Maternal and Child Health Services Title V Block Grant

Arizona

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I. General Requirements

I.A. Letter of Transmittal

Arizona Department of Health Services

Office of the Director

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DOUGLAS A. DUCEY, GOVERNOR
CARA M. CHRIST, MD, DIRECTOR

July 14, 2015

Dr. Michael Lu
U.S. Department of Health and Human Services
Health Resources and Services Administration
Maternal and Child Health Bureau
Room 18-31
5600 Fishers Lane
Rockville, MD 20857

Dear Dr. Lu:

The Arizona Maternal and Child Health Block Grant for Fiscal Year 2016 is electronically submitted with this letter. The DUNS number for the Arizona Department of Health Services is 804745420.

If you have any programmatic questions, please contact Mary Ellen Cunningham at 602-364-1419 regarding programmatic issues. Any questions of a financial nature should be directed to Jordan Glawe, Agency Grants Manager, at 602-364-1692.

Sincerely,

Cindy L. Smith, CGFM
Assistant CFO
Business & Financial Services

Sheila Sjolander
Assistant Director
Public Health Prevention Services

Health and Wellness for all Arizonans

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix C of the 2015 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.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 January 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary

In 2014, the management team of the Bureau of Women's and Children's Health, the administrators of the Title V grant in Arizona, met to plan for the Five Year Needs Assessment. The process began with a list of guiding principles: listen to those who are not traditionally involved; learn from community members as well as the Maternal Child Health Community; and honor and respect the work that others in the community and state had done in the previous year to assess the well being of Arizona's people. The goal was to determine the strengths and challenges related to women's and children's health across Arizona.

Work began with an extensive review of population and program data related to disparities, needs and strengths. The team used multiple strategies to gather public input including Listening Sessions, online community survey, community forums including a Tribal Consultation and finally an in-person and simultaneously online priority setting session to set state MCH priorities. In all, BWCH staff traveled over 2,200 miles and heard from over 1,500 people to gather stakeholder input and support the involvement of communities in the needs assessment and priority setting processes.

MCH staff looked at the needs and disparities evidenced through a review of the data and input from the community and with the help of the community identified ten priorities; seven that could be addressed by national performance measures and three Arizona specific: To improve the health of women before and between pregnancies; to reduce infant mortality and morbidity; to decrease the incidence of childhood injury; to increase early identification and treatment of developmental delays; to promote a smooth transition through the lifespan for children and youth with special healthcare needs; to support adolescents to make healthy decisions as they transition to adulthood; to reduce the use of tobacco and other substances across the lifespan; to improve the oral health of Arizona's children; to increase the percentage of women and children who are physically active and to strengthen the ability of Arizona families to raise emotionally and physically healthy children. These priorities will form the basis of Arizona's Maternal Child Health Action Plan.

The Bureau of Women's and Children's Health (BWCH) administers a range of programs that focus on the health of women and children. This discussion of the capacity of Arizona's Title V agency to meet those needs will utilize the framework of populations as outlined in the Title V Needs Assessment and application.

The priority Arizona selected for Women/Maternal population was to improve the health of women before and between pregnancies. The Needs Assessment process identified many concerns for women including access to preventive health services. The discussions centered on reproductive health and behavioral health, obesity, perinatal depression and sexual assault and domestic violence services. Assuming that preventive medical visits are comprehensive, Arizona believes that increasing preventive medical visits will help to affect national outcome

measures that speak to women's health. Arizona will also select other strategies to address preconception and interconception health. In order to support the health and wellness of Arizona's women, the programs seek to ensure that women have the information and resources necessary to achieve optimal health and wellness.

BWCH is responsible for administering the Federal Family Violence Prevention and Services Act (FVPSA) grant funds which supports the establishment, maintenance, and expansion of programs and projects that prevent family violence and to provide immediate shelter and related assistance for survivors and their dependents. The Program funds nine organizations who are a part of the Safe Home Networks in Arizona's rural communities; each reflecting the unique needs of their community and the victims that they assist. In 2014, the Rural Safe Home Network sheltered 371 women, 10 men and 299 children for a total of 23,183 bed nights. Supportive services to individuals who did not reside in a shelter were provided to 2,418 women, 155 men, and 1,013 children.

The BWCH administers the Sexual Violence Prevention and Education Program (SVPEP). SVPEP contracts with state universities and community based organizations to provide multi-session educational presentations for youth and young adults in middle and high schools as well as universities. Arizona SVEP also implements the Arizona Safer Bars Alliance (ASBA) an innovative project to decrease sexual violence by providing bystander intervention training to staff of alcohol serving establishments. In 2014, SVPEP provided educational sessions to 13,129 individuals. Of those, 1,320 were middle school students, 2,120 high school students and 9,658 university students. BWCH also administers the Sexual Assault Services Program (SASP) that provides direct services to individuals who have survived sexual violence.

As the Title V agency, BWCH supports a Preconception Health Alliance comprised of more than 30 internal and external partners working to improve the health of women and birth outcomes. BWCH has successfully integrated preconception health screening, education and referrals into home visitation, family planning and community health nursing programs.

Title V funds Community Health Grants by partnering with the County Health Departments to address preconception health. This model moves from providing direct services to community education, provider education, fostering coalitions, changing organizational practices, and implementing policy. As a result of the finding of the 2015 Title V Needs Assessment, these contracts will now provide a menu of evidence based or informed strategies based on the new priorities from which counties may choose.

BWCH uses Title V Maternal and Child Health Services Block Grant funds to support the Reproductive Health/Family Planning Program, a statewide, clinic-based, program that provides comprehensive reproductive health services to promote optimal health for Arizona's men and women. In 2014, Title V reproductive health/family planning programs provided 7,657 visits for 2,763 adults ages 20 and up.

The Title V agency serves women by supporting their entry into prenatal care through home visiting programs. Health Start is a state supported home visitation program that utilizes community health workers (CHW) to identify women early in their pregnancy and link them to prenatal care. CHWs provide education, referrals and developmental screenings until the child's second birthday. In 2014, Health Start services were provided to 2,411 clients through 16,054 home visits.

Title V funds a toll free Hot Line for assistance connecting women and children to resources.

Arizona's priority for the Infant/Perinatal domain is to reduce infant mortality and morbidity. Discussions for this domain included injury prevention, child abuse and neglect, perinatal mood disorder and breastfeeding support. Arizona's home visiting programs provide support for new families to understand the needs of their newborns and works to improve the quality of and access to preventive services. Arizona's Title V program is home to three different home visiting programs; the High Risk Perinatal Program, Health Start and Maternal Infant and Early Childhood Home Visiting Program (MIECHV).

Arizona's MIECHV Programs include Healthy Families (HF), Nurse-Family Partnership (NFP) and Family Spirit in

the White Mountain Apache Tribe. Evidence-based home visiting is augmented by a comprehensive workforce development program provided through regional training and education, online courses, regular informative e-newsletters and an annual summit. In 2014, 1,970 families were served through 25,519 visits.

The High Risk Perinatal Program/Newborn Intensive Care Program (HRPP/NICP) program addresses critically ill neonates and high risk pregnant women in imminent danger of premature delivery. This program has three components; Transport, Hospital and Community Nursing home visiting after discharge. In 2014, 3,994 infants were enrolled in the HRPP.

The Safe Sleep Task Force, staffed through BWCH, is comprised of community partners including the March of Dimes, Arizona Prenatal Trust, Child Care Licensing, Managed Care Organizations, hospitals located throughout the state and local health departments. In the summer of 2014, Arizona became a part of the national CoIIN Safe Sleep Initiative.

During the Needs Assessment process the team heard many times the concern about adverse childhood experiences, child abuse and bullying. The data also spoke to infants dying because of unsafe sleep environments and young children being injured around the home. Arizona will institute or continue measures to decrease sleep related deaths and home related accidents.

The Bureau supports many programs to serve children. The BWCH is the administrative home of Arizona's Child Fatality Review (CFR). The state team provides oversight to the local teams, produces an annual report summarizing review findings, and makes recommendations regarding the prevention of child deaths. County specific data is produced and disseminated as fact sheets. These recommendations have been used to educate communities, initiate legislative action, and develop prevention programs.

Arizona's Emergency Medical Services for Children (EMSC) program has established a pediatric designation system that set minimum voluntary pediatric emergency care standards for all emergency departments. As of May 2015, there are 33 member hospitals of which 25 have under gone a site verification visit.

BWCH holds car seat safety classes to certify car seat technicians utilizing the Safe Kids National Highway Safety Traffic Association curriculum. In 2014, five Car Seat Passenger Safety Technician (CPS) Courses were held in urban and rural areas of Arizona. In 2015, BWCH's MIECHV grant supported a Continuous Educational Units Conference for 150 technicians and three additional CPS courses.

The Bureau uses Title V funds to support the Medical Service Project (MSP). This program provides access to health care for uninsured school-age children. The goal of the Medical Services Project is to increase access to health care for Arizona's uninsured school-age children. In 2014, primary care providers, specialists, dentists or optometrists, saw 789 children from 39 difference schools.

During the Needs Assessment process, discussions regarding adolescents needs centered around stress, depression, suicide and bullying and adolescents not using seat belts. There was also concern raised about reproductive health services and obesity prevention. The priority Arizona chose for adolescent health was to support adolescents to make healthy decisions as they transition to adulthood.

Arizona's Teen Pregnancy Prevention (TPP) Program focuses on improving the health and social well-being of youth through the reduction of teen pregnancies and sexually transmitted diseases, and the awareness of healthy relationships and life skills. The program provides youth with knowledge and skills that can be applied throughout their lives and parents with skills to be able to communicate with their youth effectively.

Concerns were raised during the Needs Assessment process for Children with Special Health Care Needs spoke to the difficulties in 'navigating the system of care', the need for early intervention and specialty services.

The Office for Children with Special Health Care Needs (OCSHCN) maintains its critical Title V role in key areas:

Information and Referral, Education and Advocacy, and supporting systems of care for children and youth with special health care needs. OCSHCN educates families, stakeholders and community partners regarding best practices around CYSHCN.

OCSHCN contracts with Raising Special Kids to facilitate identification, recruitment, training and reimbursement for Family and Young Adult Advisors, to participate in projects, committees, workgroups, resource development, policy and program development implementation, and evaluation at national, state and community levels.

Looking at cross cutting issues the community focused on nutrition and physical activity, tobacco usage and oral health. The Empower Program supports licensed child care facilities' efforts to empower children to live healthier lives through the incorporation of ten standards that are based on age-appropriate best practices. With over 2,400 licensed child care facilities across the state enrolled in the Empower Program, it has the capacity to reach over 200,000 children from ages of birth to 12 years. Funded in part by Title V, the Bureau of Child Care Licensing assists by registering facilities in the Empower Program, and monitoring compliance with the regulations and rules.

Empower Schools works with 9 pilot school districts from around Arizona to incorporate 10 school wellness standards into their local wellness policies. This program has now grown to include Empower Home Visiting with Guidelines on Nutrition and Physical Activity.

The second cross cutting topic is oral health. The Arizona School-based Sealant Program provides dental screenings and referrals to children attending eligible public schools. The Program bills Medicaid for children covered by Medicaid and utilizes Title V funds to pay for the uninsured. As part of the sealant program, the Office of Oral Health (OOH) collects oral health status information. This information provides guidance on referrals for care and surveillance on oral health status of children in Arizona.

Arizona's Title V Program has also chosen to focus on tobacco use as it affects infant mortality and morbidity (SUID, prematurity), child health (asthma), preconception and interconception health and transition decision making for teen and CYSHCN. ADHS' tobacco efforts are managed and coordinated out of one of BWCH's sister bureaus, the Bureau of Tobacco and Chronic Disease (BTCD). The BWCH home visiting programs will work more intentionally with BTCD and tobacco use will be a topic of professional development for Arizona's home visitors.

Going forward Arizona has its marching orders. It is clear where current effort need to be strengthened and new evidence based strategies need to be identified. Arizona's Title V agency is proud of its community collaboration efforts and will continue to provide leadership in coordinating efforts to support all women and children of Arizona. BWCH will continue to include community voices going forward.

II. Components of the Application/Annual Report

II.A. Overview of the State

In order to understand the status of women and children in Arizona it is important to understand where the Title V program sits within the state's health care delivery system, some of the agencies' current priorities and how they are reflected in the Title V values, priorities, roles and responsibilities. This overview of Arizona's Title V program will view the state through the social determinants of health, generally described by the CDC as how the conditions where people are born, live, work, play and grow old shape affect their health and wellbeing.

The Arizona Department of Health Services (ADHS) is one of the executive agencies that report to the Governor. By statute it has been designated the Title V agency in Arizona. The Bureau of Women's and Children's Health is a component of the ADHS Public Health Prevention Services Division. The Chief of the Bureau of Women's and Children's Health serves as the Title V administrator. The Office of Children with Special Health Care Needs (OCSHCN) is one of the offices within BWCH and the Chief of the Office of Children with Special Health Care Needs serves as the Children with Special Health Care Needs director.

ADHS adopted a new five year strategic plan for 2013-2017. The Strategic Priorities for this plan are: Impact Arizona's Winnable Battles, Integrate Physical and Behavioral Health, Promote and Protect Public Health and Safety, Strengthen Statewide Public Health Infrastructure and Strengthen ADHS Integration, Effectiveness and Adaptability. The Winnable battles include: to promote nutrition and physical activity, reduce obesity, reduce tobacco and substance abuse, reduce health care associated infections, reduce suicide and reduce teen pregnancy.

In 2014, the ADHS conducted a **State Health Needs Assessment**. The findings were developed in conjunction with the 14 county health departments and hundreds of people from throughout the state. The Needs Assessment identified 15 priorities including Obesity, Tobacco Use, Substance abuse, teen pregnancy, hospital associated infections, suicide, diabetes, heart disease (cardiovascular disease and stroke), cancer, chronic lower respiratory disease and asthma, oral health, unintentional injury, access to health insurance, access to well care and behavioral health. These priorities often mirrored the findings of the Title V Needs Assessment. The Bureau of Women's and Children's Health Chief co-chairs the Teen Pregnancy Prevention and Oral Health workgroups and the Chief of the Office of Injury prevention staffs the Injury Task Force.

Four of the five winnable battles align with MCH priorities and will be addressed in some manner in the Title V Services Block Grant application. Additionally, while two of the state priorities specifically speak to Title V areas of interest; oral health and teen pregnancy, many of the other priorities speak to MCH priorities of preconception and interconception health.

When developing Maternal Child Health priorities, the Title V program looks at many factors, beginning with the intent of the Title V Maternal Child Health Block Grant. The program looks at what the community has identified as a priority and at what the data show is a concern. This means looking at disparities as well. For instance, although Arizona's infant mortality is 5.3, below the Healthy People 2020 goal, there is a disparity between White non-Hispanic and Black infant mortality. The Title V administrator also needs to determine where there is political will as well as capacity in the state. As one of the roles of the Title V administrator is to be a good steward of public funds, it is important to ensure Title V funds are not used for something that already has a dedicated funding stream.

The Title V program is responsible for tracking emerging issues and identifying how they affect the maternal child health population in Arizona. Prescription drug abuse and subsequent Neonatal Abstinence Syndrome have been identified as emerging issues. Abuse and addiction to opioids is a serious and challenging national public health problem. Deaths from drug overdose have risen steadily over the past two decades and have become the leading cause of injury death in the United States. (ASPE, 2015)

As will be described later in this Application, bullying has also been identified as an emerging issue as well as safe

sleep. Bullying was brought up many times during community input sessions and safe sleep was first identified at a statewide Infant Mortality Summit in January 2014. Arizona is participating in the Safe Sleep CoIIN.

The following section will highlight statutes relevant to the Title V program.

Arizona Revised Statute (A.R.S.36-691) formally accepts Title V and designates ADHS as the Title V agency accepting the conditions of title V of the social security act, entitled "grants to states for maternal and child welfare", enacted August 14, 1935, and asamended.

Additional state statutes authorize some maternal and child health programs or functions but are not specific to Title V. The statutory list of functions (A.R.S. 36-132) of ADHS includes: encourage and aide in coordinating local programs concerning maternal and child health, including midwifery, antepartum and postpartum care; infant and preschool health and the health of school children, including special fields such as the prevention of blindness and conservation of sight and hearing; encourage, administer and provide dental health care services and aid in coordinating local programs concerning dental public health, in cooperation with the Arizona dental association. Subject to the availability of monies, develop and administer programs in perinatal health care. Where these Programs are not housed in the Bureau of Women's and Children's Health, Bureau staff are involved in some capacity.

Amended rules, effective July 1, 2014, R9-101-117, were adopted for the licensing of lay **midwives** in Arizona. The new rules include a change to the scope of practice to include the delivery of frank breech and vaginal delivery after caesarean section under certain prescribed circumstances. The rule changes also add clear requirements for reporting, transfer of care and emergency action plans. Title V leadership was involved in the rule making process.

State statute (A.R.S. 36-697) authorized the **Health Start** program, administered by Bureau of Women's & Children's Health; the program is required to serve pregnant women, children and their families. The program is required to be statewide, based in identified neighborhoods and delivered by lay health workers through prescheduled home visits or prescheduled group classes that begin before the child's birth or during the postnatal period and that may continue until the child is two years of age.

The Bureau of Women's and Children's Health also manages the **Oral Health Fund**. ARS 36-138. The oral health fund uses funds received by the department as reimbursement from the state's Medicaid program contractors for dental services provided by the department and expends the money from the fund for dental health services.

State statute (A.R.S. 36-899.01) also requires ADHS to administer a program of **hearing evaluation services** administered to all school aged children. This program is also administered by the Bureau of Women's and Children's Health.

The **Child Fatality Review** Program is authorized by state statute (A.R.S. 36-3501). The State Child Fatality Review Team is required to conduct an annual statistical report on the incidence and causes of child fatalities and submit a copy of this report, including its recommendations for action, to the Governor and legislative leadership on or before November 15 of each year. This report also includes recommendations from the committee for the public. The Bureau Chief is a legislatively required member of the State Team. The Program is housed in the Bureau of Women's and Children's Health.

In 2011, the Arizona Legislature revised the state child fatality statute to add authority to review maternal deaths. **Maternal mortality** review is implemented through a sub-committee of the State Child Fatality Review Team.

This legislative session the Governor signed HB 2643 which prohibits the state and its political subdivisions from using any personnel or financial resources to enforce, administer or cooperate with the **Affordable Care Act** in many ways with the exception of public health prevention programs.

The following section will describe **principal characteristics** of Arizona so the reader can put context the health

status of the women and children of Arizona.

Arizona is the sixth largest state in the nation, located in the Southwest United States. One-quarter of the land in Arizona is home to 21 federally recognized Native American Tribes and Nations.

From 2003 to 2013, the population of Arizona grew from 5.6 million to 6.6 million people. From 2003 to 2006, the growth rate was between a three and four percent increase per year. With the recession in 2008 – and Arizona particularly hard hit – population growth slowed and actually decreased about three percent from 2009 to 2010. Growth resumed from 2010 through 2013 at a rate of about one percent per year.[1]

Impacts of the recession were seen in a decrease in migration to Arizona as well as a decrease in resident births. Arizona Vital Statistics also noted factors affecting the population growth such as the number of undocumented residents who left the state, the decline in construction jobs, the number of foreclosures, the number of built but vacant homes, and the decline in the number of resident births. It should be noted that these factors all apply primarily to metropolitan, not rural, counties.

The racial and ethnic makeup of the state of Arizona is different than the nation. In 2013, the proportion of the population that is Hispanic in Arizona was almost twice that of the nation (30 percent compared to 17 percent nationally). In addition to having a higher proportion of Hispanics, Arizona's population also has a smaller proportion of African Americans (4.6 percent compared to 13 percent nationally) and a higher proportion of Native Americans (5 percent compared to 1 percent in the nation).[2]

The racial makeup of Arizona varies by age group. Among older age groups, the population is predominantly white, while the proportion of the population represented by Hispanics is highest among the younger groups. Over 40 percent of those younger than five are Hispanic compared to ten percent of people 75 and older.[3]

Arizona has consistently ranked lower in the nation per pupil spending compared to the U.S. The National Center for Education Statistics reported that Arizona spent $7,382 per student compared to the nation's average of $10,667 in fiscal year 2012.[4] US Census ranked Arizona 49th of the 50 states and the District of Columbia in public per pupil spending in fiscal year 2013.[5]

The National Assessment of Educational Progress (NAEP) is an assessment of what America's students know. In 2013, eighth grade students in Arizona public schools ranked 45st of 52 states and jurisdictions in NAEP reading scores.[6] In 2013, 28 percent of Arizona eighth graders tested below basic skill level for their grade compared to 23 percent nationally. For Arizona, this represents a statistically significant improvement over the reading level of 35 percent testing below basic skill level in 2007.[7]

The economy of Arizona is growing after a hard hit during the recession. The Bureau of Economic Analysis calculates the gross domestic product (GDP) of states as well as the nation. GDP is the sum of what individuals, businesses and government spend on goods and services as well as investment and trade. Arizona contracted at a faster rate than the nation as a whole from 2005-2008, with a steep decline in 2008. Since that period, there has been positive GDP growth, but Arizona's rate of growth (1.1) has been lower than other neighbors in the southwest (3.3) and the nation as a whole(1.8).[8]

Median household income in Arizona has historically tended to be lower than national averages. According to US Census, Arizona's median household income in 2013 was $50,602 compared to the rest of the nation at $51,939.[9] Median household income also varies widely by county and type of household. The highest median household income was in Maricopa County with $53,596 and the lowest was in Apache County with $31,476. Median household income also varies by type of household, with married couple families earning $70,523, families with children under 18 earning $53,418, and female-headed single parent families earning $31,741.[10]

Unemployment varies across Arizona. The rate of unemployment in Arizona as a whole 2007 was 4.1 percent, rising to 11.1 percent in 2010 and declining again to 6.6 percent in 2015. While all parts of the state saw increased

unemployment in 2010, the Phoenix Metropolitan Statistical Area showed the lowest rates (10.4%) while the Yuma Area suffered the largest percentage of unemployment (21.8%). The highest rate of unemployment in Yuma Metropolitan Statistical Area was 31.2 percent in July of 2013.[11]

Arizona has a higher percentage of residents living in poverty compared to the nation. In a five-year estimate for 2009-2013, 15 percent of the nation lived in poverty compared to 18 percent of those living in Arizona. This rate was 14 percent in Arizona in 2000.[12] In Arizona in 2013, 26 percent of children under 18 and 31 percent of those without a high school diploma lived below the poverty line.[13]

Poverty varies dramatically by county. The highest rates of poverty are in Apache and Navajo Counties with a rates of 36 and 30 percent, respectively and the low in Greenlee, Pinal and Yavapai Counties of 16 percent. [14]

In addition to individuals, poverty can be calculated for families with children under the age of 18. In a five-year estimate for 2009-2013, 21 percent of families with children were below the poverty line in Arizona. This was three percentage points higher than the national average (18%).[15]

Rates of poverty for families with children vary widely by ethnic background. The National Center for Children in Poverty reports that in Arizona in 2012, eleven percent of Asian children live in a poor family compared to 46 percent of Native American children.[16]

Household Food Insecurity is often a consequence of poverty. The USDA definition of food insecurity can be paraphrased as: a limited or uncertain availability of food. Low food security is food insecurity without hunger. Very low food security is food insecurity with hunger.[17] Food insecurity is similar but slightly higher in Arizona than in the United States as a whole and has increased in the past 10 years, notably between 2007 and 2008. In 2011- 2013, 16 percent of Arizona households had limited or uncertain food availability and six percent of those were hungry.[18]

According to data retrieved from the 2014 Arizona State Health Assessment, about 1.2 million people (19%) of Arizona's population are uninsured.[19] Among this number, approximately 191,000 uninsured individuals are under the age of 18 [20] making Arizona's youth and children one of the least insured 0-18 populations in the country when compared to all other states.[21] Additionally, 20 percent of children in Arizona lacked consistent coverage in the past year as compared to 11 percent nationwide.[22]

Arizona's Children's Health Insurance Program (CHIP) or KidsCare, served children in households earning between 100 percent and 200 percent of the federal poverty level (FPL). Due to a number of recent changes in federal and state policy, Arizona's CHIP program has essentially disappeared. As Table 1 illustrates, policy changes occurring within the past five years have directly impacted insurance status and access to care for children living in Arizona.

Table 1. Health Care Policy Changes Affecting Children, 2010 – 2015.

Date	Federal/State Policy Change
January 2010	KidsCare/CHIP enrollment freeze. Nearly 46,000 children are enrolled in KidsCare when the freeze goes into effect. KidsCare waiting list swells to more than 100,000 by July 2011.[23]
March 23, 2010	The patient Protection and Affordable Care Act (PL 111-148) is signed into law.
May 2012	Enrollment opens for Kids Care II, a time-limited alternative CHIP program for children up to 175% of the federal poverty line, or FPL, (unlike original KidsCare eligibility limit of 200% FPL). KidsCare II was the result of an agreement with federal officials to re-open CHIP coverage for some children, with the idea that the program would end in January 2014 to

	correspond with the ACA's new marketplace coverage options.
November 2012	Kids Care II enrollment reopens for additional children.
May 2013	Kids Care II returns income eligibility limit to 200% FPL.
January 1, 2014	Federally-facilitated marketplace insurance plans can be used to access health care services.
January 1, 2014	Transfer of school-aged "stairstep" children from KidsCare to Medicaid. More than 26,000 children ages 6 through 18 enrolled in KidsCare and KidsCare II (the state CHIP program) with family incomes up to 138% FPL transferred to the Arizona Health Care Cost Containment System (AHCCCS, or Medicaid). All children with incomes up to 138% FPL now eligible for Medicaid.
January 31, 2014	Kids Care II ends, KidsCare enrollment freeze remains in effect. 14,000 children lose KidsCare II, receive notices referring them to the ACA's new federal health insurance marketplace where they could potentially purchase health insurance.

Note: Contents for this table were drawn directly from Burak, E.W. (2015). *Children's Coverage in Arizona: A cautionary Tale for the Future of the Children's Health Insurance Program* (CHIP). Georgetown University Health Policy Institute Center for Children and Families.

On January 1, 2014 two policy changes impacting Medicaid eligibility for childless adults went into effect. The first policy change was the restoration of Proposition 204, extending eligibility to childless adults earning between 0 percent and 100 percent FPL. The second change was Arizona's expansion of Medicaid eligibility to include childless adults earning between 100 percent and 138 percent FPL. Proposition 204 eligibility had been frozen since 2011. Expanding coverage to the new adult group was an opportunity provided by the ACA and supported by then Governor Janet Brewer. In the 15 months since both of these policy changes took effect, both eligibility programs have provided Medicaid coverage for just over 336,000 individuals. The restoration is still being challenged in the courts.

From December 2009 to May 1, 2015 there has been an overall increase in SOBRA enrollments for eligible pregnant women. Amended under Title VI of the Sixth Omnibus Budget Reconciliation Act of 1986, the Act gave states the option of extending coverage to women requiring pregnancy-related medical services beyond previously set income eligibility thresholds established by states.

At the close of the second open enrollment period, Arizonans selected 205,666 marketplace plans through the federally-facilitated exchange[24]. Table 2. illustrates characteristics of the individuals selecting marketplace plans in Arizona.

Table 2. Marketplace Plan Selection Characteristics – Arizona, Post-Second Open Enrollment Period

Arizona: 205,666 plans selected	% (Number)
New Consumers	48% (98,720)
Plans eligible for financial assistance	76% (156,306)
Plan selections <18	23% (47,303)

Plan selections 19-64	77% (158,363)

Note: Data displayed in this table were drawn from ASPE. (March 10, 2015). *Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report*. Retrieved May 27, 2015 from http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/Mar2015/ib_2015mar_enrollment.pdf

Recent federal and state health policy changes have increased the number of Arizonans covered by insurance. Counting marketplace plan selections (205,666) with the Proposition 204 restoration population (281,025) and the childless adult expansion population (55,136), just under half-a-million individuals (541,827) have health insurance that they may have not had it prior to the policy changes being implemented. This increase in covered lives has also lowered the percent of uninsured in Arizona from 17 percent in 2013 to right around 10 percent currently- not including effects of employer-based and other non-marketplace/Medicaid insured populations.

About two-thirds of the over 9 billion dollar Arizona budget for 2015 is made up of spending on K-12 education, AHCCCS (Arizona's Medicaid program) and the Department of Corrections. Forty-one percent of the general fund goes to elementary and secondary education ($3,808.4M), 14 percent for AHCCCS ($1,259.1M), and eleven percent for corrections ($996.8M). Health services receive six percent of the general fund expenditures ($610.8M).[25]

Arizona labor force and employment figures were severely disrupted by the recession. There are current signs of recovery but Arizona has not yet regained its pre-recession economic footing.[26] From this, Arizona has been faced with budget deficits and structural shortfalls. With the recession, the overall population and tax base of the state shrank. In an analysis by the Tax Foundation, Arizona was ranked 40th nationally in state tax collections based on per capita income and 43rd nationally in revenues per capita for fiscal year 2013.[27]

Rankings of Arizona spending relative to other states in 2011 - 2012 showed that Arizona spent comparatively more per capita on police and fire protection (rank = 14) and corrections (rank = 16), and less on highways (rank = 48), health and hospitals (rank = 35), public welfare (rank = 41), all education (rank = 48), and K-12 schools (rank = 50).[28]

[1] Arizona Vital Statistics - Population Denominators. (November, 2014). *Arizona Department of Health Services.*

[2] State and County Quickfacts. USA People Quickfacts. (n.d.). *US Census.*

[3] Arizona Vital Statistics –Population denominators for 2013 – Table 10C-1. (2014, November).

[4] Revenues and Expenditures for Public Elementary and Secondary Education: School Year 2011-2012 (Fiscal Year 2012). (2015, January 29). *National Center for Education Statistics (NCES)*.

[5] Public Education Finances: 2013. (June 2015). Educational Finance Branch, US Census.

[6] NAEP State Comparison (n.d.). *National Center for Education Statistics (NCES)*.

[7] NAEP 2013 State Snapshot (n.d.). *National Center for Education Statistics (NCES)*.

[8] Bureau of Economic Analysis. (n.d.). *U.S. Bureau of Economic Analysis (BEA)*.

[9] Table H-8. Median Household Income by State: 1984 to 2013. (n.d.). *US Census.*

[10] GCT1901. Median Income in the Last 12 Months 5 year estimates, 2009-2013. (n.d) US Census.

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II.B. Five Year Needs Assessment Summary

II.B.1. Process

In 2014, the management team of the Bureau of Women's and Children's Health (BWCH) met to plan for the Five Year Needs Assessment. The process began with a list of guiding principles: listen to those who are not traditionally involved; learn from community members as well as the Maternal Child Health Community; and honor and respect the work that others in the community and state had done in the previous year to assess the well being of Arizona's people. The goal was to determine the strengths and challenges related to women's and children's health across Arizona. Work began by an extensive review of population and program data related to disparities, needs and strengths.

To build on findings from data review and previous assessments and to promote a fuller understanding of the concerns of the MCH community, the team used multiple strategies to gather public input. First, the team set up Listening Sessions across Arizona which specifically targeted key groups to better understand their perception of health needs in their community. Listening session groups included: teen parents, LGBT community members, Arizona Health Care Cost Care Containment System (Medicaid) MCH Directors, families with children with special health care needs, participants from border communities, those living in public housing, members of African American churches and Tribal members. These sessions were intentionally participant-driven and were structured to gather insights from different populations and communities on what they saw as opportunities or concerns around the health and wellbeing of all women and children in Arizona. From May 2014 through December 2014, 17 listening sessions were held throughout the state.

In August 2014, the BWCH developed an online community survey seeking feedback from the community regarding the most important health needs for the MCH populations. The survey was posted online for 4 months with a link to the survey on the ADHS BWCH homepage and was sent to internal and external partners and posted on social media. In all, 948 individuals responded to the online survey. A shortened version of the survey was also made available via paper, but few paper surveys were received.

In March and April of 2015, a total of 11 community forums were held including a Tribal Consultation. Meetings began with a presentation by BWCH with background information on the MCH Title V Block Grant and the process of the 5-year needs assessment, after which there was discussion of data on each of the six population domains. The team then asked for input from the community on programs serving women and children in the local community. After the presentation by BWCH, participants were asked to write what they considered their top one or two needs for each population domain.

April 20th 2015, the Bureau of Women's and Children's Health held an in-person and simultaneous online session to set Arizona's MCH priorities. Participants were presented with all the information gathered previously. After a review of MCH data, participants reviewed the priorities generated through previous input. With this updated list of potential priorities, the participants voted for their top priority in each domain.

In all, BWCH staff traveled over 2,200 miles and heard from over 1,500 people to gather stakeholder input and support the involvement of communities in the needs assessment and priority processes.

The MCH staff looked at the needs and disparities evidenced through a review of the data and input from the community and with the help of the community identified ten priorities; seven that could be addressed by national performance measures and three Arizona specific: To improve the health of women before and between pregnancies; to reduce infant mortality and morbidity; to decrease the incidence of childhood injury; to promote a smooth transition through the lifespan for children and youth with special healthcare needs; to support adolescents to make healthy decisions as they transition to adulthood; to increase early identification and treatment of developmental delays; to reduce the use of tobacco and other substances across the lifespan; to improve the oral

health of Arizona's children; to increase the percentage of women and children who are physically active and to strengthen the ability of Arizona families to raise emotionally and physically healthy children.

These priorities will form the basis of Arizona's Action Plan.

II.B.2. Findings

II.B.2.a. MCH Population Needs

Women's and Maternal Health

According to BRFSS, in 2013, 82% of Arizona women reported having healthcare coverage. Women 25 to 34 were the least likely to have healthcare coverage (70%), as well as women with lower levels of income and education. Hispanic/Latina women were markedly less likely to have healthcare coverage (64%). Over 80% of women visited a doctor for a routine checkup within the past 2 years. Women 25 to 34 were the least likely to have had a routine checkup (73%) as well as women with lower levels of income and education. Almost one in 5 Arizona women reported not being able to visit a doctor in the past year because of cost (17%). Women aged 45 to 64 were most likely to report this (21%) as well as women with the lowest levels of education and income and Hispanic women (26%).

From 2009 to 2013, over 80% of mothers initiated prenatal care in the first trimester, exceeding the Healthy People 2020 goal of 77.9%. Mothers with private insurance were significantly more likely to have first trimester PNC than mothers with AHCCCS, Arizona's Medicaid (92% and 75%). By race/ethnicity, white non-Hispanic and Asian or Pacific Islander mothers were more likely to receive first trimester PNC while American Indian mothers were the least likely. Mothers in border and rural counties were significantly less likely to have first trimester PNC than mothers in non-border and urban counties.

Women are also recommended to space their pregnancies 18 to 59 months apart. In Arizona, the percentage of women doing so has remained relatively steady from 42% in 2009 to 43% in 2013. Younger mothers (<18) were the least likely to have the desired spacing between pregnancies (16%).

In Arizona, the cesarean rate has remained steady at 28%, lower than the national rate of 33% in 2013. In Arizona, the percentage of caesarean section was highest amongst Asian or Pacific Islander mothers (33%) and lowest in American Indian or Alaska Native mothers (24%).

The percentage of Arizona women smokers has decreased from 18% in 2011 to 13% in 2013. White non-Hispanic women and women of other races/ethnicities were the most likely to smoke (15% and 14%). Smoking was directly associated with low income and education levels. Women in rural counties were more likely to smoke than women in urban counties (18% and 13%).

From 2009 to 2013, less than 5% of women reported using tobacco during pregnancy. Mothers on AHCCCS, Arizona's Medicaid agency, were significantly more likely to use tobacco during pregnancy than mothers with private insurance (6% and 2%). White non-Hispanic mothers were the most likely to use tobacco during pregnancy (7%).

Second only to access to health care services, Arizonans identified domestic violence as a top health priority for women. Through an annual one-day census conducted by the National Network to End Domestic Violence, it was determined that on September 17th, 2013, 35 of the 43 identified Arizona domestic violence programs served 1,796

domestic violence victims on that one day[1]. In addition, there were 100 separate domestic violence incidents that resulted in 125 fatalities in 2013[2].

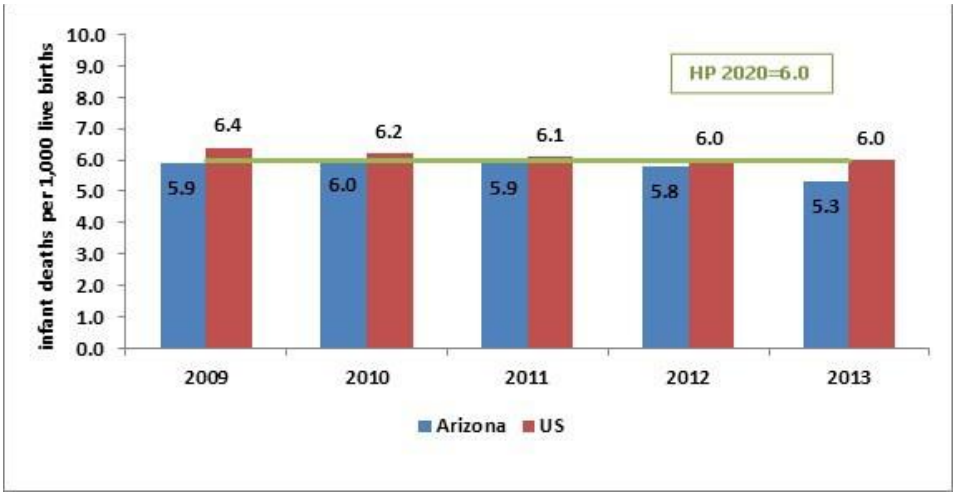
In 2013, there were 1,833 forcible rapes reported in Arizona. Rape accounted for 7.4% of all violent crimes in Arizona, and was the only major crime to see an increase in offenses[3]. Compared to the national rate of 34.4 rapes[4] per 100,000 inhabitants, the rate of rape in Arizona is higher at 46.0 (2013)[5].

The Title V Reproductive Health Program will continue to track the percentage of clients that transition to a more effective contraceptive method and maintain utilization of an effective method. The program will also focus on identifying strategies for increasing the availability of LARCs in response to growing evidence that LARCs can have a positive impact on improving birth outcomes and birth spacing. The Title V County Health Grants have been conducting community specific activities related to preconception health however, while the counties track and report on process indicators, there is a lack of outcome data. Once these program funds are included into the Healthy People, Healthy Community integrated grants the counties will be required to implement evidence based/evidence informed strategies and measurable outcomes.

Perinatal and Infant Health

Infant mortality is an important marker of the wellbeing of a population[6]. From 2009 and 2013, Arizona's Infant Mortality Rate (IMR) was consistently lower than that of the nation (Figure 1). In 2013, Arizona's IMR was 5.3 infant deaths per 1,000 live births, compared to 6.0 for the US. Arizona met or fell below the Healthy People 2020 goal of 6.0 deaths per 1,000 live births every year during this period[7].

Figure 1. Infant Mortality Rate, Arizona & US, 2009-2013



Source: Arizona Health Status and Vital Statistics, 2013 and *National Vital Statistics System*

A racial/ethnic disparity is evident in the rates of infant mortality however. The highest IMR was seen amongst Black or African-American infants (12.5) while the lowest rates were seen in white non-Hispanic (4.2) and Asian or Pacific Islander infants (2013 data not available). The IMR was also higher in rural counties than in urban counties (5.8 versus 5.2).

Preterm birth and low birth weight are associated with increased infant mortality and morbidity. Since 2009, Arizona's rate of preterm birth has decreased 10%, going from 10.0% to 9.0% in 2013, while the rate of low birth weight has remained stable (7% in 2013). Arizona's rates of preterm birth and low birth weight are lower than those

of the nation and both indicators have met the Healthy People 2020 goals of 11.4% and 7.8%[8].

In 2013, there were 74 **SUIDs** in Arizona, with 88% associated with unsafe sleep environments. From 2009 to 2013, the mortality rate due to SUID has declined from 7.2 deaths per 100,000 children to 4.5 deaths per 100,000 children.

Another issue of growing concern is the increasing rate of **neonatal abstinence syndrome (NAS)**[9]. The rate has more than double in Arizona, going from 1.71 per 1,000 births in 2009 to 4.03 in 2013[10].

Breastfeeding is a highly efficient and simple measure a mother can take to safeguard her child's well-being[11]' [12]' [13]. Arizona's rates of breastfeeding initiation have increased from 76.8% in 2009 to 81.6% in 2011[14]. Arizona's rates were generally higher than those of the nation and have nearly met the Healthy People 2020 goal of 81.9%

Arizona's MCH program will continue to work with local partners to reduce prematurity by decreasing early elective deliveries (EED). Although hospitals have informally agreed to a "hard-stop" policy to prohibit or deny payment for EEDs, the data does not support the assertions. Arizona's MCH program will work with the Arizona Perinatal Trust and March of Dimes to establish a more formal process of hospital commitment. The MCH Program will increase educational efforts. This includes providing information on the effect of EED on birth outcomes and infant well-being to home visitors and community health nurses who work with pregnant woman throughout the state. Arizona will continue the LiveItChangeIt! Campaign to address health challenges among the state's African-American population. In addition to the website (www.liveitchangeit.com), and tools for community presentations and outreach, the MCH Program added a You Tube video about preconception health targeted to the African American community.

Child Health

Nineteen percent of the state population is children aged between 1-14 years[15]. The NSCH 2011/12 reported 80% of the parents in Arizona described the **health status** of their children as excellent or very good. In Arizona, the health of White, non-Hispanic children was more often described as excellent or very good (91.8%) than was the health of Hispanic children (68.5%) and other, non-Hispanic children (78.4%) by their parents which was statistically significant[16]. The survey found that more Arizona children 10 to 17 years of age were considered overweight or obese (36.7%), compared to nation (31.3%). Furthermore, in Arizona the rates of overweight or obesity in Hispanic children (50.2%) are double that of White, non-Hispanics (23.7%).

According to NSCH 2011/12, roughly 88% of children in Arizona had any kind of **heath care coverage**. There was significant racial disparity with nearly 1 in 4 Hispanic children (24.5%) were uninsured or had periods of no coverage during the past 12 months, compared to 14.2% White, non-Hispanic children. The sample sizes were too small to yield reliable estimates for children of other races. Twenty two percent of parents in Arizona of children age 10-35 months reported their child was **screened** for being at risk for developmental, behavioral and social delays. Also, 81.4% of Arizonan children had one or more **preventive** medical care **visits**, while only 75% received one or more preventive dental care visits during past 12 months.

Self-reported data from Arizona schools and childcares showed high **immunization** coverage levels. But, the childcare center's religious belief exemption rates increased from 3.4% (2010-11) to 4.1% (2013-14). In Kindergarten, personal belief exemption rates increased from 3.2% (2010-11) to 4.7% (2013-14).

Numerous research studies have reported the association of **adverse childhood experiences (ACEs)** and morbidity[16]. Based on NSCH 2011/12, over 31% of Arizona children (0-17 years) experienced two or more ACEs, based on a list of nine. The top three adverse childhood experiences included socio-economic hardship (34.3%), separation or divorce of parent (23.7%) and lived with someone with an alcohol or drug problem. The percent of

children (0-17 years) who experienced two or more ACEs was double for those families (40.2%) with an income level below 100% federal poverty line(FPL) compared to families with income 400% or more FPL (18.7%).

According to the 2014 Child Fatality Review Report in 2013, 811 children under the age of 18 years died in Arizona compared to 854 deaths in 2012. Of the 811 child deaths, 38.2% were determined to be **preventable**; an increase of nearly 15% since 2009 (33.3%). Despite representing 5% and 6% respectively of the child population in the state, Blacks and American Indians made up 10% and 9% of all child deaths. Conversely, White, non-Hispanic, Hispanic and Asian children made up 35%, 42%, and 2% respectively of all child deaths (versus 44%, 42% and 3% respectively of child population). **Unintentional injuries** are the leading cause of morbidity and mortality among children in the United States ages 1-19 years. In 2013, for those 1-9 years of age, injuries accounted for 78 deaths, 1,202 inpatient hospitalizations and 62,991 emergency department visits. Falls and poisoning were the leading cause of those inpatient hospitalizations; together they have been termed home-safety related injuries.

The rate of substantiated child **maltreatment** in Arizona has quadrupled from 2009-13 (from 2.3/1000 children in 2009 to 8.4/1000 children in 2013)[17]. There was a 22% increase deaths due to maltreatment (n=92) as compared to 2012 (n=70)[18]. Of all of the deaths due to maltreatment, 37% were Hispanic, 29% were White, non-Hispanic, 16% were American Indian, 12% were African American, and 4% were two or more races. Nearly 46% of maltreatment deaths were among infants, 39% among children 1-9, and 15% among children 10-17. Over 79% of maltreatment deaths were among children four years of age and younger. Since 2008, the mortality rate per 100,000 children due to maltreatment has increased by 87% from 3.0 to 5.6 in 2013. The most common manner of death for maltreatment deaths was accidents (41%), followed by homicide (37%). Substance use was a factor in 55% of all maltreatment deaths. The number of children in **foster care** increased by 55.7% (from 10,112 in April-September 2009 period to 15,751 in October-March 2014 period)[19].

The rapid increase in reports of child maltreatment and increasing number of children placed in foster care signals the need for prevention efforts especially among high risk families. Arizona's Title V agency administers several home visiting and community health nursing programs: Health Start, High Risk Perinatal/Newborn Intensive Care Program, Nurse Family Partnership, Healthy Families, and Family Spirit. These provide families with support, information on child development, and connection to local resources with the goal to improve maternal and child health and reduce family violence, child injuries and child maltreatment. Native American children are at the highest risk for maltreatment, inadequate nutrition and obesity. A Native American Community Coordinator was hired to work with the Bureau of Women and Children's Health and the Maternal, Infant, Early Childhood Home Visiting program to lead an effort to expand home visiting programs to American Indian families who live on reservations or in urban areas.

Childhood injury, especially around the home, is the leading cause of hospitalization for children. The Title V program initiated a CQI project in 2013 to update a home safety checklist with the goal of it being implemented in all of the home visiting programs. In addition, the programs housed under Title V are building the capacity of local communities through a safe sleep campaign and training child seat instructors. Through a newly created integrated IGA, grants of Title V funding to county health departments will require evidence based strategies to address childhood injury.

Children with Special Health Care Needs (CSHCN)

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An estimated **19.2%** of Arizona children 0-17 years have a special health care need[20]. The parents of Arizona children with special health care needs were less likely to describe the **health status** of their children as excellent or very good (65.2%) compared to non-CSHCN children (83.6%). Furthermore, CSHCN tend to be identified when they

are older, with only 18.6% in the 0-5 year age-group. The highest numbers of children are in the 6-11 years age group with 43.6%.

The consequences of **Adverse Childhood Experiences (ACEs)** are more pronounced in the CSHCN population. The NSCH-CN in 2011/2012 reported 76% of children with special health care needs had experienced at least one adverse childhood experience as compared to only 53.1 percent of typically developing children[21].

The **Family Centered Care (FCC)** focuses on empowering families and providing a culturally competent healthcare delivery system. Approximately, 39% of families with CSHCN did not receive FCC in Arizona as compared to 35% nationwide. According to age group, 42.2% 6-11 years old and 39.9% 12-17 years old CSHCN did not receive FCC compared to only 28.2% 0-5 years old.

FCC decreased the **unmet needs** of CSHCN population[22]. The NS-CSHCN asked questions about fourteen specific healthcare services or equipment needs. The five most frequently noted types of care needed for CSHCN in Arizona were preventive dental care (91.8%), preventive medical care (89.7%), prescription medications (79.6%), specialist care (51.4%) and vision care or eyeglasses (34.6%).

Bennett et al established that **medical homes** may help in decreasing the racial disparity in unmet needs[23]. Studies have suggested that having a medical home ensures improved health outcomes[24]. Thirty percent of CSHCN in Arizona reported having at least one unmet health care need during the past 12 months. In Arizona, only 36.1% CSHCN successfully achieved receiving coordinated, ongoing, comprehensive care within a medical home[25].

The CSHCN population is more vulnerable to gaps or instability in the healthcare delivery systems[26]. Sixty four percent of parents of youth with special health care needs in Arizona reported that they did not receive the services necessary to make appropriate **transitions to adult health care**, work, and independence. Hence, smooth transition through the life course has been made one of the priority topics we are going to focus on for this population.

Roughly eight percent of CSHCN receive **Supplemental Security Income (SSI)** disability benefits in Arizona. The data obtained by matching cases from children who applied for SSI benefits between July 2011-December 2014 and birth certificates data from 2002-2013 showed that 10,145 children applied for SSI benefits in the state. Sixty five percent of children applying for SSI benefits in this duration were male children (n=6,633) while 35 percent (n=3,512) were females. Among all of the applicants, 47% were Hispanic, 26% were White, non-Hispanic, 15% were American Indian or Alaskan Native, 12% were African American, and only 1% was Asian or Pacific Islander. The top five conditions for which children applied for SSI benefits were behavioral health (22%) speech and language (19%), autism (9%), learning disorder (5%) and respiratory conditions (5%).

Considering OCSHCN's work around transition, including educational staff development through professional conferences; agency and organizational staff development through the Arizona Community of Practice on Transition; Picture of Life with the Sonoran University Center of Excellence in Developmental Disabilities and the ASPIRE project; data as reported above show that a majority of youth are not receiving services needed for transition. There is a refocus on outreach and training toward youth and families to make resources and tools, such as the Health Care Organizer, readily available. A session for youth and families has been accepted for the 2015 Arizona Department of Education Transition Conference, which will be co-presented with a young adult, focusing on self-determination and the family role in transition.

Related to medical home, OCSHCN is working with Northern Arizona University to assess three years of data from Health Advocacy for CYSHCN and Their Families project. In addition to providing inclusive nutrition and physical activity opportunities, referrals to community-based medical home are a requirement of this contract. Initial reports indicate that contractors are not as successful in making medical home referrals as anticipated nor are referral outcomes being reported. OCSHCN will be providing technical assistance for contractors to support both these goals. Medical home and effective use of systems of care is experienced by less than 60% of CYSHCN according to the NS-CSHCN, a message reinforced through the needs assessment process. OCSHCN is expanding work with school nurses at the local level, exploring data sharing opportunities around CYSHCN, identifying professional development needs for screening, managing conditions, making and tracking referrals to medical home.

Inquiries from families in 2014, indicate that families of CYSHCN have challenges navigating the system of care, with a strong need among foster/kinship and adoptive families in accessing the systems of care available. In collaboration with the Department of Child Safety (DCS), 36 case managers and over 100 families have been trained in navigating the systems, effective use of insurance and organizing records. This training will continue to be available, as part of DCS foster family re-certification conferences held quarterly around the state.

Adolescent Health

According to NSCH, 15% of Arizona adolescents aged 12-17 were not insured. Additionally, only 78% had consistent health insurance coverage during the past 12 months. Among those insured, only 71% had insurance which met their needs.
NSCH also reports that nearly 75% of parents in Arizona described their child's (aged 12 to 17) health as excellent or very good.

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In 2013, YRBS reported that nearly a quarter of Arizona high school students were overweight or obese, a percentage which has remained relatively stable since 2009. Hispanic students were more likely than white non-Hispanic students to be overweight or obese, with almost double the rate in 2013 (29% and 15%, respectively).

In addition, YRBS reported that nearly 60% of students were not physically active for at least 60 minutes per day on five or more days in the previous week. Females were less likely than males to have been physically active (67% and 50%, 2013).

In 2013, 36% of Arizona high school students reported currently drinking alcohol and 20% reported currently using tobacco (YRBS). According to the Arizona Youth Survey, marijuana is the most commonly abused substance by Arizona students, followed by prescription drugs. For all substances with the exception of inhalants, use increases with grade level. However, it is worth noting that, for the most part, substance use has been decreasing over time (Table 1).

Table 1: Behavior Reported by Students in Past 12 Months, Arizona Youth Survey, 2010-2014

	Grade 8			Grade 10			Grade 12		
	2010	**2012**	**2014**	**2010**	**2012**	**2014**	**2010**	**2012**	**2014**
Substance Abuse—*Any use in the past 30 days*									
Marijuana	8.9%	7.7%	6.9%	17.4%	17.7%	16.8%	21.3%	22.5%	22.9%
Inhalants	5.6%	4.2%	3.1%	3.0%	2.0%	1.3%	1.5%	1.3%	0.9%
Methamphetamines	0.2%	0.2%	0.1%	0.5%	0.5%	0.4%	0.6%	0.5%	0.4%
Prescription drugs	8.2%	5.7%	4.9%	11.8%	9.3%	7.1%	12.4%	10.0%	8.0%

OTC Drugs	5.4%	4.0%	3.1%	6.3%	4.9%	3.7%	6.3%	4.3%	3.4%

Arizona's **teen pregnancy** rate declined 33% from 56.1 pregnancies per 1,000 females aged 15 to 19 in 2009 to 37.7 in 2013. From 2009 to 2012, the highest rates were seen in Hispanic/Latina teens, however that rate drastically dropped almost 50% from 92.4 to 50.7. The highest pregnancy rates are now seen in American Indian or Alaska Native teens (58.6) while the lowest rates are seen in white non-Hispanic teens (18.9) and Asian or Pacific Islander teens (13.2) (2013).

Teens were less likely than older mothers to receive first trimester prenatal care, with younger teens (15 to 17 years old) even less likely than older teens (18 to 19 years old). In 2013, 63% of teens aged 15 to 17 years old received first trimester prenatal care, compared to 72% of teens 18 to 19 years old.

According to YRBS, in 2013, 29% of Arizona high school students were harassed or **bullied** on school property while 20% experienced electronic bullying. Female students, white non-Hispanic students and younger students were at higher risk of being bullied.

Some of the long term consequences of bullying include depression and suicidal thoughts[27]. YRBS also reports that in 2013, 36% of Arizona high school students reported feeling sad or hopeless, 19% seriously considered attempting suicide, and 11% attempted suicide one or more times. Females were more likely than males to report feeling sad or hopeless, and contemplating and attempting suicide.

In Arizona, effective prevention efforts have reduced the overall number of motor vehicle and transport crash fatalities, however, crashes still account for ten percent of all child deaths and a larger percentage of non-fatal inpatient hospitalizations and emergency department visits in Arizona, according to the Arizona Child Fatality Review Report. Crashes were the leading cause of injury in adolescents ages 10 to 19 and, in addition, the highest rates of motor vehicle traffic crash-related inpatient hospitalizations and emergency department visits were also seen in this age group, with rates higher in adolescents aged 15-19 years followed by those aged 10-14 years.

The Title V program will continue to utilize evidence based/informed teen pregnancy prevention curricula. The current Title V Community Health Grants work to reduce injuries however, moving forward the counties will be required to adopt evidence based/informed strategies and measurable outcomes to ensure that the selected strategies are moving the needle on injury including bullying. In addition, the bureau has determined that developing a more formal partnership with Behavioral Health to address bullying, depression and suicide will promote coordination of prevention and treatment services.

Cross- cutting or Life course

A maternal and child health life course perspective aims to approach a child's development holistically and promoting health by a comprehensive and collaborative effort which helps to eliminate disparities and barriers to healthcare[28].

Numerous researches suggests that **breastfeeding** is associated with a lot of protective factors[29]. In 2013, Arizona ranked #29 on the Maternity Practices in Infant Nutrition and Care (mPINC) survey among all states, scoring a composite of 75 from a total of 100[30]. The breastfeeding initiation rates continue to increase in Arizona from 76.8% in 2009 to 81.6% in 2011[31].

Longer duration of breastfeeding can lower the risk of pediatric **overweight**[32]. In Arizona, 17% of **children** aged 10-17 years were **overweight** while 20% were **obese**[33]. There are more children with special health care needs

(CSHCN) who are overweight or obese in Arizona (37.6%) compared children without special health care needs(36.3%). Significantly more Hispanic children (50.2%) ages 10-17 were reported as being overweight or obese compared to 23.7% of White, non-Hispanic children in Arizona. Also, the percent of overweight or obese Arizona children who live at less than 100% of the federal poverty level (FPL) is 57.1% which is more than double those who live at 200-399% FPL(24.6%) and 400% or more FPL(23.7%) and substantially higher than those at 100-199% FPL(42%).

The percent of **overweight and obese women[34]** 18 years and older in Arizona increased slightly from 2011(51.4%) to 2013(54%). From 2011 to 2013, 18-24 year old women in Arizona was less likely to be (35.3%) overweight or obese while 45-54 year olds were the most (64.7%). In 2013, 62.9% women who made less than $20,000, 56.1% who made $25,000-49,999 and 47.2% who made $50,000 or more were overweight or obese.

Good **oral health** during preconception, pregnancy or intra-partum stage is a great mechanism to promote general wellbeing, birth outcomes and their child's dental health[35]. Nearly 66% of Arizona parents described their child's teeth(1-17 years) as being in excellent or very good condition, which was significantly less compared to national average of 71.3%. Over 80% of White, non-Hispanic children were reported as having teeth in excellent or very good condition, compared to only 52.4% of Hispanic children and 64.8% of other, non-Hispanic children in Arizona. In 2012, 64% women in Arizona age 18 and older self-reported that they had a dental visit within past 12 months[36]. This varied by race/ethnicity, with Hispanic/Latina women reporting the lowest percentage (48%), and non-Hispanic White women (69%) and women of other races or ethnicities (73%) reporting the highest percentages.

A child living in household where someone smokes has ill effects due to the second hand **smoking**[37]. In Arizona, 20% of children (1-17 years) live in a household where someone uses cigarettes, cigars, or pipe tobacco[38]. Fewer Hispanic households (17.2 %) had someone who smoked as compared to White, non-Hispanics (21.2 %). Considerably more children with special healthcare needs (25.1%) live in the household with someone using tobacco as compared to non-CSHCN children in Arizona (18.7%).

Recent trends show that mortality from cigarette **smoking** is increasing among women as compared to men in the United States who have plateaued since the 1980s[39]. In 2013, 13.5% of women in Arizona were current smokers[40]. According to Vital Statistics, in Arizona, 4.4% of women giving birth smoked during pregnancy.

The Title V program has utilized home visiting as an avenue to address smoking during pregnancy but will now additionally partner with the Bureau of Tobacco and Chronic Disease on a secondary smoke related antismoking campaign. The Program will continue the Fluoride Varnish Program and supporting the Empower Program.

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II.B.2.b Title V Program Capacity

II.B.2.b.i. Organizational Structure

Doug Ducey became the 23nd person to take the oath of office as Governor of Arizona on January 5, 2015. The Arizona Department of Health Services (ADHS) is one of the executive agencies that report to the Governor. A.R.S.

Title 36-691 designated the Arizona Department of Health Services as Arizona's Title V MCH Block Grant administrator.

The Arizona Department of Health Services is organized into four divisions: Public Health Services, Behavioral Health Services, Licensing Services, and Operations. The Office of Director includes a Native American Liaison, Local Health Liaison, Border Health, Public Information Office, and Legislative Services. Bureau of Health Statistics is also part of the Division of Public Health Services. The Division of Behavioral Health Services includes the State Hospital. An ADHS organization chart can be viewed at http://azdhs.gov/diro/documents/adhs-org-chart.pdf.

The Division of Public Health Services is organized into two primary service lines: Public Health Preparedness Services and Public Health Prevention Services (PHPS). Public Health Prevention Services includes four bureaus: Women's & Children's Health (includes the Office for Children with Special Health Care Needs), Nutrition & Physical Activity (includes WIC), Tobacco & Chronic Disease, and Health Systems Development (includes Center for Health Disparities).

Arizona Department of Health Services' 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.

The Bureau of Women's and Children's Health (BWCH) is comprised of seven offices: Office of Women's Health, which includes adolescents, Office of Children's Health, which includes infants, Office for Children with Special Health Care Needs, and cross cutting which includes the offices of Oral Health, Injury Prevention, Assessment & Evaluation, and the Business & Finance Section. The BWCH chief serves as the Title V Administrator. Most of the programs funded through Title V are housed in the BWCH. Where the funded programs are not a part of the Bureau there is a clear coordination of efforts.

Title V funds or assists in funding the Family Planning Program, the MCH Hot Lines, Community Health Grants which currently address preconception health and injury, EMPOWER, Oral Health Sealant Program, the Medical Services Program, the Sensory Program, the Birth Defects Registry, Immunization Program, Midwife Program, and specifically for Children with Special Health Care Needs, Education and Advocacy, gap filling programs including Metabolic Formula, Respite and Palliative Care Programs and infrastructure for Telemedicine.

An organization chart is attached.

II.B.2.b.ii. Agency Capacity

Arizona's Title V program supports **Women/Maternal** health through Title V funded **HotLines** where women can receive information about and referrals to preventive health services, prenatal care, breastfeeding, family planning and many other topics. Title V also supports the **Family Planning Program,** the **Midwife Program** and **Community Health Grants** which support county health departments to focus on preconception health. Additionally, the program administers the Sexual Violence and Prevention Program, Sexual Assault Services Program, Family Violence Prevention and Services/Rural Safe Home Network and a home visiting program. The Bureau also houses the Maternal Mortality Review. The Program partners with the SSDI grant, housed in Public Health Statistics.

The Program supports **Infant/ Perinatal** Health again through the Title V Hotlines, breastfeeding, the neonatal emergency transport program, and early childhood home visitation programs. Additionally, Title V helps to support the **Immunization Program** and the **Empower** program that will be discussed in the Child Health section. The Bureau chairs a Safe Sleep Task Force and the Safe Sleep CoIIN. Title V funds will be used to sponsor a **Safe Sleep media campaign**. The Program works closely with Newborn Screening.

The health of **Children** is supported through the **Medical Services Program**, **Community Health Grants** by

addressing injury, and the Empower Program which support physical activity, nutrition and injury prevention in child care centers. Additionally, the Program houses the MIECHV grant.

Adolescent health is supported again through **Reproductive Health Program** funded through Title V. Additionally adolescents are supported through teen pregnancy prevention programs, home visiting for teen mothers, preconception health support and a program aimed at empowering teen to make Positive Choices.

Office for **Children with Special Health Care Needs** (OCSHCN) maintains its critical Title V role in several ways: by advocating and educating families, stakeholders, community partners regarding children and youth with special health care needs (CYSHCN) through their Education and Training program; partnering and collaborating on systems of care for CYSHCN through the **Sensory Program**; and assisting families in accessing appropriate care and services for CYSHCN through the **Information and Referral Services**, and **Respite** and **Palliative Care** programs.

The health of women and children is also supported across the **lifespan** through several injury prevention and oral health programs. The Program uses Title V funds to support the **Fluoride Sealant Program**. Additionally, the Program administers the fluoride mouthrinse program, the First Dental Visit by One campaign, and provides technical assistance to Empower for oral health in child care settings. The Injury Prevention Office supports the other programs in the Bureau with data and analysis of injury mortality and morbidity for women and children to inform program development. Additionally the Office manages the Child Fatality Report, Maternal Mortality, Safe Kids, and Emergency Medical Services for Children grant.

In order to support a statewide system of services the Arizona Department of Health Services Bureau of Women's and Children's Health is in close communication with the other state agencies serving women and children including the Departments of Education, Economic Security and Child Safety and the Early Childhood Development and Health Board. These strong partnerships are maintained through constant communication and respect.

Arizona's Title V program does not provide direct services but uses Title V funds to support local communities through interagency agreements or contracting with community groups, nonprofits or local agencies. Title V funds are being used to support county health departments to provide preconception and injury services and to strengthen the communities' ability to put into place policies and programs to strengthen the communities.

By supporting i**nfrastructure** within the Bureau, Title V supports coordination with health components of community based systems. Bureau leadership work closely with Arizona's perinatal regionalized system by serving as a consultant to the Arizona Perinatal Trust. The Child Fatality Review Program collaborates with child welfare, county medical examiners, hospitals, law enforcement, and emergency services.

The Program also coordinates health services with other services at the community level. The Medical Services Project, funded through Title V works with school nurses and local clinicians to help children access care.

II.B.2.b.iii. MCH Workforce Development and Capacity

Executive leadership for maternal and child health is provided by the Director of ADHS, Dr. Cara Christ and Assistant Director for Public Health Prevention Services, Sheila Sjolander. Dr. Christ, also currently serves as the ADHS Chief Medical Officer.

Sheila Sjolander is the Assistant Director of Public Health Prevention Services in the Division of Public Health. Ms. Sjolander served as MCH Director and Bureau Chief of Women's & Children's Health until 2013. She began her service with the Bureau of Women's & Children Health in 2001 as a manager overseeing several programs and

leading the bureau's planning functions. She holds a Master's Degree in Social Work with an emphasis on planning and policy.

The state MCH workforce is housed within the Bureau of Women's and Children's Health. While most of the staff is funded by sources other than Title V, all contribute to the Title V mission and MCH priorities.

The Bureau of Women's and Children's Health employs approximately 40 fulltime staff. Title V funds are used to support approximately 20 positions in the Bureau and in other parts of the agency. The following are brief biographies of senior level management and key staff involved in the Title V needs assessment and application processes.

Mary Ellen Cunningham has been the MCH Director and Bureau Chief of Women's & Children's Health since 2013. Previously Ms. Cunningham served as the Chief of the Office of Children's Health. Ms. Cunningham is a registered nurse with a Master's Degree in Public Administration and serves as the agencies designee to the Arizona Early Childhood Development and Health Board, consultant to the Arizona Perinatal Trust and on the US Mexico Border Health Commission Reproductive Health Task Force.

Katheryne Perez has served as the Maternal and Child Health Epidemiologist for the Bureau since April 2014. She holds a Master's of Public Health in Epidemiology from the University of South Florida and is Certified in Public Health.

Pooja Rangan has served as the Bureau's Home Visiting Epidemiologist since November 2014. She practiced as a physician in India with experience in pediatrics and obstetrics and gynecology before receiving her Master of Public Health in Epidemiology and Biostatistics from Drexel University.

Antoinette (Toni) Means serves as the Office Chief of Women's Health. Ms. Means has nearly 20 years of progressively responsible program management experience, and has served in the Bureau of Women's & Children's Health since 1991. Ms. Means received a Masters in Business Administration in Health Care Management from the University of Phoenix.

Irene Burton serves as the Chief of the Office of Children's Health. Previously Ms. Burnton served as a member of the Governor's Executive staff where she managed the Children's Cabinet and the Office of Children, Youth and Families. She also was Director of the Governor's School Readiness Board where she worked with stakeholders to develop a multi-year state strategic plan that served as a blueprint for action on early childhood health and development.

Julia Wacloff serves as the Chief of the Office of Oral Health. She holds a Master's degree in Dental Public Health and is a registered dental hygienist. She most recently served as an epidemiologist with the Centers for Disease Control and Prevention in the Division of Oral Health. In 2015, Ms. Wacloff was appointed to the Board of Directors for the Association of State and Territorial Dental Directors.

Tomi St. Mars serves as the Chief for the Office of Injury Prevention and has led the Department's injury prevention and EMS for Children initiatives since August 2005. Ms. St. Mars is Arizona's representative to Safe States Alliance, an active member of the Emergency Nurses Association (ENA) at the national and state level and is a Certified Emergency Nurse. Ms. St. Mars holds a degree in Master of Science in Nursing.

Debi Morlan has served as the Bureau's Finance Officer since 2001. Ms. Morlan provides financial and contractual oversight to Title V funded programs, as well as the other federal and state programs with the Bureau.

Katharine Levandowsky serves as the Office Chief for the Office for Children with Special Health Care Needs. Ms. Levandowsky has over 16 years of experience working with the community, families, stakeholders and providers to develop services for individuals with disabilities. She spent 7 years administering Arizona's Vocational Rehabilitation, Independent Living and Services for the Blind, Visually Impaired and Deaf programs for both youth

and adults.

Rita Aitken serves as the Education and Advocacy as well as Health Program Manager in the Office of Children with Special Health Care Needs. Ms. Aitken has two adult children with special health care needs, and has many years of experience working with families and providers, including trainings on best practices for healthcare professionals. Rita is a member of the Governor's Interagency Coordinating Council for Infants and Toddlers; Newborn Screening, and Medical Home and Consumer Advisory Workgroups with Mountain States Genetics Regional Collaborative.

Dawn Bailey serves as the MCH/OSCHN Family Advisor. She has a young daughter with complex medical needs and global developmental delays due to a rare genetic condition. For the last two years Dawn has been an active Parent Leader with Raising Special Kids participating in the State's AFN Task Force for Emergency Preparedness, Parent Panels and the Family Faculty program.

Arizona shares a border with Mexico and is home to twenty one federally recognized American Indian tribes. Additionally, while most of the population resides in two counties, geographically, most of the state is rural if not frontier. In building the state's capacity to serve women and children in a **culturally competent** fashion, Arizona's Title V agency routinely collects and analyzes data by race, ethnicity, geography (rural or urban), and border and non-border.

To better serve diverse populations this past year the BWCH required every employee to complete Culturally and Linguistic Appropriate Standards (CLAS) training as a part of their performance appraisals.

II.B.2.c. Partnerships, Collaboration, and Coordination

Arizona's Title V agency has a strong history of reaching out to partner with others in the community to better serve the women and children of Arizona.

Major decisions for Arizona's Maternal Infant and Early Childhood Home Visiting grant have been made by an Inter-Agency Team consisting of First Things First, the Arizona Departments of Health, Education (ADE), and Child Safety and a representative from the Inter Tribal Council of Arizona.
Arizona's Title V Program partners with First Things First on the ECCS grant and the Title V Administrator serves on the First Things First Board. Other Federal programs housed in the Bureau of Women's and Children's Health includes the Emergency Medical Services for Children State Partnership Grant, SUID and the EMS for Children's Demonstration Grant, Title V Abstinence Education and the Core Injury Grant, PREP, Domestic Violence, SVPE, SASP and MIECHV. The SSDI Grant is managed through the Bureau of Vital Statistics.
The Bureau works closely with the county health departments in planning and development of maternal child health programs and initiatives by providing updates to the monthly Arizona Local Health Officer Association meetings, by including county health departments in program planning and including county health departments in initiatives like CoIIN.
In an effort to institutionalize collaboration and coordination within ADHS, the Bureau hosts a Zero to Five meeting quarterly where all areas of the agency who serve families birth through age five meet quarterly to share information and identify opportunities to partner. This includes but is not limited to Chronic Disease, Health Systems Development where the capacity of FQHCs are monitored, Immunizations, Newborn Screening, Child Care Licensing, Midwives, Behavioral Health and a parent representative.

The BWCH works particularly closely with the state's Medicaid agency, AHCCCS, participating in many AHCCCS Health Plan meetings. Health Start, HRPP Community Nursing, MIECHV, Family Planning and Hotline staff all facilitate families' enrollment in AHCCCS. AHCCCS staff are part of the Safe Sleep and Preconception Health CoIIN initiatives.

The Teen Pregnancy Prevention Program, collaborating with the Arizona Department of Economic Security (DES) Teen Pregnancy Prevention Task Force, has developed a Tool Kit for foster case managers that will serve as a guide for initiating and conducting discussions with youth 12 years and older on sensitive subjects related to physical development and sexual health.

The Arizona MIECHV Program will expand home visiting services into tribal communities. The MIECHV Program has held Tribal Consultations with Tribal Leaders to guide the work and interaction with federally-recognized Tribes in Arizona in expanding the Parents As Teachers Home Visiting Model into 6 tribal communities.

The Title V program works with the three state universities. Arizona has a critical need to increase the number of family-centered, culturally competent interdisciplinary providers to improve screening, early diagnosis and intervention services, and access to a medical home for children with special health care needs and their families. In support of the University of Arizona's LEND, Picture of Life with the Sonoran University Center of Excellence in Developmental Disabilities (UCEDD), and the ASPIRE programs, OCSHCN staff participates as a member of their advisory boards.

The Office of Oral Health (OOH) collaborated with the Arizona School of Dentistry and Oral Health and Oral Health America to continue and expand a school-based sealant program in Pinal County. The OOH conducted four professional development events for dental hygiene programs in one state university and three community colleges across Arizona.

The Sexual Violence Prevention Education Program (SVPEP) contracts with Arizona State University and the University of Arizona to develop and conduct online and in-person educational sessions on consent, the link between alcohol and sexual violence, bystander intervention strategies and resources for victims.

OCSHCN has contracted with Raising Special Kids (RSK) the Arizona Family-to-Family Health Information Center to create a Family Advisor Registry of young adult and family advisors. RSK identifies, recruits, trains, and reimburses individuals and family members of CYSCHN to participate in projects, committees, workgroups, resource development, policy and program development implementation, and evaluation at national, state and community levels.

In 2015, the ADHS began working closely with the Arizona Criminal Justice Commission and other state agencies to pilot the Arizona Rx Drug Reduction Initiative. This includes adoption of Emergency Department Prescribing Guidelines in participating hospitals, improving utilization of the Prescription Drug Monitoring Program (PDMP), identifying "above average" prescribers and improving accessibility of drug drop boxes in participating counties. Additionally, the group developed voluntary, consensus guidelines that promote best practices for prescribing opioids for acute and chronic pain.

The Bureau collaborates with the local chapter of the March of Dimes, the Arizona Family Planning Council, South Phoenix Healthy Start, the Early and Children's Action Alliance. Staff participates on committees or workgroups and collaborate on projects with many child-serving community organizations including, United Cerebral Palsy of Central Arizona, Arizona Chapter of Academy of Pediatrics, and Ronald McDonald House among others.

II.C. State Selected Priorities

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1	Improve the health of women before and between pregnancies.	New	
2	Reduce Infant Mortality and Morbidity	New	
3	Decrease the incidence of childhood injury.	New	
4	Increase early identification and treatment of developmental delays.	New	
5	Promote smooth transition through the life course for CYSHCN.	New	
6	Support adolescents to make healthy decisions as they transition to adulthood.	New	
7	Reduce the use of tobacco and other substances across the lifespan.	New	
8	Improve the oral health of Arizona'swomen and children.	New	
9	Increase the percentage of women and children who are physically active.	New	
10	Strengthen the ability of Arizona a families to raise emotionally and physically healthy children.	New	

Arizona's Title V managers spent the better part of the year listening to what people felt were priorities for the women and children in Arizona. The Program concurrently looked at the data to find the scope of the problem of the issues raised. Information gathering consisted of an online poll with over 900 respondents, Listening Sessions, Community Forums, a Tribal Consultation and finally a priority setting session open to the public either in person or online.

For the final priority setting session the Program complied the data and the top issues raised through the different venues and presented it through a PowerPoint presentation. In a facilitated discussion different topics were discussed by the population.

For Women/Maternal health the highest priorities were access to preventive health services including reproductive

and sexual health, STI screening and treatment. These services were meant to include preconception or interconception counseling by all providers including midwives when requested. Additionally people brought up mental health services including post partum depression screening; nutrition and physical activity interventions to reduce obesity; chronic disease management; substance abuse services including treatment, harm reduction services, overdose training and prevention during pregnancy and sexual assault and domestic violence services. There was discussion about affordable child care and housing support for homeless pregnant women.

The discussion for the Perinatal/Infant domain concentrated on injury, parent support and breastfeeding support. Specifically the topics discussed throughout the state included injury prevention education including shaken baby and safe sleep. Early identification of delays and treatment was raised often as well as family support and education about child abuse prevention. Other topics included immunization availability for mom and newborn; substance exposed newborns; domestic violence services; mental health services for perinatal mood disorder screening and treatment and quality child care.

For Child Health the Program heard often about exposure to adverse childhood experiences, child abuse and neglect and bullying. Additionally folks raised the issues of nutrition and physical activity services for obesity prevention; oral health; mental health services including suicide prevention; injury prevention services including car seat clinics and education and early identification and intervention services to improve school readiness and access to quality childcare.

For Adolescent Health the community raised concern about behavioral health services for stress, depression, suicide prevention, sexual assault and bullying. Additionally the Program heard about the need for substance abuse education, assessment and services; teen pregnancy prevention services, STI and contraception counseling and services; nutrition and physical activity services to address obesity prevention and youth development, recreation opportunities, career development and foster care transition services.

For Children with Special Health Care Needs the need for support for navigating systems of care was raised. Included here was helping families connect to resources and access to healthcare. During the discussions about improving the health system generally the Program heard about the need for early intervention screening and services, family centered care, and access to specialty care and equipment. Finally, improving systems of care across the life course included child care where the lack of inclusive child care centers was discussed; shortage of behavioral health support in the community; the need for more disability services; more support for developmentally disabled children in schools and that schools should be more knowledgeable about available services; the need for support for young adults to transition to adulthood and to become empowered to take control of their own health decision making. Finally, the Program heard about the special concern for CYSHCN in the Foster Care system.

The groups were asked if any topic was left off. The criteria for selecting final priorities were reviewed. The group was asked to think about: the size of the problem; the severity of the problem; significant disparities; urgency and whether or not there are evidence based or informed interventions that address this need.

Finally, those in attendance were asked to put a colored dot next to the issue they felt was the highest priority for each of the population domains. Those on ILink could type in their selections.

In the end, the Program chose to select **improving the health of women before and between pregnancies** for our Women/Maternal priority. It was felt several issues could be addressed with the broader priority including family planning, and reproductive health, sexual assault and domestic violence services and preconception or interconception health education and support which would include physical activity and nutrition. While there is some opportunity to address behavioral health through substance abuse and perinatal depression screening by home visiting and referrals in the community, the Program does not have the ability to modify the behavioral health system.

There was discussion about affordable child care and housing support for homeless pregnant women and while these two issues are of paramount concern for the health and wellness of women and pregnant women it was

decided that these topics were out of the purview of the Title V MCHBG and that the Program would continue to partner with and support our sister agencies under who these areas fall.

For Perinatal/Infant health domain, the broad priority of **decreasing infant mortality and morbidity** was selected. The Program felt in would be inclusive of several of the concerns the Program is or could be in the position of addressing. Focusing efforts on breastfeeding would include parent support, preconception health, nutrition and behavioral health as it related to infant parent bonding and maternal depression. The concerns related to injury will be addressed in the Child domain.

Title V already helps to support the state's immunization program. The ADHS Bureau of Child Care Licensing and home visitors already address immunizations. We felt the discussion about early identification of delays and treatment was more appropriate for the Child Health section. As it was identified through the data that Neonatal Abstinence Syndrome is increasing in Arizona as it is nationally, the Program will also address NAS in this plan.

Again, quality child care was not considered to be a maternal child health priority that should be addressed through Title V. Arizona's Early Childhood Development and Health Board has instituted a Quality Rating System and has devoted a great deal of resources to this effort.

The priority for Child Health domain was clear: **reduce the incidence of childhood injury**. The preponderance of what was heard spoke to injury or their effects: Adverse Childhood Experiences, child abuse, safe sleep, car seats and bullying. The data pointed to safe sleep, injury around the home for children 0 to 4 years and young teens and MVC. Additionally, the community voiced concern about **early identification of developmental delays.** This was added as a performance measure as well.

The Program felt nutrition and physical activity services would be covered through breastfeeding in Infant Health, preconception health in Woman Health and again in Adolescent Health. As Arizona does not have access to PRAMS data, oral health will be selected for a state priority.

Looking to develop the Adolescent Health priority, again the Program looked for a robust priority, choosing to **increase the ability of adolescents make healthy decisions as they transition to adulthood**. The Program felt it would be able to address injury (bullying, suicide prevention, sexual assault) and wellness (substance abuse education, general prevention including reproductive health and obesity prevention, teen pregnancy prevention) under this priority.

The community made clear that taking into effect the concerns of access to care and community resources, the need for early intervention screening and services and the importance of improving systems of care, the group selected **ensuring a smooth transition through the life course for CYSHCN** as a priority.

To capture the priority that crossed the life span and that fit with one of the National Performance Measures, the Program looked to smoking. The Program felt smoking included concern about infant mortality and morbidity (SUID, prematurity), child health (asthma) preconception and interconception health and transition decision making for teens and children and youth with special health care needs. The phrase 'other substances' was added as the Program is also looking at the emerging issue of prescription drug abuse and infants born with Neonatal Abstinence Syndrome. The priority selected was to reduce **the use of tobacco and other substances across the lifespan.**

There were three other areas of concern voiced throughout the community; oral health, general wellness and activity and the ability of families to raise emotionally and physically healthy children. These were added as state priorities as: **Improve the oral health of Arizona's women and children; Increase the percentage of women and children who are physically active** and **Strengthen the ability of Arizona families to raise emotionally and physically healthy children**.

The team then reviewed the priorities Arizona had chosen five years ago: Reduce teen pregnancy among youth less than 19 years of age; Improve the percentage of children and families who are at a healthy weight; Improve the health

of women prior to pregnancy; Reduce the rate of injuries, both intentional and unintentional; Improve access to and quality of preventive health services for children; Improve the oral health of Arizonans; Improve the behavioral health of women and children; Reduce unmet need for hearing services; Prepare children and youth with special health care needs for transition to adulthood and Promote inclusion of children with special health care needs in all aspects of life to determine which should be continued and which should be eliminated.

They were very similar. The Program decided to eliminate the priority around unmet need for hearing services because NBS Follow Up and the EDHI program is addressing that need and has reduced the unmet need. Oral health will continue to be a priority but that will be a state priority, as Arizona does not currently participate in PRAM.

The adolescent priority of making healthy decisions as they transition to adulthood would encompass the old teen pregnancy priority. The decision was made to continue an injury priority. The priority about healthy weight is being addressed in preconception health, breastfeeding, Empower and teens and CSHCN making good choices to include nutrition and physical activity. The Child priority about Developmental Screening speaks to the old priority of improving access to and quality of preventive health services for children but in a limited fashion.

The team came to the understanding that there are limits in what the Program could do to improve the behavioral health of women. Women are screened for perinatal depression in all home visiting models, and BWCH staff is partnering with WIC to complete a Computer Based Training for WIC staff and home visitors about perinatal depression.

The team felt strongly about maintaining the last assessments' priority of preparing children and youth with special health care needs for transition to adulthood.

II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

NPM 1-Percent of women with a past year preventive medical visit

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective					

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective					

NPM-4 B) Percent of infants breastfed exclusively through 6 months

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective					

NPM 6-Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective					

NPM 7-Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Annual Objectives					
	2016	2017	2018	2019	2020

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	215.1	212.9	210.8	208.6	206.4

NPM 9-Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective					

NPM 10-Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective					

NPM 12-Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective					

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective					

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective					

In this discussion the Maternal Child Health Program will link eight selected National Performance Measures to the priorities Arizona chose to focus on for the next five years, based on the findings of the Title V Needs Assessment.

NPM 1: the percent of women with a past year preventive medical visit. The priority Arizona selected for **Women/Maternal** population was to improve the health of women before and between pregnancies. The Needs Assessment process identified many concerns for women including access to preventive health services. The discussions centered on reproductive health and behavioral health, obesity, perinatal depression and sexual assault and domestic violence services. Assuming that preventive medical visits are comprehensive, Arizona believes that increasing preventive medical visits will help to affect national outcome measures that speak to women's health. Arizona will also select other strategies to address preconception and interconception health.

NPM 4: a) percent of infants who are ever breastfeed and b) percent of infants breastfeed exclusively through 6 months. Arizona's priority for the **Infant/Perinatal** domain is to reduce infant mortality and morbidity. Discussions for this domain included injury prevention, child abuse and neglect, perinatal mood disorder and breastfeeding support. By selecting this measure Arizona believes that not only will the emphasis on breastfeeding support the infant's nutritional requirements but also the mother baby dyad will benefit by the bonding and attachment that a successful breastfeeding experience can support[1].

For **Child Health**, Arizona chose two measures: NPM 7: Rate of injury related hospital admissions per population ages 0-19. Arizona selected this NPM as one of our measures to address the priority of decreasing the incidence of childhood injury. During the Needs Assessment process the team heard many times the concern about adverse childhood experiences, child abuse and bullying. The data also spoke to infants dying because of unsafe sleep environments, young children being injured around the home and adolescents being injured because they were not using seat belts. Arizona will institute or continue measures to decrease sleep related deaths, home related accidents and increase adolescent use of seat belts. **NPM 6**: percent of children, ages 10-17 months, receiving a developmental screening using a parent completed screening tool and The community voiced concerns about early identification of developmental delays.

NPM 12: Percent of **children with or without special health care needs** who received services necessary to make transitions to adult health care. Arizona selected this NPM as a way to track progress on the priority of supporting a smooth transition through the life course for CYSHCN. The concerns that were raised during the Needs Assessment process spoke to the difficulties in 'navigating the system', the need for early intervention and specialty services.

Arizona chose two NPM for **adolescents**. NPM 9: percent of adolescents, aged 21-17, who are bullied or who bully others and 10: the percent of adolescents, ages 12-17, with a preventive medical visit in the past year. During the Needs Assessment process the teams heard concerns about stress, depression, suicide and bullying. There was also concern raised about reproductive health services and obesity prevention. The priority Arizona chose for adolescent health was to support adolescents to make healthy decisions as they transition to adulthood. This would of course be inclusive of adolescents with or without special health care needs.

For the **Life Course, Arizona** chose NPM : NPM 14: a) percent of women who smoke during pregnancy and b)

percent of children who live in households where someone smokes. As the community is very interested inwellness through the life course there was interest among the team to monitor smoking not just during pregnancy but during all of childhood. This measure speaks to preconception health, infancy as smoking is associated with SUID, and general wellness.

[1] John R. Britton, MD, PhD, Helen L. Britton, MD, Virginia Gronwaldt, PhD, **Breastfeeding, Sensitivity, and Attachment** PEDIATRICS Vol. 118 No. 5 November 1, 2006 pp. e1436 -e1443 (doi: 10.1542/peds.2005-2916)

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

States are not required to provide a narrative discussion on the State Performance Measures (SPMs) until the FY2017 application

II.F. Five Year State Action Plan

II.F.1 State Action Plan and Strategies by MCH Population Domain

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Improve the health of women before and between pregnancies.	By 2020, increase the number of providers who feel prepared to include preconception in a well visit by 20%.	Conduct a survey of OB/Gyn and Family Practioners regarding preconception health practices every two years. Work with medical professional organizations to promote the training and resources available on the ADHS Clinician web site	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Percent of low birth weight deliveries (<2,500 grams) Percent of very low birth weight deliveries (<1,500 grams) Percent of moderately low birth weight deliveries (1,500-2,499 grams) Percent of preterm births (<37 weeks) Percent of early preterm births (<34 weeks) Percent of late preterm births	Percent of women with a past year preventive medical visit		

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
			(34-36 weeks) Percent of early term births (37, 38 weeks) Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births			

Women/Maternal Health

Women/Maternal Health - Plan for the Application Year

The Bureau of Women's and Children's Health (BWCH) administers a range of programs that focus on the health of women during their child bearing years. The programs seek to ensure that women have the information and resources necessary to achieve optimal health and wellness. The programs are primarily preventive and serve as safety net services in communities with limited resources.

For fuller descriptions of these programs please see the Annual Report section. The bureau's work to improve the health of women will continue and will expand as resources permit. The Domestic Violence Program will work with other state and local agencies to determine how to use the data from the Balance of the State report to strengthen advocacy and support victim's needs. Also in 2016, the MCH program will strengthen Rural Safe Home Networks' collaboration with law enforcement and the judicial system. As advocates learn more about the impact of sexual assault, it is anticipated that contractors will increase services to address that need. Contractors will continue to train staff on implementing trauma informed care and work to increase their attainment of outcome measures from 88% to 90%.

Since the SVPEP Program Manager is the only Master ASBA trainer, additional Master trainers must be recruited and trained to respond to requests from alcohol serving establishments and train others to deliver presentations. To address this need, SVPEP will investigate collaborating with systems that work with alcohol serving establishments such as law enforcement and local injury coalitions. The program will also seek assistance from other partners. This next year will be focused on growing ASBA in a thoughtful manner and working to move the project from evidence informed to evidence based.

Moving forward, the SASP will continue to fund sexual assault service providers in rural, underserved communities and will partner with the ACESDV to ensure that sexual assault service providers are aware of how to access the victim compensation funds.

The 2016 goals for the Family Planning Program include continuing to move clients to a more effective method of contraception, increased preconception health education, increasing chlamydia screening rates among young females aged 15-24, and increasing the proportion of clients with gonorrhea and chlamydia that that have a 3 month follow up. With regard to the cost of LARCs, the program will research the possibility of county health departments coming together to enter into purchasing agreements with pharmaceutical companies.

During 2015/2016, the Preconception Health Alliance will develop and distribute public awareness messages, create a preconception health speaker's bureau, increase HPV series completion among adolescents, increase the use of reproductive life plans, and pilot "One Key Question. As a part of the CoIIN Preconception Health initiative, two clinics will pilot use of a newly developed reproductive life plan program for a 2 week period to assess client response and obtain provider feedback on the best method for integrating life plans in each visit.

The Preconception Health Alliance issues a women's health report every two years to track trends in women's health status. Data is broken out for women in rural and urban communities. It will be updated in 2015. In addition, during 2015/2016, the Preconception Health Strategic Plan will be updated and made available to the public.

To provide resources and tools for health care providers, the Preconception Health Coordinator will present the "Show Your Love" campaign to Title X funded agencies in August, 2015 and update the Health of Women and Girls section of the Health Babies website.

Title V funds County Health Departments to address preconception health. While the approach varies by county, each utilizes the Spectrum of Prevention. This model moves from providing direct services to community education, provider education, fostering coalitions, changing organizational practices, and implementing policy. Going forward these grants will now reflect the new Title V priorities and counties will need to utilize evidence based strategies to move the needle on the priorities they choose to address.

Each of the BWCH programs impacting Women's/Maternal Health and described in the Annual report will continue to provide core services and identify emerging issues and opportunities to improve services.

Women/Maternal Health - Annual Report

NPM 1 - Percent of women with a past year preventive medical visit

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	61.9%	62.5%	63.1%	63.7%	64.4%

BWCH is responsible for administering the Federal **Family Violence** Prevention and Services Act (FVPSA) grant

funds. FVPSA supports the establishment, maintenance, and expansion of programs and projects that prevent family violence and provide immediate shelter and related assistance for survivors and their dependents. For 27 years, funds have supported development of the Rural Safe Home Networks encompassing all BWCH-funded domestic violence programs. The cornerstone of the program is to provide guidelines and technical assistance to develop Safe Home Networks in Arizona's rural communities and to promote networking and collaboration among domestic violence and community social service providers.

The Program funds nine organizations, each reflects the unique needs of their community and the victims they assist. Each organizations funds all or some of the following culturally and linguistically appropriate services: 1) immediate emergency shelter and related supportive services 2) assistance to develop safety plans and 3) individual and group counseling, peer support groups, and referral to community-based services. In addition, they provide 1) advocacy, 2) case management, 3) information and referral, 4) help to access Federal and State financial assistance, 5) legal advocacy to assist victims and their dependents, medical advocacy, including referrals to health care such as mental health, alcohol, and drug abuse treatment, 6) homelessness prevention and assistance to locate and secure permanent housing, 7)transportation, 8) child care, 9) respite care, 10) job training and employment services and 11) parenting and educational services.

In 2014 the Rural Safe Home Network sheltered 371 unduplicated women, 10 men and 299 children for a total of 23,183 bed nights. Supportive services to individuals that did not reside in a shelter were provided to 2,418 women, 155 men, and 1,013 children.

The program collaborates with state and private agencies to implement services based on the Arizona Service Standards and Guidelines for Domestic Violence Programs. The Guidelines were developed by the State Agency Coordinating Team (SACT) and supported by the Arizona Coalition to End Sexual and Domestic Violence (ACESDV). SACT meets monthly to discuss issues and funding opportunities. ACESDV provides training and technical assistance to BWCH-supported programs.

BWCH promotes networking and collaboration among domestic violence and community social service providers at the local level to deliver services in underserved rural communities. Each community has its own network, which may include service clubs, faith based organizations, housing and homeless services, police departments, food banks and others. Each organization collaborates with local health and social service providers, including federally qualified health centers, county health department and oral health services to facilitate smooth referrals for the families they serve.

One of the successes of the program includes integration of a provider into the quarterly well women health check clinics offered by Indian Health Services. One of the organization's advocates has a permanent station in the clinic and is available to speak with women as they rotate between providers.

Challenges faced by victims of domestic violence in rural communities include a lack of access to transportation, affordable housing, legal services, child care and employment. Rural domestic violence service providers are challenged by lack of funding, staffing, and availability of supportive services.

In 2014 BWCH collaborated with ACESDV, Arizona State University Morrison Institute for Public Policy and the Arizona Department of Economic Security to implement a statewide study to ascertain how well shelters were meeting the needs of domestic violence victims and their families and prompt discussion among practitioners, funders and stakeholders about the results of the study. A key finding was that non-shelter support services are equally as important in rural and urban communities and ranked as a higher need than shelter services. In April 2015, the data was distributed to domestic violence service providers statewide.

BWCH administers the **Sexual Violence Prevention and Education Program (SVPEP)**. This funding was established in 1994 under the Violence against Women Act (VAWA) and reauthorized in 2013. The goal is to reduce sexual violence through implementation of evidence based/ informed primary prevention with individuals and

communities. The Arizona SVPEP contracts with two state universities and two community based organizations to provide multi-session educational presentations for youth and young adults in middle and high schools as well as universities. Services are provided in three of Arizona's 15 counties. In 2014, SVPEP provided these educational sessions to 13,129 individuals. Of those, 1,320 were middle school students, 2,120 high school students and 9,658 university students.

Arizona SVEP also implements the Arizona Safer Bars Alliance (ASBA) an innovative project to decrease sexual violence by providing bystander intervention training to staff of alcohol serving establishments. The staff receives five hours of education on how to recognize sexual aggression perpetration by patrons and how to intervene safely to defuse the situation. To become an Alliance member, the establishment must have 70% of staff that interact with patrons complete the training, participate in two sexual assault prevention or awareness community events each year, display the ASBA window cling and posters and hold an annual refresher training for staff. Owners are also asked to conduct an environmental scan to identify dark and other potentially dangerous areas on site and in the parking area. To date, 3 establishments have become ASBA members

In the center of the state, Arizona State University provides presentations on sexual assault and healthy relationships to students and gatekeepers (faculty, staff and student leaders who are in the position to influence student attitudes and behaviors). In addition, certain freshman classes, residential colleges and scholarship programs require an online Alcohol Education class which includes sexual assault education. The university has a media campaign that includes posters, bulletin boards in residence halls, student newspaper ads, newsletter articles, Facebook, and web-based information. They also conduct activities designed to increase awareness at the population level, such as the Sex Signals Improv production, Take Back the Night rallies, and lectures by national speakers (e.g., Jackson Katz), etc.

A local agency in northern Arizona coordinates the Men against Rape and Sexism (MARS) Project, a peer leadership/educator effort at the local university. Participants in MARS receive multi-session, theory-based and culturally relevant training on a range of sexual violence topics including violence and oppression in society, healthy relationships, homophobia/hypermasculinity, prevention theory and public presentation skills. The MARS peer leaders focus on four areas: peer education, community awareness, community action and liaison/coalition building.

The University of Arizona, in the southern part of the state provides STEP up!, an evidence based bystander intervention curricula to students. They are in the early stages of conducting a needs assessment on campus that will be used as a guide for additional curriculum related to rape myths, gender socializations, social justice and university policies related to Title IX and the Clery Act.

The Arizona SVPEP collaborates with a number of partners. The Arizona Department of Liquor Licensing Control Communications and Special Projects Director partners with SVPEP by co-training bar staff in conjunction with the ASBA training and participating in ASBA planning meetings. The SVPEP participates on the Governor's Commission to Prevent Violence Against Women and is a member of the State Agency Coordinating Team (SACT). ACESDV participates in SVPEP quarterly meetings, and will co-plan updating and revising the Arizona Sexual Violence Primary Prevention and Education Eight Year Program Plan with SVPEP. Working with the University of Arizona on the evaluation and fidelity tools and logic model for the ASBA to move it from evidence informed to evidence based have positively impacted SVPEP.

The SVPEP Program Manager also administers the **Sexual Assault Services Program** (SASP) which provides direct services to individuals who have survived sexual violence. Funding is provided by the Office on Violence against Women (OVW) to support crisis centers and nonprofit organizations that provide direct intervention and supportive services. During 2014, 412 women over the age of 18 received direct services in four Arizona counties. SASP services include: civil legal advocacy/court accompaniment, counseling services/support group, criminal justice advocacy/court accompaniment, crisis intervention, employment counseling, financial counseling,

hospital/clinic/other medical response, material assistance, transportation and victim/survivor advocacy. The SASP funds are targeted to under-served/rural areas where services for sexual assault victims/survivors are minimal ornon-existent. Funds allow contractors to provide up to twelve months of short term counseling for victim andsecondary victims. The SASP contractors are established agencies with experience providing sexual assault services in rural areas to underserved populations. The staff understands the cultural and social issues as they relate to reporting and responding to sexual violence.

In addition to serving on the SACT, the program collaborates with the Arizona Coalition to End Sexual and Domestic Violence (ACESDV). ACESDV serves on the evaluation team when the SASP issues solicitations for services and will work with SASP to conduct an updated assessment of unmet needs and underserved populations.

The SASP funds enhance the capacity of local sexual assault service providers to increase outreach and offer hotline and/or counseling and supportive services for victims. The SASP contractor serving southern Arizona is offering a support group for women in a community near the Mexico border. This would not have been possible without SASP funding. SASP contractors coordinate with community partners to ensure clients are aware of their rights and have access to services. In addition, they have established referral networks with law enforcement, health care providers, social service agencies and faith organizations. While SASP funding does not pay for forensic exams, a newly established collaboration has been forged with Holy Cross Hospital, the only hospital in one southern county to conduct medical forensic exams in their Emergency Services Department.

Some of the challenges faced are that many people who have experienced sexual violence are not aware of services, transportation in rural areas, and not all sexual assault providers, especially smaller agencies, are aware of the victim compensation fund and how it can be used to increase services to their clients.

BWCH uses Title V Maternal and Child Health Services Block Grant funds to support the **Reproductive Health/Family Planning Program**, a statewide, clinic-based, program that provides comprehensive reproductive health services to promote optimal health for Arizona's men and women. These services allow clients to make voluntary and informed decisions that fit with their personal reproductive, educational and occupational goals. Clients receive initial or annual exams which include: a choice of a family planning method, cancer and IPV screenings, STI screening and treatment, pregnancy testing, counseling, education, preconception counseling and reproductive life planning and information and referrals to other medical services. In some rural communities, there are great distances between providers, and the Title V Reproductive Health clinic is the most convenient option for receiving screening, education and contraceptives, filling a gap in services. In 2014, Title V reproductive health/family planning programs reported 2,763 unduplicated adults ages 20 and up receiving services and provided 7,657 visits, 2652 chlamydia tests, 224 syphilis tests, 2,168 gonorrhea tests, 509 HIV tests, 2,314 breast exams, 1,402 pap tests, and 2,194 pregnancytests.

The Reproductive Health Program partners with other community resource. It collaborates with the Title X grantee on data collection and training. It works with WIC, home visiting programs, and the Office of Immunizations on referrals. It works with the STD and HIV programs to obtain data and ensure the Title V clinics are following current screening and testing guidelines. Each provider maintains a comprehensive list of local resources to assist clients and refers to then for physical and/or behavioral health care and socialservices.

Several factors have contributed to the progress of Reproductive Health Program in 2014 and 2015. One is the stability of the program and its' long standing integration into rural county health departments. Social media has made sexual health easier to talk about; it allows users to find answers for many of their health concerns including dieting, physical fitness, and contraception. Many programs now use text messaging to remind clients of their next appointment.

Barriers to provision of family planning include cost. While Long Acting Reversible Contraceptives (LARCs) are receiving more attention due to their effectiveness, cost is a barrier, even if a LARC would fit best with the client's

lifestyle and reproductive goals. Unlike the Title X funded agencies, county health departments are not eligible to purchase family planning supplies under 340B and the Reproductive Health budget has remained flat for the past several years. For eleven of the twelve programs that are located in rural communities, challenges include limited public transportation, and clients sometimes have to drive more than 60 miles to get to their appointment. In addition, retaining qualified nurses and practitioners is difficult.

Health Start is a **home visitation** program that utilizes community health workers (CHW) to identify women early in their pregnancy and link them to prenatal care. CHWs provide education, referrals and developmental screenings until the child's second birthday. Health Start is in State Statute which describes the purpose, requirements and administration of the program. It is funded by the Arizona State Lottery at approximately $2.1 million per year.

Health Start contracts with 13 community based agencies including county health departments. The program identifies, screens and enrolls pregnant and postpartum women and families early in their pregnancies and assist women to obtain early and consistent prenatal care. CHWs provide prenatal and postpartum education, parenting education, depression, alcohol, tobacco and other drug screening, brief intervention and education, domestic violence screening and education, Healthy @ Home Assessments, advocacy and case management services and information and referral services. CHWs also educate women on interconception health and birth spacing. In 2014, Health Start services were provided to 2,411 clients through 16,054 home visits.

Nearly all (93.4%) children in Health Start are properly immunized. Health Start sponsored car seat safety certification education for 5 CHW and every Health Start site has at least one certified car seat technician. In 2014, 340 infant seats and 500 convertible car seats were provided to clients along with education on the proper use of car seats. Over half (50.1%) of the women were breastfeeding at 6 months postpartum. Only 4.2% of pregnant clients smoked during their pregnancy. Slightly over two percent of Health Start babies were born at Very Low Birth Weight.

Collaboration ensures that Arizona has a coordinated approach regarding provision to home visiting services to avoid duplication of services and ensure families can access the service that meets their needs. Health Start is a member of the Strong Families Arizona Home Visiting Alliance, which facilitates collaboration among all of the home visiting programs in Arizona. Health Start also coordinates with the Department of Child Safety and Medicaid health plans. It serves as a lead member of the Statewide Task Force on Preventing Prenatal Exposure to Alcohol and Other Drugs. The purpose of the Task Force is to increase awareness of substance use among pregnant women, increase screening for alcohol and other drugs, including prescription drugs, and increase awareness of treatment options.

Health Start is also collaborating with the ADHS Bureau of Behavioral Health on a project to assess the rates of substance abuse and mental health conditions among pregnant women and women with dependent children; assess community assets and resources available to address those needs and identify and prioritize needs and services. Health Start is also working with the Arizona Community Health Workers Outreach Network and the Alliance of CHW's to assess CHW training needs/requirements, adopt a standard framework regarding the scope of practice and research the possibility of creating a State certification for CHWs.

Health Start collaborates with health providers including four federally qualified health centers. As a result of implementing Screening, Brief Intervention, Referral to Treatment (SBIRT) for their Health Start contract, one of the health centers now conducts SBIRT with all female patients.

The transient nature of Health Start clients poses challenges to providing services on a long-term basis, and therefore clients do not receive the maximum benefit from program. Staff turnover is especially high in rural communities. It is sometimes difficult for clients to adopt the birth spacing recommendation of at least 18 months between births due to cultural/religious and generational beliefs.

Health Start Program has worked to integrate domestic violence screening into the scope of services provided to clients. CHWs screen using the Relationship Assessment Tool adapted from the WEB scale after 3 months of

enrollment. In 2014, 432 women were screened. Of those, 7.6% were at high risk for domestic violence or were experiencing domestic violence. Eighty five percent of women who screened at high risk accepted a referral to domestic violence resources and 72% of all women screened received and reviewed a safety plan card.

The CHWs coordinate case management to clients experiencing domestic violence. In a community near the Arizona-Mexico border, a Health Start client disclosed to the CHW that they were in a violent situation. The perpetrator only allowed her to venture out alone when she visited the community health center for prenatal care services and for Health Start office visits. During a recent visit the client decided to leave the perpetrator and go to a domestic violence shelter. The CHW and Patient Advocate helped to plan her safe evacuation and made arrangements for her to receive residential services at a shelter in a neighboring town.

Maternal, Infant and Early Childhood Home Visiting Program (MIECHV) is a part of Arizona's Title V Bureau and provides evidence-based home visiting programs to pregnant women and women with children under the age of five. While MIECHV will be described in more detail in the Infant/Perinatal section, for women, MIECHV promotes and encourages prenatal care and postpartum care; screens and refers for pre and postnatal use of alcohol, tobacco or drugs; provides information and education on birth spacing and preconception care; screens and refers for maternal depression; increases health insurance enrollment for families; screens and refers for domestic violence including completing a safety plan when needed.

The BWCH hosted "The Improving Birth Outcomes Summit" in 2014. One of the strategies identified was to educate home visitors about women's wellness and birth spacing as the provide education to women early in pregnancy. MIECHV partnered with Arizona Family Health Partnerships, the Arizona Title X provider, to develop and implement a Family Planning/Well Woman training to provide home visitors with information and tools for young families regarding birth spacing, preconception and inter-conception health.

The 2014 Strong Families Home Visiting Conference provided several sessions targeting women and maternal health. Examples of some of the workshops offered included; Client-Centered Reproductive Health and Interconception Care and Counseling; Mental Health First Aid; Helping Moms and Kids Make Healthier Food Choices; Engaging Reluctant Parents through Adult Learning; Working with Victims of Domestic Sex Trafficking; Substance Abusing Mothers and the Home Visitor and Supporting Home Visitors in Addressing Domestic Violence. Planning is underway for the 2015 Conference with similar workshop offerings.

Courses on Prenatal and Postpartum Nutrition specifically addressed women and maternal health. In 2015, MIECHV supported the ADHS Bureau of Nutrition and Physical Activity (BNPA) to create an interactive webinar series on Breastfeeding that allows Certified Lactation Consultants to receive lactation credit.

Title V helps to support the **Midwife** Licensing Program that currently licenses 73 midwives. The application for initial licensure requires documentation that the midwife is certified by the North American Registry of Midwives as a Certified Professional Midwife. The license renewal process includes a minimum of 20 hours of continuing education units to improve a midwife's ability to provide services within the scope of practice, recognize and respond to situations outside the midwifery scope, and provide guidance to other services a client may need.

Licensed Midwives' Scope of Practice includes providing information regarding perinatal care and providing assessment of the mothers for potential medical concerns. This instruction includes giving the mother information about newborn screening, appropriate immunizations, nutritional counseling for pregnancy and breast feeding, cord blood information, dangers of smoking with pregnancy, and need of protective car seats for the newborn after delivery. They provide resources to mothers to assure the newborn has the best care possible from conception through six weeks post-delivery.

Title V also helps to support the Arizona **Birth Defects Monitoring Program** in ADHS's Bureau of Public Health Statistics. The measurable outcomes of the program are to prevent or reduce birth defects and developmental disabilities and reduce health disparities in the occurrence of folic acid-preventable spina bifida and anencephaly by reducing the birth prevalence of theseconditions.

Measures to prevent or reduce birth defects and developmental disabilities include statewide surveillance to track and publish the occurrence and associated factors, providing data for national and local projects and reviews; publishing annual reports which include prevention strategies; developing, presenting, and distributing birthdefects prevention information at public health events. In addition, staff provides information at Native Health, a local center that offers of health care and social services in Phoenix for Native Americans. The Program provides information for ADHS' media coverage of Birth Defects Prevention Month; works with the BWCH Preconception Health Alliance Data and Communication Committee and ADHS CoIIN preconception health efforts and serves on the speaker's bureau of the Task Force on the Prevention of Prenatal Exposure to Alcohol and Other Drugs.

The purpose of the **High Risk Perinatal Program/Newborn Intensive Care Program (HRPP/NICP) i**s to reduce maternal and infant mortality and morbidity through a regionalized statewide system of coordinated perinatal care. The components of the program are: an Information and Referral Line; Maternal and Neonatal Transport Services; Hospital and Inpatient Physician Services; Community Nursing Services; and Hospital Developmental Care training. In 2014, 772 critically ill pregnant women were transported to the appropriate level of care as determined by program contracted physicians.

As in every state, Title V funds a toll free **Hot Line** for assistance connecting to resources for our women and children. Arizona's toll free Hot Lines provide women's health information relating to pregnancy, pregnancy testing sites, referrals, lactation referrals, prenatal vitamins, Federal Emergency Management Administration Services, AHCCCS (Arizona's Medicaid) , Family Assistance programs, Text4Baby, and Low Cost Prenatal Packages and breastfeeding support. A bilingual Lactation Consultant staffs the line during normal business hours. After hoursand on weekends/holidays breastfeeding support is provided 24/7 by a contracted ICBLC.

In 2011, the child fatality statute was expanded to include evaluation of the incidence and causes of maternal fatalities in Arizona. Maternal fatalities associated with pregnancy include the death of a woman while she is pregnant or within a year of her pregnancy. This led to the establishment of Arizona's first **Maternal Mortality Review** Subcommittee, which operates under the existing Child Fatality State Team. The Subcommittee members are highly respected professionals in the field including; OB/GYNs, perinatologists, directors of nursing, maternal-fetal medicine specialists, public health professionals, domestic violence specialists, behavioral specialists, and representatives from Arizona's tribal nations.

After passage of the legislation the Subcommittee began reviewing cases, determining preventability and making recommendations for action. The first Arizona Maternal Mortality Review Program report was issued in February, 2013. Findings indicated that obesity and substance abuse were among the most common risk factors for pregnancy associated deaths. In 40% of maternal deaths, the woman tested positive for illicit drugs and/or alcohol at the time of autopsy. There are approximately 30 maternal deaths annually. A cumulative report of the findings from 2011-2014 will be completed in 2015. The maternal mortality epidemiologist has attended training on best practices for data collection of maternal mortality data to ensure Arizona is consistent with other states and gathering all pertinent information.

Preconception Health is a major focus of the BWCH and supports a Preconception Health Alliance comprised of more than 30 internal and external partners working to improve the health of women and birth outcomes. Quarterly meetings support the goals of the Preconception Health Strategic Plan: 1) Increase the public's awareness about the importance of preconception health, 2) Promote behaviors that contribute to positive preconception health among women and men across the life span; and 3) Increase access to and delivery of physical, oral and behavioral health services that contribute to preconception health. BWCH has been providing leadership on preconception health for 8 years and as a result has successfully integrated preconception health screening, education and referrals into home visitation, family planning and community health nursing programs. The Office Chief for Women's Health is on the CDC Preconception Health Consumer Workgroup.

During 2014/2015, a CDC Public Health Associate served as the Preconception Health Coordinator with the Preconception Health Alliance. The coordinator Co-Chaired sub-committees, engaged new partners, and conducted presentations. In 2014, a 12 question survey was returned by forty OB/GYNs and thirty-nine Family Practioners assessing their views and practices regarding preconception care (PCC). The survey was sent out through the Arizona section of the American Congress of Obstetricians and Gynecologists (ACOG) and the Arizona section of the Academy of Family Physicians.

The survey results were very informative and will be used in targeting messages to physicians regarding the importance of providing preconception health care. Examples of the survey results include; that 100% of the OB/GYN respondents agreed that PCC is important and has a positive effect on pregnancy outcomes and 96.9% of practitioners agreed with both statements. Over 70% of OB/GYNs (72.2%) agreed that PCC is a high priority in their workload while 86.5% agreed they had appropriate training to provide PCC. Comparatively, 60% and 71.4%, respectively, of practitioners agreed with the statements. Over 75% of respondents (75.7% OB/GYNs, 76.7% practitioners) believe there is not sufficient time to provide PCC to all women of childbearing age during visits. 85.7% of OB/GYNs and 66.7% of practitioners believe that time devoted to PCC is not reimbursed.

Over 85% of OB/GYNs (86.5%) and 78.6% of practitioners always provide PCC to women planning a pregnancy; 91.9% of OB/GYNs and 77.8% of practitioners always provide PCC to diabetic women; 86.5% of OB/GYNs and 75% of practitioners always provide PCC to obese women planning a pregnancy; over half of OB/GYNs and practitioners (54.1% and 53.6%, respectively) always provide PCC to women indicating they want children in the future; 25% of OB/GYNs and 20% of practitioners always provide PCC to women who are sexually active; and 13.9% of OB/GYNs and 34.5% of practitioners always provide PCC to women who are using birth control.

The majority of OB/GYNs responded that the women they see sometimes or rarely (37.1% and 48.6%, respectively) plan their pregnancies, compared to 60.7% and 32.1%, respectively, of practitioners. OB/GYNs were more likely than family practioners to promote the use of folic acid to women of childbearing age and to always advocate birth spacing according to ACOG and CDC guidelines. This same disparity was evident with regards to which providers had received training regarding preconception health, the appropriate use of preconception health screening tools and the identification of preconception health risk factors. In response to this data, the alliance drafted an infographic targeted to physicians. It highlights four data points that demonstrate the need for preconception healthcare information and what can be done to improve. After physician review, the document will be distributed to physicians through Arizona medical associations.

Utilizing Title V funds, BWCH supports the Preconception Health/Family Planning module for the Arizona Behavioral Risk Factor Survey System. According to the 2013 results, 60% of women age 18-44 years indicated that they had not received any information from a health care provider regarding how to prepare for a healthy pregnancy and approximately 38% of respondents reported that they take a multi-vitamin with folic acid. Half of the women reported that they do not want to have a child now or in the future however, only 2.5% are using a contraceptive implant to prevent a pregnancy, 6.2% were using an IUD, 4.4% were using contraceptive injections and 4.6% indicated they choose sterilization.

The Collaborative Improvement & Innovation Network (CoIIN): The CoIIN is a national initiative sponsored by HRSA/MCH to reduce infant mortality and improve birth outcomes. Partners include the Association of Maternal and Child Health Programs and the National Institute for Children's Health Quality. The intent is to have all states work toward the same goal while selecting priorities and implementing strategies that will be most successful in their state. Of the five priorities to reduce infant mortality and improve birth outcomes, Arizona is working on "Promote safe sleep practices" and expanding access to preconception and interconception care. The Preconception Health Alliance serves as the team for all CoIIN activities related to expanding access to preconception health.

Arizona is participating in the US Mexico Border Reproductive Health Task Force on Maternal Mortality and Teen Pregnancy Prevention with several other states in both countries. The BWCH Office Chief is on the Maternal

Mortality workgroup and the Office Chief for Women's Health is a member of the Teen Pregnancy Prevention (TPP) workgroup. The Teen Pregnancy Prevention workgroup has two priorities; 1) Conduct a binational situational analysis on the Border Region and inventory of initiatives, programs & institutions for TPP and 2) Share successful experiences, knowledge, best practices for TPP. Moving forward, the workgroups will implement the strategic plan that was finalized in April 2015.

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Reduce Infant Mortality and Morbidity	Increase the percentage of early childhood professionals with training to support breastfeeding in the workplace, childcare and home by 5 % over the next five years.	Provide training and support for home visitors to become IBCLC certified. Distribute Breastfeeding at Work Model Policy packets.	Post neonatal mortality rate per 1,000 live births Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months		

Perinatal/Infant Health

Perinatal/Infant Health - Plan for the Application Year

For application year 2016, BWCH priorities around infants and the perinatal period will continue to focus on improving access to and quality of preventive health services and reducing the rate of injuries. BWCH will implement the following activities for the upcoming application year outlined under each program area.

In 2016, Arizona's **Newborn Screening program** will add screening for Hearing and Critical Congenital Heart Defects to the screening list. Furthermore, the program will partner with the Association of Public Health Laboratories on a 15 month CoIIN quality improvement initiative to improve outcomes for small community-based hospitals and apply lessons learned more widely to address disparities in equal access.

BWCH in partnership with the Bureau of Nutrition and Physical Activity (BNPA) will continue to support **breastfeeding** initiatives. Initiatives will be addressed by implementation of training, technical assistance, policy and procedures, and direct support services. In addition, BNPA through the Maternal, Infant, Early Childhood Home Visiting (MIEHCV) grant will implement a one-day breastfeeding course where participants will be updated on the latest evidence-based practices in breastfeeding. Subjects may include but are not limited to supporting the family with the baby in the NICU, maternity care practices and their impact on breastfeeding, and low milk supply.

In September 2015 Arizona's **home visiting** program will complete an evaluation of the Arizona home visiting system as part of the larger early childhood health and development structure. Results will analyzed and address

through continuous quality improvement. Additionally, a data management system will be launched in September 2015. It will begin with Healthy Families and Nurse Family Partnerships and expand to Parents as Teachers and then to other home visiting models. MIECHV in partnership with the Office of Oral Health will pilot a 'train the trainers' session focusing on perinatal/infant oral health with expected roll out of home visitor training in 2016. Lastly, Arizona's MIECHV program plans to expand home visiting services to tribal communities by strengthening capacity to offer services. The goal is to serve at least 130 Native American families by September 30, 2016.

The overall plan for the **Arizona's Child Fatality Review (CFR**) will be more fully discussed in the Child section of this report except for Safe Sleep efforts and SUID. This upcoming application year, CFR will offer additional trainings to law enforcement and other first responders on infant death scene investigations on the adoption of the Arizona Sudden Unexpected Infant Death Investigation checklist.

Safe Sleep is a priority for the upcoming year in Arizona, as the State has increased its role in the Infant Mortality Collaborative Improvement and Innovation Network (CoIIN). The Safe Sleep Task Force has merged with the CoIIN initiative and Arizona will use this partnership to accelerate improvements that prevent and reduce infant deaths through collaborative learning, quality improvement and innovation.

By 2016, Arizona plans to reduce safe sleep related deaths by improving safe sleep practices to decrease the safe sleep SUID mortality rate by 10%. Arizona also plans to work toward the reduction of disparities between White and Non-Hispanic Black and American Indian/Alaska natives by 10%.

Arizona selected the following CoIIN drivers: birthing hospitals, home visiting and licensed and unlicensed child care and Arizona's Drivers include: add safe sleep modeling to annual skills training; use safe sleep Bassinet Cards as visual reminders for nursery staff; standardize safe sleep messages for all home visiting; standardize education and training for home visitors on current AAP guidelines; develop standardized safe sleep message with input from community partners; partner with community tribal elders on AAP guideline; engage grandparents and caregivers on the recommended AAP guidelines; provide Safe Sleep CBT for child care providers; provide training for nursing and medical schools and help hospitals establish policies.

Arizona has chosen the reduction of infant mortality and morbidity as a priority for the next five years and will monitor performance through NPM 4; the percent of infants ever breastfeed and the percent of infants breastfed exclusively by 6 months. Arizona's Maternal Child Health program will continue its efforts breastfeeding efforts through WIC, midwives and home visitors.

Arizona will maintain car seat training and usage for infants and maternal and neonatal transport. Looking more globally at mortality and morbidity, and reflecting concerns in the community, Arizona's Maternal Child Health program will continue its emphasis on early childhood home visiting. The opportunity to educate families about infant toddler mental health, the critical importance of bonding, injuries in the home, safe sleep, immunizations and the effects of Adverse Childhood Experiences is invaluable.

Arizona has chosen NPM 3 the rate of injuries aged 0-19 covers infants; Arizona will address safe sleep in the Child Health domain in the upcoming year as Arizona does not participate in PRAMS.

Lastly, the Arizona Department of Health Services (ADHS) is sponsoring a 2 day conference in July 2015 focusing on Neonatal Abstinence Syndrome (NAS). The conference aims to bring together physicians, nurses, midwives, and others involved in the care/treatment of these mothers and infants from across the state. The conference is a strategic intervention to develop awareness to health care providers concerning the most effective ways to care for these infants and families. Topics will include: the current state of the epidemic nationally and in Arizona; the Finnegan Scoring System; current efforts in a local health plan; addiction treatment with pregnant mothers using medication-assisted treatment (MAT); DCS: the reporting process and what happens next; short-term and long-term NAS outcomes; and educating families about NAS. ADHS staff, the High Risk Perinatal Program/Newborn Intensive Care Program as well as a doctor and nurses from local hospitals make up the conference committee.

Conclusions and feedback from first NAS conference will be used to plan and develop future efforts to address risks of NAS.

Perinatal/Infant Health - Annual Report

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective					

NPM-4 B) Percent of infants breastfed exclusively through 6 months

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective					

The Bureau of Women's and Children's Health, where the Title V Block grant is administered, is organized by offices including Children's Health, Women's Health, Injury Prevention, Oral Health and Children with Special Health Care Needs. It became apparent when reviewing programmatic efforts; many of these programs care for the mother baby dyad and in doing so cross domains. This discussion will seek to focus on the Title V Program's/BWCH efforts in improving the lives of infants.

In the past five years the BWCH priorities around infants and the perinatal period has focused on improving access to and quality of preventive health services and reducing the rate of injuries. Prior National Performance Measures followed many of these topics. The previous National Performance Measure 1 addressed Newborn Screening and timely follow up. Arizona's Maternal Child Health NBS program continues to reach the annual performance measure of 100%. NPM 12 spoke to screening for hearing before hospital discharge. Arizona has held steady at about 98.5 for last few years. State Performance Measure 8 looked at the percent of newborns who failed their initial hearing screening who receive appropriate follow up services. The annual objective was 85 and Arizona reached 86.7 although that was below the 2013 score of 88.6.

In addressing quality of and access to preventive health services, Arizona's Maternal Child Health program has used a multifaceted approach including Newborn Screening. While this discussion will begin with Newborn Screening it easily transitions into other preventive services including breastfeeding support and home visiting. The Bureau's efforts to address the quality of preventive health services and reducing the rate of injuries will be discussed by program.

Newborn Screening (NBS) is widely recognized as one of the nation's most successful public health programs. The inherited disorders tested for are not apparent at birth and, if not detected and treated quickly, can lead to irreversible developmental delays, mental retardation, severe illness, or death. NBS touches all six of the MCH population health domains and continues to make an enormous difference in the lives of Arizona families. Arizona's program began in 1979 and screens for 30 inherited disorders (28 bloodspot and two point-of-care screens). The program is part of the Bureau of State Laboratory Services and consists of the following sections: Laboratory, Demographics, Case Management, Data Management, Education and Billing. However, NBS is more than just a

single program at ADHS. It is a coordinated system with many internal and external partners who must all collaborate effectively to ensure that every newborn is screened and receives the appropriate services and care.

The NBS program invests significantly in the development and maintenance of effective working relationships at the national, state and local levels and across multiple sectors. The Program works closely with the following external organizations, in part, to develop and disseminate consistent standards, policies and educational tools for the work with hospitals, clinics, pediatricians, midwives and other health care providers to better integrate and improve NBS as a system for all Arizona families: Centers for Disease Control and Prevention, Health Resources Services Administration; Arizona Health Care Cost Containment System (Medicaid), Private Insurers; Association of Public Health Laboratories, Clinical and Laboratory Standards Institute, Joint Committee on Infant Hearing, National Center for Hearing Assessment and Management; Arizona Perinatal Trust, Arizona Chapter of the American Academy of Pediatrics, Arizona Chapter of the March of Dimes, EAR Foundation of Arizona

Within ADHS, the Program partners closely with the Title V program including Home Visiting Programs and the Office of Children with Special Health Care Needs. NBS additionally partners with other programs within ADHS including Birth Defects, Midwives, Immunization and the Office of Vital Records to help ensure families are aware of the importance of newborn screening and have access to needed resources.

Of the 88,302 babies born in 2014, nearly 98% received at least one bloodspot screen (90% received a second screen) and 98.5% received a hearing screen. 130 infants were confirmed with primary bloodspot disorders and approximately 120 were confirmed with hearing loss. An additional 11 secondary disorders were identified through newborn screening as well as more than 800 traits. The most recent finalized hearing screening data reported to the CDC (2013) indicated that 16% of newborns who failed either the inpatient or outpatient screen had no documented diagnosis and were lost to follow up. The laboratory also provides routine dietary monitoring analysis of phenylalanine levels for all people (including children and adults) identified with PKU by the NBS program, at no additional cost. While these numbers represent an undeniable success for the affected newborns and their families, many hidden gaps and critical challenges remain.

The Arizona Early Hearing Detection and Intervention (AzEHDI) program has been successful at maintaining screening rates for screenings at birth and within one month of age. Rates of hearing screenings completed before one month of age continues to be excellent at more than 98% of all occurrent births. Follow up is now provided for the out of hospital births which has led to improvements in screening rates with home births and midwife attended births. Goals to increase the number of children who receive timely diagnostic evaluation have improved by a small increment of 1-2%. Tele-intervention pilot efforts have been successful and new Early Intervention (Part C) policies which end the family cost sharing related to Part C services as of July 1, 2015 should result in future improved access to early intervention services. Additionally, efforts to reduce Loss to Follow Up (LTFU) have been targeted at reinforcing the mandate to report amongst audiologists. Personal calls were made by ADHS contracted audiologists to all Arizona audiologists registered in EHDI-PALS. As part of the best practice discussion, the mandate to report was the main focus and there was a rapid increase in reporting diagnostic test results. An additional strategy involved changing the AZEHDI model for meetings by including the Arizona AAP Chapter champion in the bi-monthly meetings to help with strategies for reaching out to physicians' offices that had been identified as having patients that were missing hearing screening results. The Chapter Champions also contacted several high LTFU ENT practices and provided education about reporting screening results. An additional strategy added in 2014 was partnerships and education/outreach with home visiting programs. The Office of Newborn screening presented at the Strong Families Az conference as well as exhibiting at that and other conferences.

In the hearing screening program there is a delay between outpatient screening and diagnostic testing. Babies appear to become LTFU at the diagnostic stage of the EHDI system. The baby must go to their medical home to get a referral for diagnostic testing. Many are referred to an ENT rather than a pediatric audiologist and never receive referrals to audiology because the focus becomes middle ear issues. To address this, a mailing was sent to all

pediatricians with guidance on making referrals as well as an algorithm. Additionally, there has been low enrollment in early intervention after a baby has received a diagnosis of a permanent, bilateral hearing loss in part due to the family cost participation which has now been eliminated. The hearing follow up program is using CQI methodology to identify areas of concern and is implementing change strategies to continue to improve diagnostic hearing rates as well as early intervention enrollment.

Resource allocation constraint screening was identified among the challenges and gaps experienced by the program. While the program fee was successfully increased by $25 (in no small part due to the support of many dedicated external partners and advocacy groups), the program encountered numerous challenges in allocating these funds as intended (e.g., hiring freeze, limits on appropriation, etc.). These limitations will continue to hinder efforts to address existing challenges and gaps as well as add significant barriers to the addition of new disorders.

A significant success realized this past year was the correction of Turnaround Time. Early identification is tantamount to the success of NBS and any delay in the process can lead to a negative outcome. In 2014 one of the biggest projects, and successes, was the dramatic improvement in hospital transit times of NBS specimens. Ninety eight percent of first screen samples are now delivered to the state lab within 3 days, an improvement from the 2013 baseline of 67%. However, ensuring that sample results are released quickly from the state laboratory is equally important and can be easily affected by limits imposed on the replacement of staff lost to attrition.

One of the goals of NBS is to ensure equal access across the state, however disparities remain. For example, in many rural communities the number of completed second screens is comparatively low. In one rural community-based hospital, only 29% of newborns received the mandated second screen. Of births attended by licensed midwives (1.3%), only 50.4% had a documented hearing screen, 49.7% had a 1st bloodspot screen and only 21.7% had both required bloodspot screens. While transit times for bloodspot specimens has improved significantly overall, 13 small community-based hospitals still struggle with sustainability.

Reflecting on the work supporting the previous **National Performance Measure 11**, the percent of mothers who breastfeed their infants at 6 months, Arizona has worked through the Breastfeeding HotLine, WIC clinics, home visitors and midwives to help establish and support breastfeeding. Arizona's 2014 indicator shows that while fairly consistent, there is room for improvement.

In an effort to support parents with newborns, the BWCH utilizes Title V funds to maintain a **MCH Hotline.** Arizona Department of Health Services (ADHS) through the Bureau of Women's and Children's Health (BWCH) has provided a toll-free hotline to parents and families in Arizona since 1986. The mission of the Hotlines is to assist low-income people in Arizona in overcoming system, social and cultural barriers which otherwise separate them from health care.

The Arizona Breastfeeding Hotline provides access to skilled lactation help 24-hours a day, seven days a week. The Hotline is staffed by a bilingual Certified Lactation Consultant and afterhours by a bilingual International Board Certified Lactation Consultants (IBCLCs). In 2014, the Hotline answered over 5,000 calls related to breastfeeding issues. Approximately 400 mothers per month have reached out during evening, weekend, and holiday hours to the Hotline for answers about positioning and latch, medications, managing work and school, and infant behavior. The after-hours aspect of the hotline is especially useful for mothers unable to reach their health care providers.

The Bureau of Nutrition and Physical Activity has taken the lead on breastfeeding. It has adopted strategies that intervene on individual and community/institutional levels, and target different segments of the population. These strategies are expected to lead to a higher proportion of babies being born to mothers in Arizona who breastfeed, and who continue to breastfeed at six months and one year, and who exclusively breastfeed at three months and six months by implementing strategies in four major areas including: Training, Technical Assistance, Policy and Procedures, and Direct Support Services. The following table shows how funding from various programs and grants work together to promote breastfeeding.

Strategy by Program/Funding Source						
	WIC	**Title V Hot Line**	WIC Peer Counseling Grant	Strong Families Arizona*	Arizona Nutrition Network	CDC Grant 1305
1. Training	○		○	○	○	○
2. Technical Assistance	○	○	○	○	○	○
3. Policy and Procedure Development and Implementation	○		○			○
4. Direct Support	○	○	○	○		

* StrongFamiliesAz includes over 64 local and statewide agencies who provide maternal child health home visiting including not only the models funded through MIECHV but two BWCH programs; the High Risk Perinatal Program funded partially through Title V and Health Start.

The WIC Baby Behavior training by UC Davis Center for Human Lactation was converted to a four-hour learning management system (LMS) course for WIC staff. The course was also made available to Bureau of Women's and Children's Health (BWCH) home visitors including the Strong Families AZ Alliance, including Title V funded nurse home visitors.

A statewide Breastfeeding Coordinator Meeting was held where representatives from each county focused on the effects of the Affordable Care Act on Lactation, how childcare centers are working to support breastfeeding women, how to better collaborate with Strong Families AZ Home Visitors and integrating the WIC Nutrition Standards into current practice.

In October 2014, eight Arizona WIC Program staff earned certification as new International Board Certified Lactation Consultants (IBCLCs). These certifications are indicative of the level of training and skill possessed by WIC staff in Arizona. This raises the total number of Arizona WIC IBCLCs to 75. As a result of StrongFamiliesAz, through MIECHV funding, 27 home visitors in local communities will be eligible to sit for the ICBLC certification test in July, predominantly in rural and tribal areas.

Arizona offered professional education in breastfeeding at LATCH-AZ (LActation support To Collaborate for Health - AZ) meetings. These meetings are open to the public at no charge. They provide an opportunity for WIC staff to network with community partners interested in lactation. Topics presented included The Power of Informed Choice: Where, How, When, and Why.

The Arizona WIC Program continued to offer Peer Counselor Services in 10 of its Local Agencies, for the most part county health departments. Each month, the program helps over 6,000 pregnant and breastfeeding women overcome personal barriers to breastfeeding through the use of mother-to-mother support.

Support for the Breastfeeding Mother Baby Dyad is included as one of the ten evidence-based standards included in the **Empower Program**, a voluntary program that supports healthy eating, active living, and tobacco prevention. The 73 Midwives licensed through the ADHS Bureau of Special Licensing support the breastfeeding mother as well.

The Maternal, Infant, Early Childhood Home Visiting grant is funding a position in the Bureau of Nutrition and Physical Activity to provide breast feeding training to over 150 home visitors. Basic Training I is a two-day course where participants learn how to use evidence-based practices to support breastfeeding from conception to wean. The goal of the course is to provide the skills, tools and resources to all home visitors in order to help them to help their clients make and reach their breastfeeding goals. Topics include latch and position, newborn feeding patterns, myths and community breastfeeding resources. Basic Training II is a two-day course that emphasizes how to use evidence-based practices to help clients overcome breastfeeding challenges, such as engorgement, mastitis, jaundice, low milk supply, teething and much more. The classes provide additional education hours for any home visitor who plans on taking the International Board Certified Lactation Consultant exam.

Arizona's **home visiting programs** provide support for new families to understand the needs of their newborns and works to improve the quality of and access to preventive services. This is evident in the extensive breastfeeding support; both direct services and infrastructure support. Arizona's Title V program is home to three different home visiting programs; the High Risk Perinatal Program, Health Start and MIECHV.

Arizona has both formula and competitive funding for early childhood home visiting through the Maternal, Infant and Early Childhood Home Visiting Program (MIECHV), a federally funded grant to develop a statewide multi-pronged approach to build a system of family support programs at the state and local level. The goal is to improve the health and wellbeing of at-risk children and families. The program provides evidence based home visiting programs to pregnant women and families with children under the age of five. The program promotes and encourages breastfeeding; follows up with families on well child doctor visits and immunizations; increase health insurance enrollment for infants; educates families on safe sleep practices and car seat safety; educates families on home safety precautions and preparedness; completes child development screenings and provides families with education on proper child development and coping strategies to ensure child safety and wellbeing.

The MIECHV legislation measures this goal by requiring states to demonstrate improvement in at least four of the six benchmark areas by the end of three years. On May 15, 2015, Arizona received confirmation from Dr. Willis that based on third-year performance data; Arizona's MIECHV Program has demonstrated improvement in six of the six benchmark areas.

The Arizona MIECHV grant targets priority populations where: 67.8% are low income; 67.7% have a parental history experiencing child abuse or neglect; 35.4% have a history of substance abuse or need treatment; 27.9% are parents with low student achievement; 21.8% are pregnant under the age of 21; 7.0% use tobacco products in the home;6.5% have a child with developmental delays/ disabilities and 6.0% have family member serving or who formerly served in the Armed Forces. MIECHV supports evidence based home visiting programs for families in fifteen communities. Of those identified high-risk communities, six are tribal reservations.

Programs funded include Healthy Families (HF), Nurse-Family Partnership (NFP) and Family Spirit in the White Mountain Apache Tribe. Coordinators are funded to work in seven Arizona counties to support local capacity building, a networked home visiting referral system and engage families. Evidence-based home visiting is augmented by a comprehensive workforce development program provided through regional training and education, online courses, regular informative e-newsletters and an annual summit, rated 4.8 out of 5 by the participants who attended in 2014. MIECHV is a results-oriented program and entails comprehensive program evaluation and a state-local continuous quality improvement program.

An important component of Arizona's MIECHV is Professional Development. Home Visitors receive a variety of trainings to prepare them to work with perinatal and infant health issues. Online training topics related to this population include Baby Behavior, Safe Sleep and Breastfeeding Webinars for Lactation Education Credit. Of the forty-five (45) Benchmark Institutes for Home Visitors, the following classes addressed perinatal/infant health: Breastfeeding Basic Training; Breastfeeding Basic Training II; Current Trends in Breastfeeding; Infant Mental Health; Infant Toddler Developmental Guidelines and ASQ-3 and ASQ:SE.

Arizona's StrongFamiliesAz Conference sessions addressing infants included: First Foods: Building Healthy Babies; Introduction to the Infant and Toddler Guidelines; Unsolved Mysteries: Case Studies in Breast Feeding; Advantages of Obtaining Your Infant Mental Health Endorsement; Developmental Screening of the Infant, Toddler and Preschooler; Newborn Screening: Partnering with the Home Visitor; immunizations: Strong Communities, Strong Families; Crib Safety for Precious babies; Baby Behaviors: Healthy Eating Starts Here; Disease Prevention and Brain Development; Why Breastfeeding?

Collaboration is a key factor that contributed to progress of the Arizona MIECHV Program. It operates under the banner Strong Families AZ. A network of 64 agencies, organizations, and individuals interested in home visiting for young children and their families meet quarterly to provide input/feedback on issues related to the development and enhancement of home visiting in Arizona. An Inter Agency Leadership Team (IALT) composed of representatives from the Arizona Department of Economic Security (DES); Arizona Department of Education (ADE); Arizona Department of Health Services (ADHS) including the Bureau of Women and Children's Health (BWCH) and the Division of Behavioral Health Services (DBHS); AHCCCS; Arizona Early Intervention Program (AzEIP); and First Things First (FTF); as well as consultants and evaluators for the MIECHV Program meets monthly to support the strategic implementation of the MIECHV Grant and to coordinate and leverage.

Additional factors contributing to progress include:

- An inter-agency home visiting system governance structure has been created at the state and local level enabling penetration of home visiting in high risk communities in all Arizona counties improving outcomes for children and families in MIECHV-funded EB HV programs.

- An inclusive collaborative system change process has been the foundation of Strong Families AZ through a statewide network of home visiting programs that helps families raise healthy children ready to succeed in school and life. This network has been a catalyst for development of Coordinated Home Visiting Referral systems in most of Arizona counties.

- Professional development opportunities have been offered for all home visitors improving knowledge and skills in areas such as breastfeeding, early intervention, infant mental health, maternal depression, nutrition, and data collection; increasing the capacity of local communities through trained car seat certifiers, supporting home visitors becoming International Board Certified Lactation Consultants (IBCLC), infant mental health endorsements; and creating cross-program guidelines pertaining to domestic violence and nutrition/physical activity.

- Family Spirit, Arizona's promising practice, has evolved into the only evidence based home visiting program designed specifically for Native American families.

The **High Risk Perinatal Program/Newborn Intensive Care Program (HRPP/NICP**) is a program addressing critically ill neonates and high risk pregnant women in imminent danger of premature delivery. This Program has been managed from the Bureau of Women's and Children's Health for over 40 years. The Program has three components; Transport, Hospital and Community Nursing home visiting after discharge. The program contracts with medical transport companies; neonatologists and maternal fetal medicine specialists, hospitals and community nurses. The contracted hospitals are all Level II, II enhanced qualifications (EQ) and III hospitals that are certified by the Arizona Perinatal Trust (APT) /Arizona Perinatal Regional System, Inc. (APRS, Inc.), to provide the appropriate level of hospital care to Program babies and their families. This contract is a requirement of APT certification.

The transport component supports **NPM 17**; the percent of VLBW infants born at the appropriate level of care as it relates to the quality of and access to services. Arizona has routinely seen the percent above 90% since 2012 although 2014's percent was 91.5, slightly lower than 92.3 in 2013.

As mentioned earlier, for over forty years, Arizona has maintained a voluntary perinatal regionalization system, the Arizona Perinatal Trust. The Bureau of Women's and Children's Health High Risk Perinatal Program funds a centralized toll free, 24/7 Information and Referral Line that provides the crucial link between consulting perinatologists and neonatologists and referring health care providers caring for high risk pregnant women in crisis and neonates who present in distress. If, at the time of consult, a transport is deemed necessary, the contracted perinatologists or neonatologist will make transport arrangements with a contracted transport company.

The Program contracts with medical transport companies who can reach the high level of expertise required. The Program requirements are based on CAMTS standards. This part of the Program is available to all Arizona's critically ill neonates. In 2014, 722 infants were transported to a higher level of care. During Arizona Perinatal Trust Site reviews, maternal and neonatal transports were reviewed for appropriateness of the transport, the mode of transport and the level to which the transport was made. Technical assistance is provided to the hospital by the site review team.

In order to serve the sickest or most premature, infants are eligible for full enrollment in the HRPP if they have spent at least their first five days in the NICU. The Program requires the higher levels of care, Level II Enhanced Qualification and Level III NICUs to staff a NIDCAP® certified Developmental Specialist to support staff and families of the most premature infants. The Developmental Specialists meet quarterly as a Council to share best practices and concerns. In recent years one of the Phoenix NICUs, St Joseph Hospital became a NIDCAP® training center making it easier to maintain skill level for all hospitals. The program also contracts with neonatology groups to provide risk appropriate medical care to enrolled infants during the newborn intensive, intermediate or continuing care hospitalization by serving as the payor of last resort. In 2014, 3,994 infants were enrolled.

The Community Nursing Services component of the HRPP/NICP delivers a statewide, coordinated system of specialized nursing services to infants who are enrolled in the Program. The Community Health Nurse (CHN) provides support to families during the transition of the infant to home; conducts developmental screening (Ages & Stages), breastfeeding support, physical and environmental assessments and makes referrals to specific community services as needed. This program is linked with the Office for Children with Special Health Care Needs (OCSHCN) to provide services for families who do not meet the eligibility criteria for HRPP/NICP but could benefit from these services. The CHN's also collaborate with the Newborn Screening Program (NBS) to locate infants who require a second screening and repeat the tests.

The CHNs also provide support to the new mother by administering the Edinburgh Postnatal Depression Scale (EPDS) screening as part of the home visit made to infants, children and their families after discharge from the NICU. Each Community Health Nursing agency contracted with HRPP/NICP has developed an updated list of referral resource service providers for the community they serve. The community health nurses educate their clients on warning signs of postpartum depression as well as perinatal mood and anxiety disorders. They also provide interconception support to mothers of program infants including discussion of birth spacing, general wellness and education on the importance of folic acid. For professional development the CHNs utilize the Strong Families Arizona Network and other opportunities within their community. In 2014, 7,011 nursing home visits were made after the infant was discharged from the NICU.

The **Health Start** Program will be discussed in more depth in the Woman/Maternal section as one of the aims is to connect pregnant women with prenatal care. The Program utilizes community health workers to provide education, support, and advocacy services to pregnant/postpartum women and their families in targeted communities across the state. The community health workers live in and reflect the ethnic, cultural and socioeconomic characteristics of the communities they serve. Families receive home visits and case management with oversight by nurses and social

workers, through the enrolled child's second year of life. Clients are referred to various services as needed and assistance with accessing those services. The community health workers educate parents about child development, immunizations, home safety and vehicle safety. The community health workers also screen each child on a periodic basis using the Ages and Stages Questionnaire to identify potential developmental delays and refer the family to the appropriate provider. Health Start community health workers acquire new skills and knowledge on an on-going basis to ensure they are providing the most accurate information. There were 1,897 infants served in the program in calendar year 2014.

The other goal that included newborns from the Bureau of Women's and Children's Health 2011-2015 plan was reducing the rate of injury. The previous **National Performance Measures 10** measured the rate of children 14 years and younger caused by motor vehicle crashes per 100,000 children. Arizona's annual indicator for 2014 was 2.4, a decrease from 3.4 in 2013. However, these rates have fluctuated through the years.

The goal of **Arizona's Child Fatality Review (CFR**) is to reduce preventable child fatalities through systematic, multidisciplinary, multi-agency, and multi-modality reviews of child fatalities in Arizona. This is accomplished through interdisciplinary training and community-based prevention education and through data-driven recommendations for legislation and public policy. The CFR will be more fully discussed in the Child section of this report except for Safe Sleep efforts and SUID which will be discussed here.

The CFR program has also been responsible for supporting the increased adoption of the Arizona Sudden Unexpected Infant Death Investigation checklist, which law enforcement is required to fill out in the event of every unexplained infant death. The program has put together training and curriculum for law enforcement and other first responders on infant death scene investigations. The first training was held in 2015 with more scheduled for later in the year.

In 2013, 74 infants died from sleep related causes; this is a decrease from 81 in 2012. Rates have also declined 45% since 2008. Sixty-five of the 74 infants died in unsafe sleep environments, an increase from 51 in 2012. Thirty-four of those infants died while co-sleeping (bed sharing with adults and/or other children). Deaths due to suffocation remained high, and were determined to be the cause of death for 45 infants. Safe Sleep has been made a priority in Arizona, as the State has increased its role in the Infant Mortality Collaborative Improvement and Innovation Network (CoIIN). Arizona is partnering with CoIIN to accelerate improvements that prevent and reduce infant deaths through collaborative learning, quality improvement and innovation.

The **Safe Sleep** Task Force was formed after the Improving Infant Mortality Summit back in January of 2014. Those in attendance identified safe sleep as a priority based on Child Fatality data. The Program and those in attendance recognized that this collaboration needed to be a community effort. The Program then turned to March of Dimes, Arizona Prenatal Trust, Child Care Licensing, Managed Care Organizations, hospitals located throughout the state and local health departments. A tenant of the Safe Sleep Task Force was to utilize the AAP Guidelines and support their adoption throughout the state. The main goal then was to support healthy and safe children. The strategies identified included:

Promote universal adaption of AAP guidelines statewide by collaborating with our community partners to disseminate safe sleep education; supporting agencies/organizations to establish policies based on AAP and to evaluate these efforts by Geo mapping targeted communities. In the summer of 2014 Arizona became a part of the national CoIIN Safe Sleep Initiative and in February 2015, the team selected CoIIN drivers.

Finally, Neonatal Abstinence Syndrome is a growing concern. During 2008-2013 there were a total of 1,472 cases of Neonatal Abstinence Syndrome (NAS) in Arizona with an NAS rate of 2.83 (95% CI, 2.68- 2.97) per 1000 cases. To address this concern, the Arizona Department of Health Services (ADHS) is sponsoring a 2 day conference and will be a goal for upcoming application year.

State Action Plan Table						
Child Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Decrease the incidence of childhood injury.	Increase the number of home visitors using a standardized home safety checklist by 10% by 2020.	Provide professional development to home visitors on the burden of injury around the home. Provide an array of standardized home safety checklists for home visitors to use.	Child Mortality rate, ages 1 through 9 per 100,000 Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000	Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19		
Increase early identification and treatment of developmental delays.	Increase the number of ASQ trained home visitors over the next five years by 25%.	Support the training of additional ASQ trainers in Arizona. Support home visiting families to complete a developmental screening.	Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) Percent of children in excellent or very good health	Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool		

Child Health

Child Health - Plan for the Application Year

For application year 2016, BWCH priorities around children will continue to focus reducing the rate of injuries, both intentional and unintentional for children ages 0-19 and improve access to quality preventive health services. In FY 2016, Arizona has chosen a goal for the Child Population of reducing the incidence of childhood injury. BWCH will implement the following activities for the upcoming application year outlined under each program area.

BWCH through the **EMSC for Children Program** will continue to provide technical assistance to the hospital community to achieve a higher level of preparedness in caring for children. The program goal for 2015 is to have verified 50% of AZ emergency departments.

Many of the **Child Fatality Review** teams have been responsible for promoting increased public awareness about child safety and the prevention of fatalities. Arizona plans to continue supporting and training law enforcement and first responders on the adoption of the Arizona Sudden Unexpected Infant Death Investigation checklist, which is required to be filled out by law enforcement in the event of every unexplained infant death.

Beginning in January 2016, **Title V County Health and Prevention Grants** will be offered a menu of evidence based or evidence informed strategies from which they may choose to focus. This grant will refocus with the advent of Arizona's new MCH priorities and the new strategies will reflect the Title V State Plan. The community health prevention programs currently collaborate with other ADHS funded prevention programs including WIC, Tobacco & Chronic Disease, Teen Pregnancy Prevention Programs, Family Planning, Injury Prevention, HRPP/NICP, MIECHV, Adolescent Health, and Pre-Conception health programs to connect families to services. Through the use of an Integrated Intergovernmental Agreement, BWCH anticipates more focused collaboration with local community-based agencies and schools to coordinate information and health related services.

Arizona's **Maternal, Infant and Early Childhood Home Visiting Program (MIECHV)** program plans to expand home visiting services to tribal communities by strengthening capacity to offer services. The goal is to serve at least 130 Native American families by September 30, 2016.

Arizona has chosen **NPM 3** the rate of injuries aged 0-19 covers infants; Arizona will address **safe sleep** in the Child Health domain in the upcoming year as Arizona does not participate in PRAMS. By 2016, Arizona plans to reduce safe sleep related deaths by improving safe sleep practices to decrease the safe sleep SUID mortality rate by 10%. Arizona also plans to work toward the reduction of disparities between White and Non-Hispanic Black and American Indian/Alaska natives by 10%.

While past priorities included improving the percentage of children and families who are at a healthy weight, going forward nutrition, healthy weight and physical activity will continue to be priorities but breastfeeding will be discussed in Infant/Maternal Health and the remainder in Cross Cutting population area.

Arizona's priority for children will be to decrease the incidence of childhood injury. Some potential objectives include increasing the number of hospitals with Safe Sleep protocols and increasing standardized home safety checklists for home visitors.

Child Health - Annual Report

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	22.4%	23.1%	23.7%	24.4%	25%

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Annual Objectives					

	2016	2017	2018	2019	2020
Annual Objective	215.1	212.9	210.8	208.6	206.4

The Bureau of Women's and Children's Health previous priorities for addressing the needs of Arizona's children have been to: 1) Reduce the rate of injuries, both intentional and unintentional, 2) Improve access to and quality of preventive health services for children, and 3) Improve the percentage of children and families who are at a healthy weight. To assess rates of change, BWCH used National Performance Measures related to children's weight, motor vehicle crash deaths, access to health insurance and immunization rates. The following summarizes Arizona's progress addressing the priorities for children as formerly outlined by program. The discussion about healthy weight will be found in the Cross Cutting chapter.

The previous NPM 10 spoke to the rate of death among children less than 14 due to motor vehicle crashes. In 2014, Arizona's rate was 2.4 which was better than 3.4 the year before although the rates fluctuates somewhat from year to year. Arizona's Title V program houses the Office of Injury Prevention which serves as a coordinating body for injury prevention within ADHS. The program is responsible for (1) identifying injury problems and the specific needs for injury prevention programs, policies, and services within the state; (2) keeping abreast of developments within the field of injury prevention and sharing this information with others; (3) understanding where injury prevention fits into what other agencies are doing (integration) and serving as a coordinating force that brings different players to the table; (4) and building a solid constituency for injury prevention activities within the state.

Accomplishments include the creation of numerous injury specific data reports and fact sheets, technical assistance to community on motor vehicle safety and teaching all over the state to prepare car seat technicians. The program has an advisory council comprised of public and private agencies, health care providers, educators, law enforcement, fire safety personnel, advocates, survivors, private citizens, and other stakeholders. Working together has increased the efficiency of individual efforts, adding value to these efforts and improving the effectiveness of the state injury prevention infrastructure as a whole.

Utilizing HRSA funds, Arizona's EMSC program has improved access to and quality of pediatric emergency care. EMSC has focused on two specific areas in an effort to improve pediatric emergency care from a system perspective. The first focus area is pediatric designation; the second focus area is pediatric continuing education.

Arizona established an inclusive **pediatric designation system** that set minimum voluntary pediatric emergency care standards for all emergency departments. Modeled after Arizona's forty year old Perinatal Trust, this effort began in April 2008 with the establishment of a hospital stakeholders' group. The group developed criteria for the system focusing on staff qualifications including continuing education, minimum pediatric equipment requirements and pediatric policies including transfer agreements and process improvement requirements. The Arizona designation system model offers three tiers of pediatric preparedness for which all hospital emergency departments (ED) can apply. This model system allows rural and critical care access EDs to participate, as well as community hospitals which may have limited pediatric service lines. The AZ EMSC Program contracted with the Arizona Chapter of the American Academy of Pediatrics (AzAAP) to serve as the designation body. To build in sustainability, participating hospitals pay an annual membership fee and a three-year verification fee. As of May 2015, there are 33 member hospitals of which 25 have under gone a site verification visit meaning that 65 percent of Arizona's children can be treated in an ED prepared to care for them as children. . There have been no substantial barriers encountered to date.

Arizona has seen an increase in pediatric educational offerings in each of the state's four EMS regions because of funding from the federal grant. The EMS for Children's Program uses a portion of grant funds from HRSA to support pediatric education. The EMSC Program Manager attends Regional Council meetings and advocates for on-going pediatric education/training for all EMS personnel. Examples include: in the Northern Region, a stand-alone

pediatric conference is offered to providers from all Arizona EMS regions, and the Central Region continues to support having a pediatric track as part of their two-day conference. The Arizona Emergency Nurses Association provides a pediatric track as part of their annual conference. EMSC funds supported two Emergency Pediatric Care (EPC) Courses offered on the Navajo and Hopireservations.

Arizona's Child Fatality Review (CFR): was created in 1993 (A.R.S. § 36-342, 36-3501-4) and data collection began in 1994. Since 2006, all child death, from birth through age 17, occurring in the state are reviewed by 11 local child fatality review (CFR) teams located throughout Arizona. The state team provides oversight to the local teams, produces an annual report summarizing review findings, and makes recommendations regarding the prevention of child deaths. County specific data is produced and disseminated as fact sheets. These recommendations have been used to educate communities, initiate legislative action, and develop prevention programs. The MCH Program shares this information with partners at state wide and localmeetings.

For 2013 child fatalities there were a mixture of successes and challenges. Child fatalities due to maltreatment increased to 92 deaths in 2013 from 70 deaths in 2012. This was a priority area for the CFR State Team and their partners. Activities to focus on going forward include an increase in the sharing of relevant data and partnering during awareness events. The program has focused on analyzing the aggregate data collected by CFR to see if there are target areas or populations in maltreatment related deaths where increased services, including home visiting, could be targeted.

Deaths continued to be disproportionately higher among some minorities in Arizona during 2013. American Indian children comprised six percent of the population and nine percent of deaths. African American children comprised five percent of the population and ten percent of deaths. These two populations also accounted for a high number of motor vehicle crashes and other transport fatalities in 2013. They will be target populations for all activities from 2014 and ongoing.

Prematurity accounted for 210 of all child deaths in 2013. Medical complications during pregnancy contributed to 80 percent of all prematurity deaths. Ten percent of the pregnant mothers received no prenatal care during pregnancy. According to the data collected during Child Fatality Reviews, the number of mothers starting prenatal care in the first trimester went down ten percent from 2012 to 2013. Hispanic children carried the largest burden of these deaths making up 45 percent of the prematurity fatalities in 2013. More will be discussed about Arizona's efforts towards preconception health in the Women/Maternal section.

Eighty children died in motor vehicle crashes and other transportation related accidents in 2013. There has been a 26 percent reduction in motor vehicle crash rates since 2008 and a nine percent decrease in the rate for all transport related deaths since 2012. One hundred percent of transportation related deaths were determined to have been preventable in 2013, and lack of proper vehicle restraint remained the leading preventable factor accounting for 30 motor vehicle crash fatalities.

The improvement of data collection and the use of data to inform activities to improve community outreach and awareness and obtain changes in policies or legislation has enhanced organizational capacity and improved service delivery. As a result of findings, County Health Departments provide car seat training and instillation and where necessary, provide families without other resources car seats. This has been accomplished with Title V funding. All early childhood home visitors ensure families of infants understand the importance of and the proper utilization of car seats.

Recommendations from the CFR program will continue to target the legislature and law enforcement including support for legislation for a primary seat belt law and encouraging communities to collaborate with the ADHS and Safe Kids Arizona to promote awareness about child passenger and motorized vehicle safety, encourage participation in events such as car-seat checkups, safety workshops and sports clinics. BWCH holds car seat safety classes around the state to **certify car seat technicians** utilizing the Safe Kids National Highway Safety Traffic

Association curriculum. To reduce roadside injuries caused by car seats installed incorrectly, BWCH supports Car Seat Safety professional development. In 2014, with MIECHV funding, five Car Seat Passenger Safety Technician (CPS) Courses were held in urban and rural areas of Arizona. In 2015, BWCH's MIECHV grant supported a Continuous Educational Units Conference for 150 technicians and three additional CPS courses. To date, MIECHV funds have supported training resulting in 150 technicians, covering all counties in Arizona. In 2016, the goal is to support a cohort of 14 technicians (1 per county) to become car seat instructors.

Drowning deaths decreased from 36 children in 2012 to 23 in 2013. The number of drowning deaths, however, among children ages one through four years rose in 2013 and accounted for 83 percent of these fatalities. The CFR program will continue working with Arizona Drowning Coalition and the StrongFamiliesAz home visiting alliance to share information to help inform prevention activities throughout the state.

Many of the CFR teams have been responsible for promoting increased public awareness about child safety and the prevention of fatalities. This includes the development of resources distributed to communities and sharing of targeted interventions. Some of these activities include:

- child passenger safety training: car seat distribution, performing car seat checks
- bike and pedestrian safety: community safety events and distributing helmets
- child abuse and neglect prevention: distributing cribs to parents and promoting safe sleep practices
- home safety: sharing safety information in the community
- water safety: distributing water safety clings and training on proper supervision techniques
- The CFR program has also been responsible for supporting the increased adoption of the Arizona Sudden Unexpected Infant Death Investigation checklist, which is required to be filled out by law enforcement in the event of every unexplained infant death. The program has put together training and curriculum for law enforcement and other first responders on infant death scene investigations. The first training was held in 2015 with more scheduled for later in the year with over 90 people in attendance.

Currently there are 5 Safe Kids Coalition throughout the state of Arizona, most of which are based at the county health departments. There is Safe Kids Coconino County, Safe Kids Maricopa County, Safe Kids Pima County, Safe Kids Yuma County and Safe Kids Navajo Nation. Safe Kids Arizona is housed in the Office of Injury Prevention, which serves as a liaison to Safe Kids Worldwide and the local coalitions. While none of the coalitions are funded, they are eligible to apply for grants as they become available. All of the Safe Kids Coalitions work at the grass roots level relying on partners to make their presence known throughout the communities in which they serve. Most coalitions use the Arizona Child Fatality Review to look for trends on areas in need of focus.

Title V funds **County Health and Prevention Grants**. The two goals of this program are to decrease intentional and unintentional injuries and improve the health of women prior to pregnancy. While the approach varies by county, all address the same goals. Each county utilizes the Spectrum of Prevention. This model moves from providing direct services to community education, provider education, fostering coalitions, changing organizational practices, and implementing policy. The counties use the Arizona Logic Model to track interventions and outcomes. This gives them the information needed to reach their objectives. This program seeks to decrease the health disparities of low-income women and children. Historically, the counties review local data to determine which injury areas are in most need of intervention. These counties currently reduce the number of injuries and deaths caused by motor vehicle

crashes through the use of correctly installed child car safety seats and educating teens on motor vehicle safety. Seven Arizona county health departments are currently funded currently through this opportunity.

Arizona's **home visiting programs** work to connect all families to preventive and primary care. ADHS administers and/or funds the following home visiting programs: Health Start; High Risk Perinatal/Newborn Intensive Care Program (HRPP/NICP); Healthy Families AZ (HFAz); Nurse Family Partnership (NFP) and Family Spirit. These programs will be discussed more fully in the Infant/Perinatal domain.

All of the programs work with families and coordinate/refer with other health and family support providers to improve maternal and child health, decrease family violence including reduction of childhood injuries and maltreatment; ensure families have access to health care including immunizations; enhance child development and a child's readiness for school through parent education; and assist families to improve their economic security.

High Risk Perinatal Program/Newborn Intensive Care Program: HRPP/NICP in Arizona's oldest home visiting program initiated in 1960 to decrease Arizona's infant mortality rate of 31.8 percent. According to the Arizona Health and Vital Statistics, the infant mortality rate per 1,000 births in 2013 was 5.3 percent. The purpose of HRPP/NICP is to reduce maternal and infant mortality and morbidity through a regionalized statewide system of coordinated perinatal care.

HRPP/NICP provides early identification of women and children at risk of mortality and morbidity, education for health professionals, families and communities on developmental care and medically fragile infants; and links pregnant women and infants to the appropriate level of care and establishes standards of care. The components of the program are: an Information and Referral Line; Maternal and Neonatal Transport Services; Hospital and Inpatient Physician Services; Community Nursing Services; and Hospital Developmental Care training. As mentioned in Infant/Perinatal, in 2014, 3,994 infants were enrolled in NICP; Community Health Nurses made 7,011 visits to medically fragile infants and their families after they were discharged from the NICU; and 772 critically ill pregnant women were transported to the appropriate level of care as determined by program contracted physicians.

Health Start created in 1984 utilizes community health workers or "Promotoras" to address the needs of rural, minority pregnant women in Arizona. BWCH has administered the Health Start Program since 1992. Health Start provides education and services to infants from birth to age two including immunization education and immunization records checks and developmental screenings. In 2014, Health Start services were provided to 2,411 unduplicated clients through 16,054 unduplicated home visits to clients and families during. This program is described in more detail in the Woman/Maternal section as its original purpose was to assist pregnant women into prenatal care.

Maternal, Infant and Early Childhood Home Visiting Program (MIECHV) is a federal grant program funded as a part of the Affordable Care Act in 2010. MIECHV provides support for evidence-based home visiting programs for families in communities throughout the state. Of those identified high-risk communities, six were tribal reservations. This formed the initial basic for prioritizing and identifying the state's targeted communities. Within the last few years, the MIECHV Team has held community meetings with local leaders to decide if they would like to expand home visiting programs within their communities. Since federal fiscal year 2011, MIECHV has received approximately $12 million dollars a year.

In 2014, 1,970 families were served through 25,519 visits. MIECHV measures six benchmarks to ascertain the impact of the program on the families' well-being: 1 Improvement in maternal and newborn health, 2) Improvement in school readiness and achievement, 3) Improvement in family economic self-sufficiency, 4) Improvement in coordination and referrals to community resources; 5) Reduction in child injuries, child abuse, neglect, or maltreatment including decreased emergency department visits, and 6) Reduction in domestic violence. MIECHV uses "constructs" to measure the benchmarks and compares one cohort of families to a second cohort who received services at a later date with the assumption that as the program matures services and therefore impact on families will improve.

Nearly all families (99.7%) received information on prevention of childhood injuries. There was a decrease in the rate of emergency department visits among children at 12 months old and a decrease in the rate of physical injuries requiring medical treatment through the emergency room for children at 12 months old. Nearly all families received a screening for domestic violence (95.5%). Women who screen positive are referred and complete a safety plan within 6 months.

Professional Development has been an important component of MIECHV since the first award. From the beginning the intent has been to build capacity in local communities for all home visitors, especially in the rural areas. Home Visitors received a variety of training addressing the benchmarks. In addition to an *online class* on child nutrition, in 2014 home visitors were offered a *Benchmark Institute* on Empower Home Visiting: Physical Activity and Nutrition. One of the new oral health training sessions will address child oral health. 2014 Conference topics on child health included: Oral Health in Early Childhood; The FUN-damentals of Physical Activity; Avoiding Meal Time Power Struggles: Addressing Selective Eating with Toddlers; Positive Relationships with Children: The Why; Targeting Childhood Lead Screening Plan; Where Pink Meets Blue: Understanding Gender Issues; Understanding Children's Temperament; Helping Moms and Kids Make Healthier Food Choices; Books Build Better Brains; Emergent Literacy at Home; Introduction to the AZ Early Learning Standards. This program is described in more detail in the Infant/Perinatal Section.

While all Bureau programs work to improve access to care, many Arizonans still do not have that access. Serving as a stop gap measure to improve access to care, the Bureau uses Title V funds to support the **Medical Service Project** (MSP). The Medical Services Project (MSP) provides access to health care for uninsured school-age children from low income families who do not qualify (or are in the process of qualifying) for the Arizona Health Care Cost Containment System (AHCCCS). The goal of the Medical Services Project is to increase access to health care for Arizona's uninsured school-age children. MSP objectives include:

- Increase the number of uninsured children of low-income families living up to 300% of Federal Poverty Level, including those with special health care needs, to access and be linked to medical/dental/optometry services;
- Increase the number of children/families that are connected to resources that assist families in applying for health care services for continuous care;
- Increase the proportion of children, including those with special health care needs, that access and complete scheduled well-child visits as outlined by the American Academy of Pediatrics;
- Increase the proportion of providers, including physicians, midlevel providers, ancillary specialists, dentists, school nurses, childcare health consultants and home visitors that participate in the Medical Services Project Network and;
- Ensure access to quality, culturally competent care, including a network of referral supports, for uninsured children of low-income families.

In 2014, the Arizona Chapter of the American Academy of Pediatrics worked with school nurses to identify school-age children who meet the Medical Services Project's eligibility criteria and are in need of acute care services. The children were referred to participating health care providers who have agreed to accept a predetermined fee of $5.00 or $10.00 as payment in full for each office visit. Children may receive free diagnostic laboratory services, prescription medication and eyeglasses through the Medical Services Project.

In 2014, 789 children from 39 difference schools were seen by primary care providers, specialists, dentists or

optometrists in three Arizona counties: Maricopa, Pinal and Pima. For 2016, based on an evaluation of the MSP, ADHS revised program objectives and has added Oral Health services to meet the health needs of school-age children. Specialists have also joined the Medical Services Project. For this past year, 101 primary care doctors and 71 specialty care providers served children through this program.

With the help of Title V funding, Arizona has partnered with **The Arizona Partnership for Immunization (TAPI)** to promote immunizations statewide. TAPI is a non-profit statewide coalition formed to foster a comprehensive, sustained community program for the immunization of Arizonans against vaccine preventable diseases. TAPI was created in 1993 to improve the immunization levels of children in Arizona and later expanded to include adolescents and adults. Cooperative efforts between the public and private sectors have become a major force in implementing system changes resulting in long-term improvements in immunization service delivery in Arizona. TAPI has over 400 members representing over 200 organizations. TAPI's efforts are reflective of the importance of immunization over the life span, and will impact Arizona and its citizens' quality of life.

TAPI has developed and distributed materials and programs through the partner organizations to families during pregnancy, infancy, childhood, adolescents and adulthood. Over 126,000 educational pieces were distributed to schools, child care facilities, private providers, county health departments, community health centers, managed care organizations and WIC sites. Materials are used for new patient packets as well as single-copy distribution to parents. Not included in that total are materials distributed at conferences, health fairs and community education events.

English and Spanish parent education flyers and vaccine safety concern flyers were distributed. Additionally, reminder/recall postcards were printed and widely distributed to immunization providers throughout the state. All materials produced and available through TAPI can be ordered from www.whyimmunize.org. There is a continuous demand for TAPI materials and distribution is statewide. Additional materials include: Childcare and School Requirements Educational Tools; Parent Article: *Vaccinate or Not Vaccinate? It's not really a question;"* Pertussis Cocooning Campaign Flyers and Posters; Growth chart covering health information for pregnancy and babies through age 7; A clinical guide on giving shots; Direct to teen meningococcal campaign; and more.

The TAPI home web page, www.whyimmunize.org allows parents to ask medical experts questions about vaccines and immunizations. Parents and professionals use the web site to look for school requirements, immunization clinics, and pediatric and family practice offices. Social media messaging is coordinated with ADHS and Maricopa County to reflect the topics of the website. Changes to the federal vaccine funds use required that Arizona shift policies related to immunization access. TAPI hosted several stakeholder meetings to gather industry input on ensuring gaps in the system were minimized during the transition, and to asses community strengths and potential problems with the goal of seamless coverage for Arizona children. TAPI developed a campaign to alert providers about the changes, how to treat children based on their coverage, make appropriate referrals, ACA and immunization coverage and appropriate use of federally supplied vaccine. As a result the changes have been readily accepted into best practices for immunization sites.

In 2013 a new law allowed the Arizona Department of Economic Security (DES) to grant families who choose not to immunize their own biologic or adopted children licenses to foster children. Although the intent was to expand the number of foster families it has the potential to put vulnerable children at risk. A Tool kit was developed for families expecting new babies.

While Arizona's percentage of 19-35 month olds being adequately immunized has risen slightly (NPM 7- 72.8%), Arizona continues to be challenged by a high exemption rate in some parts of the state. Recently, the Arizona Republic published an investigative news story on immunizations and found that "about two of every five kindergarten classes in Arizona have such low vaccination rates that measles could spread rampantly among students and even to the community." They further explained that "Those schools reported that less than 95 percent of their kindergartners last year were vaccinated against the measles — placing them below herd immunity rate."[1] TAPI

hosted a childcare forum for partners to discuss materials and forms that would decrease the number of immunization exemptions from childcare. As a result ADHS has reformatted the reporting forms for centers and the exemption forms signed by parents to be more descriptive of the potential consequences of not vaccinating.

[1] http://www.azcentral.com/story/news/arizona/investigations/2015/02/03/hundreds-arizona-schools-skirting-vaccination-rule/22805897/

State Action Plan Table						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Support adolescents to make healthy decisions as they transition to adulthood.	Over the next five years, reduce the percentage of youth who report being bullied at school through the establishment of a multi-level campaign to stop bullying.	Develop a bullying prevention network-multiagency task force. With partners, develop a social marketing campaign to discourage bullying.	Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000	Percent of adolescents, ages 12 through 17, who are bullied or who bully others		
Support adolescents to make healthy decisions as they transition to adulthood.	By 2020, increase the percentage of youth receiving a preventive health visit by through formal collaborations with at least 5 partners to promote preventive medical visits for adolescents.	Collaborate with professional medical organizations and FQHCs to promote preventive medical visits for adolescents. Encourage AAP members to develop adolescent health champions in their practices.	Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000 Percent of children with a	Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.		

State Action Plan Table						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
			mental/behavioral condition who receive treatment or counseling			
			Percent of children in excellent or very good health			
			Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)			
			Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza			
			Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine			
			Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine			

State Action Plan Table						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
			Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine			

Adolescent Health

Adolescent Health - Plan for the Application Year

In 2016, Arizona's Title V efforts related to Improving adolescent health in Arizona will focus on preventing bullying, increasing seal belt usage and increasing the rate of youth that receive preventative health visits. As BWCH priorities, bullying prevention and injury prevention will be components of the Healthy People Healthy Communities integrated IGA. The strategies for addressing those priorities include providing healthy relationship education to youth and expanding the Battle of the Belt in high schools across the state. The Battle of the Belt is a contest between high schools where a baseline of seatbelt use is established either through observation or surveys of students and faculty. A marketing campaign encouraging seatbelt use is implemented and then a post survey/observation takes place. The high school with the greatest increase in seat belt use on campus is declared the winner.

In addition, the State Adolescent Health Coordinators will work with the State Adolescent Health Resource Center and coordinators in other states to identify adolescent well-care visit materials and other resources for promoting culturally and developmentally care. The BWCH will also work with AHCCCS , the Arizona chapters of ACOG and AAFP, the Arizona Alliance for Community Health Centers and others to develop strategies for providing adolescent friendly services and how to make preventive visits a priority for adolescents and their parents.

The Teen Pregnancy Prevention Program will place a greater emphasis on formal collaborations with programs and partners outside of the state-funded TPP program, in order to maximize youth access to programs and services in their community. Contractors are required to report these collaborations and community outreach on monthly narrative reports submitted to ADHS. In addition, the program will host a 2 day Adolescent Heath Workshop that will include educational tracks for teen pregnancy prevention providers, school staff, foster care case managers and home visitors. Program staff will also monitor how helpful the curriculum crosswalk is in outreaching and getting into schools.

The Positive Choices contractor and the Program Manager will review the analysis of the evaluation data and come to an agreement on what revisions may increase the effectiveness of the services. The Domestic Violence Program will continue to provide developmentally appropriate services to adolescents and work with our partners on how the BWCH program and our state partners can be responsive to the needs identified in the rural adolescent survey.

The Teen Pregnancy Prevention, Positive Choices, Family Planning, Health Start, MIECHV, Family Planning and Injury Prevention programs will continue to provide core services. Program staff will also continue to partner with internal and external programs and agencies focused on improving the life course of adolescents, especially those who face numerous risk factors and would benefit from additional protective factors in their lives. Increasing the capacity of individuals working with adolescents will be an ongoing effort in 2016. The Adolescent Brain Development and Decision Making trainings and preliminary evaluation comments highlighted the need and desire for additional skill development opportunities among diverse disciplines that work with youth. MCH Title V 2016 funds have been budgeted to offer additional Adolescent Health professional development trainings on topics identified as needs on the evaluation forms. The BWCH will work with our partners to coordinate and host these and other trainings.

There is also an overlap with adolescent health related to children with special heath care needs which is discussed in greater detail in the section specifically related to that population.

Adolescent Health - Annual Report

NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	18.6%	18.4%	18.2%	18.0%	17.8%

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	75.8%	75.8%	75.8%	76%	76%

As a critical period of the life course framework, adolescent health is a major focus of the Bureau of Women's and Children's Health (BWCH) which administers several programs that touch the lives of youth. The programs and activities that were implemented during 2014 and 2015 focused on supporting local agencies that worked with adolescents and providing professional development opportunities. A number of the professional development activities were planned and implemented with partners. Response to the professional development activities has been very positive, which demonstrates the interest and need for more training to enhance the skills and knowledge of those who work to improve the lives of youth. In addition, the State Adolescent Health Coordinator position resides within the BWCH. The Office Chief for Women's Health and the lead Teen Pregnancy Prevention Program Manager share this position.

Teen Pregnancy is described as a winnable battle in the department's strategic plan and Arizona, like other states across the nation, has seen steady decreases in the rates of teen births and pregnancies. Arizona's **Teen Pregnancy Prevention** (TPP) Program employs three strategic approaches: Abstinence Education, Abstinence Plus Education and Parent Education. The program focuses on improving the health and social well-being of youth through the reduction of teen pregnancies and sexually transmitted diseases, and the awareness of healthy relationships and life skills. The program provides youth with knowledge and skills that can be applied throughout their lives and parents with skills to be able to communicate with their youth effectively.

The program has received state lottery dollars since 2008 to provide abstinence and abstinence plus educational programs to youth, as well as parent education. Since 2010 as a result of the Affordable Care Act, ADHS has received Title V abstinence education dollars and abstinence plus education dollars under the Personal Responsibility Education Program (PREP).

In 2014, the Teen Pregnancy Prevention Program funded 13 Arizona county health departments and three tribes (Tohono O'odham, White Mountain Apache, and Pascua Yaqui) through a contract with the Inter-Tribal Council of Arizona utilizing lottery revenue to provide abstinence plus programming to youth and parent/teen communication education to parents. Many funded programs implemented a youth development/service learning focus and/or provided parent education related to talking with their teens about responsible sexual health and risk factors leading to teen pregnancy through the use of evidence-based/promising practices curricula. Contractors reached high risk youth by developing successful partnerships with county juvenile probation offices and foster care group homes in order to encourage participation among youth on probation, in detention centers and living in group homes. Abstinence plus providers delivered services to a total of 10,950 youth and 287 parents in 2014.

Seven abstinence programs provided services with funding from Arizona lottery dollars with an additional 3 programs providing services through Title V Abstinence Education funding. Contractors focused on youth development/service learning and peer leadership as well as classroom instruction. Additionally, the federally funded programs also created youth advisory groups to assist with the development of successful programming. Contractors also provided parent/teen communication education to parents. A total of 20,227 youth and 784 parents received services in 2014.

TPP staff continues to coordinate efforts with the Office of HIV/STDs to integrate STD prevention in programming and the Arizona Department of Child Safety for coordination of teen pregnancy prevention services among youth in foster care.

Lottery revenue is expected to continue and ADHS will continue to fund county health departments and tribal programs to provide abstinence plus education and fund community based organizations to provide abstinence education in their respective communities. Federal dollars made available through health care reform will continue to support Title V Abstinence Education Program and Personal Responsibility Education Program (PREP) funded contractors.

The TPP program collaborates with the Department of Child Safety as an active member of their teen pregnancy prevention task force. Additionally, TPP is in the process of coordinating projects such as the sexual health toolkit for youth and a parent/youth communication toolkit. The youth toolkit will provide foster care case managers with accurate information about various youth-related health topics that they can use as a guide when educating youth in their care. The toolkit will facilitate the provision of consistent information to all youth in the foster care system. The case manager gives the toolkit to the youth following the case management session so they can refer back to it as needed.

The TPP program is an active member of the Maricopa County Adolescent Health Community Advisory Board (CAB). The CAB consists of representatives from various community organizations in the county who work together to identify adolescent health needs, resources and gaps and leverage resources to address gaps. TPP staffs are working with county staff to host a county wide summit in October 2015 to bring adolescent service providers together to identify opportunities for meaningful partnerships and collaborations.

The TPP program offers professional development and capacity-building to state, and community partners and sponsored a two day grant writing training for all TPP contractors and other community based organizations that work with youth, to increase their capacity to seek additional funding to support their programs. Those that attended the training also had the opportunity to receive technical assistance hours from the trainers when they were applying for grant funding from non-ADHS entities. As a result of the partnership with the Department of Child Safety,

members of the joint task force helped develop a track for foster care case managers at the TPP 2014 summer adolescent health professional development conference. Due to positive response from the case managers that attended the conference, this track will be included in the 2016 conference.

The TPP program worked with a variety of partners to identify sites across the state to host MCH Title V funded two-day trainings on Adolescent Brain Development and Decision Making. The overwhelming response to these trainings demonstrated that this training was much needed. Within two weeks of accepting registrations, there were 400 registrants resulting in a wait list of 185 people. The variety of organizations represented in the trainings was very impressive, schools, tribes, behavioral health, homeless youth service providers, community health centers, substance abuse coalitions, faith based and a range of community based organizations. Three additional trainings were scheduled to accommodate those on the wait list and a smaller wait list remains.

During summer 2015, the TPP will offer curriculum trainings and program specific training on the importance of delivering programs with fidelity, and how to have conversations with youth about sensitive subjects.

Progress achieved by the TPP program can be attributed to several factors including the use of evidence based/evidence informed curricula by contractors. In addition, the TPP contractors have developed positive working relationships with owners and staff of foster care group homes and juvenile justice staff which has facilitated their ability to provide teen pregnancy prevention/youth development services on a regular basis to youth deemed as high risk. In many cases these services are the only opportunity the youth have to learn about healthy relationships, goal setting and pregnancy prevention.

Arizona has a long history of providing teen pregnancy prevention education services using lottery funds since 1997 for abstinence education and adding abstinence plus services in 2008. As a result of this longevity, some long standing contractors have become of a part of the school's annual programming. It has also been helpful that the amount of lottery funding has remained fairly stable for the past several years.

Over the years, the TPP has revised program policy and procedures to incorporate new evidence based approaches into service delivery strategies. The TPP program has implemented a fidelity monitoring too and data collection system to assess whether facilitators are complying with the curriculum developer's instructions and identify potential training/technical assistance needs.

Staff turnover and limited parent participation in the parent/teen communication courses are constant challenges faced by TPP contractors at the local level. Once new staff is hired it can take a month or more to coordinate formal curriculum training. Research has underscored the importance of parents communicating their values/beliefs to their children and that having an open dialogue with teens is key to reducing teen pregnancies. Therefore, involvement of parents in the communication courses is an important strategy that, along with school and community based teen education services has the potential to make an even greater impact on the decrease in teen pregnancy rates. Other challenges include difficulty gaining access to some rural schools or other schools whose administrators consider this topic too sensitive for their students.

The Annual Performance Indicator set for 2014, 14 births per 1,000 teenagers aged 15-17 years, has been achieved and exceeded and is now at 13.2/1,000 15-17 year olds. It is anticipated that this decline will continue due to sustained teen pregnancy prevention services to youth and other external influences, i.e. access to reproductive health, support for delaying sexual activity, television shows that portray the day to day lives of teen parents and greater access to reliable information via the internet.

Arizona's teen pregnancy rate continues to decline each year. This decline is greatest was among youth ages 15-17 years old with a decline of 51.2% between 2007 and 2013. During this same period, the pregnancy rate for young adults 18-19 years old declined by 46.6%. The 2104 TPP evaluation report provides detail regarding the results from the first full year of administering pre and posttests. Progress included a 20.2% increase in participants who reported that they intended to abstain until they were at least 20 years old. Participants also increased knowledge

about healthy relationships, increased their ability to identify potential consequences to teen sexual activity and increased positive views towards abstinence. TPP staff track completion rates for all services and 94% of youth receiving abstinence education completed at least 75% of the sessions offered, 89% of youth who received abstinence plus education completed at least 75% of the curricula provided and 86% of parents that attended the parent education sessions completed at least 75% of the course.

In a rural community in southern Arizona that sees a lot of drug trafficking, the school reported that in the two years the TPP contractor has been providing a youth development/ service learning curricula, they have noticed an improvement in their student's behavior and attitude. As a result, this contractor has been asked to help organize a community recreation center.

Staff turnover and adequate training are ever-present challenges in programs serving youth, especially those dealing with risk behaviors. In order to maintain a well-trained TPP workforce among our contracting agencies, ADHS will continue to offer a variety of professional development opportunities based needs identified by staff and contractors.

In response to challenges with outreach to new schools and districts, TPP Program Managers have organized a workgroup of TPP contractors who meet monthly to match national and state standards for sexual health with each of the curricula of the curricula in use in Arizona. The ultimate goal is to have a tool contractors can use when they outreach to schools that demonstrates how the curricula can help the school meet the national and state standards. This process has been beneficial to the contractors because they now have a more thorough knowledge of the mandates and standards schools must adhere to for providing sexual health education and how they link to the curricula offered. It has also prompted a few contractors to consider adding new curricula to the options they offer schools. With this tool it is hoped that contractors will be better equipped to extend their programs into new schools and districts across the state.

The goal of the **Positive Choices** program is to implement a proactive prevention education program in all Arizona middle and high schools promoting positive life choices by educating the students about the harms and consequences of destructive behaviors in order to reduce motivation to use drugs and become involved in harmful social environments. The outcome objectives include reducing intentions to use drugs and alcohol and engage in risky behaviors, increasing knowledge of positive life choices, healthy relationships, and mental health and supportive resources.

This new program, which was implemented in April 2015 as a single allocation was provided by the Arizona State Legislature during the 2014 legislative session. The presentations typically last from 40 to 90 minutes. Students are provided time to ask questions and are always provided with formal resources. The contractor also offers a component for parents and faculty. This component trains parents and faculty on signs and symptoms of youth destructive decisions.

The contractor is focusing on providing services to 555 Tile 1 schools in Arizona with a goal of providing presentations to a minimum of 200 of the schools in twelve months. In the first month alone, 52 schools responded by scheduling a presentation and presentations were delivered to 11 schools; two presentations to parent groups and nine to students for a total of 1,785 participants. Topics included three on substance abuse, two on unhealthy relationships, and six on bullying. The intent of the program is to change the way adolescents think about destructive behaviors in an effort to decrease motivation to engage in risky behaviors. Presenters are 18 – 30 year olds who have experience and are in recovery from substance abuse, internet safety, unhealthy relationships, bullying, body image or depression. Peer educators participate in 20 to 30 hours of training to incorporate evidence informed psycho educational prevention messaging into their personal recovery journeys. Peer educators use their story as a tool to educate adolescents about the behavioral health issue they experienced, the consequences that came from it, how they recovered and how they maintain positive life choice today. Healthy relationships and bullying presentations emphasize opportunities for appropriate intervention and bystander intervention. Presentations are offered to fit school class periods. Referral services such as Teen Lifeline, suicide hotlines and local crisis lines are

available should a participant need such a service. Surveys were distributed to participants after each presentation.

The **Sexual Violence Prevention Education Services (SVPEP) and Sexual Assault Services Program (SASP)** programs are described in greater detail in the Women/Maternal Health section. Some of the students reached by the college level prevention services supported by SVPEP funds and described above would also fall under the scope of adolescent health since freshmen and sophomores are typically 18-20 years of age. The SVPEP program also supports a southern Arizona organization that provides case management and support services for people living with HIV/AIDS and their families is a new contractor and will begin providing the Safe Dates curriculum to youth of color, Lesbian, Gay, Bisexual, Transgender and Queer/Questioning (LGBTQ) youth and straight allies.

In addition, the SVEP funds a northern Arizona agency that coordinates the Positive Youth Connections (PYC), a youth-focused program that educates youth in the community through peer education; The PYC consists of a component for high schools and another for middle schools. This contractor also provides in class primary prevention education in the schools. The topics covered during the primary prevention education sessions range from active sexual consent and rape myths to bystander intervention strategies and the link between substance abuse and sexual violence. Students learn about healthy relationships and state legal definitions of sexual violence. During 2014, the SVPEP provided services to 1,320 Middle/Junior High School Students and 2,120 High School students.

If any youth discloses they have been a victim of sexual violence while receiving prevention education services they are referred to an appropriate service provider in their community. In addition, the SASP contractors provide the following services to adolescents; counseling/support group, material assistance and victim/survivor advocacy and served 15 youth victims ages 13-17 in four rural counties during 2014.

When domestic violence occurs, children and adolescents are impacted either as an observer or a direct victim. These negative life experiences can impact an adolescent's long term physical and mental health unless they receive appropriate care and supportive services as soon as possible.

The **Domestic Violence/Rural Safe Home Network** contractors provide the following services to adolescents; immediate emergency shelter and related supportive services to adolescents including education and assistance in developing a safety plan, age appropriate individual and group counseling and peer support groups, assistance with enrolling in school and accessing medical and dental treatment. Contractors may also provide food, clothing, school supplies, and help with acquiring a GED. Some contractors also do community based education on healthy relationships, emotion regulation and domestic violence 101. During 2014, the program, 65 adolescents self-identified as victims of intimate partner violence and were provided supportive services.

At the same time as the "Balance of State" study, BWCH also surveyed 926 high school aged students. A confidential 12 question survey was distributed to three separate locations in small towns located in rural Arizona and on tribal land. The surveys were administer by teachers and counselors, The results of the surveys have been tabulated and will be used in gauging the attitudes of students towards teen dating abuse and the need for prevention program.

Most respondents believed that Teen Dating Violence is best described as physical violence which is partially correct but does not factor in emotional abuse. In addition, most students did not believe dating violence was an issue among their peers. About one-third of respondents agreed that it's easy for a victim of abuse to end the relationship, with 66% disagreeing. When asked if "Pressuring a partner to do something they don't want to do is not abusive if he/she ends up enjoying it.", most respondents answered appropriately however, almost one third indicated that it would be OK to pressure a partner as long as they ended up enjoying it. There were also differences in responses based on gender - Male and female respondents share an awareness of teen dating abuse, a willingness to discuss it and confidence in being able to help a friend in need. They also seem to share a sensitivity to the use/abuse of social media, and a relative lack of concern about the impact of popular culture on dating

violence. There also appeared to be an imbalance between male and female respondents in their appreciation of the seriousness of dating violence and the difficulty of dealing with it. Thus, males are more likely to deny that dating abuse is a problem, to downplay the difficulty victims can have in exiting an abusive relationship, to endorse pressuring a partner to do things that make him/her uncomfortable as a sign of "love," to accept "minor abuse" in a relationship, to approve of posting an embarrassing comment or image of an ex-partner as a joke, and to want to keep abuse issues as a private matter. One a positive note, 73% of the teen respondents would like to know how to help a friend if they were in an abusive relationship.

Title V funds support **reproductive health services** primarily in rural communities where there are limited providers that provide adolescent friendly services. The Reproductive Health program offers age appropriate information and services to adolescents. The services provided include a complete medical and health history, counseling and education, information regarding the various methods of contraception and assessment of their understanding regarding the contraceptive method selected. Providers also offer education about the symptoms of STIs as well as testing and treatment for STIs for those at risk. Abstinence is discussed as a valid and viable option. Adolescents are encouraged to discuss their reproductive health/family planning decisions with a parent or guardian. These services will continue to offered in 2016. In 2014 the program reported 2,129 unduplicated adolescents ages 19 and under receiving services.

The services provided by both **Health Start (HS) and Maternal and Infant Early Childhood Home Visitation (MIECHV)** are described in the Women/Maternal Health section are also provide to pregnant and parenting adolescents and their families. Home visitation services for this population are extremely important as it sets the foundation for effective parenting with the index baby and any future children. The programs also work to address the social determinants of heath that are typically associated with the long term negative outcomes of adolescent births, education, poverty etc., by supporting them in completing their education and obtaining safe housing and safe housing. The programs also provide information on a number of maternal and infant/child health topics so that adolescents can be informed and nurturing parents. The Health Start provided services to 409 adolescents (17% of the total clients served in the program) during calendar year 2014. The youngest client served was 13 years of age. These services will continue to be offered to pregnant and parenting adolescents.

The BWCH hosted a **Supporting Expectant and Parenting Teens in Achieving Academic Success** summit in September, 2014 for school personnel with the goal of addressing some of the barriers these youth face in completing school and demonstrate how providing support to these parents can have a positive lifelong impact. Pat Paluzzi with Healthy Teen Network was the keynote speaker and discussed "What Helps Teen Families Grow and Thrive". Ms. Paluzzi also informed the audience about the Title IX protections for teen parents. The day also included a panel of former teen parents who have successful careers who discussed some of the challenges they faced and who supported and encouraged them to pursue their goals. Each of the panelists identified a key person in their school that took a personal interest in their success. The workshop was also a platform for sharing information on the availability of Arizona Teen Pregnancy Prevention Programs and home visiting services. The evaluation results indicated that most of the attendees were not aware of Title IX's relevance to parenting teens prior to the workshop and the information presented was valuable and useful. Moving forward, the State Adolescent Health Co-coordinators will be working to ensure more school personnel and home visitors are aware of the Title IX protections for parenting teens and promote the resources available by the Healthy Teen Network.

The BWCH partnered with Maricopa County Department of Public Health and Touchstone Behavioral Health, Office of Adolescent (OAH) Teen Pregnancy Evidence Based grantees, to host an **Adolescent Health Summit for Maricopa County** service providers in October, 2014. The goal was to identify which services are available to youth and identify gaps in services not only by topic but by geographic location as a means of promoting partnering and potential program expansion. Victor Medrano, OAH was the keynote speaker and the agenda for the day consisted of a presentation on local adolescent health statistics as well as a case study on how to effectively provide wrap around services for adolescents. The October 2015 summit is in the planning process and the goal is to build

on the outcomes from the 2014 summit.

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Promote smooth transition through the life course for CYSHCN.	Increase the percentage of pediatric primary and specialty care practices who report that they have a written health care transition policy.	Design and conduct a baseline survey of pediatric providers concerning transition practices Repeat survey semiannually.	Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system Percent of children in excellent or very good health	Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care		

Children with Special Health Care Needs

Children with Special Health Care Needs - Plan for the Application Year

The 2015 Needs Assessment process made it clear that families were concerned about the transition of children and youth with special health care needs across the life span, not solely the transition to adulthood. Families voiced concern and this is supported by the data, that children and youth are often seen as their 'condition' or 'disability' and are not supported in daily wellness activities and programs. To that end, OCSHCN has been working to improve the overall health of CYSHCN.

Embracing the "Standards for Systems of Care for Children and Youth with Special Health Care Needs" model developed by AMCHP and the Lucile Packard Foundation, OCSHCN is moving forward with objectives and strategies to increase YSHCN services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

OCSHCN will obtain baseline data by designing and conducting a survey of pediatric practices. Provide training for pediatric primary and specialty care practices on the first element of the Six Core Elements of Health Care Transition. We will also design and conduct a survey of adult practices to develop baseline data regarding the capacity to serve YSHCN. Provide training for adult primary and specialty care practices on the first element of the Six Core Elements of Health Care Transition.

OCSHCN supports the Social Security Administration's ASPIRE initiative to assist transition age youth, who receive SSI, and their families to move toward employment by providing training for case managers on best practice for OCSHCN, and providing Health Care Organizer training.

OCSHCN will increase support to provide scholarships for youth and family members/caregivers to attend the annual Arizona Department of Education Transition Conference.

OCSHCN continues to participate in the Arizona Community of Practice on Transition (AZCoPT), a partnership among the Arizona Department of Education, Rehabilitation Services Administration, Division of Developmental Disabilities, Division of Behavioral Health, Office of Children with Special Health Care Needs, Raising Special Kids, and Tribal Vocation Rehabilitation Services and includes two Young Adult Advisors.

OCSHCN will make their Health Care Organizer accessible for youth who are blind/visually impaired participating in the Southern Arizona Association of Visually Impaired (SAAVI) "Stepping Out" summer youth transition program.

The Health Advocacy for CYSHCN and their Families contract, through Special Olympics and Hummingbird, continues to promote healthy lifestyle including physical activity and nutrition across the life course.

OCSHCN through its collaboration with counties participating in the Integrated IGA (previously the HAPI grant) will establish a baseline at the local level regarding prevalence of CYSCHN, to give us more detailed demographic information to guide decisions. The survey will be based on elements of the National Survey of Children with Special Health Care Needs (NS-CSHCN).

OCSHCN will improve and revise remote collection and types of data collected for the Health Advocacy for CYSCHN data collection system based on NAU's analysis and recommendations.

The Office for Children with Special Health Care Needs (OCSHCN) will maintain its critical Title V role in key areas: Information and Referral, Education and Advocacy, and Systems of Care for children and youth with special health care needs. OCSHCN will continue to assist families in accessing appropriate care and services by providing information and referral services to health care, insurance, and community resources for children, youth and young adults with special health care needs, to best meet the needs of the child.

OCSHCN will educate families, stakeholders and community partners regarding children and youth with special health care needs (CYSHCN).

OCSHCN will continue to advocate by partnering and collaborating with numerous state and local agencies, nonprofit, community based and private organizations, to promote family-centered, community based, comprehensive, coordinated systems of care for CYSHCN; such as Phoenix Children's Hospital for metabolic formulas and Cystic Fibrosis services, respite and palliative care through Ryan House, and Ronald McDonald's Houses offering housing for families accessing care outside of their community, Medical Services Project, and nutrition education and physical activity opportunities through health advocacy contracts.

To continue increasing the percentage of families of CYSHCN who partner in decision making, OCSHCN will continue its contract with Raising Special Kids to facilitate identification, recruitment, training and reimbursement for Family and Young Adult Advisors, to participate in ADHS and BWCH projects, committees, workgroups, resource development, policy and program development implementation, and evaluation at national, state and community levels.

OCSHCN continues to provide education and training to families and professionals on best practices focused on family–centered care; cultural competence; medical home; pediatric to adult transition, and technical assistance in the development of best practices for CYSHCN.

OCSHCN continues its efforts to increase the percentage of CYSHCN who receive care within a Medical Home. Leveraging the work OCSHCN is doing on the CDC 1305 Public Health in Action grant we are increasing the capacity of school nurses to refer CYSHCN to federally qualified health centers (FQHC) to establish a Medical House. A revision of the Medical Home Care Coordination Manual will be completed and available to families and providers in various formats (CD, flash drive, website) providing resources including an overview of systems of care with eligibility requirements, resources for families, transition to adulthood help, as well as examples of letters of

medical necessity.

OCSHCN will continue to support the BWCH Children's Health Information and Referral services Hot Line. OCSHCN continues to respond to inquiries, related referrals, insurance options, systems of care, appeals processes, and educational supports for families and professionals via telephone, email and in-person.

SSI letters will continue to be sent to families of child applicants, more accurately targeting referrals to Medicaid and other services dependent on the applicant's conditions or needs for services.

To support families who report community based systems are easily navigated, OCSHCN continues to support families and youth to be at the table when decisions are being made about systems of care for CYSHCN. OCSHCN will support providers through training for health plans, school nurses, educators, foster parents, and other child-serving agencies on strategies to support CYSHCN. OCSHCN will participate in the Governor's Coordinating Council on Infants and Toddlers (ICC), a federally mandated advisory council for the Arizona Early Intervention Program (AzEIP). OCSHCN will assist AzEIP in developing family friendly resources and updating forms related to insurance and funding for AzEIP services.

In partnering with other councils and agencies, OCSHCN is involved in policy development regarding inclusion of children and youth with special health care needs and their families. One of the roles OCSHCN fills is being responsible for the analysis and reporting of data, development of management reports, statistical analysis, study design and interpretation, performance measure and survey development and the development of the Title V Needs Assessment.

OCSHCN will continue to provide culturally competent information and training resources.

OCSHCN is researching the feasibility of utilizing Telemedicine to strengthen the CSHCN section of the CDC 1305 grant, by providing education and training to community health centers, high school personnel in selected areas of Tucson on asthma in children. Working with two local school districts we will develop a data system to track absenteeism, management, and referral of CYSHCN in the school setting.

In addition to the work we are continuing to do, we plan to hold several conferences including Parent to Parent Conference with the aim to increase parents capacity in dealing with the unique issues and challenges they face on a daily basis in caring for their children; and a conference to educate and support pediatric primary and specialty care clinicians on the first element of the Six Core Elements of Health Care Transition.

Children with Special Health Care Needs - Annual Report

NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	36%	36.3%	36.7%	37%	37.3%

The Office for Children with Special Health Care Needs (OCSHCN) maintained its critical Title V role in key areas: Information and Referral, Education and Advocacy, and Systems of Care for children and youth with special health care needs. OCSHCN assisted families in accessing appropriate care and services by providing information and referral services to health care, insurance, and community resources for children, youth and young adults with special health care needs, to best meet the needs of the child.

OCSHCN educated families, stakeholders and community partners regarding children and youth with special health care needs (CYSHCN). The Office was responsible for short and long range planning activities for tele-health, e-learning, education and advocacy, training, family and youth leadership, web page, cultural competence, medical home, and transition to adulthood. Additionally, the Office was responsible to assess and implement education for staff, providers, families, and family/youth advisors (leaders); and activities that promote improvement of quality of life.

OCSHCN advocates by partnering and collaborating with numerous state and local agencies, nonprofit, community based and private organizations, to promote family-centered, community based, comprehensive, coordinated systems of care for CYSHCN. These partnerships were coordinated to develop and implement innovative models of community based care and resources for CSHCN, to meet the complex needs of our families with children with special needs. Partnerships were built and enhanced through multiple formal and informal methods. The steps that Arizona's CSHCN program has taken to ensure key collaborations to assist in statewide delivery system of services, which reflect the principles of comprehensive, community-based, coordinated, family-centered care are highlighted. This summary is not intended to cover the full spectrum of partnerships.

The previous Title V National Performance Measures related to children and youth with special health care needs included increasing a families' ability to partner in decision making, and increasing the percentage of Children with Special Health Care Needs who receive care within a Medical Home, have adequate insurance, whose families reported they could easily navigate community systems of care and who received the services necessary for a successful transition to adulthood, including adult health care, work and independence. This discussion will focus on the previous programmatic activities related to these measures and other activities of the Program. It is important to keep in mind that often Program activities addressed more than one National Performance Measure.

To increase the percentage of families of CYSHCN who partner in decision making, OCSHCN worked to empower youth and families to be a part of the decision making around not only their own care or the care of a child, but decision making as it relates to system development. OCSHCN provided education and training to families and professionals on best practices focused on family–centered care; cultural competence; medical home; pediatric to adult transition and technical assistance in the development of best practices for CYSHCN.

The contract with Raising Special Kids facilitated identification, recruitment, training and reimbursement for Family and Young Adult Advisors, to participate in projects, committees, workgroups, resource development, policy and program development implementation, and evaluation at national, state and community levels. Family Advisors participate in the Maricopa County CYSHCN Coalition, part of the ADHS Health in Arizona Policy Initiative (HAPI), along with representatives from agencies and organizations serving CYSHCN. Family Advisors have provided Family-Centered Medical Home training and "Day in the Life," in-home experiences for healthcare professionals.

Partnering with OCSHCN, the Bureau of Women's and Children's Health, Maternal Infant and Early Childhood Home Visiting (MIECHV) program developed nine Family Advisors to participate in local coalitions across the state; four Family Advisors were active and recruitment efforts are ongoing. OCSHCN AMCHP Family Advisor, Stacy Strombeck-Goodrich stepped down at the end of 2014.

The Programs' efforts to increase the percentage of CYSHCN who receive care within a Medical Home continued and aligned with the measure around children with adequate insurance. OCSHCN used Title V funds to support the Bureau of Women's and Children's Health Information and Referral Services Hot Line, which served as a referral system as well as directly assisted families in navigating the system of care, helped them to understand eligibility requirements for different programs, application processes, and rights. OCSHCN responded directly to inquiries from families and professionals via telephone, email and in-person. Inquiries were related to insurance, care and services for children with special health care needs, providing referrals, insurance options, program eligibility information, grievance and appeals processes, and educational supports information.

OCSHCN provided information on all insurance options in response to professional and family inquiries. In family and professional trainings and presentations, insurance options and effective use of insurance were covered, and resources provided.

In Arizona, all Social Security Income (SSI) recipients are eligible for comprehensive services under Medicaid. Consequently, OCSHCN worked to ensure individuals and families were aware of their eligibility for Medicaid. Letters were sent to all families of SSI applicants to inform them of Medicaid and other services related to the applicant's conditions or need for services, and OCSHCN provided assistance with the application processes when needed.

OCSHCN staff participated in the Cover Arizona Coalition (the place to go in Arizona for health enrollment assistance), provided newsletter articles for Native Health, an e newsletter that reaches urban tribal members, and Ryan House and RSK related to Marketplace open enrollment. The OCSHCN listserv was used to reach stakeholders with information about open enrollment, updates, and the income tax special enrollment period, contact information to make appointments with Navigators in the local area and Navigators with specific knowledge around children with special health care needs.

The Medical Home Care Coordination Manual provided families and providers with resources including an overview of systems of care with eligibility requirements, resources for families, transition to adulthood help, as well as examples of letters of medical necessity. The Care Coordination resource was updated.

To support families who reported that community based systems are not easily navigated, OCSHCN sought to empower families and youth to be at the table when decisions were being made about systems for CYSHCN. OCSHCN offered training to health plans, school nurses, educators, foster parents, and other child-serving agencies on strategies to support CYSHCN in participating in school, recreational, and child care settings in the least restrictive and most inclusive environment.

OCSHCN assisted the Arizona Early Intervention Program (AzEIP) in developing family friendly resources, updating forms related to insurance and funding for AzEIP services, and provided Spanish translation of documents.

OCSHCN staff participated in the Governor's Coordinating Council on Infants and Toddlers (ICC), a federally mandated advisory council for the Arizona Early Intervention Program (AzEIP). In 2014, the team-based model was implemented statewide along with new AzEIP contracts, resulting in changes to how care is provided, and increased the need for training for all providers. AzEIP has completed the first annual year report under the new model and has identified areas of improvement in every early intervention program. Plans to address deficits are underway and being implemented this year. The 2015 annual report will guide work for 2016. OCSHCN has assisted AzEIP in developing family friendly resources and updating forms related to insurance and funding for AzEIP services.

In partnering with other councils and agencies, OCSHCN was involved in policy development regarding inclusion of children and youth with special health care needs and their families. One of the roles OCSHCN filled was responsibility for the development of management reports, statistical analysis, performance measure and survey development, and the development of the Title V Needs Assessment.

To support all families, OCSHCN purchased translation and interpreting services for trainings, forums, workgroups, and meetings to which families were invited, including this past year' community forums for the MCH Needs Assessment. The Program also translated information and resources for community partners, Arizona Early Intervention Program, AzAssist, Raising Special Kids, Ryan House and others to ensure equal access to information by all families.

In addition, efforts involved in working with the medical community to supported efficient community-based services meeting the needs of CYSHCN including transition. In *2014*, OCSHCN used Title V funds to sponsor *Opening the Doors to Patients with Special Needs* Conference. The conference provided sessions on Medical Home: Practical Aspects; Promising Models of Integrated Care and Children's Rehabilitative Services expansion beyond age 21 for

over 300 physicians and support staff, to assist in community-based service systems becoming organized so families of CSHCN can use them easily.

OCSHCN supported the Social Security Administration's ASPIRE initiative to assist transition age youth, who receive SSI, and their families to move toward employment, if possible. OCSHCN agreed to provide healthcare transition and Health Care Organizer training for families as needed.

OCSHCN provided scholarships for youth and family members/caregivers to attend the annual Arizona Department of Education Transition Conference. Scholarships were provided in 2014, and will again be provided for the August 2015 conference. A 2015 conference session proposal was submitted to be co-presented by OCSHCN staff and a Young Adult Advisor related to self-determination and transition to all areas of life.

The Program developed a project called Health Advocacy for CYSHCN and Their Families. The purpose of this project is to improve the overall health of CYSHCN by making health promotion information available and accessible along with opening up multiple opportunities for physical activity. Children learn these skills from a very young age. Obesity rates are higher in CYSHCN than children generally, and increase into adulthood. This project provided CYSHCN opportunities to build healthy lifestyle habits, supporting health into adulthood, which underlies every successful transition.

The Program is in the third year of a five year contract with Special Olympics of Arizona, which promotes overall health for CYSHCN through the Healthy LEAP Program. Healthy LEAP incorporates healthy lifestyle, injury prevention, hygiene, obesity prevention, nutrition, sports injury prevention, sun safety, alcohol and tobacco prevention education into physical activity for CYSCHN is integrated Unified Sports programs statewide. To date, 3,241 children and youth have participated in at least one season of sport, which may include track and field, golf, basketball, football, soccer or weight training. Additional sports were considered and added whenever possible.

In a small rural community in northern Arizona, after the football coach began offering Healthy LEAP, a student with SHCN was discovered to have exceptional football talent. The student joined the varsity team and became a star player. Without Healthy LEAP this student would never have played football at school in any capacity, he had not had the opportunity to play any sport until Healthy LEAP came to his school. In another small community, the principal reported that attitudes of students and staff toward students with disabilities changed since implementing the Healthy LEAP and Unified Sports program. She indicated that the Unified teams' intramural games promoted pride and a sense of belonging for all students.

Also in the third year, a contract with a local nonprofit agency in northern Apache County offered a Community Gardening program. The program incorporated healthy lifestyle, injury prevention, hygiene, obesity prevention, nutrition, sports injury prevention, sun safety, alcohol and tobacco prevention education into physical activity through gardening. The integrated program collaborated with the local Boys and Girls Club to use the facility and grounds. The program was offered to all Boys and Girls Club participants and included CYSHCN.

With the guidance of a Master Gardener, the students planned their gardens, ordered seeds, grew container plants and seedlings over the winter months, and had a weekly yoga session with a local instructor. In spring and summer the gardens were worked, soils amended, gardens planted, watered, weeded and tended. As the plants began to produce, students harvested, cooked, ate, or delivered to community members who could not garden. Students preserved extra produce, by freezing or dehydrating. They also helped with preparing produce for canning when appropriate.

Northern Apache County is a very rural area, with a strong sense of community; the community garden was a natural fit for this area. Several parents reported that their children began eating vegetables they wouldn't even taste previously. One participant, who had very limited food preferences, came to love broccoli, a food she had refused to even try until she grew it herself. Although she speaks infrequently, while harvesting she approached others to share her harvest and enthusiastically declared, "I like broccoli!"

The ADHS Division of Public Health Prevention Services collaborated across bureaus to introduce the innovative Health in Arizona Policies Initiative (HAPI). Through this initiative, ADHS has worked with 13 county health partners to educate Arizona's state, county and local decision makers about the health implications of policy. Local County Health Departments have implemented public health strategies with a strong emphasis on the K-12 settings including food availability and physical activity. Funding from Title V allowed counties and community based organizations to specifically create opportunities for CYSHCN to incorporate wellness into everyday life, and to develop local wellness policies of inclusion.

While preparing to write the request for proposals for the HAPI program, OCSHCN began seeking evidence based health promotion curriculum that was inclusive of CYSHCN and designed for an integrated setting. OCSHCN enlisted the help of Northern Arizona University (NAU) to examine existing curricula and assess it across several parameters for its applicability to the needs of CYSHCN. Two curricula were identified that could be adapted, and the efforts resulted in the development of a checklist and guide that can universally be used to assess curriculum. The tools were presented at a conference on evidence-based practice and a webinar, together reaching over 135 participants.

OCSHCN staff supported the agency in implementing the CDC 1305, State Public Health Action Grant for Domain 4, Strategy 5. This grant is related to children with chronic conditions, specifically asthma. Working with Pima County Department of Public Health, a survey of school nurses was conducted to determine professional development needs.

OCSHN collaborated with others in the community to support children and youth with special health care needs and their families. The Arizona Community of Practice on Transition (AZCoPT) is a partnership among the Arizona Department of Education, Rehabilitation Services Administration, Division of Developmental Disabilities, Division of Behavioral Health, Office for Children with Special Health Care Needs, Raising Special Kids, and Tribal Vocation Rehabilitation Services and includes two Young Adult Advisors. The group formed to improve communication across systems of care that are frequently involved in transition and transition planning. AzCOPT developed a co-operative training that was provided for conferences, organizations, community groups, and agencies throughout the state. AZCoPT also promoted local communities of practice and provided mentoring by an AzCOPT member as needed. Local Communities of Practice on Transition formed in several areas of the state including: Yuma, Flagstaff, and Lake Havasu.

At the Annual Arizona Department of Education Transition Conference, partners co-presented "Partnering for Transition," describing the role of each agency in coordinating transition for young adults with disabilities and special health care needs. This presentation was available online to Vocational Rehabilitation, Behavioral Health, and Developmental Disability case managers, as well as special educators, reinforcing collaborations across agencies, inclusive of health care, for successful transition.

OCSHCN staff participated in the Mountain States Genetics Collaborative (MSGRC) annual meeting and the Newborn Screening (NBS), Emergency Planning, Consumer Advisory and Medical Home workgroups. MSGRC and the American College of Genetics and Genomics conference were invaluable sources of information and data for Newborn Screening Partners in preparing for consideration of the addition of Krabbe, SCID and CCHD to the state newborn screening panel. OCSHCN staff who attended both conferences were able to provide data sources for NBS partners. As a result the Advisory Council recommended CCHD and SCID, and Krabbe received no recommendation.

OCSHCN communicated with health care providers, social service agencies, schools, federal, state and local officials; coordinated the administration of surveys; the collection and dissemination of data on special health needs population; represented SHCN services in the community when necessary; promoted communication and understanding of SHCN services among and between tertiary centers, key medical providers and other

stakeholders; and provided information and general data to groups regarding SHCN services.

In addition to working to affect the larger policy arena, OCSHCN oversaw contracts for social and gap filling services, such as metabolic formula; respite and palliative care including supporting overnight stays that enabled families to stay near their hospitalized CYSHCN, and increased the involvement of families and youth within OCSHCN, other ADHS programs and other state agencies.

The Metabolic Formula Program helped provide prescribed metabolic formula and/or medical foods to all eligible children and young adults statewide who were uninsured or underinsured for the treatment of genetic disorders. This was to assure normal growth and development of children and adults by preventing severe mental and physical defects or possibly death that can occur without early detection and dietary treatment.

The Cystic Fibrosis program was established by statute A.R.S. 36-143 to provide for the care and medical treatment services of Arizona residents suffering from cystic fibrosis who are twenty-one years of age or older and are either uninsured or underinsured and may not otherwise get appropriate care due to lack of funds or coverage. State funds supported this program.

OCSHCN, through community contracted providers such as Ryan House and Ronald McDonald House, provided access to respite and palliative care for children with life threatening conditions, and their families. With the support of Title V funds, Ryan House provides, at no cost to the family, respite and palliative care for children, with potentially life-limiting conditions, birth through age 16. Ryan House provides a home like environment with care provided by a highly trained medical and child life staff. It is the first facility of its kind in the country and one of only two currently available in the US. Families may stay with their child in a family suite, in their own room, or may choose to leave their child and take a long weekend break or take a rare vacation with their other children. OCSHCN supported 20 of the 256 children who were served at Ryan House in 2014; this represents 200 of the 2187 care days provided. Ninety percent of families served report that respite stays at Ryan House improve the quality of life for their entire family; 70% indicated that respite allows them to provide a higher level of care for their child upon their return home and; nearly 60% reported improvements in their child's development and/or social interaction.

The Ronald McDonald House (RMH) Charities of Phoenix provides overnight facilities for out of town families of hospitalized patients, including CSHCN. Often the Ronald McDonald Houses are located steps away from or very near the neonatal or pediatric intensive care units where the children or young adults with special health care needs are receiving treatment, including surgeries Families from all walks of life, from all ethnic and socioeconomic groups rely on the services provided by the RMH. OCSHCN provided Title V funds for the Ronald McDonald Houses in Phoenix and Tucson. The data reported on the source of insurance for families with CSHCN show: RMH in Phoenix, 100% of the families that stayed with them were on Medicaid, and RMH in Tucson, 89% were on Medicaid, 11% had private insurance and 13% had no insurance.

BWCH administered the Medical Services Project through the Arizona Chapter of the American Academy of Pediatrics. The Medical Services Project increases access to and utilization of primary care services for Arizona's uninsured children from low-income families. The Medical Services Project provides delivery of medical and dental services in participating physician's offices to children without health insurance and to those who do not qualify (or are in the process of qualifying) for Medicaid or insurance through the Marketplace. School nurses identify children who are eligible for the Medical Services Project and facilitate their enrollment. To be eligible for the Medical Services Project a child must have no health or dental insurance; must not be eligible for AHCCCS (Arizona's Medicaid) or Indian Health Services; and must have a household income less than 185 percent of the federal poverty level. A network of physicians (pediatricians, family practice physicians, and specialists) provides care to children qualifying for the Medical Services 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 Services Project children each month. In addition, prescription medications, diagnostic laboratory services and eyeglasses are provided as necessary to qualifying children. In2014, the Medical Services Project served 242 individual children. This program

will be moving to OCSHCN in 2015.

Title V funding is used to support the infrastructure necessary to carry out the state mandate A.R.S. 36-899.01 for public and charter schools to assess hearing. BWCH administered this program and provided training, equipment and technical assistance to schools to implement required hearing screening. In 2014, the hearing screenings were conducted on 591,377 children. This program will be moving to OCSHCN in 2015.

Unlike hearing screening, vision screening is not mandated in the state of Arizona. Many schools voluntarily provide vision screening to school age children. This effort is supported BWCH Title V dollars through a contract with University of Arizona to provide specific curriculum and train trainers on vision screening.

OCSHCN supported the EAR Foundation to make available National Hearing Screen Training Curriculum (NHSTC) to Maricopa Integrated Health Systems' (MIHS) community health clinics via the MIHS e-learning system. Additionally, the EAR Foundation promoted access to NHSTC to birthing hospitals. In 2013, OCSHCN hosted hospital screener training on TrainingFinder Real-time Affiliated Integrated Network (TRAIN), a public health learning management system. OCSHCN did not host the hospital screener training in 2014, and won't be hosting in the future, because the National Center for Hearing Assessment and Management (NCHAM) moved to a national standardized training which is available on their website. In 2014, this contract facilitated medical home, inclusive of hearing screening and follow-up, training for pediatric providers in 33 practices around the state. Through the EAR Foundation, eight individuals were trained as trainers of hearing screeners, 15 midwives received hearing screening training and staff at 158 Head Start, tribal, early intervention programs, and charter/public/private schools.

The following are just a few examples of mechanisms OCSHCN utilized to promote culturally competent service delivery.

In order to ameliorate the harmful effects of failing to appreciate another's everyday reality, OCSHCN promotes cultural relativism. Training activities are designed to promote an understanding that a person's experience of the world is only one of many possibilities, and a culture cannot be judged using the standards of another culture. Activities are not so much oriented towards trying to understand the intricacies of every other potential cultural belief system, which can have the unintended consequence of stereotyping (which is an over-generalization about a group), but to sensitize staff towards listening for what others may be thinking and remaining open to hearing their points of view and adapting to it.

Nowhere is it more critical to appreciate one's taken for granted assumptions than when a health care provider and a family must together decide on an appropriate course of treatment. The provider brings his or her own assumptions of what is necessary and good, which are influenced by their cultural expectations and training. They may have their own feelings about the child, and may be oriented towards a cure or amelioration of disability. The family's priorities could be different, but they are dependent upon the provider to help them to understand risks and possibilities of different treatment options.

OCSHCN embeds cultural competence concepts into contract language, which go beyond requirements for reading level, interpretation, translation, and alternative formats and includes best practices for family-centered care, including people-first language and disability etiquette. OCSHCN makes written translation and interpretation services available to other community partners. Simultaneous Interpreting equipment is used by OCSHCN and made available to other agency/bureaus for use in public forums, meetings, conferences, bilingual workshops, training seminars, where there is more than 1-2 individuals requiring real time interpreting services.

OCSHCN reviews written and video training materials and provides guidance regarding appropriate and inclusive language for CSHCN to the Bureau of Nutrition and Physical Activity's Empower program for child care facilities.

OCSHCN collaborates with the Native American Intertribal Council to provide resource information to the Native American communities regarding CSHCN and participates in Native American cultural training.

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Reduce the use of tobacco and other substances across the lifespan.	By 2020, Provide Empower training on the effects of second hand smoke on children to care providers and 100 home visitors.	Set up Empower home visitor training through the Strong Families AZ website. Present Second Hand Smoke risks at the Strong Families AZ alliance meeting.	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Percent of low birth weight deliveries (<2,500 grams) Percent of very low birth weight deliveries (<1,500 grams) Percent of moderately low birth weight deliveries (1,500-2,499 grams) Percent of preterm births (<37 weeks) Percent of early preterm births (<34 weeks) Percent of late preterm births (34-36 weeks) Percent of early	A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes		

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
			term births (37, 38 weeks) Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births Percent of children in excellent or very good health			
Improve the oral health of Arizona's women and children.	By 2020, increase the percentage of children who have dental sealants on their	Expand access to school based oral health disease prevention programs.				

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	permanent molar teeth by 10%.					
Increase the percentage of women and children who are physically active.	By 2020, increase physical activity among women ages 18-44 years by 15%.	Partner with counties working on increasing physical activity through the integrated IGA, to identify effective strategies for engaging women. Identify opportunities to partner with women serving organizations and other community based organizations to develop a community-wide campaign encouraging recommended levels of physical activity.				
Strengthen the ability of Arizona a families to raise emotionally and physically healthy children.	By 2020, 65% of parents of BWCH home visiting programs will report that they believe they have the skills	Monitor the quality of the services provided to families enrolled in BWCH home visitation programs to				

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	and knowledge needed to raise emotionally and physically healthy children.	ensure home visitors are implementing services with fidelity to the respective programs. Identify strategies that support the retention of families in voluntary home visiting program and ensure all BWCH home visitors have the opportunity to be trained on implementing these strategies.				

Cross-Cutting/Life Course

Cross-Cutting/Life Course - Plan for the Application Year

During the needs assessment process Arizonans identified three different issues that cut across the life course: nutrition, tobacco and oral health. For a richer discussion of the needs identified and programs currently in place please see the Annual Repost section of this domain. BWCH will continue efforts in the areas described below.

BWCH will continue to fund Title V Hotlines efforts directed at breastfeeding, early childhood nutrition and school aged nutrition. Arizona will continue to support childhood nutrition through the Empower Programs and will seek to expand the partnerships. ADHS will continue serving as the organizer and lead entity in conjunction with numerous other state organizations and county health departments leveraging their existing work to help the pilot locations. Starting in July 2015, the program is moving forward with implementation in this 5-year project to include a 'Menu of Options' that schools can choose which strategically-aligned partner organizations they would like to work with to help support them in their Empower Schools wellness policy and programming efforts. The program will be working with partners to determine if this model could be endorsed and expanded across Arizona.

BWCH MIECHV program will continue to support the Bureau of Nutrition and Physical Activity (BNPA) **Empower**

Home Visiting Guidelines on Nutrition and Physical Activity and to provide hands-on training to home visitors in locations throughout the state. In 2016, this training will continue with 12 sessions across the state with an anticipated audience of 400.

The Arizona Dental Sealant Program will continue to provide school-based dental sealants to high risk children in eligible public, charter and private schools throughout Arizona. The Office of Oral Health (OOH) will maintain Intergovernmental Agreements with counties, community dental clinics, and dental/ dental hygiene schools to provide school-based dental screenings, referrals and sealants to children in low-income schools. The focus will continue tobe to identify those children who are at highest risk of decay and increase the number and proportion of children served. The program will continue to seek grant opportunities to implement the program under new legislation allowing public health dental hygienist to provided dental sealants without the need for a dental exam.

Collaborations and outreach to expand the program to new service areas will continue. The program will continue to seek to increase expansion in some of the most rural counties in Arizona by partnering with local community health centers. This partnership has the potential to reach children in many small, rural communities.

In an ongoing effort to increase the proportion of public schools served by the program, the current school eligibility requirement will remain in effect for the 2015-2016 school year. The OOH will continue to review the efficiency of the dental sealant program by engaging partners and stakeholders in recommendations for improvement. Teledentistry demonstration practice models working in sealant programs will continue to develop protocols to connect children with acute dental needs to dental providers. These models will document strategies and share lessons learned with other school-based sealant programs.

In the upcoming year, OOH will explore additional data reporting that is both reliable and time efficient; continue to seek funding to expand statewide program; to incorporate mini grants as an option (e.g., serve specific high risk zip codes) with use of donated or borrowed portable dental units; further expand the incorporation of dental hygiene students within school-based sealant programs to increase cost effectiveness and to provide the students with learning opportunities for dental public health; develop tracking mechanism to evaluate cost effectiveness.

OOH will continue to expand and develop workshops and provide continuing education opportunities for dental providers, community stakeholders and program administrators. The OOH will convene oral health partners from around the state to address the decreasing participation in this program. The topics to be covered include provider participation, decreasing reimbursement from Medicaid and the confusion between public oral health and for profit mobile oral health services.

The Office of Oral Health will continue to collaborate with school-based dental clinics, and partner with private organizations and foundations to enhance prevention activities. The Office will continue to work with the Arizona Dental Association, the Arizona Dental Hygiene Association and the Arizona Alliance for Community Health Centers in an effort to improve the number of providers for the underserved. Tracking of AHCCCS (Arizona's Medicaid) utilization of care will continue, as will collaboration with internal state agencies and external partners and organizations to promote oral health education, early intervention by dental professionals and early dental referrals by medical professionals.

The OOH will continue to conduct evaluation activities with school nurses who participate in the Arizona School-based Fluoride Mouthrinse Program. Evaluation activities will be used to measure participant satisfaction, program efficiency and direct efforts for program improvement. Based on the results of findings in the 2013-14 school year, OOH has made significant adjustments to the implementation of the program and expects to increase the number of children served next year.

Through the HRSA Workforce Grant and match support provided by First Things First, teledentistry sites will continue to expand to rural and underserved areas. Additionally regional coalitions will be facilitated to support training for both providers and community stakeholders. The OOH will work with other MCH programs in the Bureau of Women's

Health to enhance integration of oral health strategies into existing programs, such as Health Start and WIC.

The Office of Oral Health will continue to work with Office for Children with Special Health Care Needs (OCSHCN) to identify opportunities to provide dental sealants to children with special health care needs. OCSHCN will continue to incorporate brochures on oral health during pregnancy and for children ages birth-3 within OCSHCN's health care organizer in English and Spanish. Additionally, the OOH will continue to partner with OCSHCN to provide funding to train dental students to provide treatment to CYSHCN and to women of child bearing age with special health care needs.

For the upcoming year, the Fluoride Varnish Program will focus on the reimbursement model piece of the program. The program will expand to process services for the entire County of Maricopa instead of a small region.

All Health Start Home Visitors will continue to receive annual training on the dangers of tobacco use among women during pregnancy, its effects on women and babies, as well as basic tobacco screening and intervention skills including how to make referrals to the ASHLine. All BWCH home visiting programs will work more intentionally with Bureau of Tobacco Chronic Disease on serving families and tobacco use will be a topic of professional development for Arizona's home visitors.

Moving forward, the data from the Life Course Power Point will be utilized in future life course presentations that include the board game. At this time, a presentation on the Life Course Project will be made to AHCCCS health plan representatives in August and the Program is working to schedule a Brown Bag presentation for ADHS staff.

Cross-Cutting/Life Course - Annual Report

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective					

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective					

Program looked at concerns that crossed through the life span where not addressed in a population domain. In some instances a concern could cross domains but seemed a better fit in one population or the other. For instance, injury certainly crosses the life course but as the strategies Arizona will focus on centered more during childhood, Injury was covered there. For this Life Course population Arizona will discuss nutrition, oral health and tobacco use.

In working to improve nutrition for Arizona's families, efforts are directed at breastfeeding, early childhood nutrition and school aged nutrition. The Arizona Department of Health Services (ADHS) through the Bureau of Women's and Children's Health (BWCH) has provided a toll-free hotline to parents and families in Arizona since 1986. The Hotline provides breastfeeding support 24/7 for all of Arizona's families. The line is staffed during the business day by a bilingual Certified Lactation Consultant and off hours by a bilingual ICBLC. In January 2001, the Women's, Infants

and Children's (WIC) Hotline was added to provide information regarding WIC. The Hotline is funded collaboratively by the Title V Maternal and Child Health Block Grant and Women, Infants and Children programs. The Hotline received over 7,500 calls in 2014.

ADHS Breastfeeding Program is a collaboration of efforts of numerous grants including the Women, Infants, and Children Program (WIC), the WIC Peer Counseling Program, Center for Disease Control and Prevention (CDC), SNAP-ED Nutrition Network, Title V and the Maternal Infant and Early Childhood Home Visiting (MIECHV) grant. This collaboration results in programs that give consistent messaging/education and facilitate the building of a community of support around the mother and the baby so that she is able to set and reach her breastfeeding goal. As breastfeeding has been chosen as the National Performance Measure for infants, it will be discussed in more detail in the Infant/Perinatal.

To meet the wellness needs of early childhood, Arizona supports child care centers through the **Empower Program**. The Empower Program supports licensed child care facilities' efforts to empower children to live healthier lives through the incorporation of ten standards that are based on age-appropriate best practices. With over 2,400 licensed child care facilities across the state enrolled in the Empower Program, it has the capacity to reach over 200,000 children from ages of birth to 12 years. The Program started as a pilot in late 2009 and after much success became an official program in 2013. These standards include a series of wellness requirements including reduced screen time, structured physical activity, family styled meals, breastfeeding, tobacco education, sun safety and oral health education. These standards go beyond licensing requirements.

The Empower Program has a strong network of internal and external partners. The larger early care and education community, valuing respective contributions and professional niches, frequently works together for the good of the whole. Internal partners work well together to leverage resources in order support collective goals and work.

At the Arizona Department of Health Services (ADHS), the Bureau of Nutrition and Physical Activity, Bureau of Women's and Children's Health and Bureau of Child Care Licensing (BCCL) work collaboratively to implement the Empower Program. Funded in part by Title V, the BCCL is the licensing/certification entity for child care facilities, registering them for the Empower Program, and monitoring compliance with the regulations and rules. They also survey the implementation of the Empower standard practices and policies during educational on-site visits. Other ADHS partners include the Bureau of Tobacco and Chronic Disease and Children's Environmental Health Program, and other elements of expertise throughout the Department who support the content and development of the Empower standards. Externally, there are many partners that support the implementation of the Empower standards such as the Department of Education, First Things First, Department of Economic Security and Local Health Agencies

EMPOWER + is a CDC funded, Nemours administered grant to ADHS/BNPA intended to improve health and nutrition practices in child care centers. Initially thought to be a 5-year grant, the project will end September 30, 2015 after only two years. Trainers were contracted to deliver five learning sessions each year to their assigned learning community and provide technical assistance to enrolled centers. Centers attend training, assess their programs, determine desired improvement areas, and work toward improvement with the support of the trainer and project resources. Primary areas include 1) increase physical activity; 2) improve nutrition, 3) support breastfeeding, 4) reduce screen (and sedentary) time, and 5) engage families. Data from Cohort 1 indicates significant gains in all areas measured. Tools used included pre and post-test for each learning session, pre and post-Let's Move Child Care (LMCC) Quiz, pre and post- Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC) tools, as well as Action Plans.

Growing from the original Empower, and funded by the CDC1305 FOA (School Health) **Empower Schools** works with 9 pilot school districts from around Arizona to incorporate 10 school wellness standards into their local wellness policies. Each district receives stipend funding annually through 2018 to implement programs that will support these wellness policies. Student health is being tracked through school health profiles and a youth risk behavior survey to

determine level of success. Through this effort ADHS is serving as the organizer and lead entity in conjunction with numerous other state organizations and county health departments leveraging their existing work to help the pilot locations.

In 2011, the BWCH MIECHV program began supporting a half time position in the Bureau of Nutrition and Physical Activity (BNPA) to develop a manual for home visitors and parents that included a set of guidelines, tools and activities that home visitors and parents could use with children in the home to encourage healthy eating and physical activity called **Empower Home Visiting Guidelines on Nutrition and Physical Activity** and to provide hands-on training to home visitors in locations throughout the state. Over several months, stakeholders developed these 10 "Empower Home Visiting Guidelines":

1. **Infant Feeding (0-6 months)** Support and encourage breastfeeding efforts. Help parents recognize and respond to baby's hunger and fullness cues.

2. **Oral Health** Encourage parents and caregivers to introduce a tooth brushing routine appropriate for every member of the family (parents, infants and children).

3. **Infant Feeding (6-12 months)** Guide parents and caregivers to introduce first foods at a developmentally appropriate time and in appropriate quantities.

4. **Toddler/Child Feeding** Work with families to incorporate healthy eating habits. Highlight opportunities for families to make small changes over time.

5. **Fruit Juice** Recommend parents and caregivers to limit servings of fruit juice to 4-6 ounces per day for children 12 months and older.

6. **Physical Activity** Promote physical activity to all members of the family. Offer ways to include physical activity for a variety of settings and abilities.

7. **Screen Time** Encourage families to modify screen time to include developmentally appropriate content that engages family members in physical activity.

8. **Family-Style Meals** Advise parents and caregivers to serve meals family-style. Provide suggestions with ways to introduce family-style meals over time.

9. **Cooking** Provide resources and tips to help families prepare healthy and affordable meals at home.

10. **Food Safety** Share basic recommendations to help families be food safe.

Each training session includes two or three days of classes where participants learn how to use Empower Home Visiting Standards to support healthy eating and active living for young families in the home visiting setting and how simple practices can improve the health of infants, children and adults in the families they serve. This training highlights how the Empower Home Visiting Standards help prevent obesity and strategies for how home visitors can share these messages with families. Topics covered include how to build support for women to reach breastfeeding goals, recognizing and responding to infant hunger/fullness cues, strategies to prepare healthy meals at home, food

safety practices for breast milk and infant formula in the home and more. In 2016, this training will continue with 12 sessions across the state with an anticipated audience of 400.

The second cross cutting topic is **oral health**. The Office of Oral Health promotes oral health for the well-being of all Arizona residents. In doing so, the office coordinates a number of initiatives and administers five main programs: Arizona Dental Sealant Program which is partially funded through Title V; Fluoride Mouthrinse Program; Dental Trailer Loan Program; Community Oral Health Systems Development Program and Healthy Teeth, Healthy Families (Early Childhood Caries prevention program). In the previous Nation Performance Measure addressing oral health; NPM 09: Percent of third grade children who have received protective sealants on at least one permanent molar tooth, Arizona has found a slight decrease with 47% of third grade children have at least one dental sealant.

During the 2013-2014 school year, the Arizona School-based Sealant Program provided dental screenings and referrals to 8,034 children attending eligible public schools. As a result, 4,399 children received dental sealants. The sealant program provided services to children in ten of the fifteen Arizona counties. This was an increase from five counties during the 2012-2013 school year. Partnerships with community clinics have provided outreach to these three additional counties.

Students who attend eligible schools, in 2nd or 6th grade, and have informed parental consent were able to receive oral health screenings and referrals for treatment needs. Uninsured children, Medicaid and SCHIP beneficiaries, those covered by Indian Health Services or by state-funded tobacco tax health care programs were eligible to receive sealants. The Program bills Medicaid for children covered by Medicaid and utilizes Title V funds to pay for the uninsured. After 20 years of fairly steady growth, the program has seen a plateau and although there are more counties involved, there is evidence that there has been a leveling off in the number of children participating in the sealant program. This may be attributed to several factors including the increasing presence of "for profit" dental vans, and the reluctance of parents/guardians to sign consent forms.

As part of the sealant program, the Office of Oral Health (OOH) collects oral health status information using the Association of State and Territorial Dental Directors' Basic Screening Survey (BSS). This information provides guidance on referrals for care and surveillance on oral health status. In addition, school nurses and parents are notified on the day of the screening if any screened child has urgent or early treatment needs. Data analysis and reporting of program services are generated for the state, county and school levels. Oral health surveillance findings from the 2013-2014 school year indicate that 31% of children had untreated tooth decay, 74% had decay experience and 5% had urgent dental treatment needs.

The Office of Oral Health (OOH) continued to work with stakeholders and partners to develop and promote policies for better oral health, establish integrated population-based interventions, set priorities and select appropriate strategies for target populations. The OOH maintained Intergovernmental Agreements with counties to provide school-based dental screenings, referrals and sealants to children in low-income schools. The Office of Oral Health collaborated with First Things First to promote and implement prevention programs for children ages 0-5 including support for establishing a dental home by age 1 and providing technical assistance for oral health initiatives.

The OOH partnered with First Things First to implement the 2015 Healthy Smiles Health Bodies Survey of kindergarten and third grade children. The primary purpose of the survey was to collect essential information necessary to report on the prevalence and severity of tooth decay in elementary school children and provide information to target and expand disease prevention programs. Information collected from the survey will be reported to the National Oral Health Surveillance System.

The OOH continued to administer a state-wide School-based Fluoride Mouthrinse Program (FMR) for children attending eligible schools. Schools are eligible if they have a 50% or greater enrollment in the National School Meal Program located in communities with sub-optimal fluoride levels in the community drinking water. In 2014, 16,795 children participated in the program.

The OOH, Arizona Fluoride Varnish Program continued to provide services in 2014 as part of a grant from the First Things First South Phoenix Regional Partnership Council. Partnering with the Maricopa County Department of Public Health (MCDPH), the application of fluoride varnish, an extremely effective cavity-prevention agent, in combination with dental screenings, referral and other educational services, are the core of the primary prevention program. During 2014, 5,884 children received dental screening and oral health education. Of those screened, 5,621 children received fluoride varnish application and referrals for treatment needs.

The OOH participated in the ADHS Empower Program. As part of the program, OOH provides guidance, training and resources to childcare providers on promoting oral health activities in childcare centers and linking children to dental homes. The Empower Program reaches more than 200,000 children in licensed early care and education facilities throughout Arizona.

The Office of Oral Health partnered with the Arizona Dental Association, Central Arizona Dental Society in the 2014 Dental Mission of Mercy (AZ MOM). This event was held in December of 2014 and with the help of 1,800 volunteers, more than 2,200 people received about $1.6 million in much needed dental care.

The Office of Oral Health collaborates with community, county and state partners to promote and expand the sealant program and reach underserved populations. OOH continues to partner with FQHC's in underserved communities to identify likely providers and engage schools in participation. OOH routinely provides continuing education opportunities for dental professionals by offering 36 instructional hours on oral health disease prevention programs. These educational workshops reached a total of 95 participants (including dentists, dental hygienists, dental/dental hygiene students, physicians, nurses, childcare providers and administrators). Training focused on the following topics: School-based Sealant Programs, Community Dental Health, Promoting Oral Health Practices in Childcare Setting, Early Childhood Tooth Decay, Oral Observations and Prevention, and Disease Disparities. The OOH collaborated with the Arizona School of Dentistry and Oral Health and Oral Health America to continue and expand a school-based sealant program in Pinal County. OOH supplied the technical assistance for program implementation, data gathering and program reporting. Having diverse community partners has been a critical component to program sustainability and outreach.

One of the main challenges to expansion of the school-based sealant program is the lack of infrastructure at the local level. Many communities and counties lack sufficient numbers of dental providers who are able or willing to participate in school-based sealant programs. Another challenge is engaging schools. Public schools are under increasing pressure to raise achievement levels and have limited time in their schedules to allow additional programs. School engagement takes time and resources that local programs are not able to consistently provide.

A challenge to the fluoride varnish program has been recruitment and retention. A major part of the program also involves billing Medicaid for services in order to build a sustainable program. Working with the Medicaid health plans, reimbursement at the appropriate rates for the services provided and denials of services remain a challenge.

Over the course of the last year, OOH has learned the following lessons to reduce barriers/challenges: allow new programs time to address challenges (can take several years) and become successful (e.g., being cost-effective); assure a reliable process for data collection and processing also allowing for several cross checks and balances in the system; offer teacher/program incentives to improve support for the program; provide a time for all grantees to network and share their experiences and lessons; market sealant and fluoride varnish programs among schools and partners/stakeholders to build trust and recognition; schedule schools one year in advance; evaluate programs to better meet the needs of the schools, teachers, parents and students; attend back-to-school nights with a sealant program booth, hand out permission slips directly to parents, and collect the signed permission that night; and pilot alternative models to delivering prevention programs.

The 2015 Healthy Bodies Healthy Smiles Survey found that 44.2% of 3rd grade children had at least one dental sealant on a permanent tooth with 74% needed one or more dental sealants. Sealant prevalence was not

significantly different among Hispanic and non-Hispanic white, black, American Indian and Asian children. While prevalence of dental sealants has not increased significantly over the last five years, there are indications that disparities are decreasing with more minorities, low income and uninsured children receiving preventive dental sealants.

For tooth decay, the 2015 Healthy Smiles Healthy Bodies Survey found that in 3rd grade children, 64% had experienced tooth decay in their permanent teeth, which is an improvement of 11 percentage points from findings in 2010. The prevalence of tooth decay was higher in Hispanic and American Indian children compared with non-Hispanic white children. Compared to children attending higher income schools, children attending schools with >50% of children eligible for Free and Reduced Meal program have a significantly higher prevalence of decay experience.

Previous State Performance Measure 6 looked at the percent of Medicaid enrollees age 1-14 who received at least one preventive dental service within the last year. The OOH continues to promote oral health as an integral component to overall health. This is facilitated by increasing the coordination and exchange of oral health information over the past year among state agencies and community organizations that address early childhood services. Development of oral health curriculum has been a main focus of the past year targeted at home visitors. Evidence-based and best practice oral health messages for families, pregnant moms, infants, toddlers and preschoolers are provided through this curriculum.

Training and calibration was provided for early childhood dental program providers on implementing anticipatory guidance and utilization of motivational interviewing techniques with clients. Over 5,000 parents/caregivers have participated in oral health education and 22 dental staff located in WIC sites have received training in oral health risk assessment criteria, anticipatory guidance, disease recognition, oral health education messages for parents and caregivers. The Empower program for licensed child care facilities provided consistent messaging about establishment of a dental home and the need for ongoing dental care for all family members.

Arizona's Title V Program has also chosen to focus on tobacco use as it affects infant mortality and morbidity (SUID, prematurity), child health (asthma), preconception and interconception health and transition decision making for teen and CYSHCN. ADHS' tobacco efforts are managed and coordinated out of one of BWCH's sister bureaus, the Bureau of Tobacco and Chronic Disease (BTCD).

BTCD is Arizona's prevention, education and cessation program for both tobacco and chronic disease, partially funded by the voter-approved and voter-protected tax on the sale of tobacco products. BTCD utilizes local, statewide, and federal resources, partners, and evidence-based strategies to reduce the prevalence of tobacco and chronic disease in Arizona. In addition BTCD seeks ways in which systems and policies change can be utilized to drive individual level behavior change.

The BTCD efforts center on youth coalitions, adult prevention and cessation efforts and reducing disparities. One such innovative program is the statewide youth coalition, Students Taking A New Direction or STAND, which is comprised of youth and teens ages 12-19. Established in 2010, STAND engages and empowers youth to speak to their peers and change attitudes and behaviors around tobacco by enabling them to be peer to peer mentors. Additionally, STAND members advocate and pursue policy change regarding tobacco regulation at the local level. There are currently 28 coalitions across the 15 counties of Arizona with approximately 400 members. This coalition fosters youth development through trainings and community work. One of the local coalitions served as an avenue for the Title V Listening Sessions in order to hear from adolescents.

The MCH community said they wanted to see a reduction in tobacco use and exposure of children to second hand smoke. In addition to the tobacco prevention efforts, BTCD also implements education and awareness regarding the effects of secondhand smoke. Smoking during pregnancy remains a significant risk to the health of fetuses in Arizona. The ADHS Health Status and Vital Statistics Report for 2013, notes that 4.4% of Arizona mothers self-

reported use of tobacco during pregnancy. Smoking during pregnancy has been associated with a significantly increased risk for many birth defects.

BTCD has partnered with Arizona Health Start Program Home Visiting Program for pregnant and parenting women, children and families, which included tobacco use as a risk factor for enrollment in the program for over 10 years. Recent data indicate that approximately 8% of women enroll in Health Start with tobacco use as an identified risk factor. Of those enrollments, 57% were pregnant moms.

In 2014, Health Start began integrating a more thorough screening process for tobacco use through the Alcohol, Tobacco and Other Drugs Screening Tool and the Healthy @ Home Assessment to ensure that women and families receive education and referrals to services to help them quit smoking. All Home Visitors have been trained to ask 6 additional questions of all prenatal clients regarding tobacco use including using smokeless tobacco products and e-cigarettes in the past 30 days. They also ask if anyone in the household smokes or uses tobacco products and where they smoke. If a Health Start client or family member indicates tobacco use, the Home Visitor advises the client about the health effects and the benefits of quitting. The Home Visitor then provides an active referral to the Arizona Smokers Helpline/ASHLine. All Health Start Home Visitors now receive annual training on the dangers of tobacco use among women during pregnancy, its effects on women and babies, as well as basic tobacco screening and intervention skills including how to make referrals to the ASHLine.

Additionally, secondhand smoke is attributable to many negative health impacts in children and adults, including ear infections, asthma attacks, SIDS, bronchitis, pneumonia, respiratory issues, increased risk of lung cancer, heart disease and heart attack. In Arizona, where for example 3 in 10 renters in Maricopa County smoke, smoking inside individual multi-family housing units is still allowed. Seventy-seven percent of Maricopa county renters live in multi-family housing and almost two-thirds of rental households include at least one “at-risk” individual, children, the elderly or those with a heart or lung condition. BTCD launched a two year education campaign to increase awareness of and educate the public about the overall negative health impacts of secondhand smoke, to increase the awareness and educate the public about the negative health impacts of secondhand smoke in vehicles and multi-housing units and to increase volume of calls to ASHLine.

Finally, BWCH’s participation in the six month AMCHP Life Course Indicator Intensive Technical Assistance Project was a very valuable experience in terms of preparing for the Title V MCHB Block Grant and increasing awareness of the life course framework among our partners and community members. The Arizona team consisted of representatives from the following agencies; Maricopa County Department of Public Health, City of Phoenix Housing Department, Tanner Community Development Corporation, Arizona Chapter of the March of Dimes, Arizona Department of Child Safety and Arizona Health Care Cost Containment Center (Arizona’s Medicaid agency). The team selected the 23 life course indicators that would be analyzed for the project. The indicators fit with the population domains for the Maternal and Child Health Block Grant. In addition, a number of the indicators were selected because the data sources were ones that our bureau had not worked with previously and the technical assistance provided by AMCHP expanded the epidemiologist’s capacity to analyze life course indicators specific to Arizona.

The final product was a Power Point that included a description of the indicators and Arizona statistics. The Life Course Power Point was used during the community prioritization meetings and the data was integrated into Arizona’s Title V MCH Five Year Needs Assessment. In addition, the bureau has begun using the City MatCH Life Course board game as a means of educating health professionals on the life course theory.

Other Programmatic Activities

No content was entered for Other Programmatic Activities in the State Action Plan Narrative section.

II.F.2 MCH Workforce Development and Capacity

Arizona's Title V agency is committed to the development of the Maternal Child Health's workforce; in the community, among its contractors and within the agency.

Arizona's Title V agency has a strong web presence including the ADHS Clinician webpage. The agency has developed a webpage to assist clinicians find information about health topics for themselves and for their clients. The page hosts Clinical Guidelines and Recommendations; public health resources; patient resources and training opportunities.

Clinician trainings include ADHS hosted trainings, information about conferences, and links to CMEs and Podcasts. Some examples of ADHS trainings include Infectious Disease training and exercise; Healthcare Associated Infections trainings and Mental Health First Aid. Mental Health First Aid is an 8 hour training to help attendees learn a process to assess a situation, select and implement appropriate interventions to help someone who may be in crisis.

Conference opportunities vary through the year with the most recent being Arizona's 2015 Immunization Conference. Slides of presentations are available on the web site. The agency links to CDCs Podcast site with a plethora of offerings including but not limited to Cost Effective Chlamydia Vaccination Programs for Young Women; Preventing Melanoma; ACA and Women; Active Living; Adolescent and School Health; Birth Control; Bisexual Health; Bullying; Childhood Diseases and Injury; Healthy Living; Pregnancy and Worksite Wellness.

During the summer of 2014, Arizona's Medicaid program began reimbursing qualified medical professionals for performing a number of developmental screenings (PEDS, M-CHAT, ASQ) and fluoride varnish application with proof of completion of training. The link to information about the different trainings is hosted on the ADHS Clinician web page.

The Office of Children with Special Health Care Needs has worked to develop opportunities in the community to support both families and professionals caring for CYSHCN. In the summer of 2014, OCSHCN partnered with United HealthCare Community Plan in the "Opening the Doors to People with Special Needs: Solutions to Prepare Your Practice" Conference, providing training on Medical Home for CYSHCN and integrating behavioral health, for over 350 providers both in person and via Webex.

OCSHCN provided "Supporting Foster Families and Children with Fragile Health" training for 47 early intervention professionals at the "Prevent Child Abuse Arizona" conference and provided resources and information for 945 attendees. Seventeen school nurses were provided "Navigating the Systems" training. Seventeen transition specialists, with the Sonoran UCEDD's Picture of Life project for transition age young adults in the foster system who have developmental disabilities, were trained as trainers to implement Health Care Organizers as part of transition planning; additional training is scheduled for 2015. Eighty three family members received Health Care Organizer and Navigating the Systems training through presentations at faith-based organizations. Forty two family members received Transition Planning training through presentations for AzAssist, an Autism-specific transition-focused organization.

During 2014, fifteen Family Advisors participated in providing in-home experiences for thirty three resident/intern health care professionals. Two Family Advisors and one Young Adult Advisor provided family perspectives in a panel discussion at the University of Arizona, School of Medicine, for 123 medical students and faculty. One Family Advisor and one Young Adult Advisor provided Health Care Organizer training for 28 transition-age youth during the 2014 Statewide Independent Living Centers Youth Leadership Summit. One Family Advisor provided family

perspectives for professionals during quarterly Statewide, and City of Phoenix, Emergency Planning Committee meetings. Ten Family Advisors participated in monthly Maricopa County Department of Public Health CYSHCN Coalition meetings, creating an organizational structure aimed at providing family advisors available to the county department of public health. Four Family Advisors and one Young Adult Advisor have been elected to the CYSCHN Coalition steering committee to serve along with 5 professionals.

Additionally, two Family Advisors participated in providing consumer perspectives during quarterly Maricopa County Health and Training Committee meetings. One Family Advisor participated in quarterly ADHS Zero to Five Workgroup meetings, providing family perspectives. The Flagstaff Medical Center Advisory Council benefitsfrom one Family Advisor supported through OCSHCN.

The Arizona Health Disparities Center housed in the Bureau of Health Systems is the federal designee for the Office of Minority Health for Arizona. The Center offers training and brown bag Lunch and Learns throughout the year to ADHS staff and access to online training and reports to the greater community. Examples of educational opportunities include a webinar on Domestic Violence Crime and Trauma; Strong Women, Healthy Families: Asian & Pacific Islander Women's Forum and a webinar called Sexual Violence 101 offered in Spanish.

The Bureau of Women's and Children's Health website also offers professional development information including preconception health, links to national trainings to include the NICHD SIDS Reduction CEU for nurses and CLAS Standard trainings.

The Bureau houses almost 40 different programs and contracts with over 175 organizations throughout the state. Many of the programs host their own contractor meetings quarterly, biannually or annually. Beyond the business aspects of the meetings, each meting provides professional development on relatedtopics.

In 2014 the Title V Reproductive Health contractor trainings focused on the guidelines for chlamydia testing and information and statistics on prevalence STDs in Arizona, connecting with home visitation resources in the community and how to talk to teens about reproductive health. The 2015 annual meeting included presentations on the impact of chronic conditions on pregnancies, Arizona Title X activities and training opportunities, STD data and how preconception health can be integrated into a family planningvisit.

Domestic Violence Prevention contractors trainings included The Sharing Experience: From Domestic Violence in Our Homes to Peace in Our Communities, Lay Legal Advocacy Training, Health Moms Happy Babies Training, Home Visitation Guidelines on Domestic Violence Trainings, Board Development Training, Be The Change: Using Your Voice to Create Safety and Justice, and Lay Legal Advocacy. The 2015 training topics included; Sexual Violence Core Advocacy, Technology, Advocacy and Victim Safety, Lay Legal Advocacy, Trauma Informed Supervision: Supporting Your Staff, Understanding the Needs of Male Survivors: Providing Support and Empowerment, Prevention: Identifying Our Role in Stopping Violence Before it Begins, Economic Justice, Advocacy and Survivor Empowerment, and Healthy Moms, Happy Babies.

The Arizona Health Start Program offered training during calendar year 2014 on Preventing Exposure to Alcohol and Other Drugs and the Effects on Newborns and Infants at two conference workshops and on a Health Start specific program I-linc training. Other trainings offered to Health Start home visitors include Healthy @ Home Assessment, Screening, Brief Intervention, Referral to Treatment of prenatal clients and Basic Health Start Policies, Procedures and Forms. Training was provided to home visitors through topic specific expert speakers on the Life Course Theory – Interconception and Preconception Health, Arizona Early Intervention Program, Promoting Physical Activity with Women and Toddlers, Arizona Cord Blood Program and the Ready Arizona Emergency Preparedness Program. Trainings that the Health Start Program Manager has attended include the Adverse Childhood Experiences Training of Trainers, CDC Fetal Alcohol Spectrum Disorders (FASD) Training of Trainers, Motivational Interviewing, C.L.A.S. and Building Resiliency Strategies for Promoting Well Being.

The Sexual Violence Prevention and Sexual Assault Services contractors' trainings topics in 2014 and 2015 include:

How to develop curricula; AZ Address Confidentiality Program; Statistics and Accuracy; and How to create more appealing power points using 'smart art'.

Teen Pregnancy Prevention (TPP) contractor topics have included information on long-acting reversible contraception for youth, parent recruitment strategies and evaluation. Biennially during the summer, TPP provides either curricula trainings or a conference. In 2014, the program offered a 2-day conference tailored to program managers, health educators and foster care case managers covering a variety of topics such as stress relievers, building youth/adult partnerships, addressing sensitive subjects with youth, and many more. Program managers also offered Teen Outreach Program® Certified facilitator trainings to Arizona and out-of-state providers interested in delivering the program. ADHS program staff attended federally offered national conferences and trainings to enhance skills and gain an understanding of strategies to enhance programs for youth.

The Office of Oral Health routinely provides continuing education opportunities for dental professionals that offered 36 instructional hours on oral health disease prevention programs. These educational workshops reached a total of 95 participants (including dentists, dental hygienists, dental/dental hygiene students, physicians, nurses, childcare providers and administrators). Training focused on the following topics: School-based Sealant Programs, Community Dental Health, Promoting Oral Health Practices in Childcare Setting, Early Childhood Tooth Decay, Oral Observations and Prevention, and Disease Disparities.

Arizona's MIECHV program developed domestic violence training for home visitors receiving national recognition at the National Futures without Violence Conference in DC in March 2015. Partnering with the Arizona Coalition to End Sexual and Domestic Violence, home visitors receive the Futures Without Violence curriculum as well as presentations from local domestic violence service providers. Beyond the education from the curricula, the linkage with the local domestic violence partners strengthens the effect of thetraining.

The Strong Families Arizona Home Visiting Coalition sponsored professional development opportunities throughout the state. Highlights included: serving over 2,579 home visitors; providing 45 Benchmark Institutes; introducing live webinar courses on breastfeeding; completion of a Best Practice, Community of Practice by Dr. Joy Browne and initiation of a new community of practice in Tucson, Improving the Quality of Home Visitation and completion of 292 online courses.

The 2014 Benchmark Institutes covered a variety of topics such as caregiver depression, Empower Early Childhood Nutrition and Physical Activity Guidelines, Early Childhood Collaboration Events featuring information on the Arizona Early Intervention Program, Ages and Stages, a selection of breastfeeding topics, infant mental health, domestic violence and Family Planning/Well Woman training.

2014 Annual Online Courses	
Baby Behaviors	27
Child Nutrition	14
Basic Nutrition	19
Postpartum Nutrition	14
Culturally and Linguistically Appropriate Services	30
Principles of Influence	16
Participant Centered Services	16
Prenatal Nutrition	15
Breaking the Diagnosis	19
TOTAL	**170**

On-line trainings became available this year. The first set of 11 online courses was completed by 170 homevisitors and an additional 122 home visitors completed the new Arizona Department of Health Services breastfeeding webinar courses. The two courses with the greatest number of registrants were Culturally and Linguistically

Appropriate Services completed by 30 and Baby Behaviors completed by 27.

OCSHCN facilitated and supported two Family Advisors to provide “Coming Home: Welcoming Children with Complex Health Needs into Family Life” training during the 2014 High Risk Perinatal/Newborn Intensive Care Program contractors meeting attended by 150 community health nurses and early interventionists.

Additionally, the Office of Injury Prevention has financially supported professional development for ED nurses to prepare to sit for certification. Each Injury Prevention Advisory Council meeting has presentations on the latest data or information from other community injury programs.

The Bureau, as the Title V program, offers various avenues to access professional development opportunities for its employees in order to maintain best practices and as a method of preparing the next generation of Maternal Child Health worker. Employees are encouraged to attend conferences, brown bag lunches, and online trainings. Program Managers who attend a conference are expected to present any new information at the next monthly Program Managers’ meeting. New employees are given a copy of the BWCH MCH 101 which strongly borrows from and links to the MCH Navigator website. Employees are encouraged to take the Self Assessment and to begin a personalized learning plan. Employees are advised that this can be done during work hours in agreement with their supervisor.

OCSHCN contracts with Raising Special Kids, the state Family to Family Health Information Center, to recruit, train, support and reimburse Family and Young Adult Advisors to participate in ADHS projects. Each Advisor participates in leadership development training as part of preparation in the Advisor program. In 2014 a new contract was established to take effect 1/1/15 which increases leadership training opportunities and requirements for Family and Young Adult Advisors working with OCSHCN.

OCSHCN’s parent advisors participated in multiple projects with OCSHCN including Care Coordination revision, webpage review and revision, AZ newborn screening rules review, outreach materials development, contract development and evaluation, OCSHCN staff hiring, ADHS Prevention events and internal committees and projects.

The Office of Injury Prevention (OIP) requires staff to complete the self-study modules on Injury Prevention that is housed on the Safe States Alliance webpage. OIP staff maintains child passenger safety certification, this allows staff to support the "baby to work" program by ensuring the child safety seat is installed correctly.

In January 2015, the Governor Ducey authorized a hiring freeze among state agencies. There are provisions for positions considered “Mission Critical” including epidemiologists and licensing surveyors. It will be the work of the Title V administrator and Bureau management to support the current workforce as positions are vacated and not filled.

II.F.3. Family Consumer Partnership

The Bureau of Women’s and Children’s Health involves parents of children and youth with special health care needs in program development and decision making. While the Bureau utilizes the knowledge and experience of some of their full time staff who are parents of children with special health care needs, it isn’t enough to fill the need for parent involvement in the numerous agencies, local communities, private projects, committees, workgroups, and other decision making bodies. As a result, OCSHCN has contracted with Raising Special Kids (RSK) the designated Arizona Family-to-Family Health Information Center, to create a Family Advisor Registry of young adults and family advisors, to be used as paid consultants. RSK identifies, recruits, trains, and reimburses individuals and family members of CYSCHN to participate in the Bureau’s policy, program development, implementation and evaluation committees, and as a resource regarding children and youth with special health care needs. In 2015, a new contract

was established which increases leadership training opportunities and requirements for Family and Young Adult Advisors working with OCSHCN.

As a result of new contract requirements with RSK related to young adults, four Young Adult Advisors have been identified and are working with the Maricopa County CYSHCN Coalition and the Arizona Community of Practice on Transition. Family Advisors have provided Family-Centered Medical Home training and "Day in the Life", in home experiences for healthcare professionals. A new initiative has prepared ten Family Advisors to deliver Health Care Organizer Training for families, with seventeen family members having received the training in a tri-lingual class including English, Spanish and ASL, with the Phoenix Early Head Start Program.

Family members are a part of other programs as well. The MIECHV program seeks to use nine Family Advisors to participate in local coalitions across the state; four Family Advisors are currently active and recruitment efforts are ongoing. The Maricopa County CYSHCN Coalition, part of the ADHS Health in Arizona Policy Initiative (HAPI), has five Family Advisors and two Young Adult Advisors participating on the Steering Committee, along with ten representatives from agencies and organizations serving CYSHCN. Family Advisors either speak at or are part of the workgroups for the Fragile Infant Training, the American Indian Disability Summit, Medicaid Infrastructure Grant Workgroup, Arizona Employment and Disability Partnership, Arizona State University's Person Centered Accessible Tech (APAcT) workgroup, and the Pima County Emergency Preparedness Summit.

During 2014, OCSHCN supported Helen Cartwright as AMCHP parent advisor, until her move out of state, then recruited Stacy Strombeck-Goodrich for the remainder of the year. Both AMCHP advisors participated in multiple projects with OCSHCN including Care Coordination revision, webpage review and revision, AZ newborn screening rules review, outreach materials development, contract development and evaluation, OCSHCN staff hiring, ADHS Prevention events and internal committees and projects.

Our AMCHP Family Advisor sits on several workgroups such as the Phoenix Children's Hospital Stakeholder Advisory Council and the state Emergency Preparedness Team. Additionally, a family member serves on the Safe Sleep Task Force and CoIIN effort. She will attend the CoIIN meeting in Boston in July, 2015.

Title V Abstinence Education sub-awardees organize Youth Advisory Groups (YAG), consisting of youth in the funded communities who have participated in Teen Pregnancy Prevention programming. The YAGs meet with the sub-awardee program staff at least once a quarter to offer input regarding strategies for addressing barriers and effective implementation of the abstinence education program in their community. ADHS meets with YAGs at least once per year to provide teen pregnancy statistical information, identify barriers and solicit suggestions for improvement in state policies and local programming.

RSK's contract requires delivery by year end, of a cadre of 80 -100 Parent Advisors and 20 -25 Young Adult Advisors who have received over 15 hours of training in policy development, leadership development, communication with professionals. It is BWCH's intent to promote and increase the number of Young Adult and Family Advisors participation and involvement in this agency and other community partner's workgroups, committees, task forces, trainings and presentations.

II.F.4. Health Reform

Recent federal and state health policy changes have increased the number of Arizonans covered by insurance. Marketplace plan selections from the first and second open-enrollment periods reached 205,666. The restoration of Proposition 204, which provides Medicaid coverage for childless adults up to 100% FPL, combined with Arizona's decision to expand Medicaid to childless adults earning up to 133% FPL, provided coverage for just over 335,000 Arizonans (281,025 and 55,136 respectively). Combining Marketplace plan selections with restored and expanded

Medicaid populations, 541,800 lives are now covered by insurance; many of whom may not have been able to have insurance without federal and state health reform. This increase in coverage has also lowered the percent of uninsured in Arizona from 17 percent in 2013 to approximately 10 percent currently- not including the effects of employer-based and other non-marketplace/Medicaid insured populations.

This legislative session Governor Doug Ducey signed HB 2643 into law. The bill prohibits the state and its political subdivisions from using any personnel or financial resources to enforce, administer or cooperate with the Affordable Care Act. Arizona's Medicaid program, AHCCCS, and many areas of public health were exempted from many components of HB 2643. However, even with a certain degree of latitude extended to public health under the legislation, efforts and expectations to actively engage in activities that promote or extend the Affordable Care Act and/or the Medicaid expansion through Title V have been tempered.

One of the critical roles of many of our Title V programs is to assist people to be able to access care and to link them to a Medical Home. Each of the programs in the Bureau who serve clients; home visiting, family planning, sensory and Medical Services has an objective to connect their families to care. The Office for Children with Special Health Care Needs (OCSHCN) assists families in accessing appropriate care and services by providing information and referral services to health care, insurance options, and community resources for children, youth and young adults with special health care needs, to best meet the needs of the child. In addition, OCSHCN oversees contracts for social services and gap filling services such as metabolic formula, respite and palliative care including supporting overnight stays that enable families to stay near their hospitalized CYSHCN, and to increase the involvement of families and youth within OCSHCN, other ADHS programs and other state agencies.

The Metabolic Formula Program helps to provide prescribed metabolic formula and/or medical foods to all eligible children and young adults statewide who are uninsured or underinsured for the treatment of genetic disorders. This is to assure normal growth and development of children and adults by preventing severe mental and physical defects or possibly death that can occur without early detection and dietary treatment.

The Cystic Fibrosis contract provides for the care and medical treatment services of Arizona residents suffering from cystic fibrosis who are twenty-one years of age or older, and are either uninsured or underinsured and may not otherwise get appropriate care due to lack of funds or coverage.

The Medical Services Project increases access to and utilization of primary care services for Arizona's children by providing delivery of medical and dental services in participating physician's offices to children without health insurance and to those who do not qualify (or are in the process of qualifying) for Medicaid or insurance through the Marketplace.

Cultural competence requirements are embedded into contract language, which go beyond requirements for reading level, interpretation, translation, and alternative formats and includes best practices for family-centered care, including people-first language and disability etiquette.

ADHS identified access to care and access to insurance as priorities in the 2014 Needs Assessment and are priority elements in the State Health Improvement Plan. Strategies for access to care in Healthy Communities include: Increase incentives and leverage funding streams to address identified workforce shortages in underserved areas and populations throughout AZ; Promote utilization of technology to increase access to well care, including EMR, Rx and utilization; Increase utilization of preventive/screening guidelines for young children, adolescents and adults through provider education. Strategies for Healthy People include: Support the expansion of Patient- and Family-Centered Medical Homes for comprehensive, high quality and accessible community health care; Support integrated medicine or team-based clinical models to improve health promotion, prevention, and care coordination and increase public awareness of the availability of preventive, self-management and wellness service benefits through their health plans and providers. Many of these were based on Arizona State Health Equity Plan.

The strategies for increasing access to health insurance for Healthy Communities include: Increase transparency of

health insurance plan components, including cost, provider networks, cost sharing requirements and formularies; Target outreach and enrollment efforts to populations disproportionately uninsured and Expand payment models to include additional provider types and preventive services that improve health outcomes. The strategies for Healthy People include: Improve health insurance literacy of consumers to increase enrollment in and utilization of insurance plans; Inform consumers of the importance of purchasing insurance and increase awareness of tax penalties for uninsured and Increase awareness of existing premium subsidies to make health insurance more affordable.

II.F.5. Emerging Issues

Arizona, as well as the nation, has seen an increase in poisoning and death due to opioid related poisonings. In 2013, poisoning was the leading cause of injury related deaths (26%) in Arizona resulting in 1,240 deaths (an age-adjusted rate of 19.1 per 100,000 population). Pharmaceutical opioids were the most commonly specified drug (n=328; 26%) documented on death certificates in 2013. As a result, opioid-related poisonings have now surpassed motor vehicle crashes as the leading cause of injury deaths in Arizona.

Arizona has taken some important steps to solve this multi-faceted epidemic. In January 2012, the Arizona Substance Abuse Partnership (ASAP) made prescription drug misuse and abuse their strategic area of focus. Staffed by the Governor's Office, ASAP is the single statewide council on substance abuse prevention, treatment, enforcement, and recovery for the state of Arizona. One month after ASAP selected prescription drug misuse and abuse as their strategic focus, the Arizona Criminal Justice Commission (ACJC) and the Arizona Governor's Office for Children, Youth, and Families (GOCYF) hosted a Prescription Drug Expert Panel to identify the opportunities and challenges associated with addressing Arizona's prescription drug problem. The expert panel was composed of representatives from law enforcement, medical/treatment, prevention/education and research communities.

Based on the expert panel and stakeholder discussion, five key strategies and associated objectives of a data-driven, multi-disciplinary approach were identified. The five strategies are as follows: Strategy 1: Reduce Illicit Acquisitions and Diversion of Prescription Medications; Strategy 2: Promote Responsible Prescribing and Dispensing Policies and Practices; Strategy 3: Enhance Prescription (Rx) Drug Practices and Policies among Law Enforcement; Strategy 4: Increase Public Awareness and Patient Education about the Risks of Prescription (Rx) Drug Misuse and Abuse; and Strategy 5: Enhance Assessment and Referral to Treatment.

Arizona developed the *Arizona Rx Drug Misuse & Abuse Initiative Toolkit*. The *Toolkit* contains materials to address the five strategies mentioned. Another important component of this initiative was the enhancement of the Arizona Controlled Substances Prescription Monitoring Program. In addition to signing-up prescribers and pharmacists to use the CSPMP, the CSPMP itself possesses a range of new abilities to improve the monitoring of prescribing practices across the state. As a result of the passage of Senate Bill 1124, effective July 24, 2014, a requirement for dispensers to upload to the system within 24 hours was implemented. The shortened period will greatly reduce the previous lag-time (i.e., 7 days) in current patient prescription drug history in the CSPMP, and in doing so reduce the likelihood of high-risk patient behavior such as "doctor shopping" and prescribers prescribing dangerous levels of morphine milligram equivalents (MME) inadvertently. SB 1124 also allows prescribers to delegate CSPMP access to qualified non-prescribing staff. This step is designed to add an extra layer of efficiency for the prescriber in utilizing the CSPMP. As a result, prescribers who utilize delegates will likely improve their prescribing practices in ways that can reduce harm to patients.

In March 2014, ADHS convened a summit for healthcare associations, academic institutions, health plans, federal healthcare providers, public health leaders, and other stakeholders where they developed voluntary, consensus guidelines to promote responsible, appropriate prescribing practices to reduce the misuse and abuse of opioid analgesics. With the *Arizona Opioid Prescribing Guidelines* now available, the group is working to connect prescribers to the material and educate them about its recommendations. The Guidelines are being distributed

globally and are located on the ADHS Clinician webpage.

At the same time Arizona is seeing an uptake in Neonatal Abstinence Syndrome. During 2008-2013 there were a total of 1,472 cases of Neonatal Abstinence Syndrome (NAS) in Arizona with an NAS rate of 2.83 (95% CI, 2.68-2.97) per 1000 cases. The provisional NAS rate for 2014 is approximately 5.38 cases per 1000 live births. As a response to the growing opioid abuse epidemic and related increase in Neonatal Abstinence Syndrome, Arizona's Title V program is developing an enhanced response. While some things are in place already this alarming emerging issue requires a coordinated effort. BWCH will partner with the *Arizona Rx Drug Misuse & Abuse Initiative* by supporting distribution of the guidelines. The Program will work with home visiting to educate home visitors about the prescription drug epidemic and the dangers of Neonatal Abstinence Syndrome. There has been some preliminary work with home visitors. The MIECHV programs assess all women for alcohol and drug abuse generally and make referrals. The Health Start Home Visiting Program has been screening women prenatally for substance use since 2008 utilizing the TWEAK screening tool that includes tobacco and other drugs including prescription drugs. The Health Start manager will be presenting information about the TWEAK program to the MIECHV Inter Agency Leadership Team.

The Arizona Department of Health Services (ADHS) is sponsoring a 2 day conference in July 2015. This inaugural NAS Conference aims to bring together physicians, nurses, midwives, and others involved in the care/treatment of these mothers and infants from across the state to receive much needed education in the various aspects of this disease. The conference is a strategic intervention to develop awareness to health care providers concerning the most effective ways to care for these infants and families. The day will end with a call to action.

The ADHS is in a state of transition of Title XIX Behavioral Health services to our Medicaid agency. At this time all decisions have not been made about where prevention efforts will be housed. Having said that, BWCH will work more purposefully with behavioral health prevention services to address these raising substance abuse issues.

Beyond the opioid and NAS concerns the other issue that impacts the women and children in Arizona is the raising numbers of abused and neglected children. Arizona, as the rest of the nation, suffered during the Great Recession. As a result of state budget deficits prevention programs and services for families were reduced or eliminated. Childcare subsidies were reduced with families put on a waiting list while the child welfare workforce was reduced. Families were of course suffering with loss or reduction of income. The rate of substantiated child maltreatment quadrupled between 2009 and 2013. As a result of the number of substantiated cases, the number of children in foster care increased by 55.7% from 209 to 2014.

According to a recently released report by the University of Chicago[1] and commissioned by the Arizona legislature, the decrease in childcare subsidies went from 45,000 in 2009 to 25,000 in 2014. The number of children receiving childcare subsidies peaked in 2009 at about 45,000. By 2014 that number was down to under 25,000. Expenditure for subsidies went from $193.7 million to $100 million in the same time. The number of children in poverty increased at the same time.

The state has taken steps to address this issue. An independent new child welfare agency Department of Child Safety (DCS) was created. Efforts are continuing to increase the number and capacity of child welfare workers. While efforts are continuing to improve services, the number of children being sent to out of home placement continues.

During the Needs Assessment process the Bureau of Women's and Children's Health heard concerns about our children and families at every meeting and survey. While BWCH has home visiting programs and the larger Strong Families Az Alliance coordinates home visiting efforts, BWCH has added as a state priority to strengthen the ability of Arizona families to raise emotionally and physically healthy children. With our MCH partners, Arizona's Title V program plans to look more closely at what is being done and how it is being done. For instance, we need to address retention of families in home visiting programs, better prepare our home visitors for the complicated

families they are seeing, strengthen community connections to ease referrals for services for our families and better partner with families to ascertain how we can better serve them.

As the Title V agency, the BWCH will continue to monitor emerging issues and work with our partners to address issues that affect the women and children of Arizona.

[1] Chaplin Hill Center for Children, University of Chicago, *Arizona Department of Child Safety Independent Report*, June 26, 2015.

II.F.6. Public Input

Arizona's Title V team used multiple strategies to gather public input. First, the team set up Listening Sessions across Arizona and with diverse groups of stakeholders. These sessions were intentionally participant-driven and were structured to gather insights from different populations and communities on what they saw as opportunities or concerns around the health and wellbeing of all women and children in Arizona. The team purposely did not start these sessions with a presentation of data about the health status of the community. The thinking was that if someone heard numbers about infant mortality or prematurity they might feel that a concern they had was not significant enough to mention. To support the free flow of information, a list of open ended questions was used to explore the insights of participants.

There were three other approaches to gathering public input. The MCH team hosted an Online Survey, Regional Meetings (to report on data, ask about local capacity and discuss community concerns), and lastly a strategic planning session (both in-person and online) for a final discussion of priorities.

Listening Sessions:

From May 2014 through December 2014, 17 listening sessions were held throughout the state and facilitated by BWCH staff and/or partners. All listening sessions took place in one of the following four Arizona counties: Maricopa, Pima, Coconino, and Santa Cruz. Participants were asked about: 1) the health needs of different populations in Arizona; 2) the health needs of their friends/family members; 3) where clients receive health information; 4) what problems/barriers clients experience when trying to access services; 5) services that are needed but not being received; 6) things homes, schools, and communities can do to improve safety; and 7) things Arizona is doing well or areas where improvement is needed to address the health needs of women and children.

Listening sessions specifically targeted key groups to better understand their perception of health needs in their community. Listening session groups included: teen parents, lesbian gay bi-sexual and transgender community members, Arizona Health Care Cost Care Containment System MCH Directors, members of the County Directors of Nursing Association, families with children with special health care needs, and participants from border communities, those living in public housing, members of African American churches and Tribal members. Notes from each listening session were manually reviewed for health topic themes, such as access to care or oral health. After reviewing each session, all listening session notes were compiled into a master document. From there, for each question, the number of responses related to each health topic was tallied.

BWCH Online Community Survey:

In August 2014, the Bureau of Women's and Children's Health developed an online community survey seeking feedback from the community regarding the most important health needs for five populations: women, pregnant women and infants, children, adolescents, and children and youth with special health care needs. (N.B. This survey was developed and posted well before the six populations for this Needs Assessment were identified) Survey

respondents were provided a list of 27 to 65 health topics, depending on the population, and were asked to rank what they felt were the top five health needs for each population, with their top ranking (#1) being their biggest health need. Additionally, there were four open-ended questions at the end of the survey that asked participants to provide information on: 1) what men can do to promote the health of women and children; 2) up to three things the health department is doing well to address the health needs of the state; 3) up to three things the health department is not doing well to address the health needs of the state; and 4) up to three solutions for how the health department can better address the health needs of the state.

The survey was posted online from August 1, 2014 through November 30, 2014. A link to the survey was posted on the ADHS BWCH homepage. Internal and external partners and program contractors were also sent the survey link via email, along with information on survey purpose. In addition, information about the survey, as well as the survey link, was posted on ADHS social media accounts. A video blog was also created and posted online. Throughout the four months the survey was posted, some minor revisions were made to the survey. One of the revisions included the option for respondents to provide their email address if they wanted to be contacted with the dates and locations of the community forums. Email information was entered on a different survey link, so email addresses were not linked to survey responses. In all, 948 individuals responded to the online survey and 325 provided their email address to receive further communication. A shortened version of the survey was also made available via paper, but few paper surveys were received.

Two different analysis methods were used to determine the top five health needs decided for each population group. The first method looked at the number of people who included a given topic as one of their top five rankings, regardless of which rank it received. The second method took into consideration where the topic was ranked in the top five. Topics ranked as number one were given a score of five points, a second ranked topic was given four points, a third ranked topic were given three points, fourth ranked received two points, and fifth ranked received one point. The points were then added together for each topic and were divided by the number of respondents for that ranking section.

Themes for the open-ended questions were determined through manual review of the responses; no qualitative analysis software was used. Broad themes were identified through the review of the responses; a tally was kept of all responses mentioning a given theme.

Community Forums- Priority Setting:

In March and April of 2015, a total of 11 community forums were held in five Counties: Pima, Yuma, Cochise, Maricopa, and Coconino. Between the 11 forums, seven different communities were represented: Tucson, Yuma, Bisbee, Phoenix, Maryvale (West Phoenix), Flagstaff, and Tribal regions (via a Tribal Consultation). The meetings began with a presentation by BWCH with background information on the MCH Title V Block Grant and the process of the 5-year needs assessment, after which there was discussion of data on each of the six population domains: 1) women/maternal health; 2) perinatal/infant health; 3) child health; 4) children with special health care needs; 5) adolescent health; and 6) cross-cutting or life course. After the presentation by BWCH, participants were asked to write their top one or two needs for each population domain.

Priority Setting:

On April 20th 2015, the Bureau of Women's and Children's Health held an in-person and simultaneously online priority setting session to set 7-10 state MCH priorities. Participants were presented with all the information gathered previously, through the online survey, listening sessions and community forums. After a review of MCH data, participants reviewed the priorities generated through previous input. With this updated list of potential priorities, the participants voted for their top priority in each domain.

In all, BWCH staff traveled over 2,200 miles and heard from over 1,500 people to gather stakeholder input and support the involvement of communities in the needs assessment and priority processes.

II.F.7. Technical Assistance

Arizona respectfully requests technical assistance going forward with developing state performance measures and outcome measures. Arizona would also like assistance in learning how to better incorporate families in a meaningful way in all aspects of what we do.

III. Budget Narrative

	2012		2013	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$ 7,065,379	$ 6,456,667	$ 6,941,708	$ 6,271,583
Unobligated Balance	$ 1,920,000	$ 1,015,975	$ 1,420,000	$ 352,441
State Funds	$ 7,625,192	$ 6,466,495	$ 7,693,086	$ 6,466,495
Local Funds	$ 0	$ 0	$ 0	$ 0
Other Funds	$ 7,472,018	$ 5,899,341	$ 7,472,018	$ 5,899,341
Program Funds	$ 0	$ 0	$ 0	$ 0
SubTotal	$ 24,082,589	$ 19,838,478	$ 23,526,812	$ 18,989,860
Other Federal Funds	$ 53,932,696	$ 44,631,639	$ 61,382,212	$ 52,968,813
Total	$ 78,015,285	$ 64,470,117	$ 84,909,024	$ 71,958,673

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$ 6,468,652	$ 7,129,932	$ 7,016,019	$
Unobligated Balance	$ 985,000	$ 294,871	$ 982,000	$
State Funds	$ 7,693,086	$ 7,503,913	$ 7,980,789	$
Local Funds	$ 0	$ 0	$ 0	$
Other Funds	$ 7,472,018	$ 6,830,828	$ 7,422,018	$
Program Funds	$ 0	$ 0	$ 0	$
SubTotal	$ 22,618,756	$ 21,759,544	$ 23,400,826	$
Other Federal Funds	$ 55,357,356		$ 60,017,948	$
Total	$ 77,976,112	$ 21,759,544	$ 83,418,774	$

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2016	
	Budgeted	Expended
Federal Allocation	$ 7,129,955	$
Unobligated Balance	$ 0	$
State Funds	$ 6,454,232	$
Local Funds	$ 0	$
Other Funds	$ 6,500,000	$
Program Funds	$ 150,000	$
SubTotal	$ 20,234,187	$
Other Federal Funds	$ 16,491,713	$
Total	$ 36,725,900	$

III.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.

III.B. Budget

The estimated Title V allocation for Arizona, FFY2016, is $7,129,955. For FFY 2016, 33.5% ($2,389,202) of the Title V Block grant will be allocated for preventative and primary care needs for children and adolescents; 32.8% ($2,240,778) will be allocated to children with special health care needs; 29.6% ($2,108,984) will be allocated for women, mothers, and infants and 4.1% ($290,991) will be budgeted for administrative costs.

For FFY 2016, the state's match and maintenance of effort includes State General, Lottery, and Dental Sealant funds. The $8,816,072 in State General funds include High Risk Perinatal Services, Adult Cystic Fibrosis, Child Fatality Review Program, Positive Choices, Newborn Screening, and operating funds allocated to the Public Health Prevention Division and, supports some of the personnel located in the Bureau of the Women's and Children Health, and the Office of Oral Health. The $4,138,160 in Lottery funds includes the Teen Pregnancy Prevention and Prenatal Outreach (Health Start) Programs. $150,000 is from fees generated by the Dental Sealant Program. Arizona's FY2016 match and overmatch of $13,104,232 continues to exceed the maintenance of effort amount of FY1989's $12,056,360.

Other federal funds administered by the MCH Chief besides the MCH Title V Block Grant Program include Rape Prevention and Education, Family Violence Prevention, Core State Injury Surveillance and Program Development, Emergency Medical Service for Children, EMSC Demonstration Project, Abstinence Education

Grant Program, Personal Responsibility Education Program, Women Infants and Children, Maternal Infant and Early Childhood Home Visiting Program, and Sudden Unexpected Infant Death Case Registry.

Public Health Services and Systems - $4,441,854: Bureau of Women's and Children's Health: $2,660,507 will support the Department's birth defect registry, management service, information technology automation, assessment evaluation and epidemiologic analysis, Immunizations, Midwife Licensing, the Empower Program, injury prevention and preconception health, including policy and organizational strategies.

Office of Children with Special Health Care Needs: $1,781,347 will support administrative initiatives, education, training, support services, advocacy and outreach. Two Health Advocacy for Children, Youth and Families contracts were issued to community based organizations focused on inclusion of CYSHCN in nutrition, physical activity and injury prevention. OCSHCN will also fund ADHS' new Population Health Policy IGAs with county health departments that focus on inclusion of CYSHCN within policy, system, and environmental change in Arizona and the Opening The Doors: How to Prepare You Practice for People with Special Needs' Primary Care Physician Conference.

Enabling Services: $1,898,903 is budgeted for initiatives that include the Sensory Program, the Medical Home Project, the Pregnancy, Breastfeeding Hotline, Breastfeeding Consultation, community nursing services for high-risk infants, Reproductive Health Services for women, injury prevention and preconception health - including raising public awareness and providing community education, and Children with Special Health Care Needs, which includes respite and palliative care services.

Direct Health Care Service: $498,207 will support Oral Health services for children and Children with Special Health Care Needs, which includes Metabolic services.

Indirect Administrative Costs: $290,991

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - AHCCCS Data Sharing Agreement.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - BWCH Org Chart 07-07-2015.pdf

VI. Appendix

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Form 2

MCH Budget/Expenditure Details

State: Arizona

	FY16 Application Budgeted	FY14 Annual Report Expended
1. FEDERAL ALLOCATION	$ 7,129,955	$ 7,129,932
(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)		
A. Preventive and Primary Care for Children	$ 2,389,202	$ 2,606,409
B. Children with Special Health Care Needs	$ 2,340,778	$ 2,373,542
C. Title V Administrative Costs	$ 290,991	$ 297,085
2. UNOBLIGATED BALANCE	$ 0	$ 294,871
(Item 18b of SF-424)		
3. STATE MCH FUNDS	$ 6,454,232	$ 7,503,913
(Item 18c of SF-424)		
4. LOCAL MCH FUNDS	$ 0	$ 0
(Item 18d of SF-424)		
5. OTHER FUNDS	$ 6,500,000	$ 6,830,828
(Item 18e of SF-424)		
6. PROGRAM INCOME	$ 150,000	$ 0
(Item 18f of SF-424)		
7. TOTAL STATE MATCH	$ 13,104,232	$ 14,334,741
(Lines 3 through 6)		
A. Your State's FY 1989 Maintenance of Effort Amount	$ 12,056,360	
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL	$ 20,234,187	$ 21,759,544
(Same as item 18g of SF-424)		
9. OTHER FEDERAL FUNDS		
Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS	$ 16,491,713	
(Subtotal of all funds under item 9)		
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL	$ 36,725,900	$ 21,759,544
(Partnership Subtotal + Other Federal MCH Funds Subtotal)		

	FY14 Annual Report Budgeted
1. FEDERAL ALLOCATION	$ 6,468,652
A. Preventive and Primary Care for Children	$ 2,127,943
B. Children with Special Health Care Needs	$ 2,019,441
C. Title V Administrative Costs	$ 325,371
2. UNOBLIGATED BALANCE	$ 985,000
3. STATE MCH FUNDS	$ 7,693,086
4. LOCAL MCH FUNDS	$ 0
5. OTHER FUNDS	$ 7,472,018
6. PROGRAM INCOME	$ 0
7. TOTAL STATE MATCH	$ 15,165,104

	FY16 Application Budgeted
9. OTHER FEDERAL FUNDS	
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP);	$ 1,019,280
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program;	$ 1,265,979
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Family Violence Prevention and Services Grants to States for Domestic Violence Shelters and Supportive Services;	$ 1,900,687
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program;	$ 643,797
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Injury Prevention and Control;	$ 180,621
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program;	$ 11,095,480
Department of Health and Human Services (DHHS) > Health Resources and Services	$ 199,869

Administration (HRSA) > EMSC Demonstration;	
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > EMSC Partnership;	$ 130,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > SUIDCR;	$ 56,000

Form Notes For Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Discrepancy is due to revised format.	
2.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Discrepancy is due to revised format.	
3.	**Field Name:**	**2.UNOBLIGATED BALANCE**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Discrepancy is due to revised format.	
4.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Discrepancy is due to revised format.	

Data Alerts:

None

Form 3a

Budget and Expenditure Details by Types of Individuals Served

State: Arizona

	FY16 Application Budgeted	FY14 Annual Report Expended
I. TYPES OF INDIVIDUALS SERVED		
IA. Federal MCH Block Grant		
1. Pregnant Women	$ 401,771	$ 116,936
2. Infants < 1 year	$ 863,082	$ 944,496
3. Children 1-22 years	$ 2,389,202	$ 2,552,159
4. CSHCN	$ 2,340,778	$ 2,337,888
5. All Others	$ 844,131	$ 881,368
Federal Total of Individuals Served	$ 6,838,964	$ 6,832,847
IB. Non Federal MCH Block Grant		
1. Pregnant Women	$ 1,482,198	$ 1,499,179
2. Infants < 1 year	$ 7,575,094	$ 7,809,935
3. Children 1-22 years	$ 3,367,890	$ 4,209,516
4. CSHCN	$ 21,618	$ 18,046
5. All Others	$ 657,432	$ 798,065
Federal Total of Individuals Served	$ 13,104,232	$ 14,334,741
Federal State MCH Block Grant Partnership Total	$ 19,943,196	$ 21,167,588

Form Notes For Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Discrepancy is due to revised format.	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Discrepancy is due to revised format.	

Data Alerts:

None

Form 3b

Budget and Expenditure Details by Types of Services

State: Arizona

	FY16 Application Budgeted	FY14 Annual Report Expended
I. TYPES OF SERVICES		
IIA. Federal MCH Block Grant		
1. Direct Services	$ 498,207	$ 432,194
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 293,240	$ 227,227
C. Services for CSHCN	$ 204,967	$ 204,967
2. Enabling Services	$ 1,898,903	$ 1,920,088
3. Public Health Services and Systems	$ 4,732,845	$ 4,777,650
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 204,967
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 227,227
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Total		$ 432,194
Federal Total	$ 7,129,955	$ 7,129,932

IIB. Non-Federal MCH Block Grant

1. Direct Services	$ 1,250,000	$ 1,083,578
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 1,100,000	$ 924,758
B. Preventive and Primary Care Services for Children	$ 150,000	$ 158,820
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 10,638,160	$ 12,404,533
3. Public Health Services and Systems	$ 1,216,072	$ 1,141,501
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 680,319
Dental Care (Does Not Include Orthodontic Services)		$ 158,820
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Other		
Transport Services		$ 244,439
Direct Services Total		$ 1,083,578
Non-Federal Total	$ 13,104,232	$ 14,629,612

Form Notes For Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4

Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Arizona

Total Births by Occurrence 88,094

1a. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Propionic acidemia	86,155 (97.8%)	20	0	0 (0%)
Methylmalonic acidemia (methylmalonyl-CoA mutase)	86,155 (97.8%)	20	1	1 (100.0%)
Methylmalonic acidemia (cobalamin disorders)	86,155 (97.8%)	20	1	1 (100.0%)
Isovaleric acidemia	86,155 (97.8%)	20	1	1 (100.0%)
3-Methylcrotonyl-CoA carboxylase deficiency	86,155 (97.8%)	8	1	1 (100.0%)
3-Hydroxy-3-methyglutaric aciduria	86,155 (97.8%)	8	0	0 (0%)
ß-Ketothiolase deficiency	86,155 (97.8%)	0	0	0 (0%)
Glutaric acidemia type I	86,155 (97.8%)	56	0	0 (0%)
Carnitine uptake defect/carnitine transport defect	86,155 (97.8%)	11	4	4 (100.0%)
Medium-chain acyl-CoA dehydrogenase deficiency	86,155 (97.8%)	167	10	10 (100.0%)
Very long-chain acyl-CoA dehydrogenase deficiency	86,155 (97.8%)	3	0	0 (0%)
Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	86,155 (97.8%)	0	0	0 (0%)
Trifunctional protein deficiency	86,155 (97.8%)	0	0	0 (0%)

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Argininosuccinic aciduria	86,155 (97.8%)	3	0	0 (0%)
Citrullinemia, type I	86,155 (97.8%)	3	0	0 (0%)
Maple syrup urine disease	86,155 (97.8%)	1	0	0 (0%)
Homocystinuria	86,155 (97.8%)	11	0	0 (0%)
Classic phenylketonuria	86,155 (97.8%)	19	3	3 (100.0%)
Tyrosinemia, type I	86,155 (97.8%)	74	0	0 (0%)
Primary congenital hypothyroidism	86,155 (97.8%)	1,174	66	66 (100.0%)
Congenital adrenal hyperplasia	86,155 (97.8%)	167	10	10 (100.0%)
S,S disease (Sickle cell anemia)	86,155 (97.8%)	19	18	18 (100.0%)
Biotinidase deficiency	86,155 (97.8%)	196	7	7 (100.0%)
Cystic fibrosis	86,155 (97.8%)	290	19	19 (100.0%)
Classic galactosemia	86,155 (97.8%)	27	0	0 (0%)
Holocarboxylase synthase deficiency	86,155 (97.8%)	8	0	0 (0%)

1b. Secondary RUSP Conditions

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Newborn Hearing	86,749	3,642	161	161

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
	(98.5%)			(100.0%)

3. Screening Programs for Older Children & Women

4. Long-Term Follow-Up

In Arizona, all cases of abnormal results are followed through confirmation of the disorder. Once diagnosis is confirmed, Arizona works to ensure that these infants and their families have access to evaluation services, specialty care, and early intervention services.\r\n\r\nThe hearing screening program has implemented periodic CQI methodology to identify gaps in follow-up care. Findings have been used to develop strategies to address issues, including increasing early intervention enrollment after diagnosis.

Form Notes For Form 4:

None

Field Level Notes for Form 4:

None

Form 5a

Unduplicated Count of Individuals Served under Title V

State: Arizona

Reporting Year 2014

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	7,703	0.0	0.0	0.0	0.0	100.0
2. Infants < 1 Year of Age	91,309	0.0	0.0	0.0	0.0	100.0
3. Children 1 to 22 Years of Age	626,339	0.0	0.0	0.0	0.0	100.0
4. Children with Special Health Care Needs	3,420	0.0	0.0	0.0	0.0	100.0
5. Others	10,825	0.0	0.0	0.0	0.0	100.0
Total	739,596					

Form Notes For Form 5a:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2014**
	Field Note: Includes HRPP maternal transports, Health Start, hotline, and community health grants.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2014**
	Field Note: Includes HRPP neonatal transports, HRPP doctor's bills, NICP, newborn screening, Health Start, hotline, and community health grants.	
3.	**Field Name:**	**Children 1 to 22 Years of Age**
	Fiscal Year:	**2014**
	Field Note: Includes sealants, Health Start, Abstinence Lottery, Abstinence Plus Lottery, Title V Family Planning, Medical Services Project, Sensory, Hotlines, and Community Health Grants.	
4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2014**
	Field Note: Includes metabolic formula, newborn screening (newborns who failed their initial hearing screening), community health grants, and Ryan House.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2014**
	Field Note: Includes Abstinence Lottery, Abstinence Plus Lottery, ACF, hotline, and community health grants.	

Form 5b

Total Recipient Count of Individuals Served by Title V

State: Arizona

Reporting Year 2014

Types Of Individuals Served	Total Served
1. Pregnant Women	7,703
2. Infants < 1 Year of Age	91,309
3. Children 1 to 22 Years of Age	665,158
4. Children with Special Health Care Needs	3,420
5. Others	37,099
Total	804,689

Form Notes For Form 5b:

None

Field Level Notes for Form 5b:

None

Form 6

Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Arizona

Reporting Year 2014

I. Unduplicated Count by Race

	(A) Total All Race	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	88,536	75,490	4,578	5,273	3,195	0	0	0
Title V Served	86,750	73,966	4,486	5,167	3,131	0	0	0
Eligible for Title XIX	46,415	38,833	3,169	3,551	862	0	0	0
2. Total Infants in State	86,648	73,812	4,522	5,145	3,169	0	0	0
Title V Served	84,900	72,323	4,431	5,041	3,105	0	0	0
Eligible for Title XIX	46,064	38,544	3,154	3,506	860	0	0	0

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	51,740	36,199	597	88,536
Title V Served	50,696	35,469	585	86,750
Eligible for Title XIX	21,020	25,000	395	46,415
2. Total Infants in State	51,267	34,938	443	86,648
Title V Served	50,233	34,233	434	84,900
Eligible for Title XIX	20,888	24,894	282	46,064

Form Notes For Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2014**
	Column Name:	**Total All Races**
	Field Note: All births in Arizona (resident & non-resident) Asian includes Asian and Pacific Islander	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2014**
	Column Name:	**Total All Races**
	Field Note: newborn screening estimates based on racial breakdown in state	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2014**
	Column Name:	**Total All Races**
	Field Note: births paid by AHCCCS	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2014**
	Column Name:	**Total All Races**
	Field Note: resident births	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2014**
	Column Name:	**Total All Races**
	Field Note: newborn screening, resident births only estimates based on racial breakdown of infants in state	
6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2014**
	Column Name:	**Total All Races**

Field Note:
resident births paid for by AHCCCS

Form 7

State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Arizona

	Application Year 2016	Reporting Year 2014
A. State MCH Toll-Free Telephone Lines		
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 833-4642	(800) 833-4642
2. State MCH Toll-Free "Hotline" Name	Pregnancy and Breastfeeding	Pregnancy and Breastfeeding
3. Name of Contact Person for State MCH "Hotline"	Laura Belucci	Laura Belucci
4. Contact Person's Telephone Number	(602) 364-1454	(602) 364-1454
5. Number of Calls Received on the State MCH "Hotline"		5,060
B. Other Appropriate Methods		
1. Other Toll-Free "Hotline" Names	Children's Information Center	Children Information Center
2. Number of Calls on Other Toll-Free "Hotlines"		1,614
3. State Title V Program Website Address		
	http://www.azdhs.gov/phs/owch/hot_line.htm	http://www.azdhs.gov/phs/owch/index.htm
4. Number of Hits to the State Title V Program Website		98,813
5. State Title V Social Media Websites		
	http://www.azdhs.gov/phs/owch/index.htm	http://www.azdhs.gov/phs/owch/index.htm
6. Number of Hits to the State Title V Program Social Media Websites		98,813

Form Notes For Form 7:

None

Form 8

State MCH and CSHCN Directors Contact Information

State: Arizona

Application Year 2016

1. Title V Maternal and Child Health (MCH) Director

Name	Mary Ellen Cunningham
Title	Chief, Bureau of Women's and Children's Health
Address 1	150 N 18th Ave
Address 2	Suite 320
City / State / Zip Code	Phoenix / AZ / 85007
Telephone	(602) 364-1419
Email	mary.ellen.cunningham@azdhs.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director

Name	Katharine Levandowsky
Title	Chief, Office for Children with Special Health Car
Address 1	150 N 18th Ave
Address 2	Suite 320
City / State / Zip Code	Phoenix / AZ / 85007
Telephone	(602) 542-2528
Email	Katharine.Levandowsky@azdhs.gov

3. State Family or Youth Leader (Optional)

Name	Dawn Bailey
Title	MCH/OCSHCN Family Advisor
Address 1	150 N 18th Ave
Address 2	Suite 320
City / State / Zip Code	Phoenix / AZ / 85007
Telephone	(602) 364-1987
Email	dawn.bailey@azdhs.gov

Form Notes For Form 8:

None

Form 9

List of MCH Priority Needs

State: Arizona

Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Improve the health of women before and between pregnancies.	New	
2.	Reduce Infant Mortality and Morbidity	New	
3.	Decrease the incidence of childhood injury.	New	
4.	Increase early identification and treatment of developmental delays.	New	
5.	Promote smooth transition through the life course for CYSHCN.	New	
6.	Support adolescents to make healthy decisions as they transition to adulthood.	New	
7.	Reduce the use of tobacco and other substances across the lifespan.	New	
8.	Improve the oral health of Arizona's women and children.	New	
9.	Increase the percentage of women and children who are physically active.	New	
10.	Strengthen the ability of Arizona a families to raise emotionally and physically healthy children.	New	

Form Notes For Form 9:

None

Field Level Notes for Form 9:

None

Form 10a

National Outcome Measures (NOMs)

State: Arizona

Form Notes for Form 10a NPMs and NOMs:

None

NOM-1 Percent of pregnant women who receive prenatal care beginning in the first trimester

FAD Not Available for this measure.

NOM-1 Notes:

None

Data Alerts:

None

NOM-2 Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	144.2	4.2 %	1,187	82,297
2011	139.6	4.2 %	1,135	81,280
2010	139.1	4.1 %	1,157	83,193
2009	138.0	4.0 %	1,218	88,268
2008	139.1	3.9 %	1,308	94,018

Legends:

- Indicator has a numerator ≤10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM-2 Notes:

None

Data Alerts:

None

NOM-3 Maternal mortality rate per 100,000 live births

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	10.6
Numerator	9
Denominator	84,963
Data Source	AZ Vital Statistics
Data Source Year	2013

NOM-3 Notes:

provisional 2013 data, 2014 data not yet available

Data Alerts:

None

NOM-4.1 Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.9 %	0.1 %	5,897	85,518
2012	6.9 %	0.1 %	5,997	86,406
2011	7.0 %	0.1 %	5,988	85,518
2010	7.1 %	0.1 %	6,190	87,450
2009	7.1 %	0.1 %	6,575	92,757

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.1 Notes:

None

Data Alerts:

None

NOM-4.2 Percent of very low birth weight deliveries (<1,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	1.1 %	0.0 %	919	85,518
2012	1.1 %	0.0 %	972	86,406
2011	1.2 %	0.0 %	994	85,518
2010	1.1 %	0.0 %	941	87,450
2009	1.2 %	0.0 %	1,084	92,757

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.2 Notes:

None

Data Alerts:

None

NOM-4.3 Percent of moderately low birth weight deliveries (1,500-2,499 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.8 %	0.1 %	4,978	85,518
2012	5.8 %	0.1 %	5,025	86,406
2011	5.8 %	0.1 %	4,994	85,518
2010	6.0 %	0.1 %	5,249	87,450
2009	5.9 %	0.1 %	5,491	92,757

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.3 Notes:

None

Data Alerts:

None

NOM-5.1 Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	9.1 %	0.1 %	7,775	85,557
2012	9.3 %	0.1 %	7,988	86,390
2011	9.3 %	0.1 %	7,980	85,505
2010	9.7 %	0.1 %	8,450	87,454
2009	10.1 %	0.1 %	9,332	92,773

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.1 Notes:

None

Data Alerts:

None

NOM-5.2 Percent of early preterm births (<34 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	2.4 %	0.1 %	2,069	85,557
2012	2.5 %	0.1 %	2,159	86,390
2011	2.5 %	0.1 %	2,143	85,505
2010	2.5 %	0.1 %	2,140	87,454
2009	2.5 %	0.1 %	2,286	92,773

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.2 Notes:

None

Data Alerts:

None

NOM-5.3 Percent of late preterm births (34-36 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.7 %	0.1 %	5,706	85,557
2012	6.8 %	0.1 %	5,829	86,390
2011	6.8 %	0.1 %	5,837	85,505
2010	7.2 %	0.1 %	6,310	87,454
2009	7.6 %	0.1 %	7,046	92,773

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.3 Notes:

None

Data Alerts:

None

NOM-6 Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	25.4 %	0.2 %	21,696	85,557
2012	25.8 %	0.2 %	22,262	86,390
2011	27.2 %	0.2 %	23,235	85,505
2010	29.2 %	0.2 %	25,518	87,454
2009	30.3 %	0.2 %	28,073	92,773

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-6 Notes:

None

Data Alerts:

None

NOM-7 Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013/Q2-2014/Q1	6.0 %			

Legends:

□ Indicator results were based on a shorter time period than required for reporting

NOM-7 Notes:

None

Data Alerts:

None

NOM-8 Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.7	0.3 %	491	85,867
2012	6.0	0.3 %	519	86,689
2011	5.7	0.3 %	486	85,779
2010	5.8	0.3 %	506	87,714
2009	6.1	0.3 %	564	93,075

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM-8 Notes:

None

Data Alerts:

None

NOM-9.1 Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.3	0.3 %	449	85,600
2012	5.8	0.3 %	500	86,441
2011	6.0	0.3 %	511	85,543
2010	5.9	0.3 %	520	87,477
2009	6.0	0.3 %	554	92,798

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM-9.1 Notes:

None

Data Alerts:

None

NOM-9.2 Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	3.4	0.2 %	292	85,600
2012	3.9	0.2 %	339	86,441
2011	3.9	0.2 %	333	85,543
2010	3.8	0.2 %	332	87,477
2009	3.9	0.2 %	365	92,798

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM-9.2 Notes:

None

Data Alerts:

None

NOM-9.3 Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	1.8	0.2 %	157	85,600
2012	1.9	0.2 %	161	86,441
2011	2.1	0.2 %	178	85,543
2010	2.2	0.2 %	188	87,477
2009	2.0	0.2 %	189	92,798

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM-9.3 Notes:

None

Data Alerts:

None

NOM-9.4 Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	167.1	14.0 %	143	85,600
2012	190.9	14.9 %	165	86,441
2011	173.0	14.2 %	148	85,543
2010	184.1	14.5 %	161	87,477
2009	220.9	15.5 %	205	92,798

Legends:
- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM-9.4 Notes:

None

Data Alerts:

None

NOM-9.5 Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	73.6	9.3 %	63	85,600
2012	67.1	8.8 %	58	86,441
2011	71.3	9.1 %	61	85,543
2010	77.7	9.4 %	68	87,477
2009	81.9	9.4 %	76	92,798

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM-9.5 Notes:

None

Data Alerts:

None

NOM-10 The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

FAD Not Available for this measure.

NOM-10 Notes:

None

Data Alerts:

None

NOM-11 The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	10.9	0.4 %	896	82,300
2011	10.1	0.4 %	821	81,280
2010	8.4	0.3 %	698	83,198

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009	7.0	0.3 %	616	88,268
2008	4.4	0.2 %	413	94,018

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM-11 Notes:

None

Data Alerts:

None

NOM-12 Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM-12 Notes:

None

Data Alerts:

None

NOM-13 Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM-13 Notes:

None

Data Alerts:

None

NOM-14 Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	22.3 %	1.5 %	340,573	1,527,105

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-14 Notes:

None

Data Alerts:

None

NOM-15 Child Mortality rate, ages 1 through 9 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	22.3	1.7 %	180	806,967
2012	21.9	1.6 %	178	811,203
2011	19.5	1.6 %	159	815,461
2010	22.3	1.7 %	183	821,838
2009	23.8	1.7 %	196	823,927

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM-15 Notes:

None

Data Alerts:

None

NOM-16.1 Adolescent mortality rate ages 10 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	32.3	1.9 %	293	906,527
2012	32.9	1.9 %	297	901,809
2011	34.2	2.0 %	309	903,716
2010	32.3	1.9 %	294	910,246
2009	37.5	2.0 %	340	907,472

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM-16.1 Notes:

None

Data Alerts:

None

NOM-16.2 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2013	13.2	1.0 %	178	1,349,352
2010_2012	12.9	11.0 %	176	1,360,105
2009_2011	11.7	9.9 %	161	1,373,799
2008_2010	13.2	11.3 %	182	1,381,224
2007_2009	18.2	15.9 %	249	1,367,906

Legends:

Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-16.2 Notes:

None

Data Alerts:

None

NOM-16.3 Adolescent suicide rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2013	10.4	8.7 %	140	1,349,352
2010_2012	10.7	8.9 %	145	1,360,105
2009_2011	10.3	8.6 %	141	1,373,799
2008_2010	10.5	8.8 %	145	1,381,224
2007_2009	10.5	8.8 %	144	1,367,906

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-16.3 Notes:

None

Data Alerts:

None

NOM-17.1 Percent of children with special health care needs

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	19.2 %	1.3 %	310,801	1,620,552
2007	17.4 %	1.3 %	288,152	1,657,543
2003	14.6 %	1.0 %	220,758	1,512,819

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-17.1 Notes:

None

Data Alerts:

None

NOM-17.2 Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	12.4 %	1.4 %	26,884	217,438

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-17.2 Notes:

None

Data Alerts:

None

NOM-17.3 Percent of children diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	1.9 %	0.5 %	26,226	1,355,638
2007	0.8 %	0.3 %	10,230	1,366,723

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-17.3 Notes:

None

Data Alerts:

None

NOM-17.4 Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	7.6 %	1.0 %	103,079	1,356,983
2007	5.5 %	0.8 %	75,119	1,362,540

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-17.4 Notes:

None

Data Alerts:

None

NOM-18 Percent of children with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	59.8%	5.7%	85,709	143,266
2007	62.1%	7.5%	69,191	111,502
2003	55.5%	5.5%	46,490	83,777

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-18 Notes:

None

Data Alerts:

None

NOM-19 Percent of children in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	80.1 %	1.5 %	1,297,338	1,620,552
2007	80.7 %	1.6 %	1,337,038	1,657,543
2003	80.7 %	1.0 %	1,220,632	1,512,175

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-19 Notes:

None

Data Alerts:

None

NOM-20 Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	36.7 %	2.7 %	245,102	668,033
2007	30.6 %	2.5 %	203,929	667,522
2003	29.7 %	2.0 %	173,000	582,694

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	30.6 %	0.2 %	18,805	61,456

Legends:

- Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable
- Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	23.4 %	1.6 %	66,669	284,716

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011	24.8 %	1.3 %	64,056	258,791
2009	27.1 %	1.4 %	78,879	291,495
2007	25.6 %	1.9 %	70,244	274,096
2005	25.4 %	1.2 %	58,931	232,232

Legends:

- Indicator has an unweighted denominator <100 and is not reportable
- Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-20 Notes:

None

Data Alerts:

None

NOM-21 Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	12.1 %	0.4 %	195,833	1,614,362
2012	12.9 %	0.5 %	208,578	1,619,974
2011	12.9 %	0.5 %	208,864	1,622,742
2010	13.0 %	0.4 %	211,648	1,632,847
2009	12.1 %	0.4 %	209,100	1,731,141

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-21 Notes:

None

Data Alerts:

None

NOM-22.1 Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	65.1 %	4.0 %	80,405	123,594
2012	67.5 %	3.8 %	86,015	127,388
2011	60.4 %	4.6 %	82,027	135,912
2010	56.0 %	3.4 %	82,550	147,433
2009	36.7 %	3.3 %	56,832	155,016

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.1 Notes:

None

Data Alerts:

None

NOM-22.2 Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013_2014	48.4 %	2.2 %	723,935	1,495,804

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2013	48.9 %	2.0 %	742,934	1,520,539
2011_2012	48.2%	3.0%	784,025	1,627,929
2010_2011	49.0%	3.7%	372,342	663,711
2009_2010	43.9 %	3.1 %	400,329	652,001

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.2 Notes:

None

Data Alerts:

None

NOM-22.3 Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Female

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	64.1 %	4.5 %	141,754	221,198
2012	54.3 %	4.9 %	119,159	219,600
2011	55.3%	5.3%	121,579	219,995
2010	52.8 %	4.8 %	108,559	205,747
2009	52.8 %	4.7 %	115,608	219,127

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Male

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	44.4 %	4.5 %	102,551	230,790
2012	19.7 %	3.6 %	45,363	230,034
2011	8.5 %	2.3 %	19,490	230,738

Legends:

 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

 Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.3 Notes:

None

Data Alerts:

None

NOM-22.4 Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	84.4 %	2.5 %	381,544	451,989
2012	87.5 %	2.3 %	393,495	449,634
2011	85.3 %	2.7 %	384,659	450,733
2010	76.5 %	2.9 %	323,449	422,929
2009	66.7 %	3.2 %	299,824	449,859

Legends:

 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

 Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.4 Notes:

None

Data Alerts:

None

NOM-22.5 Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	86.7 %	2.3 %	391,854	451,989
2012	85.5 %	2.6 %	384,271	449,634
2011	82.9 %	2.9 %	373,812	450,733
2010	78.9 %	2.7 %	333,665	422,929
2009	69.7 %	3.1 %	313,435	449,859

Legends:

- Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
- Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.5 Notes:

None

Data Alerts:

None

Form 10a

National Performance Measures (NPMs)

State: Arizona

NPM-1 Percent of women with a past year preventive medical visit

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective					

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective					

NPM-4 B) Percent of infants breastfed exclusively through 6 months

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective					

NPM-6 Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective					

NPM-7 Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Annual Objectives					
	2016	2017	2018	2019	2020

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	215.1	212.9	210.8	208.6	206.4

NPM-9 Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective					

NPM-10 Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective					

NPM-12 Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective					

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective					

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives					

	2016	2017	2018	2019	2020
Annual Objective					

Form 10b

State Performance/Outcome Measure Detail Sheet

State: Arizona

States are not required to create SOMs/SPMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10c

Evidence-Based or Informed Strategy Measure Detail Sheet

State: Arizona

States are not required to create ESMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10d

National Performance Measures (NPMs) (Reporting Year 2014 & 2015)

State: Arizona

Form Notes for Form 10d NPMs and SPMs

None

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

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	100.0	100.0	100.0	100.0	
Numerator	102	131	102	130	
Denominator	102	131	102	130	
Data Source	AZ Office of Newborn Screening	AZ Office of Newborn Screening	AZ Office of Newborn Screening	AZ Office of Newborn Screening	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

None

Data Alerts:

None

NPM 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)

	2011	2012	2013	2014	2015
Annual Objective	57.4	57.4	67.0	67.0	67.0
Annual Indicator	66.2	66.2	66.2	66.2	
Numerator		153,623	153,623	153,623	
Denominator		231,913	231,913	231,913	
Data Source	SLAITS	SLAITS	SLAITS	SLAITS	

	2011	2012	2013	2014	2015
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
For 2011-2015, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010, there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were

wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

NPM 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)

	2011	2012	2013	2014	2015
Annual Objective	47.1	47.1	47.1	47.1	38.0
Annual Indicator	36.1	36.1	36.1	36.1	
Numerator		81,306	81,306	81,306	
Denominator		225,115	225,115	225,115	
Data Source	SLAITS	SLAITS	SLAITS	SLAITS	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
For 2011-2015, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2013**

Field Note:
For 2011-2015, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip

pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

NPM 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)

	2011	2012	2013	2014	2015
Annual Objective	62.0	62.0	62.0	62.0	57.0
Annual Indicator	52.9	52.9	52.9	52.9	
Numerator		121,804	121,804	121,804	

	2011	2012	2013	2014	2015
Denominator		230,201	230,201	230,201	
Data Source	SLAITS	SLAITS	SLAITS	SLAITS	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
For 2011-2015, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws,

respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

NPM 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)

	2011	2012	2013	2014	2015
Annual Objective	89.1	89.1	89.1	89.1	65.0
Annual Indicator	59.7	59.7	59.7	59.7	
Numerator			139,501	139,501	
Denominator			233,755	233,755	
Data Source	SLAITS	SLAITS	SLAITS	SLAITS	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
For 2011-2015, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2013**

Field Note:
For 2011-2015, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	41.2	41.2	41.2	41.2	38.0
Annual Indicator	35.6	35.6	35.6	35.6	
Numerator		30,347	30,347	30,347	
Denominator		85,151	85,151	85,151	
Data Source	SLAITS	SLAITS	SLAITS	SLAITS	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
For 2011-2015, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip

pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

NPM 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.

	2011	2012	2013	2014	2015
Annual Objective	80.0	80.0	75.0	75.0	80.0
Annual Indicator	77.5	70.7	71.4	72.8	
Numerator					
Denominator					
Data Source	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
The confidence Interval is + or - 6.7% Estimates for 2014 are not recommended for comparison to years prior to 2009 because of the changes in the way the Hib vaccine is now measured and the vaccine shortage that affected a large percent of children that were included in the 2009 and 2010 samples.

2.	**Field Name:**	**2013**

Field Note:
The confidence interval is + or - 7.1%.

Estimates for 2013 are not recommended for comparison to years prior to 2009 because of the changes made in the way the Hib vaccine is now measured and the vaccine shortage that affected a large percent of children that were included in the 2009 and 2010 samples.

3.	**Field Name:**	**2012**

Field Note:
The confidence interval is + or - 8.6%.

Estimates for 2012 are not recommended for comparison to years prior to 2009 because of the changes made in the way the Hib vaccine is now measured and the vaccine shortage that affected a large percent of children that were included in the 2009 and 2010 samples.

4.	**Field Name:**	**2011**

Field Note:
The confidence interval is + or - 5.8%.

Estimates for 2010 are not recommended for comparison to years prior to 2009 because of the changes made in the way the Hib vaccine is now measured and the vaccine shortage that affected a large percent of children that were included in the 2009 and 2010 samples. The estimates are not directly comparable since they do not consider the brand type where some children may be counted as up to date with 3 doses but may require 4 doses to be up to date.

Data Alerts:

None

NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

	2011	2012	2013	2014	2015
Annual Objective	23.0	18.0	17.5	14.0	12.5
Annual Indicator	18.4	18.5	15.0	13.2	
Numerator	2,447	2,430	1,985	1,751	
Denominator	132,814	131,429	132,356	132,178	
Data Source	AZ Birth Certificates	AZ Birth Certificates	AZ Birth Certificates	AZ Birth Certificates	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
The rate of birth (per 1,000) teenagers aged 15-17 continues to decrease. This aligns with the national trend.

2.	**Field Name:**	**2013**

Field Note:
The rate of birth (per 1,000) for teenages aged 15-17 years continues to decrease. This aligns with the national trend.

Data Alerts:

None

NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

	2011	2012	2013	2014	2015
Annual Objective	47.1	47.1	47.1	47.1	47.1
Annual Indicator	47.1	47.1	47.1	44.2	
Numerator					
Denominator					
Data Source	AZ Office of Oral Health	AZ Office of Oral Health	AZ Office of Oral Health	AZ Office of Oral Health	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
Healthy Smiles Healthy Bodies 2014 survey

2.	**Field Name:**	**2013**

Field Note:
The Healthy Smiles Healthy Bodies survey was conducted for a random sample of 3rd Grade students in 2009. It is important to note that some differential misclassification bias may have occurred during the visual examination for sealants. The ADHS Office of Oral Health received some reports of oral health examiners having difficulty telling the difference between a sealant and resins on molars. This threat to the validity of the estimate will be corrected prior to the next survey in 2015.

The most recent results are from the 2009/2010 survey and are therefore unchanged since 2009.

3.	**Field Name:**	**2012**

Field Note:

The Healthy Smiles Healthy Bodies survey was conducted for a random sample of 3rd Grade students in 2009. It is important to note that some differential misclassification bias may have occurred during the visual examination for sealants. The ADHS Office of Oral Health received some reports of oral health examiners having difficulty telling the difference between a sealant and resins on molars. This threat to the validity of the estimate will be corrected prior to the next survey in 2015.

4.	**Field Name:**	**2011**

Field Note:
The Healthy Smiles Healthy Bodies survey was conducted for a random sample of 3rd Grade students in 2009. It is important to note that some differential misclassification bias may have occurred during the visual examination for sealants. The ADHS Office of Oral Health received some reports of oral health examiners having difficulty telling the difference between a sealant and resins on molars. This threat to the validity of the estimate will be corrected prior to the next survey in 2015.

Data Alerts:

None

NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

	2011	2012	2013	2014	2015
Annual Objective	2.5	2.4	1.9	1.9	3.0
Annual Indicator	2.5	2.8	3.4	2.4	
Numerator	34	38	46	33	
Denominator	1,368,206	1,358,070	1,364,423	1,355,826	
Data Source	AZ Death Certificat	AZ Death Certificat	AZ Death Certificat	AZ Death Certificat	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children decreased 29.4% from 3.4 in 2013 to 2.4 in 2014.

2.	**Field Name:**	**2013**

Field Note:
The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children

increased 21.4% from 2.8 in 2012 to 3.4 in 2013.

Numerator for 2012 was updated 07/08/014.

3.	**Field Name:**	**2012**

Field Note:
Numerator updated on 07/08/14. The coding used in 2012 was missing some ICD codes and has been updated to be comparable to other years.

Data Alerts:

None

NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.

	2011	2012	2013	2014	2015
Annual Objective	51.0	53.0	49.0	53.0	57.0
Annual Indicator	52.0	43.3	49.7	47.8	
Numerator					
Denominator					
Data Source	CDC National Immunization	CDC National Immunization	CDC National Immunization	CDC National Immunization	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
Source: Centers for Disease Control and Prevention National Immunization Survey, Provisional Data, 2011 births. http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm Data was obtained from the 2014 CDC Breastfeeding Report Card, http://www.cdc.gov/breastfeeding/pdf/2014breastfeedingreportcard.pdf

2.	**Field Name:**	**2013**

Field Note:
Source: Centers for Disease Control and Prevention National Immunization Survey, Provisional Data, 2010 births. http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm

Data was obtained from the 2013 CDC Breastfeeding Report Card, which used 2010 provisional National Immunization Survey (NIS) data. The NIS webpage did not contain 2010 state data due to website format changes

that are to take place.
http://www.cdc.gov/breastfeeding/pdf/2013breastfeedingreportcard.pdf

3.	**Field Name:**	**2012**

Field Note:
Source: Centers for Disease Control and Prevention National Immunization Survey, Provisional Data, 2009 births.
http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm

06/20/14- The 2009 data is still listed as provisional because the NIS webpage did not contain finalized 2009 state data due to website format changes that are to take place.

4.	**Field Name:**	**2011**

Field Note:
The CDC National Immunization Survey data for 2011 (2008 birth cohort). The HP 2020 Goal is 60.6%.

Data Alerts:

None

NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	97.4	98.2	98.4	98.5	
Numerator	84,335	85,666	85,151	86,749	
Denominator	86,599	87,274	86,496	88,077	
Data Source	AZ Early Hearing Detection and Intervention Progra	AZ Early Hearing Detection and Intervention Progra	AZ Early Hearing Detection and Intervention Progra	AZ Early Hearing Detection and Intervention Program	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

None

Data Alerts:

None

NPM 13 - Percent of children without health insurance.

	2011	2012	2013	2014	2015
Annual Objective	13.1	14.0	13.0	13.0	13.0
Annual Indicator	15.0	13.5	13.7	11.9	
Numerator				192	
Denominator				1,614	
Data Source	U.S. Census	U.S. Census	U.S. Census	U.S. Census	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Estimate from Table HI05 available at http://www.census.gov/hhes/www/cpstables/032014/health/hi05_acs.xls	
2.	**Field Name:**	**2013**
	Field Note: Estimate from Table HI05 available at http://www.census.gov/hhes/www/cpstables/032013/health/toc.htm	
3.	**Field Name:**	**2012**
	Field Note: Estimate from Table HI05 available at http://www.census.gov/hhes/www/cpstables/032012/health/toc.htm	
4.	**Field Name:**	**2011**
	Field Note: The estimate is available at http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html(Table HIA-5)	

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	34.0	28.5	27.0	25.0	24.5
Annual Indicator	28.9	27.8	25.6	23.9	

	2011	2012	2013	2014	2015
Numerator	30,018	27,583	22,911	20,124	
Denominator	103,873	99,071	89,344	84,254	
Data Source	AZWIC Program	AZWIC Program	AZWIC Program	AZWIC Program	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
The percentage of children, ages 2 to 5 years, receiving WIC services with a BMI at or above the 85th percentile continues to decline. Numbers reported before 2009 include duplicates by error and therefore overestimate the percentage of children with BMI at or above the 85th percentile and not comparable with numbers from 2009 and onward.

2.	**Field Name:**	**2013**

Field Note:
The percentage of children, ages 2 to 5 years, receiving WIC services with a BMI at or above the 85th percentile continue to decline.

Numbers reported before 2009 include duplicates by error and therefore over estimate the percentage of children with BMI at or above the 85th percentile and not comparble with numbers from 2009 and onward.

3.	**Field Name:**	**2012**

Field Note:
Numbers reported before 2009 includes duplicates by error, therefore are overestimating the percentage of kids with BMI at or above 85th percentile and are not comparable with numbers from 2009 and onward.

4.	**Field Name:**	**2011**

Field Note:
Numbers reported from 2006-2010 were overestimated by error because it includes duplicate records. Years 2009, 2010 and 2011 have been updated with correct percentages. Numbers reported before 2009 includes duplicates, therefore are overestimating the percentage of kids with BMI at or above 85th percentile and are not comparable with numbers from 2009 and onward.

Data Alerts:

None

NPM 15 - Percentage of women who smoke in the last three months of pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	4.0	4.0	3.9	3.8	4.0
Annual Indicator	4.3	4.2	4.4	4.1	
Numerator	3,622	3,599	3,748	3,457	
Denominator	85,109	85,644	84,963	84,701	
Data Source	AZ Birth Certificates	AZ Birth Certificates	AZ Birth Certificates	AZ Birth Certificates	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
The State of Arizona does not have a survey like PRAMS that would collect data related to smoking during the last 3 months of pregnancy. However, in 2014, Arizona began using the 2003 version of the birth certificate which collects information on smoking during pregnancy by trimester. In the past, information was only available for smoking at any time during the pregnancy. Because of this, it may not be prudent to compare percentages from 2014 and onward to past numbers. The HP 2020 Goal for abstaining from cigarettes during pregnancy is 98.6% (1.4% using tobacco during pregnancy).

2.	**Field Name:**	**2013**

Field Note:
The State of Arizona does not have a survey like PRAMS that would collect data related to smoking during the last 3 months of pregnancy. The only data available is from the birth certificate, which records wether or not the mother smoked during the pregnancy, but is not specific to the last 3 months of the pregnancy. Therefore, the percent reported is the percent of women giving birth in 2013 who smoked at any time during pregnancy.

The HP 2020 Goal for abstaining from cigarettes during pregnancy is 98.6% (1.4% using tobacco during pregnancy).

The percentage of women who smoke during preganancy increase slightly after being on the decline since 2008. The indicator is still lower than it was in 2008.

3.	**Field Name:**	**2012**

Field Note:
The State of Arizona does not have a survey like PRAMS that would collect data related to smoking during the last 3 months of pregnancy. The only data available is from the birth certificate, which records wether or not the mother smoked during the pregnancy, but is not specific to the last 3 months of the pregnancy. Therefore, the percent reported is the percent of women giving birth in 2012 who smoked at any time during pregnancy.

The HP 2020 Goal for abstaining from cigarettes during pregnancy is 98.6% (1.4% using tobacco during pregnancy).

4.	**Field Name:**	**2011**

Field Note:
The State of Arizona does not have a survey like PRAMS that would collect data related to smoking during the last 3 months of pregnancy. The only data available is from the birth certificate, which records wether or not the mother smoked during the pregnancy, but is not specific to the last 3 months of the pregnancy. Therefore, the percent reported is the percent of women giving birth in 2011 who smoked at any time during pregnancy.

The HP 2020 Goal for abstaining from cigarettes during pregnancy is 98.6% (1.4% using tobacco during pregnancy).

Data Alerts:

None

NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

	2011	2012	2013	2014	2015
Annual Objective	8.2	9.8	9.8	6.7	6.7
Annual Indicator	10.1	10.3	6.8	10.8	
Numerator	47	48	32	49	
Denominator	464,724	467,382	470,793	453,593	
Data Source	AZ Death Certificates	AZ Death Certificates	AZ Death Certificates	AZ Death Certificates	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
The rate (per 100,000) of suicide deaths among youth aged 15 through 19 increased 59% from 6.8 in 2013 to 10.8 in 2014.

2.	**Field Name:**	**2013**

Field Note:
The rate (per 100,000) of suicide deaths among youth aged 15 through 19 decreased 34% from 10.3 in 2012 to 6.8 in 2013. This was a significant decrease ($p<0.05$).

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	91.5	92.0	92.5	93.0	93.5
Annual Indicator	87.8	92.0	92.3	91.5	
Numerator	889	913	856	942	
Denominator	1,013	992	927	1,030	
Data Source	AZ Birth Certificates	AZ Birth Certificates	AZ Birth Certificates	AZ Birth Certificates	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
This 2014 estimate is based on the inclusion of Level II EQ hospitals. The Arizona Perinatal Trust certifies a Level II EQ hospital to care for neonates at 28 weeks gestation or greater. The American Academy of Pediatrics expanded their classification system for neonatal care in 2004. The new classification system describes a neonatal intensive care Level IIIA as one that can provide care for infants born at more than 28 weeks gestation. Prior to 2009 only Level III hospitals were included in the analysis.

2.	**Field Name:**	**2013**

Field Note:
The 2013 estimate is based on the inclusion of Level II EQ hosptials. The Arizona Perinatal Trust certifies a Level II EQ to care for neonates at 28 weeks gestation or greater. The American Academy of Pediatrics expanded their classification system for neonatal care in 2004. The new classification system describes a neonatal intensive care Level IIIA as one that can provide care for infants born at more than 28 weeks gestation. Prior to 2009 only Level III hospitals were included in the analysis.

3.	**Field Name:**	**2011**

Field Note:
The 2011 estimate is based on the inclusion of Level II EQ hosptials. The Arizona Perinatal Trust certifies a Level II EQ to care for neonates at 28 weeks gestation or greater. The American Academy of Pediatrics expanded their classification system for neonatal care in 2004. The new classification system describes a neonatal intensive care Level IIIA as one that can provide care for infants born at more than 28 weeks gestation. Prior to 2009 only Level III hospitals were included in the analysis.

Data Alerts:

None

NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

	2011	2012	2013	2014	2015
Annual Objective	83.0	84.0	85.0	86.0	87.0
Annual Indicator	83.3	83.9	82.7	82.0	
Numerator	70,953	71,882	70,255	47,182	
Denominator	85,190	85,725	84,963	57,548	
Data Source	AZ Birth Certificates	AZ Birth Certificates	AZ Birth Certificates	AZ Birth Certificates	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Beginning in 2014, Arizona changed from the 1989 version of the birth certificate to the 2003 version. Because of the change in reporting methods, the methods of calculating first trimester prenatal care have changed as well.	
2.	**Field Name:**	**2013**
	Field Note: The HP 2020 Goal is 77.9%.	
3.	**Field Name:**	**2012**
	Field Note: The HP 2020 Goal is 77.9%.	

Data Alerts:

None

Form 10d

State Performance Measures (SPMs) (Reporting Year 2014 & 2015)

State: Arizona

SPM 1 - The percent of high school students who report having experienced physical violence by a dating partner during the past 12 months.

	2011	2012	2013	2014	2015
Annual Objective	10.6	10.6	10.6	9.7	9.7
Annual Indicator	11.4	11.4	10.1	10.1	
Numerator	326	326	161	161	
Denominator	2,856	2,856	1,600	1,600	
Data Source	Youth Risk Behavior Survey	Youth Risk Behavior Survey	Arizona-Youth Risk Behavior Survey 2013	Arizona-Youth Risk Behavior Survey 2013	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: The 2013 CDC YRBS wording of this question has changed compared to the 2011 survey. The CDC YRBS does not contain this data. Data was obtained from the Arizona Department of Education (www.azed.gov/prevention-programs/resources/data/yrbs). The state added question was "During the past 12 months, did your boyfriend or girlfriend ever hit, slap, or physically hurt you on purpose?"	
2.	**Field Name:**	**2013**
	Field Note: The 2013 CDC YRBS wording of this question has changed compared to the 2011 survey. The CDC YRBS does not contain this data. Data was obtained from the Arizona Department of Education (www.azed.gov/prevention-programs/resources/data/yrbs). The state added question was "During the past 12 months, did your boyfriend or girlfriend ever hit, slap, or physically hurt you on purpose?	
3.	**Field Name:**	**2012**
	Field Note: The estimate represents the percent of high school students that reported being hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend (CI: 9.7-13.3%). The Survey conducted biennially, therefore reporting 2011 estimates.	
4.	**Field Name:**	**2011**

Field Note:
The estimate represents the percent of high school students that reported being hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend (CI: 9.7-13.3%)

Data Alerts:

None

SPM 2 - The percent of high school students who are overweight or obese.

	2011	2012	2013	2014	2015
Annual Objective	27.0	26.5	26.0	25.5	24.9
Annual Indicator	24.8	24.8	23.4	23.4	
Numerator	666	666	356	356	
Denominator	2,687	2,687	1,520	1,520	
Data Source	Youth Risk Behavior Survey (2011)	Youth Risk Behavior Survey (2011)	Youth Risk Behavior Survey 2013	Youth Risk Behavior Survey 2013	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2014**

Field Note:
A student was obese if >=95th percentile and overweight if >=85th percentile but <95th percentile. In Arizona, 10.7% were obese and 12.7% were overweight. The HP 2020 Goal for adolescent obesity is 16.1%.

2. **Field Name:** **2013**

Field Note:
A student was obese if >=95th percentile and overweight if >=85th percentile but <95th percentile. In Arizona, 10.7% were obese and 12.7% were overweight.

The HP 2020 Goal for adolescent obesity is 16.1%.

3. **Field Name:** **2012**

Field Note:
The HP 2020 Goal for adolescent obesity is 16.1%. The Survey conducted biennially, therefore reporting 2011 estimates.

4.	**Field Name:**	**2011**

Field Note:
Arizona overweight=13.9% and obese=10.9%. U.S. overweight=15.2% and obese=13.0%. YRBS asks high school students to report height, weight, age and gender. Overweight is students who were >= 85th percentile but < 95th percentile for body mass index, by age and sex, based on reference data. Students who were >= 95th percentile are obese. The HP 2020 Goal for adolescent obesity is 16.1%

Data Alerts:

None

SPM 3 - The percent of preventable fetal and infant deaths out of all fetal and infant deaths.

	2011	2012	2013	2014	2015
Annual Objective	31.0	30.5	30.0	30.0	29.0
Annual Indicator	11.4	39.2	18.4	11.9	
Numerator	127	372	177	70	
Denominator	1,112	949	964	587	
Data Source	AZ Vital Records	AZ Vital Records	AZ Vital Records	AZ Vital Records	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**

Field Note:
The decrease in the percent may be attributed to the changes in the fetal death certificate reporting.

2.	**Field Name:**	**2013**

Field Note:
Updated: 09/12/14 The decrease in the percent of preventable fetal and infant deaths may be partially explained by the decrease in infant deaths in 2013.

3.	**Field Name:**	**2012**

Field Note:
The 2010 birth cohort was used in this analysis.

4.	**Field Name:**	**2011**

Field Note:

The 2009 birth cohort was used in this analysis. This year AZ changed to 2003 version of death certificates that included changes in race/ethnicity categorization. These changes may have effected group used as reference. Further analysis is needed to see why the estimate is much lower than other years.

Data Alerts:

None

SPM 4 - Emergency department visits for unintentional injuries per 100,000 children age 1-14.

	2011	2012	2013	2014	2015
Annual Objective	7,400.0	7,250.0	7,100.0	6,950.0	6,800.0
Annual Indicator	7,436.0	7,587.0	7,118.2	7,182.5	
Numerator	95,181	96,422	90,773	91,324	
Denominator	1,279,995	1,270,886	1,275,227	1,271,484	
Data Source	AZ Hospital Discharge Data	AZ Hospital Discharge Data	AZ Hospital Discharge Data	AZ Hospital Discharge Data	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: The rate of emergency department visits for unintentional injuries per 100,000 children age 1-14 increased by less than 1% (0.9%) from 2013 to 2014.	
2.	**Field Name:**	**2013**
	Field Note: Updated 2012 numerator on 06/09/14. The rate of emergency department visits for unintentional injuries per 100,000 children age 1-14 decreased 6.2% from 2012 to 2013; this was significant (p<0.0002).	
3.	**Field Name:**	**2012**
	Field Note: Numerator updated on 06/09/14.	
4.	**Field Name:**	**2011**
	Field Note: If the 2011 the rate of emergency department visits for unintentional injuries was 7,436 per 100,000 and the population in this age group was 1,279,999 children; If we had met the preformance objective of 7400 per	

100,000 children age 1-14 years, approximately 461 visits would have been prevented.

Data Alerts:

None

SPM 5 - The percent of women having a subsequent pregnancy during the inter-pregnancy interval of 18-59 months.

	2011	2012	2013	2014	2015
Annual Objective	45.0	45.5	46.0	46.5	48.0
Annual Indicator	44.2	44.2	43.3	45.8	
Numerator	24,449	24,797	24,452	24,080	
Denominator	55,265	56,160	56,483	52,559	
Data Source	AZ Birth Certificates	AZ Birth Certificates	AZ Birth Certificates	AZ Birth Certificates	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

None

Data Alerts:

None

SPM 6 - Percent of Medicaid enrollees age 1-14 who received at least one preventive dental service within the last year.

	2011	2012	2013	2014	2015
Annual Objective	48.0	49.0	50.0	51.0	52.0
Annual Indicator	47.9	46.0	47.3	47.2	
Numerator	285,371	274,712	280,424	281,860	
Denominator	596,114	596,644	592,259	597,340	
Data Source	AZ Medicaid	AZ Medicaid	AZ Medicaid	AZ Medicaid	
Provisional Or				Final	

	2011	2012	2013	2014	2015
Final ?					

Field Level Notes for Form 10d SPMs:

None

Data Alerts:

None

SPM 7 - Percent of women age 18 years and older who suffer from frequent mental distress.

	2011	2012	2013	2014	2015
Annual Objective	11.0	10.5	10.0	9.5	9.0
Annual Indicator	11.7	14.0	13.4	14.4	
Numerator	404	336,672	329,300	355,408	
Denominator	3,451	2,399,700	2,460,206	2,466,457	
Data Source	AZ BRFSS	AZ BRFSS 2011	AZ BRFSS 2012	AZ BRFSS 2012	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**

Field Note:
Weighted frequencies have been reported to account for any sampling bias that could occur during the survey. Frequent mental distress is defined as having 14 or more mentally unhealthy days, as measured by the question: "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" In 2011 New weighting methodology—raking, or iterative proportional fitting—replaced the post stratification weighting method that had been used with previous BRFSS data sets. Also, BRFSS incorporated cell phones into their sample. Therefore, estimates from the 2011 BRFSS and forward may not be comparable to estimates created in previous years.

2.	**Field Name:**	**2013**

Field Note:
The 2012 numbers were updated on 06/20/14. An error was found in last year's data analysis, this has been corrected and the numbers updated.

Weighted frequencies have been reported for 2012 and 2013 to account for any sampling bias that could occur during the survey.

Frequent mental distress is defined as having 14 or more mentally unhealthy days as measured by the question: "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"

In 2011 New weighting methodology—raking, or iterative proportional fitting—replaced the post stratification weighting method that had been used with previous BRFSS data sets. Also, BRFSS incorporated cell phones into their sample. Therefore, estimates from the 2011 BRFSS and forward may not be comparable to estimates created in previous years.

3.	**Field Name:**	**2012**

Field Note:
Estimate is weighted. Frequent mental distress is defined as having 14 or more mentally unhealthy days as measured by the question: "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"

In 2011 New weighting methodology—raking, or iterative proportional fitting—replaced the post stratification weighting method that had been used with previous BRFSS data sets. Also, BRFSS incorporated cell phones into their sample. Therefore, estimates from the 2011 BRFSS and forward may not be comparable to estimates created in previous years.

Number updated on 06/20/14.

4.	**Field Name:**	**2011**

Field Note:
Frequent mental distress is defined as having 14 or more mentally unhealthy days as measured by the question: "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"

Data Alerts:

None

SPM 8 - Percent of newborns who fail their initial hearing screening who receive appropriate follow up services.

	2011	2012	2013	2014	2015
Annual Objective	79.0	81.0	83.0	85.0	86.0
Annual Indicator	81.6	85.8	88.6	86.7	
Numerator	2,240	2,389	2,920	3,156	
Denominator	2,745	2,783	3,295	3,642	
Data Source	AZ Early Hearing and Detection	AZ Early Hearing and Detection	AZ Early Hearing and Detection	AZ Early Hearing and Detection	
Provisional Or Final ?				Final	

	2011	2012	2013	2014	2015

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2013**
	Field Note: Numerator and Denominator for 2011 and 2012 updated on 06/09/14 based on 09/17/13 email from Newborn Screening.	
2.	**Field Name:**	**2012**
	Field Note: 2012 Number not ready by deadline of application. Numerator and Denominator for 2012 updated on 06/09/14 based on 09/17/13 email from Newborn Screening.	
3.	**Field Name:**	**2011**
	Field Note: Numberator and Denominator updated 06/09/14 based on 09/17/13 email from Newborn Screening.	

Data Alerts:

None

Form 11

Other State Data

State: Arizona

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the FY 2016 application and FY 2014 annual report.

State Action Plan Table

State: Arizona

Please click the link below to download a PDF of the State Action Plan Table.
State Action Plan Table