Arizona State Action Plan Table 2024 Application/2022 Annual Report

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
Women/Maternal Health					
Reduce and eliminate barriers to ensure equitable and optimal health for women.	Collaborate with the Arizona Department of Health's Office of Epidemiology and Disease Control to promote prevention, screening, and treatment of STIs/STDs to support women's health before, during, and after pregnancy. Support workforce and workforce capacity that serve pregnant and postpartum women in Arizona. Support the Preconception Health Alliance to promote behaviors that contribute to positive preconception health across the life span. Utilize information helplines and partner with WIC, home visitors, and community health workers to encourage and promote well women visits in between pregnancies. Promote the sliding fee scale sites (including FQHCs) to individuals and communities. Promote women's health preventive services through the Healthy Arizona Worksite Program. Expand the prenatal telemedicine program to additional underserved communities. Fund and promote strategies to increase awareness and address barriers to accessing Title V funded Family Planning services to women with limited financial resources in urban and rural communities.	By 2025, Arizona will increase the percentage of women ages 18 to 44 with a preventive medical visit in the past year by 4.0%.	NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	***Inactive -*** *ESM 1.1: Number of agencies participating in the Preconception Health Alliance.* ***Inactive -*** *ESM 1.2: Number of activities conducted by the Preconception Health Alliance* ESM 1.3: Percent of family planning clinics that have LARCs available ***Inactive -*** *ESM 1.4: Percent of women who participated in the Arizona Pregnancy Risk Assessment Monitoring System.* ***Inactive -*** *ESM 1.5: Percent of Family Planning Summit attendees who report a practice change after the summit.*	NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations NOM 3: Maternal mortality rate per 100,000 live births NOM 4: Percent of low birth weight deliveries (<2,500 grams) NOM 5: Percent of preterm births (<37 weeks) NOM 6: Percent of early term births (37, 38 weeks) NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.4: Preterm-related mortality rate per 100,000 live births

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				Inactive - *ESM 1.6: Rate of severe maternal morbidity associated with hypertensive disorders of pregnancy in AIM participating hospitals.* ESM 1.7: Percent of live births that occur in an AIM-participating birthing facility. ***Inactive -*** *ESM 1.8: Number of individuals trained to become community-based doulas* ***Inactive -*** *ESM 1.9: Percent of mothers enrolled in home visiting programs who received a postpartum visit with a healthcare provider within 60 days of delivery* ***Inactive -*** *ESM 1.10: The number of times home visitors access a maternal mental health consult for their clients.*	NOM 10: Percent of women who drink alcohol in the last 3 months of pregnancy NOM 11: Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females NOM 24: Percent of women who experience postpartum depressive symptoms following a recent live birth

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				Inactive - *ESM 1.11: Implement action steps to develop a community health worker reimbursement pilot program among primary care providers (e.g. community health centers), tribes, and insurance payers.* ***Inactive -*** *ESM 1.12: Percent of family planning clinics that expanded (hours or sites) family planning services* ESM 1.13: Number of unique clients served (yearly total) through local county health departments' Title V-funded family planning and reproductive health programs.	
Reduce disparities in infant and maternal morbidity and mortality.	Lead regular Maternal Health Taskforce and Tribal Maternal Health Taskforce meetings to collaborate with statewide partners to reduce severe maternal morbidity and maternal fatalities. Continue to support prevention efforts related to the Maternal Mortality and Child Fatality Review Committees. Continue to implement the Alliance for Innovation in Maternal Health safety bundles in birthing facilities. Engage partners in a statewide Maternal and Infant Mortality Summit.	By 2025, Arizona will reduce the disparity gap for maternal and infant mortality in underserved communities by 5% across all impacted groups.	NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	***Inactive -*** *ESM 1.1: Number of agencies participating in the Preconception Health Alliance.* ***Inactive -*** *ESM 1.2: Number of activities conducted by the Preconception Health Alliance*	NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations NOM 3: Maternal mortality rate per 100,000 live births NOM 4: Percent of low birth weight deliveries (<2,500 grams) NOM 5: Percent of preterm births

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	Increase statewide awareness (individuals, families, providers, facilities, systems, and communities) of maternal health risk factors through awareness campaigns and education. Partner with the Navajo Nation, Inter Tribal Council of Arizona (ITCA), and other maternal health partners to develop and implement innovative initiatives to improve maternal and infant health status in underserved communities. Support birth defects surveillance, prevention, and intervention efforts. Support training for maternal health and family wellness from an indigenous perspective in tribal and urban native communities. Improve maternal mental health status via stakeholder engagement and training. Sustain the statewide Count-the-Kicks campaign in AZ, including training, to decrease stillbirth rates in the state.			ESM 1.3: Percent of family planning clinics that have LARCs available ***Inactive -*** *ESM 1.4: Percent of women who participated in the Arizona Pregnancy Risk Assessment Monitoring System.* ***Inactive -*** *ESM 1.5: Percent of Family Planning Summit attendees who report a practice change after the summit.* ***Inactive -*** *ESM 1.6: Rate of severe maternal morbidity associated with hypertensive disorders of pregnancy in AIM participating hospitals.* ESM 1.7: Percent of live births that occur in an AIM-participating birthing facility. ***Inactive -*** *ESM 1.8:*	(<37 weeks) NOM 6: Percent of early term births (37, 38 weeks) NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.4: Preterm-related mortality rate per 100,000 live births NOM 10: Percent of women who drink alcohol in the last 3 months of pregnancy NOM 11: Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females NOM 24: Percent of women who experience postpartum depressive symptoms following a recent live birth

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				Number of individuals trained to become community-based doulas ***Inactive -*** *ESM 1.9: Percent of mothers enrolled in home visiting programs who received a postpartum visit with a healthcare provider within 60 days of delivery* ***Inactive -*** *ESM 1.10: The number of times home visitors access a maternal mental health consult for their clients.* ***Inactive -*** *ESM 1.11: Implement action steps to develop a community health worker reimbursement pilot program among primary care providers (e.g. community health centers), tribes, and insurance payers.* ***Inactive -*** *ESM 1.12: Percent of family planning clinics that expanded (hours or sites) family planning*	

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				services ESM 1.13: Number of unique clients served (yearly total) through local county health departments' Title V-funded family planning and reproductive health programs.	
Reduce and eliminate barriers to ensure equitable and optimal health for women.	Identify partnerships to better coordinate dental services for pregnant women. Provide continuing education opportunities for home visitors on oral health anticipatory guidance for pregnant women. Provide professional development for dental providers on evidence based curricula for pregnant women. Implement the Maternal and Early Childhood Sustained Home-Visiting (MECSH) with the Oral Health Module in identified at risk communities throughout the state.	By 2025, Arizona will increase the percentage of women who had a preventive dental visit during pregnancy by 6%.	NPM 13.1: Percent of women who had a preventive dental visit during pregnancy	***Inactive -*** *ESM 13.1.1: Number of inter agency partnerships implemented to coordinate dental services for pregnant women and children.* ESM 13.1.2: Number of medical, dental, and other healthcare professionals who receive perinatal oral health education.	NOM 14: Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 19: Percent of children, ages 0 through 17, in excellent or very good health
Perinatal/Infant Health					
Promote equitable and optimal care and protective factors for mothers and infants before, during, and after pregnancy.	Provide continued education and training on the use of sudden unexpected infant death doll reenactments to law enforcement and providers. The Safe Sleep Task Force will continue to convene partners to address improvements that prevent and reduce infant deaths through collaborative learning, quality improvement and innovation. Distribute Safe Sleep Baby Crib Cards with education across all birthing facilities. Support hospitals in establishing safe sleep policies in their facilities.	By 2025, Arizona will increase the percent of infants placed to sleep on their backs by 15%. By 2025, Arizona will increase the percent of infants that sleep on a separate approved sleep surface by 16%. By 2025, Arizona will increase the percentage of infants placed to	NPM 5: A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding	***Inactive -*** *ESM 5.1: Number of safe sleep-related activities that are implemented by local county health departments.* ***Inactive -*** *ESM 5.2: Number of digital impressions of the safe sleep media*	NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.5: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

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	Support local county health department Safe Sleep initiatives through the Healthy Arizona Families Intergovernmental Agreement. Continue to maintain safe sleep campaign to increase awareness of safe sleep practices among families with infants to address SUID-related deaths. Procure and distribute pack n' plays and sleep sacks with safe sleep education to families across the state. Fund and coordinate Indigenous doula training through the Maternal Health Innovation Program including SUID prevention and cradleboard teachings. Partner with IHS and tribal communities to distribute pack n' plays and safe sleep education. Implement the Maternal Early Childhood Sustained Home Visiting Program (MeSCH) in identified at-risk communities providing the safe sleep module.	sleep without soft objects or loose bedding by 15%.		*campaign.* ESM 5.3: Number of caregivers who receive safe sleep training and a pack 'n' play or a sleep sack ***Inactive -*** *ESM 5.4: Percent of at-risk communities with a safe sleep campaign outdoor media presence.* ***Inactive -*** *ESM 5.5: Number of ABCs of Sleep Crib Cards distributed.* ESM 5.6: Percentage of hospitals that are distributing the ABCs of Safe Sleep crib cards to their patient population.	
Promote equitable and optimal care and protective factors for mothers and infants before, during, and after pregnancy.	Coordinate with internal partners within ADHS' Bureau of Nutrition and Physical Activity (BNPA) to ensure appropriate nutrition for pregnant people (e.g., WIC Program, EmpowerMeA2Z folic acid supplements) and infants (WIC Program, breastfeeding support and policies). Partner with BNPA to support education and distribute Make it Work Breastfeeding Toolkit. Promote the Power Me A2Z and Folic Acid resources in county health departments Support partnership between HRPP and Newborn Screening program to	By 2025, Arizona will increase the percentage of infants who are ever breastfed to 92%. By 2025, Arizona will increase the percentage of infants who are breastfed exclusively for 6 months to 27%.	NPM 4: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	ESM 4.1: Number of home visitors who receive lactation counseling or breastfeeding support training. ***Inactive -*** *ESM 4.2: Percent of home visitors trained on lactation counseling or breastfeeding*	NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.5: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

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	connect families with community health nursing to support families with managing care for newly diagnosed children. BNPA will continue to provide lactation webinars, partnership meetings and training (LATCH-AZ) to support WIC staff, peer counselors, home visitors, and other community partners. 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. Support breastfeeding initiatives through training and certification of home visitors and health professionals, technical assistance, policy and procedures, and direct support services. Launch a fetal-infant mortality action plan to support statewide partners. Promote prenatal enrollment of ADHS administered home visiting models to support positive parenting and child development. Convene ADHS programs that provide information, resources, and/or services to the population of pregnant people, families with young children, adolescents, and children and youth with special health care needs to expand knowledge and awareness of internal resources available and collaborate on outreach efforts to reduce gaps and improve efficiency.			*support training who report an increase in knowledge and skill around breastfeeding best practices.* ***Inactive -*** *ESM 4.3: Number of local county health departments working on strategies to promote breastfeeding through the Title V-funded MCH Healthy Arizona Families IGA* ESM 4.4: Number of calls to the breastfeeding helpline	
Child Health					
Strengthen emotional, physical, and social services to achieve an equitable and optimal development for children.	Provide ongoing professional development among ADHS funded home visiting programs to complete the ASQ to ensure families follow through on the referral. Provide support and ongoing professional development for home visitors trained in a developmental screening tool to ensure timely completion, referral and follow through. Develop and finalize the classroom component of the hearing screening curriculum to be available as a computer based training.	By 2025, 1 out of every 3 children, ages 9 through 35 months, will have received a developmental screening using a parent-completed screening tool in the past year in Arizona.	NPM 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	***Inactive -*** *ESM 6.1: Proportion of new home visitors trained to provide ASQ within 6 months of hire.* ESM 6.2: Percentage of children receiving an ASQ within 1 year of program	NOM 13: Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) NOM 19: Percent of children, ages 0 through 17, in excellent or very good health

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				enrollment. ESM 6.3: Percent of children enrolled in home visiting who received a referral for developmental services and have a complete referral. ***Inactive -*** *ESM 6.4: Number of providers that receive developmental screening training.* ***Inactive -*** *ESM 6.5: Percent of providers that receive developmental screening training who report initiating developmental screenings with parents in their practices.*	
Strengthen emotional, physical, and social services to achieve an equitable and optimal development for children.	Provide funding to support Injury Prevention resources and activities (e.g. motor vehicle, safe sleep, injury prevention coalition, Safe Kids Coalition, etc.) to reduce injury hospitalization and deaths due to injury/accidents. Provide car seat safety education and distribute car seats to reduce motor vehicle/traffic injuries and fatalities. Fund the local county health departments to implement injury prevention strategies through the MCH Healthy Arizona Families IGA. Fund the Arizona American Academy of Pediatrics (AzAAP) to provide support to critical access and tribal hospitals to develop their pediatric	By 2025, Arizona will reduce the rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9 by 7%.	NPM 7.1: Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9	***Inactive -*** *ESM 7.1.1: Number of injury prevention activities done by local county health departments specific for children ages 0 through 9* ESM 7.1.2: Number of car seats and home safety kits distributed with caregiver	NOM 15: Child Mortality rate, ages 1 through 9, per 100,000 NOM 16.1: Adolescent mortality rate ages 10 through 19, per 100,000 NOM 16.2: Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 NOM 16.3: Adolescent suicide

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	emergency readiness needs and engage existing Pediatric Prepared Emergency Care member health care providers to continue to develop their capacity to stabilize and manage pediatric emergencies. Continue to engage with ADHS's Pediatric Advisory Council for Emergency Services (PACES) to ensure that Emergency Medical Services are prepared to serve children and CYSHCN. Partner with the Bureau of Nutrition and Physical Activity (BNPA) on initiatives that support the health and wellness of children (e.g., Empower, WIC Program). The Arizona Partnership for Immunization (TAPI) will distribute educational pieces to schools, child care facilities, private providers, county health departments, community health centers, managed care organizations and Women, Infants, and Children (WIC) Program sites. Share statewide AZ TAPI Immunization efforts with providers and partners.			education. ***Inactive -*** *ESM 7.1.3: Percent of local county health departments that have at least one staff trained in safe car seat installation and use.*	rate, ages 15 through 19, per 100,000
Strengthen emotional, physical, and social services to achieve an equitable and optimal development for children.	Identify partnerships to better coordinate dental services for pregnant women and children. Continue the school-based dental sealant program for high-risk children in eligible public and charter schools throughout Arizona Partner with AT Still University, School of Dentistry and Oral Health to implement the sealant program in under served schools. Implement the oral health study in Arizona's public schools.	By 2025, 4 out of every 5 children ages 1 through 17, will have a preventive dental visit in Arizona.	NPM 13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	ESM 13.2.1: Proportion of urgent dental cases identified in the sealant program referred for treatment. ***Inactive -*** *ESM 13.2.2: Proportion of early dental cases identified in the sealant program referred for treatment.* ESM 13.2.3: Percent of children who participate in the School-based dental program	NOM 14: Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 19: Percent of children, ages 0 through 17, in excellent or very good health
Strengthen	Partner with MIECHV to enhance the Children's Information Helpline to	By 2025, 2 out of every 3 children,	NPM 15: Percent of	ESM 15.1: The	NOM 17.2: Percent of children with

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emotional, physical, and social services to achieve an equitable and optimal development for children.	include a state-wide referral for home visitation programs while continuing to provide information and assistance to pregnant women and children. Partner with the Bureau of Nutrition and Physical Activity (BNPA) on initiatives that support the health and wellness of children (e.g., Empower, WIC Program). Leverage existing partnerships and resources to support child/family care for communities in need Create and provide resources that improve awareness of, and address, the impact of social isolation and loneliness on family health and building social connections. 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 health, early care and education and services that promote child development and healthy child-parent interaction. Increase community awareness on available tax resources (i.e. tax credits such as the Child Care Credit, Child Tax Credit) and other resources established to address poverty and social inequity.	ages 0 through 17 will be continuously and adequately insured.	children, ages 0 through 17, who are continuously and adequately insured	number of state loan repayment program registered sites that offer assistance with insurance applications. ***Inactive -*** *ESM 15.2: Percent of Title V staff and contractors that receive education on insurance coverage options for children and pregnant women.* ***Inactive -*** *ESM 15.3: Number of learning opportunities for external maternal and child health partners on insurance coverage for children and pregnant women.* ***Inactive -*** *ESM 15.4: Percentage of adults that have access to a personal care provider.*	special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling NOM 19: Percent of children, ages 0 through 17, in excellent or very good health NOM 22.1: Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months NOM 22.2: Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza NOM 22.3: Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine NOM 22.4: Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine NOM 22.5: Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

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					NOM 25: Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year
Reduce disparities in infant and maternal morbidity and mortality.	Continue to implement nurse workforce programs, Behavioral Health Provider Loan Repayment, the State Loan Repayment Program and preceptor programs. Partner with stakeholders to provide opportunities telehealth and telemedicine statewide Improve data collection efforts to evaluate service impact by the State Loan Repayment Program. Fund and coordinate continuing education opportunities for workforce program participants on topics of interest to Arizona's Title V program, such as social determinants of health, implicit bias, culturally and linguistically appropriate care, adolescent health, etc . Outreach to medical and dental schools, clinical professional schools, and professional organizations to promote recruitment and retention of providers in underserved communities. Provide internship rotations throughout BWCH to develop the public health workforce. Leverage existing partnerships to diversify MCH workforce. Collaborate with partners and family advisors to discuss shortage of providers, including oral health providers and specialists, that serve CYSHCN and their families and identify potential strategies.	By 2025, Arizona will increase the number of healthcare providers in underserved communities by 5%. By 2025, Arizona will increase the number of data points collected by the SLRP to understand the impact of the program in underserved communities.	NPM 15: Percent of children, ages 0 through 17, who are continuously and adequately insured	ESM 15.1: The number of state loan repayment program registered sites that offer assistance with insurance applications. ***Inactive -*** *ESM 15.2: Percent of Title V staff and contractors that receive education on insurance coverage options for children and pregnant women.* ***Inactive -*** *ESM 15.3: Number of learning opportunities for external maternal and child health partners on insurance coverage for children and pregnant women.* ***Inactive -*** *ESM 15.4: Percentage of adults that have access to a personal care provider.*	NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling NOM 19: Percent of children, ages 0 through 17, in excellent or very good health NOM 22.1: Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months NOM 22.2: Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza NOM 22.3: Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine NOM 22.4: Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

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					NOM 22.5: Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine NOM 25: Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year
Adolescent Health					
Enhance equitable and optimal initiatives that positively impact the emotional, physical, and social wellbeing of adolescents.	Promote the “Must Stop Bullying” campaign in school and community settings Promote adolescent mental health to prevent and mitigate impact of bullying, reduce adolescent suicide and depression and reduce adolescent risky behaviors. Lead the Bullying Prevention Stakeholder Workgroup (a multi agency workgroup). 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. Establish diverse youth advisory groups across the state (substance use, mental health, bullying, oral health, sexual reproductive health) to engage youth, 11-19 years of age in program development. Create a monthly podcast centered around adolescent health wellness	By 2025, Arizona will decrease the percentage of adolescents, ages 12 through 17, who are bullied or who bully others by 9%.	NPM 9: Percent of adolescents, ages 12 through 17, who are bullied or who bully others	***Inactive -*** *ESM 9.1: Number of school professionals who receive technical assistance on bullying prevention.* ***Inactive -*** *ESM 9.2: Number of schools implementing bullying prevention guidance.* ***Inactive -*** *ESM 9.3: Number of unique pageviews in the must stop bullying campaign website.* ***Inactive -*** *ESM 9.4: Number of unique pageviews to the child page of the must stop bullying campaign website.* ESM 9.5: Total	NOM 16.1: Adolescent mortality rate ages 10 through 19, per 100,000 NOM 16.3: Adolescent suicide rate, ages 15 through 19, per 100,000

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				number of youth served by an organization trained on mental health first aid for youth. ESM 9.6: 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 may impact youth.	
Strengthen emotional, physical, and social services to achieve an equitable and optimal development for children.	Implement the University of Michigan's Adolescent Champion Model to drive health centers to become adolescent-centered medical homes. Collaborate with the Office of Oral Health to identify the best methods for promoting preventive medical and mental health visits for adolescents during regularly scheduled dental visits. Collaborate with the Adolescent Health Alliance to partner with professional medical and youth-serving organizations and federally qualified health centers to promote preventive medical visits. Partner with TAPI to support oral health providers in promoting the HPV vaccine for adolescents and women. Fund and pilot a youth-centered, youth-adult partnerships project, AzRHAP, promoting sexual/reproductive health to youth to ensure adolescents/young adults have access to high-quality, medically- accurate sexual/reproductive health services.	By 2025, 3 out of every 4 adolescents, ages 12 through 17, will have a preventive medical visit in the past year.	NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.	ESM 10.1: Number of healthcare clinics implementing University of Michigan's Adolescent Champion Model at their sites. ESM 10.2: Percent of clinical sites that engage in continuous learning to maintain the adolescent champion model's high standards of practice. ESM 10.3: The proportion of adolescents and young adults 12-21	NOM 16.1: Adolescent mortality rate ages 10 through 19, per 100,000 NOM 16.2: Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 NOM 16.3: Adolescent suicide rate, ages 15 through 19, per 100,000 NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who

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				years of age who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner participating in the adolescent champion model during the measurement year ESM 10.4: Percent of adolescents in a participating adolescent champion model facility that report knowing how to contact their provider or the clinic if they have any questions or concerns. ***Inactive -*** *ESM 10.5: Number of youth advising state initiatives.* ***Inactive -*** *ESM 10.6: Number of continuing education opportunities for dental and medical providers to promote preventive medical visits and mental health for adolescents.*	receive treatment or counseling NOM 19: Percent of children, ages 0 through 17, in excellent or very good health NOM 20: Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) NOM 22.2: Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza NOM 22.3: Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine NOM 22.4: Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine NOM 22.5: Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females

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Enhance equitable and optimal initiatives that positively impact the emotional, physical, and social wellbeing of adolescents.	Provide funding to local county health departments to implement injury prevention activities with adolescents (e.g., safe driving programs and messages, mentorship to reduce injuries from violence crime and assault, and training on traumatic brain injury)	By 2025, Arizona will reduce the rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19, by 5%.	NPM 7.2: Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19	ESM 7.2.1: Number of injury prevention activities done by local county health departments specific to adolescents 10-19 years old.	NOM 15: Child Mortality rate, ages 1 through 9, per 100,000 NOM 16.1: Adolescent mortality rate ages 10 through 19, per 100,000 NOM 16.2: Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 NOM 16.3: Adolescent suicide rate, ages 15 through 19, per 100,000
Children with Special Health Care Needs					
Strengthen systems of care to advance inclusivity and promote equitable and optimal outcomes for children and youth with special healthcare needs.	Identify and convene an inter-agency group that focuses on CYSHCN services, transition resources, and supports to enhance state agency coordination, collaboration, and partnership. Work with facilities (including private practices, FQHCs, critical access hospitals [CAHs], specialty clinics, RHCs, etc.) serving children and youth with special healthcare needs (CYSHCN) to train providers in 'got transition' resources for establishing transition policies. Collaborate and support efforts with the Transition Care Network to develop family, provider, and system capacity to improve the transition of CYSHCN to a more inclusive and comprehensive adult system of care. Support the annual transition conference for special education students in partnership with the Arizona Department of Education. Partner and collaborate with several ADHS programs and other state agencies to support identification, screening, assessment and referral of CYSHCN to the care and services they need. Leverage existing partnerships with Phoenix Children's Hospital, Ryan House and Ronald McDonald Houses of Phoenix & Southern Arizona to	By 2025, Arizona will increase the percentage of adolescents with and without special health care needs, ages 12 through 17, who received transition to adult healthcare services by 11%.	NPM 12: Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care	***Inactive -*** *ESM 12.1: Number of families that received a resource from the CYSHCN program.* ESM 12.2: Number of pediatric providers registered for the GoT transition modules who already serve CYSHCN. ***Inactive -*** *ESM 12.3: Number of family advisors placed in Bureau of Women's and Children's Health administrative offices.* ***Inactive -*** *ESM 12.4: Percent of school-age*	NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

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	provide funding for gap-filling services that support families with sick children in their time of need. Support and expand pediatric emergency preparedness for CYSHCN across the state. Participate in the pediatric advisory council for emergency services. Provide technical assistance to local county health departments on how to incorporate diversity, equity, and inclusivity within the MCH activities they implement through the MCH HAF IGA. Develop and launch an online curriculum to increase the number of qualified screeners throughout the state. Place trained family advisors at all levels across the BWCH administrative offices to support MCH programming as key partners in health care decision-making. Engage partners and stakeholders to promote and participate in the Engaging Families and Young Adult Program to place trained family advisors across all sectors including leveraging the county MCH HAF IGA. Develop a training and onboarding process for office/programs to ensure they are ready to engage with placed family and young adult advisors.			*children who receive a hearing screening.* ***Inactive -*** *ESM 12.5: Percent of Arizona schools that complete their hearing screens by the assigned due date.* ***Inactive -*** *ESM 12.6: Number of providers receiving GoT transition training resources.* ESM 12.7: The percentage of providers who complete the GoT transition modules.	
Engage individuals, families, and communities as partners in the development and implementation of programs and policies to create people-	Place trained family advisors at all levels across the BWCH administrative offices to support MCH programming as key partners in health care decision-making. Engage partners and stakeholders to promote and participate in the Engaging Families and Young Adult Program to place trained family advisors across all sectors.	By 2025, Arizona will establish family and youth advisors in all of the Bureau of Women's and Children's Health programming offices.	NPM 12: Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care	***Inactive -*** *ESM 12.1: Number of families that received a resource from the CYSHCN program.* ESM 12.2: Number of pediatric providers registered for the GoT transition modules who already serve CYSHCN.	NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
centered programs that promote health equity				***Inactive -*** *ESM 12.3: Number of family advisors placed in Bureau of Women's and Children's Health administrative offices.* ***Inactive -*** *ESM 12.4: Percent of school-age children who receive a hearing screening.* ***Inactive -*** *ESM 12.5: Percent of Arizona schools that complete their hearing screens by the assigned due date.* ***Inactive -*** *ESM 12.6: Number of providers receiving GoT transition training resources.* ESM 12.7: The percentage of providers who complete the GoT transition modules.	