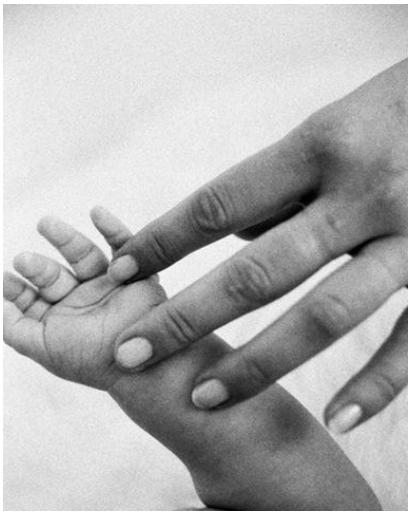
Arizona Department of Health Services

# Bureau of Women's and Children's Health

# Strategic Plan 2011-2015



## About the Bureau of Women's and Children's Health……..

The Bureau of Women's and Children's Health (BWCH) holds a vision of: Healthy Women, Healthy Children, Healthy Tomorrow. The BWCH resides within the Division of Public Health Services of the Arizona Department of Health Services, and serves as the lead state agency for maternal and child health in Arizona.

The Bureau of Women's and Children's Health:

- Employs approximately 40 dedicated staff
- Administers 20 different programs
- Has 5 major programmatic areas: Office of Women's Health; Office of Children's Health; Office for Children with Special Health Care Needs; Office of Oral Health; and Injury Prevention & Child Fatality Section; and supported by an Office of Assessment & Evaluation and a Business & Finance Section
- Administers and monitors about 200 contracts with agencies throughout Arizona
- Manages over $20 million in funding annually

This bureau strategic plan articulates the vision we share, the values we hold, and the priorities that we will focus on through 2015.

For more information about the Bureau of Women's and Children's Health, please call 602-364-1400 or find us on the internet at http://www.azdhs.gov/phs/owch/index.htm.

# *Vision Statement*

*Healthy Women...Healthy Children...Healthy Tomorrow*

# *Mission Statement*

To strengthen the family and the community by promoting and improving the health and safety of women and children

# *Values*

***Service***

We serve people in an environment of respect and understanding. We succeed through mutual participation, communication and cooperation. Our service is timely, accurate and consistent.

***Partnerships***

We partner in an environment characterized by cooperation and shared knowledge.

***Integrity***

Our relationships are based on honesty, respect, and mutual benefits.

***Teamwork***

Everyone works together to achieve goals that are guided by our vision.

***Quality***

We continually assess the effectiveness and efficiency or our processes and programs. Accurate documentation and measurement results in information that is factual, understandable, useful, and provides a basis for decision-making.

***Diversity***

We recognize and respect the many assets that people of different ethnic, cultural, and social backgrounds contribute to our society. We value this diversity and will develop strategies that build on those assets.

***Accountability***

We take ownership for our successes and our failures, realizing that by taking risks we are bound to fail at times, but it is only by taking risks that we make progress.

***Flexibility***

We anticipate change, adapt, and incorporate new experiences into our expanding base of skills and knowledge.

***Community***

We value healthy, safe communities, so we fund programs that work, in areas where they are needed, in amounts that make a difference.

## *Overarching Goals*

Three **overarching goals** guide the work of the Bureau of Women's and Children's Health:

- Reduce mortality and morbidity among women and children
- Eliminate health disparities in health outcomes and access to services
- Increase access to health care

## *Priorities 2011-2015*

Every five years, states are required by the Title V Maternal Child Health Block Grant to conduct a needs assessment of maternal and child health issues. Arizona conducted its most recent five-year needs assessment in 2010. The process included gathering and analyzing data on various maternal and child health issues, gathering input from partners, setting priorities, and defining performance measures.

The **priorities** resulting from the needs assessment are:

- Reduce teen pregnancy among youth less than 19 years of age
- Improve the percentage of children and families who are at a healthy weight
- Improve the health of women prior to pregnancy
- Reduce the rate of injuries, both intentional and unintentional
- Improve access to and quality of preventive health services for children
- Improve the oral health of Arizonans
- Improve the behavioral health of women and children
- Reduce unmet need for hearing services
- Prepare children and youth with special health care needs for transition to adulthood
- Promote inclusion of children with special health care needs in all aspects of life

## Priority 1: Reduce the rate of teen pregnancy among youth less than 19 years of age.

*While Arizona's rates of teen pregnancy and teen births have been declining over the past decade, Arizona still ranks within the top five states with the highest teen birth rates in the nation. ADHS has the capacity to address teen pregnancy through lottery dollars, and beginning in 2011 will have federal funding available through the Affordable Care Act.*

Strategies:

1. Increase the skill level of contractors and other stakeholders who work with adolescents to reduce teen pregnancy.
    - Provide training for contractors and other stakeholders on selected curricula.
    - Provide quarterly education to contractors.
    - Share information about appropriate external training opportunities as they become available.
2. Provide a forum for stakeholders working to reduce teen pregnancy to stay connected and informed of the work being done in Arizona.
    - Convene state agency stakeholders working with youth (i.e. Justice Department, DES/Foster Care, Office of STD/HIV, Juvenile Detention) on a quarterly basis.
    - Explore development of a Teen Pregnancy Prevention Coalition
    - Utilize youth advisory groups to provide input on media and other program areas
3. Increase the use of social marketing reaching the target audience.
    - Investigate utilizing existing website or developing a new website based on feedback from youth advisory group.
    - Promote the pregnancy prevention and STD prevention messages with a social marketing campaign.
    - Examine the use of tweets, Facebook, and text messaging as a means to educate parents and teens.
4. Develop and implement strategies to educate hard-to-reach populations
    - Research innovative ways to provide parent education.
    - Focus on male responsibility by implementing the Wise Guys Curricula and developing partnerships with fatherhood groups and programs.
    - Continue to research strategies that will reach foster care youth.
    - Identify or develop teen pregnancy prevention curricula or programs appropriate for youth with special health care needs.

Performance measure: rate of birth for teens ages 15 – 17 years.

## Priority 2: Improve the percentage of children and families who are at a healthy weight.

*Arizona's percentage of children who are overweight or obese has increased at higher rates than any other state. For youth 10 to 17 years of age, there was a 46% increase in the prevalence of obesity from 2003 to 2007, which was the greatest increase in the nation. Nearly half of all reproductive age women in Arizona are either overweight or obese.*

Strategies:

1. Review and disseminate evidence-based practices and emerging research regarding obesity prevention to the MCH workforce.
    - Integrate information about evidence-based practices and research into training opportunities and newsletters.
    - Utilize national initiatives such as Let's Move campaign to disseminate intervention strategies.
2. Target most at-risk populations for interventions.
    - Pilot and evaluate post-partum interventions through Health Start and WIC.
    - Consider disparities occurring among Latinas, Native Americans, and African Americans when implementing interventions or applying for grants.
    - Provide technical assistance to families and providers of children with special health care needs regarding nutrition and physical activity.
    - Partner with other organizations to implement and promote culturally appropriate interventions.
3. Facilitate coordination of agencies working on obesity prevention
    - Convene partners to share what is being accomplished across the state to promote healthy eating and physical activity.
    - Facilitate next steps for partner organizations.
4. Continue working with other ADHS programs to integrate messages and interventions
    - Support and enhance the ADHS Empower Program setting health standards for child care providers.
    - Coordinate with ADHS and ADE Coordinated School Health Program.
5. Integrate nutrition and physical activity into existing MCH programs
    - Develop, pilot, and evaluate toolkit for lay health workers and other home visitors.
    - Enhance interconception efforts targeting postpartum women to help them achieve a healthy weight.
    - Integrate opportunities for physical activity and nutrition education in teen pregnancy prevention youth development programs.
    - Promote integration of obesity prevention into all home visiting

programs statewide.
    - Promote importance of nutrition and physical activity as central to health of women and children through media and marketing opportunities.
6. Seek opportunities to influence rules, policies, organizational practices that better support physical activity and nutrition at state level.
    - Explore contract language for BWCH contracts that supports better nutrition and physical activity.
    -
7. Support local communities to work to make the healthy choice an easy one for the public through policy and organizational practices.
    - Explore bringing enhanced policy training to ADHS, county health departments, and other community partners.
    - Work with partners to apply for grants that focus on policy, organizational, environmental, or infrastructure changes.
8. Encourage best practices to promote breastfeeding
    - Provide technical assistance to hospitals to encourage them to implement Baby Steps to Baby Friendly.
    - Provide technical assistance to home visiting programs to implement best practices.
    - Improve awareness about tax deductions for breast pumps and supplies.
    - Promote worksite policies that include best practices for breastfeeding.
    - Continue 24/7 availability of pregnancy and breastfeeding hotline.

Performance measures: % of children ages 2 to 5 year receiving WIC services with a Body Mass Index at or above the 85$^{th}$ percentile; % of high school students who are overweight or obese

## Priority 3: Improve the health of women prior to pregnancy.

*Since 2006 when the Centers for Disease Control issued its recommendations on preconception health, there has been growing attention both nationally and in Arizona about the critical nature of preconception health. Preconception health comprehensively address multiple areas of women's health, including reproductive health, nutrition, physical activity, tobacco use, substance abuse, and mental health.*

Strategies:

1. Educate and increase knowledge of Preconception Health and Life Course Perspective model among ADHS program staff and other interested staff.
    - Conduct Brown Bag(s) on preconception health, Preconception Health Strategic Plan and the life course perspective.
    - Convene an ADHS internal workgroup to identify opportunities for integrating preconception health and the life course perspective into existing programs/initiatives.
        a. Promote use of Every Woman Arizona Materials
        b. Develop system for tracking where preconception health information is being provided by ADHS programs/individuals
    - Develop/identify preconception health toolbox containing PowerPoint presentations, screening tools etc that ADHS staff can distribute to their partners for use with coalitions and community members
    - Share information regarding preconception health and the life course perspective with interested ADHS staff as it becomes available to ensure they have access to current information and resources.
    - Identify potential data sources within ADHS that can be used to assess the preconception/interconception heath status of women in Arizona.

2. Increase public awareness about preconception health.
    - Develop a speaker's bureau that consists of people from all regions of the state.
    - Identify resources and supports available to the public that will assist them in improving their preconception health.
    - Convene focus groups of youth and women to determine how to talk about preconception health to youth/other target populations
        a. Solicit input from members of the teen pregnancy prevention advisory groups to identify effective means of increasing awareness about preconception heath among young people.
    - Explore the use of social media to increase awareness
        a. Increase amount of information available about preconception health on the ADHS/BWCH website and ensure the content of the site is relevant, aesthetically pleasant and user friendly.

   b. Work with ADHS Public Information Officer to identify opportunities to promote preconception health in various media outlets. Ie, newspapers, local newsletters
   c. Identify funding or other means of support to promote the national preconception health marketing product(s) developed by the CDC Consumer workgroup.

3. Increase provider awareness of the importance of preconception health and health care and the life course perspective.
   - Develop partnerships with health professional organizations to identify opportunities to provide information about preconception health.
   - Promote use of Every Woman Arizona materials.
   - Identify and provide access to resources available for use by health care providers

4. Develop a report on the heath status of women that contains state level data on health factors and social determinants that impact preconception health to guide policy decisions and monitor progress
   - Update the report every two years
   - Post the report on the web
   - Publicize availability of the report among health care providers, insurance plans, county health departments, other state agencies, community based organizations and colleges/universities.

5. Build and support infrastructure at local level for promotion of preconception health.
   - Use Title V funding to support county health departments to implement local preconception health projects that address local needs across the spectrum of prevention.
   - Provide technical assistance to community-based organizations and other partners on preconception health.

6. Promote role of men in preconception health.

Performance measures: % of women having a subsequent pregnancy during the inter-pregnancy interval of 18-59 months; rate of low birth weight; % of high school students who are overweight or obese

## Priority 4: Reduce the rate of injuries, both intentional and unintentional, among Arizonans.

*Injuries are the leading causes of death for Arizonans ages 1-44. Homicides and suicides remain a significant issue for teens and young adults, and dating violence among Arizona high school students increased significantly between 2003 and 2007.*

Strategies:

**1.** By 2015, reduce injuries from Motor Vehicle Crashes by 15%.
- Facilitate networks and continue collaborations with multiple partners in the traffic safety community.
- Support statewide child passenger safety capacity building through training new technicians
- Promote implementation of Safe Routes to School Program.
- Analyze injury data related to impact of policies implemented to reduce motor vehicle crashes.
- Provide technical assistance on implementation of the high school Battle of the Belt Program.
- Promote use of booster seats for children ages 5 – 8.

2. By 2015, reduce home related* injuries by 15% among children ages 1-14 years.
- Strengthen collaboration with identified coalitions and existing resources.
- Update and standardize home safety assessment to be used in ADHS programs.
- Integrate home safety strategies with home visiting programs.
- Promote evidence-based practices for keeping children injury-free in child care centers.

*home-related: drowning, falls, poison, unattended firearms

3. By 2015, reduce injuries resulting from violence by 15%.

- Implement evidence-informed, theory-based, age appropriate, and culturally relevant sexual violence prevention education for kindergarten through college/university student participants.
- Implement an evidence-informed and theory-based sexual violence prevention and education program for participating members of faith-based organizations.
- Implement bystander intervention campaign to increase knowledge and skills of bystanders in the community to prevent sexual assault from initially occurring.
- Conduct outreach and training to management staff of alcohol-serving establishments that are frequented by college students to increase their

knowledge of sexual violence prevention issues, strategies and policies
- Investigate strategies for the development and adoption of a more comprehensive approach to sexual violence data collection by all reporting sources in Arizona.
- Scan/inventory existing efforts to address bullying, promote healthy interaction
- Coordinate training for contractors and other targeted partner groups on mandated reporting of child abuse
- Require all future contracted agencies to adhere to the Shelter Standard developed by the State Agency Coordinated Team.
- Integrate domestic violence screening within family planning clinics, home visiting programs, etc.
- Increase community-based services (non-shelter services) to victims/survivors of domestic violence.
- Collaborate with Arizona Coalition Against Domestic Violence to assist agencies in increasing capacity for providing DV services.

4. Build and support infrastructure at the local level for injury prevention.
   - Provide Title V funding to selected county health departments to implement strategies across the spectrum of prevention for injury prevention based on local needs.
   - Provide technical assistance to counties, First Things First Regional Councils, local Child Fatality Review Teams, and other organizations on injury data and evidence-based practices.

Performance measures: % of high school students reporting dating violence; rate of emergency department visits for unintentional injuries among children 1-14; rate of death of children ages 14 and younger caused by motor vehicle crashes; rate of suicide deaths among youths ages 15-19.

## Priority 5: Improve access to and quality of preventive health services for children.

*The priority of preventive health services for children was identified by the group of stakeholders and ADHS staff charged with setting priorities. Arizona has experienced decreased capacity due to cuts in the state Medicaid program and a waiting list for children to access the state SCHIP program, Kids Care. Preventive health services include among other things screenings, immunizations, assistance with entry into a medical and dental home and home visiting.*

Strategies:

1. Increase understanding of the importance of preventive health services for children.
    - Collaborate with other agencies and stakeholders to develop public education opportunities about the importance of preventive health services for children
    - Continue to utilize BWCH Hot Lines to educate families and the community about preventive services; i.e. immunization, WIC, importance of prenatal care, breast feeding support
    - Coordinate with the statewide early childhood system to increase awareness of preventive health services

2. Develop local and statewide children's preventive health referral processes
    - Collaborate with other agencies/stakeholders to determine availability of referral resources both statewide and in local communities
    - Support the development of regional early childhood associations/communities that will work to develop a smooth preventive health services referral process for families
    - Continue to support emergency perinatal transport to appropriate level of care
    - Continue to utilize BWCH Hot Lines to help families access Baby Arizona, Children's Information and WIC information

3. Support use of evidence based preventive health practices
    - Identify and encourage use of best practice screening and assessment instruments
    - Partner with early childhood community to promote standards of practice and professional development for early childhood home visitors

4. Develop and implement a continuous quality initiative process to improve the quality of preventive health services for children

    - Establish process and performance (outcome) goals
    - Collect data on identified goals annually
    - Share data with partners on the progress towards the established goals

Performance measures: % of 19 to 35 month olds who receive full schedule of age appropriate immunizations; % of children without health insurance; % of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

## Priority 6: Improve the oral health of Arizonans

*The oral health of children residing in Arizona is significantly worse than for their national peers. Arizona's Healthy Smiles, Healthy Bodies survey reported that 40% of 3rd grade children had untreated tooth decay, ranking 40th out of 42 states.*

Strategies:

1. Provide leadership to address oral health problems to improve departmental capacity to perform core public health functions.

    - Monitor and identify opportunities to increase internal program capacity by collaborating with internal offices and programs for oral health collaboration. For example; Office of Children with Special Health Care Needs, School-age Workgroup, WIC, Healthy Start, Health Systems Development and chronic disease.

2. Build linkages with partners to leverage resources and advocate for and act on oral health issues.

    - Identify and convene external partnerships to foster joint oral health initiatives, sharing of resources, providing technical assistance, advocacy and quality improvement such as with Head Start, Arizona Department of Education, IHS, ITCA, Area Health Education Centers, school-based health clinics and dental and medical associations.
    - Facilitate and support development of local and state oral health coalitions and strengthen collaboration with identified coalitions. Sustain coalitions after funding is gone (look at integrating with county IGAs for preconception & injury)

3. Build community capacity to implement evidence-based and best practice community-level interventions.

    - Implement outreach and training for the expansion and improvement of the Arizona School-based Sealant Program.
    - Support and facilitate outreach and training for workforce demonstration practice models; including but not limited to underserved and special needs populations, teledentistry, young children 0-5, affiliated practice and traditional dental home models.
    - Facilitate and build state and regional program infrastructure and technical assistance; including support for First Things First oral health efforts.

4. Establish and maintain the state-based oral health surveillance system for ongoing monitoring, timely communication of findings, and the use of data to initiate and evaluate interventions.

   - Analyze, disseminate and share findings from the Healthy Bodies/Healthy Smiles 2010 Survey and the Arizona Preschool Oral Health Survey 2009.
   - Integrate oral health data with other health surveillance data to access health risks and improvements such as the BRFSS, YRBSS, and PRAMS.
   - Assist and support local efforts in oral health data collection, reporting and surveillance.

Performance measures: % of 3rd graders who have dental sealants on at least one permanent tooth; % of Medicaid enrollees ages 1-18 who received at least one preventive dental service within the past year.

## Priority 7: Improve the behavioral health of women and children.

*BWCH survey as well as input through public sessions indicated that mental health and substance use/abuse (including alcohol as well as illegal drug use) are critical issues that need to be better addressed. Areas of particular concerns include post-partum depression, substance abuse among adolescents, substance abuse among pregnant women, depression among women, and mental health of children.*

Strategies:

1. Work with Division of Behavioral Health Services to increase knowledge of behavioral health resources and how to access services
    - Provide training for existing program providers on how to initiate behavioral health services for clients
    - Provide updated lists of public behavioral health services and how to access them to community partners/stakeholders
    - Coordinate and collaborate with community partners/stakeholders who offer services to non-title XIX/XXI families

2. Identify and distribute a standardized set of screening tools for assessing the social/emotional health of children 0 – 8 years of age
    - Collaborate with community partners/stakeholder to research available evidenced based screening tools and develop a list
    - Distribute screening tools and provide training to contractors

3. Promote behavioral health wellness in existing programs
    - Research positive behavioral health messages and identify integration strategies
    - Implement strategies in existing programs

4. Provide screening of pregnant and postpartum women for perinatal depression
    - Coordinate and arrange training on perinatal depression and the Edinburgh Postnatal Depression Scale (EPDS) through the Arizona Postpartum Wellness Coalition for contractors
    - Integrate perinatal screening of pregnant and postpartum women into existing programs

5. Facilitate expansion of FASD screening, brief intervention and referral (as piloted and implemented in Health Start) to other home visiting programs and WIC
    - Identify programs that serve pregnant women and explore integration strategies
    - Provide training and materials for community partners/stakeholders on screening and brief intervention

6. Improve parent education/skills to promote optimal social/emotional health of children 0 to 8 years of age
    - Collaborate with community partners/stakeholders to identify evidenced based effective parenting skills curricula
    - Coordinate and arrange training on curricula for existing programs through collaboration with community partners/stakeholders

7. Promote prevention of substance use among adolescents
    - Coordinate with DBHS on identifying existing prevention programs
    - Research prevention strategies and identify integration opportunities into existing programs that reach adolescents
    - Collaborate with community partners/stakeholders to provide training on selected strategies

Performance measures: rate of suicide deaths among 15-19 year olds; % of women ages 18 and older who suffer from frequent mental distress

## Priority 8: Reduce unmet need for hearing services

*While every newborn in Arizona is screened for hearing loss, approximately 1/3 of those who fail the initial screening do not receive appropriate follow-up services. There is a relatively high proportion of unmet need related to hearing, with one in four of the children with special health care needs with an identified need for hearing aides or hearing care failing to have those needs met.*

Goal: By 2015, 90% of newborns who fail their initial hearing screening will receive appropriate follow-up services.

Strategies:

1. Ensure that all children in Arizona receive appropriate follow up services for hearing related problems.
    - Collaborate with the Early Hearing Detection and Intervention (EHDI) Program and the EAR Foundation to develop resources for families who have an identified need but lack services in their communities or coverage to pay for them
    - Work with Newborn Screening (NBS) Program to revise and translate notification letters and fact sheets for disorders identified by NBS
    - Partner with First Things First and other home visiting programs to assist in ensuring that children receive needed second screenings and audiology services
    - Explore opportunities for partnering with the BWCH's Sensory Program

2. Assist the EAR Foundation and EHDI to develop analytic capabilities to support strategic planning and extend their reach
    - Explore collaboration with the EHDI and in the National Early Childhood Assessment Project (NECAP)
    - Use the telemedicine system to extend reach

3. Establish telemedicine connections for hearing screening follow up
    - Work with hospitals, EHDI and providers
    - Facilitate contract with University of Arizona for telemedicine connections
    - Make the Learning Management System available for training and offer physicians CMEs

4. Provide training and technical assistance
    - Target community health centers, physician's office and Early Head Start Programs
    - Implement an IGA with the University of Colorado to analyze data
    - Make the OCSHCN E-Learning system available for training

Performance measures: % of newborns who fail their initial hearing screening who receive appropriate follow-up services. (CSHCN SP #8)

## Priority 9: Prepare children and youth with special health care needs for transition to adulthood.

*Most children with special health care needs will eventually become adults and will require transition services. The transition process begins long before adolescence. Whether a child will grow to live independently or require some kind of assistance, every family must address how health care needs will be met as well as all of the requirements of everyday living. All avenues of public input emphasized the importance of transition, and several community partners have some kind of programmatic activity directed towards it.*

Strategies:

1. OCSHCN contracts will require transition planning
    - Family and youth involvement contract will provide a venue to identify, recruit, support, train, compensate and provide leadership development to youth
    - Family and youth involvement contract will develop an OCSHCN youth council to participate in management activities

2. Increase awareness about transition for CYSHCN
    - Exhibit at transition fairs and conferences
    - Offer scholarships for youth and families to attend transition conferences
    - Develop transition resources
    - Provide translation services for conference materials, educational and informational resources, DVDs and other materials

3. Develop and provide training on transition
    - Train contractors on best practices regarding transition
    - Training developed by youth about what makes transition successful will be made available online for physicians serving adults with disabilities
    - Explore ways to incorporate youth transition practices into Medicaid health plan training
    - Make the OCSHCN E-Learning Platform available for educational training and materials

Performance measures: % of youth with special health care needs who received services necessary to make transition to all aspects of adult life, including health services, work, and independence. (CSHCN PM # 6)

## Priority 10: Promote inclusion of children with special health care needs in all aspects of life.

*Inclusion of children with special health care needs in child care, school, sports, work, and in wellness activities such as nutrition and physical activity and injury prevention presents many opportunities for improvement. During public input, families often spoke about the lack of accommodations for children with special health care needs to participate in all aspects of life, and how important these were to address.*

Strategies:

1. Collaborate with partners to ensure that the needs of CYSHCN and barriers to their participation are understood and addressed.
    - Partner with the Ryan House to provide inpatient respite and pediatric palliative care
    - Expand support to Ronald McDonald House to more locations
    - Work with the Arizona University Centers of Excellence on Developmental Disabilities (UCEDD) programs to increase opportunities and services
    - Work with the Arizona Planning Council on Developmental Disabilities to increase opportunities and services
    - Represent ADHS on the Arizona Early Intervention Council for Infants and Toddlers Interagency Coordinating Council (AzEIP-ICC) and Arizona Transition Community of Practice (AzCOPT)
    - Provide technical assistance on policy development and planning to ensure inclusion of CYSHCN

2. Identify opportunities to encourage inclusion for CYSHCN in wellness activities, child care, behavioral health services and injury prevention
    - Participate on the Injury Prevention Council to ensure car seat safety, TBI/SCI and training first responders on CYSHCN are included
    - Partner with the Arizona Special Olympics to promote wellness for CYSHCN, share resources and data
    - Explore opportunities to partner with other bureau programs
    - Explore social networking technologies as an additional way to provide and receive information

3. Provide information and referrals services
    - Send letters to SSI applicants under age 21 informing them of community based services
    - Work with Newborn Screening to develop processes and resources for families and providers

- Provide guidance on application processes
- Assist with understanding CYSHCN rights in school, healthcare and community settings

4. Provide training on strategies for communication with physicians, school IEP teams, child serving agencies and nurses
    - Train medical and dental students on family centered care practices and promote family home visits
    - Train school nurses on supporting CYSHCN so they can stay in school and participate in the least restrictive and most inclusive school environment
    - Train school nurses on eligibility rules, application processes, community resources and an overview of public and private insurance
    - Expand training to include therapists
    - Make the Navigating the Systems training available online

5. Maintain telemedicine infrastructure and expand network
    - Identify potential partners and vehicles
    - Explore funding opportunities
    - Educate partners on the benefits of using telehealth videoconferencing capabilities

Performance measures: % of children with special health care needs ages 0-18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN PM #5)

## Appendix I

## Conceptual Frameworks

The Bureau of Women's & Children's Health utilized three conceptual frameworks in the development of the strategies and action steps identified in the 2011-2015 Strategic Plan: 1) Life Course Perspective; 2) Spectrum of Prevention; and 3) MCH Pyramid of Health Services. Brief descriptions of each framework are provided below.

### Life Course Perspective

The Life Course Perspective Model, as described by Milton Kotelchuck and Amy Fine, is comprised of four key concepts: timeline, timing, environment and equity. Timeline recognizes that genetics, current and prior health behaviors, social experiences and environmental conditions have a cumulative affect not only on an individual's long term health but that of future generations. The Life Course Perspective acknowledges that there are critical or sensitive periods of development when exposure to various events and experiences, harmful or positive, can have significant long term impact. Environment encompasses physical, social and economic factors such as housing, clean air and water, poverty, racism, employment opportunities and the capacity of a community to engage in change. Equity highlights the need to adopt strategies that will result in population-level and systems-level changes designed to address persistent health disparities across populations and communities and the root causes of differences in health status. The identification of risk factors and the promotion of protective factors in the lives of individuals and communities is interwoven throughout this model as is the reality that these factors can change during a person's life span. The life course perspective acknowledges the link between individual health behaviors and social, economic and environmental factors and proposes that communities and agencies develop strategies that support good health by addressing all these factors.

### Spectrum of Prevention

The Prevention Institute developed the Spectrum of Prevention to provide a multi-level, multi-faceted approach to improving health of communities. This model acknowledges that teaching people about health behaviors alone is not likely to result in improved health status. The Spectrum of Prevention identifies six levels of intervention that serve as a framework for a comprehensive approach to effective primary prevention. Those levels include 1) Strengthening Individual Knowledge and Skills; 2) Promoting Community Education; 3) Educating Providers; 4) Fostering Coalitions and Networks; 5) Changing Organizational Practices; and 5) Influencing

Policies and Legislation. When all of these levels work in concert with each other there is greater chance of producing effective and meaningful results then when prevention strategies are limited to a single level of intervention. While public health has had great expertise in the first three levels of the spectrum, there is growing recognition that we need to focus more efforts in coalition-building, changing organizational practices, and influencing policies in order to affect greater, lasting change in the environment and communities in which we live.

MCH Pyramid of Health Services

The Maternal and Child Health Pyramid of Health Services is a conceptual framework developed by the federal Department of Health and Human Services MCH Bureau to help states implement their MCH Block Grant Programs. The pyramid is comprised of four tiers of service that represent the full spectrum of services designed to improve the health of women, mothers and children. The foundation of the pyramid is Infrastructure Building Services. Examples of these MCH activities include evaluation, needs assessment, planning, policy development and systems of care. The next tier of the pyramid is Population-Based Services which encompasses services available to the broad population and are not restricted only to people in specific categories. Population–Based Services include immunizations, injury prevention, teen pregnancy prevention, and newborn screening. The third tier is considered Enabling Services and the focus is on improving access to needed benefits, information and/or services. Supportive activities in this tier include transportation, outreach, health education, case management as well as coordination with Medicaid and WIC. The tip and smallest portion of the pyramid is Direct Health Care Services which are gap-filling, direct health care services for individuals with limited or no access to needed services. Great care is taken to ensure available funds are used at the level of the pyramid that will best serve the needs of Arizona while making the best use of precious resources.

The three frameworks are consistent with each other and in some cases aspects of one model can serve to expand the focus of another model. The strategic plan integrates the unique feature of the longitudinal perspective of the Life Course Model by adopting priorities that promote health across the life span beginning as early in life as possible. The BWCH Strategic Plan is considered a living document that will be modified based on new strategic direction from within ADHS, from national initiatives, and other important influences as appropriate.