay Health Workers have bilingual staff available.

Through the SSDI grant, BWCH and OCSHCN are defining processes to identify children and facilitate their enrollment in programs for care coordination and direct medical services and refer them to OCSHCN eligibility coordinators who facilitate enrollment in appropriate services, like the Sickle Cell Program and OCSHCN Service Coordination. The OCSHCN Community Nursing Program works with contractors, primary care physicians and other agencies to assist infants and their families in accessing appropriate services.

OCSHCN is developing training for the BWCH hotline workers on services available for children who may require follow-up services to assist in diagnosis and treatment of special needs. In collaboration with Raising Special Kids, OCSHCN is developing training modules to help families to navigate systems of care. OCSHCN refers families to the Family-to-Family Health Information Center, who helps families understand resources available to them.

c. Plan for the Coming Year
The Newborn Screening Program plans to reduce the number of unsatisfactory newborn screen specimens received, through education and continuous feedback to submitters. The program also plans to determine the positive and negative predictive values of all newborn screen analytes in order to plan program changes to improve testing specificity, and plans for technological changes to receive newborn demographic information electronically from specimen submitters.

Health Start Program community Health Nurses and Lay Health Workers will continue to educate families about the need for a second newborn screen and facilitate referrals to the medical home for those screens. In an effort to ensure comprehension of the urgency of the screens, the Program will continue to ensure that Community Health Nurses and Lay Health Workers are bilingual.

Through the SSDI grant, BWCH and OCSHCN will collaborate to define a new state performance measure to track the percent of children identified through the newborn screening process who are known to receive services through an OCSHCN program. The OCSHCN website and e-learning system will be expanded to include trainings on navigating the systems of care for CSHCN.

Cystic Fibrosis will be added to the Arizona Newborn Screening panel in 2007. The Arizona Newborn Screening Program will make newborn screening laboratory results available to providers through an Internet browser application in addition to postal delivery as is currently done. The number of Follow-up Specialists in Arizona's Newborn Screening Program will increase from 2 to 5 full time equivalents.

Education about the disorders screened in newborns will be developed and provided to healthcare providers, hospitals, parents, and the general public. Educational venues will increase, including web pages with resources for providers and web pages with resources for parents and the general public. Brochures will be revised and distribution tracking improvements made.

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	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	51.4	52	53	54	55
Annual Indicator	51.4	51.4	51.4	51.4	51.4
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	56	57	58	59	59

Notes - 2006

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

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

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

a. Last Year's Accomplishments
From its inception in 1992, OCSHCN went beyond the MCHB requirement to have a parent in the office, infusing family and youth partnerships throughout its business. Throughout the nineties, OCSHCN included parents as decision-makers on committees and made a commitment to involve them from the start, during the design phase of any new project or program. OCSHCN began hiring parents as professional staff in 2002, and began to involve youth. Over the past two years, contracts, policies and procedures for all OCSHCN programs have been revised to require family and youth involvement, which has now been implemented across all programs. Currently, 55 parents and youth are paid to participate on various projects.

The Community Development Program develops parents as leaders, who organize their communities to increase capacity to provide support for CSHCN. In 2006 and 2007, this program supported 37 parent leaders in 13 community teams representing 50 communities. Six community teams have now attained 501(c)3 status; 2 are in process. Teams represent diverse populations. The Page Partnership, lead by a member of the Navajo Nation, mentored a new team on the Hopi Reservation, the Turtle Nation, which became a community team during 2006. Canne represents a border community, and the Quest to Cure is a disability-specific team focusing on Sickle Cell. Three teams represent areas that are designated as medically underserved.

On March 9, 2007, with the support of Governor Napolitano, the Community Development Initiative Summit brought together 115 agency and family representatives from child-serving state agencies and families from around the state, including the Office of the Governor, AHCCCS and the Departments of Health, Economic Security, Education, and Juvenile and Adult Corrections. Agencies developed a plan to implement family and youth involvement in their agencies.

Of the 567 children who received care through ADHS Arizona Early Intervention Program (AzEIP), 94.5% of the children, parents and families had direct input into the child's services and therapies through collaboration with professionals in the development of the Individual Family Service Plan (IFSP) that dictates services the child will receive. The families of all 299 individuals served through CYSHCN Service Coordination and the families of all 333 individuals served through TBI/SCI had direct input to develop and implement their service plans.

During 2006, OCSHCN contracted with Raising Special Kids and Pilot Parents of Southern Arizona and Arizona Consortium for Children with Chronic Illness. Through these contracts, families train residents, physicians, other health care professionals, and educators in effective techniques for partnering with families and youth. OCSHCN resources helped Raising Special Kids to reach 57 families through their NICU program, which provides families with information and resources to encourage and facilitate family involvement with decisions regarding their neonate.

OCSHCN-contracted parent organizations and leaders recruited families for focus groups throughout the state to help inform the design for CRS as the program goes out for a new RFP. The 2007 CRS Family Satisfaction Survey asked several questions related to decision-making. Nearly 90% of respondents said that they were usually or always involved as much as they

wanted when decisions were made about their child's health care, 87% reported being offered choices, and 90% reported being asked to tell the health care provider what choice they prefer. Results for both of these questions are significantly better than results in 2006. Overall, CRS care was rated at an average of 9.0 on a 10-point scale. Families felt they were well informed and involved in decision making. Nearly 80% reported that clinic staff always listen carefully to them, and a similar proportion reported that clinic staff always explained things to them in a way they could understand.

Approximately 32% of respondents needed an interpreter within the last 12 months and 97.2% always received translation services when they were requested, an improvement over the 2006 results of 86.4%. Seventy-three percent agreed that the staff was sensitive to their cultural/ethnic background. Results showed a significant improvement in providers' communication with Hispanic families, with 96.5% reporting that they always or usually understood their providers.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. OCSHCN directly provides training to parent and youth to develop leadership skills through its e-learning program.				X
2. OCSHCN partners with Raising Special Kids to develop a family-leadership job bank.				X
3. OCSHCN partners with Pilot Parents of Southern Arizona to identify parents who have graduated from their Partners in Policy-Making Program and moving them into leadership roles.				X
4. The OCSHCN Community Development Program provides financial and administrative support and technical assistance to parent leaders to guide community teams in building community capacity to meet the needs of families of CYSHCN.				X
5. OCSHCN leads Arizona's child-serving agencies to develop a plan to implement family and youth involvement in their agencies.				X
6. OCSHCN includes requirements for family and youth participation in all of its contracts and monitors for family-centered culturally-competent care.				X
7. OCSHCN hires parents of CSHCN in all levels of staff positions.				X
8. OCSHCN supports Raising Special Kids in training medical providers on best practices related to family-centered care.				X
9. OCSHCN monitors family decision-making and satisfaction with services in all its direct-service programs and OWCH surveys recipients of Community Health Nursing.				X
10. OCSHCN requires that its staff and contractors participate in self-assessments and training on cultural competence.				X

b. Current Activities

All OCSHCN contracts now incorporate requirements for family and youth involvement. Family and youth participate in developing and improving resources, including curriculum, website, member handbooks, fact sheets, and brochures. Family- friendly, culturally competent materials are developed and reviewed for ADA compliance. A parent whose children have used multiple systems for CYSHCN works in the office part time, which facilitates incorporating a family perspective. Families and youth serve on the task force and every committee of the Integrated Services Grant and the OCSHCN cultural competence committee. Parents and youth are reimbursed for their time and travel, and accommodations are made if needed.

The CRS Program involves parents as decision makers on the Statewide and Local Parent Action Councils, and parents participate in Quarterly Administrator and Medical Director meetings, and the Quality Management Committee. Parents and families collaborate with contracted professionals in the development of the IFSP that dictates services the child will receive.

Community Development staff provide the infrastructure for parent leaders to develop leadership skills, assisting in the development of curriculum and providing technical support on facilitation, public speaking, budgeting, hiring, and supervision. This allows them to take on projects they would not have had the capacity to undertake. OCSHCN requires parent and youth leaders to complete e-learning leadership training.

c. Plan for the Coming Year

The Community Development Program will be working on plans to evaluate performance and outcomes associated with the activities of community teams, including cultural competence. Parent leaders will partner with OCSHCN to host the Statewide Community Development Biennial Conference, in which each of 13 community teams will bring 12 of their members. This year's conference will focus on continuing leadership development, evaluation and sustainability as teams plan to develop funding sources that will make them less dependent on State funds and more reliant on funding from their own communities. In partnership with Raising Special Kids and using funds from the Integrated Services Grant, OCSHCN will assist in the development of two new teams. The Community Development Initiative will host a summit to reunite the participants of the March 9th CDI Summit.

OCSHCN will continue to encourage other agencies to include family and youth as leaders. OCSHCN will promote incorporating family and youth involvement in contracts with other state agencies and encourage them to develop mechanisms to reimburse parents and youth for their time, travel and other accommodations.

Parent leaders participating in the Integrated Services Grant will help write the white paper with recommendations to the Governor on integrating services for CYSHCN. CRS will continue to seek ways to increase participation of parents as decision makers through committees and through the State and Local Parent Action Councils. Focus group input from parents and other stakeholders will be incorporated into a series of public input meetings to widen the discussion regarding the strengths and weaknesses of the current program and to look for opportunities for improvements to the program design. Parents will also help develop a telemedicine video to introduce families to the service and help them decide whether it is a satisfactory alternative to traveling.

OCSHCN will develop an IFSP module to add to its current online training targeting both providers and parents, which was originally developed with an MCHB Champions Grant. A DVD and other resources will be developed with Raising Special Kids for families with babies in the neonatal intensive care unit. Opportunities will also be explored to partner with Raising Special Kids to identify more parent and youth to participate in volunteer opportunities and to provide reimbursement mechanisms that are less costly and cumbersome to manage than the current State model.

OCSHCN will develop all outreach materials in both English and Spanish, and will continue to evaluate all contracts to formalize parent and youth involvement. OCSHCN and OWCH will work together to identify opportunities to partner with Behavioral Health Services to integrate family and youth partners into all aspects of health care.

The High Risk Perinatal Program will continue to survey parents on satisfaction with services and

will use the data to drive program changes.

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	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	50.5	50.5	51	51.5	52
Annual Indicator	50.5	50.5	50.5	50.5	50.5
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	52.5	53	53.5	54	54

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

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

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 hired a recognized expert as the medical home program manager to coordinate medical home activities under the Integrated Services Grant and to encourage the development of medical home throughout the state and study barriers to implementation and sustainability. Four medical home sites were established, including two rural medical practices, a CRS clinic in Phoenix, and one housed at the team office of the Turtle Nation, a community team on the reservation. Medical home care coordinators will serve as advocates for community members seeking assistance and also work on building improved relationships between community members and their local health center.

Five care coordinators were recruited by the OCSHCN community action teams to introduce and implement the medical home concept and a model of care coordination developed by OCSHCN into each of the sites. Care coordinators will also participate in community meetings and events to further advocacy efforts for the CYSHCN they are serving and to promote the medical home concept throughout their communities.

A comprehensive care coordination manual was developed for use by each of the medical home sites and corresponding community action teams. The manual includes practical materials that will help a medical home site develop a highly efficient, streamlined and organized care coordination process. Materials include important contacts for state-funded resources, intake forms for CYSHCN, detailed instructions on how to complete prescriptions for items commonly

used by CYSHCN, guidelines on how to obtain durable medical equipment, templates for letters of medical necessity, and multiple family handouts for local and national resources. This manual will also be mass- produced and distributed as a resource to other medical practices, physicians and community team members who wish to increase their knowledge of the medical home concept.

An all-day training was conducted on the care coordination model that will be implemented at each of the sites. The training included all 4 care coordinators and 11 community action team members. Training components included an overview of the medical home concept and family-centered care, navigating the system, grief and loss issues of families of CYSHCN, and instructions for implementation of the care coordination model into each unique site.

The Arizona Early Intervention Program provided service coordination for 567 infants and children age 0-3 who had or were at risk for developmental delays. Of the 567 children who received services through ADHS AzEIP, 94.5% reported that their children received coordinated, ongoing, comprehensive care within a medical home. The Traumatic Brain Injury and Spinal Cord Injury Program provided service coordination for 333 children through age 21, 82% of whom reported receiving coordinated, ongoing, comprehensive care within a medical home. CYSHCN Service Coordination Program served 299 families, 92% of which reported receiving coordinated, ongoing, comprehensive care within a medical home. These three programs together served 1,199 families.

The CRS Program, through its Centers for Excellence, has helped the state to recruit rare subspecialists. Although CRS clinics serve a relatively small proportion of Arizona's CSHCN, the clinics provide an opportunity to reach the larger population of CSHCN through the clinics' provider networks, which include most of the pediatric specialty providers in the state. Consequently, best practices promoted at the clinics reach beyond clinic membership. The medical home concept was integrated into the contracts for the four CRS regional clinics, which provide multi-specialty, interdisciplinary, family-centered care. Administrative site reviews incorporated the monitoring of contractors' medical home implementation plans, including cultural competence.

OCSHCN partnered with a local hospital to host 320 school nurses in an annual school nurses conference, where best practices for CSHCN were taught. The 2006 Arizona School Nurse Resource Survey Summary was published in 2006, which found that school nurses play an important role in family centered care.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. OCSHCN requires that a medical home approach is central to service delivery in all of its contracts.				X
2. OCSHCN employs a full-time expert on medical home to promote the concept of medical home.				X
3. The medical home program manager developed and is distributing a comprehensive care coordination manual for use in a medical home.				X
4. The Integrated Services Grant Task Force is identifying barriers to implementation and sustainability of medical homes.				X
5. OCSHCN care coordinators facilitate the identification of a medical home for CYSHCN.		X		
6. OCSHCN provides training and resources on best practices related to medical home to the health care provider community				X

and families.				
7. The Arizona Birth Defects Registry program manager refers children with birth defects to OCSHCN for follow up.		X		
8.				
9.				
10.				

b. Current Activities

CRS clincs provide an integrated medical record for members' CRS condition, and provide care in multi-specialty, interdisciplinary, family-centered clinics. CRS contracts require contractors to coordinate care with the child's PCP. Before youth transition out of the CRS Program, the contractor is required to identify an adult PCP.

Service coordination is provided through the Arizona Early Intervention Program (AzEIP), the Traumatic Brain Injury and Spinal Cord Injury Program, and the OWCH and OCSHCN Community Nursing Programs. AzEIP enrolls children who meet eligibility criteria and works with primary care physicians to approve recommended services. All care coordination programs encourage contractors to collaborate with the primary care physician, AHCCCS, CRS, and other providers to facilitate continuity of care and the provision of ongoing services.

The Integrated Services Grant is evaluating barriers to the statewide implementation and sustainability of medical home. The grant's task force and committees represent the Arizona Chapter of the American Academy of Pediatrics, Arizona Medical Association, all of the major child-serving agencies, the three state universities, family organizations, parents and youth, the Governor's office, and many other key stakeholders.

c. Plan for the Coming Year

The Integrated Services will include recommendations to overcome barriers to implementing medical home across Arizona in its final report to the Governor. The medical home program manager will implement the medical home concept across the state by developing training (e-learning and face-to-face) and distributing the care coordination manual to physicians, medical practices, and community team members. Funding will be required to maintain the services provided by the care coordinators who are placed in the medical home sites through the Integrated Services Grant when the grant period has ended. OCSHCN will facilitate discussion about strategies to sustain funding for ongoing care coordination. OCSHCN will also sustain training and resources to support medical home by maintaining resources like the care coordination manual and other trainings on its website and will offer training to health plans and other child serving agencies. A CRS clinic will serve as a pilot site for grant.

OCSHCN will provide training on medical home to school nurses, health educators, and health plans, and will continue to educate school nurses about OCSHCN programs and their eligibility criteria and referral processes. Community action teams will be provided with the medical home project training and curriculum manuals in a train-the-trainers event in the Fall of 2007. OCSHCN will also partner with organizations such as the Arizona Chapter of the American Academy of Pediatrics to reach a higher number of physicians across the state and also to increase the distribution of the care coordination manual.

ADHS will no longer provide direct services through AzEIP, which will impair the ability of the office to make assurances about medical home for this population. CSHCN will continue to offer education and training on care-coordination and medical home best practices to ADES, as they absorb responsibility for this population.

The scopes of work for Traumatic Brain Injury and Spinal Cord Injury, and OCSHCN Service Coordination for 2008 stipulate that contractors must collaborate with the primary care physician,

the Arizona Long Term Care Services, Children's Rehabilitative Services and other providers to facilitate continuity of care and the provision of ongoing services.

CRS will continue to work on plans to develop the provider network for CSHCN, and to improve integration of primary and specialty care through an examination of reimbursement of primary care services for CSHCN and monitoring coordination of care.

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	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	60.8	61	61	61	61
Annual Indicator	60.8	60.8	60.8	60.8	60.8
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	61	61	61	61	61

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

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

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

a. Last Year's Accomplishments
All 13 of OCSHCN community teams distributed information in their communities about services available to families of CYSHCN that helped them understand available resources. The Turtle Nation Community Team on the Hopi Reservation did a training for families about accessing all available health coverage through Indian Health Services and Title XIX health plan providers.

The Arizona Birth Defects Monitoring Program identified and referred 12 families of children with spina bifida or cleft lip/cleft palate to OCSHCN for follow up with Children's Rehabilitative Services (CRS). Of the 567 children age 0-3 served through the Arizona Early Intervention Program (AzEIP), 94.5% of families reported that they have adequate private or public insurance to pay for the services they need. This number is based on information provided by the family and collecting and submitting this information is optional for AzEIP service coordinators. Of the 333 children served through the Traumatic Brain Injury and Spinal Cord Injury, 80% say they have adequate private or public insurance to pay for the services they need. Of the 299 children served through CYSHCN Service Coordination, 86% reported having adequate private or public

insurance to pay for the services they need.

CRS provided services to more than 22,000 children in the state with certain qualifying conditions regardless of their financial status; 88% of them are Title XIX and XXI. An eligibility task force and a position for an eligibility worker were established to facilitate CYSHCN enrollment into Title XIX, XXI, and other services. The task force will study barriers to enrollment, and findings will be used to streamline processes and potentially redesign the eligibility process for Children's Rehabilitative Services. CRS contractors were required to identify a primary care provider for youth aging out of Title XIX services. They were also required to develop and update plans to prepare for transitioning to non-Title XIX services.

The Integrated Services Grant (ISG) established a Health Benefits Committee to look at the adequacy of coverage for CYSHCN. The committee identified gaps in coverage or limitations that could possibly be resolved by the committee in the future. The Young Adult Committee identified health care and insurance as issues to address at their Youth Summit.

OCSHCN partnered with Raising Special Kids on an MCHB grant application, which was awarded to them in April 2007. The grant is for the Family-to-Family Health Information Center to provide information and resources to families on accessing health care, among other things. OCSHCN launched an e-learning module developed by Raising Special Kids on navigating Arizona's health care system.

Children and youth with certain rare metabolic disorders must remain on a restricted diet for life. The cost of the medical foods (formula and low protein food) is very expensive, but is the only treatment for the disorder. Public and private insurance do not typically cover all of the costs of these foods. State funding covers the family copay for medical food for children with special health care needs that are enrolled at the Children's Rehabilitative Services clinics. Public insurance covers the cost of enteral feedings as well as oral nutrition supplements when medically necessary. MCH has coordinated with the Arizona WIC program and AHCCCS to ensure that CSHCN are covered in a timely manner and receive the medical nutrition therapy as prescribed. MCH has provided training on the approval process with WIC Special Needs Nutritionist and AHCCCS MCH Coordinators.

With the Newborn screening expansion in Arizona, several new Teacher's Guides have been created as educational material regarding the dietary treatment of Fatty Acid Oxidation, and Urea Cycle inborn errors of metabolisms. Teacher's guides are available for Phenylketomuria, Galactosemia, Homocysteinuria, Isovaleric Acidemia, Maple Sugar Urine Disorder, Methymalonic Acidemia, and Propionic Acidemia. The Maternal Child Health program provided technical assistance for 12 participants enrolled in WIC, AHCCCS or CRS for coverage of medical nutrition therapy including appealing denied cases.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The OCSHCN SSI coordinator identifies children who may be eligible for services and refers them to a number of programs.		X		
2. All OCSHCN programs identify possible sources of insurance or other resources for care.		X		
3. The Integrated Services Grant Health Benefits and Young Adult Committees are assessing coverage for CYSHCN and making recommendations for improvements.		X		X
4. OWCH and OCSHCN are working on systems to track children who are identified through the Newborn Screening Program and Neonatal Intensive Care Program for follow up to		X		X

appropriate systems of care.				
5. The OCSHCN Eligibility Task Force is examining barriers to enrollment to services.		X		X
6. OCSHCN hosts an e-learning module developed by Raising Special Kids on navigating Arizona's health care system.		X		X
7. OCSHCN provides training to OWCH Hotline workers to services available to CYSHCN.		X		X
8. Office of Chronic Disease and Nutrition provides technical assistance for medical nutrition therapy.		X		X
9.				
10.				

b. Current Activities

All OCSHCN programs identify possible sources of insurance or other resources for care. The Arizona Birth Defects Monitoring Program and the OWCH Newborn Screening Program identify newborns, who are potentially eligible for OCSHCN programs. The SSI coordinator receives information on children who are applying for SSI and refers them for services. OCSHCN sends the family a packet of information about genetic services and state and community resources specific to the child's diagnosis and makes follow-up calls to answer questions and assist parents in enrolling in state services. Children who do not have US citizenship are referred to community health centers, where they receive primary care. Families who are unable to pay may receive services through Assistance to Families, which provides funding to assist families who do not have insurance coverage, enabling them to receive needed services. A task force is examining barriers to eligibility for CSHCN.

The Health Benefits Committee of the Integrated Services Grant is looking at assessing the adequacy of coverage for CYSHCN, including children who fall on and off Medicaid. MCH nutritionists attend meetings of the AHCCCS MCH Coordinators to share information about medical nutrition therapy and provide coordination with the Arizona WIC agency.

c. Plan for the Coming Year

The Integrated Services Grant Health Benefits Committee will assess the adequacy of coverage for CYSHCN and make recommendations for solutions. The Young Adult Committee has identified health care finance as a priority for their summer institute. Representatives from health plans, AHCCCS, physicians, advocacy groups and other state agencies have been invited to participate in developing recommendations to forward to the ISG Task Force for inclusion in a White Paper to the Governor.

The OCSHCN Service Coordination Programs will continue to link children to services. The eligibility task force will study barriers to enrollment, and findings will be used to streamline processes and potentially redesign the eligibility process for Children's Rehabilitative Services (CRS). CRS contractors will continue to be required to identify a primary care provider for youth aging out of Title XIX services and to develop and update plans to prepare for transitioning to non-Title XIX services. An eligibility worker will be hired to facilitate CYSHCN enrollment into Title XIX, XXI, and other services.
Clear protocols will be defined and implemented to facilitate the enrollment of children who are eligible for SSI services into appropriate health care systems.

OCSHCN will partner with Raising Special Kids with their Family-to-Family Health Information Center (F-2-F HIC) grant. As part of the grant activity, OCSHCN will work with Raising Special Kids to evaluate how CYSHCN are identified within private insurance companies and how services are coordinated. The project will be implemented in partnership with communities and other state agencies to identify and implement coordinated financing of services, as appropriate. OCSHCN will work with the F-2-F HIC to convert their Arizona Health Care Systems Workshop

into an on-line interactive class available to families and providers.

The Maternal Child Health program of the Office of Chronic Disease Prevention Services will continue to provide technical assistance on coverage of medical nutrition therapy, coordinate sharing of information with AHCCCS and ADHS, and provide assistance for processing insurance claims for medical foods. MCH will provide AHCCCS medical nutrition therapy training to new WIC nutritionists and Local Agency Directors. MCH will continue to provide educational materials to the special needs community as new disorders are screened.

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	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	70.9	71	72	73	74
Annual Indicator	70.9	70.9	70.9	70.9	70.9
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	75	76	77	78	78

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

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

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

a. Last Year's Accomplishments
Southwest Institute for Families and Children with Special Health Care Needs designed and supported an interactive web-based database on available community-based resources in Arizona. The database goes beyond government resources, individuals, organizations or agencies, to include the skills, talents and knowledge that people are willing to share. Three OCSHCN community teams participated.

The Community Development Program supported 13 community teams across the state. Teams chose projects reflecting priorities within their own communities, distributed information on community resources related to special needs (including navigating health and education systems), developed resource guides, published newsletters, and sponsored sporting and social events. Four teams established medical home sites funded by the OCSHCN Integrated Services

Grant, which will evaluate families' experiences of services in their communities.

Two community teams participated in radio shows with information on resources and services for CYSHCN that reached families throughout northern Arizona, including the Navajo and Hopi Reservations, where internet and telephone access is not always available. The Turtle Nation on the Hopi Reservation conducted training for 25 families on how to use Indian Health Services and other insurance, and added Turtle Nation to the Hopi Tribe Resource Guide.

The Tri-City Partnership implemented Pathways, a computer-based transition program where employers and youth post and research employment opportunities. The Tri-City Partnership trained 37 new law enforcement recruits on the needs of children and youth with mental illness and developmental disabilities during emergency situations through its First Responders program, and expanded participation around the state to Verde Valley, Kingman, Flagstaff, Tucson, and Bullhead City. A key feature of the program is the Smart Card, which informs first responders that a person has a special need that may impact their response during an emergency. The Flagstaff team sponsored 6 parents and 6 teachers to attend an Autism conference.

The Quest to Cure implemented the Sickle Cell Advocate-thumb drive used to store patient's health information to facilitate communicating with providers who are unfamiliar with patients' needs in an urgent setting to 130 families. The team presented information on Sickle Cell to more than 30 groups of health care providers, schools, and families. The Alliance team developed and offered a 2-credit hour course through Northern Pioneer College for respite workers, which exceeds the training requirements of several agencies, including DES DDD, school districts, and childcare and behavioral health providers.

OCSHCN funds supported Raising Special Kids, who trained 178 physicians and students about best practices related to family-centered care. Fifty-six of them also participated in site visits hosted by families in their homes for further training on effective techniques to assist families in identifying resources and to observe the interactions of the family in the child's natural environment. OCSHCN partnered with Banner Desert Medical Center to sponsor the Annual Statewide School Nurses Conference, which was attended by 320 nurses, and focused on current and best practices related to children's health, including special needs. The Integrated Services Grant brought together partners from state child-serving and community-based agencies, parents and youth, to identify barriers to statewide implementation of medical home and care coordination for CYSHCN.

Children's Rehabilitative Services served over 22,000 children in multi-specialty interdisciplinary clinics, which allow families to get care related to their qualifying conditions all in one place. The CRS telemedicine program saved 88 families from traveling on average 98.2 miles and from missing an average of 10.7 work hours to receive pediatric sub-specialty, which would not have been available in their communities. Families reported high satisfaction levels with the service, and reported savings on average of $112 per visit. Without telemedicine, providers would have had to travel an average of 300 miles to see a patient, and three providers said they would not have been able to see the patient at all. CRS also provided pediatric sub-specialty care in outlying areas through outreach clinics and attracted two new pediatric neurologists to the state.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CRS provides multi-specialty interdisciplinary clinics that allows families to access care related to the member's qualifying condition all in one place.		X		
2. CRS provides field clinics and telemedicine services statewide		X		X

in the members' communities.				
3. CRS annually surveys families regarding access to and satisfaction with health care services.				X
4. OCSHCN service coordinators help to identify community-based resources for families.		X		
5. The Integrated Services Grant Task Force is working on recommendations to the Governor on how to integrate resources of CYSHCN and improve the system of community-based care.				X
6. OCSHCN community development teams identify needs and resources in their own communities and work to increase their capacity.				X
7.				
8.				
9.				
10.				

b. Current Activities

Rehabilitative Services (CRS) provides multi-specialty interdisciplinary clinics, which allow families to get care related to their qualifying conditions all in one place. CRS outreach clinics and telemedicine bring services to geographically remote areas where pediatric subspecialty care would not have otherwise been available in their communities. Care coordinators manage network of pediatric subspecialists that are in short supply to ensure that services are available across the state.

OCSHCN collaborates with OWCH to provide community nursing for children who are ineligible for other care, but are at risk for developmental delay. OCSHCN provides care coordination through AzEIP, TBI/SCI, and CYSHCN Service Coordination in home and community settings, and administrative support and technical assistance to 13 community development teams who choose projects based on the needs of their own communities. Teams disseminate and share practices for promoting community-based services. CRS and service coordination staff serve on all community teams. OCSHCN is supporting Raising Special Kids' efforts to expand their NICU program.

Integrated Services Grant is identifying barriers to implementation of medical home concepts and is working on recommendations improve the system of community-based care for CYSCHN. The OCSHCN Cultural Competency Committee as well as the Integrated Services Cultural Competency Committee identify and implement best practices around culturally effective care.

c. Plan for the Coming Year

The Integrated Services Grant Task Force will synthesize committee findings into a paper with specific recommendations to the Governor on how to integrate resources for CYSHCN and improve the system of community-based care. A key activity will be to evaluate how current systems for serving CYSHCN, including OCSHCN programs, promote Title V performance measures, which encompass family-friendly, community-based care. OCSHCN strategic planning will use results from this evaluation to strategically target scarce Title V resources and align them with identified gaps. A primary evaluation question will be whether OCSHCN is effectively directing its Title V resources to address performance measures.

Input from focus groups and public input meetings will be evaluated to identify performance issues and inform the program design of Children's Rehabilitative Services for a new RFP. An eligibility task force will look at barriers to children with special health care needs being efficiently enrolled in services to which they are entitled, including Title XIX and XXI, as well as state-funded services. A new position will be hired to facilitate timely enrollment into services. OCSHCN

continues to leverage Title XIX resources on behalf of the larger community of CYSHCN through an expansion of the telemedicine program and development of the pediatric sub-specialty provider network in Arizona. OCSHCN will continue to educate pediatric subspecialists on best practices for CYSHCN through introducing concepts into the CRS clinics, where most of the subspecialists participate to some degree, thus influencing the care of the larger population of CYSHCN throughout the state.

The learning management system had 14 trainings on line as of May 15th, with 27 more under review. Trainings include standards on Culturally and Linguistically Appropriate Services (CLAS), medical home, service care coordination, and parent and youth leadership. Other educational plans include presentations to AHCCCS health plans, NICU staff and families, residents, physicians, dental students, and OWCH Hotline staff on accessing systems of care for CYSHCN and best practices. A DVD and supporting resources will be developed with Raising Special Kids through their new Family-2-Family Health Information Center for families with babies in the NICU. OCSHCN will continue to support the two school nurse organizations with information and resources around best practices for CYSCHN.

All new service coordination and community nursing contracts for 2008 will include in their scope of work that contractors must work with families, community providers, ADHS Community Action Teams, and others including home and community settings in which members without disabilities participate. ADHS is transitioning out of providing direct services through the AzEIP Program, and after June 30, 2007 will only provide technical assistance to the ADES, who will have full responsibility for providing care.

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	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	5.8	6	6	6	6
Annual Indicator	5.8	5.8	5.8	5.8	5.8
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	6	6	6	6	6

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

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

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
Since 2002, OCSHCN has infused youth partnerships throughout its business, including youth as decision-makers on committees from the start of any new project or program. Over the past two years, contracts, policies and procedures for all OCSHCN programs have been revised to require youth involvement, which has now been implemented across all programs. Over the past year, 16 youth were paid for their expertise to develop and improve resources, including curriculum, website, member handbooks, fact sheets, and brochures. Youth review web pages and other materials for ADA compliance. Youth are reimbursed for their time and travel, and accommodations are made if needed.

OCSHCN is an active partner on Arizona Department of Education's (ADE) Arizona Transition Leadership Team. OCSHCN co-sponsored ADE's annual transition conference, attended by 2,500 parents, youth, and educators. The OCSHCN transition program manager served as the Arizona state adolescent health coordinator. Three community teams promoted the 40 assets-based training program, through which 100 participants were trained.

The Integrated Services Grant (ISG) incorporates youth on its task force and in most of its committees. The ISG Young Adult Transition Committee (formerly known as the ISG Youth Advisory Council) was developed to ensure that the voice of youth with special health care needs is integrated into the design, implementation and evaluation of all the components of grant activities. During 2006 the Arizona Medical Association Adolescent Committee folded into the ISG Health Community Advisory Committee. This group promoted the implementation of Get Healthy: Improving Adolescent Access to Appropriate Health Care Plan and the use of a health risk appraisal by primary health care providers who work with adolescents and promoting coordination of services for adolescents through a medical home. They wrote a concept paper that supports the use of a health risk appraisal by all health care providers who work with adolescents and for the development of a comprehensive adolescent health website.

The ISG Young Adult Transition Committee secured a young adult chair and a co-chair, who also works with the Governor's Council on Developmental Disabilities. The committee identified topics for a July 2007 summit: transportation and mobility; employment and financial support; health care and benefits (available services and providers); higher education and vocational education; self-advocacy, social life, peer support and leadership; and housing, independent living and assisted living. The young adult committee created a Youth Participation Summit Nomination Form for young adults age 16-25 years, which included selection criteria on diversity of special health care needs and diverse geographic location.

The Young Adult Transition Committee includes diverse partners representing Arizona State University-Youth in Transition Program, Arizona Department of Education-Exceptional Student Services, Department of Economic Security Rehabilitation Services Administration, Value Options, DES-Division of Developmental Disabilities, ADHS-BHS, Arizona Governor's Council on Developmental Disabilities, and 6 young adult consultants. Additional partners were added recently from Southwest Autism Research and Resource Center and the Phoenix Mayor's Commission on Disability Issues.

OCSHCN educated CRS contractors on guardianship, advanced directives, and transition resources and mandated participation in a performance improvement project focused on transition to adulthood in CRS contracts. Contracts require documentation of a transition plan beginning by the time members turn 15. Quality management staff completed an interim evaluation based on chart reviews and offered training based on findings. OCSHCN staff reviewed and approved contractors' annual transition plans and evaluations. CRS utilization management staff monitored contractors' requirement to locate primary care for members who

aged out of Title XIX services.

OCSHCN is on the ADE Transition Conference Planning Committee and added a Medical/Social Empowerment track to the 2007 conference. Three young adults presented transition recommendations to clinics and medical providers. An OCSHCN young adult partner wrote a mini grant proposal on transition that was accepted by the Southwest Autism Research and Resource Center, which will use OCSHCN's leadership training curriculum and OCSHCN young adult partners as mentors.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CRS requires a transition plan for all youth 14 and older and monitors compliance with it through a performance improvement project.	X	X		
2. OCSHCN contracts with youth to assist in the development and monitoring of resources, including websites, trainings, and other educational materials.		X		X
3. The ISG Young Adult Transition Committee ensures that voices of YSHCN are integrated into the design, implementation and evaluation of all components of grant activities.				X
4. The ISG Adolescent Health Community Advisory Committee supports the use of a health risk appraisal by all health care providers who work with adolescents for the development of a comprehensive adolescent health website.				X
5. The ISG Young Adult Committee is hosting a summit on Creating Effective and Sustainable Systems Change for Families and Youth.				X
6. OCSHCN employes a youth transition program manager, who is also Arizona's adolescent health coordinator.				X
7. OCSHCN educates providers on guardianship, advanced directives, and transition resources.				X
8. OCSHCN works with the Arizona Department of Education to develop training and resources related to health and transition for YSHCN.		X		X
9.				
10.				

b. Current Activities

The Integrated Services Grant (ISG) Adolescent Health Community Advisory Committee is identifying potential grant funding to implement recommendations from the concept paper that supports the use of a health risk appraisal by all health care providers who work with adolescents for the development of a comprehensive adolescent health website. They are also identifying potential grant funding to implement the recommendations. They secured the Arizona Chapter of the American Academy of Pediatrics as their fiduciary agent. The ISG Young Adult Transition Committee is planning a July 28, 2007 summit on Creating Effective and Sustainable Systems Change for Families and Youth.

The CRS Program continues to monitor its Transition Performance Improvement Project, which is aimed at providing transition services to enrolled Title XIX members, and leverage the education beyond CRS members by introducing concepts into the clinics, where most of the subspecialists participate to some degree, thus influencing the care of the larger population of youth with special health care needs about transition issues.

All OCSHCN service coordination contracts will include a young adult on the RFP application review team.

c. Plan for the Coming Year
The ISG Adolescent Health Community Advisory Committee will create a comprehensive adolescent health website and promote and provide training on the use of a health risk appraisal by health care providers who work with adolescents. The ISG Young Adult Transition Committee will review recommendations from their July summit with the Committee and have the membership select activities that they would like to continue to work on beyond the ISG.

OCSHCN will require leaders to participate in the OCSHCN Youth and Parent Leadership Institute. Training will support them in their efforts to be better self-advocates as well as learning skills to allow them to effectively interface with local communities and state and federal agencies to effect positive change in the delivery of health care, education, and financial services for Youth with special health care needs.

During the summer of 07 young adults will work with the OCSCHN Transition Program to develop resources and web-based information for transitioning youth, their families and service and healthcare providers for youth with special needs. Youth and young adults will participate in the development of fact sheets, newsletters, OCSHCN web page redesign, curriculum, training, OCSHCN staff education, and guidance for youth participation in OCSHCN activities.

Children's Rehabilitative Services will continue to train clinic staff on transition issues, and will complete a remeasurement on its performance improvement project to assess the effectiveness of interventions and training related to the transition. Utilization and quality management staff will continue to focus on monitoring compliance with contractual requirements related to transition. Training will be developed for health care plans to train on best practices related to young adults with special health care needs, and also to raise awareness about the need to develop the capacity to care for young adults with health conditions that the provider community is only accustomed to seeing in pediatric populations.

OCSHCN will continue to support the leadership development of young adults with special health care needs through e-learning training, as well as offering in-person leadership opportunities. OCSHCN youth partners will provide presentations on decision-making, healthcare choices, guardianship, advanced directives, and general transition issues. OCSHCN will co-sponser an annual Arizona Department of Education Transition Conference for over 2,000 youth, parents, educators. OCSHCN staff and youth consultants will organize and present at for the Medical and Social Empowerment Track at the conference.

OCSHCN will partner with Raising Special Kids new Family-to-Family Health Information Center grant to establish an online learning community to facilitate the exchange of ideas and solutions about challenges faced and develop an interactive transition game about adult life activities and programs.

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	2002	2003	2004	2005	2006

Annual Performance Objective	70	70	71	78	79
Annual Indicator	69	75	78	78.6	79.2
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	79.5	80	80	80	80

Notes - 2006
The source of immunization data is the CDC National Immunization Survey (http://www.cdc.gov/nip/coverage/NIS/01/toc-01.htm). Previously, the reported rate represented the coverage level for 4DPT, 3OPV and 1 MMR only, because data were not reliably available for the full series recommended by the CDC, which also includes 3 doses of Hep B and 3 doses of Hib. No data were available for this measure for 1998, but the data points for 1999 forward have been changed to reflect the full 4:3:1:3:3 series. Performance objectives were also changed to reflect the change in the measure. Estimates for data points are based on reports for the following date ranges:
1999 = July 1998 through Jun 1999
2000 = "2000"
2001 = Jan 01 through Dec 01
2002 = Jul 01 through Jun 02
2003 = Jul 02 through Jun 03
2004= Jul 03 through Jun 04
2005= Jan 04 through Dec 04
2006=Jan 05 through Dec 05
The 2006 estimate reflects the immunization status of children by age two for children who were 19-35 months of age, born between February 2002 and July 2004. The estimate tolerates 4.2% error at a 95% confidence level.

Notes - 2005
The source of immunization data is the CDC National Immunization Survey (http://www.cdc.gov/nip/coverage/NIS/01/toc-01.htm). Previously, the reported rate represented the coverage level for 4DPT, 3OPV and 1 MMR only, because data were not reliably available for the full series recommended by the CDC, which also includes 3 doses of Hep B and 3 doses of Hib. No data were available for this measure for 1998, but the data points for 1999 forward have been changed to reflect the full 4:3:1:3:3 series. Performance objectives were also changed to reflect the change in the measure. Estimates for data points are based on reports for the following date ranges:
1999 = July 1998 through Jun 1999
2000 = "2000"
2001 = Jan 01 through Dec 01
2002 = Jul 01 through Jun 02
2003 = Jul 02 through Jun 03
2004= Jul 03 through Jun 04
2005= Jan 04 through Dec 04
The 2005 estimate reflects the immunization status of children by age two for children who were 19-35 months of age, born between February 2001 and May 2003. The estimate tolerates 4.2% error at a 95% confidence level.

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
Arizona's 2010 immunization goal for children is to have at least 90% of all children immunized at the standard 4:3:1:3:3 coverage level (4 or more doses of DTaP; 3 or more doses of IPV; one or more dose of MMR; 3 or more doses of Hib; and 3 or more doses of Hep B vacccine) by 2 years of age. As of September 2006, according to the National U.S. Immunization Survey, the immunization rate for 4:3:1:3:3 is 81%. Arizona's rate is 79%.
The Arizona Partnership for Immunization (TAPI) website, www.whyimmunize.org, which allows parents to ask medical experts questions about vaccines and immunizations was updated. A postcard was developed and distributed to guide parents and providers to the website for immunization information. TAPI supplied articles for the quarterly Immunizations newsletter, which was produced and distributed to immunization providers by the ADHS Immunization program. English and Spanish parent education flyers, "Is Your Child Protected?" and provider flyers, "Welcome to Our Office," were revised and distributed. Additionally, reminder/recall postcards were printed and widely distributed to immunization providers throughout the state. All materials produced and available through TAPI can be ordered from the TAPI resource catalog and from www.whyimmunize.org. Over 75,000 educational pieces were distributed to schools, child care facilities, private providers, county health departments, community health centers, managed care organizations and WIC sites in 2006. TAPI organized and conducted 15 regional immunization programs with the Vaccines for Children Program and the Arizona State Immunization Information System for providers statewide. The programs emphasized the importance of using resources such as reminder/recall cards and parent education flyers. Because of an incentive program initiated by the Arizona Immunization Program Office (AIPO) to increase completion of the 4th DTaP by 24 months of age, the demand for reminder/recall postcards and other materials required additional printing of several materials. TAPI partnered with ADHS/AIPO, the Centers for Disease Control and Prevention, and the Pan American Health Organization to launch an immunization campaign during National Infant Immunization Week at the end of April. In cooperation with AIPO, TAPI designed and mailed a Vaccines for Children (VFC) provider satisfaction survey to 870 VFC provider sites. Sixty-three percent (63%) of the surveys were completed and returned by the December 31, 2006, deadline. Analysis of the survey data indicated 97% of respondents are overwhelmingly very satisfied/satisfied with the program; 92 % strongly agreed/agreed VFC representatives are knowledgeable and helpful; 85% strongly agreed/agreed that participation in the VFC program had increased the number of children immunized by the practice; 78% strongly agreed/agreed that participation on the VFC program had decreased the number of children referred to public clinics; 90% were reporting immunization data to the state immunization registry, ASIIS (Arizona State Immunization Information System); and 70% used ASIIS to look up immunization records of their patients. TAPI developed a curriculum for pediatric offices that have fallen below the national average for immunization coverage of their patient population. The curriculum was tested in pediatric clinics

in 2006 and will be fully implemented in 2007.

The County Prenatal Block Grant program funded assessments of 1,687 infants/children under the age of two years old to determine if they had completed age-appropriate immunizations.

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.

The Special License Midwifery Program brought information to the midwifery community regarding immunization schedules for infants.

Health Start and the HRPP Community Health Nurses monitored the immunization status of the children enrolled in their programs and continued to promote and facilitate immunization. In order to communicate with all clients many of the HRPP Community Health Nurses are bilingual and the Health Start Lay Health Workers are hired from and reflect the ethnic and socioeconomic makeup of the communities that they serve.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Arizona Partnership for Immunization works with immunization service providers to ensure immunization services are available in underserved areas.				X
2. The Arizona Partnership for Immunization meets and confers with managed care plans to promote and institute methods to ensure local health departments are reimbursed vaccine administration costs for AHCCCS enrolled children.				X
3. The County Prenatal Block Grant holds regular immunization clinics which are staffed by program staff.	X			
4. The County Prenatal Block Grant develops assessments that are administered by Community Health Nurses, which assess immunization, health and safety.	X			
5. The High Risk Perinatal Program and the Health Start program both monitor the immunization status of enrolled children.	X			
6. The High Risk Perinatal Program and the Health Start program both provide transportation to a medical home for immunization if needed.		X		
7. The High Risk Perinatal Program and the Health Start Program both provide translation services at the medical home to facilitate and promote immunizations.		X		
8. Through the Office of Chronic Disease Prevention and Nutrition Services, WIC participants are screened and referred for proper timing of the DtaP Shots.	X			
9. The Arizona Partnership for Immunization plans and conducts at least ten immunization workshops for staff of public and private clinics, medical offices, schools and other VFC enrolled sites		X		
10. The Arizona Partnership for Immunization is revising and updating the web site and print materials as needed to keep current with established guidelines.				X

b. Current Activities

The Arizona Partnership for Immunization will continue to print and distribute immunization materials to public and private providers throughout the state, and will plan and conduct at least ten immunization workshops. The program will continue to meet and confer with managed care plans to promote and institute methods to ensure local health departments are reimbursed vaccine administration costs for AHCCCS enrolled children, continue to work with immunization service providers to ensure immunization services are available in underserved areas, and will revise and update the web site and print materials as needed to keep current with established guidelines.

Health Start and the High Risk Perinatal Program Community Health Nurses monitor the immunization status of children enrolled in their programs and continue to promote and facilitate immunization.

The Office of Chronic Disease and Nutrition Services (OCDPNS) coordinates statewide immunization record screening and referral by WIC staff to ensure proper timing of the DtaP shots in WIC children. The office met with the Office of Immunizations and the Health Start program to increase the immunization rates. Arizona WIC rates for the coverage of the 4:3:1:3:3 series is 81% in 2004 and 73% in 2005.

The County Prenatal Block Grant Program continued with immunization clinics, and home visits to assess needs and monitor immunization schedule.

c. Plan for the Coming Year

The County Prenatal Block Grant Program will continue to include immunizations as a component of Public Health nurses' home visits. The Program will continue and increase the numbers of immunization clinics, and will improve the current tracking system.

The Office of Chronic Disease Prevention Services will continue train WIC staff to screen and refer WIC participants to receive the proper timing of the DtaP shots. The MCH and WIC programs will continue to assess screening and referral services and implement coordination between local WIC clinics and the Health Start program. The Office of Immunizations will provide screening and referral training to WIC staff.

The Arizona Partnership for Immunization program will continue to participate in statewide initiatives and programs to promote immunizations to reach the goal of 90% of children 19 to 35 month olds who have received full schedule of age appropriate immunizations. TAPI will develop, print and distribute immunization materials and distribute them to providers and parents statewide.

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

The Special License Midwifery Program will continue with education of the midwives regarding the immunization needs of infants.

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	2002	2003	2004	2005	2006

Annual Performance Objective	43	42	41	35	35
Annual Indicator	35.5	35.9	35.8	34.1	34.1
Numerator	3952	4110	4227	4179	
Denominator	111218	114368	118082	122496	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	34	33	32	32	32

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

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

a. Last Year's Accomplishments
The Abstinence Education Program funded 11 contractors to provide education to positive youth development services and parent education in 10 counties. A total of 22,820 youth and 1,879 parents were reached under the Abstinence Program. The Teen Pregnancy Prevention Program initiated and funded 3 comprehensive sexuality education projects serving youth in two counties. A total of 565 youth were reached under the Comprehensive Sexuality Education program. Four quarterly trainings were provided, eleven teen maze events were funded, and all contractors received on annual site visit in which education services were observed. The trainings included information on current trends, transmission and primary prevention for sexually transmitted diseases. Training is provided each quarter on topics of interest to all Abstinence Education program contractors. The abstinence education program media campaign was continued featuring radio and television spots, theater advertising and outdoor billboards.

The Women's Health Policy Advisor participated in state agency Teen Pregnancy and STD workgroup, which was developed from the Governor's Commission on the Health Status of Women and Families in Arizona. Group activities have included working on development of teen health resource guide (focus on sexual health) and discussion of how to bring a comprehensive reproductive health curriculum to kids in care. Group meetings entail collaboration on behalf of multiple state agencies. A draft curriculum has been proposed to the group.

Through a RFP/RFG process the Teen Pregnancy Prevention Program recruited and developed outreach programs in Pinal, Gila, Yuma and Maricopa County. Each county contractor was tasked with developing an implementation plan to introduce comprehensive reproductive health education programs and activities to school and community venues.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Abstinence Education program funds contractors who provide abstinence education program services and youth			X	

development.				
2. The Abstinence Education program funds contractors who provide comprehensive sexuality education services.			X	
3. The Abstinence Education program provides information on effective community based abstinence, teen pregnancy and std prevention education.			X	
4. The Abstinence Education program continues to maintain the abstinence until marriage media campaign			X	
5. The Abstinence Education program continues to fund an Evaluation Study of the Abstinence Education Program.			X	
6. The Teen Pregnancy Prevention program provides information on effective community based teen pregnancy and std prevention education.			X	
7. The Teen Pregnancy Prevention program funds teen alternative activities and community invlvement to delay sexual debut.			X	
8. The Teen Pregnancy Prevention program funds programs encouraging parents to discuss pregnancy prevention with their children.			X	
9.				
10.				

b. Current Activities

The Abstinence Education Program Funds were utilized to continue the current contractor's expansions to serve additional youth and parents in underserved areas. The Abstinence Education and Teen Pregnancy Prevention (TPP) Programs participate on the Arizona Department of Education Materials Review Committee and collaborate 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 STD prevention to all community providers. The TPP program was initiated at identified sites in Gila, Yuma, Pinal and Maricopa counties. The program began discussions with several American Indian tribal programs and CBO's to begin outreach to American Indian youth and their families related to teen pregnancy prevention using a comprehensive reproductive health model.

The Women's Health Policy Advisor is participating in a workgroup that is looking at best practices for youth in care and how to implement an effective curriculum among this population. This workgroup will also be examining how to prevent second pregnancies in teen parents.

c. Plan for the Coming Year

The Abstinence Education and Teen Pregnancy Prevention Programs will continue to identify underserved areas of the state and encourage education programming in those areas. Program will also identify target populations and underserved geographic areas with high rates of teen pregnancies and births that would benefit from prevention programs. The program will continue to examine the results from individual program evaluation reports as well as monitor the Abstinence Program Evaluation Study being conducted in Pinal County over the next 4 years. Program will use individual program evaluation data to assist with updating program content, implementation of interventions to improve positive outcomes with youth and parents. New research on innovative approaches regarding abstinence education services and teen pregnancy prevention will continue to be distributed to community providers.

The Women's Health Policy Advisor will participate on state agency Teen Pregnancy and STD workgroup, which will look at best practices for youth in care and how to implement an effective curriculum among this population. Group will also be examining how to prevent second pregnancies in teen parents.

The Teen Pregnancy Prevention (TPP) program plans to continue school and community comprehensive reproductive health outreach programming enhancement and development, through ongoing site visits, trainings, technical assistance sessions and follow-up. TPP plans to expand program services to encompass more of the native/indigenous tribes including the Navajo nation. TPP plans to work with county and community contractors to develop and expand parental involvement activities and education around comprehensive reproductive health education and awareness. The TPP plans to continue to work with existing contractors to modify their programs to enhance and develop safe and healthy summer activities to keep youth busy and thus less likely to become sexually active.

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	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	13	30	30	25	36.5
Annual Indicator	29	36.2	24	36.2	36.2
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	36.5	36.5	36.5	37	37

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

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

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 Office of Oral Health's Arizona Dental Sealant program uses the sealant indicator from data collected in Arizona every 5 years. Thus the measure is the same as reported in 2005: 25%. In 2006 the program expanded to an additional county thus providing dental sealants to 6 counties in schools with 65% or greater participation in the Free and Reduced Meal Program. The program provided dental screenings and referrals to 9,878 2nd and 6th grade children in 143 schools. Of those receiving a dental screening 7,920 children with no dental insurance or on Medicaid received dental sealants. The total number of dental sealants placed was 29,361. The Arizona Dental Sealant program manual was revised to include the new dental provider of Affiliated Practice Dental Hygienist. Training for these practitioners has taken place. Contracts must be in progress before this program can expand to another county. A new database for the program is still in testing stage and has not been completed for final implementation. When the new database comes live new data will be collected on how many children with special health care needs received dental sealants.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Office of Oral Health provides dental sealants to high risk children.	X			
2. The Office of Oral Health evaluates the dental sealant program.				X
3. The Office of Oral health collaborates with key stakeholders to expand services.				X
4. The Office of Oral Health plans open mouth surveillance for 2008.				X
5. The Office of Oral Health provides data on the dental sealant program to internal and external partners.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Office of Oral Health will continue to provide an excellent program to 6 counties, serve 8,200 high risk children and provide dental examinations and referrals to at least 9,000 high risk children. Implement Affiliated Practice Dental Hygienist to provide dental sealants in a new county and 2 existing counties. Implement a new delivery model that will promote a dental home for the children receiving dental sealants. A pilot will start this year where a community health center will provide the sealants to the surrounding geographically close schools. The dental screening will also provide a referral to the health center dental clinic. The program will also use a dentist doing a dental residency with the health center, in hopes of creating an understanding of the need for community dental services in a school setting and how to provide the dental care with portable dental equipment. The 2008 sealant indicator survey will be completed, which will be conducted in randomized selected schools through out Arizona. Data on how many children have dental sealants in the 3rd grade, and other selected data will be included in this survey. The Office will include a report on how many children with specials health care needs are served in the Arizona Dental Sealant program in sealant data.

c. Plan for the Coming Year
The Oral Health Program will continue to provide and expand the number of dental screenings, referrals and dental sealants to high-risk children. Collaborations and outreach to expand program to new service areas will continue. New delivery models for the dental sealant program will be evaluated for their cost effectiveness, and compared to the traditional delivery model. An open mouth surveillance will take place in 2008 to collect data on the number of 3rd grade children with dental sealants.

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	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	6.3	5.9	5.9	5	4.2
Annual Indicator	4.8	5.3	4.5	4.2	4.2
Numerator	59	67	58	56	
Denominator	1226721	1261764	1300444	1347557	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	4	4	3.8	3.5	3.5

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

Notes - 2005
Estimates for 2001 on reflect motor vehicle death rates for all children ages 0-14. Prior to 2001, estimates were based on ages 1-14.

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
As part of Arizona's effort to reduce the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children, the Community Health Services Program funded 7 car seat safety projects throughout the state. Through these programs 6,588 child car safety seats were installed with accompanying education for the self-installation of the child car seat by the caregiver/parent. 81 child car seat safety events were conducted, 80 new Child Passenger Safety Technicians were certified, at least one technician was certified as a trainer, and over 466 bicycle helmets were distributed along with helmet safety education. 599 high school students were provided with education regarding seat belt safety, crash dynamics, and dangers from drug and alcohol use while operating a motor vehicle. 2,535 infant car seats were checked in local communities for proper installation, wear, damage, or product recalls.

Newspaper advertisements on motor vehicle safety for pregnant women have been published in Native American newspapers. Periodicals using photographs of local tribal members and at least two radio Public Service Announcements focused on seat belt use by women have been aired in tribal communities. These advertisements have reached thousands of tribal members throughout the state. Over 3,000 brochures and 165 posters were distributed throughout the reservations in Arizona. A baseline survey of low-income families with children who are living on the reservation indicated that 88% of families had a car seat for their child, which is an increase of 3% compared to the previous year.
Health Start provided families with education on car seat safety and user training was offered to all participants. Parents were required to complete car seat training at each hospital before the discharge of their infant. Community Health Nurses and Lay Health Workers, many of whom are certified car seat technicians monitored car seat usage at each home visit.

The Arizona Child Fatality Review Program (CFR) provided data reports for research and presentations on preventing child deaths due to motor vehicle crashes in Arizona. Reports included data on child victims of fatal motor vehicle crashes, types of motorized vehicles involved with the fatal crashes, and factors such as use of passenger restraints, substance abuse, and age of driver. In 2006, the 13th Annual Child Fatality Report was produced, summarizing reviews of childhood deaths that occurred in Arizona in 2005. For the first time since its inception, the CFR Program reviewed 100% of childhood deaths. In 2005 there were 134 deaths of children in Arizona due to motor vehicle crashes. 68 victims were ages 14 years and younger. The most frequently noted contributing factors to motor vehicle crash deaths were lack of passenger restraints, inexperienced driver, and driving at an excessive speed. The report was used to support legislation introduced in the 2007 legislative session related to reduction of motor vehicle crash deaths including primary seat belt laws and enhancement of graduated driver's license laws. In 2006, the Child Fatality Review Teams began participating in the MCH National Center for Child Death Review data collection system. Additional information will be collected on each death and should enhance understanding of the circumstances surrounding motor vehicle crash deaths of children.
The County Prenatal Block Grant Program provided car seats and education. County Prenatal Block Grant staff sponsored car seat rodeos parents are educated on car seat safety and proper installation.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Helath Start Lay health Workers monitor car seat usage at every home visit	X			
2. Health Start Lay Health Workers educate about car safety in the home language of the family.	X			
3. Multiple programs provide child car seat safety education and teach correct self-instalation of the car seat.		X		
4. Community Health Services contractors distribute bicycle helmets with safety education for children.		X		
5. Revise brochure on Child Fatality Review including recommendations to reduce MVC deaths.				X
6. The Child Fatality Review Program produces reports requested for research and campains to reduce MVC deaths of children.				X
7. The County Prenatal Block Grant funds training for car seat technicians.			X	
8. Multiple programs provide free car seats and training on installation of the seats.			X	

9. Data reports on injuries are provided to agencies/organizations for various requests.				X
10. A booster seat fact sheet was developed which included data on motor vehicle occupant injuries among 5-8 year olds as well as prevention steps to advocate for the booster seat legislation in Arizona.				X

b. Current Activities

County Prenatal Block Grant staff provide free inspections and installation of car seats to the public, and free training and car seats as incentives for clients to attend prenatal classes. The program funds staff training to become certified car seat technicians.

Child Fatality Review (CFR) Teams review circumstances surrounding motor vehicle crashes. The CFR program will produce the 14th annual report on statistical trends and recommendations for prevention of child fatalities, including those due to motor vehicle crashes. CFR staff will continue to provide TA to local teams in the development and implementation of local culturally sensitive teams, and will identify and promote campaigns to educate the public on preventing fatal motor vehicle crashes.

Health Start provides families with education on car seat safety. Prior to taking their infant home the discharging hospital trains parents on car seat safety. Parents are assisted 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.

Community Health Services funds 4 car safety programs to reduce MVC fatalities, with an emphasis on child car and booster seats. Attempts are being made to attract ethnic groups that are at higher risk by using methods that are attractive specifically to those populations. Contractors continue to try and find car safety seat donations to extend the services they provide

c. Plan for the Coming Year

Through the Community Health Services Program, a total of four car safety programs were funded during 2007, and will continue to receive funding in 2008. The major focus of each program will be to reduce the number of women and children killed in motor vehicle crashes, with a special emphasis on child car safety seats and booster seats. Contractors will continue with their current programs through December 31, 2008, but will adjust their objectives as needed to meet their selected outcomes. Their programs will be continuously reviewed and adjusted as needed to accomplish the selected objectives. In addition, attempts will be made by the program to attract ethnic groups that are less likely to use child car safety seats by using methods that are attractive specifically to those populations.

Health Start 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, and 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, with education provided in Spanish or English, as appropriate.

The Child Fatality Review (CFR) program will continue to review the deaths of all children to identify preventable factors and for surveillance of causes and circumstances surrounding motor vehicle crash deaths of children in Arizona. The CFR staff will continue to provide technical assistance to the local child fatality teams in the development and implementation of local culturally sensitive teams, and will identify and promote campaigns to educate the public on preventing childhood deaths. The 15th Annual Child Fatality Report will be produced and will include information on the incidence and causes of MVC deaths of children and

recommendations to prevent motor vehicle

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

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	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective					38
Annual Indicator				37.6	36.8
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	38	38.5	39	39	39

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

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

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

a. Last Year's Accomplishments
The High Risk Perinatal Program (HRPP) contracts with all Neonatal Intensive Care Units (NICU) throughout the state. Each NICU has a lactation consultant available to help encourage and support breastfeeding. When mothers are discharged they can contact the NICU with concerns about breastfeeding. During follow-up home visits the HRPP Community Health Nurses (CHN) also 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. All three of the BWCH Hot Line staff are Certified Lactation Consultants, and are bilingual in Spanish and English.

The Office of Chronic Disease Prevention and Nutrition Services (OCDPNS) created a statewide coalition called LATCH-AZ, which aims to serve as an umbrella coalition to bring together breastfeeding advocates with the WIC community and provide educational and networking opportunities. ADHS provided training and technical assistance to Hotline staff to enhance

services provided to callers. The breastfeeding pump loan program continued through WIC. A one-day training on breastfeeding the 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, targeted at WIC breastfeeding mothers and Arizona businesses. Funding was awarded to four WIC agencies to begin breastfeeding peer counseling programs. Additional breast pumps have been purchased for the breast pump loan program through WIC so that wait lists can be avoided. Promotion of worksite lactation policies were supported by the Breastfeeding Coordinator and the website developed during the social marketing campaign. The Health Start program received breastfeeding training at their annual meeting.

The County Prenatal Block Grant Program documented that 700 women statewide have received information and supportive services from certified lactation counselors in the hospital and follow-up after discharge. Maternal Child Health programs have funded the training of health workers to Certified Lactation Counselors through the County Prenatal Block Grant.

The Special License Midwifery Program licenses midwifes who provide services in Arizona. During 2006, this program received reports regarding 388 births attended by licensed midwives. These midwives provide education and literature to pregnant mothers regarding the importance of breast-feeding their infants. They also follow up with the mother at her post partum visits with teaching and additional support to help the mother when she is having difficulty with her baby.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. A pump loan program is available for WIC participants.				X
2. WIC conducts free lactation education and networking events, and provides scholarships for training.				X
3. Continue the IBCLC and bilingual certified lactation consultants 24 hour service to the breastfeeding hotline.				X
4. WIC provides technical assistance to AZ buisnessess to develop and promote breastfeeding policies in the workplace.				X
5. Community Health Nurses for the Newborn Intensive Care Program assist with breastfeeding concerns.	X			
6. Health Start Lay Health Workers teach breastfeeding classes and assist mothers with breastfeeding post partum.	X			
7. Every Newborn Intensive Care Unit has a lactation consultant available.	X			
8. The Special License Midwifery program provides education to midwives about screenings, breast feeding and resources available.		X		
9. The County Prenatal Block Grant continues to train and utilize certified lactation counselors in program services.			X	
10. The County Prenatal Block Grant program incorporates breastfeeding education into prenatal classes and is increasing the numbers of County Prenatal Block Grant staff to be trained in breastfeeding education.			X	

b. Current Activities

LATCH-AZ is a coalition of breastfeeding advocates and providing educational and networking opportunities. LATCH-AZ holds quarterly free lactation education events. The Breastfeeding Coordinator provides support and materials to Breastfeeding Hotline staff, continues to assess

and recommend training for WIC and MCH breastfeeding counselors, and coordinates training opportunities for partners. The breast pump loan program continues to service local WIC agencies. Formative research will be gathered to develop a breastfeeding duration social marketing campaign. Funding for an additional breastfeeding peer counseling program was 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 policy serving as a model.

Some County Prenatal Block Grant program contractors are forming coalitions with local businesses to encourage breastfeeding in the workplace. Several counties are developing a tracking system to determine how many women continue to breastfeed for the first six months.

The HRPP contracted with all NICUs throughout the state. Each NICU has a lactation consultant available to encourage and support breastfeeding. During home visits HRPP Community Health Nurses support the mother with breastfeeding. Health Start Lay Health Workers teach breastfeeding classes before delivery and follow mothers' breastfeeding progress after delivery.

c. Plan for the Coming Year

Through the Office of Chronic Disease Prevention and Nutrition Services, the ADHS 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. Formative research will be gathered to develop a breastfeeding duration social marketing campaign. Funding for an additional breastfeeding peer counseling program was released, and peer counseling services will be provided through selected local WIC agencies. Employee breastfeeding policies will continue to be promoted to Arizona businesses, and the ADHS breastfeeding policy will serve as a model.

The County Prenatal Block Grant program will continue to incorporate breastfeeding education in prenatal classes, and will develop a valid tracking system to determine breastfeeding retention among postpartum women. The program will continue to train and utilize certified lactation counselors in program services, and will tracking postpartum women to determine if they are continuing to breastfeed for the first six months.

The High Risk Perinatal Program will continue to contract with all NICUs throughout the state. Each NICU will have at least one lactation consultant available to help encourage and support breastfeeding. When mothers are discharged they will be able to 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. All three of the BWCH Hot Line Human Services Specialists are Certified Lactation Consultants, and are bilingual. The Hot Line will continue to provide 24/7 breastfeeding support manned during the day by the Hot Line staff and after work hours by an International Board Certified Lactation Consultant (IBCLC).

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	2002	2003	2004	2005	2006

Annual Performance Objective	85	98	98	98.5	98.8
Annual Indicator	97.9	98.0	98.3	98.2	96.3
Numerator	85368	89233	96876	94750	98363
Denominator	87200	91054	98551	96487	102095
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	97	97	98	98	99

Notes - 2006
The rates of newborn hearing screening from previous years were based on a combination of reported screen results and inferred rates from non-reporting screening sites. Due to the promulgation of rule this year, requiring providers to report newborn hearing screening results, the newborn hearing screening rate for 2006 is based on actual reported data from all birthing hospitals.
Newborn Screening Rules were approved in April 2006. Two of the 47 birthing hospitals began reporting after the rules had been approved. Two hospitals began birthing services during 2006. Of the 47 hospitals 102,095 babies were born (Vital Records) and 98,363 were screened before discharge (HI*Track).

Notes - 2005
The data reported are estimated based on 44 out of 46 birthing hospitals. While all 46 birthing hospitals have universal screening programs, reporting to the ADHS is voluntary, and not all report. Among the 88,150 births at these 44 hospitals, 86,604, or 98.2% were screened. The best estimate of the numerator for this measure on a statewide basis is 98.2% of all births: 96,487 x .982 = 94,750.

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 49 hospitals in Arizona admitting newborns (all birthing or pediatric hospitals) now voluntarily perform newborn hearing screening. In 2006, with the adoption of Arizona Administrative Code R9-13-201-208, all providers performing newborn hearing screening or subsequent tests were required to provide the Arizona Department of Health Services (ADHS) with test results. All hospitals began reporting screen results weekly, allowing the ADHS to maintain a centralized database of newborn and infant hearing test results and provide timely follow-up services. Hearing screening follow up protocols were developed and used for state-wide follow up services. An assessment of availability of audiology and otology services in Arizona was completed. Referral tools and educational materials were created for providers and families. Loss to follow up at one month of age was reduced from 60% to 40%. The number of newborns referred for further testing was reduced from 6% to 4%. This reduction brings the state average of referrals to a nationally accepted refer rate.

ADHS is participating in a National Initiative for Children's Healthcare Quality Learning

Collaborative to improve follow up to newborn hearing screening by working through the medical home. The team has been assembled and has completed the initial planning stage. Small tests of change have been initiated for communication between screening program, the audiologist and medical home.

Collaboration with state Medicaid program (Arizona Health Care Cost Containment) led to a change in published performance standards for periodic hearing screening in newborns and infants. The revised standards reflect ADHS program goals and national initiatives. Three community health centers in rural Arizona received grants from the ADHS to initiate newborn hearing screening.

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

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

In addition to Newborn Hearing Screening, Arizona conducts hearing screening in schools. The Arizona Legislature has mandated hearing screening for children in all Arizona schools, including all public schools, accommodation schools, charter schools, pre-schools and private schools. 752,965 children were screened in the 2005-2006 school year. Of those, over 2,000 were identified for the first time as deaf or hard of hearing. Arizona Hearing Screening Rules require that all hearing trainers and screeners must be trained using a curriculum approved by the Arizona Department of Health Services. The Sensory Program contracts with the University of Arizona to develop the training curriculum and hold two training institutes per year. The numbers of trained and qualified screeners went from 548 in the 2002-2003 school year to 4,652 in the 2005-2006 school year.

The Sensory Program purchases and loans audiometers to schools so that they may provide hearing screening to Arizona children. Previously, there were two locations in the state for schools to pick up equipment. During 2005-2006, an additional location (Flagstaff) was added.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Newborn Hearing Screening Program is improving communications at referral points for infants with possible hearing loss.				X
2. The Newborn Hearing Screening Program provides technical assistance to hospitals and providers in newborn hearing screening and reporting.				X
3. The Newborn Hearing Screening Program provides follow up services to newborns and infants with possible hearing loss.		X		
4. The Newborn Hearing Screening Program is enhancing the newborn hearing screening case management database for improved program evaluation.				X
5.				
6.				
7.				
8.				
9.				

10.				

b. Current Activities
The Newborn Hearing Screening program is facilitating program changes based on findings of performance improvement tests through participation in the NICHQ Learning Collaborative. The program is implementing the data transfer from hearing screening database to newborn screening case management database for improved ability to access current demographic and provider information. The Arizona Department of Health Services 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 of newborns and infants identified as not passing the newborn hearing screen and not accessing follow up services of rescreening, audiologic evaluation, and early intervention will be performed. An analysis of barriers to follow up and plan to decrease loss to follow up will be prepared. The program is facilitating the integration of hearing screening and testing prompts in Medicaid documentation tools.

The Special License Midwifery program is teaching 51 midwives what the law specifies related to both newborn screening and hearing testing for the mother and her new baby. The program will continue to review the quarterly report form for statistical data related to screenings.

c. Plan for the Coming Year
The Newborn Hearing Screening Program will improve percentage of infants with congenital hearing loss meeting national screen, diagnosis, and intervention milestones. The program will provide education to providers, families, and the general public related to the importance of infants with congenital hearing loss to meet national screen, diagnosis, and intervention milestones. The program will provide tools for providers and families to promote smooth transition between provider groups.

The Special License Midwifery Program will continue rules revisions for updates related to newborn screening needs, and will review of quarterly report forms for determining needs for teaching of the midwifery community.

In addition to newborn hearing screening, Arizona also screens children of school age for hearing and vision. The Sensory Program will continue to monitor the number of children in Arizona schools that receive hearing and vision screening via school data reports submitted to the Sensory Program. Program staff will continue to research new schools to educate regarding the Hearing Screening Rules requirements. The program will continue to insure that students will receive hearing screenings by qualified hearing screeners according the Hearing Screening Rules. The program will purchase additional hearing screening equipment to accommodate the increased number of participating schools. The program will continue to provide updates on programs, mandates and T3 Trainings through the publishing of a bi-annual Sensory Newsletter that is sent to all schools and trainers that are on the Sensory Database. The program will continue to loan audiometers to schools so that they may provide hearing screening to children. The Sensory program has contracted with the University of Arizona to conduct two Vision Screening Train the Trainer seminars in the 2007-2008 school year.

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	2002	2003	2004	2005	2006

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

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

Notes - 2005
Data source is http://www.census.gov/hhes/hlthins/historic/hihistt5.html.

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

a. Last Year's Accomplishments
To identify children without health insurance and facilitate obtaining coverage, the High Risk Perinatal Program and Health Start Program assessed the health insurance status of each client throughout program enrollment. Families were educated on the importance of establishing and maintaining a medical home and assisted in overcoming barriers to accessing health care. The BWCH Hotline staff assisted callers with finding health care in their communities.

To address the issue of children without health insurance on a broader level, the Bureau of Women's and Children's Health funded a study to assess the impact of proposed premium increases in KidsCare (SCHIP) on enrolled families. The results showed that increased premiums have a negative affect on retention and enrollment, especially for families in the lowest income categories. The report was distributed by the Children's Action Alliance to child advocacy organizations around the state to use to inform partners and the legislature.

In 2006, 122 children who did not have medical insurance were assessed in their individual schools and referred to providers for medical and/or dental care by the Community Health Services Program. The children's parents were assisted with filling out the appropriate forms to obtain medical insurance for their children. The Mohave County program coordinator educated the school nurses as to what services and programs were available for children that do not have health insurance. The coordinator also created a list of physicians and dentists who were willing to provide services at reduced or no cost.

The Medical Home Project (MHP) continued to link uninsured children that do not qualify for AHCCCS with medical providers. The MHP is available in seven out of 15 counties in Arizona. In 2006, the Medical Home Project made 321 referrals to primary care physicians and 239 referrals to specialists were made for school age children and younger siblings of school age children. Each year, the number of specialist referrals through the MHP has increased. This reflects the higher level of care provided through the MHP. Services provided through the MHP included 52 eyeglasses; 85 diagnostic laboratory services, and 260 prescription medications. The Medical Home Project has 81 primary care physicians providing acute care services, seven

physicians providing a true medical home, 57 specialty physicians and 859 referral sources. Wherever possible, Spanish-speaking families are referred to bilingual physician's offices. All written materials about this program are available in both English and Spanish.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Office of Women's and Children's Health conducted to assess the impact of proposed premium increases in KidsCare (SCHIP) on enrolled families, analyzed findings and disseminated the report.				X
2. The High Risk Perinatal and Health Start programs educate families on the importance of establishing and maintaining a medical home.	X			
3. The High Risk Perinatal and Health Start programs provide training and updates on available public insurance plans.	X			
4. The High Risk Perinatal and Health Start programs assist families to overcome barriers to health care.	X			
5. The Medical Home Project provides uninsured children with health care services.				X
6. The Medical Home Project screens children for AHCCCS eligibility and refer them as appropriate.				X
7. The Office of Oral Health supports a safetynet for uninsured children by providing a referral service for low or no cost care.				X
8.				
9.				
10.				

b. Current Activities

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

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

c. Plan for the Coming Year

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

The Medical Home Project will continue to link uninsured children that 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 Medical Home Project. The goal will also be to continue to increase the number of children who receive a true medical home from the Medical

The Office of Oral Health will continue to investigate alternatives to improve access to care issues. Education of dental providers for dental care for children with special health care needs will continue as a collaboration with A.T. Still, School of Dentistry and Oral Health. Training and technical assistance will continue to non-dental providers on applying fluoride varnish and dental screenings.

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	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective					35
Annual Indicator				35.1	35.6
Numerator				31345	31537
Denominator				89325	88620
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	35	34.5	34.5	34.5	34

a. Last Year's Accomplishments

The Maternal Child Health (MCH) program of the Office of Chronic Disease Prevention Services provided prevention messages for the Arizona Health Care Cost Containment System (Medicaid) managed care newsletters and developed guidelines for nutrition interventions. The guidelines for interventions are based on a promising practice model which divides BMI into three tiers. Based on this model, nutrition intervention and behavioral modification are recommended for individuals above the 75th percentile for BMI. This model incorporates behavioral, nutritional, and physical activity components into their interventions. The project is currently being evaluated and will be retooled.

The goal of the Nutrition and Physical Activity Self Assessment for Child Care (NAP SACC) project is to promote healthy eating and physical activity in young children by assessing and implementing changes in policy, environment, and communication in child care settings. Our goal is to create the infrastructure to support NAP SACC and empower Arizona childcare centers to create a foundation for healthy lifestyles for all children in Arizona. NAP SACC currently is a cross county intervention for the Steps to a Healthier Arizona Initiative composed of Yuma, Santa Cruz, Cochise Counties and the Tohono O'odham Tribe. The plans for expansion across the state are a long-term goal. Governor's School Readiness Committee is involved in the discussions around the Early Childhood Development and Health Initiative. The Initiative will be funding regional partnerships to develop a plan for meet the communities needs around early childhood development and health. The pilot intervention began in May 2005 and will concluded

in June 2006. Yuma County has seventeen pre-school/child care/day care centers participating in NAP SACC. Thirteen centers have completed the NAP-SACC self-assessment. Twelve centers have developed an Action Plan. Three Child Care Centers have scheduled their initial assessments within the next year. ADHS Nutrition and Physical Activity Program and MCH Nutrition Staff are Child Care Health Consultants who 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 acceptance of the program is very good with clients requesting to participate in the classes. The Arizona State WIC program has added 13 more 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.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The WIC program provides training for the STEP communities for obesity reduction.	X			
2. The WIC program continues to implement NAPSACC statewide.				X
3. The WIC program will continue Fit WIC programs.	X			
4. The WIC program provides overweight resources to health care providers in Arizona.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The goal of the Nutrition and Physical Activity Self Assessment for Child Care (NAP SACC) project is to promote healthy eating and physical activity in young children by assessing and implementing changes in policy, environment, and communication in child care settings. NAP SACC is currently is a cross county intervention for the Steps to a Healthier Arizona Initiative composed of three counties, with plans for expansion across the state a long term goal.

Growing a Healthy Child-Taking Action Together conference was a combined meeting of WIC, Food Stamp education, Nutrition and Physical Activity Program and MCH programs. The workshop goal was to increase the proportion of children, adolescents and adults who are at a healthy weight. A community action plan was developed, and a follow up survey will be sent to the community in July 07.

The Healthy Eating TV spot began airing statewide. The integrated marketing campaign includes Arizona Nutrition Network , Women, Infants and Children Program , and Nutrition and Physical Activity Program, with materials distributed through programs. The new look of the eatwellbewell website was launched. It includes new graphics; games; and better nutrition and physical activity information for parents, kids, and partners. The Arizona Health Care Cost Containment System Childhood Obesity Prevention Model's guidelines for nutrition intervention were developed and now posted on the ADHS website.

c. Plan for the Coming Year
The Maternal Child Health Program of the Office of Chronic Disease Prevention and Nutrition Services will continue to provide technical assistance for the AHCCCS Childhood Obesity, Prevention Program and the Governor's Council on School Readiness. Program staff will attend the Governor's Council on School Readiness and help address nutrition and physical activity issues in Arizona. Arizona State WIC program will develop lesson plans for FIT WIC and distribute to the local agencies at the bi monthly meetings. The OCDPNS will develop resources to assist Health Care Providers in Arizona in counseling and referring children to overweight prevention programs.

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	2002	2003	2004	2005	2006
Annual Performance Objective					5
Annual Indicator				5.4	5.1
Numerator				5128	5225
Denominator				95798	102042
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	5	4.5	4.2	4	4

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

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

a. Last Year's Accomplishments
Prenatal classes funded by the County Prenatal Block Grant Program include information, education and referrals to Tobacco Prevention programs. Program contractors conducted assessments when clients presented for pregnancy tests. Clients were provided with information on smoking cessation and the impact of smoking on birth outcomes.

The Special License Midwifery Program reviewed quarterly report forms for inclusion of education of the mother regarding importance of not using tobacco products. The program reviewed CEU information to ensure that midwives were educated on the dangers of using tobacco products

when pregnant.

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

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The County Prenatal Block Grant program includes education on the impact of tobacco use on birth outcomes in prenatal classes.			X	
2. The County Prenatal Block Grant program collaborates with smoking cessation programs to focus on pregnant women and preconception health.			X	
3. Bilingual Lay Health Workers for the Health Start program inform pregnant women of the effects of smoking on the infant.	X			
4. Bilingual Lay Health Workers for the Health Start program refer pregnant women to smoking cessation classes.	X			
5. Bilingual OWCH Hot Line staff refer interested mothers to ADHS Tobacco Education program.	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The County Prenatal Block Grant program collaborated with tobacco cessation programs to develop programs focusing on pregnancy and smoking. The program includes information regarding the impact of smoking on birth outcomes in prenatal care classes.
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 refers the mother for smoking cessation classes. Bilingual BWCH Hot Line staff refer pregnant women who are seeking smoking cessation information to the ADHS Tobacco Education and Prevention Program.

The Special License Midwifery program continues to review quarterly report forms of all births. The program determines what if any trends are occurring with the population related to tobacco use for pregnant mothers. The Special License Midwifery program issued 3 new licenses after testing which included questions on the dangers of smoking with a pregnancy.

c. Plan for the Coming Year

The County Prenatal Block Grant Program will continue to include information and education on impact of tobacco on birth outcome in prenatal classes. The program will develop courses related to preconceptual care that includes education on impact of tobacco on birth outcome in prenatal classes.

Health Start Lay Health Workers will continue to 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 BWCH Hot Line staff will continue to refer pregnant

women seeking smoking information to the ADHS Tobacco Education and Prevention Program.

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	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	16.7	16.4	16.4	9.5	11.5
Annual Indicator	9.9	9.7	11.8	14.1	14.1
Numerator	39	39	49	61	
Denominator	391964	403088	417019	431964	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	13.5	13	12	11	10

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

a. Last Year's Accomplishments
In 2006, the 13th Annual Child Fatality Report (CFR) was produced, summarizing reviews of childhood deaths that occurred in Arizona during 2005. For the first time since its inception, the CFR Program reviewed 100% of childhood deaths that occurred in Arizona. During 2006, CFR Teams reviewed circumstances surrounding suicides of 36 children that occurred in 2005. 23 of the suicide deaths were children 15 through 17 years, 13 children were 9 through 14 years. The most common method of suicide was hanging, followed by gunshot wounds, and poisoning. Recommendations in the annual report to reduce suicide deaths among youth included: expansion of programs that help parents, teachers, youth, and other members of the community recognize depression; expansion of accessible mental health services for children and adolescents; hotlines for youth in crisis promoted through media campaigns, schools, places of worship, and other community organizations; and expansion of substance abuse prevention programs in schools. In 2006 data reports on childhood deaths, including suicide, were provided to researchers, media, and community programs to enhance awareness on prevention of childhood deaths. The CFR Teams began participating in the MCH National Center for Child Death Review data collection system. Additional information will be collected on each death and should enhance understanding of the circumstances surrounding suicide deaths of children.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Child Fatality Review program produces an annual report that includes findings and reccomendations regarding suicides of children.				X
2. The Child Fatality Review program produces reports requested for research and campaigns to reduce suicides of				X

children.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In 2007 the Child Fatality Review (CFR) program continues 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 14th Annual Child Fatality Review Report in November, 2007. The report will include recommendations to reduce preventable deaths of children and data compiled through reviews of child fatalities that occurred in 2006. The Child Fatality Review staff will continue to provide technical assistance to the local child fatality teams in the development and implementation of local culturally sensitive teams, and will identify and promote campaigns to educate the public on preventing childhood deaths.

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

c. Plan for the Coming Year

Child Fatality Review program will continue to review the deaths of all children to identify preventable factors and for surveillance of causes and circumstances surrounding childhood suicides in Arizona. The Child Fatality Review staff will continue to provide technical assistance to the local child fatality teams in the development and implementation of local culturally sensitive teams, and will identify and promote campaigns to educate the public on preventing suicides of children. The 15th Annual Child Fatality Report will be produced and will include data on suicides and recommendations to prevent suicides of children.

In the Bureau of Women's and Children's 2006 -- 2010 strategic plan, one of the seven priority areas is to integrate mental health with general health care. The Office plans to conduct a provider survey to determine gaps in screening for mental health issues. Results of this survey will be used to facilitate the Bureau's efforts to integrate mental health with general health care.

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	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	80.5	81	81.5	82	82
Annual Indicator	77.6	80.1	81.6	77.6	77.6
Numerator	678	741	805	868	
Denominator	874	925	986	1119	
Check this box if you cannot report the numerator					

because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	82	82.5	83	83.5	84

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

Notes - 2005
The data source for this measures is birth certificate data for live births. Births in which the birth weight was recorded as being under 450 grams are excluded as a data quality measure, as it is unlikely that these records represent actual birth weights. Only facilities certified by the Arizona Perinatal Trust as level III facilities are included in the numerator. Banner Desert Samaritan became certified as a Level III on 10/1/02.

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 continued funding for a centralized Information and Referral Service hotline for providers. 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 perinatologist determines the availability of a bed, authorizes the transport, 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 ll Enhanced Qualification or Level lll centers. During FY 2006, 1,434 women received maternal transports to an appropriate level of care.

The Special License Midwifery Program reviewed quarterly report forms for 388 deliveries with follow up for any that resulted in need to transfer with a complicated birth, and reviewed medical records to ensure that midwifes followed the law related to delivery of low risk mothers in the home environment.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Special License Midwifery program reviews quarterly				X

report forms to ensure that women at risk for delivering a low birth weight infant are referred to the appropriate facility.				
2. The High Risk Perinatal Program transports at risk pregnant women to the appropriate level of care regarless of their ability to pay.	X	X		
3. The High Risk Perinatal Program ensures the public awareness of the availability of transport.	X			
4. THe High Risk Perinatal Program conducted a survey of perinatal providers to asses the knowledge of the program and experiences of the providers with the HRPP program.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

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 availablity 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 ll Enhanced Qualification or Level lll centers. BWCH contracts with the Arizona Perinatal Trust to collect, analyze, and distribute annual perinatal data comparing Arizona hospitals to national perinatal data. Staff within BWCH participate in the APT hospital certification process. The Program initiated a survey of perinatal providers to determine the level of knowledge and understanding of the perinatal transport system and to provide opportunities for education.

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. This line will continue to offer toll free consultation services by board certified perinatologists throughout Arizona to providers caring for pregnant women who present with risk factors. Providers will make one telephone call to be connected with a perinatologist. If a transfer is deemed necessary, the board certified perinatologist will determine the availability of a bed and authorize and provide medical direction for transport to an appropriate level of care regardless of the woman's ability to pay. The program will continue to fund all uncompensated care associated with the transport of high-risk pregnant women to Level ll enhanced Qualification or Level lll centers. The Program will educate physicians and Level ll and lower hospitals about the availability of the toll free consultation line based on the results of the perinatal provider survey.

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	2002	2003	2004	2005	2006
Annual Performance Objective	78	79	80	78	78
Annual Indicator	75.7	75.6	76.3	77.7	77.7

Numerator	66146	68632	71268	74453	
Denominator	87379	90783	93396	95798	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	79	79	80	80	80

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

a. Last Year's Accomplishments
The Health Start program utilizes Lay Health Workers who reflect the ethnic and socioeconomic makeup of the area to identify pregnant women within their community to facilitate early entry into prenatal care. In CY 2006, a comprehensive Health Start evaluation was conducted. This report included three measures to evaluate Health Start participant entry into prenatal care. Results showed that Health Start participants entered prenatal care earlier than the control group (matched on pertinent demographic and risk factors).

Through the County Prenatal Block Grant Program, 2,640 pregnant women received early assessments, education and direct services. 1,420 women participated in prenatal classes and demonstrated an overall average of 3% increase in knowledge regarding prenatal care, breastfeeding, nutrition, childbirth and parenting.

The WIC program will continue to screen pregnant women and refer them to prenatal care.

The BWCH Pregnancy and Breastfeeding Hotline prescreens pregnant women for eligibility into Baby Arizona (AHCCCS), thereby expediting the initiation of prenatal care. 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.

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 prenatal care.	X			
2. Bilingual Hotline staff prescreens women for eligibility for the Baby Arizona program to facilitate obtaining medicaid coverage and entry into prenatal care.	X			
3. Bilingual Hotline staff referrs to other providers offering sliding scale services if the woman is not eligible for Baby Arizona.	X			
4. The Office of Oral health promotes the importance of oral health before and during pregnancy.				X
5. The Office of Chronic Disease Prevention and Nutrition Services refers pregnant WIC participants for prenatal care.	X			

6. The County Prenatal Block Grant progam provides free pregnancy tests to women to identify them early and get them into prenatal care.			X	
7. The County Prenatal Block Grant program partners with other agencies for new referrals to get women into early prenatal care.			X	
8.				
9.				
10.				

b. Current Activities
The County Prenatal Block Grant staff partnered with agencies and providers, family planning and private providers in order to identify women who are early into their pregnancy. Program staff provided free pregnancy tests to identify as many women as possible who were pregnant and in their first trimester, who were then referred to prenatal care, offered prenatal classes and provided case management services.

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.

Health Start utilized Lay Health Workers to identify pregnant women within their community and facilitated early entry into prenatal care. Program evaluation demonstrated that Health Start participants enter prenatal care earlier than controls. The Pregnancy and Breastfeeding Hotline prescreens pregnant women for eligibility into Baby Arizona, which 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 not eligible the Hotline refers them to other providers in their area who offer sliding scale fees.

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

The Office of Chronic Disease Prevention Services promote the benefits of early entry into prenatal care. WIC participants will be referred and tracked, and new WIC staff will be trained to refer pregnant women for early prenatal care. WIC staff will regularly meet with AHCCCS MCH coordinators.

Health Start utilizes Lay Health Workers, who reflect the ethnic and socioeconomic makeup of the area will continue to identify pregnant women within their community and facilitate early entry into prenatal care. Program data will be collected and analyzed to determine the Program's success in addressing this measure.

The BWCH Pregnancy and Breastfeeding Hotline will continue to prescreen pregnant women for eligibility into Baby Arizona, thereby expediting the initiation of prenatal care. Baby Arizona is a program of participating obstetricians willing to enroll pregnant women into 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 will refer them to other providers in their area who offer sliding scale fees.

The Office of Oral Health (OOH) will expand efforts to educate health professionals on oral health

before, during and after regnancy, to improve access to oral care during pregnancy and thus 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, pregnancy and early childhood decay.

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	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	17.9	17.9	17.9	11	50
Annual Indicator	14.1	9.3	49.2	49.2	49.2
Numerator	41231	29610	126442		
Denominator	291862	319289	256879		
Is the Data Provisional or Final?				Provisional	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	50	51	51	51	51

Notes - 2006
Starting with the 2004 data point, the numerator is women at or below 200% FPL who received family planning services through Title V, TItle X, Title XIX, or 330/340 Federally Funded Community Health Centers. The denominator is women at or below 200% FPL who are fertile.

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

Notes - 2005
Starting with the 2004 data point, the numerator is women at or below 200% FPL who received family planning services through Title V, TItle X, Title XIX, or 330/340 Federally Funded Community Health Centers. The denominator is women at or below 200% FPL who are fertile.

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

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 that focused on women at or below 150% of the federal poverty level. In 2006, 6,222 women received initial or annual exam visits. Of those women, 98.5% were at or below 150% of the federal poverty level and received services at no charge. By age women served were: .5% age 14 and under, 10% age 15-17, 11% age 18-19, 24% age 20-24, 20% age 25-29, 17% age 30-34, 10.5% age 34-39, 5% age 40-44, 2% age 45 or above. All Reproductive Health/Family Planning Program contractors received one site monitoring visit with no contractual issues identified. The Reproductive Health/Family Planning Program collaborated with the Title X Arizona Family Planning Council (AFPC), sharing information and data for trending purposes and outcome studies. The Reproductive Health/Family Planning Program has provided ongoing technical assistance regarding policy changes, best practices and funding to all contractors. In response to a need expressed by the County contractors, the program allocated an extra $400,000 to offset the rising costs of contraceptives.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Family Planning Program contracts with county health departments to provide family plannin and reproductive health services.	X			
2. The Women's Health Coordinator will revise the Governor;s Commission recommendations regarding increasing access to family planning services.				X
3. The Office of Women's and Children's Health will partner with the Title X agency to conduct a family planning needs assessment.				X
4. The Women's Health Coordinator participates in the Arizona Rural Women's Health Initiative Council that also includes reproductive health and family planning services.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In addition to working with the county health departments, the Reproductive Health/Family Planning Program is providing funding to Maricopa Integrated Health Services in an effort to reach a more diverse population. The program will continue to focus on women at or below the 150% of the federal poverty level. The Program will host an annual contractors meeting where contractors will be able to share strategies, discuss goals and review new developments in reproductive health. The program will be working with contractors to improve access for low income clients to preconception care. As part of this goal, the Program is collaborating with the Office of Nutrition to provide folic acid to the clients at Family Planning Clinics.

The Women's Health Policy Advisor participated in revision of recommendations proposed by the Governor's Commission on the Health Status of Women and Families in Arizona. Focus relating to this indicator was examining ways to increase access to family planning services for low-income women.

c. Plan for the Coming Year
The initial plan of the Women's Health Policy Advisor was to conduct discussions with AHCCCS and ADHS to determine what data is available regarding utilization of the SOBRA program. Based on data obtained, the advisor will work with AHCCCS and ADHS to determine reasons for potential underutilization and tactics for improving utilization based on findings. The advisor will examine the issue of low-income women receiving family planning services within a social determinants model, determine next steps with the Commission, and complete activities accordingly. The advisor will continue participation in Arizona Rural Women's Health Initiative Council, including participation in development of a statewide action plan.

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

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

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

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					25
Annual Indicator			25.1	25.5	25.5
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	25	24.5	24.5	24	24

Notes - 2006
The YRBS report already provides the calculated percentage. The percent at risk was added to the percent overweight to get the total at-risk +overweight.

The YRBS report is done every two years. Therefore, the 2006 rate is set at the 2005 rate. The next report available will be for 2007.

Notes - 2005
The YRBS report already provides the calculated percentage. The percent at risk was added to the percent overweight to get the total at-risk +overweight.

Notes - 2004
The YRBS report already provides the calculated percentage. The percent at risk was added to the percent overweight to get the total at-risk +overweight.

The YRBS report is done every two years. Therefore, the 2004 rate is set at the 2003 rate. The next report will be for 2005.

a. Last Year's Accomplishments
One of the main goals of the Steps Across America Initiative is to reduce overweight and obesity in high school students. One strategy that the Office of Chronic Disease Prevention Services Steps Across Arizona Initiative employed to address this goal was to develop 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. 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. The ADE Steps School Coordinator conducted a train-the-trainer session to the contractors, subcontractors and relevant affiliated partners from the four Steps communities. The School Wellness Policy Mini-Grants provided four Local Educational Agency (LEAs) with $10,000 each to create and implement a local school wellness policy in response to the USDA federal mandate that all schools on the National School Lunch Program (NSLP) have a wellness policy in place by the 2006-2007 academic year that focuses nutrition and physical activity. Grant funds were used to create school health councils in each school to include a team of members such as principals, food service directors, teachers, school nurse, students, and all those whom are a part of impacting school health to drive the goal of achieving a healthy school environment. The Tools for Healthy Schools training and technical assistance to create their wellness policy was provided.

A Women's Health Programs was funded through the Community Health Services program. This program was established to improve the health of women of child bearing age by increasing physical activity, maintaining a healthy weight, and improving diet by consuming at least five fruits and vegetables a day. An example of one
improvement in physical activity was demonstrated by an average increase in daily steps, measured by pedometers, of more than 2,500 steps. 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. Having a culturally sensitive approach has been a great asset to the success of the women's health programs that serve this population. Establishing programs to include the ethnic food 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.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Office of Chronic Disease Prevention and Nutrition Services will increase the number of high schools that adopt the Arizona Helathy School environment Model.				X
2. The Office of Chronic Disease Prevention and Nutrition Services will increase the number of high school districts that create and implement a local school wellness policy.				X
3. The Coummunity Health Services program funds a program that focuses on the health of women of childbearing age and children, by increasing physical activity and fruit and vegetable consumption and maintaining a healthy weight.				X
4. Office of Women's and Children's Health staff participate in the Arizona Healthy Weight Learning Collaborative that focuses on women of childbearing age.				X
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities
The School Wellness Policy Mini-Grants are providing funding to 4 Local Educational Agency to create and implement a school wellness policy in response to the USDA federal mandate that all schools on the National School Lunch Program (NSLP) have a wellness policy in place by the 2006-2007 academic year that focuses nutrition and physical activity. Grant funds are used to create school health councils in each school to include a team of members such as principals, food service directors, teachers, school nurse, students, and all those whom are a part of impacting school health to drive the goal of achieving a healthy school environment.

The Arizona Department of Education Steps School Health Coordinator continues to provide training and technical assistance as needed to schools that have received School Health Index training and the school health coordinators from the local Steps programs. Schools are working with their local districts to develop their School Wellness Policies through School Wellness Committees. Five school districts in Arizona Steps communities are receiving Steps funds to provide additional support for the development of the School Wellness Policies.

Through the Community Health Services Program, five health programs will be funded, with the major focus of each program is to reduce obesity and overweight among women and children by encouraging clients to achieve and maintain a healthy weight through improvements in nutrition and physical activity.

c. Plan for the Coming Year
The Maternal Child Health program of the Office of Chronic Disease Prevention Services will partner with Action for Healthy Kids to promote nutrition and physical activity in schools, which will include a Wellness Policy Evaluation conference and coordinate School Health outreach. The Steps School Health Coordinator will continue to promote school health councils / committees and will remain 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. The Program will increase the number of high schools districts that create, and will implement and evaluate local school wellness policies.

Through the Community Health Services Program, 5 Women's and Children's Health Programs were funded during 2007, and will continue to receive funding in 2008. The major focus of each program will be to reduce obesity and overweight among women and children. Programs will be designed to improve the health of women of childbearing age. Clients will be encouraged to achieve and maintain a healthy weight through improvements in nutrition and physical activity, to reduce their experience of having "a lot" of stress, substance use/abuse and smoking, as well as deaths caused by motor vehicle accidents. By improving the health status of women in child bearing years, it is believed that infant birth weights will be directly affected and increase. These programs will also directly affect and improve the health of children. Each will promote increasing physical activity, maintaining a healthy weight, and improving diet by consuming at least 5 fruits and vegetables a day. Having a culturally sensitive approach will continue to be a great asset to the success of the women's and children's health programs. Establishing programs to include the ethnic food 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.

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	2002	2003	2004	2005	2006
Annual Performance Objective					33
Annual Indicator			33.9	33.2	25.8
Numerator			248	251	191
Denominator			732	756	739
Is the Data Provisional or Final?				Final	Final
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	32.5	32	31.5	31	31

Notes - 2006
Data provided is for the 2004 birth cohort, which is the most recent data available.

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

Notes - 2004
Data provided is for the 2002 birth cohort, which is the most recent data available.

a. Last Year's Accomplishments
In 2006, the Bureau of Women's and Children's Health updated the Perinatal Periods of Risk (PPOR) analysis to guide prevention efforts in the area of infant and fetal deaths. This analysis demonstrated that, for the state as a whole, approximately 1/3 of feto-infant deaths are preventable. Excess infant deaths are fairly evenly divided among the maternal health/prematurity period, the maternal care period, and the infant health. The conclusion from the state-wide analysis is that, in order to reduce preventable infant mortality, our prevention efforts should be focusing on preconception (and interconception) care, prenatal care, safe sleep, breastfeeding, and other interventions that are proven to be successful during these three periods. However, subgroup analysis showed that some populations have different patterns of excess infant death than the state as a whole. For instance, in the African American population, the period with the highest excess death rate is the maternal health/prematurity period (4.3 per 1,000 fetal deaths and live births) while in the American Indian population, the period with the highest excess death rate is the infant health period (2.5 per 1,000). In addition to being used to guide prevention efforts within the Department, the results of these analyses were shared with stakeholders and partners to encourage them to utilize the information to guide prevention strategies. One of the outcomes of the PPOR analysis is that the Health Start program is moving towards a stronger emphasis on preconception and interconception care.

The Child Fatality Review (CFR) program provided copies of the Infant Death Checklist for investigations of unexplained infant deaths and a protocol for investigations of these deaths to law enforcement agencies throughout Arizona. Law enforcement in turn, submitted completed forms to the Medical Examiner's office and to the CFR program. These forms provide critical information regarding circumstances surrounding unexplained infant deaths. In 2006, CFR teams reviewed 100% of deaths of all children in Arizona, including infant deaths. Reviews determined the circumstances surrounding these deaths and identify preventable factors that may have contributed to the death. This data was analyzed for public policy and prevention campaigns. Data reports were provided to the public for research, media reports, and public health campaigns. The Unexplained Infant Death Council was staffed by the CFR Unit. The Council's purpose is to advise the department, legislature and governor on issues related to unexplained infant deaths and fetal deaths. In 2006 the Report on Incidence and Reported Causes of Stillbirth was produced. This report was presented to the Council. In 2006, the Citizen Review Panel reviewed 25 Child Protective Service's cases, including 12 involving maltreatment and death of

infants. The panel prepared an annual report of review findings and recommendations to improve the state's child protection system.

In 2006 the Bureau of Women's and Children's Health funded Prevent Child Abuse Arizona's Never Shake a Baby project to reproduce and distribute brochures, posters, and videos on shaken baby syndrome. This educational material was distributed to birthing hospitals and home visiting programs. The information was used to supplement educational efforts designed to educate parents on shaken baby syndrome and to teach parents how to manage a crying infant.

In 2006, The Arizona Birth Defects Monitoring Program (ABDMP) participated in four health fairs to promote the adequate intake of folic acid by women of childbearing age. The ABDMP also conducts statewide, population-based surveillance for 44 major categories of birth defects. Preliminary data for 2001-2003 shows a 6% decline in neural tube defect rates compared to 1998-2000 data (post-mandatory folic acid fortification). The rate of NTDs for 2001-2003 is 5.77 per 10,000 (preliminary data).

The Folic Acid Distribution Program of the Office of Chronic Disease Prevention Services provides a year supply of multivitamins with folic acid at no charge and served 7020 low-income women in 2005. Also, over 1650 women received ADHS's brochure "Baby In Your Future" for education. Folic Acid Education and Vitamin Distribution program served 20 different health centers (13 County Health Departments and 7 Community Health Centers) throughout the state.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Child Fatality Review program produces an annual report that includes findings and recommendations regarding infant deaths.				X
2. The Child Fatality Review program will enhance the website to include information and resources on preventing infant deaths.				X
3. The Child Fatality Review program produces an annual report of Citizen Review Panel activities and findings.				X
4. The Child Fatality Review program produces an annual report on the incidence and causes of fetal deaths.				X
5. The Child Fatality Review program will distribute the Infant Death Scene Checklist to law enforcement agencies and promote its use.				X
6. The Office of Chronic Disease Prevention and Nutrition Services continues a statewide folic acid distribution program.	X			
7. The Office of Chronic Disease Prevention and Nutrition Services will implement a health marketing program regarding the benefits of folic acid.	X		X	
8. The Prevent Child Abuse Arizona/Never Shake a Baby program will reproduce and distribute educational material on shaken baby syndrome.				X
9. The Arizona Birth Defects Registry participates in health fairs to provide folic acid education.			X	
10. The Arizona Birth Defects Registry conducts state-wide, active, population based birth defect surveillance for neural tube defects.			X	

b. Current Activities

The Perinatal Periods of Risk was updated to ensure that those working towards reducing preventable infant deaths understand the distribution and causes of excess infant deaths in Arizona.

The Folic Acid Education and Vitamin Distribution program is serving health centers throughout the state. The ABDMP is working with the Office of Chronic Disease Prevention to encourage all women of childbearing age to consume adequate amounts of folic acid daily for NTD prevention. The ABDMP is conducting statewide surveillance on NTDs to provide feedback on the effectiveness of prevention programs.

The Child Fatality Review program promotes the use of the Infant Death Checklist through distribution of the checklist to law enforcement agencies. Report findings were presented to the Maricopa County Medical Examiners Office, including trends related to reported causes of infant deaths. The Unexplained Infant Death Council continues to advise the department, legislature and governor on issues related to unexplained infant and fetal deaths. The Citizen Review Panel continues to review CPS cases, policies, and procedures and reports review findings and recommendations to improve the state's child protection system.

The Community Health Services Program funded four programs that reduce infant mortality in 2007, focusing on improving preconception health among women of childbearing age, which will include education about preconception health and maternal and newborn health care as well.

c. Plan for the Coming Year

The Bureau of Women's and Children's Health will continue to conduct an annual Perinatal Periods of Risk Analysis to provide guidance for preventable infant death interventions.

The Arizona Birth Defects Monitoring Program (ABDM) will continue to work with the Office of Chronic Disease Prevention and Nutrition to encourage all women of childbearing age to consume adequate amounts of folic acid daily for neural tube defect (NTD) prevention. The ABDMP will continue to participate in three or four health fairs a year where information will be provided to the public about the importance of folic acid for birth defect prevention. The ABDMP will also continue to conduct statewide surveillance on NTDs to provide feedback on the effectiveness of prevention programs in the state. By the end of 2008, the ABDMP will have complete NTD data for 2006 births.

The Child Fatality Review program will continue to review the deaths of all children, including infants, to identify preventable factors and for surveillance of causes and circumstances surrounding childhood deaths in Arizona. The program staff will continue to provide technical assistance to the local child fatality teams in the development and implementation of local culturally sensitive teams, and will identify and promote campaigns to educate the public on preventing infant deaths. The Unexpected Infant Death Council will provide recommendations to the department for enhancement of programs and public health messages to reduce incidence of fetal and infant deaths in Arizona. 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 15th Annual Child Fatality Report will be produced and will include information on prevention of infant deaths.

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

an folic acid education program.

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	2002	2003	2004	2005	2006
Annual Performance Objective					7478
Annual Indicator			7,478.6	7,174.4	7174.4
Numerator			90739	90201	
Denominator			1213314	1257269	
Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	7477	7477	7476	7476	7476

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

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

a. Last Year's Accomplishments
The Safe Kids Program purchased promotional materials that focus on the Safe Kids risks areas for distribution during Safe Kids week 2006 and EMS week 2006. Safe Kids AZ co-sponsored a child safety calendar with the Governor's Office of Highway Safety that was distributed statewide during the first half of 2006. Five child passenger safety courses were taught in partnership with Banner Health for the following AZ communities: Mesa, Hopi, Flagstaff, Peach Springs and White River. A one-day Child Passenger Safety refresher was held in July in Pinetop. The state coordinator chairs a subcommittee with Worldwide Buckle Up to determine journal articles applicability for technical CEU acceptance. The Safe Kids coordinator serves as an appointed position with the Governor's Traffic Safety Advisory Council. This Council held a legislative day in early January 2006, where Safe Kids information on booster seats and child passenger safety was offered. In addition, the coordinator is a member of the legislative subcommittee and school based issues subcommittee from this group. Safe Kids AZ participated with Walk Your Child to School day and was a Walk This Way grant recipient. An environmental modification was done at an AZ school that experienced a pedestrian death. Epidemiological data sheets that support local community efforts have been developed for communities to use to direct their activities and as support for grant opportunities.

Community Health Nurses of the High Risk Perinatal Program conduct environmental risk assessments on every home visit and Health Start 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, thereby reducing risks and ER visits.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Injury Prevention program continues to support				X

community child passenger safety trainings and events.				
2. The Injury Prevention program continues offer CEU's that will allow current CPS technicians to recertify.				X
3. The Injury Prevention program sponsors a pediatric symposium for EMS personnell.				X
4. High Risk Perinatal Program and Health Start program staff conduct Safe Home/Safe Child assessments at each home visit.	X			
5. The Injury Prevention program provides car seat checks and training on safe installation of car seats.	X	X		
6. A booster seat fact sheet was created, which included data on motor vehicle occupant injuries among 5-8 year olds as well as prevention steps to advocate for the booster seat legislation in Arizona.				X
7. The Community Health program provides free car seats and car seat education for parents.	X			
8. Data reports are provided to agencies/organizations for injury prevention efforts.				X
9. The County Prenatal Block Grant program conducts annual car seat rodeos where free car seats can be obtained, and parents are educated on the proper installation of car safety seats.	X			
10.				

b. Current Activities

High Risk Perinatal Program Community Health Nurses conduct environmental risk assessments at every home visit and Health Start 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, thereby reducing risks and ER visits.

The Injury Prevention program continues to support community child passenger safety trainings and events. The program offers continuing education that will allow current CPS technicians to recertify. The program creates fact sheets that will be sent to county health directors that illustrate injury in their counties. The program is providing sponsorship for the National Drowning Conference. The program will create a pedestrian fact sheet. The program is sponsoring a pediatric symposium for EMS personnel.

The Community Health Services funds a program to reduce the rate of injury among children in 2007. A major focus of the program is on reducing the rate of injuries among adolescents. Services are offered for women and children, as well as for adolescents. First-time mothers are provided with education and support about home and transportation safety during regular visits from a public health nurse. Adolescents are provided with education about healthy and abusive dating relationships.

c. Plan for the Coming Year

The Injury Epidemiologist will continue to provide data upon request to the injury prevention community so that interventions can be guided by data.

Health Start 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 Community Health Services funded a program to reduce the rate of injuries among children during 2007. The program will continue to receive funding in 2008. The major focus of the program will be to reduce the rate of injuries among adolescents. Yavapai County will continue with its current program through December 31, 2008, but will adjust its objectives as needed to meet the selected outcomes. The program will be continuously reviewed and adjusted as needed to accomplish the selected objectives.

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	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective					48
Annual Indicator			49.6	47.2	47.2
Numerator			62	60	
Denominator			125	127	
Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	48	47	47	46	46

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

Notes - 2005
Numerator is the number of Primary Care Area's (PCA's) with less than 74% of women giving birth receiving prenatal care in the first trimester. Denominator is the total number of PCA's in Arizona.

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. One of the main goals of this program is to ensure that women receive early prenatal care. These services are provided by women who are recruited from within the community, with the idea that these women will offer culturally appropriate serves to their 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.

Over 5,000 women were provided prenatal services in rural/medically underserved areas through the County Prenatal Block Grant Program. Rural counties utilize mobile clinics for women who have no or minimal transportation; immunization clinics that attract women who are at risk of getting pregnant; "diplomatically" approach high schools and develop teen pregnancy programs and teen mazes; provide Boot Camp for Dads as a module in prenatal classes; provide gifts as incentives to complete prenatal classes (ie., car seats, gift certificates, gift bags, etc.); collaborate with schools, private providers, agencies such as WIC, AHCCCS, Baby Arizona, police and fire

departments; interested private business and community members and groups. The CPBG's basic objective is to link services and build infrastructure that will insure accessibility to services. This is a major challenge and accomplishment for rural areas to market the CPBG programs and services and meet the needs of the target populations.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The High Risk Perinatal program and Health Start program both provide outreach to high risk pregnant women and children in underserved areas.	X			
2. The High Risk Perinatal program and Health Start program both offer services in appropriate languages.	X			
3. The County Prenatal Block Grant program sponsors public events to increase the awareness of services for women of childbearing age.			X	
4. The County Prenatal Block Grant program collaborates with other agencies such as Health Start and Healthy Families to idenfiy pregnant women.			X	
5. The County Prenatal Block Grant program supports mobil prenatal care clinics to make services accessible.			X	
6. The County Prenatal Block Grant program provides assistance to women to access prenatal care such as AHCCCS or WIC.			X	
7. The County Prenatal Block Grant program utilizes immunizations and pregnancy tests to identify pregnant women early in their pregnancies.			X	
8. The Women's Health Coordinator developed strategies and action steps to examine how to increase prenatal and preconception care.				X
9. The Women's Health Coordinator continues working to produce Arizona women's health calendar and distribute throughout the state			X	
10. The Women's Health Coordinator participates in the Arizona Rural Women's Health Initiative Council.				X

b. Current Activities

The Health Start Program contracts with agencies that provide serves to high risk pregnant women in communities that are designated as primary care areas and are also categorized as medically underserved.

The County Prenatal Block Grant employs multiple strategies to identify women as early as possible who are at risk of getting or being pregnant. The program provides funding for mobile clinics in rural areas where services are limited and/or transportation is a barrier to service.

The Women's Health Policy Advisor participated in the Governor's Commission on the Health Status of Women and Families in Arizona regarding the goal of increasing prenatal and pre-conception care for women in Arizona. The focus relating to this indicator was examining ways to increase access to family planning services for low-income women in Arizona. The advisor worked on a women's health calendar to be distributed statewide in the future that incorporates pre-conception health. The advisor also participated in the Arizona Rural Women's Health Initiative Council's to bring together stakeholders from rural areas to discuss rural women's health needs (including prenatal care, pre-conception care, family planning and domestic violence). The advisor connected Arizona Rural Women's Health Initiative Council with information from the

County Prenatal Block Grant as well as the Governor's Commission on the Health Status of Women and Children to determine how the Council might be able to address priorities

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

The County Prenatal Block Grant Program will improve documentation of when women enter prenatal care, increase contractors who provide mobile prenatal clinics in rural areas, and will continue current programs and services that identify women early into their pregnancies. The program will increase collaborations with other agencies and identify more private providers to educate them on available services.

To augment improvements in birth outcomes realized by early entry into prenatal care, Arizona Title V Block Grant partners are also increasingly addressing preconception care. The Women's Health Policy Advisor will ensure that pre-conception health is a focus of women's health week, and will continue working to produce Arizona women's health calendar and distribute throughout the state. The advisor will revisit strategies developed by the Governor's Commission and determine next steps. The advisor will collaborate with ADHS programs working on pre-conception health and determine how pre-conception health can be included in other ADHS Prevention Services Programs. The advisor will also continue working to produce Arizona women's health calendar and distribute throughout the state and continue participation in Arizona Rural Women's Health Initiative Council, including participation in development of a statewide action plan.

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	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective					43
Annual Indicator			42.6	42.6	30.9
Numerator				255983	170018
Denominator				600379	550768
Is the Data Provisional or Final?				Final	Final
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	43.5	44	44.5	44.5	44.5

Notes - 2004
Data for 2004 not available at this time.

a. Last Year's Accomplishments
In an effort to increase the percent of Medicaid enrollees age 1-18 who received at least one preventive dental service within the last year, a Dental Public Health Institute was held to discuss oral health disparities and solutions for local communities. Fact sheets on the dental health disparities continue to be disseminated to key stakeholders. Support for two new oral health coalitions in Mohave and Apache counties continues. Continued support to our local partners and dissemination of materials has been one strategy to promote oral health on the local level. Provided grant to Cochise County for dental facility from funds from State Appropriations. The first 6 months of this program provided dental care to 3 schools in Cochise County.

Through collaborations with the Arizona Dental association 18 dentists were trained on dental care for children with special health care needs. During this 2 day training, the dentists saw 91 patients with special health care needs. Also these dentists are recognized on the referral list as having training with this population, in hopes to improve access to dental care for this population. This training is being transferred to the ATStill School of Dentistry and Oral Health to ensure its sustainability.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Office of Oral Health will track AHCCCS utilization.				X
2. The Office of Oral Health supports and maintains dental trailers.	X	X		
3. The Office of Oral Health will coordinate the Dental Public Health Institute and will provide professional continuing education.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Office of Oral Health provides trainings to child care centers, WIC programs, Head /start programs and /community Health /centers on oral health and the importance of early intervention. The Office monitors AHCCCS Health Plans on policies for dental care and case management issues, collaborates with school based dental clinics to ensure success, and partners with private organizations and foundations to enhance preventive efforts. The Office promotes dental trailer program in underserved areas. The Office provides support to state funded dental facility for underserved areas, and supports dental health professionals to provide services in their area to improve access to oral care. Two programs being supported are the conference on policy development and another on the culture of poverty. The Office will continue to work with Arizona Dental Association and Dental Hygiene Association on improving the number of providers for the underserved.

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 continue to support dental schools, alternative providers to improve access to care issues and other new dental practice act initiatives. OOH will continue to support dental trailer program and the two new settings. OOH will continue building oral health infrastructure through local coalitions and aiding new start up oral health coalitions.

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	**2002**	**2003**	**2004**	**2005**	**2006**

Annual Performance Objective					24
Annual Indicator				12.0	77.4
Numerator				12	48
Denominator				100	62
Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	50	65	75	90	90

a. Last Year's Accomplishments

The Parent & Youth Leadership Curriculum was used for round table sessions at the "Breakthrough Learning" Summit hosted by Department of Economic Security. The summit was attended by 360 staff, community and family partners representing 20 DES community teams statewide.

Nine modules were developed as online pre training courses for the March 9th Community Development Initiative (CDI) one day Summit "Circles of Success, Communities of Strength". Six 15-member teams from 7 child serving state agencies participated. Each team included staff and family partners. The agencies represented were Department of Health Services, Governor's Office for Children Youth and Families, Juvenile Corrections, Department of Corrections, Health Care Cost Containment System, Department of Education and the Department of Economic Security. The online pre training prepared them on the basics of CDI that promoted participation and attainment of the learning outcomes. Fifty-eight parents and youth and 86 agency staff completed all 9 modules and reported they were easy to use and provided essential information. It included the CDI History, Elements of Community Development, Relationship Building, Service to Development, Taking Action, Parent Compensation, Family-Professional Partnerships, Job Description, and Lesson Plan Summary.

Tucson Community Action team presented a Train the Trainer day and trained 15 members of their team using lesson plans from the Curriculum on strategic planning, sustainability and community development.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. OCSHCN posts Parent youth Leadership Curriculum online in both English and Spanish.				X
2. OCSHCN posts a link to register and promote training on the OCSHCN website and the community action teams.				X
3. OCSHCN continues to develop training modules with its community partners and with input from families and youth.				X
4. OCSHCN contracts with RSK to hold focus groups and recruit families to participate in training and resource development committee.				X
5. OCSHCN shares training data with RSK for reporting family involvement.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The entire Parent Youth Leadership Curriculum is posted on the OCSHCN website in English and Spanish and is currently being modified into 33 online learning courses. The Learning Management System tracks individual participant's pre and post test results as well as issuing a certificate for completion of the courses. The link to register and promote the training will be posted on the OCSHCN website and the Arizona Community Action Teams website.

Some of the active modules are: Navigating Health Systems, Budgets & Financial Reporting, HIPAA, OCSHCN Overview, Building Strengths, Identify Community Capital, Decision Making, Cultural Competency, Elements of Community Development, Facilitation, Integrating: Spreading and Sharing the Work, Levels of Participation & Cycle Groups, Persuasive Speeches, Recognizing Mentoring Opportunities, Relationship Building, OCSHCN Roles and Expectations for Family and Youth Involvement Volunteers and Leaders, Running Effective Meetings, Self-Determination, Self-Esteem, Service vs. Development, Spreading the Word, Strategic Planning, Taking Action, Team Building, Logic Model, Communication & Partnership, Leadership, Mentoring, Writing a Job Description and Scope of Work.

OCSHCN has a contract with Raising Special Kids to recruit and coordinate activities for parent and youth participation in training, resource development, focus groups and committees.

c. Plan for the Coming Year

The CDI Steering Team, comprised of the 7 child serving agencies and Raising Special Kids, will be holding a Family Leadership Conference in November 2007 that promotes the Community Development Initiative and uses the Parent and Youth Leadership online training as a foundation for participants. All OCSHCN family and youth volunteers, partners and leaders will be required to develop a learning plan that details their plans for taking core modules related to their specific job duties. The Children's Rehabilitative Services Statewide Parent Action Council (SPAC) and Regional Parent Action Councils (PAC) will promote the use of existing modules and the development of future training modules. All of these on-line training modules will be available to anyone and will be shared with all state agency partners, families, youth and family organizations. Individuals will be able to self-register and use the curriculum to meet the specific needs of their organizations or work with us to modify the curriculum to meet parent and youth leadership needs.

OCSHCN plans to transition the tracking of parent and youth participation with state agencies in CDI activities to Raising Special Kids. We will provide data from our LMS for these reporting purposes. OCSHCN and Raising Special Kids (RSK) will partner to develop a Family Leadership Job Bank. The Family to Family Health Information Center (F2FHIC) will collaborate with their Parent To Parent staff, OCSHCN and, its community action teams and others to recruit families and youth for this leadership development experience, with particular emphasis on outreach to families of diverse language and culture, and those in rural and underserved areas. OCSHCN and RSK staff connections to the Native American and Hispanic communities will be an asset in recruitment efforts. Concurrently, the F2FHIC will work with state agencies and other community partners to develop opportunities for family and youth representation within their programs. RSK will create a system to match Institute graduates with leadership positions. To assist programs and successfully incorporate parent and youth leaders as full partners on boards and committees, the F2FHIC will also work with state CDI leaders to develop a Family Youth Involvement Manual (FYI). This manual will include strategies for involving families and youth in all aspects of decision-making within state agencies, including policymaking. The National Center for Family/Professional Partnerships for CYSHCN, KASA and national Family Voices network members are resources for this project.

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.

/2008/For the 2008 application year, Arizona is requesting technical assistance to assist with one of our state defined priorities. The Bureau of Women's and Children's Health would like assistance with integrating mental health with general health care./2008//

V. Budget Narrative

A. Expenditures

The state's match and overmatch continues to exceed the 1989 maintenance of effort.

The budgeted amounts are based on previous year's projections and do not correlate well with the actual budgeted amount because of the unpredictability of the actual award amount and program changes that occur.

/2007/There are no updates for this year//2007//

/2008/There are no updates for this year//2008//

B. Budget

In 1998, the Arizona Department of Health made the decision to transition the MCH budgeting cycle from a federal fiscal year to a calendar fiscal year. Consequently, the annual reporting of budgeted, encumbered, and expended monies through September 30th is misleading in that we actually have another three months remaining in our calendar year budget cycle so expenditures will appear less than they should be while remaining money will appear greater.

Arizona state funds (match and overmatch) will be $13,262,434 in FY2006, surpassing our state's maintenance of effort level in FY89 of $12,056,360./2007/Arizona state funds (match and overmatch) will be $13,032,329 in FY2007, surpassing our state's maintenance of effort level in FY89 of $12,056,360.//2007// ***/2008/Arizona state funds (match and overmatch) will be $16,879,160 in FY2008, surpassing our state's maintenance of effort level in FY89 of $12,056,360.//2008//***

The estimated Title V allocation for Arizona, FY2006, is $7,769,858. Slightly more than thirty-two percent ($2,512,683) of the block grant will be allocated for preventative and primary care needs for children and adolescents; thirty percent ($2,330,957) will be allocated to children with special health care needs; slightly
less than twenty-eight percent ($2,149,233) will be allocated for women, mothers and infants and ten percent ($776,985) will be budgeted for administrative costs./2007/The estimated Title V allocation for Arizona, FY2007, is $7,512,293. Slightly more than thirty percent ($2,286,514) of the block grant will be allocated for preventative and primary care needs for children and adolescents; thirty percent ($2,253,688) will be allocated to children with special health care needs; slightly less than thirty percent ($2,220,862) will be allocated for women, mothers and infants and ten percent ($751,229) will be budgeted for administrative costs.//2007// ***/2008/The estimated Title V allocation for Arizona, FY2008, is $7,255,120. Slightly more than thirty percent ($2,242,127) of the block grant will be allocated for preventative and primary care needs for children and adolescents; thirty percent ($2,176,536) will be allocated to children with special health care needs; slightly less than thirty percent ($2,110,945) will be allocated for women, mothers and infants and ten percent ($725,512) will be budgeted for administrative costs.//2008//***

We have another three months remaining in our calendar year budget cycle, so our remaining money will appear greater. It is projected that there will be $2,848,328 remaining as carry over from our FY2005 block grant in the following types of service: $1,170,788 for pregnant women, mothers and infants; $943,360 for preventative and primary care needs for children and adolescents; and $734,180 for children with special health care needs./2007/We have another three months remaining in our calendar year budget cycle, so our remaining money will appear greater. It is projected that there will be $2,861,375 remaining as carry over from our FY2006 block grant in the following types of service: $517,867 for pregnant women, mothers and infants; $467,312 for preventative and primary care needs for children and adolescents; and $1,876,196

for children with special health care needs.//2007// ***/2008/We have another three months remaining in our calendar year budget cycle, so our remaining money will appear greater. It is projected that there will be $1,618,200 remaining as carry over from our FY2007 block grant in the following types of service: $341,000 for pregnant women, mothers and infants; $402,000 for preventative and primary care needs for children and adolescents; and $875,200 for children with special health care needs.//2008//***

The state's maintenance of effort includes line-item funding for High Risk Perinatal Services, $3,630,600; a Perinatal block grant to all fifteen counties, $1,148,500; Children's Rehabilitation Services (CRS), $3,587,000; Adult Cystic Fibrosis and Sickle Cell Anemia Programs, $138,200; Child Fatality Review Program, $100,000; Prenatal Outreach Program (Health Start), $226,600 and Newborn Screening Program, $3,205,100. An additional $1,226,434 in state general funds is allocated to the Public Health Prevention Bureau and, in part, supports half of our personnel located in the Offices of the Bureau Chief, Women's and Children Health, Children With Special Health Care Needs and Oral Health and supplements above-the-line activities. Our state's FY2006 match and overmatch of $13,262,434 continues to exceed the maintenance of effort amount of FY1989's $12,056,360./2007/The state's maintenance of effort includes line item funding for High Risk Perinatal Services, $3,630,600; a Perinatal block grant to all fifteen counties, $1,148,500; Children's Rehabilitation Services (CRS), $3,587,000; Adult Cystic Fibrosis and Sickle Cell Anemia Programs, $138,200; Child Fatality Review Program, $100,000 and Newborn Screening Program, $3,727,900. An additional $700,129 in state general funds is allocated to the Public Health Prevention Bureau and, in part, supports half of our personnel located in the Offices of the Bureau Chief, Women's and Children Health, Children With Special Health Care Needs and Oral Health and supplements above-the-line activities. Our state's FY2007 match and overmatch of $13,032,329 continues to exceed the maintenance of effort amount of FY1989's $12,056,360.//2007// ***/2008/The state's maintenance of effort includes line item funding for High Risk Perinatal Services, $5,430,600; a Perinatal block grant to all fifteen counties, $1,148,500; Children's Rehabilitation Services (CRS), $3,587,000; Adult Cystic Fibrosis and Sickle Cell Anemia Programs, $138,200; Child Fatality Review Program, $100,000 and Newborn Screening Program, $5,597,796. An additional $877,064 in state general funds is allocated to the Public Health Prevention Bureau and, in part, supports half of our personnel located in the Offices of the Bureau Chief, Women's and Children Health, Children with Special Health Care Needs and Oral Health and supplements above-the-line activities. Our state's FY2007 match and overmatch of $16,879,160 continues to exceed the maintenance of effort amount of FY1989's $12,056,360.//2008//***

For fiscal year 2006, we will receive additional state and local funding as a result of our collaboration with other state government agencies and charitable foundations. The total of $20,187,058 is designated for Children's Rehabilitative Services, Teen Pregnancy Prevention and Abstinence Services, and the Prenatal Outreach Program (Health Start)./2007/For fiscal year 2007, we will receive additional state and local funding as a result of our collaboration with other state government agencies and charitable foundations. The total of $22,721,775 is designated for Children's Rehabilitative Services, Teen Pregnancy Prevention and Abstinence Services, and the Prenatal Outreach Program (Health Start).//2007// ***/2008/For fiscal year 2008, we will receive additional state and local funding as a result of our collaboration with other state government agencies and charitable foundations. The total of $28,991,313 is designated for Children's Rehabilitative Services, Teen Pregnancy Prevention and Abstinence Services, Pregnancy Services and the Prenatal Outreach Program (Health Start). //2008//***

Other federal funds in the amount of $57,926,638 represent matching funds from Title XIX and Title XXI for Children's Rehabilitative Services. Additional federal monies will contribute another $86,348,660 toward MCH initiatives which include the WIC food grant, $76,938,417; Universal Newborn Hearing, $149,970; Rape
Prevention and Education, $753,331; Family Violence Prevention, $1,685,611; SSDI Primary Care, $100,000; Abstinence Education, $1,034,776; Kids Care, $3,319,509; Arizona Early

Intervention, $500,000; Child Fatality Review, $148,000; Early Childhood Comprehensive Systems, $100,000 and $1,619,046 for the
Preventive Health and Health Services Block Grant. /2007/Other federal funds in the amount of $43,307,910 represent matching funds from Title XIX and Title XXI for Children's Rehabilitative Services. Additional federal monies will contribute another $84,785,126 toward MCH initiatives which include the WIC food grant, $74,254,722; Universal Newborn Hearing, $149,970; Rape Prevention and Education, $750,932; Family Violence Prevention, $1,665,286; Core State Injury Surveillance and Program Development, $120,000; Emergency Medical Service for Children, $114,999; SSDI Primary Care, $100,000; Abstinence Education, $1,034,776; Kids Care, $4,271,205; Spinal Head Injury, $237,500; Arizona Early Intervention, $580,647; Child Fatality Review, $148,000; Early Childhood Comprehensive Systems, $140,000 and $1,217,089 for the Preventive Health and Health Services Block Grant.//2007// ***/2008/Other federal funds in the amount of $49,574,056 represent matching funds from Title XIX and Title XXI for Children's Rehabilitative Services. Additional federal monies will contribute another $76,113,790 toward MCH initiatives which include the WIC food grant, $65,996,173; Universal Newborn Hearing, $149,970; Rape Prevention and Education, $711,008; Family Violence Prevention, $1,699,821; Core State Injury Surveillance and Program Development, $116,760; Emergency Medical Service for Children, $114,702; SSDI Primary Care, $94,644; Kids Care, $5,009,499; Spinal Head Injury, $286,846; Integrated Community Systems implementation, $429,278; Child Fatality Review, $148,000; Early Childhood Comprehensive Systems, $140,000 and $1,217,089 for the Preventive Health and Health Services Block Grant.//2008//***

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//

/2008/Core Public Health Infrastructure: $4,039,754

Office of Women's and Children's Health (Part A & B): $32,666 will support the Department's Office of Birth Defects; $594,781 will support management service; $62,041 will support information technology automation; $97,589 for the Assistant Director's Office for special projects; $493,174 for assessment, evaluation and epidemiologic analysis; $82,625 for Nutrition support; $106,170 for women's health initiatives; $544,455 for planning, education & partnership initiatives that include Community Grants and the Early Childhood Program; and $37,717 for Midwife Licensing.

Office of Children with Special Health Care Needs (Part C): $871,531 will support administrative initiatives; $689,350 for Community Development; and $427,655 for Quality Assurance and Utilization Review for the Children's Rehabilitation Services program.//2008//

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//

/2008/Population-Based Services: $593,128

$222,148 is budgeted for planning, education and partnership initiatives that include the Sensory Program and Community grants; $322,650 for Community development/services that include the Pregnancy and Breastfeeding Hotline Program and the High Risk Perinatal Services; and $48,330 for Immunizations.//2008//

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//

/2008/Enabling and Non-Health Support: $308,150

$308,150 will support planning, education and partnership initiatives that include the Medical Home Project and Community grants.//2008//

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//

/2008/Direct Health Care Service: $1,588,576

$188,000 will support community nursing services for high-risk infants; $500,576 for oral health services for children; and $900,000 for planning, education, and partnership initiatives that include the Reproductive Health Program.//2008//

Indirect Administrative Costs: $776,985
/2007/Indirect Administrative Costs: $751,229//2007//
/2008/Indirect Administrative Costs: $725,512//2008//

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.