Arizona State Action Plan Table 2025 Application/2023 Annual Report

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Women/Maternal Health					
Reduce and eliminate barriers to ensure equitable and optimal health for women.	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%.	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. 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.	***Inactive -*** *ESM WWV.1 - Number of agencies participating in the Preconception Health Alliance.* ***Inactive -*** *ESM WWV.2 - Number of activities conducted by the Preconception Health Alliance* ESM WWV.3 - Percent of family planning clinics that have LARCs available ***Inactive -*** *ESM WWV.4 - Percent of women who participated in the Arizona Pregnancy Risk Assessment Monitoring System.* ***Inactive -*** *ESM WWV.5 - Percent of Family Planning Summit attendees who report a practice change after the*	NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV	NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

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			summit. ***Inactive -*** *ESM WWV.6 - Rate of severe maternal morbidity associated with hypertensive disorders of pregnancy in AIM participating hospitals.* ESM WWV.7 - Percent of live births that occur in an AIM-participating birthing facility. ***Inactive -*** *ESM WWV.8 - Number of individuals trained to become community-based doulas* ***Inactive -*** *ESM WWV.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 WWV.10 - The number of times home visitors access a*		NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression,

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			maternal mental health consult for their clients. ***Inactive -*** *ESM WWV.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 WWV.12 - Percent of family planning clinics that expanded (hours or sites) family planning services* ESM WWV.13 - Number of unique clients served (yearly total) through local county health departments' Title V-funded family planning and reproductive health programs.		Formerly NOM 24) - PPD
Reduce disparities in infant and maternal morbidity and	By 2025, Arizona will reduce the disparity gap for maternal and infant mortality in underserved communities by 5% across all impacted groups.	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	***Inactive -*** *ESM WWV.1 - Number of agencies participating in the Preconception Health Alliance.*	NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) -	NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM

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mortality.		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. 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. Update the Arizona Maternal Mortality Action Plan with stakeholder input	***Inactive -*** *ESM WWV.2 - Number of activities conducted by the Preconception Health Alliance* ESM WWV.3 - Percent of family planning clinics that have LARCs available ***Inactive -*** *ESM WWV.4 - Percent of women who participated in the Arizona Pregnancy Risk Assessment Monitoring System.* ***Inactive -*** *ESM WWV.5 - Percent of Family Planning Summit attendees who report a practice change after the summit.* ***Inactive -*** *ESM WWV.6 - Rate of severe maternal morbidity associated with hypertensive disorders of pregnancy in AIM participating hospitals.*	WWV	NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Preterm-related mortality

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			ESM WWV.7 - Percent of live births that occur in an AIM-participating birthing facility. ***Inactive -*** *ESM WWV.8 - Number of individuals trained to become community-based doulas* ***Inactive -*** *ESM WWV.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 WWV.10 - The number of times home visitors access a maternal mental health consult for their clients.* ***Inactive -*** *ESM WWV.11 - Implement action steps to develop a community health worker reimbursement pilot program among primary care*		rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression, Formerly NOM 24) - PPD

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			providers (e.g. community health centers), tribes, and insurance payers. ***Inactive -*** *ESM WWV.12 - Percent of family planning clinics that expanded (hours or sites) family planning services* ESM WWV.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.	By 2025, Arizona will increase the percentage of women who had a preventive dental visit during pregnancy by 6%.	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 and medical 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.	***Inactive -*** *ESM PDV-Pregnancy.1 - Number of inter agency partnerships implemented to coordinate dental services for pregnant women and children.* ESM PDV-Pregnancy.2 - Number of medical, dental, and other healthcare professionals who receive perinatal oral health education.	NPM - Percent of women who had a dental visit during pregnancy (Preventive Dental Visit - Pregnancy, Formerly NPM 13.1) - PDV-Pregnancy	NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

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Reduce and eliminate barriers to ensure equitable and optimal health for women.	By 2025, the percentage of mothers who receive a postpartum visit will increase by 5%.	Promote Arizona's Medicaid extension (coverage to 12 months postpartum) via home visits, helpline calls, and family-centered events.	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.
Perinatal/Infant Health					
Promote equitable and optimal care and protective factors for mothers and infants before, during, and after pregnancy.	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 sleep without soft objects or loose bedding by 15%.	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. 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.	***Inactive -*** *ESM SS.1 - Number of safe sleep-related activities that are implemented by local county health departments.* ***Inactive -*** *ESM SS.2 - Number of digital impressions of the safe sleep media campaign.* ESM SS.3 - Number of caregivers who receive safe sleep training and a pack 'n' play or a sleep sack ***Inactive -*** *ESM SS.4 - Percent of at-risk communities with a safe sleep campaign outdoor media*	NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID

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		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.	*presence.* ***Inactive -*** *ESM SS.5 - Number of ABCs of Sleep Crib Cards distributed.* ESM SS.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.	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%.	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 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.	ESM BF.1 - Number of home visitors who receive lactation counseling or breastfeeding support training. ***Inactive -*** *ESM BF.2 - Percent of home visitors trained on lactation counseling or breastfeeding support training who report an increase in knowledge and skill around breastfeeding best practices.* ***Inactive -*** *ESM BF.3 - Number of local county health departments working on strategies to promote breastfeeding*	NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID

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		Support breastfeeding initiatives through training and certification of home visitors and health professionals, technical assistance, policy and procedures, and direct support services. Implement the Stillbirth and Infant Mortality Action Plan and sustain the Perinatal and Infant Health Taskforce. 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. Provide professional development for oral health providers on the benefits of breastfeeding. Coordinate with ADHS Sexually Transmitted Infections team to address the rise in congenital syphilis in Arizona. Partner with Hushabye Nursery and Jacob's Hope to provide evidence-based care to babies exposed to substances and their caregivers.	*through the Title V-funded MCH Healthy Arizona Families IGA* ESM BF.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.	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.	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.	***Inactive -*** *ESM DS.1 - Proportion of new home visitors trained to provide ASQ within 6 months of hire.* ESM DS.2 - Percentage of children receiving an ASQ within 1 year of program enrollment.	NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (Developmental Screening, Formerly NPM 6) - DS	NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

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			ESM DS.3 - Percent of children enrolled in home visiting who received a referral for developmental services and have a complete referral. ***Inactive -*** *ESM DS.4 - Number of providers that receive developmental screening training.* ***Inactive -*** *ESM DS.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.	By 2025, Arizona will reduce the rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9 by 7%.	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 emergency readiness needs and engage existing Pediatric Prepared Emergency Care member health care providers to continue to develop their	***Inactive -*** *ESM IH-Child.1 - Number of injury prevention activities done by local county health departments specific for children ages 0 through 9* ESM IH-Child.2 - Number of car seats and home safety kits distributed with caregiver education.	NPM - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9 (Injury Hospitalization - Child, Formerly NPM 7.1) - IH-Child	NOM - Child Mortality rate, ages 1 through 9, per 100,000 (Child Mortality, Formerly NOM 15) - CM NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle

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		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.	***Inactive -*** *ESM IH-Child.3 - Percent of local county health departments that have at least one staff trained in safe car seat installation and use.*		NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide
Strengthen emotional, physical, and social services to achieve an equitable and optimal development for children.	By 2025, 4 out of every 5 children ages 1 through 17, will have a preventive dental visit in Arizona.	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. Disseminate the findings of the oral health study to providers and Arizona schools.	ESM PDV-Child.1 - Proportion of urgent dental cases identified in the sealant program referred for treatment. ***Inactive -*** *ESM PDV-Child.2 - Proportion of early dental cases identified in the sealant program referred for treatment.* ESM PDV-Child.3 - Percent of children who participate in the School-based dental program	NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child	NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
Strengthen emotional, physical, and	By 2025, 2 out of every 3 children, ages 0 through 17 will be continuously and adequately	Partner with MIECHV to enhance the Children's Information Helpline to include a state-wide referral for home visitation programs while continuing to provide information and assistance to pregnant women and children.	ESM AI.1 - The number of state loan repayment program	NPM - Percent of children, ages 0 through 17, who are continuously and	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who

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social services to achieve an equitable and optimal development for children.	insured.	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.	registered sites that offer assistance with insurance applications. ***Inactive -*** *ESM AI.2 - Percent of Title V staff and contractors that receive education on insurance coverage options for children and pregnant women.* ***Inactive -*** *ESM AI.3 - Number of learning opportunities for external maternal and child health partners on insurance coverage for children and pregnant women.* ***Inactive -*** *ESM AI.4 - Percentage of adults that have access to a personal care provider.*	adequately insured (Adequate Insurance, Formerly NPM 15) - AI	receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months (Childhood Vaccination, Formerly NOM 22.1) - VAX-Child NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV NOM - Percent of adolescents, ages 13 through 17, who have

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					received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC
Reduce disparities in infant and maternal morbidity and mortality.	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.	Continue to implement nurse workforce programs, Behavioral Health Provider Loan Repayment, the State Loan Repayment Program and preceptor programs. Improve data collection efforts to evaluate service impact by the State Loan Repayment Program. Outreach to medical and dental schools, clinical professional schools, and professional organizations to promote recruitment and retention of providers in underserved communities. 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.	ESM AI.1 - The number of state loan repayment program registered sites that offer assistance with insurance applications. ***Inactive -*** *ESM AI.2 - Percent of Title V staff and contractors that receive education on insurance coverage options for children and pregnant women.* ***Inactive -*** *ESM AI.3 - Number of learning opportunities for external maternal and child health partners on insurance*	NPM - Percent of children, ages 0 through 17, who are continuously and adequately insured (Adequate Insurance, Formerly NPM 15) - AI	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by

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			coverage for children and pregnant women. ***Inactive -*** *ESM AI.4 - Percentage of adults that have access to a personal care provider.*		age 24 months (Childhood Vaccination, Formerly NOM 22.1) - VAX-Child NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC
Strengthen emotional, physical, and	By 2025, the percentage of children receiving coordinated, ongoing, and comprehensive care	Engage community stakeholders and families with lived experience to design an approach that supports expanding the use of medical home models throughout the state.	No ESMs were created by the State. ESMs were optional	NPM - Percent of children with and without special health care needs, ages 0	This NPM was newly added in the 2025 application/2023 annual report. The list of associated

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social services to achieve an equitable and optimal development for children.	within a medical home by 5%.		for this measure in the 2025 application/2023 annual report.	through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	NOMs will be displayed in the 2026 application/2024 annual report.
Adolescent Health					
Enhance equitable and optimal initiatives that positively impact the emotional, physical, and social wellbeing of adolescents.	By 2025, Arizona will decrease the percentage of adolescents, ages 12 through 17, who are bullied or who bully others by 9%.	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 Youth Mental Health Steering Committee (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	***Inactive -*** *ESM BLY.1 - Number of school professionals who receive technical assistance on bullying prevention.* ***Inactive -*** *ESM BLY.2 - Number of schools implementing bullying prevention guidance.* ***Inactive -*** *ESM BLY.3 - Number of unique pageviews in the must stop bullying campaign website.* ***Inactive -*** *ESM BLY.4 - Number of unique pageviews to the child page of the must stop bullying campaign website.* ESM BLY.5 - Total number of youth served by an organization trained on mental health first	NPM - Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others (Bullying, Formerly NPM 9) - BLY	NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
			aid for youth. ESM BLY.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.	By 2025, 3 out of every 4 adolescents, ages 12 through 17, will have a preventive medical visit in the past year.	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 in eligible middle schools. 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.	ESM AWV.1 - Number of healthcare clinics implementing University of Michigan's Adolescent Champion Model at their sites. ESM AWV.2 - Percent of clinical sites that engage in continuous learning to maintain the adolescent champion model's high standards of practice. ESM AWV.3 - The proportion of adolescents and young adults 12-21 years of age who had at least one comprehensive well-care visit with a	NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV	NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
			primary care practitioner or an OB/GYN practitioner participating in the adolescent champion model during the measurement year ESM AWV.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 AWV.5 - Number of youth advising state initiatives.* ***Inactive -*** *ESM AWV.6 - Number of continuing education opportunities for dental and medical providers to promote preventive medical visits and mental health for adolescents.*		mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
					meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB
Enhance equitable and optimal initiatives that positively impact the emotional, physical, and social wellbeing of adolescents.	By 2025, Arizona will reduce the rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19, by 5%.	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)	ESM IH-Adolescent.1 - Number of injury prevention activities done by local county health departments specific to adolescents 10-19 years old.	NPM - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19 (Injury Hospitalization - Adolescent, Formerly NPM 7.2) - IH-Adolescent	NOM - Child Mortality rate, ages 1 through 9, per 100,000 (Child Mortality, Formerly NOM 15) - CM NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide
Children with Special Health Care Needs					
Strengthen systems of care to advance inclusivity and promote equitable and optimal outcomes for	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%.	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.	***Inactive -*** *ESM TR.1 - Number of families that received a resource from the CYSHCN program.* ESM TR.2 - Number of practitioners who have ever enrolled in	NPM - 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 (Transition, Formerly NPM 12) - TR	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
children and youth with special healthcare needs.		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 the Arizona Chapter of the American Academy of Pediatrics, Phoenix Children's Hospital, Ryan House, and Ronald McDonald Houses of Phoenix & Southern Arizona to provide funding for gap-filling services that support families 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 incorporating diversity, equity, and inclusivity within the MCH activities they implement through the MCH Healthy Arizona Families Intergovernmental Agreement. 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.	Got Transition modules. ***Inactive -*** *ESM TR.3 - Number of family advisors placed in Bureau of Women's and Children's Health administrative offices.* ***Inactive -*** *ESM TR.4 - Percent of school-age children who receive a hearing screening.* ***Inactive -*** *ESM TR.5 - Percent of Arizona schools that complete their hearing screens by the assigned due date.* ***Inactive -*** *ESM TR.6 - Number of providers receiving GoT transition training resources.* ESM TR.7 - Percentage of practitioners who have completed the full course of 8 Got Transition modules within 15 months of course initiation.		

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
		Develop a training and onboarding process for office/programs to ensure they are ready to engage with placed family and young adult advisors.			
Engage individuals, families, and communities as partners in the development and implementation of programs and policies to create people-centered programs that promote health equity	By 2025, Arizona will establish family and youth advisors in all of the Bureau of Women's and Children's Health programming offices.	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.	***Inactive -*** *ESM TR.1 - Number of families that received a resource from the CYSHCN program.* ESM TR.2 - Number of practitioners who have ever enrolled in Got Transition modules. ***Inactive -*** *ESM TR.3 - Number of family advisors placed in Bureau of Women's and Children's Health administrative offices.* ***Inactive -*** *ESM TR.4 - Percent of school-age children who receive a hearing screening.* ***Inactive -*** *ESM TR.5 - Percent of Arizona schools that complete their hearing screens by the assigned due date.* ***Inactive -*** *ESM TR.6 - Number of providers receiving GoT transition training*	NPM - 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 (Transition, Formerly NPM 12) - TR	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
			resources. ESM TR.7 - Percentage of practitioners who have completed the full course of 8 Got Transition modules within 15 months of course initiation.		
Engage individuals, families, and communities as partners in the development and implementation of programs and policies to create people-centered programs that promote health equity	By 2025, the percentage of children with special healthcare needs who receive coordinated, ongoing, and comprehensive care within a medical home will increase by 5%.	Engage community stakeholders and families with lived experience to design an approach that supports expanding the use of medical home models throughout the state. Conduct focus groups with families of children with special healthcare needs to understand their perspectives and experiences on the critical areas for a well-functioning system: health equity, quality of life and wellbeing, access to services, and financing of services.	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.