STATE TITLE V BLOCK GRANT NARRATIVE
STATE: AZ
APPLICATION YEAR: 2006

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 the current application process, the home page of the Office of Women's and Children's Health website, as well as other forms of electronic communications such as emails and newsletters were used to disseminate information about the needs assessment process, issues, and findings, and to seek input. Program managers and staff who work directly with the public, contractors, and community partners, also brought the perspective of those stakeholders to the process. The Office of Women's and Children's Health and the Office for Children with Special Health Care Needs met with stakeholders independently and jointly.

Four formal public input sessions were held around the state. One session was scheduled to coincide with the Arizona chapter of the American Public Health Association meeting held in Tucson, in the southern part of the state. Another session was held in more centrally located Phoenix. A third session coincided with the Arizona Local Health Officers Assocation conferences, and was held in Prescott, in the northern part of the state. Another session in Phoenix focused specifically on Native Americans. Each of these sessions were structured both to present information on health trends and issues, and to gather input on community concerns, priorities, and preferred strategies.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

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

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

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

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

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

POPULATION

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

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

There are 15 counties in Arizona; however, 77 percent of the state's population resides in either Maricopa or Pima Counties. Maricopa County alone added 500,000 people since 2000, more than any other county, making it the third largest county in the United States. Overall, three of every four Arizonans lives in an urban area, one in five lives in a rural area; 2 percent live in a frontier area, and 3 percent live on Indian reservations.

RACE/ETHNICITY

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

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

residents are American Indians.

Four counties border Mexico, and Arizona has an increasing Hispanic population, with a higher proportion of Hispanics (28 percent) compared to the nation (13 percent). An even higher percentage of children are Hispanic (39 percent in Arizona, compared to 19 percent nationally). In 2003, the number of births to Hispanic mothers surpassed Anglos for the first time. Arizona has a smaller percentage of African Americans than the nation (3 percent compared to 13 percent) and a higher proportion of Whites (88 percent compared to 81 percent nationally).

LANGUAGE SPOKEN

Arizona residents are more likely to speak a language other than English at home (26 percent in Arizona compared to 18 percent nationally), and more likely to report speaking English "less than very well" (11 percent in Arizona compared to 8 percent nationally). Among Arizona residents who spoke English "less than very well," 85 percent spoke Spanish, while the other 15 percent spoke one of many other languages.

ECONOMY

Arizona is second in the nation in generating jobs; however, wages and personal income lag behind the rest of the nation. Arizona's main economic sectors include services, trade and manufacturing, and most of the fastest growing jobs in Arizona are jobs with relatively low wages and fewer benefits (such as health insurance). The average per capita personal income in Arizona ranked 38th among the 50 states, at $27,232 in 2003. Although the cost of living in Arizona mirrors national averages, the per-employee compensation tends to be lower.

Based on the 2003 U.S. Census three-year average estimate of 2001-2003, 13.9 percent of Arizona's population earned incomes below the federal poverty line, while the national rate was 12.1 percent. In Arizona, 21 percent of children under the age of 18 years lived in poverty in 2003, relative to 17 percent children in the nation as a whole. Children continue to constitute a large proportion of the poor population (45 percent) while representing only 30 percent of the total population. In 2001, 26 percent of Arizona children lived in families in which no parent had full-time, year round employment, and 29 percent lived in families headed by a single parent. These families bear an increased risk for living in poverty.

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

HOMELESSNESS

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

There are many factors that contribute to homelessness, including poverty, domestic violence, gender (the majority of homeless adults are males), substance abuse, mental illness, lack of affordable housing, decreases in public assistance, low wages and lack of affordable health care. Families, specifically women with children, are the fastest-growing subpopulation of people who are homeless. Twenty-seven percent of homeless women, children, and teens came from a domestic violence

situation. In spite of an overall positive economic picture in the state, the large number of households earning less than a livable wage and a disproportionate rise in housing costs versus incomes points to increasing numbers of homeless persons.

EDUCATION

Arizona has more than 583 school districts, which includes 364 charter holders. Arizona's has 2,270 schools and the largest number of charter schools in the nation. According to the National Educational Association, Arizona per pupil spending is among the lowest in the nation. In a national study of reading proficiency, nearly half of Arizona's 4th graders (46 percent) read below proficiency, compared to 38 percent in the rest of the nation.

Among Arizona's population age 25 and older, 84 percent have graduated from high school, and 24 percent have a college degree, similar to the proportions of all United States residents. However, Arizona has one of the highest high-school dropout rates in the nation. During the 2003-2004 school year, the statewide dropout rate was 7.4 percent. For American Indians and Hispanic students, the dropout rates were even higher (12.4 percent and 10.1 percent, respectively).

Arizona adopted high stakes testing requiring students to pass proficiency tests in reading, writing, and mathematics in order to earn a high school diploma. The Arizona Instrument to Measure Standards (AIMS) has been administered annually in recent years. Although passing the test has not yet been required to earn a high school diploma, students have been taking AIMS for purposes of evaluating school performance. High proportions of students across the state, and even higher proportions of minority students, have failed to meet AIMS standards for graduation. Implementation of the requirement to pass the AIMS before receiving a diploma was postponed in order to give schools time to align their curriculum to testing standards. The class of 2006 will be the first graduating class required to pass the test in order to graduate. In 2005, legislation was passed to allow students to apply points towards their AIMS scores for some classes in which they earned As, Bs, or Cs.

According to the Annie E. Casey Foundation Kids Count 2004 study, a disconnected youth is defined as a teen that is not in school or working. Currently, there are an estimated 3.8 million (15 percent) young adults nationally who are neither in school nor working. In Arizona, 12 percent of teens age 16 to 19 are not in school or working. Referred to as "disconnected youth," they lack the skills, support and education to make a successful transition to adulthood. This study determined that the most disconnected youth were the teens in foster care, youth involved in the juvenile justice system, teens that have children of their own, and those who have never finished high school. These subgroups were determined to need the most urgent attention.

JUVENILE DELINQUENCY

The proportion of violent crimes attributed to juveniles by law enforcement has declined in recent years, while drug and alcohol-related arrests have increased. Between 1993 and 2002, there were substantial declines in juvenile arrests for murder (64 percent), motor vehicle theft (50 percent), and weapons law violations (47 percent) and major increases in juvenile arrests for drug abuse violations (59 percent) and driving under the influence (46 percent). Fourteen percent of all arrests in Arizona were juveniles under age 18, compared to 16 percent nationally, and 71 percent of the arrests were male. Of the arrests of Arizona juveniles ages 8 through 17 in 2003, 16 percent of those offenses were larceny/theft. Runaways, drug violations, and assaults each make up 10 percent of the total number of juvenile offenses, and liquor law violations made up 9 percent of the total violations.

HEALTH INSURANCE

Eighty-three percent of Arizona residents have some kind of health insurance, according to 2003 United States Census data. Many people have more than one kind of insurance: 64 percent of people have private insurance--either employment-based (55 percent) or direct purchase (9 percent); and 30

percent had some kind of government-sponsored insurance--such as Medicaid, (13 percent), Medicare (14 percent), or military health insurance (6 percent).

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

Recognizing the importance of affordable health care, the Healthcare Group was created in 1985 by the Arizona State Legislature with the support of the Robert Wood Johnson Foundation. It is a state-sponsored, guaranteed issue health insurance program for small businesses and public servants. AHCCCS, Arizona's Medicaid agency, oversees and administers the program, although it will receive no state subsidies after July of 2005. Over 4,000 businesses participate in Healthcare Group, covering more than 12,000 Arizona residents.

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

MANAGED CARE

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

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

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

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

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

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

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

The state budget passed in 2003 directed AHCCCS to increase the premiums paid by families with children enrolled in KidsCare. The new premiums are based on a sliding scale depending on family income and number of children. Before July of 2003, the scale ranged from $0 to $20, depending on income. As of July 2004, the premiums increased to a range of $10 to $35.

GENERAL AND SPECIAL HOSPITALS

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

PROFESSIONAL HEALTH CARE PROVIDERS

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

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

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

Arizona has developed its own designation system for identifying under-served areas. All federally designated shortage areas are automatically designated as Arizona shortage areas. In addition, Arizona's system involves the application of an index which weights 14 indicators such as providers to population ratios, travel time, percent of population below poverty and adequacy of prenatal care.

There are 13 state designated Arizona medically under-served Areas. A recent survey of State Title V Directors on pediatric provider capacity for children with special health care needs pointed out network concerns specific to CSHCN. The most commonly identified significant access barrier in this survey was the uneven distribution of pediatric providers.

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

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

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

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

PERINATAL SYSTEM

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

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

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

ORAL HEALTH

Arizona has 15 counties that have been subdivided into 94 Dental Care Areas, which are geographic areas defined by the state of Arizona based on aggregates of census tracts. These Dental Care Areas are considered rational service areas for dental care by the State and are used for Federal Dental Health Professions Shortage Area designations. Thirty of the 94 areas are designated by the federal government as Dental Health Professional Shortage Areas. An area may also be designated as a "vulnerable population" if it is in the top quartile of any of the following: percent of the population less than 200% of the federal poverty level, percent of population that is Hispanic, or percent of the population that is American Indian.

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

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

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

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

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

BEHAVIORAL HEALTH

The Arizona Department of Health Services Division of Behavioral Health Services has reorganized permanent statutory authority to operate the state's behavioral health system, including planning, administration, and regulation and monitoring of all facets of the state behavioral health system. The division's focus is to promote healthy development and to provide effective prevention, evaluation,

treatment, and intervention services to people in need who would otherwise go unserved.

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

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

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

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

ARIZONA IMMUNIZATION PROGRAM

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

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

MEDICAL HOME PROJECT

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

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

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

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

COMMUNITY HEALTH CENTERS

Community health centers were established in the 1960s by federal law to treat and provide primary care to all patients regardless of their ability to pay. The Arizona Association of Community Health Centers reports that their membership includes 35 community health centers with more than 100 satellite locations statewide, serving more than 400,000 people in 2002. The Association represents health centers statewide and provides advocacy, professional education programs, financial services, and programs for health centers to improve and ensure clinical excellence.

SCHOOL-BASED HEALTH CENTERS

There were 100 school-based or school-linked health care clinics in Arizona, delivering more than 45,000 medical visits to over 14,000 children during the 2002-2003 school year. Most of the children served had no health insurance (79 percent). Thirty-five percent of the centers operate in rural areas, and six operate on tribal lands. These clinics offer access to health care in communities where there is a significant provider shortage and transportation to health care services may be problematic.

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

many students, these centers are the only source of medical care.

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

OTHER PROJECTS TO INCREASE ACCESS TO CARE

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

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

TELEMEDICINE

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

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

CULTURAL COMPETENCE

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

Since insurance coverage among people whose incomes fell below 200 percent of the federal poverty

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

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

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

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

The Center for Minority Health is currently conducting its own infrastructure assessment within the Arizona Department of Health Services to determine minority health resources existing within the agency, examine the capacity of the agency to identify and address health disparities and barriers to access to care among minority groups and vulnerable populations, and to establish an inventory and directory of minority health resources.

B. AGENCY CAPACITY

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

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

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

OWCH DIRECT HEALTH CARE SERVICES

The High Risk Perinatal Program provides direct health care services in two of its three components: the maternal transport component authorizes and funds the transport of high risk pregnant women to appropriate medical centers for delivery and the community nursing component provides in-home nursing consultation to enrolled families.

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

OCSHCN DIRECT HEALTH CARE SERVICES

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

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

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

OCSHCN ENABLING SERVICES

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

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

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

OWCH ENABLING SERVICES

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

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

Community Health Services contracts for community-based efforts addressing specific performance measures related to women and children. Contractors provide a variety of services. One contractor implemented a program to provide health education and activities addressing smoking, physical activity, stress reduction, and proper nutrition for adolescents. Another contractor is targeting efforts directed toward women who are low-income, have a limited education and women of color. They are providing a program that addresses healthy weight management, nutrition, physical activity, stress management, and smoking cessation. Many of the contractors are also focusing on injury prevention by providing child safety seats and bicycle helmets, conducting car safety seat inspections, training in the proper use of car seats, educating pregnant women regarding proper seat belt use, and training car passenger safety technicians.

OWCH POPULATION-BASED SERVICES

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

OCSHCN POPULATION-BASED SERVICES

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

OWCH INFRASTRUCTURE-BUILDING SERVICES

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

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

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

The OWCH's organizational structure is based on a functions approach rather than programs for specific populations. The office provides technical assistance to entities serving the Title V population (i.e. communities, contractors, coalitions, schools, county health departments, other state agencies, etc.). The Planning, Education, and Partnerships Section (PEP) provides technical assistance on adolescent growth and development, dealing with adolescents, adolescent risk behaviors, and health and safety in child care settings. The Newborn Hearing Screening Program provides technical assistance to hospitals implementing universal hearing screening. A PEP Section employee sits as a non-voting member of the Arizona School-based Health Care Council board. The OWCH is working with the Governor's School Readiness Board to improve early childhood systems. A statewide plan will be completed by June 2005.

OCSHCN INFRASTRUCTURE-BUILDING SERVICES

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

Asthma Program. This public health program primarily supports local coalitions throughout the state in their efforts to develop and implement community-based programs to address the needs of children who have asthma. Additionally, OCSHCN uses its network of providers, community-based

organizations, and those with an interest in asthma to share information on: materials, advances in diagnosis and treatment, grant opportunities, data, and conferences.

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

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

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

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

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

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

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

Learning Management System. ADHS has created the infrastructure to develop a learning management system by combining the resources of four office: the Office of Nutrition and chronic Disease, Public Health Preparedness and Response, the Office for Children with Special Health Care Needs, and Emergency Medical Services. This system will allow the electronic tracking and evaluation of all web-based educational modules. These modules are available 24/7 and can be utilized real time or can be stored and reviewed at a later time. In addition to the tracking and educational modules, there will be a list serve available to participants to discuss the information with

other e-learners. This system will be available to the four offices to provide training opportunities to their staff, their community partners, and family members. OCSHCN plans to utilize this technology to implement many of its training curriculums.

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

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

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

C. ORGANIZATIONAL STRUCTURE

Governor Janet Napolitano was sworn into office in January 2003. Prior to being elected Governor of Arizona, she served one term as Arizona Attorney General and four years as U.S. Attorney for the District of Arizona. A hallmark of Governor Napolitano's administration has been government reform on all levels. She established an efficiency review initiative that has identified hundreds of millions in savings over five years. Her various citizens' commissions have recommended important improvements to Child Protective Services, Department of Corrections, and the Arizona tax code. She erased a billion-dollar state budget deficit without raising taxes or eliminating vital services. She has tackled the spiraling price of prescription drugs by launching what is now the CoppeRx CardSM, a discount program that is saving Medicare-eligible Arizonans more than $100,000 a week. She is a distinguished alumna of Santa Clara University and the University of Virginia Law School.
The Arizona Department of Health Services (ADHS) is one of the executive agencies that report to the Governor. ADHS was established as the state public health agency in 1973 under A.R.S. Title 36 and is designated as Arizona's Title V MCH Block Grant administrator. Eight divisions in ADHS report to one of two deputy directors: Office of the Director, Arizona State Hospital, Division of Assurance and Licensure Services, Division of Behavioral Health Services, Division of Business and Financial Services, Division of Information Technology Services, Organizational and Employee Development, and Division of Public Health Services.

The Division of Public Health Services is organized into two primary service lines; Public Health Preparedness Services and Public Health Prevention Services (PHPS).
PHPS administers Title V funds and coordinates activities through the Office of Women's and Children's Health (OWCH) and the Office for Children with Special Health Care Needs (OCSHCN). Included in PHPS are the Office of the Deputy Assistant Director which includes the medical director, business operations, and epidemiology services. Other offices within PHPS are the Office of Chronic Disease Prevention and Nutrition Services, (including WIC), the Office of Oral Health (OOH), the Office of Health Systems Development, and the Office of Tobacco Education and Prevention. Title V funding is used to support many activities throughout the various offices within the Division of Public Health Services as well as other bureaus.

OFFICE OF WOMEN'S AND CHILDREN'S HEALTH

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

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

The Community Services Section programs provide services to children and their families who are at risk for developmental delay, metabolic/genetic disorders or hearing impairment. The programs within this section are Newborn Screening, Newborn Hearing Screening, Health Start, the High Risk Perinatal Programs, the Pregnancy and Breast Feeding Hot Line, the Children's Information Center, and the WIC Hot Line.

The Planning, Education and Partnerships Section (PEP) provides leadership for statewide priority setting, planning, and policy development, and supports community efforts to assure the health of women, children, and their families. PEP works with a variety of public, private, and non-profit community partners to identify health needs, improve systems of care, and develop public health policies. PEP provides and supports educational activities that advance good health practices and outcomes, including promoting the use of "best practices," providing client and provider education, sponsoring public information campaigns, and developing and distributing education materials. Current Planning Education and Partnership programs include: Abstinence, Sensory, Domestic Violence, Rural Safe Home Network, Rape Prevention and Education, County Prenatal Block Grant, Reproductive Health/Family Planning, the Medical Home Project, and Community Health Services.

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

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

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

OWCH funds block grants to communities to address maternal and child health priorities. The block grants give latitude to local communities in developing strategies but require that the strategies be research based.

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

of women and children. The OWCH partner presents an overview of current health status data and trends to the partner agency.

OFFICE OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS

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

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

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

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

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

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

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

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

Center for Health Care Financing, and the MCHB State Leadership Network.

D. OTHER MCH CAPACITY

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

ADHS SENIOR LEVEL MANAGEMENT

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

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

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

OFFICE OF WOMEN'S AND CHILDREN'S HEALTH

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

Sheila Sjolander has been the section manager for Planning, Education and Partnerships (PEP) since 2001. PEP provides leadership for statewide priority setting, planning, and policy development, and supports community efforts to assure the health of women, children, and their families. Ms. Sjolander oversees a variety of statewide maternal and child health programs, including domestic violence and rape prevention, injury prevention, prenatal block grant to the counties, community health projects targeting Title V priorities, hearing screening, family planning, and teen pregnancy prevention. For the last twelve years, Ms. Sjolander has used her expertise in strategic planning and policy development in the states of Arizona, Wisconsin, and Oregon, and has had leadership roles in public health for the past eight years.

Joan Agostinelli joined the Office of Women's and Children's Health as the section manager for Assessment and Evaluation in 2004. The section is responsible for supporting research and evaluation related to women's and children's health. Ms. Agostinelli has over twenty years experience in health care, including ten years as a private consultant providing services to both public agencies and private health care organizations related to research design, needs assessment, performance measurement, program evaluation, and reimbursement system design.

OFFICE OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS

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

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

OTHER PUBLIC HEALTH SERVICE PREVENTION MANAGEMENT

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

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

ROLE OF PARENTS OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS

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

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

E. STATE AGENCY COORDINATION

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

COORDINATION AMONG STATE HUMAN SERVICES AGENCIES

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

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

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

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

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

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

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

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

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

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

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

Arizona Department of Education (ADOE): OWCH staff sits on a committee reviewing HIV/AIDS educational material. ADOE works with ADHS on the Youth Risk Behavior Factor Survey and general school health issues. OCSHCN participates on the Arizona Transition Leadership Team (ATLT), developed by the ADOE to develop statewide policies to ensure timely access to post-secondary disability resources and to design of research of post school outcomes. OCSHCN partners with ADOE on the state transition conferences.

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

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

Arizona Health Care Cost Containment System (AHCCCS): Arizona's Title XIX agency. OWCH programs collaborate to improve access to health care and increase enrollment. OCSHCN works with AHCCCS to providing administrative oversight to the CRS program; these activities include formal data sharing agreements, the development and implementation of quality improvement activities, and coordination of capitated payment mechanisms to the four regional CRS sites.

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

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

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

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

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

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

Association of Community Health Centers: OWCH provides funds to the health centers for immunizations through The Arizona Partnership for Immunization (TAPI). OWCH also has contracts with some community health centers for the Health Start program.

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

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

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

March of Dimes (MOD): Ongoing partnership. MOD provided technical support for the expansion of screening tests provided by the OWCH Newborn Screening program.

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

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

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

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

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

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

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

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

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

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

Arizona Adolescent Health Coalition (AAHC): OWCH collaborates with the AAHC to promote healthy

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

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

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

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

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

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

Children's Action Alliance: Children's Action Alliance (CAA) is a non-profit, nonpartisan research, policy and advocacy organization dedicated to promoting the well-being of all of Arizona's children and families. Recently, CAA participated in an informal School Health Focus group that was facilitated by OCSHCN to discuss how the health needs of children and youth with special health care needs are being addressed in the school setting.

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

STATE SUPPORT FOR COMMUNITIES

Community Teams: OCSHCN works to develop parent-led, self-reliant, self-sustaining community organizations that can mobilize local, state, and federal resources to improve the quality of life for C/YSHCN and their families. Each community identifies its unique resources and issues impacting

C/YSHCN and their families, and purposefully woks to improve the system of care within their community. The community is strengthened by recognizing and building upon local community capacities to care for children. The goal is to provide this program throughout Arizona; currently services are provided in Page, Prescott, Prescott Valley, Chino Valley, Bullhead City, Kingman, Somerton, San Luis, Gadsen, St. Johns, Springerville, Eager, Concho, Mesa, Flagstaff, and the Verde Valley (Cottonwood, Clarksdale, and Sedona).

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

F. HEALTH SYSTEMS CAPACITY INDICATORS

Form 17 tracks several health systems capacity indicators over a five-year period, and several of these measures showed improvement. Both the percent of Medicaid enrollees and the State Children's Health Insurance Program (SCHIP) enrollees whose ages are less than one year during the reporting year who received at least one initial periodic screen rose to their highest levels in the five year period tracked. For Medicaid enrollees, 95 percent of children were screened, an increase of 13 percent over the previous year. Among SCHIP enrollees, 79.7 percent were screened, an increase of 11 percent from the previous year. The percent of EPSDT eligible children aged 6 through 9 years who received a dental service during the year also increased to 49.2 percent, the highest level observed over the five-year period tracked. The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program increased to 58.1 percent.

Two of the measures moved in the wrong direction. The rate of children hospitalized for asthma among children less than five years of age was 26.5 per 10,000 children in 2003, higher than in the previous 5-year period. The percent of women age 15-44 receiving adequate prenatal care as measured by the Kotelchuk index decreased slightly from 69.9 percent in 2002 to 67.9 percent in 2003.

Form 18 compares prenatal care and birth outcomes for the Medicaid and non-Medicaid populations. On each measure, similar to findings reported in previous block grant applications, results were more favorable for the non-Medicaid population than the Medicaid population in 2003. 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 direct access to several of the databases specified in Form 19. The program has direct access to linked infant birth and infant death certificates, to linked birth certificates and newborn screening files, to hospital inpatient discharge data, and the birth defects surveillance system. The program does not have access to linked birth certificates and Medicaid eligibility or paid claims files, or to linked birth certificate and WIC eligibility files, nor does it participate in a survey of mothers (like PRAMS) every two years. The Arizona Department of Education began implementing the Youth Risk Behavior Survey during the 2002/2003 school year, and also participates in the Arizona Youth Tobacco Survey. The percent of adolescents who are obese or overweight can be determined through the Youth Risk Behavior Survey and in WIC program

data. The state also participates in the Pediatric Nutrition Survey. 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 the MCH program. Examples of such reports include: AHCCCS EPSDT reports, and clients served by race/ethnicity and age by WIC.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

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

B. STATE PRIORITIES

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

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

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

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

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

$2 million in lottery funds will be aimed at teen pregnancy, and another $2 million in state and federal dollars will be directed specifically towards abstinence education. Community-based programs are being piloted in two communities with the highest teen pregnancy rates. $1 million of Title V funds are being spent on family planning, and OWCH initiated the Family Planning Coalition, which has been in operation for about 4 years.

PRIORITY 2: REDUCE OBESITY AND OVERWEIGHT AMONG WOMEN AND CHILDREN

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

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

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

PRIORITY 3: REDUCE PREVENTABLE INFANT MORTALITY

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

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

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

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

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

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

Prenatal care is an opportunity to identify risks and mitigate their impact on pregnancy outcomes through medical management. Prenatal visits also offer an opportunity for education and counseling on proper nutrition and risk factors, such as smoking and alcohol use during pregnancy. Prenatal care is more effective when women enter care early in their pregnancy.

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

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

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

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

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

PRIORITY 7: INTEGRATE MENTAL HEALTH WITH GENERAL HEALTH CARE

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

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

C/YSHCN PRIORITIES

The data gathered from numerous sources pointed to the fact that C/YSHCN and their families have many unmet or partially met needs. These needs were for specific services and for system changes to allow better access to services. However, there were also more ephemeral needs such as the need to have a provider understand the culture of the family, to speak the language of the family, and to engage the family as a partner in the decision making process. Not all of the needs delineated by the survey data, the focus groups, and other information are incorporated into the priority needs. Many of

the needs for specific services will be addressed through the Specialty Care subcommittee of the Integrated Services grant and still other issues will be part of the office's strategic plan for 2005-2010.

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

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

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

PRIORITY 10: INCREASE THE RECOGNITION OF FAMILIES AS INTEGRAL PARTNERS IN THE CARE OF THEIR CHILD'S HEALTH AND WELLBEING.

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

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of 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.*

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

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			100	100	100
Annual Indicator			100.0	100.0	100.0
Numerator			59	69	75
Denominator			59	69	75
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual					

Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

High Risk Perinatal Program community health nurses and Health Start lay health workers educated families about the need for a second newborn screen and facilitated referrals to the medical home for those screenings. The Special License/Midwifery program reviewed quarterly report forms submitted by the licensed midwives with documented metabolic screenings completed for each newborn. It also provided information to the midwives regarding metabolic screening of newborns.

The Newborn Screening Program reported 90,606 initial bloodspot screens and 80,346 second screens in 2004. Of those screened, 120 were diagnosed with clinically significant disorders: 53 cases of primary congenital hypothyroidism, 1 of secondary hypothyroidism, 2 of other thyroid disorders, and 21 of thyroid binding globulin deficiency; 10 cases of salt-wasting congenital adrenal hyperplasia (CAH), 1 of non-classical CAH, and 1 of other than 21-OHP deficiency CAH; 4 cases of phenylketonuria (PKU) and 4 of hyperphenylalaninemia; 1 case of biotinidase deficiency; 1 case of hypermethioninemia and 1 related disorder; 7 galactosemia variants and 1 galactosemia carrier; 6 cases of sickle cell anemia and 6 other hemoglobin diseases. These rates are within the expected range for Arizona's population.

The Newborn Screening Program located 1005 of affected infants. All infants accessed appropriate needed services. There was a 1.7 times increase in the number of infants receiving Newborn Screening Program follow up services (increase from 69 in 2003 to 120 in 2004) due to an increase in births in Arizona and an increase in less severe secondary disorder findings. Improved laboratory reporting of specimens collected prior to 24 hours of age now reminds physicians that such specimens are considered invalid and must be repeated. Specimens may be collected prior to 24 hours of age because of early hospital discharge, collection prior to transfusion, or as a result of timing error. Hospital education is planned in the coming year to reduce the number of collections prior to 24 hours of age.

The OCSHCN Sickle Cell Program focused education on three populations: families with a child having the disease or trait, families at risk for having a child with the disease or trait, physicians, and emergency room personnel. The families of each of the identified were contacted and provided information about the disease, advised as to the importance of follow up with their primary care physicians, and the importance of following the continuous antibiotic regime. Additionally, parents were encouraged to obtain the second screening to confirm the diagnosis. All of the parents of children diagnosed with Sickle Cell Disease were referred to the appropriate CRS regional site for eligibility screening. Families of newborns diagnosed with variants of the Sickle Cell Trait were referred to the Sickle Cell Society for follow-up, and the Sickle Cell Society referred families to OCSHCN for continuing education.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Review quarterly report data for metabolic screenings for the newborn populations.		X		X
2. Initiate implementation of expanded panel of newborn blood screening and all recently legislated activities.				X
3. Develop newborn hearing follow up services.				X
4. Provide follow-up services to affected infants until the infant accesses		X		

appropriate diagnostic care.				
5. Provide technical assistance on hearing screening and reporting procedures.				X
6. Educate hospitals and healthcare providers on newborn blood and hearing screening policies and procedures.				X
7. Implement data collection system for newborn screening referrals to OCSHCN.				X
8. Conduct satisfaction surveys of families referred to OCSHCN by Newborn Screening.				X
9.				
10.				

b. Current Activities

Community Health Nurses and Lay Health Workers educate families about the need for a second newborn screen and facilitate referrals to the medical home for the necessary screenings.

A legislative bill for newborn screening was enacted into law in April 2005. The amended law requires the department to establish a committee that is charged with recommending what tests should be included in the newborn screening panel, mandates reporting of newborn and infant hearing screening results, and establishes follow up services by ADHS for abnormal blood and hearing screening results. The law also allows for a limited fee increase for blood screening.

Tandem Mass Spectrometry instrumentation was purchased by the Arizona State Laboratory and will initially be used for amino acid assay. Program planning for the addition of more screened disorders will be underway in 2005, including the development of protocols, procedures, electronic record keeping, and educational programs.

Follow Up services continue to be provided to newborns and infants affected by the screened disorders. Follow Up Services added the monitoring of newborns whose specimens are unsatisfactory; to ensure another satisfactory screening is done.

OCSHCN service coordinators and community health nurses monitor families for follow-up of anomalous screening results when the child has been discharged to home to ensure appropriate follow-up.

OCSHCN continues to provide consultation and educational services for children with Sickle Cell Disease, as well as those with the Sickle Cell Trait. OCSHCN holds the contract with the Sickle Cell Society to counsel all family members of newborns with the Sickle Cell Trait. Parents are informed of the materials/resources provided by the Sickle Cell Society and parents are offered the option to be tested if they are unaware of their status.

OCSHCN Sickle Cell Program staff contact parents immediately upon notification by the Newborn Screening Unit of a diagnosis of Sickle Cell Disease. OCSHCN staff maintains contact with the family during the first three months following the diagnosis to ensure that the families understand the disease.

As of February 2005, CRS began receiving information on all spina bifida and cleft lip/palate births in the state from the Arizona Birth Defects Registry. The CRS social worker contacts the family to inform them of the services offered through CRS and to assist them in making contact with the appropriate CRS regional site. Since February there have been 6 newborns with Spina Bifida and 13 with Cleft lip/palate that were referred to OCSHCN from the Birth Defects

Registry.

c. Plan for the Coming Year

The High Risk Perinatal Program community health nurses and the Health Start lay health workers will continue to educate families about the need for a second newborn screen and will facilitate referrals to the medical home for those screenings.

Special License/ Midwifery will continue to inform the licensed midwives about the current laws concerning required metabolic screenings for newborns.

ADHS will expand blood screening to include organic acid, fatty acid oxidation, and additional amino acid disorders as recommended by the Newborn Screening Committee. The Newborn Screening Program will develop reporting and follow up protocols for all newly screened disorders and provide education to hospitals, healthcare providers, consumers, and the public about changes in newborn screening. Educational forums will include: provider notification of new testing; an article in the Arizona Chapter of Academy of Pediatrics newsletter; an article in the ADHS Prevention Bulletin; a state-wide perinatal conference presentation; development of brochures and other educational materials, and presentations for a variety of provider groups, hospitals, and clinics throughout Arizona. The Office of Women's and Children's Health will initiate newborn hearing screening follow up.

The Office of Women's and Children's Health will participate in the development of the Data Integration System, a data warehouse linking 16 state databases such as Arizona's birth certificates, newborn screening, and related health services and outcomes. The intent is to assure that every child with a genetic or congenital condition, developmental delay or other special health care need is identified and receives appropriate care.

CRS will continue to identify and implement strategies to provide transition services for families with youth turning 21 years of age and receiving a formula for metabolic conditions through CRS. OCSHCN will continue to monitor the timeliness with which children with positive diagnoses of Sickle Cell Disease or are carriers of the Sickle cell Trait receive appropriate follow-up care.

The Data, Planning, and Evaluation Section will design and implement a data collection system to ensure the timely tracking of all contacts with families referred by the Newborn Screening Program or Birth Defect Registry. Satisfaction surveys will be conducted with families contacted by OCSHCN to evaluate the effectiveness of the service in meeting their needs. All educational and outreach efforts will be evaluated for ability to meet the educational objectives of both the audience and the presenter.

CRS will provide monthly reports on the number of newborns with a diagnosis of spina bifida and cleft lip/palate, the number and type of contacts with the families, and the disposition of the case, and will work with the Newborn Screening Program to define procedures for identifying children under the new, expanded testing procedures to ensure that appropriate referrals are made to CRS.

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

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

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			51.4	52	53
Annual Indicator			51.4	51.4	51.4
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	54	55	56	57	58

Notes - 2004

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

a. Last Year's Accomplishments

Respondents to the National Survey of Children with Special Health Care Needs (NSCSHCN) State and Local Area Integrated Telephone Survey (SLAITS) reported that 51 percent of Arizonans partnered in decision-making and were satisfied with the services they received compared to 58 percent nationally, which ranked Arizona 46 among the 50 states. The component analysis of the SLAITS questions showed that 82 percent of respondents to the NSCSHCN reported that doctors usually or always made the family feel like a partner compared to 84 percent nationally and 60 percent in the focus groups. Fifty four percent of the Arizona respondents to the NSCSHCN reported they were satisfied with the services they received compared to 60 percent nationally and only 32 percent of the focus group participants.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. CRS Family-Centered Survey will be expanded and conducted annually.				**X**
2. OCSHCN will provide a statistical comparison of the results of the NSCHSNC and the National Survey of Children to identify unique health needs of C/YSHCN.				**X**
3. PAC parents will receive orientation and training about the administrative activities of CRS.				**X**
4. PAC parents will be active participants in the development of training for family members participating in CRS administrative committees.				**X**
5. Families and youth will participate in all Integrated Service Grant committee activities.				**X**
6.				

7.				
8.				
9.				
10.				

b. Current Activities

In 2005, Arizona conducted focus groups throughout the state in preparation for the 2005 Needs Assessment and repeated the SLAITS questions with families having a known C/YSHCN (n=100). Only 25 percent of the members of the focus group agreed that they were treated as a partner in the decision-making process and only 32 percent were satisfied with the services they received.

Additional logistic regression analyses of SLAITS data for Arizona families of C/YSHCN showed that family members of Hispanic descent and families that rated their child's condition as severe were significantly less likely to endorse the performance measure related to families partnering in the decision making process. While not significant, it is interesting to note that families with children age 6-11 years and 12-18 years were more likely to view themselves as being involved in the decision making process than were families with children under the age of 5 year. There were no other significant associations between the demographic characteristics of the NSCSHCN respondents and endorsement of the performance measure.

OCSHCN surveys families enrolled in the Children's Rehabilitative Services every two years to assess their satisfaction with the services received and to measure the degree to which the families perceive the services as family-centered. In 2004, a simple random sample of 1,350 CRS members who had received at least one service in FY 2003 was selected. The family was asked to rate each of the multi-disciplinary providers within the CRS clinic on aspects of family-centered care and care coordination. There was a very high level of satisfaction with all the staff, and there was no statistically significant difference between the different CRS staff members. However, these results may be biased due to disproportionately low response rates.

Through the Tsunami Project, 35 parents and youth were paid to assist OCSHCN in the: Parent/Youth/Physician Interaction Project, the Parent-Youth Leadership Institute, and in the development of the Train the Trainers-parent/Youth Leadership Institute. Numerous parents were paid to participate in focus groups conducted as part of the 2005 MCHB Needs Assessment, provide input on the Needs Assessment and Block Grant, and review the final documents. Parents and youth also participate in the planning design of the Integrated Service Grant. Parents are active participants in the OCSHCN Cultural Competency Committee and are in the process of collecting stories from families of different cultures on their experiences of having a special needs child in a culturally diverse world.

c. Plan for the Coming Year

CRS Family-Centered Survey will be expanded and conducted annually.

OCSHCN will provide a statistical comparison of the results of the NSCHSNC and the National Survey of Children to identify unique health needs of c/yshcn.

PAC parents will receive orientation and training about the administrative activities of CRS.

PAC parents will be active participants in the development of training for family members participating in CRS administrative committees.

Families and youth will participate in all Integrated Service Grant committee activities.

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

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

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			50.5	50.5	51
Annual Indicator			50.5	50.5	50.5
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	51.5	52	52.5	53	53.5

Notes - 2004

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

a. Last Year's Accomplishments

Fifty-one percent of Arizonans agreed with the overall achievement of a Medical Home compared to 53 percent nationally, ranking Arizona 39th out of 50 states and the District of Columbia. In general, Arizona respondents to the NSCSHCN were not significantly different from the overall national figures; the only exception was that Arizona had a significantly higher rating than the national data for the receipt of professional care coordination (84.0% and 81.9%, respectively). Consistently more members of the Arizona NSCSHCN reported that their child had a usual source of care than was seen in the national data (91.2% and 90.5%, respectively). However, Arizona respondents were less likely than the National respondents to endorse the statements that: their child had a personal doctor or nurse, their child had no problems obtaining referrals, their child received effective care coordination, or their child received family-centered care than was noted in the national figures.

In an attempt to build a provider directory of physicians offering medical services to C/YSHCN in Arizona, OCSHCN contacted and engaged in discussions with the Illinois Division of Specialized Care regarding their physician directory. These discussions lead to the decision to, at this time, to not pursue this activity. This decision was made based on input from the Illinois Division of Specialized Care who reported that physicians wanted to self-identify as serving C/YSHCN rather than having their names listed in a directory.

OCSHCN was not able to evaluate practices in Arizona currently implementing a Medical Home, that were not already part of an ongoing project, as these practices do not self-identify as Medical Homes.

OCSHCN was prepared to submit a grant proposal for the Integrated Services for Children with

Special Health Care Needs (CFDA #93.110) Maternal and Child Health Improvement Projects Priority #2 Integrating and Sustaining Medical Homes through Statewide Implementation Grants. However, the funding was revoked two weeks prior to application due date.

OCSHCN developed a plan to construct four Medical Homes; two in private practices and two in school-based clinics. The purpose of this project is to define a seamless process for implementing Medical Homes in different settings with different personnel. This project will be defined and evaluated by members of the Quality Improvement Committee of the Integrated Services Grant.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor the integration of the screening instruments employed in Medical Home into treatment planning process				X
2. Evaluate communities using the Communit Adolescent Health Profile Survey developed by National Adolescent Health Information Center				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Arizona focus group respondents were less likely to endorse the medical home performance measure than the NSCSHCN respondents (17.7% and 52.6%, respectively). This may have been due to the fact that many of the focus group respondents were from rural communities and did not feel that the multiple long-distance providers identified one place where comprehensive care was delivered.

Additional analyses of the SLAITS data showed that families that rated their child's special health care need as severe were significantly less likely to endorse the medical home performance measure than were families who rated their child's condition as mild. There were no other significant associations between the demographic characteristics of the NSCSHCN respondents and endorsement of the performance measure.

In general, the focus group respondents were less likely to endorse the performance measure than the NSCSHCN respondents. This may have been due to the fact that many of the focus group respondents were from rural communities and did not feel that the multiple long-distance providers identified one place where comprehensive care was delivered.

Arizona's MCHB Medical Home Project conference calls occur monthly with parent leaders from the community teams, Southwest Institute for Families, and OCSHCN staff.

OCSHCN continues to offer technical assistance (i.e. training, curriculum, presentations, etc.) to the professional and administrative staff of the four Arizona Children's Rehabilitative Service

Clinics on Medical Home. Each of the regional CRS contractors submit an annual update on how the Medical Home Plan was implemented. These plans, activities, and updates are evaluated during the site visits conducted by OCSHCN staff.

OCSHCN provides financial support for families (through Raising Special Kids) to share their stories and experiences with the dental students and pediatric resident training programs in Arizona through a joint agreement between OCSHCN and Raising Special Kids. Seventy volunteer families from Raising Special Kids are trained as Family Faculty to provide educational opportunities for physicians. Clinical Experience Agreements are in place with the following programs: Phoenix Children's Hospital, Maricopa Medical Center, Good Samaritan Hospital, St. Joseph's Pediatrics, St. Joseph's Family Practice, Phoenix Baptist Hospital, John C. Lincoln Hospital, Scottsdale Healthcare, and Midwestern University.

By the fall of 2005 OCSHCN will have a Learning Management System (LMS) in place that will allow for "e-classes" hosting listservs, etc. OCSHCN has existing curriculum that will be repurposed into an "e-class" format and is developing new curriculum. Additionally, the LMS will accept external "e-classes" that fulfill Shareable Content Object Reference Model (SCORM) standards. This capability will allow OCSHCN the opportunity better address the educational needs of both providers and the families of C/YSHCN.

c. Plan for the Coming Year

Utilizing funding from the Integrated Services Grant, OCSHCN will implement a Medical Home model in two practices and two school-based clinics. This model will include each practice site having access to a Medical Home Screener and a care coordinator. A needs assessment of the health status of the local communities will be developed using the Community Adolescent Health Model developed by National Adolescent Health Information Center.

The Medical Home Screener will provide developmental, mental health, oral, and transition screening services to all children and adolescents who receive clinical care services at the Medical Home sites. Technical support will be provided to integrate screening results across relevant programs to evaluate the thoroughness, timeliness, and integration of the screening results into the treatment plan and care delivered.

The Medical Home model also includes placing a care coordinator at each of the sites. A variety of technology applications will be investigated to determine the best way for all members of the treatment team to communicate "real-time." A variety of web-based applications will be reviewed for cost and efficiency.

Several committees will provide oversight to the Medical Home Project. The Quality Improvement Committee which will assist in the selection of the screening instruments, monitor the results and integration of the screening results, and will monitor the overall quality and family satisfaction of services provided in the Medical Home. The Parent Council and Youth Advisory Board will provide youth and family input into both the design of the systems utilized in the Medical Home, and they will also participate in the evaluation of these systems. Ultimately, the results from these three groups will be reviewed by the Integrated Services Task Force and integrated into their System-Change Recommendations to the Governor.

A social marketing plan will be initiated in 2006 to enhance the understanding and acceptance of the concept of medical home among both lay and professional communities.

Collaborate with Arizona's Medicaid provider (AHCCCS) to share the cost effectiveness of utilizing the care coordinators and screeners in private practices or school-based clinics to develop a model of reimbursement for these services.

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

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

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			60.8	61	61
Annual Indicator			60.8	60.8	60.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	61	61	61	61	61

Notes - 2004

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

a. Last Year's Accomplishments

Sixty-one percent of Arizona NSCSHCN respondents reported their families have adequate insurance compared to 60 percent of national respondents, ranking Arizona 23rd among the 50 states and the District of Columbia. Only 27 percent of the respondents in the Arizona focus groups had a similar endorsement. While a similar proportion of focus group respondents and Arizona NSCSHCN respondents reported their child was covered by insurance at the time of the interview and that there were no gaps in coverage during the proceeding year, the focus group respondents were less likely to report that insurance met the child's needs, that the costs were reasonable, or that they were permitted to see needed providers than were Arizona respondents to the NSCSHCN.

Data from the NSCSHCN indicated that the majority of C/YSHCN in Arizona are covered through some form of private insurance (67percent). Additional analyses of the insurance questions in the NSCSHCN showed that 10 percent of Arizona's C/YSHCN had no health insurance and their family income was less than 200 percent FPL which ranked Arizona 48th, ahead of Louisiana (10 percent) and Montana (10 percent). However, these analyses also showed that Arizona C/YSHCN were less likely to be uninsured than non-C/YSHCN (5 and 14 percent, respectively). C/YSHCN were as likely to be insured through private insurance than non-C/YSHCN (67 and 66 percent, respectively) and more likely to be covered by a public insurance program than non-C/YSHCN (21 and 16 percent, respectively).

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

	Pyramid Level of

Activities	Service			
	DHC	ES	PBS	IB
1. Report the number of hits to the Raising Special Kids Website regarding insurance information.				X
2. Monitor consumer satisfaction with insurance-related information.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Additional analyses of the SLAITS data indicated that families that had incomes of less than 200% FPL and were or Hispanic origin were less likely to endorse the availability of adequate insurance than were families with higher incomes (>=200% FPL and non-Hispanic, respectively). It was somewhat surprising that non-White respondents were twice as likely to endorse the adequacy of insurance coverage than were white respondents. There were no other significant associations between the demographic characteristics of the NSCSHCN respondents and endorsement of the performance measure.

OCSHCN Office Chief has been invited to participate in the National Committee evaluating Alternative Financing of Health Care for C/YSHCN out of Boston University.

OCSHCN provides funding and technical support to Raising Special Kids in their endeavor to make a user-friendly insurance information website for families of C/YSHCN. This website will serve as a resource for families to identify the multiple coverage options, the application and qualifying process, and to provide assistance in the application process. This will be one of the first tasks that the Integrated Services Task Force investigates with the objective being to define how the various governmental agencies offering coverage or other forms of financial assistance can provide "Hot Links" to this site.

c. Plan for the Coming Year

OCSHCN will place links on the OCSHCN website links to all different public dollar health coverage and provide an opportunity to post questions or connect with an ombudsman to answer questions.

OCSHCN will evaluate through surveys available on the OCSHCN and Raising Special Kids websites, the satisfaction of users with the Insurance information and linkages on the two websites.

OCSHCN will continue to work with private employers and their health care providers to provide information on OCSHCN and on how to maximize health care coverage for this vulnerable population.

OCSHCN will continue to continue to work with AHCCCS to integrate services provided and paid for by AHCCCS into the CRS service delivery system to enhance the ability of the CRS clinics to meet the needs of the children and youth they serve. The first of these transitions will

be that the CRS clinics will manage the delivery of reimbursement of durable medical equipment provided to their members. The long-range plan is to integrate many primary care services into the CRS clinics as the clinic becomes the medical home for the populations they serve.

CRS has completed an RFP for reinsurance and a provider has been selected. This option, when implemented in 2005-2006, will allow the CRS clinics to reduce the financial risk of high dollar procedures.

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

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

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			70.9	71	72
Annual Indicator			70.9	70.9	70.9
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	73	74	75	76	77

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

a. Last Year's Accomplishments

Arizona respondents to the NSCSHCN were less likely to endorse the ease of use of community service systems than national respondents (70.9% and 74.3%, respectively). Only 41% of the respondents in the focus groups endorsed the ease of use of community service systems. Arizona ranked 41st among the 50 states and the District of Columbia on this performance measure.

OCSHCN has connected all 4 CRS telehealth sites and ADHS without the need to use the U of A's bridge. OCSHCN had 79 telehealth events in 2004: 9 Grand Rounds/Public Health Seminars, and 95 telehealth tests. OCSHCN managers, parents, and ADHS contractors participated in AzEIP Community forums related to the redesign of the State's early intervention program. 648 clients received AzEIP services in 2004 as compared to 563 in 2003.

OCSHCN supported 42 parent leaders coordinating 11 community teams in 23 communities. In

2004, two new organizational support contracts were established for the Community Teams. OCSHCN provided network and information sharing opportunities between the Community Action Teams by coordinating a monthly conference call and a biennial statewide Parent Community Development Leader meeting. The Parent Community Development Leader meeting was held in February 2004. Kingman and Tucson were identified as communities for new team development. Pilot Parents of Southern Arizona hosted the graduates of Partners in Policymaking to explore the development of a new community action team in Tucson. OCSHCN developed a Community Development Team Sustainability Workgroup.

The ACTION Partnership for People with Special Needs, in existence for 5 years, was awarded 501(c)3 non-profit status. They worked with a local program to include CSHCN in their summer activities and petitioned the Verde Valley Medical Center to establish a pediatric ward with an examination room and a playroom. An OCSHCN Parent Leader from the Tri City Partnership for Special Children and Families participated in the Communities Can -- Communities of Excellence Conference. The Bullhead Area Partnership for Children with Special Needs facilitated the installation of wheelchair adaptive playground equipment and worked with a local physician to bring CRS services to their community. The Parents Who Care Community Action Team partnered with local community resources to create the S.E.L.F. (Special Extraordinary Library Fun) program for cshcn during their summer vacation.

Referrals to the Traumatic Brain Injury (TBI) Service Coordination Program increased from 83 in 2003 to 121 in 2004. The TBI service coordinators made 59 referrals to local behavioral health programs/services in 2004. OCSHCN, BHHS Legacy Foundation, and the Governor's Council on Spinal & Head Injuries produced two publications about TBI in Spanish and English that were distributed to EMS, teachers, schools, and communities throughout Arizona. Information and education about the TBI service coordination program was provided to 6,507 individuals

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop two new community teams.		X		
2. Conduct Community Development Summitt II.				X
3. Community Development teams will conduct an annual evaluation of their strategic plans.				X
4. Teams will have a sustainability plan.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Analyses of the SLAITS data utilizing logistic regression showed that families who rated their child's medical condition as severe were significantly less likely to endorse the performance measure related to ease of use of community-based systems of care than were families who rated their child's condition as mild.

OCSHCN staff partnered with parent community development leaders to develop guidelines for parent involvement.

The Sustainability Workgroup, comprised of one parent leader from each of the community action teams and OCSHCN staff, developed a series of recommendations around recruitment and retention of team members and finding additional financial resources. Each team is to develop a sustainability plan to maximize the use of alternative funding.

The Governor's Children's Cabinet endorsed the participation of all state agencies serving children and youth in a summit, "Circles of Success, Communities of Strength," which was held in April 2005. As a result of the Summit, each agency will develop an action plan to implement the initiative within their own agencies. A report is due to the Governor October 2005 describing activities and outcomes that resulted from the Summit.

In August 2005, the community development teams will host their Parent-led Community Action Teams Biennial Conference.

ADHS/OCSHCN and the Governor's Council on Spinal & Head Injuries provided TBI trainings to ADHS/OCSHCN Service Coordinators and school nurses. Service coordinators developed a list of providers for TBI services for the Brain Injury Association of Arizona. The impact of these outreach activities is seen by the increased service provision from third party payers and schools for TBI related services.

OCSHCN conducted a satisfaction survey of the families receiving TBI service coordination; 100% of the respondents agreed that working with the service coordinator benefited their child/teen and family. The families stated they were satisfied with the services and support provided by the service coordinators.

Through funding provided by the Governor's Council and the BHHS Legacy Foundation, Dr. Prigatano continues his clinical study related to the Care of Children with Traumatic Brain Injury.

OCSHCN and OWCH provided a two-day training to 60 community health nurses that included information about state and local services for infants, toddlers, and children.

New information to the OCSHCN website: Community Action Team membership; data related to the health status of C/YSHCN, and the 2005 Needs Assessment and Block grant Application. Information and links are in Spanish and English. Action items related to the implementation of the Integrated Services Grant will be posted with links to the participating partner's websites. The ability to post a comment on the Needs Assessment, the Block grant Application, or the activities performed by the various committees of the Integrated Services grant will be available in 2005.

c. Plan for the Coming Year

Service coordination will develop a database that will allow the timely accounting of types of children served, services received, and timeliness of the services. In addition, a semi-annual satisfaction survey will be administered to families receiving all types of service coordination as well as to the service coordinators regarding the effectiveness of the service administration system, the timeliness and effectiveness of the services provided, and the ease of utilizing the systems of care provided by service coordination. During the Service Coordinator Trainings, focus groups will explore strengths and weakness of the service delivery system and action plans will be shared on how to maximize the strengths of the system and minimize the weaknesses.

OCSHCN will work with the Southwest Institute for Human Development on defining the appropriate screening instruments to use with infants and toddlers and this information will be provided to the service coordinators for their input and evaluation.

Beginning in August 2005, OCSHCN will assume the administrative authority for managing the Arizona Head and Spinal Injury Registry under a grant provided by the Governor's Office on Head and Spinal Injuries. This report will allow OCSHCN to analyze the results of head and spinal trauma as assessed through hospital emergency room and discharge databases.

Through funding from the Governor's Council on Head and Spinal Injuries and the BHHS Legacy Foundation, the clinical study of evaluation and diagnostic tools to use with adolescents with TBI will be continued with the Barrows Neurological Institute.

OCSHCN will initiate two new community development teams with a focus on an underserved population. These teams will be funded jointly between OCSHCN and Raising Special Kids.

As part of the Community Development Teams' strategic plan, they will conduct an annual evaluation of the extent to which the targeted changes were accomplished and the impact those changes had on the community.

There will be a follow-up Community Development Summit in April 2006 to evaluate the progress made on the objective set by the Summit in April 2005. OCSHCN will partner with the leaders of this initiative to respond to requests for technical assistance, training, and mentoring. The e-classes will offer another mechanism for information dissemination.

Performance Measure 06: *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)*

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

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			5.8	6	6
Annual Indicator			5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6	6	6	6	6

Notes - 2004

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted. The

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

a. Last Year's Accomplishments

The 2001 NSCSHCN showed that 2.5% of the Arizona respondents endorsed the transition national performance measure. This measure was achieved by only 5.8% of the general population. Data for this measure may not be accurate due to the small sample sizes in many states. There were two main components to this performance measure: did the child received guidance and support in the transition to adulthood; and did the child receive vocational or career training.

Arizona achieved 3.9% compliance on the first component, compared to 15.3% nationally. This component was broken into three parts. The first asked whether doctors had talked about the changing medical needs of the child as they become an adult. Arizona had a compliance of 35.0%, compared to 50.0% nationally. The second part of the first component was whether the child had a plan for addressing changing needs. Arizona achieved 40.9% compared to 59.3% nationally. The third part asked whether doctors discussed a shift from a pediatric provider to an adult provider; Arizona achieved 28.9% compared to 41.8% nationally. The second principle component was whether the child had received vocational or career training. Arizona achieved 28.0% compared to 25.5% nationally. Arizona ranked 45th among the 50 states and the District of Columbia.

Each CRS site submits a Transition to Adulthood Plan to OCSHCN for members age 14. Some sites mail information to members about transition; other sites have a face-to-face encounter. This inconsistent implementation methodology was identified by the CRS Quality Improvement Committee as a key issue in the delivery of services to youth. The Quality Improvement Committee initiated a Performance Improvement Project to monitor the timeliness of member notification, the quality of the information provided, and any follow-up activities.

OCSHCN contracted service coordinators assisted youth with TBI and other special health care needs in assessing transition services.

OCSHCN contributed to the Arizona Transition Leadership Team in defining the vision, goals, and core principles for families, youth, educators, agencies, and advocates involved with transitioning youth.

An OCSHCN staff member was identified as the State Adolescent Health Coordinator to work with other State Coordinators in facilitating collaboration and dissemination of best practices regarding adolescent health.

In conjunction with contracted parents and youth, OCSHCN developed a Parent and Youth Leadership Institute Curriculum to train both parents and youth in the areas of leadership, community development, strategic planning, communication, partnerships, and mentoring.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. OCSHCN offers technical assistance to the Transition Learning Community and disseminates transition program information at a national level.				X
2. OCSHCN includes youth in needs assessment focus groups and they will continue to participate in the Youth Advisory Group as part of the Integrated Services Grant.				X

3. OCSHCN participates on the Arizona Medical Association Maternal and Child Health Adolescent Subcommittee's Adolescent Health Community Advisory Group to create a plan that will address how adolescents access appropriate health care.				X
4. OCSHCN participates in the Arizona Transition Leadership Team.				X
5. OCSHCN provides training on transition.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Additional analyses of the SLAITS data showed that respondents who rated their child's condition as severe were significantly less likely to endorse the performance measure dealing with transition to adulthood than were family members that reported the severity of their child's condition as mild. One explanation of this may relate to the child's precarious life expectancy or it may be do to transition services are only directed at youth who have a less severe level of impairment.

The Parent and Youth Leadership Institute Curriculum was piloted with a group of parents and youth. The participant's comments were incorporated into the revised 400-page curriculum.

OCSHCN participates in the Transition Learning Community, a Champions for Progress Center Initiative, to offer technical assistance regarding transition and to disseminate successful transition program information at a national level.

OCSHCN included youth in the Needs Assessment focus groups and this endeavor was so successful that additional outreach to various groups of youth are planned.

OCSHCN currently participates on the Arizona Medical Association Maternal and Child Health Adolescent Subcommittee's Adolescent Health Community Advisory Group to create a plan that will address how adolescents access appropriate health care. OCSHCN created an adolescent survey that evaluates how adolescents view their own health care. This survey can be completed by yshcn or non-yshcn. OCSHCN was instrumental in having the Arizona Department of Juvenile Corrections and ADHS Office of Oral Health participate with the Advisory Group in the development of an Adolescent Health Plan for Arizona.

OCSHCN participated in the Arizona Transition Leadership Team and attended the National Conference on Secondary Education Transition, 2nd Annual Summit as a member of the Arizona Transition Team.

OCSHCN, in conjunction with contracted YSHCN, developed transition fact sheets and brochures. The content of these materials is from a youth perspective and include.

OCSHCN provided many trainings on transition: the Regional Family Voices Conference for Region 9 State Coordinators and Title V Directors, the Arizona Adolescent Health Coalition Annual Conference attendees, and the professional staff at the CRS regional sites. In addition, OCSHCN participated in a web-cast with DHHS/Office for Adolescent Health on Transition for Title V directors.

c. Plan for the Coming Year

OCSHCN will continue to participate with the Arizona Transition Leadership Team and investigate the feasibility of a statewide survey of youth transitioning from the secondary education system into systems of higher education and/or the work force.

Training will be conducted utilizing the Parent and Youth Leadership Institute training module. Other e-classes regarding youth development, transition, and youth self-advocacy will be available on the ADHS e-learning system in 2006.

OCSHCN will begin collecting data from the CRS sites on the status of their transition plans and how many youth receive all the components of a transition plan.

OCSHCN will continue to participate with the American Medical Association Maternal and Child Health Adolescent Subcommittee's Adolescent Health Community Advisory Group in the development of an Adolescent Health Plan for Arizona.

Youth contracted with OCSHCN will develop, implement, and administer the Youth Advisory Council as part of the MCHB Integrated Services Grant, making recommendations to the Integrated Services Task Force on issues related to youth transitioning to adulthood. In addition, youth will participate as members in all of the subcommittees and task forces developed as part of this grant.

Youth will participate in the implementation of the Community Development Initiative assisting other state agencies in defining and implementing a mechanism to involve youth in the strategic activities of their agencies. Youth under contract with OCSHCN will serve as mentors to youth in other agencies.

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

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

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	70	70	70	70	71
Annual Indicator	67.2	65.7	69	75	78
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	78	78	79	79	80

Notes - 2004

The source of immunization data is the CDC National Immunization Survey (http://www.cdc.gov/nip/coverage/NIS/01/toc-01.htm). Previously, the reported rate represented the coverage level for 4DPT, 3OPV and 1 MMR only, because data were not reliably available for the full series recommended by the CDC, which also includes 3 doses of Hep B and 3 doses of Hib. No data were available for this measure for 1998, but the data points for 1999 forward have been changed to reflect the full 4:3:1:3:3 series. Performance objectives were also changed to reflect the change in the measure. Estimates for data points are based on reports for the following date ranges:
1999 = July 1998 through Jun 1999
2000 = "2000"
2001 = Jan 01 through Dec 01
2002 = Jul 01 through Jun 02
2003 = Jul 02 through Jun 03.
2004= Jul 03 through Jun 04
The 2004 estimate reflects the immunization status of children by age two for children who were 19-35 months of age, born between August 2000 and November 2002. The estimate tolerates 3.8% error at a 95% confidence level.

a. Last Year's Accomplishments

In 2001, the CDC National Immunization Survey estimated that 66% of Arizona's two-year old population completed the combined recommended series of immunizations including at least 4 DTP, 3 OPV/IPV, 1 MMR, 3 HiB, and 3 Hep B by age two. Since then, the 4:3:1:3:3 series rate has increased steadily. The rate reached 78 percent in 2004, exceeding the 2004 objective of 71 percent. The national 4:3:1:3:3 series rate for the same time period rose to 80.5%.

The Arizona Partnership for Immunization's (TAPI) website, which allowed parents to ask medical experts questions about vaccines and immunizations, received 58,000 hits between July and December of 2004. The partnership distributed its newsletter to over 1,800 organizations and individuals, distributed parent education and provider flyers in English and Spanish, and distributed reminder/recall postcards to immunization providers statewide. Providers who have achieved an immunization coverage level of over 90% of their two-year old patients received the Cloud Award.

Over 50,000 educational pieces were distributed to schools, child care facilities, private providers, county health departments, community health centers, managed care organizations, and WIC sites in 2004. TAPI conducted ten regional immunization programs with the Vaccines for Children Program for providers statewide, and 120 individual provider offices and health departments participated.

In March 2004, the Arizona Department of Health Services, TAPI, and the Office of the Governor held the Arizona Immunization Health Plan Summit. CEOs, medical directors, and quality assurance managers from all health plans operating in Arizona convened to discuss improving health, preventing disease, and controlling costs through good immunization practices. The Arizona Small Business Association distributed 1,150 community education flyers developed for small business employers.

TAPI partnered with the Arizona State University School of Nursing in a training seminar for graduate level community nursing students to promote community partnerships in immunization. The partnership also participated in grand rounds at the University of Arizona to promote effective immunization practices, and with
Phoenix Children's Hospital residents to promote continuing program development on reporting to the state immunization registry and the benefits of immunization history in emergency medicine.

In cooperation with AIPO, TAPI designed and mailed a "Vaccines for Children" provider

satisfaction survey to 770 VFC provider sites. Overall, survey data indicated high levels of satisfaction with the program.

The Children's Information Center served on TAPI committees and disseminated immunization materials in information packets to families who contacted the hotline for assistance. Health Start and the High Risk Perinatal Program community health nurses monitored the status of and promoted immunizations of children enrolled in their programs.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Arizona WIC participants are screened and referred for proper timing of the DtaP	X			
2. Reviewed immunization recommendations with parents/caregivers and referred for immunization		X		
3. Monitor the status of children enrolled in program				X
4. Promote immunizations by providing transportation to medical home if needed		X		
5. Notify clients of immunization clinics		X		
6. Designing, printing and distributing immunization materials for parents and providers				X
7. Working with managed health care plans to promote on-time immunizations for enrolled children/adolescents				X
8. Conducting educational/training programs to improve immunization practices				X
9. Continue to partner with Arizona Small Businesses Association to distribute immunization information				X
10.				

b. Current Activities

The Arizona Partnership for Immunization prints and distributes immunization materials to public and private providers throughout the state; prints and mails "Upshots," the quarterly newsletter; plans and conducts at least six immunization workshops for staff of public and private clinics, medical offices, schools and other VFC enrolled sites; and meets and confers with managed care plans to promote and institute methods to ensure local health departments are reimbursed vaccine administration costs for Arizona Health Care Cost Containment System enrolled children. It also works with immunization service providers to ensure immunization services are available in underserved areas (pockets of need) where children lack access to immunization services. The Arizona Partnership for Immunization revises and updates its web site and prints materials as needed to keep current with established immunization recommendations and practices.

All programs in the Office of Women's and Children's Health who come in direct contact with families provide education and monitoring of immunizations. The Health Start program, and the High Risk Perinatal Program community health nurses monitor the status of and promote immunizations of children enrolled in their home visiting programs. The Children's Information Center served on TAPI committees and disseminated immunization materials in information packets to families who contacted the hotline for assistance. The Office of Chronic Disease and Nutrition Services coordinates statewide immunization record screening and referral by WIC

staff to ensure proper timing of the DtaP shot in WIC children.

c. Plan for the Coming Year

TAPI will utilize the Children's Information Center Hotline phone number for the upcoming immunization campaign. Office of Women's and Children's Health staff will continue to participate in TAPI committees and will continue to provide educational materials to contractors and clients related to childhood immunizations.

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

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

TAPI will continue programs and partnerships that promote childhood immunizations.

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

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

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	45	44	43	42	41
Annual Indicator	41.1	37.8	35.5	35.9	35.9
Numerator	4284	4080	3952	4110	
Denominator	104344	107846	111218	114368	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	35	35	34	33	32

Notes - 2004

2004 data are not yet available. The rate is provisionally set at the 2003 rate until the data becomes available in Fall 2005.

a. Last Year's Accomplishments

In 2003 there were 35.9 live births per 1,000 teen girls in Arizona, which is below the target rate of 42.0. 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 has continued to decrease at a faster rate. While Arizona experienced a slight increase in the teen birth rate in 2003 compared to the previous year, there has been a 23.6% decrease in the teen birth rate from 1998 to 2003 for females 15-17 years of age. (Because data are not yet

available for 2004, the 2003 rate is also provisionally listed as the rate for 2004).

Eleven of 15 county health departments received intergovernmental agreements with Title V funding to provide reproductive health/family planning services. Four of the 11 contractors also received Title X Reproductive Health/Family Planning funds. OWCH determined that an increased focus on teens was needed.

In collaboration with Arizona Family Planning Council, the state lab, and the office of HIV/STD/Hepatitis C; five Title V only funded programs participated in the CDC Infertility Prevention Project to screen clients for chlamydia and gonorrhea. The Reproductive Health Family Planning Program purchased the book State Minor Consent Laws: A Summary to clarify the state laws about providing medical care to adolescents, and distributed it to all contractors.

The Abstinence Education Program funded 10 contractors to provide services in seven counties. A total of 26,277 youths and 640 parents were reached from January 1, 2004 through December 31, 2004. An abstinence conference was held, four quarterly trainings were provided, and two Teen Maze events were funded. All contractors received one annual site visit in which education services were observed. Print ads were completed and placed in high school newspapers, yearbooks, and planners. The Teen Pregnancy Prevention Program initiated 11 intergovernmental agreements with county health departments to conduct Teen Maze educational events. ADHS also sponsored Dr. Kirby, a national expert on best practices for teen pregnancy prevention, to share research and a logic model on teen pregnancy prevention at the Arizona Public Health Association Annual Conference.

Staff from OWCH participated in 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 subcommittee discussed strategies to reduce the teen pregnancy and STD rates in Arizona, recommending to "reduce teen pregnancies with an emphasis on reducing the number of second pregnancies to teens."

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increase number of teens receiving services in the reproductive health/family planning clinics.	X			
2. Continue to fund contractors who provide Abstinence Education Program services			X	
3. Provide information on effective abstinence and teen pregnancy prevention programs/data to providers			X	
4. Develop a teen pregnancy prevention media campaign that promotes an abstain or use condoms message, targeting high risk youth and parents			X	
5. Fund teen maze educational events in communities			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

All 11 reproductive health/family planning contractors are asked in the 2005 intergovernmental agreements to increase teen services by five percent to address the state's high teen pregnancy rate. The contractors are to meet this goal by working collaboratively with schools, counselors, and community organizations that directly provide services or support to teens. The Reproductive Health/Family Planning Program will hold a contractors meeting for collaboration and partnership building, focusing on sharing initiatives and strategies in getting teens into the clinics.

The Abstinence Education Program increased its number of contracts to 11, adding a community-based agency that educates with drama presentations. The FY06 state budget included a new $1 million allocation dedicated to abstinence programming available July 1, 2005 -- June 30, 2006, so the number of abstinence providers is expected to grow.

The Abstinence Education Program participates on the Arizona Department of Education Materials Review Committee and collaborates with local and national abstinence education and teen pregnancy prevention stakeholders. OWCH continues to provide information on effective community-based and research-based best practice approaches for teen pregnancy prevention services to community providers. Quarterly training is provided to funded programs, including training on approved abstinence curricula.

The state-funded Teen Pregnancy Prevention Program initiated two intergovernmental agreements with county health departments to plan and implement a teen pregnancy prevention program in areas of the state with high rates of teen pregnancy and births. These programs will examine the needs of their communities and implement strategies to reduce teen pregnancy over the next year. A new media campaign focuses on delaying sexual activity, increasing condom usage among adolescents, and increasing parent/youth communication on sexuality. The campaign will span one year, developing two 30-second television spots for teens, one 30-second spot for parents, and one teen radio spot. Additional print media are being developed to be placed on outdoor boards, bus shelters, mall kiosks, and newspapers.

The Governor's Office's strategy for teen pregnancy prevention is to link community resources and education with those state agencies that serve Arizona teens. In 2005 the Governor's Division for Women staff will create an interagency work group to collaborate on obtaining prevention services and information to youth most at risk of teen pregnancy and STDs. This group will work to collect baseline data from the agencies about teen pregnancy and STDs in the populations they serve, survey state agencies to determine levels of knowledge and need for education and training, and, based on the results of the survey, develop an education and training program that includes materials for managers and front line staffs that deliver programs to teens.

c. Plan for the Coming Year

The Reproductive Health/Family Planning program will continue to focus on outreach to teens and increasing teen access to services. After January 2006, the program will evaluate if there was a 5% increase in teen services in 2005.

The Abstinence Education Program will continue to examine evaluation results from programs to improve program content, implementation, and delivery models of educational services. Data on teen births by county, age, and ethnicity will be analyzed and distributed to ensure that programs are targeting those populations and geographic areas with high rates of teen births. New research on innovative approaches regarding abstinence education services and teen pregnancy prevention will continue to be distributed to community providers.

The Abstinence Education Program plans to serve additional numbers of young teens through new state funded allocated for state fiscal year 2006. It will also work to increase the number of

parents receiving education on how to communicate with their teens about abstinence, sex, and relationships. Staff will continue to participate on the Arizona Department of Education HIV/AIDS Materials Review Committee as well as other local and national groups.

The Governor's Division for Women will continue to lead efforts to coordinate community and state efforts to reduce teen pregnancy and STD rates. The division will, as needed, train the trainers for those agencies that contract delivery of teen pregnancy prevention services to community agencies. It will continue to work with stakeholders to look for opportunities to achieve better effectiveness and efficiency, and to collaborate on identifying and securing additional funding. During 2006 and 2007, the Governor's Division for Women will monitor agencies' progress in implementating teen pregancy prevention strategies, assessing whether the education and training has been incorporated into their programs and if there has been any change in teen pregnancy and STD rates.

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

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

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	12	12.5	13	30	30
Annual Indicator	29	29	29	36.2	24
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	25	26	27	28	29

Notes - 2004

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

a. Last Year's Accomplishments

Because the source of data for this measure has changed, the 2004 rate is not comparable to

previous years.

The Arizona Dental Sealant Program operated in five counties, provided 8,772 children in 97 schools with dental screening, and 7,049 high risk children received 26,207 dental sealants. Of those children screened, 3,986 needed referrals for other dental care.

One of the communities funded through Office of Oral Health's (OOH) Community Development Initiative is in the process of implementing a school sealant program in a rural section of the state.

In 2004, three communities were funded to implement oral health improvement projects through the Arizona Community Oral Health Systems Development Initiative. This initiative funds communities to develop and implement projects to improve oral health. One of the funded communities is in the process of implementing a school sealant program.

The Community Health Services Program screened 1,136 children to assess their dental needs; 473 children received sealants, 161 were referred for urgent dental care, and 216 were referred for early treatment, while 170 children received oral health hygiene kits.

The Robert Wood Johnson Foundation (RWJF) grant funded pilot programs initiated in two community-based sites in rural Arizona. One site is based in Head Start, targeting preschool children and early head start population, the other site is a Perinatal Program targeting pregnant moms and infants and toddlers. Both
initiatives seek to reduce early childhood caries.

OOH provided school-based fluoride mouth rinse to 22,137 children, and developed and provided continuing education courses to dental professionals, training to WIC educators and other community health professionals, and collaborated with the School Readiness Board to develop an oral health training component for day care providers. Other collaborations included the Arizona Chapter of the American Academy of Pediatrics and the Arizona Academy of Family Physicians.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Oral Health Office provides dental sealants to high risk children	X			
2. The Dental Sealant Program is being evaluated				X
3. Collaborations are taking place with other interested entities to expand services				X
4. Implement and evaluate pilot programs in two community-based sites to determine impact on preschool		X	X	X
5. Train dental workforce on treatment of patients with special health care needs and evaluate impact.	X			X
6. The education and screening of children's oral health and assessing their need for dental care		X		
7.				
8.				
9.				
10.				

b. Current Activities

The Oral Health Program provides dental sealants, examinations, and referrals to high risk children, and is implementing a quality improvement program for the Arizona Dental Sealant program, and is conducting an evaluation of the Arizona Dental Sealant Program. The program collaborates with other agencies and organizations to increase the number of children receiving dental sealants and educates schools and the public on the benefits of sealants, monitors pilot programs and continues the special needs training program.

The Office of Oral Health supports dental team special needs workshops and links trained dentists to special needs populations. It is also developing an implementation plan for the new affiliated practice relationship opportunity for dental hygienists and providing technical assistance to partners seeking policy changes as a part of improving oral health. The program promotes dental visits at age one and prenatal dental care for expectant mothers and partners with Arizona Head Start Association and stakeholders as they develop a policy statement on issues related to caring for pregnant women, infants, and toddlers. The Office of Oral Health provides fluoride mouth rinse as well as oral health education to health professionals and educational materials for early childhood caries prevention. Office of Oral health is also continuing the mobile dental trailer program.

Arizona Governor Janet Napolitano signed HB 2194 into law in the spring of 2004. This bill creates a new opportunity for dentists and dental hygienists to expand the traditional walls of dental practice through the creation of an Affiliated Practice Relationship, enabling hygienists to provide preventive oral health services (fluoride, cleanings, sealants, etc.) to qualified children in a variety of community-based health and educational settings without a prior examination by a dentist. It allows the most underserved children access to preventive services at an earlier age and in a convenient setting (Head Start Program, school. etc.) and provides an opportunity for early referral to dental services.

c. Plan for the Coming Year

Oral Health will provide dental sealants to at least 8,000 high-risk children and dental examinations and referrals to at least 7,000 high risk children. Implementation of a quality improvement program for the Arizona Dental Sealant program will continue. The program will conduct an evaluation of the Arizona Dental Sealant Program and collaborate with other agencies and organizations to increase the number of children receiving dental sealants. Office of Oral Health will educate schools and the public on the benefits of sealants, expanding the program to Navajo County.

Office of Oral Health will continue to support and expand efforts to train the dental workforce on the treatment of special needs populations. It will promote best practices learned from community-based pilot programs. The office will provide technical assistance for efforts to improve access to oral health services and proven preventive interventions like community water fluoridation and school-based sealant programs. The Office of Oral Health will continue to assist local coalitions and community organizations to conduct oral health needs assessments, develop strategic plans, and implement oral health improvement projects through both the Arizona Community Oral Health Systems Development Initiative and Office of Oral Health's mini-grant program (target no less than six communities). Office of Oral Health will provide fluoride mouth rinse for 25,000 children, and will increase the knowledge of early childhood caries by providing education on infant and toddler oral health to professionals and consumers and supporting community-based early childhood caries pilot prevention programs.

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

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

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	7.1	6.7	6.3	5.9	5.9
Annual Indicator	5.8	5.5	4.8	5.3	5.3
Numerator	62	65	59	67	
Denominator	1073045	1189772	1226721	1261764	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5	5	4	4	4

Notes - 2004

Data for 2004 are not yet available. The estimate for 2004 is provisionally set at the 2003 rate until data become available in the Fall of 2005. Estimates for 2001 on reflect motor vehicle death rates for all children ages 0-14. Prior to 2001, estimates were based on ages 1-14.

a. Last Year's Accomplishments

Motor vehicle deaths to children age 14 and under have been declining in Arizona since 1995. Although the rate of 5.3 per 100,000 in 2003 represents an increase over the previous low of 4.8 in 2002, it remains below the target rate of 5.9. (Because data are not yet available for 2004, the 2003 rate is also provisionally listed as the rate for 2004). The 11th Annual Child Fatality Review Report, published in November 2004, concluded that fewer children (birth through 17 years) died as a result of motor vehicle crashes in 2003 (105 in 2003 compared to 127 in 2002). In 2002, 68 motor vehicle crash fatalities reviewed were of children birth through 14 years compared to 61 children in 2003.

Twelve community-based car seat safety projects were funded with Title V funds, and 7,040 child car seat safety seats were installed with accompanying education. Over 97 child car seat safety events were conducted; 46 new child passenger safety technicians were certified; 153 bicycle helmets were distributed; and 258 parents/caregivers were educated on home safety. Posters and brochures were developed in Native American communities and distributed to several tribes throughout the state. Over 900 car seat checks were completed. Contractors developed public service announcements addressing car seat safety tips and the importance of wearing a bicycle helmet. A total of 733 30-second spots were aired. A one-hour radio show reached a target audience of 50,863 women.

Arizona Safe Kids provided technical support to five community coalitions and one chapter. Over 20 child safety seat inspection and education events were held in Arizona. Maricopa Safe Kids Coalition partnered with a local automobile dealer to provide the first permanent child safety seat inspection station in Arizona.

The EMSC program funded development and delivery of pediatric education for prehospital providers in rural areas of Arizona. It also funded distance-learning curriculum for future pediatric education for prehospital providers and provided funding for durable training supplies

for pediatric prehospital care for rural areas.

The Arizona Child Fatality Review Program provided data reports for research and presentations on child deaths due to motor vehicle crashes, and established a prevention subcommittee.

The Health Start Program provided parents with education on car seat safety and user training has been offered to all participants. Community health nurses and Health Start lay health workers monitor car seat usage at each home visit.

The Injury Prevention Program received a technical assessment review from the State and Territorial Injury Prevention Directors Association. Recommendations covered infrastructure, data, interventions, technical assistance/training, and policy.

The County Prenatal Block Grant funded the distribution of 418 car seats, and certified technicians held 213 training and inspection events.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Prevent injury and death through community-based child car seat safety programs		X		
2. Increase geographic scope of Safe Kids coalitions/chapters in Arizona			X	
3. Facilitate child restraint system inspections			X	
4. Increase vehicular-business partner support of child restraint system education			X	
5. Facilitate regular child passenger safety screening and intervention by healthcare providers			X	
6. Conduct Child Fatality Reviews of MVCs, producing an annual report of findings and recommendations to reduce fatal MVCs				X
7. Monitor car seat usage at every home visit		X		
8. Educate parents about car seat safety and assist in obtaining car seat		X		
9. Provide car seats and training to low income families			X	
10. Revise and implement the state injury surveillance and prevention plan, including a chapter on motor vehicle crashes				X

b. Current Activities

The Title V funded car seat safety contractors will continue with their current programs through December 31, 2005, but will adjust their objectives as needed to meet their selected outcome. Their program is continuously reviewed by their program coordinator and the Department of Health Services program manager and adjusted as needed to accomplish the selected objectives.

Efforts will increase to attract ethnic groups that do not have a comparable interest in child car seat safety, using methods attractive specifically to those populations. Contractors look for car safety seat donations to extend the services they provide. As word of the child car safety seat and bicycle helmet program spreads, the need grows--stimulating partnership and collaboration within the various communities.

Arizona's Safe Kids coalitions conduct ongoing child safety seat inspections through special events, regular permanent stations, and individual sessions. The program increases partnerships with automobile vendors for permanent inspection stations of child passenger safety seats, increasing the geographic scope of community coverage with Safe Kids coalitions in Arizona in 2005.

OWCH is funding the evaluation of screenings tool to identify children at high risk of inappropriate use of child restraint systems. The EMSC program is developing training curriculum for pediatric advanced life support for prehospital providers and critical access hospitals. Basic life support pediatric education for prehospital providers and critical access hospitals with need is also provided.

Child Fatality Review produces data-driven recommendations for reduction of preventable motor vehicle crash fatalities, with an emphasis on identification of circumstances surrounding fatal motor vehicle crashes. It also produces an annual report each year for the public, the Governor, and the legislature on statistical trends and recommendations for preventing fatal motor vehicle crashes. Technical assistance is provided to the local child fatality teams in the development and implementation of local culturally sensitive teams. It also identifies and promotes campaigns to educate the public on preventing fatal motor vehicle crashes.

The Health Start Program provides parents with education on car seat safety, and user training is offered to all participants. The program is working to increase the number of Lay Health Workers who are certified car seat/seat belt instructors. Community health nurses and Health Start lay health workers monitor car seat usage at each home visit.

The Office of Women's and Children's Health has developed an action plan to implement the recommendations of the technical assistant review from the State and Territorial Injury Prevention Directors Association (STIPDA). The 2002-2005 Injury Prevention Surveillance and Prevention Plan is being updated for 2006-2010.

c. Plan for the Coming Year

The Community Health Services Program has contracts for Title V funded car seat safety projects that are renewable for three more years. Contractors will continue their programs, delivering services while building stronger partnerships and collaborating with other entities in their communities to provide more services.

The Arizona Safe Kids Coalition will target communities with lower compliance in child restraint system use for education, enforcement, and surveillance.
It will also focus local community coalition goals on parental seat belt use, child booster seat use to eight years of age, child restraint systems for children with special needs, and child restraint system use in non-parental vehicles and open-bed trucks. A screening tool appropriate for use by healthcare providers to identify children at risk for unsafe child restraint in motor vehicles will be selected. The EMSC program will promote use of validated distance-learning training modules throughout Arizona and U.S.

The Child Fatality Review Program will continue to review circumstances surrounding motor vehicle crashes, resulting in the development of data-driven recommendations for reducing child deaths from motor vehicle crashes. It will continue to produce an annual report for the public, the Governor, and the legislature on statistical trends and recommendations for preventing child fatalities due to motor vehicle crashes. It will also continue providing technical assistance to the local child fatality teams in the development and implementation of local culturally sensitive teams. Campaigns to educate the public on preventing fatal motor vehicle crashes will be identified and promoted.

The Health Start Program will continue to provide parents with education on car seat safety, and user training will continue to be offered to all participants. The program is working to increase the number of lay health workers who are certified car seat/seat belt instructors, the goal being that each Health Start contractor have at least one certified instructor available. Community health nurses and Health Start lay health workers will continue to monitor car seat usage at each home visit.

The County Prenatal Block Grant will continue to provide car seats and training to low income families. New employees will receive safety technician training, and the program will identify sources to increase numbers of car seats (i.e., discounted prices or donations).

The Core Injury Prevention Program will distribute the revised 2006-2010 Injury Surveillance and Prevention Plan, and work with partners within and outside of ADHS to begin implementing the plan. The program will support the ADHS Injury Prevention Advisory Council to annually review progress on the plan and recommend priorities for action to the ADHS director.

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

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

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	73	74	80	80	80
Annual Indicator	78.6	80.1	78.4	75.4	75.4
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80	80	80	80	80

Notes - 2004

Source: "Mothers Survey," Ross Products division, Abbott Laboratories, Inc. Data for 2004 not yet available. The estimate for 2004 is provisionally set at the 2003 rate until data become available.

a. Last Year's Accomplishments

The percent of mothers in Arizona, who breastfed upon hospital discharge rose steadily each year, reaching a high of 80.1% in 2001. Since then, the rate has been declining, and dipped to 75.4 in 2003, below the target rate of 80%. However, the rate remains well above the national rate of 68.0%. (Because data are not yet available for 2004, the 2003 rate is also provisionally listed as the rate for 2004).

MCH Nutrition found that 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; 18.6 percent of Arizona WIC participants continued to breastfeed at 6 months, compared to 22.1 percent nationally. 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 the Certified Breastfeeding Counselors Course and scholarships were provided for local agency WIC staff to attend breastfeeding training. CDC breastfeeding data were assessed and recommendations were made regarding general breastfeeding education to Arizona's population. The Office of Chronic Disease and Nutrition Services is developing a social marketing campaign to promote duration of breastfeeding, focusing on worksite policies. They have also begun development of the statewide Breastfeeding Peer Counselor Program.

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 the Office of Women's and Children's Health and to county prenatal block grant coordinators.

The Pregnancy and Breastfeeding Hotline served 5,834 callers, providing information and telephone support utilizing the certified lactation counselor on staff.

The High Risk Perinatal Program reports that Community Health Nurses and Health Start Lay Health Workers promoted breastfeeding to women enrolled in these programs and referred women for breastfeeding consultation as needed. In addition, mothers with babies in a newborn intensive care unit were encouraged to breastfeed as indicated.

The County Prenatal Block Grant provided 497 people with breastfeeding education and trained 13 lactation counselors. It also put a tracking mechanism in place to identify the numbers of women at hospital discharge that are breastfeeding.

Midwives from the Special License/Midwifery program provided pregnant mothers with education and information pamphlets on the importance of breastfeeding their infants. They followed up at postpartum evaluation for all 497 mothers during the calendar year of 2004.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC Participants were able to use the pump loan program	X			
2. Developed a statewide strategic plan for breastfeeding				X
3. Scholarships were provided for local agency WIC staff to attend breastfeeding training				X
4. Provide telephone support to breastfeeding mothers		X		
5. Provides information packets on breastfeeding to pregnant women		X		
6. Promote breastfeeding to mothers with medically fragile babies	X			
7. Refer women for breastfeeding consultation as needed		X		
8. Promote breastfeeding during home visits and in group sessions	X			
9. Provide breastfeeding information and education in prenatal classes		X		
10. Provide breastfeeding support by Certified Lactation Specialists			X	

b. Current Activities

The Arizona Department of Health Services, Office of Chronic Disease Prevention and Nutrition Services received funds provided by the United States Department of Agriculture targeted at "Using Loving Support to Build a Breastfeeding Friendly Community." The project is a collaborative effort among USDA/FNS, Best Start Social marketing, and the Mississippi State Department of Public Health, and consists of a two day training program, ongoing technical assistance (including a follow-up two day site visit), and implementation funds. Arizona is one of 10 states to be chosen to participate in this project in FY 2004. Through this funding, an implementation plan was created that included development of a statewide coalition (LATCH-AZ), creating opportunities for WIC staff to achieve advanced certification in lactation (IBCLC), and enhanced social marketing efforts to promote breastfeeding in the workplace.

The Pregnancy and Breastfeeding Hotline staff provides telephone support to breastfeeding mothers and includes information on breastfeeding to pregnant women through the dissemination of information packets.

The Community Health Nursing, Health Start and Hospital Services Programs promote breastfeeding to women enrolled in the programs and refer women for breastfeeding consultation as needed.

The County Prenatal Block Grant provides breastfeeding information and education in prenatal classes and breastfeeding support by certified lactation counselors (three in the state that are reported).

Special License/Midwifery continues to provide information to all women who choose delivery by midwives. The midwives provide handout information and childbirth education classes for the mothers. The information is available to the mothers both in English and Spanish. Continuing education is required for all midwives during their license period and all continuing education class information is provided to the Midwife Association and to all midwives who request this information from the department. The license period for each midwife is a two year period and each midwife is informed of potential classes and pamphlet information that the department has available. Education opportunities for newborn screening, breastfeeding, and hearing screening has been provided to the midwives.

c. Plan for the Coming Year

The Arizona Department of Health Services Breastfeeding Coordinator will provide support and materials to Breastfeeding Hotline staff, assess and recommend training for WIC and MCH breastfeeding counselors, and coordinate training opportunities for internal and external partners on breastfeeding. A Breastfeeding Peer Counselor Program will be developed and implemented. The computer system for the Arizona WIC program will be updated in mid-2005, and will begin to provide sound breastfeeding data on WIC participants. The pump loan program will continue for WIC clients. The Arizona WIC Program intends to assist eligible employees in preparing to sit for the IBCLC exam in July 2005 and again in July 2006. Nutrition consultants will meet with Arizona Health Care Cost Containment System MCH coordinators to promote breastfeeding, and will assess and recommend training for breastfeeding counselors. They will continue to monitor CDC breastfeeding data and assess newly captured Arizona WIC data, and develop a statewide breastfeeding coalition to bring training and networking opportunities to the state. The Arizona Department of Health Services breastfeeding policy for employees will serve as a model for Arizona businesses. Scholarships for local agency WIC staff to attend Certified Breastfeeding Counselor training will be continued. A training on Breastfeeding the Neonatal Intensive Care Unit baby will be hosted for WIC staff, hospital Neonatal Intensive Care Unit nurses, lactation consultants, and Health Start staff. Other training opportunities will be hosted, such as the Certified Lactation Consultant course. Qualified individuals will be encouraged and assisted to prepare for the IBCLC exam. The

Office of Chronic Disease Prevention and Nutrition Services plans to develop high risk perinatal breastfeeding guidelines.

Office of Women's and Children's Health Community Services programs will continue to promote breastfeeding to women enrolled in the programs and refer women for breastfeeding consultation as needed.

The County Prenatal Block Grant will continue to focus on breastfeeding as a priority, and will increase numbers of certified lactation counselors in the state. Breastfeeding will continue to be included in prenatal classes. In some areas of the state douhlas are utilized.

Special License/Midwifery continues to provide education to all women who choose delivery by midwives. The midwives provide handout information and childbirth education classes for the mothers. The information is available to the mothers both in English and Spanish. Continuing education is required for all midwives during their license period and all continuing education class information is provided to the Midwife Association and to all midwives who request this information from the department. The license period for each midwife is a two-year period and each midwife is informed of potential classes and pamphlet information that the department has available.

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

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

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	85	85	85	98	98
Annual Indicator	91.2	93.3	97.9	98.0	98.3
Numerator	77500	79470	85368	89233	96876
Denominator	84985	85213	87200	91054	98551
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	98.5	98.8	99	99	99

Notes - 2004

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

a. Last Year's Accomplishments

In 2004, 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 ADHS is voluntary, and only 39 participated in the Early Hearing Detection and Treatment Program's HI*TRACK data collection.

Special License/ Midwifery provided education to midwives regarding hearing screening and attended the AZ Midwife Association meetings, providing pamphlets for hearing screening.

All 47 hospitals in Arizona admitting newborns (all birthing or pediatric hospitals) now voluntarily perform Universal Newborn Hearing Screening (UNHS). All but three voluntarily report the results to the Arizona Department of Health Services (ADHS). Two of the three non-reporting hospitals have expressed intent to report
in the coming year. The number of hearing screenings reported to ADHS reflects 85% of all hospital births recorded by Arizona Vital Statistics. Considering tests performed at the non-reporting screening hospitals, ADHS estimates 90 to 95% of all newborns admitted to screening hospitals receive an initial hearing screening.

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

The State Systems Development Initiative (SSDI) grant has developed a data warehouse project to incorporate the data from 16 different state systems within Arizona. The intent of the SSDI is to help assure that every child with a genetic or congenital condition; developmental delay or other special health care need is identified and receives appropriate care.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assist all hospitals with inpatient newborns to implement hearing screening and reporting.				X
2. Prepare newborn hearing follow up services				X
3. Educate hospitals and healthcare providers in newborn hearing screening.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Special License/ Midwifery answered phone calls regarding hearing screening. Midwives requested information regarding how to obtain hearing screening for newborns delivered in the home environment. The information is available to the mothers both in English and Spanish.

A legislative bill for Newborn Screening was enacted into law, requiring mandatory reporting of

newborn and infant hearing screening, creation of a database to monitor hearing screening results, and follow up services for failed hearing screening results. Hearing screening follow up will be a new service in Arizona that can be implemented in 2006, once rule writing is completed. Hearing screening follow up protocols will be developed in 2005, prior to implementation of follow up services. Prior to implementation of follow-up services, an assessment of the availability of audiology and otology services in Arizona will be completed, referral tools will be created and educational materials for providers and families will be developed.

The Newborn Screening Program contracted with University of Arizona to provide a workshop for audiologists and other healthcare providers in Arizona in 2005 on the link between genetics and hearing loss.

Four large reporting hospitals agreed to pilot weekly screening reporting. ADHS will use experience reports from these hospitals to guide program planning as reporting guidelines and follow up services are added.

c. Plan for the Coming Year

Special License/ Midwifery will bring updated laws to midwives regarding changes for newborn hearing screenings and will provide information and pamphlets to the midwives regarding hearing screening.

The Office of Women's and Children's Health will initiate newborn hearing screening follow up. The Newborn Screening Program will develop protocols for newborn hearing screening reporting requirements and follow up services.

The newborn hearing report database will be expanded to include: reporting of infants with hearing screening up to two years of age; demographic information to enhance follow up; and, final diagnosis, intervention, and treatment.

The Newborn Screening Program will provide education to hospitals, healthcare providers, consumers, and the public about newborn hearing screening and the benefits of early intervention in hearing disorders.

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

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

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

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	17	15	14	14	14
Annual Indicator	12.8	17.8	14.7	14.6	14.6

Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	14	14	13.5	13.5	13

Notes - 2004

Data source is http://www.census.gov/hhes/hlthins/historic/hihistt5.html. Data for 2004 not yet available. The estimate for 2004 is provisionally set at the 2003 rate until data become available in the Fall of 2005.

a. Last Year's Accomplishments

In 2003, 14.6% of children in Arizona were estimated to have no health insurance, exceeding the targeted rate of 14%. (Because data are not yet available for 2004, the 2003 rate is also provisionally listed as the rate for 2004).

In 2001, the passing of Proposition 204 expanded eligibility criteria and increased enrollment in AHCCCS and KidsCare by more than 15%, from 631,745 enrollees in federal fiscal year 2002 to 730,752 enrollees in federal fiscal year 2004. In 2004, results of a mail survey of dental clinics statewide were compiled electronically and shared with a referral hotline housed at the Arizona Dental Association.

The Office of Oral Health (OOH) and the Office of Health Systems Development (OHSD) partnered with the Arizona Dental Association to develop a mail survey for all dental professionals licensed in Arizona (approximately 2,800 dentists and 2,400 dental hygienists). Starting in 2003, the survey was to be distributed with the triennial licensure renewal notices for three years. The survey would provide data for Health Professional Shortage Area reporting needs and answer other questions about the dental workforce in Arizona. Instead of completing the survey over the initially agreed upon three-year period, OOH sent the survey to all 2004 and 2005 licensees at the time of the 2004 mailing. The licensees received the surveys in June and returned them by the end of September. A database was created and given to OHSD for use in HPSA applications. OOH hopes to have a comprehensive report ready for release by the end of 2005. The office funded nine communities through its mini-grant program (funding up to $5,000) to conduct needs assessments aimed at detecting gaps in oral health services for children. At least one of the mini-grants awarded resulted in funding for a new sliding fee scale, AHCCCS-contracted dental clinic.

During 2004, the Pregnancy and Breastfeeding hotline served 5,834 callers, and the Children's Information Center Hotline served 4,775 callers. Both hotlines provide information to the public on AHCCCS and Baby Arizona and assist eligible people applying for AHCCCS.

The Medical Home Project linked uninsured children that did not qualify for AHCCCS with medical providers. Acute care services (including eyeglasses for 46 children, diagnostic laboratory services for 88 children, and prescription medication for 273 children) were provided to 389 school age children; 21 children from 11 families received a true medical home, and 16 children below school age received services.

Community Health Services reports that 236 children who did not have medical insurance were assessed and referred to sources for medical care. The parents/caregivers were assisted with filling out the appropriate forms to obtain medical insurance for their children.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expand outreach efforts to increase utilization of dental services by AHCCCS enrollees.				X
2. Support safetynet for uninsured by providing a referral service for low or no cost.		X		X
3. Complete dental workforce survey		X		X
4. Provide uninsured children with health care services.	X			
5. Screen children for AHCCCS eligibility and refer as appropriate.		X		
6. Finding children in the school system that do not have medical/dental insurance and referring them		X		
7. Educate families on the importance of establishing and maintaining a medical home	X			
8. Provide training and updates on available public insurance plans		X		
9. Assist families to overcome barriers to health care		X		
10. Link with agencies to identify and assess qualified families		X		

b. Current Activities

The Office of Oral Health (OOH) is working to expand outreach efforts to increase utilization of dental services by current AHCCCS enrollees. The percent of enrollees who received dental treatment in federal fiscal year 2002 was 26.72% and despite the growing enrollment, the percent of children in federal fiscal year 2004 who received dental treatment was 30.4%. Supporting the Arizona Committed to Improving Oral Health Needs program provides dental referrals to help establish a dental home for children and recruits dentists to serve as a safety net for uninsured individuals by providing free or reduced cost dental treatment to those in need. The office will publish dental workforce survey to identify dental shortage areas and expand programs to these areas to start to meet some dental needs. The OOH continued to participate in collaboratives to improve access to oral health services, including partnerships with AHCCCS and multiple community coalitions. These partnerships improve the dissemination of oral health messages through community clinics and organizations.

The Pregnancy and Breastfeeding Hotline and the Children's Information Center Hotline provides information to the public on AHCCCS and Baby Arizona.

The Medical Home Project continues to link uninsured children that do not qualify for AHCCCS with medical providers. Medical Home Project continues to provide acute care services to children and will continue to expand the number of families who receive services through a true medical home. It continues to seek additional providers and school nurses and public health nurses to refer children to the Mecical Home Project.

The High Risk Perinatal Program educates families on the importance of establishing and maintaining a medical home and assists in overcoming barriers to health care access. Training and updates on available public insurance plans are provided for specific populations. The High Risk Perinatal Program and Health Start programs continue to assess the health status of each client throughout program enrollment.

County Prenatal Block Grant holds or attends public events--health fairs, etc.-- and promotes insurance options particularly related to the target population: women of childbearing age and

infants up to age two years. It will continue home visits, referrals, and follow-ups to assess needs and assist in application processes.

c. Plan for the Coming Year

The Office of Oral Health will continue to support the Arizona Committed to Improving Oral health Needs program and expand its outreach, promote the coordination of care between physicians and dentists, develop strategies for workforce shortage areas, and promote new afilliated practice rules in underserved children populations. The office will continue to participate in collaboratives to improve access to oral health services, including partnerships with AHCCCS and multiple community coalitions.

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 Medical Home Project will continue to link uninsured children that do not qualify for AHCCCS with medical providers. Additional physicians that provide services to children will be recruited through the Medical Home Project. The project will increase the number of participating school nurses and public health nurses who refer children to it. The number of children who receive a true medical home from the Medical Home Project will be increased.

Community Health Services anticipates no changes unless it finds that objectives are not being met after the evaluation is completed.

High Risk Perinatal Program will continue to educate families 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 High Risk Perinatal Program and Health Start programs will continue to assess the health status of each client throughout program enrollment.

County Prenatal Block Grant will continue to hold or attend public events--health fairs, etc.--and promote insurance options particularly related to the target population: women of childbearing age and infants up to age two years. It will continue home visits, referrals, and follow-ups to assess needs and assist in application processes.

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

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

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	66	66	67	67	68
Annual Indicator	69.2	69.3	73.6	72.0	72.6
Numerator	243498	246830	317629	366273	402079
Denominator	351749	356179	431697	508776	553763
Is the Data					

Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	73	74	74	75	75

Notes - 2004

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

a. Last Year's Accomplishments

During fiscal year 2003-2004, 72.6% of children eligible for Medicaid received a paid service, exceeding the target of 68%. During that same year, the combined Pregnancy and Breastfeeding Hotline and the Children's Information Center responded to approximately 22,700 callers. 1200 of those callers were referred to the Baby Arizona program which expedites the Medicaid eligibility process. The Health Start program assisted 719 families in applying for Medicaid in FY 04. The High Risk Perinatal program enrolled 4,906 infants in 2004. All were screened for Medicaid eligibility. Assistance was provided to those who did not have a source of health coverage. Clinical services provided through the office of Women's and Children's are supported under a "payor of last resort" policy that requires recipients to apply for Medicaid benefits if potentially eligible.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Answer questions about eligibility, i.e. how to apply, where, what to bring, etc.		**X**		
2. Check eligibility online and advise applicants of next steps.		**X**		
3. Call eligbility office with client on-line to resolve barriers.		**X**		
4. Identify women early in their pregnancy and assist them in making application for the Medicaid program.		**X**		
5. Assisting in eligibility issues. Working with local Medicaid eligibility office.		**X**		
6. Assist families at risk in applying for Medicaid benefits.		**X**		
7.				
8.				
9.				
10.				

b. Current Activities

The Office of Women's and Children's Health offers outreach and linkage to Medicaid services through several programs. The Pregnancy and Breastfeeding Hotline and the Children's Information Center assist callers in applying for Medicaid benefits, checking on their Medicaid status, and resolving eligibility issues related to Medicaid. Through a data sharing agreement with the state Medicaid agency, operators are able to advise callers of their status and assist

them in identifying and locating items that are still needed to establish eligibility. Three way calling is used to link with local Medicaid eligibility offices and provide support to callers. The Health Start program identifies women early in their pregnancy and assists them in entering prenatal care. They follow the family until the child is age 2 to ensure that the family has a medical home. Services include assisting with the Medicaid eligibility process. The High Risk Perinatal program supports the transport and care of high risk mothers and newborns. Services include financial aid to alleviate the catastrophic costs associated with a sick newborn. Families are assisted in applying for Medicaid or any other potential 3rd party payor.

c. Plan for the Coming Year

The Children's Information Center hotline will continue to provide assistance to callers to facilitate access to care. The Health Start program will continue to serve high risk communities by assisting families in establishing Medicaid eligibility. The High Risk Perinatal Program will continue to serve high risk mothers and infants by assisting them to identify a source for health care services.

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

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

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1	1	1	1	1
Annual Indicator	1.3	1.1	1.1	1.1	1.1
Numerator	1115	923	982	1024	
Denominator	84985	85213	87379	90783	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1	1	1	1	1

Notes - 2004

Data for 2004 are not yet available. The estimate for 2004 is provisionally set at the 2003 rate until data becomes available in the Fall of 2005.

a. Last Year's Accomplishments

In 2003, 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 2004, the 2003 rate is also provisionally listed as the rate for 2004).

Five Community Health Services women's health programs were funded throughout the state. They were established to improve the health in women of childbearing age by reducing the number of women who smoke, increasing physical activity, maintaining a healthy weight,

improving diet by consuming at least five fruits and vegetables a day, reducing stress, reducing substance use/abuse, and reducing the number of women injured or killed in motor vehicle accidents. Hopefully, improving women's health status will increase infant birth weights. Eight hundred thirty one classes were conducted, and 6,528 women attended them.

Arizona Department of Health Services beagn a partnership with Maricopa County Department of Public Health to bring the National Friendly Access Program philosphy to areas of the county where infant mortality rates are highest. Friendly Access is based on the premise that the way services are delivered impacts accessibility. A prenatal baseline assessment survey was developed in English and Spanish, which will evaluate how "consumer friendly" prenatal care services are.

Eleven of the 15 county health departments received intergovernmental agreements to provide reproductive health/family planning services, and 5,955 women received initial/annual family planning visits. Ninety-nine percent of those women served were at or below the federal poverty level and received services free of
charge; 12,977 screenings were provided to women for either pregnancy, cervical or breast cancer, or HIV/STD testing. Of the 7,022 pregnancy tests provided, 4,426 (63%) were positive, and 10,017 referrals were made for additional medical care, nutrition services (WIC), domestic violence, behavioral health services, prenatal care, or to other community agencies/organizations. The Reproductive Health/Family Planning program manager participated in the Arizona Family Planning Coalition, which focuses on community outreach, promotion of family planning programs, and collaboration and partnering with various related agencies and organizations. The program works closely with Title X Arizona Family Planning Council to fill in the gaps of family planning services offered in the state.

The Health Start Program educates pregnant women about prenatal care, nutrition, and danger signs of pregnancy. The lay health workers follow-up with the participants to verify that they are attending prenatal care medical appointments and are complying with physician's instructions. In 2004, the Health Start Program served 2,148 unduplicated clients and provided a total of 9,718 home and/or office visits. Each client received nutritional education as well as referrals to WIC as indicated.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Improving the general health of women in child bearing ages through education.		X		
2. Lay Health Workers educate pregnant women		X		
3. Lay Health Workers ensure clients are attending prenatal medical appointments		X		
4. Lay Health Workers will assist the client by transporting them to apointments when necessary		X		
5. Women in preterm labor, in imminent danger of delivery, are transported to appropriate hospital	X			
6. Critically premature neonates are transported to appropriate hospital	X			
7. Maintain or increase number of women who receive reproductive health/family planning services	X			
8. Increase African American access to services.	X			

9.				
10.				

b. Current Activities

The Community Health Services programs fund local efforts to improve the health in women of childbearing age. A variety of approaches are used to help women quit smoking, get active, eat healthy, control stress and stay safe on the road. The objectives and evaluations of these programs are continually being reviewed by
the contract's program coordinator and the Department of Health Services program manager, and changes are made accomplish the chosen goals and objectives. The contracts were renewed on December 1, 2004 and run for 13 months, renewable for three more years.

A contract is being developed with Arizona State University to administer the survey for Friendly Access.

The Reproductive Health/Family Planning Program provides services to assist women in planning and spacing their pregnancies, and reducing the numbers of unplanned pregnancies. The program serves as an entry point into the health care system to obtain early prenatal care when pregnant. All of these will ultimately assist in a decrease in low birthweight babies. The program will focus on increasing African American access to reproductive health/family planning services to address the health disparities of African Americans and the disproportional high rates of negative birth outcomes and infant mortality. The program participates in the Arizona Family Planning Coalition and works closely with Title X, Arizona Family Planning Council to serve the uninsured and underinsured populations of the state.

One of the Health Start Program's goals is to reduce very low birth weights among program participants. To facilitate this goal, the program includes prenatal education on care, nutrition, and danger signs of pregnancy. The lay health workers follow-up with the participants to verify that they are attending prenatal care medical appointments and are complying with the physician's instructions. They make referrals to smoking cessation programs, as needed. Health Start contractors distribute the Arizona Family Resource Guide, and the Health Start Program has established an ordering and tracking system for the guides. The High Risk Perinatal Program Maternal/Neonatal Transport Program coordinates with neonatologists and obstetricians/pediatricians throughout the state to ensure that pregnant women in danger of premature delivery or critical neonates are transported to the most appropriate hospital level. This program is based on the level of care needed and makes no consideration of ability to pay. The contracted hospitals agree not to hold families financially responsible beyond the program-established family liability.

c. Plan for the Coming Year

Community Health Services will continue to fund local projects to improve the health of women of child bearing years.

The Friendly Access program, through contracted services with Arizona State University, will hire and train interviewers. It will administer a survey that will be evaluated by ASU to 540 patients in 4 area hospitals, and a then develop a community action plan.

The Reproductive Health/Family Planning Program will monitor numbers of individuals served and referrals given, and will evaluate the outcome of focusing on African American access to services.

Health Start contractors will continue to provide education on prenatal care, the danger signs of pregnancy, and nutritional counseling, and will make referrals to smoking cessation programs. Lay health workers will continue to monitor participants' compliance with prenatal care

appointments and physician instructions and help with transportation to appointments when necessary. Health Start contractors will continue to distribute the Arizona Family Resource Guide, and the program will continue to order, distribute and track the use of the guides. The High Risk Perinatal Program Maternal/Neonatal Transport Program will continue to coordinate with neonatologists and obstetricians/pediatricians throughout the state to ensure that pregnant women in danger of premature delivery or critical neonates are transported to the most appropriate level of the hospital.

Special License/Midwifery will continue monitoring the quarterly report forms for the weight of infants born in the midwife care. Continuing education classes that meet the specific needs of each midwife will be researched, and the Midwifery Association will be notified of each class.

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

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

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	17.3	17	16.7	16.4	16.4
Annual Indicator	11.1	10.5	9.9	9.7	9.7
Numerator	41	40	39	39	
Denominator	367722	380103	391964	403088	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	9.5	9	8.5	8.5	8

Notes - 2004
Data for 2004 are not yet available. The estimate for 2004 is provisionally set at the 2003 rate until data becomes available in the Fall of 2005.

a. Last Year's Accomplishments

In 2003 there were 9.7 suicides per 100,000 adolescents in Arizona, a rate well below the target rate of 16.4. 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 2004, the 2003 rate is also provisionally listed as the rate for 2004).

During 2004, Child Fatality Review teams reviewed circumstances surrounding suicides of 24 children in 2003. Nine of the 24 children who committed suicide were less than 15 years old, and 15 were in the 15 through 17 age group. The reviews determined that Caucasion children and American Indian children were overrepresented among suicides compared to their population proportions. The most frequent method of suicide was hanging followed by gunshot

wound. Recommendations to reduce child fatalities due to suicide were included in the 11th Annual Child Fatality Review Report, published in November 2004.

The Community Health Services Program used Title V funds to support a community project in Pima County addressing adolescent depression and suicide prevention. Pima County provided education on a depression-screening tool for teens to several community mental health agencies/organizations as well as to the ADHS Suicide Prevention Coordinator and several employees of the Arizona Health Care Cost Containment System (AHCCCS).

The Injury Prevention Program requested and received a technical assistant review from the State and Territorial Injury Prevention Directors Association. The review of the program covered infrastructure; data collection, analysis, and dissemination; interventions; technical assistance and training; and public policy. The review team recommended that Arizona establish a role for the injury prevention program to promote a public health approach to suicide prevention.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct reviews of child fatalities due to suicide.				X
2. Produce reports upon request for research related to incidence of suicide.				X
3. Produce an annual report of findings and recommendations to reduce suicides among children.				X
4. Educated mental health workers about an adolescent depression screening tool and pediatric checklist in Pima County		X		
5. Revise the state injury surveillance and prevention plan, including the chapter on suicide				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Child Fatality Review will continue to conduct comprehensive reviews of child fatalities due to suicide; produce an annual report each year for the public, the Governor, and the legislature on statistical trends and recommendations for prevention of childhood suicides; provide technical assistance to the local child fatality teams in the development and implementation of local culturally sensitive teams; and continue to participate in local, statewide, and national initiatives to reduce the incidence of childhood suicides.

The 2002-2005 Injury Prevention Surveillance and PreventionPlan is being updated for the years 2006-2010. The ADHS suicide prevention coordinator is leading the effort with the Arizona Suicide Prevention Coalition to update the suicide chapter of the plan.

c. Plan for the Coming Year

Child Fatality Review will continue to review circumstances surrounding suicides, resulting in

the development of data-driven recommendations for reduction of child deaths from suicides. The program will continue to produce an annual report for the public, the Governor, and the legislature on statistical trends and recommendations for prevention of suicides among children and youth. It will also continue to provide technical assistance to the local child fatality teams in the development and implementation of local culturally sensitive teams. Campaigns that educate the public on prevention of suicide among children and youth will be identified and promoted.

Injury Prevention Program will distribute and begin implementing the revised 2006-2010 Injury Surveillance and Prevention Plan. The program will continue to help address suicide as part of the state injury plan. This includes continued networking with the Division of Behavioral Health, the Arizona Suicide Prevention Coalition, and EMPACT, the suicide prevention hotline.

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

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

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	79.5	80	80.5	81	81.5
Annual Indicator	69.5	78.7	77.6	80.1	80.1
Numerator	775	657	678	741	
Denominator	1115	835	874	925	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	82	83	83	84	84

Notes - 2004

The data source for this measures is birth certificate data for live births. Births in which the birth weight was recorded as being under 450 grams are excluded as a data quality measure, as it is unlikely that these records represent actual birth weights. Only facilities certified by the Arizona Perinatal Trust as level III facilities are included in the numerator. Banner Desert Samaritan became certified as a Level III on 10/1/02. Births occuring there were included in the numerator for 2002 if the date of birth was on or after 10/1/02. Data for 2004 are not yet available. The estimate for 2004 is provisionally set at the 2003 rate until data become available in the Fall of 2005.

a. Last Year's Accomplishments

In 2003, 80.1% of very low birth weight babies were born at facilities with Level III neonatal intensive care units, just below the targeted rate of 81%. (Because data are not yet available for 2004, the 2003 rate is also provisionally listed as the rate for 2004).

The Maternal Transport component of the High-Risk Perinatal Program 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 present with high-risk factors. Providers make one telephone call to obtain consultation, bed placement, transfer of care, and transport arrangements regardless of the woman's ability to pay. The program continued to fund uncompensated care for maternal transport associated with transfer of high-risk pregnant women to Level III centers. The High-Risk Perinatal Program Hospital Program created a funding formula that helped with HIPAA compliance and decreased the amount of information hospitals send to the program. During FY 2004, 4,906 infants were enrolled into the High-Risk Perinatal Program. Community health nurses conducted 10,399 home visits and provided anticipatory guidance, developmental assessments and medical home information to families. One thousand two hundred forty five women received maternal transports, and 953 infants received neonatal transports.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Transport critically premature neonates to risk-appropriate hospitals	X	X		
2. Transport gravid women in imminent risk of preterm delivery	X	X		
3. Coordination of transport services				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Maternal Transport component of the High-Risk Perinatal Program 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. The Office of Women's and Children's Health contracts with the Arizona Perinatal Trust to collect, analyze, and distribute annual perinatal data comparing Arizona hospitals to national perinatal data. Staff members within the Office of Women's and Children's Health participate in the APT hospital certification process.

c. Plan for the Coming Year

The High Risk Perinatal Program will continue to contract with specialized perinatology physician groups to provide medical case management, consultation, and technical services to hospitals, physicians, communities, and medical transport teams. The Office of Women's and Children's Health will continue to contract with the Arizona Perinatal Trust to collect, analyze, and distribute annual perinatal data comparing Arizona hospitals to national perinatal data. Staff members within Office of Women's and Children's Health participate in the APT hospital certification process. In order to streamline information and referral services, High Risk Perinatal Program transport services will be coordinated through a 1-800 phone line.

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

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

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	76	77	78	79	80
Annual Indicator	75.0	75.5	75.7	75.6	75.6
Numerator	63697	64377	66146	68632	
Denominator	84985	85213	87379	90783	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	78	78	79	79	80

Notes - 2004
Data for 2004 are not yet available. The estimate for 2004 is provisionally set at the 2003 rate until data become available in the Fall of 2005.

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, although in recent years progress seems to have leveled. In 2003, 75.6 percent of women received prenatal care during the first trimester, which is below the targeted rate of 79%. (Because data are not yet available for 2004, the 2003 rate is also provisionally listed as the rate for 2004).

The Pregnancy and Breastfeeding Hotline provided pre-screenings for potential eligibility for the Baby Arizona Project to facilitate early entry into prenatal care. Baby Arizona calls totaled 1,168 in 2004.

Arizona Department of Health Services (ADHS) began a partnership with Maricopa County Department of Public Health to bring the National Friendly Access Program philosphy to select areas of the county where infant mortality rates are highest. A prenatal baseline assessment survey was developed in English and Spanish. ASU has been contracted to administer and evaluate the survey.

The Office of Chronic Disease Prevention and Nutrition refers pregnant WIC participants for prenatal care.

The Office of Oral Health (OOH) provided technical assistance to community-based organizations, Arizona Health Care Cost Containment System programs, the Arizona Perinatal Trust, Arizona State University nursing students and other state agencies on the relationship between oral health and pregnancy outcomes. St. Luke's Health Initiative hosted its first task force meeting on pregnancy and oral health. St. Joseph's Mercy Care Mom-mobile initiated a

pilot program with at-risk moms offering them clinic-based dental hygiene services and education as part of their prenatal care. Of the 133 patients who opted to receive free dental hygiene services, 44 completed treatment and 21 were in progress at the closing of the project. Thirty-seven women did not complete treatment.

The Health Start Program utilizes lay health workers to identify pregnant women within their community and facilitate early entry into prenatal care. Program data is analyzed to assess the program's success in addressing this measure.

The County Prenatal Block Grant provided subsidized funding for prenatal care for low-income women and utilized pregnancy tests to identify women early and refer them to prenatal care. In areas where they tracked 1st trimester prenatal care, 87 out of 146 (60%) were seen in the first trimester.

The Governor's Commission on the Status of Women's Health and Families in Arizona formed a subcommittee to look at prenatal care issues including early entry into prenatal care. The subcommittee met three times in 2004 and recommended to "increase the number of women who access early prenatal care to improve birth outcomes."

Special License/ Midwifery reviewed quarterly report forms for the date the mother began her prenatal care and informed the midwives of continuing education classes that would improve their knowledge base for care provided.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide pre-screenings for Baby Arizona Project to facilitate early entry into prenatal care		X		
2. Develop a baseline assessment survey				X
3. Administer and evaluate survey				X
4. Develop a community action plan				X
5. Refer pregnant WIC participants for prenatal care		X		
6. Lay Health Workers identify pregnant women in the community and facilitate entry into care		X		
7. Provide pregnancy testing in order to promote early identification of pregnant women	X			
8. Provide subsidized funding for prenatal care for low-income women		X		
9. Review date of quarterly report form for date of prenatal care beginning				X
10.				

b. Current Activities

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.

Friendly Access interviewers will be hired and trained. The survey will be administered to 540 patients in 4 area hospitals and evaluated by ASU. A community action plan will then be

developed.

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

OOH continues to provide technical assistance to agencies and health professionals as requested. It partners with and provides technical assistance to the Arizona Head Start Association in an effort to educate the OB/GYN and dental community on pregnancy and birth outcomes. The office serves on the newly-established prenatal oral health advisory board and develops position statements that promote research-based oral health prevention and promotion efforts targeting expectant mothers and newborns. Technical assistance is provided to St. Luke's Task Force on Pregnancy and Oral Health to helo them achieve task force goals. The Robert Wood Johnson Foundation supports Pilot programs with Early Head Start and Cochise County Perinatal Program, including an oral health education and prevention component for pregnant women.

The Health Start Program continues to utilize lay health workers to identify pregnant women within their community and facilitate early entry into prenatal care. Program data is collected and analyzed to determine the program's success in addressing this measure.

County Prenatal Block Grant networks with WIC, family planning, pregnancy clinics, and Health Start. It provides services to pregnant women who were not eligible for other programs and pregnancy testing in order to identify pregnant women early. Trainings, brochures, and other educational opportunities have been developed in bilingual format and with bilingual staff in order to provide culturally competent programs.

A subcommittee to the Governor's Commission on Women developed a strategy to identify subpopulations that are not accessing prenatal care early in their pregnancies using Arizona Health Care Cost Containment System and other health plan data and vital statistics data. Challenges to access will be addressed and promotion of Baby Arizona will be revived.

Special License/Midwifery reviewed the quarterly report forms for date of prenatal care begun for each delivery with review of each infant delivered. It informed the midwives of the continuing education courses that address the information, which is available to the mothers both in English and Spanish.

c. Plan for the Coming Year

The Pregnancy and Breastfeeding Hotline will continue to assist pregnant women with expedited access to prenatal care through the Baby Arizona project.

Nutrition services will continue to train WIC staff to refer pregnant women for early prenatal care.

The Office of Oral Health plans to increase the knowledge of the link between oral disease and pre-term, low birth weight babies through collaboration with Arizona Health Care Cost Containment System and other agencies by providing technical assistance and consultation. It will expand efforts to educate health professionals on the link between oral health and birth outcomes, and will promote policy statements on oral health and pregnant women, newborns, and toddlers.

The Health Start Program will continue to utilize lay health workers to identify pregnant women within their ommunity 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 provide subsidized funding for prenatal care for low-income women. It will expand marketing of programs, increase focus on undocumented pregnant women, and continue networking and partnering with other agencies/providers to provide services to pregnant women who were not eligible for other programs.

The Governor's Office's plan will be developed after fact finding and program review occurs during 2005.

Special License/Midwifery will conduct a review of quarterly report forms related to the time when care began and its outcomes with respect to infants born without complications. It will notify midwives of upcoming continuing education available to them for improvement of their clinical abilities, and will attend the association meetings to be aware of concerns and share information with the licensed midwife who attends these meetings.

D. STATE PERFORMANCE MEASURES

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

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

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	17.9	17.9	17.9	17.9	17.9
Annual Indicator	19.5	17.2	14.1	9.3	10.8
Numerator	54495	50260	41231	29610	36135
Denominator	280108	291862	291862	319289	333400
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	11	11	11	11	11

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 10.8 percent of the women age 25-44 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 2004, falling short of the target of 17.9.

Arizona Department of Health Services began a partnership with Maricopa County Department of Public Health to bring the National Friendly Access Program philosphy to areas of the county where infant mortality rates are highest. A prenatal baseline assessment survey was developed in English and Spanish, and a contract was initiated between Maricopa County Deptartment of Public Health and ASU to administer and evaluate the survey.

Office of Chronic Disease Prevention and Nutrition Services developed and implemented a statewide Folic Acid Education and Vitamin Distribution program for low-income women. Over 28,000 low-income women of child bearing age were served.

Eleven of the 15 county health departments received intergovernmental agreements to provide reproductive health/family planning service. Ninety-nine percent of the 5,955 women who received initial/annual visits were at or below 150% of the Federal Poverty Level and received services free of charge. By race and ethnicity, women served were 55% White, 43% Hispanic, 1% Native American, 0.5% African American, and 0.5% Asian. Of the 12,977 women screened for either pregnancy, cervical or breast cancer, or HIV/STD testing, 10,017 referrals were made to receive follow-up medical care, nutritional services (WIC), domestic violence, behavioral health, prenatal care, or other community services.

All Reproductive Health/Family Planning Program contractors received one site monitoring visit with no contractual issues identified. The program provided technical assistance regarding policy changes, best practices, and funding to all contractors. The program worked collaboratively with Title X, Arizona Family Planning Council, sharing information and data for trending purposes and outcome studies. The program manager participated in the Arizona Family Planning Coalition.

The Reproductive Health/Family Planning Program supports community education and co-sponsored the annual Arizona Family Planning Conference. The Reproductive Health/Family Planning Program distributed a Spanish Language resource, "la planificacion familiar" to all contractors and at family planning related conferences, and advised all contractors of continuing educational opportunities.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop and administer a baseline assessment survey				X
2. Develop a community action plan				X
3. A Statewide Folic Acid Education and Vitamin Distribution Program			X	
4. Maintain or increase number of women receiving initial or annual exam	X			
5. Increase African American access to services	X			
6. Enhance services to teens	X			
7.				
8.				
9.				
10.				

b. Current Activities

Friendly Access will hire and train interviewers for a survey administered to 540 new moms in four area hospitals and evaluated by ASU, and a community action plan will be developed.

Nine of the 11 Title V Reproductive Health/Family Planning Program contractors will receive an increase in the unit reimbursement to meet the increasing medical costs of providing the required services of the program. The program will monitor the outcome of this increase on covered costs and numbers of individuals served, and all contractors will have at least one site monitoring visit. Some projects will focus on increasing African American and teen access to services. The Reproductive Health/Family Planning Program will continue to work collaboratively with other agencies, organizations, and coalitions regarding the provision of reproductive health and family planning education, counseling, clinical care services, and referral services. It is also planning to co-sponsor the Annual Arizona Family Planning Coalition Conference and will continue to provide technical support and resources for infrastructure building, continued education, and funding. The contractors will continue to build collaborative relationships and partners with the other contractors by attending an annual contractors meeting.

c. Plan for the Coming Year

The MCH nutrition consultant will continue activities to increase folate awareness as part of preconception care.

The Reproductive Health/Family Planning Program will continue to contract with the county health departments serving the underserved populations, and providing services in many of the rural areas of the state. Services are targeted to the uninsured and underinsured, focusing on women at or below 150% of the federal poverty level. The program will evaluate the outcome of focusing on African American and teen access to services, as well as the outcome of increasing the unit rate of nine of the 11contractors and how it affected the numbers served. There will be an annual contractors' meeting for collaboration and partnership building, and the program will work collaboratively with Title X. The program manager will continue to participate on the Arizona Family Planning Coalition, and will continue to provide technical support as needed by each contractor.

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

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

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	695	690	685	680	675
Annual Indicator	710.3	659.8	659.8	627.4	627.4
Numerator	2612	2508		2529	
Denominator	367722	380103		403088	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective	625	625	625	625	625

Notes - 2004

Problems with tabulating hospital discharge data prevented reporting on this measure for 2002. Data for 2004 are not yet available. The estimate for 2004 is provisionally set at the 2003 rate until data become available in the Fall of 2005.

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. In 2003, 60% of all child and adolescent deaths among Arizonans ages 1-19 were due to injury.

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. In 2001, 29 adolescents died per day due to injuries nationally.

In 2003, there were 627.4 hospitalizations for nonfatal injury and poisoning per 100,000 adolescents age 15-19, below the target of 680.

The Office of Women's and Children's Health addresses nonfatal injuries to 15-19 year olds in primarily two ways: the Rape Prevention and Education Program and the Injury Prevention Program. Programs primarily focused on sexual assault, motor vehicle crashes, and suicide attempts.

The Injury Prevention Program requested and received a technical assistant review from the State and Territorial Injury Prevention Directors Association. The review of the program covered infrastructure, data collection, analysis and dissemination, interventions, technical assistance and training, and public policy, and made recommendations to improve the program in each area.

The Rape Prevention and Education program launched Arizona's first rape prevention and education media campaign and won a Health Education Media Makers Award for its public service announcement about date rape prevention. Services were provided from November 1, 2003 through October 31, 2004 to a total of 39,260 youth, community, and professionals. Another milestone included a contractor who successfully presented "Healthy and Unhealthy Relationships" to students who were either mildly mentally retarded or severely emotionally disabled. The program identified Yuma County as an underserved portion of the state. One of the Rape Prevention and Education contractors was selected to present at the National Centers for Disease Control Sexual Violence conference.

In addition, Title V funds were used to support a community project in Pima County addressing adolescent depression and suicide prevention. Pima County provided education on a depression-screening tool for teens to several community mental health agencies/organizations as well as to the ADHS suicide prevention coordinator and several employees of AHCCCS.

Another Title V funded community-based project provided safe motor vehicle education to 218 high school students in at least five high schools.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop a plan to implement recommendations from STIPDA review of Injury Prevention Program				X
2. Revise the state injury surveillance and prevention plan for 2006-2010				X
3. Increase public awareness on prevention and occurrence of sexual violence			X	
4. Continue to fund contractors who present Rape Prevention and Education sessions/workshops			X	
5. A statewide rape prevention and education media campaign reached 900,000 Arizona households			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A plan has been developed to implement the recommendations of the technical assessment review from the State and Territorial Injury Prevention Directors Association. The 2002-2005 Injury Prevention Surveillance and Prevention Plan is being revised and updated to address 2006-2010. Chapters include suicide, motor vehicle crashes, firearm-related injuries, falls, homicide, and violence against women.

The Rape Prevention and Education Program will continue to support the development of rape prevention and education efforts throughout Arizona, including sustaining or expanding successful programs and stimulating the development of new efforts in un-served areas of the state. The program will continue its date rape prevention media campaign. It will also continue to support communication, coordination, and collaboration among contractors and with other organizations involved in rape prevention and sexual assault services. Additionally, it will incorporate any appropriate recommendations from the Governor's Commission to Prevent Violence Against Women into the grant plan for the Rape Prevention & Education Program.

c. Plan for the Coming Year

The Rape Prevention and Education Program will continue communication, coordination, and collaboration among contractors and with other organizations involved in rape prevention and sexual assault services. It will support the development of rape prevention and education efforts throughout Arizona, including sustaining or expanding successful programs and stimulating the development of new efforts in unserved areas of the state. Partnership and collaboration with those involved in the Rape Prevention and Education arena will be continued.

Injury Prevention Program will distribute and begin implementation of the revised 2006-2010 Injury Surveillance and Prevention Plan. The program will work with partners through the Injury Prevention Advisory Council to identify strategies to address the most common causes of injuries among 15-19 year olds.

State Performance Measure 6: *Preventable child deaths per 100,000 children under age 18.*

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

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	19.5	18.5	17.5	17.5	17.5
Annual Indicator	18.1	17.5	15.0	16.5	16.5
Numerator	247	247	277	248	
Denominator	1366947	1413518	1849413	1499040	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	16	16	16	16	16

Notes - 2004

Beginning with the rate presented for 2003, the preventable death rate is adjusted to factor in an estimate of the number of deaths likely to have been preventable among the cases that were not reviewed. There were a total of 995 resident deaths under age 18 in the state of Arizona during 2003. The Child Fatality Review Team reviewed 904 (or 91%) of the deaths, and found 24.9% of the cases reviewed to have been preventable. There were 91 deaths that the team did not review. Assuming that 24.9% of those cases had been preventable, there would be 23 more preventable deaths (91 x .249 = 22.6; rounded to the nearest whole number=23). These cases are added to the numerator (225 reviewed cases found to be preventable + 23 cases among non-reviewed cases assumed to be preventable = 248). Data for 2004 are not yet available. The rate for 2003 is provisionally submitted as the estimate for 2004.

a. Last Year's Accomplishments

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 2003 16.5 per 100,000 child deaths of children under 18 were determined to have been preventable. This is below the target rate for 2003 set at 17.5. (Because data are not yet available for 2004, the 2003 rate is also provisionally listed as the rate for 2004.) Overall, Arizona death rates for the leading causes of preventable child deaths have declined between 1995 and 2003. Beginning with the rate for 2003, the preventable death rate is adjusted to factor in an estimate of the number of deaths likely to have been preventable among the cases that were not reviewed. There were 995 deaths under age 18 in the state of Arizona during 2003. The Child Fatality Review Team reviewed 904 (or 91%) of the deaths, and found 24.9% of the cases to have been preventable.

In August 2004, the Arizona Child Fatality Review Program established a database link with Arizona's vital records that enabled the Arizona Child Fatality Review Team to compare the deaths reviewed by the local teams with the state's vital statistics, allowing a more complete set

of data. The Arizona Child Fatality Review Prevention Subcommittee was created to identify and promote prevention activities in order to reduce child deaths. Local review teams participated in several initiatives to reduce childhood injuries and deaths in the areas of SIDS education, bicycle helmet safety, and shaken baby education. The program published its 11th annual report, which identified motor vehicle accidents and drowning as two of the major preventable causes of childhood mortality.

Arizona Safe Kids provided technical support to the local Safe Kids coalitions. Over 20 child safety seat inspection and education events were held in 2004. Maricopa Safe Kids Coalition partnered with a local automobile dealer to provide the first permanent child safety seat inspection station in Arizona. The program also provided educational materials to the public related to drowning prevention, pedestrian safety, bicycle helmet use, and fire safety.

Twelve community-based car seat safety projects were funded with Title V funds, and 7,040 child car seat safety seats were installed with accompanying education. Over 97 child car seat safety events were conducted; 46 new child passenger safety technicians were certified; 153 bicycle helmets were distributed; and 258 parents/caregivers were educated on home safety.

Various programs within the Community Services Section provided case management services to high-risk pregnant women and their children for the purpose of improved birth outcomes and child health status. The HRPP/NICP program ensured the provision of risk-appropriate transport services and hospital/physician care for high-risk infants.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct reviews of fatalities of children birth through 17 years, due to all causes, in Arizona.				X
2. Produce an annual report of findings and recommendations to reduce child deaths.				X
3. Produce data reports for child fatality research.				X
4. Provide staffing support to the Unexplained Infant Death Advisory Council.				X
5. Complete pediatric ALS education program and deliver to prehospital providers/critical access hospitals.				X
6. Validate child restraint system screening tool and implement use in healthcare settings.				X
7. Increase geographic scope of Safe Kids coalitions/chapters in Arizona.			X	
8. Facilitate child restraint system inspections.			X	
9. Provide case management for critically ill neonates.	X			
10. Prevent injury and death through community-based child car seat safety programs.		X		

b. Current Activities

Child Fatality Review conducts reviews of fatalities for Arizona children aged birth through 17 years due to all causes. It produces an annual report of review findings and recommendations for the reduction of preventable deaths, and provides data reports for research and presentations on preventing child deaths in Arizona. The program participates in initiatives locally, statewide, and nationally to reduce preventable deaths of children. Staffing support is

provided to the Unexplained Infant Death Advisory Council, charged with informing the Governor and legislature of public needs related to unexplained infant deaths. Local child fatality teams are assisted in the development and implementation of local culturally sensitive teams. The program promotes professional awareness and knowledge of child fatalities, their causes, prevention factors, and the importance of thorough case investigation.

Arizona Safe Kids Coalition supports efforts of local coalitions to provide ongoing child safety seat inspections through special events, regular permanent stations, and individual sessions; increasing partnerships with automobile vendors for child passenger safety seat permanent inspection stations; increasing geographic scope of community coverage with Safe Kids coalitions in Arizona in 2005; and providing public education on safe child passenger practices. The program also provides oversight and technical assistance for local community efforts in drowning prevention, pedestrian safety, bicycle (and other wheeled sports) helmet use, and fire safety.

The EMSC program is funding the evaluation of screening tools to identify children at high risk of unsafe child restraint in motor vehicles as well as the development of training curriculum for pediatric advanced life support for prehospital providers and critical access hospitals. It supports basic life support pediatric education for prehospital providers and critical access hospitals with need.

The Title V funded car seat safety contractors will continue with their current programs through 2005, but will adjust their objectives as needed to meet their selected outcome.

Various programs within the 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. The High Risk Perinatal Program/NICP program ensures the provision of risk-appropriate transport services and hospital/physician care for high-risk infants. The High Risk Perinatal Program staff has begun to implement recommendations of the advisory committee relating to developmental follow-up services and transport. The Health Start Program provides parents with education on car seat safety and user training has been offered to all participants. Community health nurses and Health Start lay health workers monitor car seat usage at each home visit and conduct home safety checks.

c. Plan for the Coming Year

Child Fatality Review will increase percentage of child fatalities reviewed by local teams, through improvements in timely identification of child deaths occuring in Arizona and on-site training of local teams. The program will continue to produce an annual report on statistical trends and recommendations for preventing child fatalities. Data reports for research and presentations on prevention of childhood deaths will continue to be provided. The program will continue to provide technical assistance to the local child fatality teams in the development and implementation of local culturally sensitive teams.

Arizona Safe Kids Coalition will target communities with lower compliance in child restraint system use for increased education, enforcement, and surveillance. Local community coalition goals will focus on parental seat belt use, child booster seat use to eight years of age, child restraint systems for children with special needs, and child restraint system use in non-parental vehicles and open-bed trucks. OWCH will disseminate a screening tool selected for use by healthcare providers to identify children at risk for unsafe child restraint in motor vehicles.

The Community Health Services Program has contracts for Title V funded car seat safety projects that are renewable for three more years. Contractors will continue their programs, delivering services while building stronger partnerships and collaborating with other entities in

their communities to provide more services.

The Community Services Section will continue to provide case management services to high-risk pregnant women and their children and will ensure the provision of risk-appropriate transport services and hospital/physician care for high-risk infants. 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 work with an advisory committee to address recommendations regarding the design of the High Risk Perinatal Program.

The Health Start program is working to increase the number of lay health workers who are certified car seat/seat belt instructors, the goal being that each Health Start contractor have at least one certified instructor available. Community health nurses and Health Start lay health workers will continue to conduct home safety checks and monitor car seat usage at each home visit.

State Performance Measure 7: *The rate of children 1 through 14 hospitalized for ambulatory care sensitive conditions per 100,000.*

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

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	545	535	525	515	515
Annual Indicator	528.4	489.7	489.7	568.7	568.7
Numerator	5670	5434		6693	
Denominator	1073045	1109672		1176805	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	565	565	565	565	565

Notes - 2004

Problems with tabulating hospital discharge data prevented reporting on this measure for 2002. Data for 2004 are not yet available. The estimate for 2004 is provisionally set at the 2003 rate until data become available in the Fall of 2005.

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. In 2003 there were 568.7 hospitalizations per 100,000 children age 1-14, a rate that was well above the

target of 515 hospitalizations per 100,000 children.

More than 700 AHCCCS and KidsCare enrolled six year olds have been hospitalized for extractions each year in federal fiscal years 2003 and 2004. The Arizona Department of Health Services now has emergency room data available, and an inquiry into the number of emergency room dental visits in Arizona for the last six months of 2003 shows that for children ages one through 14, 592 children presented to the emergency room with a non-traumatic dental problem as the primary diagnosis and 324 children with non-traumatic dental problems as the secondary diagnosis. The office collaborated with other agencies to promote water fluoridation monitoring and reporting standards, and continued reporting to the CDC Water Fluoridation Reporting System. Preventive oral health services were provided to preschool children on the San Carlos Reservation. Fluoride varnish was provided to preschool children. Four hundred eighty children received fluoride varnish.

The Office of Chronic Disease Prevention and Nutrition Services participates on the WIC medical advisory committee and will continue to train WIC staff to identify children in need of services to appropriate community resources. WIC staff screens and provides nutritional counseling and refers for low Hb.

Health professionals received 35 School Nurse Asthma Resource Guides. This contractor created the Asthma Guide and has it available for physicians, school nurses, and other health care professionals as they request. The object was to educate the health care professionals and lay workers that deal with children to recognize symptoms of an imminent asthma attack prior to a full-blown attack and take prophylactic measures to prevent hospitalization and trips to the Emergency Department for treatment.

The High Risk Perinatal Program and Health Start providers educated families on the importance of establishing and maintaining medical homes and assisted families in overcoming barriers to health care.

The Early Childhood program provided training for nine health professionals utilizing the National Training Institute for Child Care Health Consultants as a guide. It updated the Safety Information flipchart for childcare providers and participated on the Arizona School Readiness Board, which has recommended a statewide implementation of an early childcare health consultation system.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Track AHCCCS dental utilization.				X
2. Monitor water for fluoride level			X	
3. Link families with medical home provider		X		
4. WIC staff to screens and identifies children in need of services to appropriate community resources		X		
5. Prevent hospitalizations and/or emergency department visits due to asthma attacks in children through education and linking families with a medical home.		X		
6. Educate families on the importance of establishing and maintaining a medical home		X		
7. Assist families in overcoming barriers to health care		X		

8. Provide Health Care consultation Services to Child Care in Pima County		X		
9. Provide Health Care Consultation Training to Health Professionals				X
10. Update the communicable Disease flipchart utilized by childcare providers in the state		X		

b. Current Activities

The Office of Oral Health focuses on prevention, early intervention, referral, and sealants in eight and 12 year olds. It promotes water fluoridation, and reports to the CDC Water Fluoridation Reporting System.

Office of Women's and Children's Health staff members educate community providers about various services, eligibility, and coverage. They assist eligible children and their families in applying for AHCCCS. Information is provided to the public on AHCCCS and Baby Arizona through the Pregnancy and Breastfeeding Hotline, health fairs, and the Medical Home Project.

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. Community nurses provide home visiting evaluations to identify problems early and link families with medical providers.

The Health Start program links new parents with a primary care provider and ensures that infants receive all immunizations and scheduled well baby visits.

Early Childhood responds to requests from childcare programs for resources to improve health and safety in childcare, primarily in Pima County. The program collaborates with county partners in the development of resources for childcare programs, promotes best practices related to health and safety of childcare centers
including updating the Communicable disease flipchart used by childcare providers, and providing training for health professionals utilizing the National Training Institute for Child Care Health Consultants as a guide.

The Medical Home project links uninsured school children with primary care providers who are willing to see them for conditions that otherwise would be untreated.

c. Plan for the Coming Year

The Office of Oral Health will continue to track emergency room data to look for trends and opportunities to plan interventions that will improve oral health. It will collaborate with other agencies and organizations to promote water fluoridation monitoring and reporting standards. The program will continue reporting to the CDC Water Fluoridation Reporting System. The Office of Chronic Disease Prevention and Nutrition Services will continue to train WIC staff to identify children in need of services to appropriate community resources. The office participates on the WIC medical advisory committee. WIC will tests new technology in screening for low Hb and provides phlebotomy training for staff.

The High Risk Perinatal Program and Health Start providers will continue to educate families on the importance of stablishing and maintaining a medical home and will assist families in overcoming barriers to health care.

Early Childhood will strengthen the health care consultation system in Arizona.

State Performance Measure 9: *Percent of children age 3 through 20 who had their teeth cleaned by a dentist or dental hygienist within the last year.*

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

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		58.7	60	62	64
Annual Indicator		58.7	58.7	58.7	72.5
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	73	73	73	73	73

Notes - 2004

Previously, this measure was based on Arizona survey data from 2001 for children age 3 through 20. This estimate is based on National Survey of Childrens Health data, which includes data on children under age 18. Respondents were asked whether children received routine preventive dental services in the last 12 months. Respondents were not asked the question about children who had no natural teeth, or who were younger than age one. To remain as consistent as possible with the previous measure, children younger than age three were excluded from analysis.

a. Last Year's Accomplishments

In 2003, 72.5% of children age 3 through 17 had their teeth cleaned by a dentist or dental hygienist within the past year. This estimate is based on the National Survey of Children's Health data, which includes children under the age of 18. Children who have no natural teeth or are younger than three were excluded from this measure. The question was whether child received routine preventive dental services in the last 12 months. Previously, this measure was based on a statewide survey from 2001 for children age 3 through 20, which has not been replicated.

Mohave Community College accepted 18 students in its new Dental Hygiene Program. As part of the educational process, students will provide preventive therapies to this rural community. In addition, 14 of the students are residents of rural Arizona and more likely to stay in the community and provide the appropriate workforce to ensure residents get annual dental cleanings. AHCCCS data shows that of the 171,457 AHCCCS and KidsCare enrollees age birth to 20 years old who received dental care in federal fiscal year 2002, 139,060 (81%) received at least one preventive service. This number will serve as a baseline to see if any of the Robert Wood Johnson initiatives helped to increase access to preventive and other dental services in 2006. Office of Oral Health is managing the School-Based Health Center Grant, funded by the Office of Women's and Children's Health. Through this grant and for 2004, 437 children were referred by the nurse practitioners at 22 participating sites, 249 were scheduled for appointments at St. Vincent de Paul Dental Clinic, 187 were referred to other clinics and

dentists, 232 completed treatment in 2004, and 200 children had their teeth cleaned.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop new oral health training module for WIC nutrition counselors		X		
2. Develop educational piece for affiliated practice.		X		
3. Answer oral health provider questions generated by the media campaign		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Office of Oral Health (OOH) promotes the benefits of early intervention and prevention. It will develop the Affiliated Practice Educational Seminar and promote proper utililization of this new law.

The Children's Information Center distributes appropriate oral health educational materials in informational packets, refers callers to appropriate agencies, and responds to Spanish-speaking callers for OOH referrals.

c. Plan for the Coming Year

The Office of Oral Health will continue to promote an integrated approach to oral health prevention by working with medical professionals on early recognition, prevention, and referral for dental needs. It will continue to promote affiliated practice agreements. The office will utilize the Children's Information Center Hotline phone number in its media campaign to improve oral health in Arizona.

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

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

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		7.5	7.5	7.5	7.5

Annual Indicator	7.5	10.3	10.3	9.9	9.9
Numerator	103	145		149	
Denominator	1366947	1413518		1499040	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	9	9	9	9	9

Notes - 2004

Problems with tabulating hospital discharge data prevented reporting on this measure for 2002. Data for 2004 not yet available. The estimate for 2004 is provisionally set at the 2003 rate until data becomes available in the Fall of 2005.

a. Last Year's Accomplishments

There were 149 inpatient hospitalizations for child abuse during 2003, representing a rate of 9.9 per 100,000 children under the age of 18, above the rate of 7.5, which was the objective for 2003. (Because data are not yet available for 2004, the 2003 rate is also provisionally listed as the rate for 2004.)

In 2004, 25 dental hygiene students were educated on the oral manifestations of child abuse. An additional 250 people (most of which were likely non-health care professionals) were educated as part of the Children's Justice Project with the Maricopa County Attorney's Office.

In 2004 Child Fatality Review Teams identified 37 child maltreatment deaths from 2003. Reviews identied infancy as the greatest period of risk for death due to child maltreatment. Reviews completed found that 57% of children whose death was attributed to maltreatment were under the age of one year. The Child Fatality Review Program reported the 37 maltreatment deaths to the Child Abuse Hotline. The intent behind making the reports was to prevent maltreatment, through either initiating an investigation into the welfare of children currently in the household or providing background information in the event of a future referral to the Child Abuse Hotline. In 2004 the Citizen Review Panel completed 24 reviews of Child Protective Service cases involving child fatalities and near fatalities and other high-risk cases of maltreatment. The Citizen Review Panel published its 6th Annual Report of findings from the reviews and recommendations to improve the child protective services system. Staff members participated in statewide efforts to reduce child abuse, such as the Children's Justice Task Force and Never Shake a Baby Arizona.

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.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Child Abuse Oral manifestations Education			**X**	
2. Identify child deaths resulting from child maltreatment, therough Child Fatality Reviews.				**X**

3. Citizen Review Panels will conduct reviews of Child Protective Service's activities.				**X**
4. Prepare annual Citizen Review Panel Report.				**X**
5. Lay health Workers monitor for potential violence in the home		**X**		
6. Referrals made to appropriate community resources when warning signs are present.		**X**		
7.				
8.				
9.				
10.				

b. Current Activities

The Office of Oral Health will promote education on the oral manifestations of child abuse.

Child Fatality Review Teams identify child fatalities resulting from child maltreatment and report maltreatment deaths to Arizona's Child Abuse Hotline. Through reviews, recommendations are developed to reduce child maltreatment deaths. The Citizen Review Panel examines Child Protective Service's cases, policies, and procedures and prepares an anuual report of review findings and recommendations to improve the state's child protection system.

Lay health workers serving families through the Health Start Program monitor for potential violence in the home. Referrals are made to appropriate community resources when warning signs are present.

c. Plan for the Coming Year

Child Fatality Review Teams will continue to identify child fatalities resulting from child maltreatment, and will report maltreatment deaths to Arizona's Child Abuse Hotline. Through reviews, recommendations will be developed in the 2006 Child Fatality Review Annual Report to reduce child maltreatment deaths. The Citizen Review Panel will continue to examine Child Protective Service's cases, policies, and procedures and prepare an anuual report of review findings and recommendations to improve the state's child protection system.

Lay health workers serving families through the Health Start Program will continue to monitor for potential violence in the home. Referrals will be made to appropriate community resources when warning signs are present.

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

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

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	21.2	21	21	20	20
Annual Indicator	21.2	24.3	24.3	17.5	17.5

Numerator	404	479		365	
Denominator	1903939	1969619		2089402	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	17	17	17	17	17

Notes - 2004

Problems with tabulating hospital discharge data prevented reporting on this measure for 2002. Data for 2004 not yet available. The estimate for 2004 is provisionally set at the 2003 rate until data becomes available in the Fall of 2005.

a. Last Year's Accomplishments

There were 365 inpatient hospitalizations attributed to violence against women during the year 2003, representing a rate of 17.5 per 100,000 women age 18 and over, falling below the objective set for this year of 20. (Because data are not yet available for 2004, the 2003 rate is also provisionally listed as the rate for 2004.)

The Rape Prevention and Education program launched Arizona's first rape prevention and education media campaign and won a Health Education Media Makers Award for its public service announcement about date rape prevention. Services were provided from November 1, 2003 through October 31, 2004 to a total of 39,260 youth, community, and professionals. Another milestone included a contractor who successfully presented "Healthy and Unhealthy Relationships" to students who were either mildly mentally retarded or severely emotionally disabled. The program identified Yuma County as an underserved portion of the state. One of the Rape Prevention and Education contractors was selected to present at the National Centers for Disease Control Sexual Violence conference.

The Rural Safe Home Network Program (Domestic Violence) continued contracts with six providers in FY 03-04 for emergency temporary safe shelter. It continued contracts for the Arizona Coalition Against Domestic Violence and the Never Again Foundation and awarded a contract to the Verde Valley Sanctuary, Inc. to provide crisis intervention, prevention, and outreach to children who have experienced and/or witnessed domestic violence. The program implemented and assessed the strategic plans for each safe home program and their safe home networks. Contractors continued to document their safe home networks and expand membership as appropriate. Rural Safe Home Network program contractors have developed a peer review tool and process for review of each contractor within the program. Standards for providers have been developed with input from all members of the Rural Safe Home Network Program.

Between October 1, 2003 and September 20, 2004, 408 women and 489 children received shelter services. The average length of stay was 9.09 days. Only 56 individuals were turned away due to lack of shelter space. Adults were provided 1,063 individual counseling units and 1,324 group counseling units. Rural Safe Home Network providers answered 1,685 crisis line calls, providing 1,460.05 hours of domestic violence related training and technical assistance to 11,257 persons.

The Injury Prevention Program requested and received a technical assistant review from the State and Territorial Injury Prevention Directors Association. The review of the program covered infrastructure; data collection, analysis and dissemination; interventions; technical assistance and training; and public policy. A recommendation was made to coordinate violence

prevention efforts among the state and local governments and community-based organizations.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increase the public awareness on prevention and occurrence of sexual violence			X	
2. Continue to fund contractors who present rape prevention and education workshops			X	
3. A statewide Rape Prevention and Education media campaign reached 900,000 Arizona households			X	
4. Temporary, emergency safe shelter for domestic violence victims		X		
5. Counseling, case management, and information and referral		X	X	
6. Training and technical assistance to communities and individuals as requested				X
7. Develop a plan to implement recommendations from the STIPDA review of the ADHS injury prevention program				X
8. Revise the state injury surveillance and prevention plan to include sexual assault in chapter on violence against women				X
9. Identify how OWCH will conduct violence surveillance as part of an injury surveillance system				X
10.				

b. Current Activities

The Rape Prevention and Education Program will continue to support the development of rape prevention and education efforts throughout Arizona, including sustaining or expanding successful programs and stimulating the development of new efforts in un-served areas of the state. The program will continue its date rape prevention media campaign. It will also continue to support communication, coordination, and collaboration among contractors and with other organizations involved in rape prevention and sexual assault services. Additionally, it will incorporate any appropriate recommendations from the Governor's Commission to Prevent Violence Against Women into the grant plan for the Rape Prevention & Education Program.

Rural Safe Home Network Program contractors have implemented the use of the Arizona Logic Model design to enhance their ability to develop and track measurable outcomes. All Rural Safe Home Network contractors have written process and outcome objectives for FY04-05. Providers will continue to provide services to domestic violence victims as needed/requested, and will provide training and technical assistance to agencies and individuals in their respective communities as requested.

A plan has been developed to implement the recommendations of the injury prevention technical assessment review from the State and Territorial Injury Prevention Directors Association. The 2002-2005 Injury Prevention Surveillance and Prevention Plan is being updated for 2006-2010. A chapter on violence against women will be revised to include sexual assault in addition to domestic violence. A plan is being developed to outline show OWCH will conduct surveillance of violence as part of an injury surveillance system. ADHS has implemented the new CDC modules for the Behavior Risk Factor Surveillance System on intimate partner violence and sexual violence.

OWCH staff continue to work with the Governor's Office and other state agencies to coordinate services and prevention activities related to domestic violence and sexual assault. OWCH participates on the State Agency Coordination Team (SACT) with the other agencies that administer violence against women programs. The SACT conducted a survey of a variety of community providers to assess gaps in service for victims as well as the level of activity around prevention. Results are being analyzed and will be presented to the Governor's Commission to Prevent Violence Against Women.

c. Plan for the Coming Year

The Rape Prevention and Education Program will continue communication, coordination, and collaboration among contractors and with other organizations involved in rape prevention and sexual assault services. It will support the development of rape prevention and education efforts throughout Arizona, including sustaining or expanding successful programs and stimulating the development of new efforts in unserved areas of the state. Partnership and collaboration with those involved in the Rape Prevention and Education arena will be continued.

Arizona Department of Health Services will release a new RFP in 2006 for Rural Safe Home Network (domestic violence) services. The objectives of the new RFP will be: provide temporary, emergency safe shelter and adjunct services to victims of domestic violence; establish and continue collaborative efforts in rural communities that can result in improvements to specific women's and children's health outcomes regarding family and domestic violence; work with and maintain existing Rural Safe Home Networks (RSHN) in rural communities to ensure continued funding; establish Rural Safe Home Network programs for persons experiencing domestic violence in rural communities with clearly identified needs; and use a set of standards and guidelines as developed by the Rural Safe Home Network and Arizona Coalition Against Domestic Violence for rural safe home/shelters that will ensure the use of "best practices" in service delivery for domestic violence victims.

The injury prevention program will distribute and begin implementation of the revised 2006-2010 Injury Surveillance and Prevention Plan. The data from the new CDC modules from the Behavior Risk Factor Survey on intimate partner violence and sexual violence will be analyzed and evaluated. The Office of Women's and Children's Health will implement the plan developed in 2005 to conduct violence surveillance and report out the findings.

Members of the Office of Women's and Children's Health will continue to participate on the State Agency Coordination Team to enhance coordination with other state agencies that administer domestic violence and sexual assault programs. The office will work with partners to identify ways to address recommendations from the Governor's State Plan to Prevent Domestic Violence and Sexual Assault.

E. OTHER PROGRAM ACTIVITIES

Data Linkage/Sharing. The Arizona Department of Health Services continues to expand efforts to link data sources to provide complete, accurate and time sensitive information to department staff. A data warehouse has been developed utilizing SSDI funding that includes vital records, newborn screening, and Children's Rehabilitative Services. OWCH received a CDC grant to fund data linkage efforts related to early identification of hearing loss. Data warehouse progress included development of a data dictionary, data elements and data identifiers for data linking, data scrubbing rules, and development of standard reports. Reports will identify infants who have not passed a newborn hearing screen and allow a closer look at demographic data to evaluate trends and look for patterns. The Newborn Screening Program provided assistance to the Arizona School for the Deaf and the Blind to

improve the quality and integrity of data both for their use and for submission to the data 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 has assumed responsibility for the WIC Hotline and WIC provides training and technical assistance for the Hotline staff. A decision was made to reinstitute Baby Arizona, which is a presumptive eligibility process which guarantees physicians who see pregnant women that their first prenatal care visit will be covered by AHCCCS, even before the woman is determined to be eligible for AHCCCS services. Hotline staff will assist in referring women to Baby Arizona.

State Early Childhood Comprehensive Systems Grant (SECCS). The Office of Women's and Children's Health worked in partnership with the Governor's Office to submit the application for the SECCS to work with stakeholders to develop strategies to better integrate early childhood services and to develop a statewide Early Childhood Systems Plan. ADHS was awarded $100,000 per year for two years beginning July 1, 2003. Funds were used to provide support to the Governor's School Readiness Board. Many people from ADHS, including OWCH staff, participated on subcommittees of the School Readiness Board. Staff will provide support to SECCS planning process as needed. The Board provided its recommendations to the Governor in the fall of 2003, and an implementation plan was released in 2005.

One of the recommendations of the Governor's School Readiness Action Plan recommends developing a health and safety consultation system for childcare providers. The Office of Women's and Children's Health, in conjunction with the Arizona Center for Community Pediatrics, sponsored a telephone survey to evaluate health and safety issues that childcare providers deal with on a regular basis. This survey, which was conducted in 2004, assessed the need for technical support and training in licensed childcare for children five years old and younger. Results of the survey are summarized in the five-year needs assessment document (in the section on Children and Adolescents) accompanying this application.

The OWCH Assessment and Evaluation Section is working with individual program managers in developing evaluation plans for programs. Working sessions to date have focused on articulating measurable goals and defining appropriate performance measures for evaluation. The Assessment and Evaluation Section is also working to assess the information needs of program managers so that databases can be streamlined and to ensure that they are responsive to program management needs.

Cultural competence:

OWCH programs take measures to ensure that services are linguistically and culturally appropriate, and family centered. The following are just a few examples: Community grants were set up specifically to address cultural competence by putting program design into the hands of the community to ensure that they will reflect the unique circumstances and cultural characteristics of each community. The Health Start Program identifies women early in their pregnancies, facilitates their entry into prenatal care, and supports families throughout the pregnancy and the postpartum period. The program identifies natural community leaders and recruits them as lay health workers who live in and reflect the ethnic and cultural characteristics of their communities. The Child Fatality Review Program coordinates the activities of 13 local teams comprised of volunteers with roots in their communities. Team compositions reflect the diversity of the populations they serve. Each year

OWCH sponsors the statewide Family Centered Practice Conference which supports family involvement and improves families' ability to access and utilize community services. OWCH is currently working with the Governor's Minority Advisory Council to develop specific strategies to address disparities, including health issues. Meetings focus attention on issues affecting each minority group to examine relationships between the group's social and cultural characteristics and their health status. Health disparity information is shared with community leaders who provide context to statistics, and who can mobilize support.

F. TECHNICAL ASSISTANCE

Only one request is being made for technical assistance, and it is related to data systems development. The Governor's School Readiness Health Implementation Committee has identified the need to make immunization information, EPSDT information and newborn screening information accessible to primary care providers. The Office of Women's and Children's Health requests assistance in the development of a central data system which combines these data and provides easy access to primary care providers.

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 $13,262,434 in FY2006, surpassing our state's maintenance of effort level in FY89 of $12,056,360.

The estimated Title V allocation for Arizona, FY2006, is $7,769,858. Slightly more than thirty-two percent ($2,512,683) of the block grant will be allocated for preventative and primary care needs for children and adolescents; thirty percent ($2,330,957) will be allocated to children with special health care needs; slightly less than twenty-eight percent ($2,149,233) will be allocated for women, mothers and infants and ten percent ($776,985) will be budgeted for administrative costs.

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

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

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

Other federal funds in the amount of $57,926,638 represent matching funds from Title XIX and Title

XXI for Children's Rehabilitative Services. Additional federal monies will contribute another $86,348,660 toward MCH initiatives which include the WIC food grant, $76,938,417; Universal Newborn Hearing, $149,970; Rape Prevention and Education, $753,331; Family Violence Prevention, $1,685,611; SSDI Primary Care, $100,000; Abstinence Education, $1,034,776; Kids Care, $3,319,509; Arizona Early Intervention, $500,000; Child Fatality Review, $148,000; Early Childhood Comprehensive Systems, $100,000 and $1,619,046 for the Preventive Health and Health Services Block Grant.

Core Public Health Infrastructure: $4,112,928

Office of Women's and Children's Health (Part A & B): $12,392 will support the Department's Office of Birth Defects; $362,796 will support management service; $70,165 will support information technology automation; $160,577 for the Deputy Assistant Director's Office for special projects; $506,684 for assessment, evaluation and epidemiologic analysis; $63,896 for Nutrition support; $100,000 for women's health initiatives; $667,601 for planning, education & partnership initiatives that include Community Grants, Child Health Primary Care, Healthy Mothers/ Health Babies contract with Banner Health Foundation of Arizona, and the Early Childhood Program; and $37,860 for Midwife Licensing.

Office of Children with Special Health Care Needs (Part C): $860,226 will support administrative initiatives; $878,502 for Community Development; and $347,343 for Quality Assurance and Utilization Review for the Children's Rehabilitation Services program; $28,998 for epidemiological support; and $15,888 for Child Fatality support.

Population-Based Services: $724,252

$310,640 is budgeted for planning, education and partnership initiatives that include the Sensory Program and Community grants; $363,612 for Community development/services that include the Pregnancy and Breastfeeding Hotline Program and the High Risk Perinatal Services; and $50,000 for Immunizations.

Enabling and Non-Health Support: $403,391

$403,391 will support planning, education and partnership initiatives that include the Child Health Program's contract with Arizona Academy of Pediatrics and Community grants.

Direct Health Care Service: $1,752,302

$200,000 will support community nursing services for high-risk infants; $523,772 for oral health services for children; and $1,028,530 for planning, education and partnership initiatives that include Reproductive Health Program's contracts and Community grants.

Indirect Administrative Costs: $776,985

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.