

STATE TITLE V BLOCK GRANT NARRATIVE

STATE: AZ

APPLICATION YEAR: 2005

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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; published June, 2003; expires May 31, 2006.

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. During FY 02 the OWCH established the Partnership Initiative. An OWCH staff member is assigned as a partner to those agencies/entities and programs that the office should work closely with to better address the needs of the maternal and child population. The effort facilitates the ability to increase the impact on critical problems, reduce duplication, and integrate OWCH efforts with others who share the same goals. The assigned OWCH partner presents the updated outcome and performance measure data to their designated partner agencies. Input from the partners is solicited to identify emerging trends and critical community issues.

The OWCH and OCSHCN web sites are updated each year to reflect the new data. A link to the HRSA web site is included so that the viewer can access the entire Block Grant document.

II. NEEDS ASSESSMENT

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

Arizona continues to be one of the fastest growing states in the U.S. The Arizona Department of Commerce reports that Arizona is the second fastest growing state in the nation. Arizona's 2000 population was 5,130,632. The state population grew by approximately 1,465,404 an increase of 40 percent during the 1990s. The total population growth within the U.S. during that same time frame was 13.2 percent. /2003/ Arizona's 2001 population estimate = 5,307,331 (www.census.gov).

/2004/

Arizona's 2002 population estimate is 5,472,750. There were 1,157,231 women of childbearing age (age 15-44); 1,144,139 children age 1-14; and 391,964 adolescents age 15-19. Preliminary reports indicate that there were 87,200 births in 2002.

//2004//

/2005/

Arizona's population estimate for 2003 is 5,629,870; representing a growth rate of 9.7% since the April 2000 census, and making Arizona the second fastest growing state since the year 2000.

//2005//

Despite its reputation as a retirement center, Arizona's population is slightly younger than the national average. The state's median age is 34.4 while the nation's is 34.9 years. The median age for American Indians is relatively younger at 27 years, compared to the U.S. population. The proportion of people younger than 25, as well as those over 65, is roughly the same as the United States as a whole (www.azcommerce.com, 2000). /2003/ Arizona's median age for 2000 = 34.2; U. S. = 35.3 year (www.census.gov).

There are 15 counties in Arizona, each of which has seen a significant growth in total population from 1990 to 2000. Seventy-seven percent of the state's population resides in either Maricopa or Pima Counties. Maricopa County, with the largest population, experienced a growth of 44.8 percent in from 1990 to 2000, with a growth of 77,674 during 1999 alone. Only Los Angeles County growth outpaced Maricopa County in 1999. Projections indicate that Arizona will gain another two million residents by 2025.

/2003/ Maricopa's estimated 2001 population of 3,194,798 increased by 4% with a growth of 122,649 within one year. The estimated 2001 population has Maricopa County growth surpassing Los Angeles County.

/2004/

In 2002, 76% of the state's population resided within the counties of Maricopa (60%) and Pima (16%). Maricopa County, the fourth most populous county in the U.S., continued to be one of the fastest growing counties in the U.S. during 2002 with a population increase of 101,452 (3%).

//2004//

Racial/Ethnic Composition

The majority of Arizona's population growth is due to increases in racial and ethnic minorities. Minorities now comprise 36 percent of the state's total population as opposed to 28 percent in 1990. There are 22 American Indian recognized tribes in Arizona. These tribes are located across the state and even cross between state and country lines such as T'Oodono Odham between Arizona and Mexico, or Navajo between Arizona, New Mexico and Colorado.

/2004/

In 2002, 64% of the state population were White non-Hispanic, 25% were Hispanic, 5% were

American Indian, 3% were Black and 2% were Asian. Approximately 1 percent of Arizonans were unable to identify with any of these groups.

//2004//

Arizona is one of four states that borders Mexico; four of the 15 counties border Sonora, Mexico. There is an increasing population of Hispanic heritage, the majority reporting that they are of Mexican descent. Based on the findings from a new survey of children in Arizona (CSHCN 2001), the primary caregiver reported that for 74 percent of children in Arizona, English was the primary language spoken in their home, while 22 percent primarily spoke Spanish. The remaining four percent spoke either an American Indian language, or some other language.

According to the Immigration and Naturalization Service, approximately five million undocumented immigrants lived in the U.S. in October 1996 and comprised 1.9 percent of the total U.S. population. The largest estimated numbers of undocumented immigrants reside in California (2,000,000), Texas (700,000), New York (540,000), Florida (350,000), Illinois (290,000), New Jersey (135,000) and Arizona (115,000). Nearly 2.7 million undocumented immigrants from Mexico established residence in the U.S., comprising 54 percent of the total undocumented population.

According to the U.S. Department of Justice, the southern Arizona Douglas-Naco area is the busiest illegal immigration corridor in Arizona. The public health concern of this illegal immigration is the risk for injury and death from exposure to the intense desert sun and unavailability of water while walking across the desert.

Socio-Economic

The Arizona Department of Economic Security Research Administration description of the state's economy for the first half of 2001 reflects a decrease in job gains from previous, more robust years. Arizona's main economic sectors include services, trade and manufacturing.

/2003/ According to Arizona Department of Economic Security Research Administration, in 2001, Arizona businesses expanded by nearly 23,000 non-farm payroll jobs. Arizona's economy showed considerable weakness during the second half of 2001. This trend is expected to continue during 2002, with a recovery expected in 2003.

/2004/

The most recent report from the Arizona Department of Economic Security regarding Arizona's workforce indicates that the state has been experiencing a slow and gradual recovery and increase in the number of jobs. The state expects a modest expansion of the economy through 2003-04. Nonfarm jobs are expected to grow by 37,800 in 2003 and by 54,600 in 2004.

//2004//

/2005/

While the Arizona economy continues to push forward with job gains, the estimated job growth rate appears to be weaker than expected, according to an April 15, 2004 press release, "Arizona's Workforce" issued by Arizona Department of Economic Security. The report also noted higher levels of employment and a decline in the unemployment rate.

//2005//

According to the U.S. Bureau of Labor Statistics, the unemployment rate in Arizona has consistently been lower than the national rate during the past five years, however Yuma, Arizona, which has a large agriculture industry, had one of the highest unemployment rates (23.0%) in April 2001. The Phoenix metropolitan area specifically, had an unemployment rate of 3.1 percent in March and April 2001. While the rate is below the national rate, it is above the 2000 rate for the Phoenix metropolitan area during the same period.

/2003/ The seasonally adjusted unemployment rate for April 2002 was 6.0 nationally and 5.7 in

Arizona (U.S. Bureau of Labor Statistics). According to the Arizona Department of Economic Security, the national seasonally adjusted unemployment rate for April 2001 was 4.5, with Yuma being 23.8. Yuma's rates fluctuated between 26.2 and 22.8 during 2001, with an annual rate of 24.4 compared to the national annual rate of 4.8. For April 2002, the national seasonally adjusted unemployment rate was 6.0, with Yuma being 18.2. The Phoenix-Mesa metropolitan area had a seasonally adjusted annual unemployment rate of 3.9 for 2001, with a significantly higher April 2002 rate of 5.7 compared to the April 2001 rate of 3.4.

/2004/

The Arizona economy continued to struggle throughout 2002. The State's average annual unemployment rate was 6.2% compared to 5.8% nationally. Unemployment rates in the larger counties were somewhat smaller (5.6% and 4.9% in Maricopa and Pima respectively) while many of the less populous counties experienced much higher rates (e.g 13.9% in Santa Cruz County and 23.8% in Yuma County). The unemployment rate for Native American Reservations was also significantly high at 23.4%.

//2004//

Although Arizona continues to gain jobs, 88 percent of the fastest growing jobs in Arizona pay below a livable wage. The U.S. average per capita personal income was \$29,676 in 2000 compared to \$25,578 in Arizona (U.S. Bureau of Economic Analysis). Arizona ranked 36th among the 50 states with a per capita personal disposable income of \$21,947 in 2000 (12.5 percent below the national average of \$25,090). Figure 1 shows the current employment status of the primary caregiver of children in Arizona according to a recent telephone survey (CSHCN 2001).

/2003/ U.S. average per capita personal income was \$29,469 in 2000 compared to \$24,988 in Arizona. The preliminary estimates for 2001 have the U.S. average at \$30,271 compared to Arizona at \$25,479. Arizona ranked 36th among the 50 states with a per capita personal disposable income of \$21,947 in 2000 (12.5 percent below the national average of \$25,090). (U.S. Department of Commerce, Bureau of Economic Analysis).

/2004/

There has been a slight increase in the per capita personal income both nationally and in Arizona in 2002. The U.S. average per capita personal income was \$30,041 compared to \$26,183 in Arizona.

//2004//

Based on a September, 2000 U.S. Census report, an average of 14.3 percent of Arizona's population had incomes below the federal poverty line in 1998-1999. The national poverty rate for the same two-year time span was 12.3. Nationally 16.9 percent of children under the age of 18 years lived in poverty relative to 25.4 percent of Arizona children in 1999. Children continue to constitute a large proportion of the poor population (39 percent) while representing only 26 percent of the total population.

/2003/ Based on a September, 2001 U.S. Census report, "Poverty in the United States: 2000", an average of 12.0 percent of Arizona's population had incomes below the federal poverty line in 1999-2000. The national poverty rate for the same two-year time span was 11.5. Nationally 17 percent of children under the age of 18 years lived in poverty relative to 19 percent of Arizona children in 2000. (Kids Count Special Report: Children At Risk, State Trends 1990-2000).

/2004/

The U.S. poverty rate in 2001 increased slightly to 11.7. The U.S. poverty rate for children was 16.3. Arizona's average poverty rate for 2000-01 was 13.2. (U.S. Census report, "Poverty in the United States: 2001")

//2004//

Indicators of poor economic conditions are evident for Hispanics, Blacks and American Indians in the last U.S. census. The poverty rates for these populations range from 22.8 percent for Hispanics to

25.9 percent for American Indians compared to 11.8 percent of the U.S. population as a whole. /2003/ The poverty rates for these populations range from 21.2 percent for Hispanics to the unchanged three year average of 25.9 percent for American Indians compared to 11.3 percent of the U.S. population as a whole.

Education is an important component of our well-being. Based on statistics from the Arizona Department of Education, there were 847,762 students enrolled during the school year of 1999. However, Arizona has one of the highest dropout rates in the nation. While the national average dropout rate has remained around five percent for the past ten years, Arizona's dropout rate has been rising. During the 1998-1999 school year, the dropout rate was 12.2 percent in high school and 2.7 percent in the seventh and eighth grade. In the 1999-2000 school year Arizona spent \$4,754 per student, compared to the national average of \$6,585, thus earning the state a national ranking of 49th in per student expenditures.

/2003/ Arizona's high school dropout rate declined from the 12.2% in school year 1998-1999, to 11.1% in 1999-2000 and 9.8% in 2000-2001. There was also a small reduction in the dropout rate in the seventh and eighth grades from the 2.7 % in school year 1998-1999 to 3.1% in 1999-2000 and 2.7% in 2000-2001. (www.ade.az.gov).

/2004/

The statewide dropout rate for elementary schools for 2001-2002 was 2.8% and 9.5% for high schools. The high school dropout rate has continued to decline since 1998-1999. The dropout rate for males is consistently higher than for females in elementary grades as well as high school. "The 2001-2002 female dropout rate for high school was 8.5% compared to the male rate of 10.4%. African American, Hispanic and Native American students continue to drop out at significantly higher rates than White and Asian students. However, African American and Hispanic students are continuing to show decreases in the dropout rate, thereby reducing the gap between the dropout rates of ethnic groups". (www.ade.az.gov)

//2004//

/2005/

The high-school dropout rate for 2002-2003 declined to 8.5%, with every racial and ethnic group showing a decrease in dropout rates. The Annie E. Casey Foundation's KIDSCOUNT 2004 reported on the number of disconnected young adults. Disconnected young adults are defined as persons age 18-24 who are not enrolled in school, are not working, and have no degree beyond high school. Lacking the skills, supports, experience and education to successfully transition to adulthood, disconnected youth face a future with more financial and social risks. In Arizona, 19% of young adults fit this description, compared to 15% nationally in 2002.

//2005//

Juvenile Delinquency

One in five arrests by U.S. law enforcement agencies in 1997 involved a juvenile, representing approximately 2.8 million arrests of individuals under age 18. According to The National Longitudinal Survey of Youth 1997, an estimated eight percent of youth between the ages of 12 and 16 stated they had been arrested, 40 percent of those reported two or more arrests. A little less than a quarter (21 percent) of 16 years olds who had been arrested were first arrested by the age of 12.

/2003/ According to the Federal Bureau of Investigation, juveniles accounted for 17% of all arrests and 16% of all violent crimes arrests in 1999, representing an estimated 2.5 million arrests of individuals under age 18 (Juvenile Justice Bulletin, Juvenile Arrests 1999).

Nationally, the rate of serious violent crime perpetrated by juveniles is lower today than a decade ago but still remains 21 percent above the average of the 1980s. Approximately 12 percent of all murders involved at least one juvenile offender in 1997. Juvenile murders were mainly committed by males (93

percent) and by offenders 15 years of age and older (88 percent) (Juvenile Offenders and Victims: 1999 National Report).

/2003/ Between 1994 and 1999, the juvenile arrest rate for Violent Crime Index offenses fell 36%. As a result, the juvenile violent arrest rate in 1999 was the lowest in the decade. Juveniles were involved in 9% of murder arrests in 1999. (Juvenile Justice Bulletin, Juvenile Arrests 1999).

/2004/

The percent of U.S. crimes perpetrated by juveniles was reduced to 16.9% in 2000 from 17.2% in 1999. In Arizona, 19.6% of all crimes committed in 2000 were committed by juveniles, compared to 20.8% in 1999. Nationally, 15.8% of all violent crimes committed in 2000 were committed by juveniles compared to 19.5% in Arizona.

//2004//

In Arizona, data are presented for juveniles ages 8 through 17 years of age. Uniform Crime Reports divide offenses into two major classifications: Part I and Part II offenses. Part I offenses include violent crimes such as criminal homicide, forcible rape, robbery and aggravated assault, as well as property crimes such as burglary, larceny-theft, motor vehicle theft and arson. Part I offenses per 1,000 juveniles steadily declined during the 1990's from a high of 39.6 in 1990 to 19.3 in 2000.

Part II offenses include a range of offenses such as simple assaults, forgery, counterfeiting, fraud, embezzlement, stolen property and drug/liquor offenses, vandalism, weapons, sex offenses, gambling, disorderly conduct, vagrancy, curfew violations and running away. The method of counting offenses varies with the type of crime committed, and the number of offenders does not equal the number of offenses. For multiple offenses that occur in one crime incident, only the most serious offense is counted, with the exception of arson. When arson occurs in conjunction with another Part I crime, both are counted. Part II offenses per 1,000 juveniles increased from a low of 59.8 in 1992 to a high of 82.4 in 1996 before beginning a steady decline to 58.8 in 2000.

/2004/

The number of referrals to the juvenile court system has declined from a high of 84,719 in fiscal year 1998 to a low of 77,302 in 2002.

//2004//

/2005/

There were 75,030 referrals to juvenile court in fiscal year 2003, a decrease of 2.9% from fiscal year 2002.

//2005//

Mobility

Arizona has a rapidly growing population with a relatively high degree of mobility and sometimes homelessness. A recent survey (CSHCN 2001) found that primary caregivers of 18 percent of children under age 21 had lived at their current address for less than one year, and another 24 percent had lived at their current address from one to two years.

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. According to the National Coalition for the Homeless (NCH) in February 1999 the national estimate of homeless individuals were 700,000 per night compared to 500,000 to 600,000 in 1998. In Arizona, according to a point-in-time survey, approximately 26,670 people are homeless on any given day. /2003/ In Arizona in 2001, approximately 30,277 people were homeless on any given day. (Arizona Department of Economic Security, Homeless Coordination Office, Annual Report: 10th Edition, December 2001).

/2004/

There continue to be as many as 30,000 people homeless in Arizona on any given day. "The estimated 30,000 homeless people includes persons who are in emergency shelters or transitional housing, which was a total of 7,688 for one night in 2002, or other locations such as on the streets, camped in forests, or living in cars or buildings that are unsafe and/or unsuitable for habitation." Approximately 39% of the homeless population is comprised of children in families who are under 18 years of age, compared to 36% in 2001. Of those 39%, 11% were children 6 years of age or younger. (Arizona Department of Economic Security, Homeless Coordination Office, December, 2002).
//2004//

The Arizona Department of Economic Security (DES) reported in 1999 that homeless single people are the largest group of homeless persons. There are many factors associated to homelessness, including poverty, domestic violence, substance abuse, mental illness, lack of affordable housing, decreases in public assistance, low wages and lack of affordable health care. 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. (Arizona Department of Economic Security, Homeless Coordination Office, Annual Report: 10th Edition, December, 2001).

/2003/ According to the U.S. Census Bureau 2000, 13.6 percent of the population in Arizona (more than 650,000 people) were living at or below the Federal Poverty Level of \$17,650 for a family of four in 2001.

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 OWCH provides services and facilitates systems development to improve the health of all women of childbearing age, infants, children and adolescents. The 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.

/2004/

In 2003, the OCSHCN developed a three-year strategic plan. As a consequence, staff were re-organized to facilitate cross-team approaches between the areas of administration, data, clinical services, education/training, and community development. This new organization has led to better communication and partnering between staff.

//2004//

Program Capacity within the Core Public Health Pyramid

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.

Direct Health Care

The OWCH funds programs based upon various criteria of need (financial, risk factors, health status, etc.). The High Risk Perinatal Program provides direct health care services in three of its four components: maternal transport in which the program authorizes and funds the transport of high risk pregnant women to appropriate medical centers for delivery, the community nursing component provides in-home nursing consultation to enrolled families, and the developmental services component provides assessment and services in specialty areas (e.g. physical therapy, occupational therapy, etc.)

/2004/

In 2003, funding for the developmental services component of the High Risk Perinatal Programs was discontinued.

//2004//

The OWCH Reproductive Health/Family Planning Program, through contracts with the county health departments, provides direct services to Title V women of childbearing age. In addition, the Health Start Program provides in-home prenatal outreach services through lay health workers, to at-risk women.

/2004/

Contracts were awarded by the OWCH for community-based efforts to address specific performance measures related to women's and children's health. Many of the contractors are providing direct services to the population for such things as: dental care, family planning services, developmental assessments, health risk assessments and immunizations. Through contracts awarded by the Domestic Violence Program, shelter services and counseling are provided to victims of domestic violence and their children.

//2004//

OCSHCN provides the following direct health care services:

Regional/Outreach Clinics. Through a system of four regional clinics and twenty-seven outreach clinics, the Children's Rehabilitative Services (CRS) provides children with special health care needs (with specified medical conditions) multispecialty, interdisciplinary care. Last fiscal year CRS again provided services for approximately 16,000 clients with a variety of diagnoses and levels of functional disability. CRS is the primary referral source for families seeking SSI eligibility for their disabled children. Of the 10,760 SSI-eligible children under age 16 last year, 6,909 or 64.2 percent received services through CRS.

/2004/

Of the 12,280 SSI-eligible children under age 16 in 2002, 6,940, 56.5%, received services through CRS.

//2004//

/2005/

Of the 13,618 SSI-eligible children under age 16 in 2003, 7,514, (55.2%) received services through CRS.

//2005//

Developmental Clinics. Through a statewide system of developmental clinics, children receive assessment, evaluations and early intervention services. OCSCHN serves about 2,000 children each year through these clinics.

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

/2005/

The developmental clinics ceased operation by the end of 2003.

//2005//

Enabling Services

Service Coordination. The activities of service coordination represent the hub of OCSHCN's capacity

to promote family-centered, community-based, coordinated care for children with special health care needs. This service emphasizes and supports family-centered and culturally appropriate practices through ADHS partnerships with local management teams. Parent/professional partnership and family-centered practice is modeled through the participation of service coordinators with a five-agency coordinating council and associated committees and workgroups. Parents attend meetings as paid experts and partners to offer direction and energy in order to influence other state programs to adopt family-centered, culturally appropriate practices.

It has been documented in the statewide needs assessment that coordination of health services for this population is desperately needed. Ideally, ADHS/OCSHCN would become the umbrella agency for service coordination for these children.

A preliminary attempt to assess the system revealed numerous challenges to addressing the medical, psychological, and rehabilitative needs of all children who could be at risk. While service coordination could address some of these challenges, state and federal statutes limit eligibility for services by covering only certain diagnosis categories or certain age groups. As a result, many children and families who could benefit from service coordination are not offered this service. OCSHCN is in the process of trying to quantify the unmet need for service coordination among Arizona's children with special health care needs.

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, and the Pregnancy and Breastfeeding Hotline make referrals to AHCCCS, Kids Care 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, funded by OWCH, links uninsured and underinsured children with a primary care provider.

/2004/

Through contracts awarded for community-based efforts addressing specific performance measures related to women and children, OWCH has expanded its provision of enabling services. 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 health weight management, nutrition, physical activity, stress management and smoking cessation. Three other contractors offer similar programs for women. Many of the contractors who are addressing child health measures are conducting car safety seat inspections, training in the proper use of car seats and are providing car seats to families in need.

//2004//

/2005/

Service coordination was provided to 400 children under the AzEIP program, to 80 children through the Traumatic Brain Injury program, and to 50 through OCSHCN services.

//2005//

Population-Based Services

OWCH manages a number of programs that provide population based services. The Newborn Screening Program screens all newborns for seven 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. In 2000, 82,021 first screenings were completed. Fifty-two (52) infants were confirmed with one of the screened disorders among which 40 were diagnosed with congenital hypothyroidism, four (4) with PKU, and eight (8) with hemoglobin disorder. The Sensory

Program facilitates the implementation of newborn hearing screenings prior to hospital discharge through the provision of technical assistance, data collection and collaboration to provide screening equipment to Arizona hospitals. Arizona schools provide hearing and vision screenings in compliance with the State Statute and submit results to the Sensory Program.

/2003/ On February 1, 2002, the Newborn Screening Program began screening for the eighth condition, Congenital Adrenal Hyperplasia. In 2001, 83,153 first screenings were completed. Fifty-nine (59) infants were confirmed with one of the screened disorders among which 44 were diagnosed with congenital hypothyroidism, two (2) with PKU, and eleven (11) with hemoglobin disorders. Never Too Young (NTY), also known as the Newborn Hearing Screening Program, has been assigned to the Newborn Screening Program. Newborn hearing screening has increased from 5% to 98% over the past seven years in Arizona. Of the 46 birthing hospitals, 45 provide screening and 39 participate in NTY's monthly HI*TRACK data collection. Arizona schools provide hearing and vision screenings in compliance with the State Statute and submit results to the Sensory Program now assigned to the Policy, Planning, Partnership and Education Section.

Infrastructure-Building Services

OWCH facilitates infrastructure development through coalition building to enhance service delivery and addresses issues of the Title V population. Examples of OWCH coalition building efforts include: the Adolescent Health Coalition that addresses adolescent health status issues; the Safe Kids Coalition, a forum for sharing ideas and resources; and 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.

/2003/ During FY 2002 the Domestic Violence Program was moved from the Office of Prevention and Health Promotion to the OWCH. This program administers the federally funded Family Violence Prevention and Services Grant. The funds are used to work with existing Rural Safe Home Networks (RSHN) for individuals experiencing family and domestic violence to ensure continued funding; to establish Rural Safe Home Networks (RSHN) for persons experiencing family and domestic violence in rural communities with clearly identified needs; 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).

/2004/ All projects funded by the Women's Health Grant and Child Health Grant are required to use the Logic Model to define their program goals, objectives, measurements and program evaluation component. Staff from the OWCH Planning, Education and Partnership Section provide training to potential contractors and those awarded contracts in the use of the Logic Model.

//2004//

OWCH provides technical assistance to entities serving the Title V population (i.e. communities, contractors, coalitions, schools, county health departments, other state agencies, etc.). For example, the Child Health Program provides technical assistance to communities interested in establishing and/or maintaining school-based or school-linked health centers; the Adolescent Health Program provides technical assistance on adolescent growth and development, dealing with adolescents, and adolescent risk behaviors; the Early Childhood Program provides technical assistance in the areas of health and safety in child care settings; and the Sensory Program provides technical assistance to hospitals interested in implementing universal hearing screening.

/2003/ OWCH's new organization structure is based on a functions approach, rather than programs for specific populations. The new Planning, Education and Partnerships Section (PEP) will continue to provide technical assistance to communities interested in establishing and/or maintaining school-

based or school-linked health centers; technical assistance on adolescent growth and development, dealing with adolescents, and adolescent risk behaviors; and technical assistance in the areas of health and safety in child care settings once provided by the former Child Health Program, Adolescent Health Program and the Early Childhood Program. The Sensory Program works with schools that provide hearing and vision screenings. The Newborn Hearing Screening Program provides technical assistance to hospitals implementing universal hearing screening.

Children's Rehabilitative Services. In addition to its regular program activities, this past year the CRS Program completed three activities designed to improve the quality of care and enhance the capacity of the system of care. First, CRS facilitated the work of parents and regional staff in organizing and conducting the Biannual Meeting. The goal of the meeting this year was communication. Through numerous sessions all participants addressed a variety of aspects related to the transfer of knowledge and information.

A second key activity was the completion of the CRS Policy and Procedure Manual. In eight detailed sections, families, providers and funders can obtain information about program administration, enrollment procedures and guidelines, covered and excluded conditions, services, standards for payment, grievance and appeal procedures, record keeping, and program oversight.

Finally, CRS conducted its tri-annual survey of families to assess the degree to which family centered care is provided at the regional centers and outreach clinics. A one page tool was developed and tested, and then translated into Spanish so that language would not be a barrier to participation. The tool was mailed to all active members and a 14.4% response rate was obtained (this was nearly double the response of the previous survey). The overall score for all questions was 4.2 out of a possible 5.0 (indicating the most satisfaction).

/2005/

CRS completed a review and revision of the CRS Policy and Procedure Manual. The member and provider grievance and appeals process was revised to have direct reporting to the Quality Management department within OCSHCN. The CRS Handbook for members was reviewed and revised to assure that the information was accurate, the reading and language levels were appropriate, and to ensure cultural sensitivity.

//2005//

/2004/

OCSHCN has continued to expand its telehealth network. Providers and families in additional communities now have access to this real-time audio/visual communication methodology. The network has also been used to provide access for ADHS staff to continuing education opportunities that otherwise would not have been available.

//2004//

/2005/

CRS contractors and OCSHCN staff completed training from the University of Arizona Telehealth program and OCSHCN staff have subsequently provided training for representatives from each office within the Community and Family Health. Additionally funding from the Arizona Department of Health Services provided for the purchase of compatible equipment by each of the CRS clinics.

//2005//

Community-Based Systems of Services. For the past two years, the Community Development Section of OCSHCN has been providing intensive consultation to the activist group, Building a Healthier Mesa, Inc. This group was primarily engaged in conducting a community needs assessment for CSHCN. It held forums, conducted key informant interviews, surveyed the families of CSHCN, and collected a variety of critical demographic, provider, economic, and community data. The work culminated in the publication of the "2001 Report Card for Mesa" which was debuted in a community

forum at which the results were presented and plans were made to move forward with work to improve the system of care.

In June 2001, the Community Development Section will hold its biannual Communities Can Meeting. Parent and other stakeholder teams from throughout the state will meet for two days to work on team building, communication, and planning. As with all OCSHCN programs, this conference was planned by parent leaders and community members as well as state staff.

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 development strategies are implemented and enhanced through participation within community infrastructures. Community resources are further linked with research findings to impact policy, planning and program development at local, state and national levels.

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.

/2004/

The number of active Community Parent Leaders increased to 27 from 18 the previous year. The number of Community Action Teams increased to 10; up three from the previous year. Children, youth and family participation in the decision-making process is incorporated in contractual agreements with the following programs: Children's Rehabilitative Services (CRS), Traumatic Brain Injury Program (TBI), and Developmental Clinics serving Neonatal Intensive Care Program (NICP) patients and Arizona Early Intervention Program (AzEIP) children, Sickle Cell Program.

//2004//

/2005/

There were eight Community Action teams encompassing 21 distinct communities in 2003. These teams had an increase in participation by families of children experiencing behavioral health issues in the communities. Two of the Community Action Teams were approved for 501c3 non-profit status enabling them to work towards becoming self-sustaining community organizations. Contracts were awarded to seven community agencies willing to partner with the Community Action teams in their community to provide organizational and administrative support. This was the first time Teams had received this type of fiscal support from OCSHCN and this administrative support allowed Parent Leaders to focus their efforts primarily on leadership activities and advancing the initiative identified by their communities.

During 2003, AzEIP Service Coordination increased by 70% over 2002; services for Children with Special Health Care Needs (not AzEIP eligible) increased by 26% over 2002; Service Coordination for children with Traumatic Brain Injury increased 283% over 2002.

//2005//

A number of OWCH programs have community development as a major focus. The County Prenatal Block Grant Program established inter-governmental agreements with each county for efforts focused on enhancing the health of women of childbearing age, infants, children and adolescents through a systems development approach. The School-based/School-linked Health Center Program through Child Health provides technical assistance to communities interested in establishing such centers.

/2003/ The School-based/School-linked Health Center Program, now referred to as the School-based/School-linked Health Care Initiative, under the PEP Section, provides technical assistance to communities interested in establishing such centers.

/2005/ The School-based/School-linked Health Care Initiative is now known as the Arizona School-based Health Care Council. With OWCH funding the Council published a directory of members and a companion document providing technical assistance to communities wanting to establish a community-based center. The Council is not receiving funding for any current projects. A PEP Section employee sits as a non-voting member of the council's 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.

//2005//

C. ORGANIZATIONAL STRUCTURE

The Arizona Department of Health Services (ADHS) is one of the executive agencies that report to the Governor. The 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 Agency. There are eight divisions within ADHS that 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 Bureau of Community and Family Health Services (CFHS), Division of Public Health Services administers Title V funds through the Office of Women's and Children's Health (OWCH) and Office for Children with Special Health Care Needs (OCSHCN). CFHS coordinates Title V and related activities. Included in the office of the CFHS Deputy Assistant Director are the Medical Director, Business Operations, and epidemiology services. Other offices within CFHS include: Office of Nutrition and Chronic Disease (including WIC), Office of Oral Health (OOH), Office of Health Systems Development, and Office of Tobacco Education. 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.

/2004/

The OWCH assumed responsibility for programs that had previously been located in other CFHS Offices. The following programs are now located within OWCH: Domestic Violence Prevention, Rape Prevention and Child Fatality Review. The Preventive Health Block Grant and Healthy Communities Initiative (Healthy People 2010 and Older Adult Health) were moved to the Office of Health Systems Development.

//2004//

/2005/

July 1, 2003 the Division of Public Health Services reorganized to better reflect services provided to the community. The Division established two new primary service lines, Public Health Preparedness and Public Health Prevention (PHPS). PHPS includes the following offices that had been in the Bureau of CFHS; the Tobacco Education Program, OWCH, OCSHCN, Nutrition and Chronic Disease Prevention Services (including WIC), Health Systems Development, and OOH. Rose Conner serves as Assistant Director, and Raul Munoz was promoted to Deputy Assistant Director.

//2005//

After the completion of the five year needs assessment, OWCH reviewed its current methods for identifying and prioritizing the needs of women and children in Arizona. The conclusion was that OWCH wanted to create a new process that was more participatory, more easily articulated, and more strategic in nature. The hope was to create a process that would result in funding decisions that had the best chance of making an impact on the health of the maternal and child health population.

The team wanted the strategy to be clearly reflected in the budget. A thorough evaluation of the Title V program was conducted to address three goals: 1) develop a process for identifying the health needs of women and children, 2) develop a process for allocating funding to address those needs and 3) develop a way to evaluate the effectiveness of those efforts.

Eight specific recommendations were made with regard to the needs assessment and allocation process for the MCH grant: 1) Look at current allocations and identify allocations that shouldn't change, allocations that can or OWCH wants to change, and all available carry-over monies, 2) For those allocations that are determined to be best unchanged, increase accountability and effectiveness and apply standard funding principles, 3) Create a funding pool consisting of carry over and allocations we can or want to change, 4) Appoint an Advisory Committee made up of both external and internal stakeholders to assist in determining priority areas, 5) Select a limited number (2-3) of priority areas for funding, 6) Determine the core public health focus within each of the priority areas, 7) For the funding pool, issue a single MCH Block Grant Request for Proposals, and 8) Create standardized contracts and reports for recipients of these funds.

Overall recommendations to improve efficiency and effectiveness included: Put a business system in place that will allow easy tracking by month of the pass-through funds and the number of contracts with their related expenditures; initiate a process to examine what role OWCH should play in realizing the overall mission of Community and Family Health Services; consolidate and standardize contract and reporting for all OWCH contracts, examine and revise data collection to ensure the data collected minimizes redundancy, meets the requirements of funders, supports current priorities, and can be utilized to create summarized management reports to track accountability.

OWCH moved quickly through the initial recommendations having already implemented an interim system to improve accountability for MCH funded activities that requires identification of key performance and outcome measures supported by the activity and reporting on progress towards those measures. In addition, the OWCH management team with the participation the CFHS Bureau Chief, identified key strategic issues and priorities. The team reviewed programs currently funded and determined which should remain unchanged as well as which ones may be considered for the funding pool.

/2003/ During FY 2002 the following outcomes resulted from the analysis of OWCH: implementation of a new OWCH organizational structure based upon functions rather than discreet programs, development of a strategic plan, development and implementation of an OWCH financial management plan, implementation of a block grant to communities to address child health issues, and development of the Partnership Initiative.

The office organizational structure is comprised of four sections, Assessment and Evaluation, Community Services; Planning, Education and Partnerships; and Finance and Support Services. The implementation of this structure based upon functions resulted in the elimination of many of the topic-specific or population-specific programs within OWCH. Examples of programs that were eliminated include: Child Health, Adolescent Health; Early Childhood, and Social Work, etc. The Assessment and Evaluation section is responsible for addressing internal and external customer requirements related to needs assessments, data analysis, preparation and distribution of reports on the health status of women and children. In addition, the section serves as the office lead in assessing and monitoring data related to the maternal and child population to identify and address ongoing and emerging health concerns. Specified expertise will be needed to fully perform the identified functions of this section. Personnel processes have been implemented to establish and hire a research and statistical analyst, two epidemiologists and a technical writer.

/2004/

New positions were established during this year. Staff were hired for the positions of Research and Statistical Analyst Chief, Epidemiologist, and Computer Programmer.

//2004//

/2005/

April 2004, five lab-contracted positions providing data entry for the Newborn Screening Program were relocated to OWCH, Assessment and Evaluation Section. The positions will be supervised by the Assessment and Evaluation Unit Manager, but remain assigned to the lab.

//2005//

The Community Services Section is comprised of those programs that receive state line item funding and provide services to a client directly or through a contractor. The programs within this section are Newborn Screening, Health Start, and the High Risk Perinatal Programs.

/2005/

February 2004, the Breast Feeding Hot Line and the Children's Information Center were transferred out of the Planning Education and Partnership Section and into the Community Services Section.

//2005//

The Planning, Education and Partnerships Section provides leadership for statewide priority setting, planning and policy development, and supports community efforts to assure the health of women, children and their families. The staff work with a variety of public, private and non-profit community partners to identify health needs, implement systems of care, and develop public health policies. The section 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.

The Finance and Support Services Section coordinates all budget, fiscal and operational issues for the office. All support staff positions are housed within the section and function as a pool of resources for the entire office.

/2005/

Support staff positions are no longer housed within the Finance and Support Services Section. Administrative Assistants are now assigned to each section and support staff personnel are assigned to each unit. The Finance and Support Services Section name has been changed to Finance Section to reflect this change.

//2005//

The OWCH strategic plan is available at the OWCH web site. The plan identifies two priority areas (reduce mortality and morbidity of the maternal and child population; 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. These priorities and related measures were 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 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 accomplish the following: 1) Reduce the amount of year two funds that had historically occurred. At the end of the funding year, any funds not expended will be transferred to a central cost center which will be used to fund community based efforts. Each year, funded projects will be reevaluated in relationship to OWCH priorities and expenditures from the previous years. No OWCH funded projects are allowed to carry-over funds to the next contract year. 2) Provide closer management of Title V funds. Each project utilizing Title V funds requires the development of a funding plan and an allocation plan that details how and when the funding will be used. These plans are reviewed for alignment with Title V goals and serve to eliminate duplicate funding. 3) Reduce administrative costs. Several methods have been considered, such as enhancing staff expertise to reduce the need for consultant services, leaving non-critical staff positions vacant, and identifying and eliminating situations of duplicate funding (e.g. funding a

computer programmer position as well as providing a percentage of funding for information technology support). 4) Streamline budget oversight by reducing the number of contracts and cost centers. Over time, this should reduce the number of positions needed.

Block grants to communities were awarded during FY 2002. One million dollars in carry-over funds were used to award contracts to communities to address child health priorities. The request for proposals gave considerable latitude to local communities in developing strategies but still requiring that they be research based. The logic model was included as a requirement to ensure that efforts could be defined, tracked, evaluated and related to the identified issues.

/2004/

Approximately \$1.5 million was awarded to five contractors to promote healthy behaviors in women.
//2004//

/2005/

Women's and Children's Health Community Grants in the amount of \$840,374 were awarded to 8 contractors to promote healthy behaviors in women, increase access to primary care for children, reduce the rate of deaths to children caused by motor vehicle accidents, and to reduce infant mortality among Native American and/or African Americans.

//2005//

The Partnership Initiative was established to enhance 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. At least annually, the OWCH partner will present an overview of current health status data and trends. Input will be solicited to identify priorities and emerging issues.

/2005/

In 2004 the additional positions of Planning and Evaluation Manager, Research Chief, and Medical Director were added to the OCSHCN.

//2005//

D. OTHER MCH CAPACITY

During FY 2001 the Bureau of CFHS relocated four of its offices to a location approximately three miles from the ADHS administrative location. For the first time in over nine years, the Office of the Bureau Chief, Office of Women's and Children's Health, Office of Children with Special Health Care Needs, and Office of Nutrition and Chronic Disease are located at the same site.

/2004/

In the summer of 2003 a new five story building will open to house all ADHS staff who have been out-stationed throughout Phoenix in one building. The building is adjacent to the existing ADHS administrative offices. This move to the capitol hill area of the city will enhance collaborations between all ADHS Divisions and Bureaus as well as other state agencies.

//2004//

Program planning, evaluation and data analysis functions are served by designated OWCH and OCSHCN staff, as well as the CFHS epidemiologist, Emma Viera-Negron. Contracts are awarded to consultants on an as-needed basis for particular projects related to planning, evaluation, data analysis and data system design.

/2005/

OCSHCN expanded its analytic staff with the hiring of a research chief. OWCH expanded its planning capacity by hiring a health program manager to coordinate planning activities and special projects.

//2005//

Catherine Eden, Ph.D. was appointed permanent Director in June 2000. Dr. Eden served as County Manager of Coconino County and as Associate Director for the Arizona Association of Counties, lobbying on behalf of Arizona's fifteen counties and was instrumental in establishing AHCCCS. From 1990 to 1994, she represented District 25 in the House of Representatives. Dr. Eden has an extensive background in health issues facing communities and the state (e.g. serves on the Board of Directors for the Dougherty Foundation, Women in Health and the National Head Injury Foundation, and the City of Phoenix Public Defender Review Committee). She is Faculty Chair of the Public Administration Department, Rio Salado College and is a consultant specializing in jails and criminal justice issues.

Rose Conner was appointed Assistant Director of the Division of Public Health Services this year. Rose is a registered nurse with a Bachelor's of Science degree in Vocational Education and a Master's Degree in Education/Counseling. She 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.

Elsie E. Eyer, M.S., the Bureau Chief for CFHS retired after four years in that position. Raul V. Muñoz Jr., B.S., M.P.H., joined ADHS as the CFHS Bureau Chief. Mr. Muñoz has an extensive background in public health with the State of Texas. Prior to his move to Arizona, Mr. Muñoz 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. Muñoz was a lecturer at the University of Texas at El Paso, College of Nursing and Allied Health.

/2004/

In 2003 the Bureau of Community and Family Health Services was expanded to include the Office of Tobacco Education and the Office of Health Systems Development with Mr. Muñoz serving as the Deputy Assistant Director. Rose Conner serves as the Senior Public Health Official.

//2004//

/2005/

July 1, 2003 the Division of Public Health Services reorganized to better reflect services provided to the community. The Division established two new primary service lines, Public Health Preparedness and Public Health Prevention (PHPS). PHPS includes the following offices that had been in the Bureau of CFHS; the Tobacco Education Program, OWCH, OCSHCN, Nutrition and Chronic Disease Prevention Services (including WIC), Health Systems Development, and OOH. Rose Conner serves as Assistant Director.

//2005//

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, most recently serving as the Manager of the Women's and Infant's Section for OWCH. 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, most recently including seven years as a member of the Executive Board for the Association of State and Territorial Public Health Social Workers. She has provided consultation to the 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.

Susan Burke is the OCSHCN Office Chief. Marriage and Family Life Sciences for undergraduate work provided the framework for Dr. Burke's doctorate in Early Childhood Education. She has been immersed in MCH public health since the early 1970s. Dr. Burke provides a diverse array of technical assistance to national and state advisory groups and organizations, including assisting states in the development and implementation of needs assessment, issues related to managed care; research and presentations on vulnerable infants; and grant reviews. She serves on numerous boards and advisory groups, including the ACF-MCH TAG, MCHB Steering Committee on Cultural Competence, and the AMCHP Program & Policy Committee. Dr. Burke served as the Program Chair for the 1999 AMCHP Conference and is in the first year of her second term on a very large local school board.

/2003/ Dr. Susan Burke retired as OCSHCN Office Chief in December, 2001. Cathryn Echeverria, R.N., was appointed to replace her in January, 2002. Ms. Echeverria was formerly the manager of the OCSHCN Quality Assurance Section; as such she directed the state Children's Rehabilitative Services Program. Ms. Echeverria has considerable experience in the clinical, managed care, and public health issues facing children with special health care needs, their families and their communities.

Margaret Tate, M.S., R.D., joined CFHS in June, 1999 as the Chief of the Office of Nutrition Services. Ms. Tate is very 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, currently serving as Director-at-Large.

Dorothy Cooper, M.S., R.N. is Chief of the Office of Prevention and Health Promotion. Ms. Cooper has been employed with ADHS since 1990, originally as the School Health Consultant. Subsequently she served as the OWCH Primary Care Nurse Consultant and Manager of the Child Health Section of OWCH. Prior to her association with ADHS, Ms. Cooper was employed as a district nurse for a Phoenix school district for thirteen years. She served as Principal Investigator of the "Study of the Nature, Incidence and Consequences of School Playground-Related Injuries". Ms. Cooper has made numerous presentations nationally and internationally on child health, school injury surveillance and primary care, served as President of the National Association of State School Nurse Consultants from October 1997 to October 1999, and was a member of many advisory boards on child health.

/2003/ The Office of Prevention and Health Promotion will no longer exist after June 30, 2002. The existing programs will be reassigned to the Office of Women's and Children's Health, the Office of Nutrition, and the Bureau of Emergency Medical Services. Dorothy Cooper will retire June 30, 2002.

Kneka Smith, R.D.H., B.S. is the Chief of the Office of Oral Health Services. Prior to her tenure at ADHS as a Health Planning Consultant and as a Program and Project Specialist II in 1999, Ms. Hayward was a public health educator for the Maine Department of Health Services. She has experience in water fluoridation campaigns, grant writing, data collection management and reporting, fiscal management and community development.

/2005/ Kneka Smith left the Office of Oral Health in May of 2004, and Tina Strickler is currently acting as Office Chief. Ms. Strickler has a B.S. in Political Science from Truman State University and a Certificate in Nonprofit Management from ASU's Nonprofit Management Institute. Prior to joining the Office of Oral Health, she was the Assistant Executive Director of the Arizona Dental Association and the Executive Director of the Central Arizona Dental Society. During her 10 years promoting and supporting professional dentistry, she served in a number of capacities in the community including various community foundations, municipal fluoride committees and state regulatory committees. She also planned Arizona's first Give Kids a Smile Day. She has presented at the National Fluoridation Summit, the League of

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 child care. Of interest for the past two years is parent participation in the needs assessment project. They have assisted with data collection and prioritization of system issues. Parents have also been, and will continue to be, members of the team working on the Utah State University Monitoring and Measuring Project to develop indicators for CSHCN system performance outcome measures.

/2004/

The CRS State Parent Action Council includes parents from the four regional sites and advocacy group representatives.

//2004//

/2005/

There are eight parent-led community action teams throughout the state of Arizona. These action teams are primarily located in border communities and/or rural communities; however, there are plans to develop teams in Kingman, Tucson, and west Phoenix. The parent leaders of these teams are paid with Block grant funds and they work with other parents of CSHCN, state agencies, schools, and support groups in their local communities to improve services for CSHCN. An \$18,000 grant from Utah State University will allow for the formal development of training materials for new and existing parent leaders. Parent leaders will continue to work to develop the Arizona Medical Home Network within local communities which will include working with six physician practices to implement the medical home philosophy, developing training modules for nurses and residents, as well as creating informational packets for families of CSHCN.

//2005//

E. STATE AGENCY COORDINATION

ADHS collaborates with the following agencies/advisory boards:

Abstinence Only Advisory Board collaborates with ADHS regarding implementation plans for federally funded statewide effort. ***/2005/ Board is currently inactive. //2005//***

Adolescent Health Coalition is a statewide multi-disciplinary group including parents and adolescents, focusing on improved adolescent health status.

Alliance for Children and Families of Southern Apache County collaborates on issues relevant to families of CSHCN involving the medical, public health, social services, local business and local government sectors.

American Academy of Pediatrics, Arizona Chapter manages the Medical Home program, supported and funded in part by OWCH.

Arizona Child Fatality Review Team has 30 members and oversees the authorization and operation of 13 local child fatality review teams. ***/2005/ Membership is 250: 14 teams. //2005//***

Arizona County Health Officers Association includes the participation of all county health department directors and collaborates with ADHS to address all public health issues. ***/2005/ Name has changed to Arizona Local Health Officers Association to reflect addition of Tribal Health***

Officers. //2005//

Arizona Family Planning Council receives and disperses Title X funds throughout Arizona counties for family planning services. OWCH collaborates and assists in addressing data collection methodology.

Arizona Medical Association, Maternal and Child Health Committee.

Arizona School Health Association established a school health committee to address issues related to the provision of services through school-based health programs. This committee has assumed the functions formerly coordinated by the OWCH Technical Assistance Group.

/2003/ Arizona Suicide Prevention Coalition began in the spring of 1999, with the purpose of reducing suicidal acts in Arizona through awareness, intervention and action. Membership represents state and federal agencies, coalitions, associations and some tribes.

Building A Healthier Mesa, Inc. is working to develop a framework for a community-based needs assessment and community action teams, partnering with the City of Mesa, Mesa Community College, Mesa Chamber of Commerce, Mesa United Way, Mesa Public Schools, ASU East and the Salt River Pima Indian Community.

Coconino Coalition for Children collaborates across medical, public health, social services and local community sectors to address issues pertinent to families of CSHCN in Coconino County.

Easter Seals is a private, non-profit agency that works to improve the quality of life for persons with disabilities by creating opportunities for employment, education and recreation.

/2005/There is no current partnership with Easter Seals//2005//

Genetics Advisory Committee has 33 professional members who provide direction on definition of the service system and strategies required to accomplish this system.

Never Too Young Advisory Committee has 9 members appointed by the ADHS Director who make recommendations on data collection, practice standards, public education and awareness plans, and provide a link to the medical community and other agencies.

Newborn Screening Advisory Committee is a legislatively mandated 6-member committee. Professionals provide guidance on the operation of the Newborn Screening program. The Director of ADHS serves as chair.

Partnership for People with Special Needs-Page, Arizona is a collaboration of LeChee, Kaibeto and surrounding communities serving people with disabilities in Northern Coconino County involving the medical, public health, social services, local business and government sectors.

Perinatal Nutrition Network, consisting of hospital dietitians and the MCH Nutritionist, assist in the implementation of Perinatal Nutrition Guidelines in their respective hospitals

Perinatal Social Worker Network, consists of social workers from hospitals and community organizations address current issues. **/2005/ OWCH no longer participates. //2005//**

Prescott Children's Council collaborates across medical, public health, social services and local community sectors to address issues pertinent to families of CSHCN in Yavapai County.

Project Tsunami is a group of parents with CSHCN who contract or volunteer to work with OCSHCN teams to ensure the program is community and family focused. Advisory members review documents, participate on committees, facilitate community development efforts and work with other agencies. Partnering with health professionals, Project Tsunami parents assist in building a family-centered health care system.

School Nurse Consortium has a membership of school nurse supervisors from throughout Arizona. The Task Force collaborates with OWCH on school health issues.

SIDS Advisory Council has 11 members and advises staff on mandated training activities.

/2003/ During the 2002 Legislative session, SB2011 was passed that changed the name of the Sudden Infant Death Advisory Council to the Unexplained Infant Death Advisory Council. The bill allows the council to consider issues related to stillborn infants when assisting DHS in developing training and educational programs.

/2004/

Southwest Institute for Human Development is a private, non-profit agency that is affiliated with Arizona State University. OCSHCN partners with the Institute on numerous projects including medical home, traumatic brain injury and transition.

//2004//

State Agency Linkages:

/2005/

The State Agency Coordination Team is composed of eight state agencies that work on issues surrounding domestic violence and sexual assault. Representatives meet monthly to identify ways to partner and leverage collective resources. Agencies include: Arizona Criminal Justice System; Arizona Department of Housing; Arizona Supreme Court; Department of Economic Security; Department of Health Services; Department of Public Safety; Governor's Office for Children, Youth, and Families; and Office of the Arizona Attorney General. Staff from the PEP Section participate on this team.

//2005//

Administrative Office of the Courts, Arizona Supreme Court - this judicial agency for the state partners with OCSHCN in the monitoring of CSHCN in the state foster care system.

Arizona Department of Economic Security partners with ADHS, AHCCCS, ADE and ASDB on the following projects: the Arizona Early Intervention Program, provides for diagnostic, evaluation, treatment, rehabilitative and service coordination services for CSHCN (OCSHCN staff serve on governor-appointed interagency coordinating council); Arizona Long Term Care Services (AHCCCS ALTCS), a Title XIX funded program of evaluation and treatment services for children with functional impairments; Eligibility Determination and referral for children eligible for Title XVI and XIX for CRS clients; and the Arizona Early Childhood Self Study Program; and the Governor's Council on Spinal and Head Injuries, a division of Vocational Rehabilitation, for systems development for children with traumatic brain injury; Interagency Agreements between these partners are on file.

Arizona Department of Education collaborates with OWCH and OCSHCN through special education, school health and school nutrition programs. ADE collaborates with DES and OWCH for the Arizona Early Childhood Self Study Program, and an Interagency Agreement is currently on file. ADE staff is involved in OCSHCN teams, and OCSHCN community forums. ***/2005/ OWCH no longer participates. //2005//***

/2004/

Arizona Department of Environmental Quality: OCSHCN is working with this agency on the Governor's mandate to address the effects of the environment on the health of children. The initial project for this partnership is reduction of the impact of asthma in Arizona children.

Arizona Department of Health Services (ADHS) Office of Health Systems Development OCSHCN partners with this office to publish local data on health statistics and resources.

//2004//

ADHS State Laboratory- Under contract, the State Laboratory performs laboratory testing of newborn screening samples, testing for phenylketonuria, galactosemia, homocystinuria, maple syrup urine disease, biotinidase deficiency, congenital hypothyroidism and hemoglobinopathies. The laboratory also screens the specimens for acceptability, keeps records of tests performed, and conducts quality control studies of laboratory methods and practices.

Arizona Health Care Cost Containment System (AHCCCS) is Arizona's Title XIX Medicaid agency. OWCH and OCSHCN work with AHCCCS on standards and policies to improve access to and appropriate use of services for enrolled people and to advocate on behalf of local providers for reimbursement. CRS and OOH have formal Inter-Agency Service Agreements with AHCCCS.

Arizona State School for the Deaf and Blind (ASDB) coordinates education and support services for children with visual and hearing impairments. Issues relevant to CSHCN families have been shared and ASDB staff is active in helping resolve them. The OWCH Newborn Screening Manager works closely with this organization.

University Affiliated Programs, housed at NAU, is a collaborative with the three state universities to provide training and resources around CSHCN and genetic issues.

University of Arizona - OWCH High Risk Perinatal (HRP), Injury Prevention, and Genetics Program collaborate with University of Arizona to provide program services to their particular populations as evidenced by the Interagency Agreements. ***//2005/ OWCH HRP no longer collaborates on this program. //2005//***

Special Populations:

Arizona Association of Community Health Centers supports its members through advocacy, shared services and information, and technical assistance. Members include nonprofit and public primary health centers that serve about 250,000 people in 60 medically underserved locations. ***//2005/ 100 clinics serving over 350,000 in 85 locations. //2005//***

Arizona Coalition Against Domestic Violence, in coordination with other organizations, is developing a statewide plan to prevent and address problems related to domestic violence.

Arizona Consortium for Children with Chronic Illnesses (ACCCI) is a nonprofit organization that offers individual and legislative advocacy, training and support for families of children with chronic illnesses.

Arizona Perinatal Trust (APT) is a private nonprofit organization formed in 1980 to improve perinatal outcomes through professional and public education, voluntary hospital certification, and data for participants in the regional certification process.

Baby Arizona is a statewide effort to improve access and utilization of prenatal services and streamline Medicaid eligibility by use of presumptive eligibility for AHCCCS. Providers volunteer to accept pregnant women. Physicians' office staffs are trained to initiate the AHCCCS application process at the first appointment. The OWCH Pregnancy and Breastfeeding Hotline at 1-800-833-4642 is the primary contact number for Baby Arizona and is publicized in all Baby Arizona media campaign materials.

Children's Action Alliance (CAA) is a nonprofit child advocacy organization focusing on increasing the awareness of children's issues among Arizona policy makers, business, media and the general public.

Children's Information Center is a statewide bilingual/bicultural toll free number that provides referral, support, education, and advocacy to family and health care professionals statewide.

Collaborations for a New Century is an alliance of business, faith, philanthropic, government and service providers who have joined together in efforts to strengthen vulnerable families around issues of health insurance, housing, livable wage employment, and safe, healthy environments for kids. Chaired by one the state's top business leaders. Collaborations seeks to make a significant impact on the quality of life for working poor families. OCSHCN provides leadership in working with businesses, the faith community and philanthropic organizations to develop strategies that will increase access to health insurance among working poor families.

Arizona Early Hearing Detection and Intervention Project is an OWCH project funded by the Maternal and Child Health Bureau. With the involvement of experts in the field of otology, audiology and primary care, as well as family participants, this project is working to enhance Arizona's effort to identify children with hearing impairments at the earliest possible time and to implement early intervention services.

Governor's Council on Developmental Disabilities is an advisory and advocacy council for consumers and providers of services to the adult and child disabled population in Arizona.

Governor's Council Against Domestic Violence is an advisory and advocacy council for prevention of and treatment of victims of domestic violence.

//2005/

Governor Napolitano changed this into the Commission to Prevent Violence Against Women, and it now includes a focus on preventing sexual assault.

//2005//

High Risk Perinatal Transport Program provides high risk obstetrical and neonatal medical consultation and case management through a toll free phone line with available air or ground transport services statewide.

Institute for Human Development/NAU provides training to providers and families of CSHCN.

Inter-Tribal Council of Arizona is an association of 19 of the 22 tribal governments in the state of Arizona and California. ITCA obtains, analyzes and disseminates information vital to Native American community self-development. CFHS organizes and conducts seminars, workshops, conferences and public hearings to facilitate participation of tribal leaders in the formulation of public policy at all levels.

OWCH Newborn Screening maintains a collaboration of specialists in the area of endocrinology, metabolic genetics and pediatric hematology. These specialists act as consultants to physicians and other health providers, to parents of children and to the NBS Program. NBS also maintains a 1-800 # which parents can call with questions or concerns. Parents of children with abnormal test results are informed of this number in letters telling them of the abnormal result.

Phoenix Birthing Project is a nonprofit project funded by the Kellogg Foundation, which partners pregnant African American women with community "sister-friends" who mentor them. The purpose is to help women obtain necessary services and to provide emotional and other types of support.

Raising Special Kids (formerly known as Pilot Parent Partnership) is a nonprofit organization funded through a combination of private governmental sources to provide support for families of CSHCN and to train providers.

South Phoenix Health Start Project, funded by HRSA is targeting minority populations in two Phoenix Communities to implement efforts to reduce infant mortality. The OWCH partners with this program.

U.S. Public Health Service, Indian Health Service - ADHS has a history of coordination with IHS. Through an OWCH/Arizona State University Partnership, training was offered in the area of pediatric physical assessment through six-day courses offered to public health nurses, including IHS employees.

Toll-Free Phone Numbers and Other Modes of Public Communication:

ADHS maintains a 1-800 phone number, the Children's Information Center (CIC) line, which can be accessed by families and providers across the state. Bilingual personnel on this line are trained to direct callers to available resources around the state for CSHCN. Information on the CIC is updated annually. In addition, each CRS clinic maintains 1-800 numbers. The OWCH/OCSHCN Family Resource Guide lists all the 800 numbers families have available to them from state programs.

World Wide Web Site ADHS now has a World Wide Web page, which includes information about CFHS, its offices and programs, as well as teen pregnancy statistics and the Arizona Food Pyramid. Information specific to CSHCN and the state programs is included. The address is:
<http://www.hs.state.az.us>.

WIC:

The WIC program is managed by the Office of Nutrition and Chronic Disease within CFHS. OWCH and OCSHCN programs have a reciprocal referral arrangement with WIC. Programs such as Health Start, Children's Information Center, Newborn Screening and AzeIP refer clients to WIC and WIC refers clients back to OWCH and OCSHCN as needs are identified. The OWCH Hotline staff have assumed responsibility for the WIC Hotline and WIC provides training and technical assistance for the Hotline staff.

EPSDT:

OCSHCN will develop a plan of action in collaboration with the state Medicaid agency to provide for Title XIX reimbursement for EPSDT services to CSHCN. This plan of action will include developing policies around the types of services included in the reimbursement, periodicity of EPSDT visits and determination of who qualifies as an EPSDT provider.

OWCH has worked closely with the Child and Adolescent subcommittee of the Arizona Medical Association (ARMA), is piloting the Guidelines for Adolescent Preventive Services (GAPS) screening tool. Results from the pilot effort supported the need for and the willingness of health care providers to utilize the tool. OWCH will provide funding to ARMA to help with printing and distribution costs of the document. The OWCH School-Based Health Care Program and the Arizona School-Based Health Care Consortium have had preliminary discussions with AHCCCS to investigate ways the centers can receive payment for EPSDT services they provide. **/2005/ One Center has an agreement with an AHCCCS plan. //2005//**

Other Federal Grant Programs:

Various OWCH programs serving pregnant women and young children (Community Health Nursing, Family Planning, Prenatal Outreach Program and the Newborn Intensive Care Program) refer clients to WIC for services. The Health Start Program contracts with a number of Community Health Centers to provide outreach services and health education to enrolled families through lay health workers. This relationship with the community health centers enhances the ability of the program to ensure a medical home for the enrollees.

/2005/

The Rape Prevention and Education Grant, funded by the Centers for Disease Control and Prevention, is administered through the OWCH Planning, Education, and Partnership Section.

The Family Violence and Services Grant, funded by the Administration for Children and Families, is administered through the OWCH Planning, Education, and Partnership Section. Funds are coordinated with other state agencies administering federal funds used for domestic violence services, including the Victims of Crime Act, STOP Violence Against

**Women Formula Grant, Social Services Block Grant, and Temporary Assistance to Needy Families (TANF).
//2005//**

OCSHCN is working with community-based groups on both medical home and integration of services projects. Through the Arizona Early Intervention Program (AzEIP), OCSHCN works with DES in the implementation of the federal Office of Special Education Programs Individuals with Disabilities Education Act (IDEA). Through IDEA, Arizona has established an interagency coordinating council, of which OCSHCN is a voting member. OCSHCN's responsibilities through AzEIP include provision of developmental clinic services to children age 0-3. Through Title V dollars, this program has been supplemented to provide similar services to older children as well.

Identifying Title XIX Eligible Women and Infants. The Health Start Program, County Prenatal Block Grant Program, and The Pregnancy and Breastfeeding Hotline, as a collaborator under the Baby Arizona Project, facilitate referral of pregnant women to the Title XIX program.

Social Security Administration/State Disabilities Determination Services Unit. OCSHCN has developed working relationships with the regional SSA and the State DDS. These entities are involved in developing policies around SSI determination and redetermination processes and how families who apply for SSI for their children, regardless of outcome, as referred for other services. Discussions have taken place regarding the development of memoranda of agreement.

Vocational Rehabilitation. OCSHCN is now in the second year of an interagency agreement with the DES Vocational Rehabilitation Administration for the implementation of the MCHB Traumatic Brain Injury (TBI) Demonstration Project. OCSHCN provides project coordination, service coordination, family training, materials development and evaluation services for the project. Through this project, OCSHCN intends to document the strengths and barriers in the system of care for children with TBI and their families and to develop recommendations for improvement. As the project moves into the third year, OCSHCN is working with DES and the local communities to institutionalize best practices around care for children with TBI.

Family Leadership and Support Programs. The philosophy of the OWCH is based on the foundation that consumer involvement in decision-making for their health care and that of their family results in better health outcomes. To facilitate consumer involvement in decision-making, OWCH established the Community Involvement Project and established the Community Involvement Committee. The project was designed to encourage community participation in policy development, rules writing, organizational planning, advisory boards and other activities. The original concept of parents representing families was broadened to a more all-encompassing approach to partners.

The Community Involvement Guidelines have been developed to operationalize the philosophy and to encourage consumers to participate. The term Community Advisor was initiated to refer to a consumer assisting the OWCH in various capacities. A small budget is available to provide for a token payment for the hours spent by Community Advisors in the pursuit of OWCH activities. **//2005/ This project is inactive. //2005//**

OCSHCN continues to support several family leadership and support programs including Project Tsunami, where OCSHCN contracts with families and reimburses them for their time spent on policy, needs assessment, planning, program/community development and evaluation issues; Family Voices, where OCSHCN provides technical assistance and minimal financial support to this family advocacy organization; CRS Parent Advisory Councils, where OCSHCN support the operations of the regional and state PAC's who monitor and provide input on CRS services; and Family Centered Institute, where OCSHCN supports the training provided by this institute to ensure that all OCSHCN staff are aware of the issues families with CSHCN face.

F. HEALTH SYSTEMS CAPACITY INDICATORS

In last year's block grant application, it was reported that all of the health systems capacity indicators tracked on form 17 improved. With this submission, indicators are less positive. Due to a problem with the hospital discharge data base, the rate of hospitalizations for asthma among children under age 5 could not be updated. Some of the indicators moved in an unfavorable direction: the percent of infants enrolled in each of the Medicaid and SCHIP programs receiving at least one EPSDT screening decreased; and the percent of state SSI beneficiaries under age 16 receiving rehabilitation services from CSHCN program decreased. On the positive side, the percent of EPSDT-eligible children age 6-9 receiving dental services during the year increased again, and the percent of women age 15-44 receiving adequate prenatal care as measured by the Kotelchuk index increased slightly.

Form 18 compares prenatal care and birth outcomes for the Medicaid and non-Medicaid populations. On each measure, similar to findings reported in the previous block grant application, results were more favorable for the non-Medicaid population than the Medicaid population in 2002. Pregnant women on Medicaid were less likely to enter care during their first trimester and to receive an adequate number of prenatal visits as measured by the Kotelchuk index, and babies born to women enrolled in the Medicaid program were more likely to be born weighing less than 2500 grams. (Infant death statistics in Arizona are not available by payer.)

Eligibility levels for Medicaid and SCHIP remained unchanged in 2003. Pregnant women and infants are eligible for Medicaid up to 140 percent of the Federal Poverty Level (FPL); children age 1 to 5 are eligible up to 133 percent of the FPL; and children ages 6 to 18 are eligible up to 100 percent of the FPL. SCHIP extends eligibility to 200 percent of the FPL for infants and children up to age 18 for those who do not otherwise meet Medicaid eligibility criteria.

The maternal and child health program has some direct access to databases specified in Form 19. There are current efforts directed toward increasing linkage capabilities to additional databases. Through the State Systems Development Initiative grant, a data warehouse has been designed and testing is being conducted to transfer data from various sources into the warehouse and conduct data matching. Testing of the database has begun. The warehouse, once operational, will provide direct access to databases currently housed within the ADHS (e.g. birth and death records, hospital discharge, birth defects registry, Children's Rehabilitative Services, Traumatic Brain Injury, Newborn Screening and Newborn Hearing Screening). The SSDI data workgroup is addressing the issues of data sharing in view of HIPAA Privacy Standards.

The Arizona Department of Education began implementing the Youth Risk Behavior Survey during the 2002/2003 school year. The ADHS collaborated with them in preparing for implementation, and data are now available.

Although direct linkage is not available to a number of databases valuable to the maternal and child health program, data is shared on an as-needed basis. Requests for data reports are made to the specific agency/program and those reports are prepared and submitted to us. Examples of such reports include: AHCCCS EPSDT, and clients served by race/ethnicity and age by WIC.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

After the completion of the five year needs assessment, OWCH reviewed its methods for identifying and prioritizing the needs of women and children in Arizona with the goal creating a process that was more participatory, more easily articulated, and more strategic in nature. This process would result in funding decisions that had the best chance of making an impact on the health of the maternal and child health population, and this strategy would be clearly reflected in the budget. A thorough evaluation of the Title V program was conducted to address three goals: 1) develop a process for identifying the health needs of women and children, 2) develop a process for allocating funding to address those needs and 3) develop a way to evaluate the effectiveness of those efforts.

The OWCH strategic plan, which is available at the OWCH web site, identifies two priority areas: to reduce mortality and morbidity of the maternal and child population; and to increase access to health care. The plan also identifies the need to decrease health disparities as an overarching priority. The functions of the various office sections are specified within the plan. These priorities and related measures were 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.

As a result of the strategic planning process, OWCH discontinued four of its previously defined performance measures and defined three new ones. For example, a measure to track the rate of babies born with spina bifida was dropped because OWCH would have very limited opportunity to impact this measure. It had earlier been defined as a proxy for appropriate folate use. However, spina bifida is a rarely occurring condition and even if all women consumed appropriate levels of folate, there would still be a certain level of neural tube defects. Other measures were discontinued either because of problems in collecting reliable data or redundancy with other measures. National and state performance measures and activities related to each of them are presented in section IV.C. and IV.D. of this document. Other activities which do not relate to performance measures are presented in section IV.E.

B. STATE PRIORITIES

The first identified priority is to reduce the postneonatal mortality rate. The Arizona rate continues to be above the selected target. Data from the Periods of Risk Assessment indicate that the Native American population has the poorest outcome. It is thought that targeted interventions at the community level may be an appropriate approach to this priority.

The second priority need is to increase the percent of children who have health care insurance/coverage. Data reveal that the percentage of children without health insurance is increasing again after a drop in 2000. The downturn in the state's economy over the past two years is likely to have affected this issue.

Improvement of women's health behavior is another identified need. Improvement in the overall health behaviors of women will have a positive effect not only on the health status of women but will also effect birth outcomes such as perinatal mortality and low birth weight rates.

Reducing health disparity between Native Americans, African Americans, and the general population is the fourth priority. Areas of concern for Native Americans include: incidence of anemia during pregnancy, incidence of diabetes during pregnancy, incidence of pregnancy-related hypertension, maternal weight gain, alcohol use, and infant mortality related to infant care. Areas of concern among African Americans include: tobacco use, alcohol use, SIDS, STDs, cardiovascular diseases and hypertension during pregnancy.

The fifth identified priority is that all children/youth with special health care needs should be in a system of primary and specialty care. The Office for Children with Special Health Care Needs (OCSHCN) in conjunction with Parent Leaders, providers, and other community partners, decided to revise this priority need to bring it into line with the nationally developed performance outcome measures related to comprehensive, coordinated care. Children with special health care needs (CSHCN) require not only the specialty care necessary to address their disease or condition but basic primary care in the same way that all children do. Also, in order to optimize their health potential, it is essential that primary and specialty-care providers work in a systematic way to share diagnosis and treatment information and cooperate in the development of care plans.

The sixth need is that all children and youth with special health care needs should have access to a comprehensive, coordinated system of health care. Children and youth with special health care needs often require services from a variety of providers in order to completely address their issues. In addition, in order to maximize the benefits of each caregiver, it is essential that their efforts be coordinated so that there are no gaps in services. Therefore, this priority has been revised to bring it in line with OCSHCN philosophy and programs and with the national outcome measures.

Reducing the rate of children 1 through 14 hospitalized for ambulatory care sensitive conditions per 100,000 is a priority. Ambulatory care sensitive conditions are those conditions which would not likely require hospitalization if adequate primary care services had been provided. In 2001 there were 490 hospitalizations per 100,000 children age 1-14, a rate that was below the target set for 2001 at 535 hospitalizations per 100,000 children.

The OCSHCN 2001 survey reported that 15 percent of children had gone without needed dental care within the past twelve months. Arizona children suffer from a high rate of tooth decay. The proportion of children in Arizona ages 6 - 8 years with tooth decay is 60 percent, which exceeds the national level of 52 percent. Over 43 percent of Arizona children, ages six to eight, have untreated tooth decay compared to 31 percent of children in the same ages nationally. Only 31 percent of Arizona children have dental sealants. These findings led Arizona to establish the eighth priority to increase the percent of children who have access to and utilize preventive dental care.

The ninth identified priority need is that children/youth with special health care needs and their families are involved in all aspects of program planning and policy development. Since the Office for Children with Special Health Care Needs was established, children and families have been the focus of the office goals. Adding this priority formalizes this philosophy and underscores the commitment of the office to the national goal.

Priority number ten is reducing disparity in teen pregnancy rates between Hispanics and the general population. Hispanic teenage females continued to have the highest age-specific pregnancy rates among all ethnic groups. Among girls aged 17 and younger, the 1999 pregnancy rate was 3.9 times greater for Hispanics (30.1) than non-Hispanic whites (7.8).

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

a. Last Year's Accomplishments

In 2003, 96.5% of infants received an initial screen, and 83% received a second screen. There were 69 positive screens identified, and all were appropriately treated. Metabolic conditions screened include phenylketonuria, galactosemia, homocystinuria, hypothyroidism, maple syrup urine disease, and biotinidase deficiency. During FY0203 CRS had 96 members with PKU, 2 with homocystinuria, 13 with maple syrup urine disease, and 8 with biotinidase

deficiency. Of the 119 CRS members with metabolic conditions, 98 receive a formula for their condition.

Newborn Screening Services (NBS) staff met with hospitals to discuss the follow-up process in their facilities. The major challenges to efficient follow-up were staff shortages and funding. Hospitals suggested a centralized data system to track babies who did not pass the inpatient screen and did not return for rescreening. NBS staff also participated in meetings regarding potential legislation to remove the requirement to contract out for laboratory services and to increase screening fees to allow expansion of the number of disorders screened, cover the cost of billing, and fund the Newborn Hearing Program to include follow-up.

The OCSHCN Sickle Cell program focused education on three areas. Each parent received a handbook with materials covering topics such as to when to call their primary care physicians and the importance of following the continuous antibiotic regimen. The 3rd revision of the Sickle Cell Disease Protocols as outlined by a panel of experts and a consortium of physicians was mailed to approximately 200 physicians who were treating children with Sickle Cell Disease and to emergency rooms. Primary care physicians were monitored to ensure compliance with providing children with prophylactic penicillin by the age of 3 and annual spleen exams. Program staff provided educational presentations to school nurses, physical education teachers, and homeroom teachers.

The Sickle Cell Patient and Family Needs Assessment Survey was developed by the Sedona Group, a world renowned group of hematologists, the state Sickle Cell Program, and consumers from several states. There were 42 parent/caregiver respondents for children ranging in age from 9 months to 20.9 years. Results indicated that 74% had no problems getting good health care; 76% felt comfortable treating and controlling their child's pain; 79% were having no problems with health insurance; 88% were comfortable with the clinic staff's knowledge of Sickle Cell Disease; 90% stated the clinic understood and were sensitive to the family's cultural background and needs; 95% felt they were part of the decision-making process; and 60% of those with children over age 12 felt their children were being prepared for an independent life. In open-ended questions, parents indicated they had difficulty dealing with children's pain and needed more information on support groups, transition to adulthood, and research/transplants.

b. Current Activities

The Office of Newborn Screening provides testing of blood specimens for specific disorders, conducts follow-up on abnormal test results, and together with Children's Rehabilitative Services, acts as payer of last resort for metabolic formula. In addition, the High-Risk Perinatal Program works with the Governor's Office, AHCCCS, insurance plans and other health providers on increasing the availability of developmental screens and evaluations for preschool-age children.

The Newborn Screening Program continues to provide education to primary care physicians and parents on infants with an abnormal newborn screen regarding specific disorders and on the resources available to them. The program works closely with parents, parent advocacy groups and interventionists to improve parent-to-parent support opportunities and to facilitate sharing of how to access services. Collaboration with the Sickle Cell Program continues to assure a smooth transition of follow-up for infants with abnormal hemoglobin test results on the newborn screen.

Community health nurses and lay health workers educate families about the need for a second screening and facilitate referral to the medical home for those screenings.

OCSHCN provides consultation and educational services for children with Sickle cell Disease

as well as those with the trait. OCSHCN holds the contract with the Sickie Cell Society to consult and they have the Arizona state contract to counsel all newborns with the trait. Counseling is offered one time with follow-up provided only at the initiation of the family. Parents are informed of the materials/resources provided by the Sickie cell Society and parents are offered the option to be tested if they are unaware of their status.

OCSHCN Sickie Cell Program staff contact parents immediately upon notification by the Newborn Screening Unit of a diagnosis of Sickie Cell Disease. The interface may be either by telephone or face to face with the family in their home or in the physician's office. The OCSHCN Sickie Cell program focused education on parents, physician and school. Staff maintain contact with parents up to three times a week during the first three months following diagnosis to ensure that parents understand the disease, and are encouraged to call the OCSHCN with additional questions. CRS currently serves 148 Sickie Cell Disease cases and there are another 100 individuals with Sickie Cell disease who are not part of CRS.

c. Plan for the Coming Year

OWCH and OCSHCN will continue to provide a safety net of services, conduct screening and follow-up services and act as payer of last resort for metabolic formula. They will continue to work with insurance plans and health providers on increasing the availability of developmental screens and evaluations, and with hospitals that have recently opened birthing facilities and are not yet screening for hearing loss.

OWCH will integrate standardized anticipatory guidance related to first-year risks into OWCH programs. This process will begin with an identification of existing materials into a resource list. The Community Services Section will work with the Arizona chapter of the American Academy of Pediatrics and community health nursing agencies to revise and communicate expectations to providers, and will monitor utilization of anticipatory guidance standards among contractors.

In partnership with developmental care coordinators and the Arizona Early Intervention Program, OWCH plans to increase the number of children screened and referred for developmental delays. A screening process will be developed for use prior to hospital discharge that is recognized in the perinatal community for referral. Resources to be used for anticipatory guidance and parent education will be developed with the High-Risk Perinatal Program (HRPP) follow-up committee and hospital discharge coordinators. HRPP will collaborate with other agencies and community resources to define an appropriate referral process to facilitate entry into early intervention services.

A white paper will be developed to identify barriers and opportunities for improvement within the referral and enrollment process. A quick reference guide on screening and referral mechanisms will be created for use by providers. Healthy Steps training and other educational sessions will identify ways to educate on the screening and referral process at many levels including resident, medical staff and community provider inservice training.

OWCH Assessment and Evaluation staff will work with the Newborn Screening Program to provide technical support for the development of electronic data reports thus reducing dependency on use of contractor services.

CRS will develop strategies to improve the process through which families receive information about transitioning out of CRS for families lacking financial resources to continue with the dietary regimen of children turning 21 years of age and receiving a formula for metabolic conditions.

OCSHCN will continue to monitor the timeliness with which children with positive diagnoses receive appropriate care for Sickle Cell disease and the results of the Sickle Cell Family Survey will be shared with parents/caregivers as part of a process to develop an action plan to address some of the areas of concern.

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)

a. Last Year's Accomplishments

In 2001, 51.4% of parents of CSHCN partnered in decision making at all levels and were satisfied with the services they received. Based on SLAITS data: 82.2% in Arizona agreed that doctors usually or always made the family feel like a partner, compared to 84.3% nationally; and 54.4% in Arizona agreed that the family was very satisfied with the services received, compared to 60.1% nationally.

Through the Tsunami Project, 45 parents and youth were paid to assist OCSHCN in developing or evaluating the office brochures and web page and participating in interviews for key staff. Tsunami parents and youth were involved in creating trainings and making presentations on Transition to Adult Care, Breaking the Diagnosis, and Care Coordination to the four regional CRS sites and a multidisciplinary class that is part of Northern Arizona University's graduate program. Spanish-speaking and multicultural parents and youth were recruited to assist in the development of culturally effective programs and resources for OSHCN staff, medical providers, and other families and youth.

Through contracts with Raising Special Kids and Pilot Parents of Southern Arizona, OCSHCN supported the promotion of family-centered care at the Phoenix and Tucson CRS regional clinics.

Education on patient rights and responsibilities was provided to staff, families, and specialty providers. Raising Special Kids training programs were offered to eight residency-training programs in Maricopa County and a community college nursing program.

OCSHCN provided support to 27 active parent leaders coordinating 8 community action teams statewide. The May conference was attended by 130 parent leaders, community action team members, and other stakeholders throughout the state and provided training on team building, communication, and planning. Topics for the September meeting were selected, researched, and delivered by the parent leaders and included conducting community assessments, collaborating with community leaders, the changing roles of parent Leadership, and resources for planning recreational programs.

Parents of CRS enrollees are part of the administrative team and representatives from all four of the regional clinics are included in administrative and medical director meetings.

b. Current Activities

Based on the parent reported need to sustain parent trainings, OCSHCN applied for and received an \$18,000 Champions for Progress grant from Utah State University to create a Parent and Youth Leadership Institute. Parents and youth are developing the curriculum, providing training of the trainers, and evaluating the effectiveness of the training. A database is being developed that will allow tracking of parent/youth leadership development, work activities, outcomes, and cost.

Tsunami parents and youth are revising the training modules offered through the Parent/Youth/Physician Interaction Project. They are also developing protocols and informational guides to assist parents, youth, and providers in utilizing the telehealth system.

OCSHCN continues to provide networking opportunities for the Community Action Teams by coordinating a monthly Parent Leader facilitated conference call and biannual meetings/trainings. Additionally, families of children experiencing behavioral health issues are actively participating on the Community Action Teams.

Families are developing and implementing a plan to create the Community Development Interagency Initiative. Families plan to provide education to the staff of Arizona Department of Health Services, the Arizona Medicaid Agency (AHCCCS), DES, and the Department of Education on the community development model used by the OCSHCN. This group will present a proposal to the Governor's Children Cabinet in August 2004 and ask for a commitment to pursue this development further.

c. Plan for the Coming Year

Tsunami parents and youth will work with the OCSHCN Medical Director to develop new training modules for the Parent/Youth/Physician Interaction Project. This project will include an expanded number of presentations at Northern Arizona University as well as pursuing opportunities to provide these modules throughout the Arizona community college system, Arizona State University, and the University of Arizona. CME approved training modules will include: Breaking the Diagnosis; Communication with Families; Culturally Effective Care; and Transition from Pediatric to Adult Care.

OCSHCN will encourage increased involvement of the Regional Behavioral Health Authorities as a professional partner on the Community Action teams.

The Parent Leader from the Tri-City partnership will continue working with the Prescott Valley School Superintendent, Special Education Director, teachers, and other parents to expand their special education programming and develop curriculum for the self-contained, mid-level, and extended resource programs allowing teachers to individualize the curriculum to meet the needs of their students and provide the teachers with the opportunity to acquire needed skills.

OCSHCN will conduct a Family Centered Care Survey to evaluate the satisfaction of three separate groups: family and youth of transition age; families and youth who have received inpatient and outpatient services; and families and youth who have received only outpatient services. Additionally, stratified analyses of the SLAITS data will attempt to identify some of the priority needs among family members of children with special health care needs throughout Arizona.

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)*

a. Last Year's Accomplishments

The 2001 Survey of Children with Special Health Care Needs showed that 50.5 percent of those surveyed in Arizona received ongoing comprehensive care within a Medical Home compared to the national average of 52.6 percent. Five questions contribute to this core outcome measure: the child has a usual source of care (Arizona 91.2 percent, National 90.5 percent); the child has a personal doctor or nurse (Arizona 88.2 percent, National 89 percent);

the child has no problem obtaining referrals when needed (Arizona 74.4%, National 78.1 percent); effective care coordination was received when needed (Arizona 30.5 percent, National 39.8 percent); and the child received family-centered care (Arizona 63.7 percent, National 66.8 percent).

The Medical Home philosophy became part of the Scope of Work for the CRS regional contractors effective July 1, 2003. Plans have been received from all contractors on how they will implement the Medical Home philosophy.

During 2003 OCSHCN partnered with the state MCHB Medical Home grantee to establish Medical Home teams in eight Arizona communities. OCSHCN staff worked to promote the Medical Home project to the existing community action teams and recruited medical home parent leaders in each of the communities. OCSHCN staff provided training to these parent leaders on the concepts of Medical Home and participatory action research. Parent leaders identified pediatric or family practices in six communities to participate in this implementation project. OCSHCN provided in-service trainings on Medical Home to individual practices in each of the six communities. OCSHCN hosted a monthly conference call for the Medical Home parent leaders around the state as they developed the Arizona medical home network. OCSHCN established a Medical Home/Transition program manager to coordinate medical home initiatives for our office and to identify and address issues related to the transition of youth to adult care.

OCSHCN contracted providers partner with the family and their primary care physician to facilitate a coordinated, ongoing, comprehensive system of care within a medical home. Information regarding the medical home status of CSHCN was routinely gathered from families receiving service coordination, developmental follow-up services, or community health nursing services through OCSHCN. Families received information and assistance in establishing care within a medical home.

b. Current Activities

In September 2004, each regional CRS contractor will submit a description of how their Medical Home plan was implemented and an evaluation based on their approved plan. An evaluation of the Medical Home implementation will be included in the clinical site visits.

While continuing the monthly conference calls and staff meetings with the Arizona Medical Home project staff, OCSHCN is developing a Medical Home campaign. Key partners are being identified who will assist in the preparation of a medical home article for the newsletters of the two parent training and information centers. OCSHCN has been asked to develop a Medical Home training module for parents with children/youth with special health care needs to be offered through the two information centers and to include Medical Home information in the Resident and Student Nurse training, as well as include information about Medical Home in the Partners in Policymaking resource packets.

The Medical Home and Transition Program Manager is currently working with the OCSHCN Medical Director to evaluate the communication process between physicians and children/youth with special health care needs. This evaluation will provide data to support the production of pamphlets and a video to help both the physicians and child/youth with special health care needs communicate more effectively. These pamphlets and the video will be developed in partnership with Tsunami Youth. Also the Medical Home and Transition Program Manager is developing curriculum for educators (e.g. special education teachers, 504 Coordinators, Homebound teachers, instructional assistants, and nurses) to better understand the Medical Home concept and process. The goal is for educators to view physicians as integral figures in planning educational goals and objectives related to the IEP or 504 plan.

OCSHCN community teams partner with the Southwest Institute for Families and Children with Special Needs on the implementation of the Medical Home and Building Community Health in Arizona, Maternal and Child Health Block grants. OCSHCN provides support that assists teams in implementing grant activities.

Staff from the OCSHCN as well as a youth and family member will be attending the National Medical Home Conference in July 2004. The youth and family member have been offered a scholarship by the conference.

c. Plan for the Coming Year

Plans for 2004-2005 are to:

- * Develop a coordinated and strategic plan for the development of Medical Homes that includes OCSHCN, OWCH, community, state, and federal partners.
- * Publish a training manual on Medical Home for educators.
- * In conjunction with contracted CSHCN children, youth, and parents, OCSHCN Medical Director will write an issue brief on the communication process between physicians and children/youth with special health care needs.
- * Develop and implement e-classes related to Medical Home.
- * Offer mini-grants to physicians to implement the Medical Home process in their practices.
- * Evaluate all practices in Arizona that are currently implementing a Medical Home using the Medical Home Improvement Toolkit.
- * Offer educational modules for clinicians on how to create and sustain a Medical Home.
- * Apply for Medical Home grants beginning October 2004.
- * Partner with Arizona AAP and Family Voices on upcoming Medical Home grant.
- * Partner with the Illinois Division of Specialized Care to implement a Provider Directory of Physicians offering medical services to children/youth with special health care needs in Arizona.

Additional analyses of the data from the Survey of Children with Special Health Care Needs will focus on potential explanations of the low occurrence and/or lack of satisfaction with the care coordination received. Additional analyses will be directed at evaluating those variables most likely associated with participation in a Medical Home to determine if there are specific outreach/educational efforts that might increase the number of families of children with special health care needs participating in a Medical Home.

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)*

a. Last Year's Accomplishments

According to SLAITS data, 60.8 percent of families of CSHCN had adequate private and/or public insurance to pay for the services they need. The total CRS population in 2003 was 17,440. Of the total enrolled, 14,710 CRS children were eligible for Title XIX (84.3 percent); 987 CRS children were eligible for Title XXI (5.7 percent); and 2,730 CRS children were funded by state only coverage (15.7 percent).

CRS is working with AHCCCS to develop joint educational opportunities for providers and other community resources to learn about the CRS program. A general overview session has been provided to both the acute and long-term care programs. CRS, Arizona Early Intervention Program, Newborn Hearing and Metabolic Screening, Office of Nutrition and WIC representatives met in December to discuss communication issues between hospital discharge planners and social workers and programs offered by the State for CSHCN. A date was set for

an inservice training for labor and delivery and nursery discharge planners and social workers statewide regarding referral to state programs.

The Arizona Birth Defects Monitoring Program identified children in Arizona with neural tube defects who were diagnosed before the age of one with a major birth defect. The program identified them within 6-18 months of birth. The program participated in parent education and information on cardiac defects and Down Syndrome at a Sharing Down Syndrome Fair. Requests from the community on how to access programs for CSHCN were answered. A brochure on the Arizona Birth Defects Monitoring Program was developed which included basic information on birth defects and contact phone numbers for more information about the program.

The OWCH Newborn Screening Program continued to serve as payer of last resort for special formulas for children with metabolic diseases at the four CRS regional clinics. The Birth Defects Monitoring Program collaborated with CRS to provide follow-up contacts with families of children identified by the rapid-surveillance registry to inform the families of available community services. Analysis of data from the High Risk Perinatal Programs showed that 63% of the infants served had AHCCCS coverage, 58% had private insurance, and less than 1% were either uninsured or had an unknown insurance status. On-site eligibility screening and enrollment services are provided through CRS.

b. Current Activities

Families who report no insurance coverage for CSHCN receive information and assistance in applying for appropriate insurance coverage. The CRS Regional Clinics provide on-site enrollment services. There are numerous activities underway by the contracted CRS providers to maintain continuous Title XIX and XXI coverage by providing families with a 60- and 30-day notice of expiration of coverage to allow sufficient time for the families to reapply.

Numerous state agencies including AHCCCS, DES, and ADHS/OCSHCN are developing plan which will be submitted to the Governor's Efficiency Review Board which will recommend the adoption of a Universal Eligibility Application Form allowing all of the agencies to share information on one enrollment form.

Plans are underway to provide a statewide training on CRS to DES/DDD service coordinators.

Capitation reports from the CRS database are generated and sent monthly to the regional contractors. 0% Pay with and without Insurance reports are sent quarterly to regional contractors to research whether the members do not qualify for AHCCCS (Title XIX) or KidsCare (Title XXI), and if they are at 0% by checking their deductions.

The Arizona Birth Defects Monitoring Program gathers information for future development of diagnosis-specific flyers summarizing state and community services and resources and eligibility requirements of children diagnosed with particular birth defects to be distributed to families of children identified by the rapid-surveillance system.

c. Plan for the Coming Year

OCSHCN will continue the education and referral process to ensure that all eligible children/youth receive appropriate coverage to pay for needed services. A significant amount of research will occur, as part of the FY 2005 Needs Assessment process, to identify the uninsured and underinsured in Arizona.

OWCH Newborn Screening Program will continue to pay for metabolic formula for uninsured children. OCSHCN will continue outreach activities to ensure that all eligible children receive

needed services.

The Arizona Birth Defects Monitoring Program will continue to gather information for future development of diagnosis-specific flyers summarizing state and community services and resources and eligibility requirements of children diagnosed with particular birth defects to be distributed to families of children identified by the rapid-surveillance system. They will also mail neural tube defect recurrence prevention information discussing the potential benefits of increased folic acid intake to families of children with neural tube defects identified by the rapid-surveillance system. Free multivitamins will be provided through a CDC grant to families for recurrence prevention.

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)

a. Last Year's Accomplishments

The 2001 Survey of Children with Special Health Care Needs showed that 70.9 percent of the families with children with special health care needs (CSHCN) reported that community-based service systems were organized so they could use them easily. Nationally, 74.3 percent of the families of CSHCN reported they services were easy to use.

From July 2002 to June 2003, Children's Rehabilitative Services (CRS) contracted with 22 outreach clinics statewide. Out of a total of 37,707 clinic visits during this time, 1,731 visits were to outreach clinics (5%). The majority of these clinics occurred in Native American communities.

In 2003, the CRS telehealth network connected the four CRS clinics and the OCSHCN, providing families with the opportunity to receive services in their own community. Additionally, there was increased utilization of other rural videoconference equipment throughout the state to provide services in local communities. The OCSHCN was awarded a \$250,000 grant from the Arizona Department of Health Services Office of Health Systems to enhance the technical capabilities of the videoconferencing system. In addition, a \$109,000 donation was designated to purchase additional videoconferencing equipment. CRS contractors and OCSHCN staff successfully completed training with the University of Arizona Telehealth Program. OCSHCN staff developed protocols for videoconferencing as well as a tracking system to monitor videoconferencing request, scheduling, activities, and usage. Parents and youth under contract at each CRS site were involved in the development of the telehealth system.

Through family satisfaction surveys, home visits, and personal interviews, families of CSHCN were encouraged to participate in the evaluation and ongoing development of service delivery systems. OCSHCN continued to partner with parents, state agencies, community organizations, and other professionals to evaluate and respond to barriers impacting the current service delivery system.

OCSHCN provided financial support to 27 active parent leaders coordinating 8 community action teams statewide. The Community Action teams provided special education services in rural communities with a high population of special needs children; built recreational facilities in public parks that are appropriate for CSHCN; incorporated specific medical information on CSHCN into the 911 databases to assist personnel responding to emergency calls; petitioned the US Postal service to provide home mail delivery in a rural community dependent on post office boxes 30 miles away; and built resource centers in three rural communities that provide the public with information and assistance on issues related to children and youth with special health care needs. One team secured a grant from Wells Fargo to provide financial assistance

to families of CSHCN whose insurance or financial resources were not adequate.

b. Current Activities

OCSHCN continues to partner with parents, state agencies, community organizations, and other professionals to evaluate and respond to barriers impacting the current delivery system. OCSHCN supported parent leaders receive training and technical assistance that enables them to influence policy development and to advocate for CSHCN on a state, local, and federal level.

OCSHCN supported parent-led community action teams are currently participating in the development and implementation of an interactive data system to map community resources on a statewide basis. The Flagstaff Community partnership is currently compiling their community assessment data into a comprehensive report outlining specific challenges and opportunities impacting CSHCN and their families. This report will be critical in focusing attention on strengths and weaknesses in the system of care in the Flagstaff community.

OCSHCN is working with the University of Arizona and the four regional CRS sites to establish protocols for clinical usage of the equipment. These protocols include establishing guidelines for inter-clinic transfers for youth receiving services at multiple sites as well as developing quality improvement monitoring systems. All of the sites are collecting evaluation data from the telehealth facilitator at each site as well as from each of the participants in each telehealth presentation. This data will be used to evaluate the technical quality of the transmission as well as the utility for the users of the system.

By August 2005, the OCSHCN will disseminate the results of the clinical study on "Care of Children with Traumatic Brain Injury in Maricopa County" conducted by Barrows Neurological Institute, St. Joseph's Hospital and Medical Center.

c. Plan for the Coming Year

The Community Development Section of OCSHCN will be working with families and youth to develop a parent-led team in Tucson and Kingman. These teams will work with state and local agencies to identify existing resources and assets and to build capacity within their community. Community Health Nursing and Service Coordination contract providers will continue to assist families in identifying and accessing appropriate services.

OCSHCN, in collaboration with Michael Allison, Native American Liaison for the Arizona Department of Health Services, will develop and disseminate a quarterly newsletter that will highlight new opportunities and programs that are responsive to tribal needs.

The challenge for the next year in telemedicine will be to establish compatibility between the contractors. The contractors will be purchasing clinical equipment to augment the telehealth system including digital stethoscopes, general-purpose cameras, and still cameras. One site will purchase equipment to conduct cardiac evaluations with other CRS sites, while another site is planning on establishing a link between the hospital's neonatal intensive care unit and the University of Arizona's health service specialists. Each of the sites will continue to recruit and contract with youth to serve as advisors. The telehealth sites will explore expanding the telehealth services by working with other departments within ADHS (i.e., Emergency Preparedness), collaborating with other states, tribal outreach clinics, various border communities, and interfacing with Shriner's Hospital.

a. Last Year's Accomplishments

The 2001 Survey of Children with Special Health Care Needs showed that only 2.5% of the population of Arizona satisfactorily met this standard, a number that did not meet the NCHS standard for reliability or precision for Arizona. Nationally this core measure was achieved by only 5.8% of the population. The core outcome measure was a composite of five questions, all of which met the criteria for reliability and precision. The first was whether doctors had talked about the changing medical needs of a child becoming an adult; Arizona had 35% compliance compared to 50% nationally. The second question was whether the child had a plan for addressing changing needs. Arizona achieved 40.9% compared to 59.3% nationally. The third was whether the doctors discussed a shift to an adult provider; Arizona achieved 28.9% compared to 41.8% nationally. The fourth question was whether the child had received guidance and support in transition to adulthood; Arizona achieved 3.9% compared to 15.3% nationally (the Arizona proportion was not a reliable estimate). The final question asked if the child had received vocational or career training; Arizona achieved 28% compared to 25.5% nationally. Part of the reason for the low level of compliance was due to the fact that only children over the age of 13 years of age were queried for this measure.

Every September the CRS regional contractors must submit a Transition to Adult plan and an evaluation based on their approved plan for the previous year. Contracted youth in the Tsunami project were involved in the development and provision of training on "Youth Transition to Adult Care" to the four regional CRS sites.

OCSHCN supported an Arizona Governor's Council on Developmental Disabilities funded grant through our partnership with the Healthy Ready to Work transition implementation project. Several modules of training were offered to youth leaders over an eight-day leadership institute. Graduates of this program were offered position within the Tsunami project.

OCSHCN contracted service coordinators assisted youth with traumatic brain injury and other special health care needs in assessing age-appropriate services.

b. Current Activities

OCSHCN contracted service coordinators throughout the state receive training on planning for and transition to adult services. OCSHCN worked with the Governor's Council on Spinal and Head Injuries to present "Transition Issues for Youth with TBI" at a joint conference of the Arizona Department of Education and Rehabilitation Services Administration.

To provide a more coordinated focus on transition issues, a Medical Home/Transition Program Manager was hired; this individual also serves as the State Adolescent health Coordinator. A Youth Coordinator position has been filled by a former Healthy Ready to Work Youth Facilitator who will coordinate the activities of the Tsunami youth. The Youth Coordinator will attend the 2004 national Youth Leadership Conference in Washington, DC. Tsunami youth who graduated from the leadership institute are assisting the OCSHCN in the development of transition brochures. The content of these brochures are from a youth perspective and include: "What I Want My Physician to Know About Transition;" "What I Want My Parents to Know About Transitions;" "What I Want My Peers to Know About Transition;" and "What is Telehealth: A Youth Perspective." The OCSHCN will partner with Pilot Parents of Southern Arizona and their Partners In Policy MAKing program to offer some of their youth graduates the opportunity to put their skills to use as advisors or partners in the OCSHCN activities.

Numerous partnerships with other agencies have been initiated to address areas associated with transitioning youth that may participate in multiple systems. These partnerships include: the ADHS Office of Nutrition; the Division of Developmental Disabilities; and the Arizona

Medicaid program, AHCCCS.

Staff from the OCSHCN is participating in the development of new questions regarding transition issues to be included in the next Survey of Children with Special Health Care Needs conducted by the National Center for Health Statistics.

c. Plan for the Coming Year

OCSHCN will continue regional training and technical assistance for providers who coordinate transition to adult services. Community outreach efforts will be continued through collaboration with other state agencies and organizations such as Children's Information Center, Raising Special Kids, Pilot Parents of Southern Arizona, and the Arizona Brain Injury Association.

OCSHCN will identify youth at each CRS site that are willing to be available to youth at other locations that are planning for transition. Utilizing the telehealth equipment, sites with a small number of transitioning youth will benefit from sites with larger numbers and a more diverse group of transitioning youth. OCSHCN will also work with the regional CRS sites to identify opportunities for connecting pediatric specialists with adult providers who may assume the responsibility of providing care to transitioning CSHCN.

OCSHCN will partner with the Department of Education to evaluate changes in health risk behaviors over time utilizing data from the Youth Risk Behavior Surveillance System. This system which determines the prevalence of health risk behaviors, will allow for a determination of change in health risk behaviors over time for certain subpopulations of youth. This information will assist in designing health prevention strategies for special needs youth. The OCSHCN Medical Director will develop and disseminate educational modules to clinicians working with CSHCN on how to effectively promote good nutrition and physical activity and decrease tobacco use. The Medical Director will also coordinate efforts with the AzAAP to provide presentations to clinicians on adequate monitoring for obesity prevention for CSHCN.

OCSHCN will develop curriculum for educators, medical providers, health plans, and school nurses to provide appropriate resources and support to transitioning youth in maintaining their health, accessing health care, and evaluating the psychosocial status.

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.

a. Last Year's Accomplishments

In 1997, the CDC National Immunization Survey (NIS) estimated that 55% of Arizona's two-year old population completed the combined recommended series of immunizations including at least 4 DPT, 3 OPV/IPV, 1 MMR, 3 HiB, and 3 Hep B by age two. For the next few years, the 4:3:1:3:3 series rate ranged between 65.7% and 69.0% until the most recent estimate for 2003 rose to 75%, exceeding the 2003 objective of 73.0%. The national 4:3:1:3:3 series rate for the same time period rose to 77.9%. With the exception of DtaP, the percent of children receiving the recommended numbers of doses of individual vaccines each exceeded 90%: 79% received 4 DtaP; 90% received 3 polio; 92% received 1 MMR; 94% received 3Hib; and 94% received 3 Hep B.

The Arizona Partnership on Immunization (TAPI) continued to exhibit at professional organizations and immunization-related conferences, such as the Arizona chapters of the American Academy of Pediatrics and Academy of Family Physicians, the 10th Annual Arizona Immunization Conference, and hosted the National Immunization Coalition Conference. TAPI

continued to encourage participation and in the Learn at Lunch programs to enhance and improve parental understanding and acceptance of childhood immunizations and compliance with the recommended schedule.

TAPI partnered with the ASU College of Nursing in a training seminar for graduate-level community nursing students on the value of community partnerships in immunization; with St. Luke's Hospital and Western International University to provide comprehensive immunization training for 50 medical students; with Phoenix Children's Hospital to continue program development with residents on reporting to the Arizona State Immunization Information System (ASIIS) and the benefits of immunization history in emergency medicine; with WIC to develop an incentive program for parents who brought in immunization records to their six-month recertification visit; and with health plan and pharmaceutical representatives to assist provider offices in reporting to ASIIS immunizations given through age 18 so all children will have a reliable immunization record in the registry.

The Children's Information Center served on TAPI and ADHS immunization committees and disseminated immunization materials in all information packets to families who contact the hotline for assistance. Health Start and High Risk Perinatal Programs monitored the immunization status of children and promoted immunizations, with Health Start documenting 90% of two-year olds were properly immunized. The immunization records of children in the WIC Program were screened to ensure proper timing of DtaP shots.

Seed money was provided through a child health community grant with Phoenix Children's Hospital and St. Joseph's Hospital to establish a clinic on site at the Salvation Army homeless shelter, which provided 150 children with immunizations during its first 10 months.

b. Current Activities

OWCH continues to fund The Arizona Partnership for Immunizations. Their activities include conducting educational programs in immunization provider offices to improve reporting to the Arizona State Immunization Information System, enhancing and improving parental understanding and acceptance of childhood immunizations, collecting and analyzing data from selected health plans; and developing an immunization education component into the curriculum for teaching hospitals in the state.

OWCH Community Services programs and the County Prenatal Block Grant contractors promote awareness of the need for age appropriate immunizations and facilitate referral of children to their medical home or other community resources for obtaining immunizations. Anticipatory guidance for infants on immunizations is identified and promoted and immunization completion rates are assessed among program children. Provision of education to parents regarding immunization are reviewed during site visits.

County health departments provide immunization clinics in their clinics, and in schools. The Children's Information Center Hotline assists callers in identifying resources for the provision of immunizations, and distribute information regarding childhood immunizations in all of their packets.

c. Plan for the Coming Year

The OWCH will continue to fund the TAPI contract to support efforts aimed at increasing Arizona's immunization rate for children. TAPI plans to develop a newsletter to be published and distributed quarterly to all immunization service providers on their mailing list, and will continue their education and assessment efforts. TAPI will evaluate and modify its Learn at Lunch program, and will develop marketing materials to include comprehensive immunization coverage in the company insurance package for distribution to the one hundred largest

employers in Arizona. They also will collaborate with the Arizona Immunization Program Office to promote, support and sponsor legislation for the purpose of strengthening immunization practices.

OWCH staff will participate as requested on TAPI committees and will provide educational materials to contractors and clients related to childhood immunizations. Assessment of the immunization status of Health Start and High Risk Perinatal Program children will be conducted to determine status, educate parents and refer families to appropriate resources when immunizations have been missed. OWCH will review the provision of education to parents regarding immunizations during site visits. The Office of Chronic Disease and Nutrition Services will coordinate immunization record screening by WIC staff to ensure proper timing of the DtaP shot in WIC children.

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

a. Last Year's Accomplishments

In 2002, there were 35.5 live births per 1,000 teen girls in Arizona, which is below the target rate of 43. There has been a steady decline in teen births since the high of 53.0 per 1,000 teens in 1994; and although the teen birth rate in Arizona remains above the national rate, it continues to decrease at a faster rate. (Because data are not yet available for 2003, the 2002 rate is also provisionally listed as the rate for 2003.)

Through the Abstinence Education Program, 16 contractors were funded to provide abstinence education services in 11 counties. A total of 31,654 youths and 127 parent participants were reached. A local abstinence conference was held, quarterly trainings were provided, four Teen Maze events were funded and all contractors received one annual site visit in which education services were observed. Three new thirty-second television spots were produced and aired on cable networks, and four radio spots were aired on local radio stations.

b. Current Activities

Due to state funding reductions the Abstinence Program is currently supporting only seven education contractors. The media component of the Abstinence Program will end on June 30, 2004. Plans are being developed to spend the remaining Proposition 204 Tobacco Settlement funds for teen pregnancy prevention education and projects.

OWCH continues to collaborate with local and national teen pregnancy prevention and abstinence education advisory groups to promote effective strategies among youth and parents, and to participate on the Arizona Department of Education HIV/AIDS Materials Review Committee. Staff attend local and national conferences and meetings to share data and information. OWCH continuously researches best practices for teen pregnancy prevention and abstinence education services and distributes it to community providers. Quarterly training is provided to funded programs, which includes training on approved abstinence curriculum.

The OWCH assessment and evaluation staff presented data to key stakeholders earlier in 2004 regarding teen pregnancy in Arizona.

c. Plan for the Coming Year

The Abstinence Education Program will continue to research best practices and distribute information to community providers. OWCH will continue to provide Proposition 204 funding for teen pregnancy prevention education and projects, and will implement a plan to spend remaining Proposition 204 funds. Staff will continue to participate on the Arizona Department of

Education HIV/AIDS Materials Review Committee, and continue to educate providers regarding best practices for teen pregnancy prevention and abstinence education services.

OWCH Assessment and Evaluation staff will assist community services programs in evaluating their programs aimed at reducing teen births, and Health Start data will also be analyzed for information related to teen births. Statewide, county and community level data will be analyzed to identify subpopulations with the high rates of teen births.

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

a. Last Year's Accomplishments

The Office of Oral Health (OOH) estimates that in the year 2003, 36.2 percent of third graders had received protective sealants on at least one tooth (95% confidence interval = 31.4% - 41.1%). The estimate was based on a multi-stage stratified random sample of students within urban and rural communities with populations of at least 1,000 from the 1990 census, and excluding Indian reservations. Methodology included sampling schools with high, medium, and low free and reduced lunch enrollment where classrooms from third grade were then randomly selected. Data collection began in the Fall of 1999 and continued through Spring 2002, representing three complete school years.

OOH funded three communities to conduct oral health improvement plans, develop strategic plans or design/implement oral health improvement plans through the Arizona Community Oral Health Systems Development Initiative, which awards local communities funding and provides technical assistance to improve oral health. In addition to implementing a quality improvement program for the Arizona Dental Sealant Program, OOH provided 29,459 dental sealants to 7,663 high-risk children in 6 counties; dental screenings and referrals to 9,065 high-risk children; and school-based fluoride mouthrinse to 26,500 school children.

A statewide oral health Head Start summit was held to engage traditional and nontraditional partners in improving oral health and to develop a state oral health action plan targeting young children. Technical assistance was provided to at least 40 Arizona agencies on dental public health issues, and 2,162 people received training on working with developmentally disabled patients, early childhood caries, collecting data for surveillance and osteoporosis. OOH provided extensive technical assistance to Pima County Health Department and United Community Health Center in the development of new community-based dental sealant programs and to a community collaborative to elevate the importance of pediatric oral health issues.

In order to help underserved populations locate low-cost dental services, the OOH conducted a survey of all public dental clinics in Arizona to determine the scope of services and eligibility of clientele. Information is now available through a referral hotline housed at the Arizona Dental Association. OOH also conducted surveys of dental hygienists and dentists to identify dental health professional shortage areas.

The OWCH included oral health as a priority issue in the Request for Proposals advertised this year. Four contracts were awarded to community-based programs to increase access to oral health services and/or provide preventive oral health services.

b. Current Activities

The Office of Oral Health (OOH) continues to provide dental sealants to high risk and low income children throughout the state, and school-based fluoride mouthrinse to school children.

OOH provides technical assistance on dental health policy issues to Arizona agencies, and assists local coalitions, counties, and agencies in conducting oral health needs assessments and strategic planning. OOH continues to collaborate with other agencies and organizations to increase the number of children receiving dental sealants and to develop new models of dental health care delivery.

Children's Rehabilitative Services provides dental sealants to specific diagnostic groups, such as those with Cleft Lip/Palate as part of their treatment plan.

c. Plan for the Coming Year

The Office of Oral Health (OOH) will assist in the development of policy and standards in oral health care by providing technical assistance on policy issues to at least 20 Arizona agencies. They will continue the grant program to assist local coalitions, counties, and agencies in conducting oral health needs assessments, developing strategic plans, and implementing oral health initiatives (target 6 communities). They will increase the knowledge of oral health care by providing education, training, resources, and communication to Arizona residents, communities and health professionals.

The OOH will prevent tooth decay in Arizonans through the Arizona Flouride Mouthrinse Program, which will provide school-based flouride mouthrinse to 20,000 school children; and will prevent tooth decay in high risk and special needs populations through the Arizona Dental Sealant Program, providing sealants to high-risk, uninsured children, and dental assessments and referrals to at least 7,000 high-risk, uninsured children. They will continue to implement a quality improvement program for the Arizona Dental Sealant Program, and conduct an evaluation of it. OOH will collaborate with other agencies and organizations to increase the number of children receiving sealants (e.g., National Guard, Arizona Dental Association, dental hygiene schools), and will pilot an alternative model for services to meet the needs of rural communities.

OOH will conduct a statewide children's oral health needs assessment. Data capacity within OOH will be maintained for surveillance and program reporting and evaluation. With key collaborators, OOH will design and implement a statewide oral health surveillance system to include preschool population, elementary schools, adolescents and women of child-bearing age/pregnant or postpartum women (exploratory only). Community oral health profiles will be completed.

OOH will increase knowledge of early childhood caries prevention by providing education on infant and toddler oral health to professionals and consumers, and supporting community-based early childhood caries pilot prevention initiatives. OOH will maintain the Arizona Dental Trailer Loan Program and continue to participate in collaboratives to improve access to oral health services, including partnerships with AHCCCS, AZ OH Task Force, and community-based coalitions.

Under a grant from OOH, funding will be available to provide protective sealants at each of the CRS regional clinics. Logistics as to who is qualified to do this procedure are being worked out.

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

a. Last Year's Accomplishments

Motor vehicle deaths to children age 14 and under have been declining in Arizona since 1995. In 2002, there were 4.8 deaths per 100,000 children caused by motor vehicle crashes, below

the set target of 6.3. (Because data are not yet available for 2003, the 2002 rate is also provisionally listed as the rate for 2003.)

OWCH used Block Grant monies to fund community-based projects focusing on motor vehicle safety, incorporating activities from the Statewide Injury Prevention Plan. The hospital discharge database was geocoded to facilitate analysis of high-risk areas and identify opportunities for intervention. OWCH worked with the Bureau of Emergency Medical Services, local policy and fire departments and community groups to address motor vehicle safety among infants, children and teens throughout the state.

Eleven car seat safety projects were funded throughout the state and 66 car seat safety classes were held. Home safety devices were received by 566 families, 1,954 people received car seat fittings and education on existing seats, and 1,983 car seats/booster seats and 760 bicycle helmets were distributed.

Car seat information packets were provided to 868 members of the Arizona chapter of the American Academy of Pediatricians. Packets included training videos in Spanish and English, as well as training manuals and brochures to use in physicians' practices. Bilingual staff has been hired and bilingual safety materials have been purchased and distributed. A car seat safety presentation has been put on the Web by one of the contractors for any interested party's access. Among those trained in car seat safety are 165 physician residents, 133 employees of Maricopa Integrated Health Systems Clinics (not certified), and 59 who were certified as technicians at NHTSA training. Two continuing medical education classes on auto safety, *Asleep At The Wheel*, were presented to 13 health providers. Pre-test/post-test analysis shows an improved understanding of proper car seat installation techniques, importance of using car seats, and importance of using home safety devices for protection of children.

The Hopi Tribe now has its own NHTSA car seat safety trainer and can host its own trainings. The Hopi and San Carlos Tribes have developed their own brochure and poster using local children in the photographs. In addition, a Violator's Program has been established in the Hopi Tribe and Tribal police have been involved and are supportive.

b. Current Activities

OWCH partners with the Arizona Child Fatality Review Team and the ADHS Bureau of Emergency Medical Services to conduct policy research on proven strategies to reduce childhood mortality related to motor vehicles. Issue reports are summarized into brief fact sheets and distributed to stakeholders. The Arizona Child Fatality Review Program provides numerous ad hoc reports to stakeholders on circumstances surrounding child fatalities resulting from motor vehicle crashes. Such reports are intended to identify target populations and prevention strategies.

Community program development is facilitated by funding efforts using identified proven strategies in communities with greatest need. An RFP was released in 2004. Seven community-based projects throughout Arizona will provide car seat education and activities.

Promotion efforts are incorporated in direct service programs through provision of training and information in specific subject areas such as home and product safety. OWCH contractors are provided with education materials and information regarding car safety and are informed of any advisories or new technology in safety devices. Information is distributed to contractors on car seat training classes for staff, best practices, and latest statistics, and to the public through hotline services.

Community Services program managers are reviewing the curricula of the Newborn Intensive Care Program and Health Start parent education plans to determine if car safety and user

training is provided to all recipients. They are also working to increase the number of lay health workers who are certified car seat/seat belt instructors, with the goal that each Health Start Contractor will have at least one certified instructor.

OWCH staff participates on the ADHS Injury Prevention Advisory Council which includes motor vehicle crashes as a major focus area.

c. Plan for the Coming Year

OWCH will continue to work with the Arizona Child Fatality Review Team and ADHS Emergency Medical Services Bureau to conduct policy research on proven strategies at state and local level using the annual Child Fatality Report and the ADHS Statewide Injury Prevention Plan. Issue briefs will be prepared and reported to stakeholders. The OWCH Assessment and Evaluation staff will continue to provide technical assistance to the Planning and Partnership Unit to support their efforts to analyze trends and identify high-risk populations.

The Child Fatality Review Prevention Committee selected child fatalities resulting from motor vehicle crashes as a focus of the subcommittee. The Prevention Committee, using the 2003 Child Fatality Annual Report and available data, will develop recommendations for reduction of motor vehicle crash related fatalities. This committee will identify existing initiatives designed to reduce such fatalities, identify gaps in prevention efforts, and develop strategies to address gaps.

Promotion efforts will continue in direct service programs by providing training and information in specific subject areas. OWCH contractors will be informed about car seat training classes, best practices and latest statistics. Information on training opportunities or financial support will be provided as appropriate. OWCH will continue funding seven car seat safety projects throughout Arizona.

Community Services program managers will revise curricula of the Newborn Intensive Care Program and Health Start parent education plans depending upon results of their review to determine if car safety and user training is provided to all recipients. They will also continue to work to increase the number of lay health workers who are certified car seat/seat belt instructors.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

a. Last Year's Accomplishments

In 1991, 68.5% of mothers in Arizona breastfed upon hospital discharge. This rate has risen steadily each year, reaching a high of 80.1% in 2001. The rate declined slightly in 2002 to 78.4%, representing the first time this measure has dipped below the target rate. However, the rate remains well above the national rate of 70.1%. (Because data are not yet available for 2003, the 2002 rate is also provisionally listed as the rate for 2003.)

Arizona relies on the Ross Mothers' Survey (RMS) as the data source for estimates of the percent of mothers breastfeeding upon hospital discharge, and the RMS provides additional data regarding breastfeeding at six months and breastfeeding among WIC participants. In 2002, 35.3 percent of women in Arizona were breastfeeding at 6 months compared to 33.2 percent nationally. Among WIC participants, 68.3 percent of those in Arizona were breastfeeding at hospital discharge compared to 58.8 percent nationally, and 18.6 percent of Arizona WIC participants continued to breastfeed at 6 months, compared to 22.1 percent

nationally.

Counties funded by the County Prenatal Block Grant provided classes to pregnant women and new mothers on breastfeeding. Other services such as free breast pumps and counseling by Certified Lactation Counselors were provided. The Healthy Mothers/Healthy Babies Coalition continued their efforts to promote breastfeeding by providing educational materials at health fairs, maternity fairs, Baby Showers and other community events. Health fairs, Baby Showers, and Teen Mazes were conducted by the following coalitions: Coconino County, Maricopa County, Pima County, Pinal County and Mohave County.

The Pregnancy and Breastfeeding Hotline served 6,442 callers, providing information and telephone support. The Health Start Program provided home and classroom education on the importance and techniques of successful breastfeeding. The program lay health workers received advanced training on breastfeeding technical assistance.

The Office of Nutrition and Chronic Disease Services provided training and technical assistance to Hotline staff to enhance service provided to callers. Breastfeeding pump loans continued for WIC clients. Training curricula were developed for WIC Breastfeeding Coordinators Certification, and scholarships were provided for local agency WIC staff to attend breastfeeding training. A statewide WIC Breastfeeding Peer Counselor Program was developed and CDC breastfeeding data were assessed and recommendations were made regarding general breastfeeding education to Arizona's population.

b. Current Activities

All OWCH Community Services programs promote breastfeeding to women enrolled in the programs and refer women for breastfeeding consultation as needed. The Office of Nutrition and Chronic Disease continues to develop a social marketing campaign to promote breastfeeding. They have also begun development of statewide WIC Breastfeeding Peer Counselor Program and provide continued support to the staff of the Pregnancy and Breastfeeding Hotline. Most county health departments funded by the County Prenatal Block Grant hold breastfeeding classes and provide breastfeeding consultation through the use of Certified Lactation Counselors. The Pregnancy and Breastfeeding Hotline staff provide telephone support to breastfeeding mothers and include information on breastfeeding to pregnant women through the dissemination of information packets.

c. Plan for the Coming Year

The benefits of breastfeeding will be included on the educational components of all programs providing a direct service to pregnant women. Resources to provide technical assistance will be identified for program participants. The OWCH nutrition consultant will provide support and materials to Breastfeeding Hotline staff, continue to assess and recommend training for WIC breastfeeding coordinators. A WIC Breastfeeding Peer Counselor Program will continue to be developed and implemented and the pump loan program will continue for WIC clients.

Nutrition consultants will meet with AHCCCS Maternal Child Health Coordinators to promote breastfeeding and will assess and recommend training for WIC Breastfeeding Coordinator Certification. They will continue to monitor CDC breastfeeding data, assess and develop a statewide WIC Breastfeeding Peer Counselor Program, and support the ADHS breastfeeding policy for employees as a model for Arizona businesses. Scholarships for local agency WIC staff to attend Certified Breastfeeding Counselor training will be continued. The Office of Nutrition Services plans to develop high risk perinatal breastfeeding guidelines.

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

a. Last Year's Accomplishments

In the year 2002, 98% of newborns were screened for hearing impairment before hospital discharge, meeting the target objective for the year. 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 only 39 participated in the Early Hearing Detection and Treatment Program's HI*TRACK data collection. Among the 79,267 births at these 41 hospitals, 68,873, or 98% were screened. The best estimate of the numerator for this measure on a statewide basis is 98% of all births: $91,054 \times .98 = 89,233$. Of the 73,401 infants receiving newborn hearing screening, 3,314 were identified with a possible hearing loss.

The Newborn Screening (NBS) Program provided technical assistance to hospitals throughout the state to ensure that newborn hearing screening policies and procedures follow relevant state laws, quality assurance recommendations and hospital guidelines. A meeting of hospital representatives was convened to assess the Newborn Screening (NBS) Program's capacity and role in conducting follow up without financial support from legislative action.

The Sensory Program completed the revision of the "Recommended Vision Guidelines" and initiated the action for placing them on the Internet. The number of Annual School Reports received was increased through mass mailing notifications to schools, and communication with schools was improved by using electronic mail. The number of schools that conducted hearing and vision screening and the number of qualified persons for performing vision and hearing screening to Arizona students was increased.

b. Current Activities

NBS is collaborating with its partners, including the Governor's Commission for the Deaf and Hard of Hearing Ear Foundation on determining the necessity of seeking a mandate for hearing screening, and is seeking a decision from ADHS senior management regarding a formal role in potential legislation.

The Sensory Program continues to facilitate community knowledge of mandated hearing screening rules and vision screening guidelines. The program is working to identify all public, private and charter schools in Arizona through collaboration with the Arizona Department of Education, and a database is being developed. The Sensory Program mails hearing rules and information to all schools twice a year and provides vision screening guidelines to all public, private and charter schools in Arizona.

The Sensory Program collaborates with the University of Arizona, Maricopa County Cooperative Extension and the Prevent Blindness Association to arrange and coordinate training for professionals to become hearing and/or vision screening trainers. The Sensory Program participates on the Train the Trainer steering committee to monitor and recommend activities for improving the hearing and vision system and is developing a database of all trained hearing screeners. Hearing screeners are notified prior to the renewal date of training.

c. Plan for the Coming Year

The Newborn Screening Program will work with delivering hospitals on the development of a consistent protocol for conducting follow up of infants with abnormal hearing screening tests, and will work with the Assessment and Evaluation section of OWCH on procedures for identifying infants not screened in the birthing facility prior to discharge and will provide authorized follow up. OWCH is also working with the Commission on the Deaf and Hard of Hearing to make hearing screening mandatory. If legislation passes, the Newborn Screening

Program will track screening data.

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

a. Last Year's Accomplishments

In 2002, 14.7 percent of children in Arizona were estimated to have no health insurance, slightly exceeding the targeted rate of 14%. (Because data are not yet available for 2003, the 2002 rate is also provisionally listed as the rate for 2003.)

The HRPP and Health Start programs 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 health care access. Training and updates on available public insurance plans were provided for specific populations.

During 2003, the pregnancy and breastfeeding hotline served 6,442 callers, and the Children's Information Center served 2,167 callers. Both of the hotlines provide information to the public on AHCCCS and Baby Arizona, and assist eligible children and their families in applying for AHCCCS.

Counties receiving Prenatal Block Grant funding assisted uninsured families with the application process for AHCCCS. OWCH funded the Medical Home Project, which provided acute care services to 477 school-age children who were uninsured.

b. Current Activities

The HRPP and Health Start programs continue to assess the health insurance status of each client throughout program enrollment. Families are educated on the importance of establishing and maintaining a medical home and assisted in overcoming barriers to health care access. Training and updates on available public insurance plans are provided for specific populations. The pregnancy and breastfeeding hotline and the Children's Information Center hotline provide information to the public on AHCCCS and Baby Arizona. Counties receiving Prenatal Block Grant funding assist uninsured families with the application process for AHCCCS. OWCH funds the Medical Home Project which links uninsured children with medical providers.

c. Plan for the Coming Year

The HRPP and Health Start programs will continue to assess the health insurance status of each client throughout program enrollment. Families will be educated on the importance of establishing and maintaining a medical home and assisted in overcoming barriers to health care access. Training and updates on available public insurance plans will continue to be provided for specific populations. The pregnancy and breastfeeding hotline and the Children's Information Center hotline will continue to provide information to the public on AHCCCS and Baby Arizona. The Office of Oral Health will collaborate with AHCCCS and other funding agencies to expand outreach efforts. The Planning, Education, and Partnership section will continue to use Title V funds to support the Medical Home Project.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

a. Last Year's Accomplishments

During fiscal year 2002-2003, 72% of the children eligible for Medicaid received a paid service, exceeding the target of 67%. The methodology used for this measure deviates from the exact specifications outlined in the detail sheet. 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 who were determined to be 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 during a year, yielding a result of over 100%.

The Office of Oral Health collaborated with AHCCCS and other agencies to expand outreach, health systems and appropriate services for AHCCCS-enrolled individuals and provided extensive technical assistance to AHCCCS and the AHCCCS-contracted health plans in order to enhance CHIP/Medicaid accessibility and utilization.

b. Current Activities

AHCCCS-enrolled children who access care through school-based services are identified and staff assist those families in seeking care through the Medicaid program. The OWCH Planning, Education and Partnership Section provided funding to some community organizations to identify children without coverage and assist families with applying for AHCCCS and KidsCare. CRS provides services to Medicaid eligible children.

c. Plan for the Coming Year

All OWCH programs that have contact with AHCCCS-enrolled children will assist families with accessing needed acute and preventive services through their designated health plan. The Newborn Screening Program will work with AHCCCS providers to ensure that all babies receive the mandated second screening. The Children's Information Center Hotline will provide assistance to callers to facilitate access to care.

The Office of Oral Health (OOH) will implement a plan to improve access to dental care for CSHCN to help ensure that those who are Medicaid-eligible are identified and obtain needed services. OOH will continue to collaborate with AHCCCS and other funding agencies to expand outreach, health systems and appropriate services for individuals enrolled in AHCCCS and CHIP. OOH will work with the Office of Health Systems Development to identify dental-health professional shortage areas and to develop new models of dental health care delivery.

The Arizona Early Intervention Program has succeeded in developing an agreement with AHCCCS to contract with their developmental assessment providers. This will bring special needs populations into the Medicaid system of care.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

a. Last Year's Accomplishments

In 2002, 1.1 percent of live births weighed less than or equal to 1,500 grams, which is slightly higher than the target rate of 1.0 percent. (Because data are not yet available for 2003, the 2002 rate is also provisionally listed as the rate for 2003.)

One of the goals of the Health Start Program is to reduce very low birth weight births of program participants. To facilitate this goal, the program includes prenatal education on prenatal care, nutrition, and danger signs of pregnancy. The lay health workers monitored enrollee compliance with attending prenatal care appointments and compliance with physician instructions. The program continued outreach efforts to identify women early in their pregnancy.

The Health Start Program served 2,406 clients and provided a total of 10,254 home and/or office visits. Each client received nutritional education as well as referrals to WIC as indicated.

Healthy Mothers/Healthy Babies conducted two regional trainings on preterm labor in 2003, held in both southern and northern locations. Several health fairs, Baby Showers, and Teen Mazes were conducted by the following coalitions: Coconino County, Maricopa County, Pima County, Pinal County and Mohave County.

OWCH provided funding to support the Governor's Commission on the Health Status of Women and Families and the establishment of the Women's Health Advisor in the Governor's Office. Staff from OWCH participated on the sub-committees of the Commission which focus on increased access to health care for women, reproductive health and family planning, improving health care response and raising awareness about health risks for women, and prenatal care. Six contracts focusing on women's health were also funded.

b. Current Activities

Health Start contractors provide education on prenatal care and the danger signs of pregnancy, nutritional counseling, and referral to smoking cessation programs, as needed. Lay health workers monitor compliance with prenatal care attendance and physician instructions.

Healthy Mothers/Healthy Babies program provides coordination and fiduciary services for the Arizona HMHB Coalitions. The coordination services include professional technical assistance and publication of a newsletter to enhance communication between the coalitions. Fiduciary services are provided for managing the coalitions' financial accounts. The coalitions engage in activities that focus on improving health outcomes for mothers and babies in their communities.

OWCH funds County Prenatal Block Grants which increase access to prenatal care and provide education regarding healthy pregnancies.

The overall health of women of childbearing age has been identified as playing an important role in birth outcomes. The OWCH Planning, Education and Partnership Section has a goal to promote healthy behaviors in women of child-bearing age by reducing the percentage of women who smoke, experience "a lot" of stress, and use alcohol and other drugs during pregnancy; and to increase the percentage of women who are a healthy weight, exercise regularly, and consume at least five fruits and vegetables per day. OWCH partners with other stakeholders to provide education that promotes healthy behaviors among women and funds community program development that will positively impact women's health outcomes.

OWCH staff worked to coordinate state activities related to Women's Health Week in May of 2004, including development of a proclamation, calendar of events, women's health luncheon and a women's health screening day. OWCH staff coordinate, facilitate and support the Governor's Commission on the Health Status of Women and the workgroups for each of the focus areas: 1) increasing access to health care for women; 2) Reproductive health and family planning; 3) Improving health care response and raising awareness about health risks for women; and 4) prenatal care.

The OWCH Assessment and Evaluation Section continues to contract with the Arizona Perinatal Trust to conduct data analysis and to identify disparities in birth outcomes. Title V and Title X family planning clinics provide comprehensive physical exams and other primary health care services to low-income women and teens.

c. Plan for the Coming Year

Community Health Nurses and Health Start contractors will distribute the Women's Health Resource Directory and establish an ordering and tracking system for it. Health Start contractors will continue to provide education on prenatal care and the danger signs of pregnancy, nutritional counseling, and referral to smoking cessation programs, and lay health workers monitor compliance with prenatal care attendance and physician instructions. Healthy Mothers/Healthy Babies program will continue to provide coordination and fiduciary services for the Arizona Healthy Mothers/Healthy Babies Coalitions.

OWCH will continue to fund County Prenatal Block Grants to increase access to prenatal care and provide education regarding healthy pregnancies. OWCH staff will continue to support the Governor's Commission on the Health Status of Women and participate in its workgroups. The OWCH Assessment and Evaluation Section will continue to evaluate birth outcomes data to identify disparities in birth outcomes and opportunities for interventions.

Office of Nutrition Services plans to participate in APT-coordinated site visits to evaluate perinatal nutrition services to women and infants and will provide technical assistance to county prenatal block grant coordinators. The WIC program will continue to screen pregnant women and refer them to prenatal services.

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

a. Last Year's Accomplishments

In 2002 there were 9.9 suicides per 100,000 adolescents in Arizona, a rate well below the target rate of 16.7. In the past, the suicide rates in Arizona were consistently higher than national statistics on adolescent suicides, but in recent years Arizona rates are approaching the national rates. (Because data are not yet available for 2003, the 2002 rate is also provisionally listed as the rate for 2003.)

The Child Fatality Review Team's 10th Annual Report was issued in November of 2003. In 2003, data collected was enhanced to more clearly identify risk factors associated with childhood suicide, such as child maltreatment, domestic violence, and substance abuse. The team reported that 19 of the 24 suicides of children under the age of 17 could have been prevented. Suicide was the second most common cause of preventable death for children 10-14 years old and the third most common cause for children 15-17 years old. Males appeared to be a much higher risk for dying from a suicide than females. Eleven of these deaths were due to self-inflicted gunshot wounds and 10 were due to hanging.

On reviewing the records of the children and adolescents who died due to suicide, the teams found that 15 of the children were having a life crisis and six of the children had expressed suicidal thoughts to others. In three cases, the victim had recently lost a friend or acquaintance due to suicide. Five of the suicide victims had substance abuse problems. Family problems were noted in 11 of the suicide deaths including domestic violence and substance abuse.

The team's recommendations to elected officials and public administrators included the enforcement and expansion to legislation that restricts adolescent's access to guns, and funding adequate, appropriate and timely behavioral health services and substance abuse treatment for children, adolescents, and their families. To the Arizona public, they recommended keeping guns away from children and adolescents, and to remove guns and ammunition from the home of children who are at risk for suicide. They also recommended learning how to recognize children at risk for suicide and seek intervention for these children, and to report suspected child abuse and neglect to authorities.

b. Current Activities

The Child Fatality Review Team continues to look at preventable deaths and make recommendations to reduce them. A prevention subcommittee has been instituted and has begun to meet. Their purpose is to identify key recommendations made in prior years reports and to identify what programs are in the community that support those recommendations. They will then identify gaps and support and/or advocate for programs to fill the gaps between recommendations and programs. The OWCH Planning, Education and Partnership Section conducts policy research on proven intervention strategies at the state and local level. The Planning, Education and Partnership Section participates in statewide planning and coordination through the ADHS Injury Prevention Advisory Council.

c. Plan for the Coming Year

OWCH will partner with other stakeholders and participate in statewide planning on the ADHS Injury Prevention Workgroup. The Planning, Education and Partnership Section will continue to conduct policy research on proven intervention strategies at the state and local level and disseminate educational materials about proven methods of reducing injuries and poisonings. OWCH Assessment and Evaluation staff will continue to analyze hospital discharge data and make statistical information available to partners and stakeholders.

The Child Fatality Review Team will continue to examine each child death due to suicide, identify preventability factors and develop recommendations to reduce childhood suicides.

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

a. Last Year's Accomplishments

In 2002, 77.6% of very low birth weight babies were born at facilities with Level III neonatal intensive care units, below the target of 80.5%. (Because data are not yet available for 2003, the 2002 rate is also provisionally listed as the rate for 2003.)

The Maternal Transport component of the High-Risk Perinatal Programs (HRPP) continued funding for Information and Referral Services. Consultation and transport coordination services by board certified perinatologists were available throughout Arizona to providers caring for pregnant women who presented with high-risk factors. Providers make one telephone call to obtain consultation, bed placement, transfer to care and transport arrangements regardless of the woman's ability to pay. The program continued to fund all uncompensated care for maternal transport associated with transfer of high-risk pregnant women to Level III centers.

A High-Risk Perinatal Program Advisory Group was convened and three subcommittee workgroups were established to review and evaluate the program. An environmental scan was conducted and recommendations were drafted related to transport, developmental screenings, and sustainability of the program. A list of state and community resources was supplied to providers.

The HRPP Hospital Program created a funding formula that will help with HIPAA compliance and decrease the amount of information hospitals will have to send to the Program next fiscal year. During calendar year 2003, 4,784 infants were enrolled into the HRPP. Community health nurses conducted 7,364 home visits and provided anticipatory guidance, developmental assessments and medical information to families. Maternal transports were received by 1,193 women, and 1,011 infants received neonatal transports.

OWCH provides funding to the Midwifery Licensing Program which works to ensure that midwives who attend home births are well-prepared and appropriately trained. They report that there has been only one infant death in which a licensed midwife attended a home birth, and this was an infant with a rare chromosome anomaly (Trisomy 18) who expired in the hospital 6 weeks after birth (50% of these infants expire within 1 week of life and 90% expire by 5 months of age). Two complaints were investigated with action taken to suspend a license. Four midwives were tested for Arizona Midwife Licenses, with three of these achieving license. Policies for licensing were reviewed and testing processes updated.

b. Current Activities

The Maternal Transport component of the High-Risk Perinatal Program (HRPP) funds transport of women with high risk pregnancies to Level III facilities. The program also contracts with specialized perinatology physician groups to provide medical case management, consultation and technical services to hospitals, physicians, communities and medical transport teams. OWCH contracts with the Arizona Perinatal Trust to collect, analyze, and distribute annual perinatal data comparing Arizona hospitals to national perinatal data. Staff within OWCH and Nutrition Services participate in the Level III hospital certification process.

HRPP partners with the March of Dimes and Healthy Start to provide case management services to high-risk pregnant women and their children. Working with air transport couriers, neonatologists and perinatologists, HRPP supports risk-appropriate transport services and hospital/physician care. Community Health Nurses provide nurse home visitation services to babies who receive care in a neonatal intensive care unit for at least 72 hours.

The HRPP Advisory Group continues to receive feedback on its draft recommendations related to transport, developmental screenings, and sustainability of the program, and is compiling a final report of recommendations.

The Midwife Licensing Program continues to monitor quarterly reports to determine infant mortality related to cause of death and report trends to the program manager; and to review and update current policy and procedures for midwife licensing. The program continues to test prospective candidates and provides information to the general public regarding what the law stipulates for scope of practice, and to review current testing to ensure candidates have knowledge needed to assure safety for the women of Arizona who seek home delivery. Complaints from the public regarding practice of Arizona licensed Midwife are investigated.

The Office of Nutrition Services provides consultation and education to the Perinatal Nutrition Network and continues to distribute the Perinatal Nutrition Guidelines to Arizona Perinatal Trust certified hospital units. Technical assistance is provided to OWCH and to county prenatal block grant coordinators.

c. Plan for the Coming Year

OWCH will continue to fund the Arizona Perinatal Trust to conduct perinatal data analysis. Technical assistance will be provided to hospitals to address issues identified through the certification process. OWCH and Nutrition staff will continue to participate in the certification site visits.

Upon completing the final recommendations of the HRPP Advisory Group, a report will be issued to members of the perinatal care community and RFP's will be issued based on the new format of the HRPP. The HRPP will work with the Arizona Perinatal Trust and the medical directors of the transport contractors to train physicians on maternal and neonatal transports. The Office of Oral Health will collaborate with AHCCCS and other agencies to provide consultation and technical assistance on issues related to pregnancy.

Licensed midwives will monitor the health status of women receiving their care to identify risk conditions and ensure that women deliver at the most appropriate facility. The Midwife Licensing Program will monitor quarterly reports from practicing midwives and will follow up on reported infant mortality on the cause of death. Policies and procedures will continue to be reviewed and updated and complaints will continue to be investigated.

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

a. Last Year's Accomplishments

There has been a general upward trend in the percent of women receiving early prenatal care over the past ten years. In 2002, 75.7% of women received prenatal care during the first trimester, slightly below the targeted rate of 78%. (Because data are not yet available for 2003, the 2002 rate is also provisionally listed as the rate for 2003.)

OWCH staff participated on the prenatal subcommittee of the Governor's Commission on Health Status of Women and Families in Arizona. The focus of the subcommittee is to make recommendations on increasing community education and access to prenatal care. The Perinatal Periods of Risk model was presented to the subcommittee.

Counties used Prenatal Block Grant funds to provide classes on prenatal care, birthing, breastfeeding, and parenting for pregnant women and fathers. Many counties have developed programs that will identify women early in their pregnancy and encourage and support their early entry into prenatal care by use of incentives, financial assistance and appropriate referrals.

The Pregnancy and Breastfeeding Hotline provided prescreens for potential eligibility for the Baby Arizona project to facilitate early entry into prenatal care. Baby Arizona calls totaled 1,694 in 2003. The Health Start Program monitored enrollees' compliance with attending prenatal care appointments and compliance with physician instructions. The program continued outreach efforts to identify women early in their pregnancy. The Office of Nutrition refers pregnant WIC participants for prenatal care.

b. Current Activities

OWCH funds County Prenatal Block Grant which increases access to prenatal care and provides education regarding healthy pregnancies. Contractors under the County Prenatal Block Grant are conducting early prenatal care campaigns utilizing various strategies such as: pregnancy testing for early identification and risk assessment, teen programs in local high schools, and educational programs on television and radio. A supplemental prenatal care package is also provided for families who are not insured or are under insured.

OWCH contractors serving pregnant women and families assist them in applying for AHCCCS and Baby Arizona coverage for their prenatal care. Through the Pregnancy and Breastfeeding Hotline pregnant women are assisted with expedited access to prenatal care through the Baby Arizona project and hotline staff are providing follow-up calls to verify entry into prenatal care. The OWCH Assessment and Evaluation Section continues to contract with the Arizona Perinatal Trust to conduct data analysis and to identify disparities related to this measure.

The Office of Nutrition Services promotes the benefits of early entry into prenatal care. WIC participants are referred and tracked, and WIC staff are trained to refer pregnant women for early prenatal care. WIC staff regularly meet with AHCCCS MCH coordinators. The Office of

Nutrition continues to implement the Anemia Team's Strategic Plan, and continues efforts to strengthen relationship with the medical community by referring low Hb values. They also participate in Medical Advisory committee on anemia issues in WIC.

OWCH is participating in a statewide planning initiative on the prenatal care sub-committee of the Governor's Commission on the Health Status of Women. Recommendations to the Governor are to be completed in the fall of 2004.

c. Plan for the Coming Year

The Health Start Program will continue to utilize lay health workers 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 County Prenatal Block Grant will continue to address early entry into prenatal care using strategies previously developed. The Pregnancy and Breastfeeding Hotline will be providing assistance to callers to assist with early entry into prenatal care and to facilitate an expedited application process for AHCCCS coverage.

Midwife licensing unit will monitor data from midwife quarterly reports and examine relationships between the gestational age of entry into care of the midwife, the number of prenatal visits, and pregnancy outcomes. Training materials will be sent to midwives through their association, and requested from them regarding findings during postnatal visits for women that they have assisted with births. Data will be kept from phone calls to the Special License Department for Midwives and compared with information available to the general public on the type of care desired during pregnancy.

The Office of Oral Health will promote the benefits of early entry into prenatal care, and initiate a strategic planning process with partners on oral health and pregnancy outcome. Nutrition services will continue to train WIC staff to refer pregnant women for early prenatal care.

OWCH will coordinate policy and planning efforts around prenatal care with the Governor's Commission on the Health Status of Women.

FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

General Instructions/Notes:

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				
1. Formula for metabolic conditions provided by CRS.	☒	☐	☐	☐
2. Consultation, education, and referral provided statewide for children diagnosed with Sickie Cell.	☐	☒	☐	☐
3. Development of a data system linking newborn screening records with	☐	☐	☐	☐

birth certificates.	☐	☐	☐	☒
4. Arranging transportation, as needed, to access follow up services.	☐	☒	☐	☐
5. OCSHCN collaborates with OWCH to coordinate statewide follow-up care for metabolic conditions	☒	☐	☐	☐
6. The Sickie Cell Program provides education, consultation, and information and referral	☐	☒	☐	☐
7. Newborns receive first and second screenings for 8 conditions	☐	☐	☒	☐
8. Babies with a failed screening receive follow-up services	☒	☐	☐	☐
9. Develop strategies to improve transition services for families receiving formula for their metabolic condition	☐	☐	☐	☒
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) 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)				
1. Tsunami youth and families participate in trainings and presentations to families and professionals.	☐	☐	☐	☒
2. Champions grant will create a Parent and Youth leadership Institute to train other youth and parents.	☐	☒	☐	☐
3. Parent/Youth/Physician project will continue to develop professional CME approved trainings.	☐	☒	☐	☐
4. Participation in decision making by C/YSHCN and their families is included in program contracts.	☐	☐	☐	☒
5. Develop and implement Statewide Integration of Community Development model.	☐	☐	☐	☒
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) 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)				
1. OCSHCN partners with the Southwest Institute on an MCHB Medical Home Grant.	☐	☐	☐	☒
2. Birth Defects Monitoring Program uses a rapid surveillance system to identify children.	☐	☐	☐	☒
3. CRS incorporated medical home requirements in provider contracts.	☐	☐	☐	☒
4. OCSHCN in discussions about integrating the Primary care Physician into the regional CRS clinics.	☐	☐	☐	☒
	☐	☐	☐	☐

5. OCSHCN will develop and implement e-classes related to Medical Home.	☐	☐	☐	☒
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) 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)				
1. OWCH is consulting perinatal experts to propose system changes for High Risk Perinatal Program	☐	☐	☐	☒
2. On-site eligibility screening and enrollment are provided by CRS.	☐	☒	☐	☐
3. OCSHCN is working with other Arizona agencies to develop and implement a universal eligibility application process.	☐	☐	☐	☒
4. OCSHCN contractors have increased continuous enrollment of Title XIX and XXI children and youth.	☐	☐	☐	☒
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) 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)				
1. Telehealth services expanded in scope for both geography and type of use.	☐	☐	☐	☒
2. Interagency care coordination team identifying opportunities to improve care coordination.	☐	☐	☐	☒
3. OCSHCN working with the ADHS Native American Liason to develop ways of more effectively interfacing with native communities.	☐	☐	☐	☒
4. At least one additional community action team will be added in the next year.	☐	☐	☐	☒
5. Community action teams are developing an interactive data system to map community resources on a state-wide basis.	☐	☐	☐	☒
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
	☐	☐	☐	☐

8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. CRS contracts require providers to offer comprehensive transition services.	☐	☒	☐	☒
2. OCSHC, in conjunction with the Governor's Council on Spinal and Head Injuries presented "Transition Issues for Youth with TBI statewide via videoconferencing.	☐	☐	☐	☒
3. OCSHCN is participating in national committee to add more questions regarding transition to the National Survey of Children with Special Health Care Needs.	☐	☐	☐	☒
4. Tsunami youth will develop four brochures dealing with transition issues.	☐	☒	☐	☐
5. Utilizing videoconferencing transition-age youth will mentor other youth at remote locations.	☐	☒	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) 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.				
1. Immunization assessment and referrals are provided at all CRS certification visits	☐	☐	☒	☐
2. OWCH funds the TAPI coordinator position	☐	☐	☐	☒
3. OWCH programs and contractors serving children assess immunization status	☐	☒	☐	☐
4. OWCH programs and contractors facilitate referral for immunizations	☐	☒	☐	☐
5. Specific OWCH grantees administer immunizations during home visits and at schools	☒	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐

10.	☐	☐	☐	☐
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NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. Abstinence education is provided through community contracts	☐	☐	☒	☐
2. Geomapping is used to identify and prioritize geographic areas for intervention	☐	☐	☐	☒
3. Contractors are providing health education to teens at community events	☐	☒	☐	☐
4. OWCH collaborates with local and national teen pregnancy prevention and abstinence education advisory groups to promote effective strategies among youth and parents	☐	☐	☐	☒
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Oral Health Office provides dental sealants to high risk children	☒	☐	☐	☐
2. The Dental Sealant Program is being evaluated	☐	☐	☐	☒
3. Collaborations are taking place with other interested entities to expand services	☐	☐	☐	☒
4. A pilot program to investigate alternative models of delivery is being funded	☐	☐	☐	☒
5. OWCH funds community projects to provide dental sealants and referral for care	☒	☐	☐	☐
6. CRS provides dental services to diagnosis specific populations.	☒	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. OWCH funds community projects to train car seat safety installers	☐	☐	☐	☒
	☐	☐	☐	☐

2. OWCH funds community projects to conduct car seat inspections	☐	☐	☐	☒
3. OWCH funds community projects to provide car seats to low income families	☒	☒	☐	☐
4. OWCH collaborates with Emergency Medical Services and their injury prevention programs	☐	☐	☐	☒
5. Direct services programs instruct families in the proper use of car seats	☒	☐	☐	☐
6. Child Fatality Review Program provides ad hoc reports to stakeholders on circumstances surrounding child fatalities resulting from motor vehicle crashes.	☐	☐	☐	☒
7. OWCH coordinates planning and policy efforts through the ADHS Injury Prevention Advisory Council	☐	☐	☐	☒
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Distribute Guidelines for Promoting Breastfeeding to all maternity units statewide	☐	☒	☐	☐
2. Direct services programs promote breastfeeding to all clients	☐	☒	☐	☐
3. Hotline staff provide technical assistance to callers	☐	☒	☐	☐
4. OWCH contractors hold breastfeeding classes	☐	☒	☐	☐
5. Contractors provide consultation by Certified Lactation Counselors	☒	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. Technical assistance is provided to all delivering hospitals regarding best practices	☐	☐	☐	☒
2. Collaborations are taking place to determine the need for a state mandate	☐	☐	☐	☒
3. Data are collected from birthing hospitals willing to submit to the central registry	☐	☐	☐	☒
4. Data are analyzed and reported	☐	☐	☐	☒
5. Data matching methodology between the program and Newborn Screening is being developed	☐	☐	☐	☒

6. Developmental clinics facilitate hearing screening for at risk children.	☒	☐	☐	☐
7. Participate on Train the Trainer steering committee to monitor and recommend improvements in hearing and vision system and develop database of trained hearing screeners	☐	☐	☐	☒
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. Contractors provide outreach to the uninsured	☐	☒	☐	☐
2. Home health nurses verify insurance status of children being served	☐	☒	☐	☐
3. Medical Home Project provides health care services to uninsured children	☒	☐	☐	☐
4. Hotline assists callers with AHCCCS and KidsCare enrollment information	☐	☒	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. AHCCCS enrollees served by school based clinics are referred for followup to PCP	☐	☒	☐	☐
2. Contractors assist clients in accessing covered services	☐	☒	☐	☐
3. Contractors assist families in applying for AHCCCS and KidsCare	☐	☒	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live				

births.				
1. Maternal Transport Program facilitates transports to Level II and III hospitals	☐	☒	☐	☐
2. Birth data is analyzed to identify disparities	☐	☐	☐	☒
3. Workgroup addressing VLBW among American Indians is continuing and membership expanding	☐	☐	☐	☒
4. Counties are working with advisory groups to conduct community needs assessments	☐	☐	☐	☒
5. Health Start links high risk pregnant women with prenatal care services	☐	☒	☐	☐
6. Direct services programs provide prenatal education	☐	☒	☐	☐
7. Family Planning contractors assist clients with pregnancy spacing	☒	☐	☐	☐
8. OWCH promotes healthy behaviors in women through education and support of community program development and policy development	☐	☐	☒	☒
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐
NATIONAL PERFORMANCE MEASURE		Pyramid Level of Service		
		DHC	ES	PBS
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. Contractor is identifying behavioral health services available to adolescents	☐	☒	☐	☐
2. A depression screening method is being promoted	☐	☒	☐	☐
3. Treatment options are being identified	☐	☒	☐	☐
4. Geomapping of data is being conducted	☐	☐	☐	☒
5. Child Fatality Review Team examines suicides for preventability factors and develops recommendations	☐	☐	☐	☒
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐
NATIONAL PERFORMANCE MEASURE		Pyramid Level of Service		
		DHC	ES	PBS
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. Maternal Transport Programs funds transport of high risk women to Level III hospitals	☐	☒	☐	☐
2. Contracted perinatology experts provide consultation to the medical community	☐	☒	☐	☐
3. OWCH staff participate in the hospital certification process	☐	☐	☐	☒
4. OWCH funds the Arizona Perinatal Trust to work with individual hospitals needing assistance	☐	☐	☐	☒

5. OWCH funds the Perinatal Trust to collect and analyze data regarding deliveries	☐	☐	☐	☒
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				
1. Data is collected and analyzed to identify disparities	☐	☐	☐	☒
2. Infant mortality workgroup continues to address the needs of American Indians	☐	☐	☐	☒
3. Office of Nutrition refers WIC pregnant women to prenatal care	☐	☒	☐	☐
4. All direct services programs facilitate referral to prenatal care	☐	☒	☐	☐
5. The Hotline assists callers with the presumptive eligibility process for care	☐	☒	☐	☐
6. Contractors conduct campaigns to promote early prenatal care	☐	☒	☐	☐
7. Governor's Commission on Health Status of Women is creating recommendations to improve prenatal care	☐	☐	☐	☒
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *SPM#01. Proportion of low-income women who receive reproductive health/family planning services.*

a. Last Year's Accomplishments

Title V and Title X family planning clinics provide birth control and other vital health care services to low-income women and teens including breast and cervical cancer screening, screening and treatment for STDs, HIV and pregnancy testing and counseling, comprehensive physical exams and other primary health care services. Often, family planning clinics are the only source of primary care for women. Approximately 9.3% of the women age 15-44 estimated to be living in Arizona below 150% of the federal poverty level received a reproductive health/family planning service through Title V and/or Title X in 2003, falling short of the goal of the target of 17.9%.

The OWCH Family Planning Program contracted with county health departments to fund reproductive health/family planning service visits to women below 150% of the federal poverty line. Eleven out of 15 county health departments received Intergovernmental Agreements to provide services. Initial and/or annual visits have been provided free of charge to 6,498 women below 150% of the federal poverty line. Of those receiving free visits, education, and referral, 1,542 were adolescents. Among the services provided are 14,497 screenings provided to women for either pregnancy, cancer, or HIV/STD; and 8,779 referrals to women for assistance

with medical care, WIC, domestic violence, behavioral health, prenatal care, and services of other community agencies/organizations.

OWCH provided contractors with ongoing technical assistance regarding policy changes, funding, and educational opportunities. Contractors have been advised of AHCCCS reimbursement and SOBRA information has been provided to Health Start lay workers. The ACOG publication "Health Care for Adolescents" was purchased for each of the 11 contractors. Eleven contractors received a site visit for an annual review.

OWCH maintained a collaborative relationships with the Arizona Family Planning Council (AFPC) and the Arizona Family Planning Coalition, and data was shared with AFPC. Seven coalition meetings were attended in 2003 and participation was provided for evaluating AFPC's RFA's. ADHS sponsored the annual conference in September of 2003 and OWCH participated on the Governor's Commission on the Health Status of Women and Families in Arizona's sub-committee on Reproductive Health, Family Planning, and Teen Pregnancy Prevention. The OWCH assessment and evaluation staff geocoded women of reproductive age and compared their distribution to clinic locations. They also provided technical assistance to review data collection from program contractors to ensure that data needs are met.

Family planning referrals were among the top four types of referrals made to women during registration and enrollment in the Health Start program, and the Office of Nutrition developed and implemented a statewide Folic Acid Education and Vitamin Distribution program for low income women.

b. Current Activities

OWCH Planning, Education and Partnership Section funds family planning and reproductive health services to low-income women through contracts with county health departments. Contractors provide community education regarding reproductive health and family planning and are providing information and referral to clients for other medical, social, and behavioral needs. Collaboration efforts with the Title X agency are focused on ensuring that Title V and Title X funds are maximized to efficiently serve the greatest number of low-income women throughout the state. Health disparities are considered when providing funding to communities. Services are provided through Intergovernmental Agreements to provide services at the local level with special emphasis on African Americans, teens, and rural underserved areas.

OWCH Planning, Education and Partnership Section staff educate providers about family planning services, health disparities related to family planning, and efforts to increase access to services. They work with contractors to target outreach to women who may be eligible for SOBRA and Family Planning Services Extension and provide technical assistance and support services.

Health Start links women to family planning services through lay health workers. Women who have a negative pregnancy test and wish to delay pregnancy are referred to family planning services, and lay health workers provide education on the various birth control methods to all Health Start clients. Together with Title V and X family planning providers, lay health workers assist every client in establishing a family planning goal and monitor achievement of the goal. Client forms are reviewed during site visits to assess establishment of family planning goal.

OWCH staff participate in the Reproductive Health/Family Planning subcommittee of the Governor's Commission on the Health Status of Women, which is developing recommendations to improve access to family planning services.

c. Plan for the Coming Year

OWCH will continue to provide Title V funding for family planning services and continue to consider health disparities when providing funding to communities. The Family Planning/Reproductive Health Program will collaborate with the Arizona Family Planning Council to ensure that Title V and Title X funds are maximized to efficiently serve the greatest number of low-income women. The program will work with health plans to target outreach to women who may be eligible for SOBRA and Family Planning Services Extension. All Health Start enrollees will establish a family planning goal. Lay health workers will refer program enrollees who have a negative pregnancy test and wish to delay pregnancy to family planning services and information on various birth control methods will be provided by lay health workers. The nutrition consultant will continue activities to increase folate awareness as part of preconception care. OWCH will coordinate with the Governor's Commission to implement recommendations to improve family planning services.

State Performance Measure 2: *SPM#02. Hospitalizations for nonfatal injuries and poisonings per 100,000 adolescents age 15 - 19*

a. Last Year's Accomplishments

Injury is the leading cause of death among children one year of age and older, both nationwide and in Arizona. Injury accounts for more premature child deaths than all major diseases combined. From 1985-1995, injury accounted for nearly 70 percent of all child and adolescent deaths among Arizonans ages 1-19, and exceeded the rate of child deaths due to injury for the United States.

Many serious injuries do not result in death. Between 1989 and 1992, national data show that for every one child or youth who died from an injury, more than 11 were admitted to a hospital. Adolescent injury mortality and hospitalization are much lower than for children. While there were 656 injury-related deaths among adolescents aged 15-19 in Arizona from 1995 to 1999, there were 6,614 injury-related hospitalizations during the same period.

Problems with tabulating hospital discharge data prevent reporting on this measure for the year 2002, and discharge data for the year 2003 are not yet available. The estimates for 2002 and 2003 are provisionally set at the 2001 rate until data become available. In the year 2001, there were 659.8 hospitalizations for nonfatal injury and poisoning per 100,000 adolescents age 15-19, below the target of 690.

The Domestic Violence Program provided educational materials to the public and groups with similar interests on domestic violence and adolescent suicide associated with the use of alcohol, tobacco and other drugs. OWCH funded community-based projects addressing prevention of hospitalizations and injuries. OWCH collaborated with the Bureau of Emergency Medical Services' injury prevention programs to provide technical assistance to the contractors. The ADHS Injury Prevention Plan was reviewed and sections relevant to the OWCH Strategic Plan were highlighted. OWCH staff participated on the ADHS Injury Prevention Internal Workgroup and Council.

The Rape Prevention and Education Program provided educational presentations to 9,183 adolescents. OWCH Assessment and Evaluation completed statewide county and community level data analysis and geocoded the hospital discharge database to identify communities with the greatest number of adolescents hospitalized for various conditions and published results on the internet.

b. Current Activities

OWCH Planning, Education and Partnership Section (PEP) addresses this measure through

funding community-based projects. Community program development is facilitated by funding efforts using identified proven strategies in communities with greatest need. PEP staff provide leadership by partnering with other stakeholders and participating in statewide planning, including participation on the Bureau of Emergency Medical Services' injury prevention programs to provide technical assistance and education to contractors. PEP staff conduct policy research on proven intervention strategies at state and local level and issues reports on policy analysis about proven methods for reducing injuries and poisonings. The OWCH Assessment and Evaluation section analyze data by county and community, and geocode data to identify areas with disproportionate numbers of injuries and poisonings for potential intervention. Assessment and Evaluation staff are working with the ADHS Bureau of Public Health Statistics to resolve recent issues with using the hospital discharge data base for analytic purposes. A media campaign targeting date rape prevention among young people will continue throughout 2004.

c. Plan for the Coming Year

OWCH Planning, Education and Partnership Section (PEP) will continue to fund community-based projects, facilitating community program development using proven strategies in communities with greatest need. Rape prevention and education contracts with agencies targeting teens will be renewed and the media campaign will continue if funds are available.

PEP staff will continue to partner with other stakeholders and participate in statewide planning, including participation on the ADHS Injury Prevention Advisory Council. PEP staff will continue to research proven intervention strategies at state and local level and issue reports on policy analysis about proven methods for reducing injuries and poisonings. The OWCH Assessment and Evaluation section will continue to analyze data by county and community, and geocode data to identify areas with disproportionate numbers of injuries and poisonings for potential intervention.

State Performance Measure 3: *SPM#06. Preventable child deaths per 100,000 children under age 18.*

a. Last Year's Accomplishments

This is a global measure of outcome for all children. While individual programs may target specific causes of child death, this measure looks at all child deaths that could reasonably have been prevented with appropriate intervention. While the number of children who die is relatively small, it is directly related to the much larger number of children who are harmed by the same cause.

In 2002 there were 277 deaths determined to have been preventable, representing a rate of 15.0 per 100,000 children under the age of 18. This is below the target rate for 2002 set at 17.5. (Because data are not yet available for 2003, the 2002 rate is also provisionally listed as the rate for 2003.)

Overall, Arizona death rates for the leading causes of preventable child deaths have declined between 1995 and 2002 per 100,000 children under age 18. Deaths from motor vehicle crashes were reduced from 12.9 to 8.6; and deaths from other unintentional injuries were reduced from 9.7 to 5.4 per 100,000. Homicides decreased from 4.7 to 3.2 and suicides decreased 5.5 to 4.0 per 100,000 children under age 18. Deaths from Sudden Infant Death Syndrome decreased from 1.1 in 1995 to 0.5 per 1,000 infants under age one in 2002.

In 2003, the Child Fatality Review Teams reviewed 935 of the 979 child fatalities that occurred in 2002, and the Citizen Review Panels reviewed 34 Child Protective Services Cases of child

fatalities and near fatalities due to maltreatment. Their annual reports provided findings and recommendations to the public on the reduction of preventable child fatalities.

The Child Fatality Review 10th Annual Report was published in November of 2003 and was provided to the Governor, the President of the State Senate and the Speaker of the State House of Representatives. The Citizen Review Panel annual report was provided to the Department of Economic Security and to the Secretary of the U. S. Health and Human Services. Both reports were made available to the public on the Department's website. Specialty data reports were provided, upon request, to county health departments, community programs, and other local, statewide and national initiatives to reduce preventable child fatalities, including violence-related fatalities. With the Arizona Unexplained Infant Death Council, the program developed and distributed the Infant Death Checklist and infant death scene investigation protocols to 95 law enforcement offices throughout Arizona.

The Planning, Education and Partnerships Section released an RFP targeting specific priorities, including infant mortality among African American and/or Native Americans. The County Prenatal Block Grant coordinators were trained on social marketing. A White Paper for the County Prenatal Block Grant was developed describing the purpose and uses of the grant. Work began on the development of an educational package on health risks and issues for infants.

b. Current Activities

The Child Fatality Review Team provides support to 14 local child fatality review teams with approximately 250 volunteer members and three citizen review panels with approximately 40 volunteer members throughout Arizona. They develop data-driven recommendations for reducing preventable childhood deaths and develop recommendations for improvement of Child Protective Services (CPS), through Citizen Review Panel activities.

The Child Fatality Review Team Prevention Committee, formed during 2004, uses the Child Fatality Annual Report as its focus to identify the leading causes of preventable deaths, review the Annual Report recommendations linked to causes of preventable deaths, determine which recommendations can be targeted for specific advocacy, advocate for implementation of strategies that support the targeted report recommendations, identify and track existing prevention activities, identify gaps in prevention efforts, and develop strategies to address the gaps in prevention.

The Child Fatality Review Team provides administrative support to the Unexplained Infant Death Council and distributes the Infant Death Checklist and investigative protocols to law enforcement agencies and promotes training opportunities for first responders on unexplained infant death investigations.

OWCH Planning, Education and Partnerships Section (PEP) funds community efforts to build capacity around the areas of best practices and planning, providing technical assistance to counties to strengthen prevention programs. Currently seven community-based projects are funded focused on preventable deaths, primarily focusing on motor vehicle accidents. None of the current grants are focused on infant mortality.

Various programs within OWCH Community Services Section provide case management services to high-risk pregnant women and their children for the purpose of improved birth outcomes and child health status. Programs ensure the provision of risk-appropriate transport services and hospital/physician care for high-risk infants. The Newborn Screening Program tests blood specimens for specific disorders and provides follow up so that families and physicians receive screening results as quickly as possible. Metabolic formula is provided through the program as a payer of last resort. Collaborations with insurance plans and health

providers increase the availability of developmental screens and evaluations for high-risk infants. An advisory committee of perinatologists, neonatologists and other experts is reassessing and redesigning the High-Risk Perinatal Programs.

c. Plan for the Coming Year

Planning, Education and Partnerships Section (PEP) will continue to fund community efforts to build capacity around the areas of best practices and planning, and provide technical assistance to counties to strengthen prevention programs, particularly related to car safety.

PEP will educate providers and stakeholders on mortality risk in the first year of life, specifying disparities in risk in the population. They will identify and promote standardized anticipatory guidance for infants on immunizations, injury control and other related first-year risks. PEP works with OWCH Community Services Section to identify existing materials and list available resources to give to contractors during site visits, at health fairs, and in newsletters.

OWCH Community Services Section will continue to provide case management services to high-risk pregnant women and their children and to ensure the provision of risk-appropriate transport services and hospital/physician care for high-risk infants. The Newborn Screening Program will continue to test blood specimens for specific disorders and provide follow up to expedite screening results, as well as to provide metabolic formula through the program as a payer of last resort. Community Services will continue to collaborate with insurance plans and health providers to increase the availability of developmental screens and evaluations for high-risk infants, and will work with the advisory committee of perinatologists, neonatologists and other experts to address recommendations regarding the redesign of the High-Risk Perinatal Programs.

The Child Fatality Review Program will continue to identify strategies for the reduction of preventable child deaths, through reviews of child fatalities in Arizona. The Prevention Committee will begin activities designed to identify, track, and promote development of child fatality prevention efforts throughout Arizona. OWCH and the Child Fatality Review Program will make funding to enhance child fatality reviews available to all local child fatality review teams.

State Performance Measure 4: *SPM#07. The rate of children 1 through 14 hospitalized for ambulatory care sensitive conditions per 100,000.*

a. Last Year's Accomplishments

Ambulatory care sensitive conditions are conditions that may not have required hospitalization if adequate primary care services had been provided. There are both medical and financial consequences as children become sicker than necessary before they get treatment and the cost of treatment in an inpatient hospital setting is far higher than in a physician's office.

Problems with tabulating hospital discharge data prevent reporting on this measure for the year 2002, and discharge data for the year 2003 are not yet available. The estimates for 2002 and 2003 are provisionally set at the 2001 rate until data become available. In 2001 there were 489.7 hospitalizations per 100,000 children age 1-14, a rate that was below the target set of 535 hospitalizations per 100,000 children.

The OWCH-funded Medical Home Project provided acute care services to 477 children,

medical homes to 10 families and services to 5 younger than school age children. The Project provided 58 eye glasses to children, 158 diagnostic laboratory services, 322 prescription medications, 475 primary care referrals and 292 specialist referrals. OWCH Assessment and Evaluation staff developed fact sheets for Medical Home and Uninsured Children in Arizona and conducted quarterly data quality assurance of High Risk Perinatal Program and Health Start data.

OWCH contracted with Phoenix Children's hospital to provide seed money to begin a clinic at the Salvation Army Homeless Shelter. The goal of the project was to reduce the number of children age 1-14 who were hospitalized for ambulatory care sensitive conditions. 794 clinic visits were made by shelter residents; 122 immunizations and 136 TV skin tests were given; and 84 emergency department visits were reported.

The Planning, Education and Partnership (PEP) Section of OWCH supported School Based Health Centers in building their infrastructure by attending board meetings and providing technical assistance. A Nurse Asthma Resource Guide was researched and developed based on direction from school nurses and distributed to 91 schools within zip codes identified as underserved and with high incidence of asthma. PEP coordinated outreach activities for AHCCCS and KidsCare with partner agencies, and supported the efforts of the Arizona Department of Education and Arizona Association of Food Banks to automatically qualify children for KidsCare if they qualify for free and reduced lunch. Social Marketing information was provided to County Prenatal Block Grant Contractors. In partnership with Mesa United Way, OWCH supported the training on and distribution of a new video, "What We Have Always Known," about early brain development made by and for Native American communities. The video has gained national attention.

OCSHCN continued to fund the efforts of Phoenix Children's Hospital in developing a coalition of community partners and the Pinal County Health Department to meet primary health care needs of CSHCN.

b. Current Activities

A variety of OWCH funded programs and projects function to identify children and families in need of services and refer them to appropriate primary care resources. The Medical Home Project identifies critical areas of need within the state and provides a system of linkage between school nurses, Head Start sites and the health care providers to provide pediatric services, specialty services, laboratory and x-ray, medication and other ancillary services to uninsured school age children and their younger siblings. Medical practitioners donate their services to these children.

OWCH continues to fund the Medical Home Project and works to increase the number of physicians who will agree to provide a true medical home including primary and specialty care as well as hospital care. OWCH partners with the Arizona chapter of the American Academy of Pediatrics to conduct outreach for the Medical Home Project and funds community program development to reduce ER visits and hospitalizations.

OWCH continues to fund the Child Health Indicator Project that provides software that tracks encounters a school nurse has related to ambulatory care conditions such as diabetes and asthma. The OWCH Planning, Education and Partnership (PEP) provides technical assistance to school-based health clinics and data collected from the Child Health Indicator Project is provided to stakeholders on ambulatory care sensitive conditions.

The Office of Nutrition Services educates WIC staff on screening to refer children to intervention services and to coordinate services within the community. The High-Risk Perinatal Program and Health Start providers educate families on the importance of establishing and

maintaining a medical home and assist families in overcoming barriers to health care access.

OWCH staff educates community providers about available services, eligibility and coverage, including disparities and trends. They assist eligible children and their families in applying for AHCCCS. Information is provided to the public on AHCCCS and Baby Arizona through the Hotline, health fairs, and the Medical Home Project.

OWCH Assessment and Evaluation Staff is investigating the ability to access birth records to match data between Newborn Screening, Newborn Hearing Screening, and Vital Records to identify children who are not being screened.

OCSHCN is currently supporting a contract with the Arizona and New Mexico American Lung Association to hire a coordinator for the Asthma Coalition, support the production of materials and resources and promote collaboration between all asthma partners and projects.

OCSHCN also provides education and technical support for school nurses and community partners and asthma resources and information for parent-led community action teams as well as the four regional CRS clinics.

c. Plan for the Coming Year

Staff from the Planning, Education and Partnership Section will participate with stakeholder groups (e.g. school based health centers, Arizona School Nurse Consortium, etc.) to improve access to primary care services. Funding will continue for the Arizona Medical Home Project which links uninsured children with primary care providers who donate appointment slots. Staff will collaborate with the Medical Home Project to gain hospital participation and specialty care physicians willing to participate in the project. Through a community health grant, Mohave County will focus on increasing access to health care for children.

The High Risk Perinatal Program and Health Start providers will continue to educate families on the importance of establishing and maintaining a medical home and assist families in overcoming barriers to health care access. The Office of Oral Health will monitor water fluoridation and promote reporting standards. The Office of Nutrition Services will continue to train WIC staff to identify children in need of services to appropriate community resources and plans to participate on a medical advisory committee to address coordinated referrals for low Hb values, and will continue implement Anemia Team's Strategic Plan.

OWCH Assessment and Evaluation staff will conduct geomapping to identify communities with the greatest number of children hospitalized for various conditions. Disparities in age groupings, gender and race will be identified. Comparative national data will be researched. Results of the analysis will be published on the OWCH web site and in newsletters. Findings will be presented to OWCH management and community partners to determine areas most in need of interventions. Data from the Newborn Screening and Newborn Hearing Screening programs will be matched to Vital Records to identify children who are not being screened.

Through a variety of OCSHCN projects and programs such as Medical Home, Transition to Adult Care, Asthma, and School Nursing, OCSHCN will identify issues, barriers, and concerns regarding the needs of children/youth with special health care needs related to ambulatory-care sensitive conditions.

State Performance Measure 5: *SPM#09. Percent of children age 3 through 20 who had their teeth cleaned by a dentist or dental hygienist within the last year.*

a. Last Year's Accomplishments

One of the most significant findings from the Maternal-Child Health Needs Assessment was the high proportion of children who were reported to have unmet need for dental services. This measure provides a way to track the percent of children who receive ongoing preventive dental care.

According to a survey conducted during the spring of 2001, 58.7 percent of children age 3 through 20 in Arizona had their teeth cleaned by a dentist or dental hygienist within the previous year. No new data are available for this measure. The estimates for 2002 and 2003 are provisionally set at the 2001 rate until data become available.

Funding was provided to the Office of Oral Health to support community activities. Four oral health contracts provided dental screenings and dental sealants to low income children and 210 schools participated in the Child Health Indicator Program. An RFP was issued for child health with an outcome of increasing the proportion of children receiving dental care.

The School-Based Health Care Council reported that 803 children were referred by the nurse practitioners to receive various dental services from 22 participating sites: 491 children were referred and scheduled for appointments with St. Vincent de Paul dental clinic or private dentists, 119 children were left pending appointments and carried into year 2004, and 220 children completed their treatment by December of 2003.

The Office of Oral Health (OOH) provided dental screenings to 1,912 elementary school children in nine urban and three rural school districts. Through the program, 791 children received dental sealants and 621 children were identified as needing further treatment and were referred for care. Treatment was provided to 82 children with urgent dental needs and 21 are on a waiting list. Two Oral Health for Infants and Toddlers workshops were held and a Dental Resource Guide was developed.

An intergovernmental agreement (IGA) was developed for the OOH to bill AHCCCS for services as appropriate. Through the IGA, 486 fluoride varnish treatments were applied to San Carlos Apache Tribe children; 219 sippy cups were distributed; 59 infant tenders were distributed; and 819 participant caregivers were educated on dental health. Through the case management program, 499 client phone calls were made. Information was mailed to 290 clients; 91 appointments were scheduled; 63 dental office confirmations were received; 76 phone verifications were received and 31 home visits were conducted.

The OOH continued to participate in collaboratives to improve access to oral health services, including partnerships with AHCCCS and a community coalition to improve dissemination of oral health prevention messages through community dental and medical clinics.

b. Current Activities

OWCH provides MCH block grant funding to the Office of Oral Health (OOH) to support community activities to increase access to preventive dental services to Arizona's Children. OOH provides dental sealants, water fluoridation, dental exams, and fluoride mouth rinse and mobilizes local communities to support policy that improves oral health (e.g. water fluoridation). The Arizona Dental Trailer Loan Program continues to provide fully-equipped mobile clinics to underserved communities.

Funding received through the Robert Wood Johnson Foundation is being used to establish a dental referral network and hotline, train local dentists on issues relating to oral health care for people with disabilities, design a curriculum for non-dental health practitioners emphasizing early detection of dental problems and referral to dentists, develop a community outreach worker program to assist families in preventing dental problems and in obtaining dental care. A

social marketing campaign is being developed to increase the public's awareness of oral health issues, develop a policy maker education initiative, and initiate a dental care management program in pediatric medical practices.

OWCH incorporates the promotion of good oral health in all direct service programs through distribution of educational materials and training opportunities. The Child Health Indicator Program documents the oral health needs of children and use of sealants and identifies and distributes appropriate oral health educational materials. The Children's Information Center (CIC) refers callers to appropriate agencies, and responds to Spanish-speaking callers for OOH dental referrals. Oral health information is mailed in CIC prenatal care packages.

c. Plan for the Coming Year

OWCH will continue to incorporate the promotion of oral health in all direct service programs and distribute data on oral health needs through health fairs, the Child Health Indicators Program and the Children's Information Center hotline. Oral health information will be distributed with the annual Sensory Program mailing and through the Medical Home Project Program.

The Office of Oral Health will ensure the competency of the public health work force by expanding the early childhood caries training program and will support training through the School Based School Linked Health Care Coalition.

The OWCH Assessment and Evaluation Section will work with OOH, ADHS Tobacco Program, and Planning, Education and Partnership Section contractors to conduct statewide needs assessment on an on-going basis. Questions related to oral health will be added to the youth Tobacco Survey and monitored. Data from the Child Health Grant Contractors will be evaluated. Reports will be issued on the oral health status of children using findings from the needs assessment.

State Performance Measure 6: *SPM#10. Child abuse hospitalizations per 100,000 children under age 18.*

a. Last Year's Accomplishments

The Arizona Department of Health Services sought public input from its partners (e.g., community health centers, adolescent health coalition, foundations, county health departments and other state agencies). Partners were presented with data related to health status indicators, performance measures, and needs assessment. Data were then collected from the partners on what they considered to be critical issues. Two issues emerged as most important: child abuse and violence against women.

Problems with tabulating hospital discharge data prevent reporting on this measure for the year 2002, and discharge data for the year 2003 are not yet available. The estimates for 2002 and 2003 are provisionally set at the 2001 rate until data become available. There were 145 inpatient hospitalizations for child abuse during the year 2001, representing 10.3 per 100,000 children under the age of 18, above the rate of 7.5, which was set as an objective for 2001.

The Child Fatality Review Program developed recommendations for improvement of Child Protective Services (CPS) through the Citizen Review Panel. The Program's annual report was made available for decision making purposes to those entities addressing CPS.

OWCH staff continued to participate in local and state efforts to reduce incidence of child maltreatment including the Never Shake a Baby Arizona committee, Subcommittees to the

Governor's Advisory Commission on Child Protective Services, Arizona's Children's Justice Task Force, and the Child Abuse Prevention Conference.

School nurses used the electronic encounter system provided by OWCH to document incidents of child abuse and neglect in the school population. Staff from the OWCH Planning, Education and Partnership Section participated in the State Child Abuse Prevention Conference Planning. Valley Verde Sanctuary was awarded a contract to provide crisis intervention and counseling services to children witnessing domestic violence in their homes.

The Children's Advocacy Center provided training to the Rural Safe Home Network providers on the recognition of childhood domestic violence trauma and intervention strategies. They also provided crisis intervention and stabilization services to children experiencing domestic violence trauma and their caretakers. Lay health workers serving families through the Health Start Program continued to monitor for potential violence in the home. Referrals were made to appropriate community resources when warning signs were present. The Office of Oral Health educated health professionals on the oral manifestations of child abuse.

b. Current Activities

The Child Fatality Team expanded its activities to include tracking and support of local child fatality prevention initiatives. Through funding made available by the Planning, Education and Partnership (PEP) Section, school nurses are documenting through the use of the Child Health Status Indicator application, the prevalence of child abuse and neglect in the school population. PEP is assisting in the development of education activities related to preventing violence to children and is developing a plan to identify the role of OWCH in efforts to prevent child abuse. Through collaboration between the Medical Home Project and the Plan to Access Children's Health Services grant, health care resources are being provided to children in domestic violence shelters. OWCH staff serve on the CPS subcommittee developing guidelines to identify substance exposed infants and refer them to CPS.

c. Plan for the Coming Year

The Rural Safe Home Network plans to continue counseling services for children who have been affected by domestic violence. OWCH staff will continue working with the Governor's Office on interagency collaboration efforts to improve identification of abuse and appropriate services for victims.

School nurses will continue to document incidents of child abuse using the electronic encounter system provided by OWCH. Lay health workers serving families through the Health Start Program will continue to monitor for potential violence in the home and to make referrals to appropriate community resources.

State Performance Measure 7: *SPM#11. Rate of hospitalizations due to violence against women per 100,000 women age 18 and over.*

a. Last Year's Accomplishments

Input from ADHS partners (e.g., community health centers, adolescent health coalition, foundations, county health departments and other state agencies) indicated that child abuse and violence against women are emerging as critical issues. Problems with tabulating hospital discharge data prevent reporting on this measure for the year 2002, and discharge data for the year 2003 are not yet available. The estimates for 2002 and 2003 are provisionally set at the 2001 rate until data become available. There were 479 inpatient hospitalizations attributed to violence against women during the year 2001, representing 24.3 per 100,000 women age 18

and over, above the objective set for this year of 21.

OWCH staff participated on sub-committees of the Governor's Commission to Prevent Violence Against Women. Recommendations were completed and provided to the Governor. A statewide plan is expected to be completed in 2004. ADHS has approved the development of a rape prevention media campaign. OWCH Community Services Section provided education and information regarding domestic violence and sexual assault to Health Start Coordinators and Lay Health workers.

Partnerships related to domestic violence and rape prevention programs were strengthened with representation at all State Agency Coordination Team (SACT) meetings. The SACT conducted a strategic planning process in 2003, which included analysis of the various funding sources for domestic violence and sexual assault. Technical support and training were offered at all quarterly contractor meetings for domestic violence and rape prevention programs.

OWCH collaborated with Department of Public Safety to fund the prevention component of a new sexual assault program in the Navajo Nation. Rape Prevention and Rural Safe Home Network contracts were renewed. Rural Safe Home Network contractors provided shelter to 249 women and 404 children, turning away 32 individuals because shelter was unavailable. The average stay in a shelter was 24 days. Contractors provided individual counseling to 1,133, group counseling to 523, and took 1,688 hotline calls and 1,615 requests for information and referral. Other services included 261 batterer support services, 670 legal advocacy services, and 2,326 transportation services. In addition, 1,465 persons were given 2,950 training hours.

The Rape Prevention and Education Program awarded three new contracts for Fiscal year 2004 and renewed eight. One of the new contracts cover services to the gay, lesbian, and transgender population and another serves the Navajo Nation. Services were provided to a total of 11,183 youth, community and professionals. Verde Valley Sanctuary was awarded a contract to provide crisis intervention and counseling services to children experiencing domestic violence. The Rape Prevention Program identified Yuma County as an underserved portion of the state.

b. Current Activities

OWCH funds prevention, education, and intervention activities at the community level through rural safe homes, services to children in families impacted by domestic violence, rape prevention and education projects, and contracts to domestic violence community providers. PEP identifies underserved areas of the state and provides funding as allowable and works with partners to develop statewide strategies for domestic violence and sexual assault, including the development of a statewide plan to prevent violence against women. PEP began a rape-prevention media campaign in May and will continue to expand the campaign through 2004. PEP staff participates on the Governor's Commission to Prevent Violence Against Women and the State Agencies Coordination Team. Quarterly, the OWCH programs meet with contractors to assess progress of programs and offer technical support and training.

OWCH provides education and information regarding domestic violence and sexual assault to Health Start Coordinators and Lay Health Workers. Lay health workers assess families for indicators of domestic violence and provide clients in need with information about shelters, referral agencies, and survival skills.

The OWCH Assessment and Evaluation Staff provide technical assistance in evaluating the Rape Prevention Education Program, and continue to analyze data on domestic violence and to evaluate the Health Start program in offering education and outreach services for behavioral health issues.

c. Plan for the Coming Year

The rape prevention media campaign will continue if funding is available. OWCH will continue to provide education and information regarding domestic violence and sexual assault to Health Start Coordinators and Lay Health workers and will require case conferencing with a social worker when they suspect domestic violence. During site visits, documentation of case conferencing will be reviewed.

OWCH Planning, Education and Partnership staff will continue to collaborate with the Rural Safe Home Network and Rape Prevention and Education Program to provide training common to both programs. They will continue to fund prevention, education, and intervention activities at community level and plan to enhance services to children in families impacted by domestic violence, and expand rape prevention and education projects. Contracts will be renewed to for domestic violence community providers, and for Rape Prevention and Education. Underserved areas of the state will continue to be identified and funding provided as allowed. PEP will continue to work with its partners to implement recommendations in the State Plan on Domestic and Sexual Violence, developed by the Governor's Commission to Prevent Violence Against Women.

The OWCH Assessment and Evaluation Section will continue to provide technical assistance in evaluating the Rape Prevention Education Program, to analyze data on domestic violence, and to evaluate health start program in offering education and outreach services for behavioral health issues.

FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) SPM#01. Proportion of low-income women who receive reproductive health/family planning services.				
1. Family planning/reproductive health services are provided by contractors	☒	☐	☐	☐
2. Contractors provide community education regarding family planning choices	☐	☒	☐	☐
3. Collaboration with Title X occurs to maximize services to low income women	☐	☐	☐	☒
4. Health Start refers women with negative pregnancy tests to family planning services	☐	☒	☐	☐
5. Lay health workers assist clients with establishing and monitoring family planning goals	☒	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐
	Pyramid Level of Service			

STATE PERFORMANCE MEASURE	DHC	ES	PBS	IB
2) SPM#02. Hospitalizations for nonfatal injuries and poisonings per 100,000 adolescents age 15 - 19				
1. Contractors address the use of seat belts in a variety of initiatives	☐	☒	☐	☐
2. Contractors are addressing efforts to reduce alcohol and substance use	☐	☒	☐	☐
3. Collaboration with the EMS Injury Prevention Program occurs	☐	☐	☐	☒
4. Data is collected and geomapping is conducted	☐	☐	☐	☒
5. The Citizen Review Panel is developing a process to enhance community outreach	☐	☐	☐	☒
6. Coordination occurs through the ADHS Injury Prevention Advisory Council.	☐	☐	☐	☒
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) SPM#06. Preventable child deaths per 100,000 children under age 18.				
1. Multiple contractors are conducting car seat safety efforts	☐	☒	☐	☐
2. Child Fatality Review Program provides technical assistance to local teams	☐	☒	☐	☐
3. Car seats are provided to low income families with young children	☒	☒	☐	☐
4. The SIDS Advisory Council provides technical assistance in the use of protocols for first responders	☐	☐	☐	☒
5. Direct services programs conduct home safety evaluations	☐	☒	☐	☐
6. Child Fatality Review Team identifies leading causes of preventable deaths and their causes and recommends prevention strategies	☐	☐	☐	☒
7. Child Fatality Review Team identify and track existing prevention activities, identify gaps in efforts and develop strategies to address gaps.	☐	☐	☐	☒
8. Community Services provide case management to high-risk pregnant women and their children	☐	☒	☐	☐
9. High-Risk Perinatal Program provides perinatal consultation and transportation of high-risk pregnant women to risk-appropriate settings for delivery	☐	☒	☐	☐
10.	☐	☐	☐	☐
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) SPM#07. The rate of children 1 through 14 hospitalized for ambulatory care sensitive conditions per 100,000.				
1. The Medical Home Project links uninsured children with health care providers	☐	☒	☐	☐
2. The encounter system for school nurses is maintained and data				

analyzed and reported	☐	☐	☐	☒
3. Geomapping is conducted to identify areas of significance	☐	☐	☐	☒
4. The Asthma Coalition meets regularly to address systems of care issues	☐	☐	☐	☒
5. Several programs screen children and refer them to services and assist with coordinating services	☐	☒	☐	☐
6. Educate community regarding available services, eligibility and coverage, and the application process	☐	☒	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) SPM#09. Percent of children age 3 through 20 who had their teeth cleaned by a dentist or dental hygienist within the last year.				
1. School based health centers screen children and fund referrals for restorative care	☒	☐	☐	☐
2. RWJ Foundation grant being used to establish a dental referral network and hotline, professional training, community outreach and social marketing campaign	☐	☐	☐	☒
3. Public health nurses for one county are providing oral hygiene products during home visits	☒	☐	☐	☐
4. The Office of Oral Health is working collaboratively to identify alternative service models	☐	☐	☐	☒
5. A dental hygiene training program is providing students to conduct oral health screenings in schools	☒	☐	☐	☐
6. Office of Oral Health provides water fluoridation and preventive dental care to children	☒	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) SPM#10. Child abuse hospitalizations per 100,000 children under age 18.				
1. School nurse encounter system is documenting the prevalence of child abuse	☐	☐	☐	☒
2. Educational materials are being developed for distribution to contractors and the public	☐	☒	☐	☐
3. OWCH is developing a plan to determine its role in addressing this measure	☐	☐	☐	☒
	☐	☐	☐	☐

4. Health care services are being provided to children in domestic violence shelters	☒	☐	☐	☐
5. Direct services programs conduct home safety evaluations	☐	☒	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) SPM#11. Rate of hospitalizations due to violence against women per 100,000 women age 18 and over.				
1. Rape Prevention Program is funding prevention and education activities	☐	☒	☐	☐
2. Rape Prevention Program evaluation is being conducted	☐	☐	☐	☒
3. Educational opportunities are provided to law enforcement, legal systems and medical community	☐	☒	☐	☐
4. Legal advocacy is provided for victims	☐	☒	☐	☐
5. Shelter and supportive services are provided to domestic violence victims in rural Arizona	☒	☒	☐	☐
6. A rape prevention media campaign is being conducted	☐	☐	☒	☐
7. Statewide planning and coordination is occurring through the Governor's Commission to Prevent Violence Against Women and the State Agency Coordination Team	☐	☐	☐	☒
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

E. OTHER PROGRAM ACTIVITIES

Telemedicine. The OCSHCN has implemented a Memorandum of Understanding with the University of Arizona Telemedicine program to facilitate the development of a statewide network of sites and protocols for care. Rural families with CSHCN are extremely eager to use this technology so that they can have readier access to a wide range of services. Additionally, OCSHCN will be pursuing use of the equipment to help establish parent communication networks.

Data Linkage/Sharing. CFHS staff are pursuing grant funding opportunities to enhance efforts regarding this issue. OWCH received a CDC grant to fund data linkage efforts related to early identification of hearing loss. SSDI grant funding was approved to address data sharing/linkage between other ADHS programs including vital records, newborn screening, and Children's Rehabilitative Services. A data warehouse is being designed and the process will continue to start transferring data from targeted programs to the warehouse.

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 have assumed responsibility for the WIC Hotline and WIC provides training and technical assistance for the Hotline staff.

HIPAA Planning. The ADHS is preparing for HIPAA implementation. An analysis of agency databases was completed and efforts are underway to ensure compliance with the transaction standards. Staff are receiving training regarding HIPAA from the ADHS HIPAA program manager and through video and teleconferences. OWCH policy and procedures were developed and implemented to secure privacy of personal health information.

Application Development. An assessment of OWCH software applications revealed the need for a number of enhancements to existing applications and replacement of some obsolete applications. A computer programmer position was created and a programmer was hired. In 2003 a new data system for the Health Start program was designed and implemented. A new application for School Vision and Hearing Screening was designed and is being beta tested for implementation in 2004. In addition, the Sensory database and the Hotline database will both be redesigned in 2004.

Childhood Obesity. Office of Nutrition staff serve on Action for Health Kids State Coalition to promote nutrition and physical activity in schools. They are working to create a data surveillance system related to obesity. A statewide plan to address obesity is under development in 2004.

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.

Ready to Learn. OWCH financially supported the training on and distribution of a new video about early brain development made by and for Native American communities. The "What We Have Always Known" Ready to Learn video has gained interest and attention nationwide. OWCH supported Mesa United Way in providing training on the video to people throughout the state.

Child Care Survey. The OWCH began working with the Transitioning Healthy Child Care Arizona grantee on the development of a statewide survey of child care providers. The survey will be conducted in 2004 to gather information on the health and safety needs of providers.

OWCH Quality Assurance Processes. During FY03-04, OWCH investigated the potential use of the Logic Model as a tool for office-wide implementation. A draft office policy and procedure for program evaluation was completed and is being piloted with the Rape Prevention Education Program. The OWCH is working towards developing and implementing evaluation methodologies for each program. Customer service satisfaction surveys are mailed out every six months to current contractors. Results are analyzed and findings are presented to program managers and supervisors. Aggregate reports are prepared for Management Team. The Assessment and Evaluation Section staff work to improve the usefulness of program databases and data collection by identifying the essential information needs for each program and evaluating whether information needs are met by data collection and analysis.

F. TECHNICAL ASSISTANCE

The OWCH has three requests for technical assistance. The first two requests are general systems

capacity issues that involve services for high-risk infants, and the third request is data-systems related.

Assistance is requested to support an analysis of the public health nursing followup system for high-risk infants. Currently, high-risk infants are followed by specially trained community nurses who provide physical assessment, developmental assessment and anticipatory guidance. Funding has come from the high-risk perinatal program, which has had its funding levels decreased for many years. Developing a mechanism through which Medicaid payment can be made to cover followup services for Medicaid-eligible infants would free up funding to move children off of waiting lists and into needed services. An analysis of potential funding mechanisms would include, but not be limited to researching billing codes, provider agreements, coverage of reimbursable services and training of contractors.

Assistance is requested to develop a system to provide for at least one visit with a community nurse prior to hospital discharge for infants experiencing certain high-risk complications at birth. Work with stakeholders in the early childhood system has identified the need for more intensive followup of infants who may not have evident delays at the time they are discharged from the neonatal intensive care unit, but are at high risk for developing them after discharge. The OWCH is looking at developing a system of triage to provide for more intensive followup by specially trained community nurses. A screening tool has been developed by neonatologists and the pre-discharge visit is key to the continuity of care. An analysis of system capabilities and a plan for connecting tertiary care centers to all areas of the state is needed, including utilizing the telehealth system as a component for reaching remote areas of the state. University of Arizona is a possible contractor for this technical support.

Technical assistance is requested to bring all of the newborn screening systems under one data system. As newborn hearing screening data is being added to the Newborn Screening Program, problems have been encountered with the Neometrics system's inability to run with other systems. A uniform system that could be easily accessed by providers would be very helpful in both gathering and reporting reliable data on newborn screening services.

The OCSHCN has two requests for technical assistance. Both are needs assessment data-related issues, and both relate to assessing unmet need.

Technical assistance is requested in developing a statistical model to identify variables that are associated with unmet needs of CSHCN utilizing data from the State and Local Area Integrated telephone Survey. OCSHCN staff would like assistance in review their knowledge of hierarchical modeling techniques, and supervision in their applications. Michael Kogan is suggested as the individual to provide this assistance.

Technical assistance is requested in the development of questions for focus group use in Native American and Hispanic communities. OCSHCN staff plans to develop measures of the unmet needs of children and families with special health care needs in racial and ethnically isolated communities. The Office of Health Care Disparities is suggested as the provider of this assistance.

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.

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 \$13,684,737 in FY2005, surpassing our state's maintenance of effort level in FY89 of \$12,056,360.

The estimated Title V allocation for Arizona, FY2005, is \$7,842,357. Slightly more than thirty-two percent (\$2,548,805) of the block grant will be allocated for preventative and primary care needs for children and adolescents; thirty percent (\$2,352,708) will be allocated to children with special health care needs; slightly less than twenty-eight percent (\$2,156,609) will be allocated for women, mothers and infants and ten percent (\$784,235) will be budgeted for administrative costs.

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 \$4,279,039 remaining as carry over from our FY2004 block grant in the following types of service: \$1,233,693 for pregnant women, mothers and infants; \$1,580,846 for preventative and primary care needs for children and adolescents; and \$1,464,500 in the Children's Rehabilitation Services program.

The state's maintenance of effort includes line-item funding for High Risk Perinatal Service, \$3,630,600; a Perinatal block grant to all fifteen counties, \$1,148,500; Children's Rehabilitation Service (CRS), \$3,587,000; Child Fatality Review Program, \$100,000; Prenatal Outreach Program (Health Start), \$760,429 and Newborn Screening Program, \$3,239,800. An additional \$1,218,408 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 FY2005 match and overmatch of \$13,684,737 continues to exceed the maintenance of effort amount of FY89's \$12,056,360.

For fiscal year 2005, 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 \$14,375,700 is designated for Children's Rehabilitative Services.

Other federal funds in the amount of \$32,668,102 represent matching funds from Title XIX and Title XXI for Children's Rehabilitative Services. Additional federal monies will contribute another \$81,235,503 toward MCH initiatives which include the WIC food grant, \$72,208,184; Universal Newborn Hearing, \$236,587; Early Hearing Detection and Intervention, \$146,549; Rape Prevention and Education, \$753,834; Family Violence Prevention, \$1,665,286; SSDI Primary Care, \$100,000; Abstinence Education, \$1,056,905; Kids Care, \$2,668,686; Arizona Early Intervention, \$527,494; Child Fatality Review, \$148,000; Early Childhood Comprehensive Systems, \$100,000 and \$1,623,978 for the Preventive Health and Health Services Block Grant.

Core Public Health Infrastructure: \$4,387,912

Office of Women's and Children's Health (Part A & B): \$11,955 will support the Department's Office of Birth Defects; \$438,974 will support management service; \$70,517 will support information technology automation; \$157,701 for the Deputy Assistant Director's Office for special projects; \$616,152 for assessment, evaluation and epidemiologic analysis; \$59,908 for Nutrition support; \$838,386 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 \$41,611 for Midwife Licensing.

Office of Children with Special Health Care Needs (Part C): \$864,725 will support administrative initiatives; \$814,238 for Community Development; and \$430,445 for Quality Assurance and Utilization Review for the Children's Rehabilitation Services program; \$29,091 for epidemiological support; and \$14,209 for child Fatality support.

Population-Based Services: \$675,113

\$338,651 is budgeted for planning, education and partnership initiatives that include the Sensory Program and Community grants; \$286,462 for Community development/services that include the Pregnancy and Breastfeeding Hotline Program and the High Risk Perinatal Services; and \$50,000 for Immunizations.

Enabling and Non-Health Support: \$431,170

\$431,170 will support planning, education and partnership initiatives that include the Child Health Program's contract with Arizona Academy of Pediatrics and Community grants.

Direct Health Care Service: \$1,563,927

\$200,000 will support community nursing services for high-risk infants; \$525,542 for oral health services for children; and \$838,385 for planning, education and partnership initiatives that include Reproductive Health Program's contracts and Community grants.

Indirect Administrative Costs: \$784,235

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.