# Arizona State Action Plan Table 2026 Application/2024 Annual Report

| Priority Needs | Five-Year Objectives | Strategies | Evidence-Based or –Informed Strategy Measures | National and State Performance Measures | National and State Outcome Measures |
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| **Women/Maternal Health** | | | | | |
| Support women's wellbeing by expanding mental health resources and removing barriers to respectful preventive, maternity, and postpartum care. | By 2030, increase the percentage of birthing individuals in Arizona who attend a postpartum visit within 12 weeks of delivery by 4% by expanding mental health resources, strengthening partnerships with WIC, home visitors, and CHWs, promoting the use of adapted postpartum warning signs in non-emergency settings, and enhancing workforce capacity to deliver respectful, culturally responsive care. | Support workforce and workforce capacity that serve pregnant and postpartum women in Arizona.<br><br>Utilize information helplines and partner with WIC, home visitors, and community health workers to encourage and promote postpartum visits in between pregnancies.<br><br>Adapt the postpartum warning signs to promote the importance of postpartum visit in non-emergency settings. | ESM PPV.1 - Mean Score of Provider Confidence in Teaching Postpartum Warning Signs | NPM - Postpartum Visit | **Linked NOMs:**<br>Maternal Mortality<br>Neonatal Abstinence Syndrome<br>Women's Health Status<br>Postpartum Depression<br>Postpartum Anxiety |
| Support women's wellbeing by expanding mental health resources and removing barriers to respectful preventive, maternity, and postpartum care. | By 2030, increase the percentage of birthing individuals in Arizona who receive a postpartum mental health screening by 4%, by implementing AIM mental health safety bundles, conducting statewide awareness and education campaigns, and strengthening provider capacity through training and coordination via the Maternal Health Taskforce and Tribal Maternal Health Taskforce. | Lead regular Maternal Health Taskforce and Tribal Maternal Health Taskforce meetings to collaborate with statewide partners to reduce severe maternal morbidity and maternal fatalities.<br><br>Implement the Alliance for Innovation in Maternal Health safety bundles related to mental health and perinatal substance use in birthing facilities.<br><br>Increase statewide awareness (individuals, families, providers, facilities, systems, and communities) of maternal health risk factors through awareness campaigns and education.<br><br>Improve maternal mental health status via stakeholder engagement and training. | ESM MHS.1 - Percent of Birth Hospitals Implementing Mental Health and Perinatal Substance Use Patient Safety Bundles | NPM - Postpartum Mental Health Screening | **Linked NOMs:**<br>Maternal Mortality<br>Infant Mortality<br>SUID Mortality<br>Neonatal Abstinence Syndrome<br>Child Injury Hospitalization<br>Women's Health Status<br>Postpartum Depression<br>Postpartum Anxiety |
| Support women's wellbeing by expanding | By 2030, increase the percentage of pregnant individuals in Arizona who receive a preventive dental visit during pregnancy by 5% | Provide professional development to dental and OBGYNs on the importance of perinatal oral health, including evidence-based guidance on preventive dental care during pregnancy. | ***Inactive -*** *ESM PDV-Pregnancy.1 - Number of medical, dental, and other healthcare* | NPM - Preventive Dental Visit - Pregnancy | **Linked NOMs:**<br>Women's Health Status<br>Children's Health Status |

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| mental health resources and removing barriers to respectful preventive, maternity, and postpartum care. | through provider training, referral strengthening, and public awareness efforts coordinated through MCH partnerships. | Collaborate with public health partners and health professional associations to reduce myths, promote integrated care, and support referrals between medical and dental providers. | *professionals who receive perinatal oral health education.*<br>ESM PDV-Pregnancy.2 - Number of Dental and OB Providers Trained in Perinatal Oral Health | | |
| **Perinatal/Infant Health** | | | | | |
| Support healthy infant development by strengthening early identification and intervention systems and linking families to needed care. | By 2030, increase the percentage of very low birth weight (VLBW) infants born at Level III or higher NICUs in Arizona by 4%, by strengthening prenatal home visiting enrollment for high-risk pregnancies and expanding utilization of the High Risk Perinatal Program's Consultation Line to improve maternal transport and coordination of care. | Promote prenatal enrollment of agency administered home visiting models to support positive parenting and child development.<br><br>Strengthen and expand the High Risk Perinatal Program's Consultation Line. The service coordinates medical consultations and transport for high-risk pregnant women and neonates. | ESM RAC.1 - Percentage of Very Low Birthweight (VLBW) Births Originating at Level I/II Hospitals that are Delivered at Level III+ NICUs via Maternal Transport | NPM - Risk-Appropriate Perinatal Care | **Linked NOMs:**<br>Stillbirth<br>Perinatal Mortality<br>Infant Mortality<br>Neonatal Mortality<br>Postneonatal Mortality<br>Preterm-Related Mortality |
| Support healthy infant development by strengthening early identification and intervention systems and linking families to needed care. | By 2030, reduce safe sleep–related infant deaths in Arizona by 15% through culturally responsive education, resource distribution, and strengthened partnerships with birthing facilities, tribal communities, and home visiting programs to promote safe sleep practices statewide. | Distribute Safe Sleep Baby Crib Cards with education across all birthing facilities.<br><br>Continue to maintain safe sleep campaign to increase awareness of safe sleep practices among families with infants to address SUID-related deaths<br><br>Procure and distribute pack n' plays and sleep sacks with safe sleep education to families across the state.<br><br>Partner with the local Indian Health Service areas and tribal communities to distribute pack n' plays and safe sleep education.<br><br>Fund and coordinate Indigenous doula training through the Maternal Health Innovation Program including safe sleep and cradleboard teachings. | ***Inactive -*** *ESM SS.1 - Number of caregivers who receive safe sleep training and a pack 'n' play or a sleep sack*<br>***Inactive -*** *ESM SS.2 - Percentage of hospitals that are distributing the ABCs of Safe Sleep crib cards to their patient population.*<br>ESM SS.3 - Percent of Caregivers Reporting Use of | NPM - Safe Sleep | **Linked NOMs:**<br>Infant Mortality<br>Postneonatal Mortality<br>SUID Mortality |

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| | | Increase awareness and use of the Strong Families AZ Helpline to provide information and connect pregnant people and families with children to available resources and services, including home visiting services, that will improve maternal and child health outcomes.<br><br>Promote prenatal enrollment of ADHS administered home visiting models to support positive parenting and child development. | Distributed Safe Sleep Materials | | |
| **Child Health** | | | | | |
| Support children's social, emotional, and developmental growth by advancing public health strategies for digital safety, early identification of needs, and behavioral health promotion. | By 2030, improve child oral health status in Arizona by 10% by continuing school-based dental sealant programs in high-risk schools, strengthening connections to oral health through home visiting services, and expanding dental workforce development. | Continue the school-based dental sealant program for high-risk children in eligible public and charter schools throughout Arizona<br><br>Continue to promote Strong Families AZ, Arizona's home visiting alliance supporting home visiting as a key link to early childhood intervention, community supports such as health care, mental and oral health, early care and education and services that promote child development and healthy child parent interaction.<br><br>Outreach to medical and dental schools, clinical professional schools, and professional organizations to promote recruitment and retention of providers in underserved communities.<br><br>Explore dental workforce development initiatives by expanding access to the State Loan Repayment Program, establishing dental preceptor and mentorship opportunities, and supporting dental provider recruitment and retention programs to increase access to preventive oral health services in underserved communities. | ESM PDV-Child.1 - Percent of Urgent Dental Cases Referred for Treatment<br>ESM PDV-Child.2 - Percent of Eligible Children Receiving School-Based Dental Services | NPM - Preventive Dental Visit - Child | **Linked NOMs:**<br>Tooth decay or cavities<br>Children's Health Status<br>CSHCN Systems of Care |
| Support children's social, emotional, and developmental growth by advancing public health strategies for digital safety, | By 2030, increase the percentage of children in Arizona with a personal doctor or nurse by 10% by engaging families and stakeholders in designing medical home strategies, promoting provider recruitment and retention in underserved areas, and implementing the Family Connects nurse home visiting model in | Engage community stakeholders and families with lived experience to design an approach that supports expanding the use of medical home models throughout the state.<br><br>Outreach to medical and dental schools, clinical professional schools, and professional organizations to promote recruitment and retention of providers in underserved communities.<br><br>Implement the Family Connects universal nurse home visiting model at participating birthing hospitals to ensure that all families receive a | ESM MH.1 - Implementation of Medical Home Model Activities in Arizona<br>ESM MH_PDOC.1 - Percent of Hospital Births Enrolled in Family Connects | NPM - Medical Home; Medical Home_Personal Doctor | **Linked NOMs:**<br>Children's Health Status<br>CSHCN Systems of Care<br>Flourishing - Young Child<br>Flourishing - Child Adolescent - CSHCN<br>Flourishing - Child Adolescent - All |

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| early identification of needs, and behavioral health promotion. | birthing hospitals. | postpartum nurse home visit within the first few weeks after birth. | | | |
| **Adolescent Health** | | | | | |
| Expand youth-centered programs that support mental health, digital well-being, and access to age-appropriate health education to achieve their full health potential. | By 2030, increase the percentage of adolescents in Arizona who receive needed mental health treatment or counseling by 5% through statewide Youth Mental Health First Aid training of health educators, enhanced school-based outreach, and the development of a youth-driven digital resource hub that connects adolescents to mental health education and care. | Train and certify youth program health educators in all 15 counties across the state in Youth Mental Health First Aid and fund county health departments and CBOs to provide training to youth serving organizations in their communities.<br><br>Collaborate with the Office of Oral Health to identify the best methods for promoting preventive medical and mental health visits for adolescents in eligible middle schools.<br><br>Develop a youth mental health resources website created by young people and stakeholders. | ESM MHT.1 - Number of Youth Served by Youth Mental Health First Aid Trained Organizations<br>ESM MHT.2 - Percent of Youth Mental Health First Aid (YMHFA) Trained Adults Reporting High Knowledge of Youth Mental Health | NPM - Mental Health Treatment | **Linked NOMs:**<br>Adolescent Mortality<br>Adolescent Suicide<br>Adolescent Firearm Death<br>Adolescent Injury Hospitalization<br>Children's Health Status<br>Adolescent Depression/Anxiety<br>CSHCN Systems of Care<br>Flourishing - Child Adolescent - CSHCN<br>Flourishing - Child Adolescent - All |
| Expand youth-centered programs that support mental health, digital well-being, and access to age-appropriate health education to achieve their full health potential. | By 2030, reduce the percentage of adolescents in Arizona who report being bullied or bullying others by 4% through promotion of the “Must Stop Bullying” campaign in school and community settings, and by partnering with local health departments to deliver annual training on social emotional learning and bullying prevention to youth and educators statewide. | Promote the “Must Stop Bullying” campaign in school and community settings.<br><br>Partner with local health departments to provide training to youth and educators training on social emotional learning and bullying prevention. | ***Inactive -*** *ESM BLY.1 - Total number of youth served by an organization trained on mental health first aid for youth.*<br>***Inactive -*** *ESM BLY.2 - Percentage of Youth Mental Health First Aid trained adults that report being very knowledgable on recognizing the signs or symptoms of mental health or substance use challenges that* | NPM - Bullying | **Linked NOMs:**<br>Adolescent Mortality<br>Adolescent Suicide<br>Adolescent Firearm Death<br>Adolescent Injury Hospitalization<br>Adolescent Depression/Anxiety<br>Adverse Childhood Experiences |

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| | | | *may impact youth.*<br>ESM BLY.3 - Number of Youth and Educators Trained on Bullying Prevention and Social Emotional Learning (SEL) | | |
| **Children with Special Health Care Needs** | | | | | |
| Support families of Children and Youth with Special Healthcare Needs through accessible resources, caregiver and family-centered wellness programs, and streamlined care systems. | By 2030, increase the percentage of families of children and youth with special health care needs (CYSHCN) who report receiving effective care coordination by 10%, through the implementation of medical home models developed by the C-SALT collaborative, CHN training on Family Service Plans, distribution of health care organizers, and targeted technical assistance to local health departments. | Engage community stakeholders and families with lived experience through the CYSHCN State Alliance Leadership Team (C-SALT) to design an approach that supports expanding the use of medical home models throughout the state.<br><br>Provide technical assistance to local county health departments to strengthen maternal and child health activities implemented through the MCH Healthy Arizona Families Intergovernmental Agreement.<br><br>Strengthen care coordination for families with high-risk infants by training Community Health Nurses (CHNs) of the High Risk Perinatal Program (HRPP) on the Family Service Plan model and supporting consistent implementation of the plans statewide.<br><br>Develop and distribute a customized health care organizer to families of children and youth with special health care needs (CYSHCN) to support care coordination, empower families to manage complex medical information, and enhance communication across providers, schools, and service systems. | ESM MH.1 - Implementation of Medical Home Model Activities in Arizona<br>ESM MH_CC.1 - Percent of High Risk Perinatal Program (HRPP) Community Health Nurses (CHNs) Trained in the Family Service Plan<br>ESM MH_CC.2 - Percent of High-Risk Families in the High Risk Perinatal Program (HRPP) with a Documented Family Service Plan<br>ESM MH_CC.3 - Cumulative Number of Memorandums of Understandings (MOUs) Enacted by CYSHCN State Alliance Leadership Team (C-SALT) Organizations | NPM - Medical Home; Medical Home_Care Coordination | **Linked NOMs:**<br>Children's Health Status<br>CSHCN Systems of Care<br>Flourishing - Young Child<br>Flourishing - Child Adolescent - CSHCN<br>Flourishing - Child Adolescent - All |
| Support | By 2030, increase the percentage | Collaborate and support efforts with the Transition Care Network to develop | ***Inactive -*** *ESM* | NPM - Transition To Adult | **Linked NOMs:** |

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| families of Children and Youth with Special Healthcare Needs through accessible resources, caregiver and family-centered wellness programs, and streamlined care systems. | of adolescents with special health care needs (CYSHCN), ages 12 through 17, who report receiving services to prepare for the transition to adult health care by 6%, by expanding cross-sector collaboration through the Transition Care Network, supporting youth-focused transition conferences, providing technical assistance to local health departments, and equipping families with customized health care organizers. | family, provider, and system capacity to improve the transition of CYSHCN to a more inclusive and comprehensive adult system of care.<br><br>Support the annual transition conference for special education students in partnership with the Arizona Department of Education.<br><br>Provide technical assistance to local county health departments to strengthen maternal and child health (MCH) activities implemented through the MCH Healthy Arizona Families Intergovernmental Agreement<br><br>Develop and distribute a customized health care organizer to families of children and youth with special health care needs (CYSHCN) to support care coordination, empower families to manage complex medical information, and enhance communication across providers, schools, and service systems. | *TAHC.1 - Number of practitioners who have ever enrolled in Got Transition modules.*<br>***Inactive -*** *ESM TAHC.2 - Percentage of practitioners who have completed the full course of 8 Got Transition modules within 15 months of course initiation.*<br>ESM TAHC.3 - Percent of Scholarship Recipients Reporting Transition Readiness After the IDEA Conference | Health Care | CSHCN Systems of Care |
| **Cross-Cutting/Systems Building** | | | | | |
| Advance strong systems that connect families to comprehensive, coordinated care across MCH populations. | By 2030, increase the number of providers participating in Arizona's provider incentive programs by 15% to improve access to primary and behavioral health services in underserved communities across the state. | Continue implementation of the State Loan Repayment Program (SLRP) and J-1 Visa Waiver Program to recruit and retain primary care providers in underserved areas of Arizona.<br><br>Promote outreach to medical schools and professional associations to expand awareness and participation in provider incentive programs.<br><br>Enhance recruitment and retention of behavioral health providers through targeted loan repayment programs (e.g., Behavioral Health Loan Repayment Program), workforce development initiatives, and collaboration with universities and behavioral health training programs to expand service availability in rural and high-need areas. | SPM ESM 1.1 - Number of Behavioral Health Providers Enrolled Annually in the State Loan Repayment Program (SLRP) and Behavioral Loan Repayment Program (BLRP).<br>SPM ESM 1.2 - Number of Primary Care Providers Enrolled in the J-1 Visa Waiver Program or the Student Loan | SPM 1: Percent of Primary Care Areas with Ideal Provider-to-Population Ratios | |

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| | | | Repayment Program (SLRP) | | |
| Promote healthy development and well-being for all Arizona families by building community-rooted supports, strengthening interventions, and investing in sustainable public health systems. | By 2030, increase the proportion of Arizona families reporting high levels of family resilience by 10% by engaging and strengthening community-rooted supports through technical assistance, infrastructure support, and investment in programs across counties. | Engage and strengthen local community networks that promote family well-being by investing in programs such as home visiting, community health workers, peer-led supports, and family advisors. These networks foster trust, empower families, and provide a foundation for navigating adversity.<br><br>Provide technical assistance to local county health departments through the Healthy Arizona Families IGA to implement cross-cutting MCH strategies that strengthen family resilience and MCH.<br><br>Provide technical assistance and data infrastructure support to ensure MCH programs are integrated across sectors and areas, with a focus on sustainability, shared measurement, and community partnership engagement. | SPM ESM 2.1 - Percent of Counties Implementing MCH Activities via Healthy Arizona Families Intergovernmental Agreements | SPM 2: Percent of Children Living in Families who Demonstrate Qualities of Resilience During Difficult Times. | |