**Agenda**

<table>
<thead>
<tr>
<th>I. Welcome</th>
<th>Director Jami Snyder</th>
</tr>
</thead>
<tbody>
<tr>
<td>II. Introductions of Members</td>
<td>ALL</td>
</tr>
<tr>
<td>III. Approval of October 17, 2018 meeting summary</td>
<td>ALL</td>
</tr>
</tbody>
</table>

**Agency Updates**

| IV. SMAC Revised Bylaws                        | ALL                  |
| V. AHCCCS Updates                              | Jami Snyder          |
| VI. State Health Assessment Update             | Sheila Sjolander, Carla Berg |
| VII. Committees/Councils Presentation Schedule to SMAC | ALL                |
| VIII. Call to the public                       | Jami Snyder          |
| IX. Adjourn at 3:00 p.m.                       | ALL                  |

*2019 SMAC Meetings*

Per SMAC Bylaws, meetings are to be held the 2nd Wednesday of January, April, July and October.  
**Unfortunately due to scheduling conflicts the meeting dates have changed**

All meetings will be held from 1 p.m.- 3 p.m. unless otherwise announced at the AHCCCS Administration  
701 E. Jefferson, Phoenix, AZ 85034, 3rd Floor in the Gold Room:

- January 9, 2019  
- April 11, 2019  
- July 11, 2019  
- October 18, 2019

For more information or assistance, please contact Yisel Sanchez at (602) 364-4577 or yisel.sanchez@azahcccs.gov
October 2018 Meeting Summary
State Medicaid Advisory Committee (SMAC) Meeting Summary
Wednesday, October 17 2018, AHCCCS, 701 E. Jefferson, Gold Room
1:00 p.m. – 3:00 p.m.

Members in attendance:
Jami Snyder
Cara Christ (phone)
Tara McCollum Plese
David Voepel
Kim VanPelt
Marcus Johnson
Greg Ensell

Members Absent:
Kathy Waite; Kevin Earle; Amanda Aguirre; Peggy Stemmler; Vernice Sampson; Frank Scarpati; Kathleen Collins Pagels

Staff and public in attendance:
Yisel Sanchez, HRC Coordinator, AHCCCS
Dana Hearn, AHCCCS
Tim Walker, FEI SYSTEM
Brendon Blake, AARP
Erin Vredeveld, Canyon Physical Therapy
Kelly Vredeveld, Canyon Physical Therapy
Kamila Bernstein, FTF
Erika Mach, AACHC
Shannon Grosppenber, JNJ
Brian Hummell, ACA CAN
Shirley Gunther
Josh Crites, AHCCCS
Jim Hammond, The Hartel Report
Jennifer Carusetla, HSAA

AGENDA
I. Welcome & Introductions  Jami Snyder
II. Introductions of Members  All
III. Approval of October 17, 2017 Meeting Summary/Minutes  Unanimous

AGENCY UPDATES
IV. SMAC Revised Bylaws  All
   o Revised bylaws to be sent to member for review
   o Discussion at January 2019 meeting

V. AHCCCS Updates  Jami Snyder
   o AHCCCS Strategic Plan
   o SFY20 Budget Request
   o ACC
   o Post Go-Live Monitoring
   o AHCCCS Contract Timeline
   o State Opioid Grant
   o State Opioid Response
   o SOR Program Activities
   o Behavioral Health Service Schools
   o Strategies in CYE19
Pending Waiver Requests
AHCCCS Works
Prior Coverage
On the Horizon

VI. DEMO ACC Update
Angela Aguayo
- DUGless Background
- Demographics Data
- Transition
- 3 Pronged Strategy
- Online Portal
- Data Elements
- Online Portal Reporting

IX. Housing Update
Josh Crites
- Housing and Homeless in Arizona
- AHCCCS play an important part in affordable housing throughout the state
- Over 3000 units of affordable housing for members
- Housing for SMI, GMH/SU, ALTCS and ACC
- Who has the Funding?
- ACC and Housing Human Services Campus
- Driving Changes
- Goal 1, Capital Investment
- Laurel Tree, Surprise
- Goal 2, Innovative Rental Subsidy
- Emerald Program, Prescott Valley/Flagstaff
- Goal 3, Meaningful Public Housing Partnerships
- Goal 4, Homeless Systems Collaboration
- Mercy Care’s Phoenix Rise Program
- Goal 5, Deliver Outstanding Supportive Housing Services
- Upcoming Initiatives

X. Call to the Public
Jami Snyder

XI. Adjourn at 3:07 p.m.
All
Bylaws
BYLAWS FOR THE
A.H.C.C.C.S
STATE MEDICAID ADVISORY COMMITTEE (SMAC)

MISSION

The SMAC will participate in the development of policy and program administration for the Arizona Health Care Cost Containment System (AHCCCS). Participation will include review of policy, rules and administrative issues for applicable AHCCCS programs. The SMAC will advise the Director of AHCCCS on policy and administrative issues of concern to the SMAC member constituency.

To facilitate accomplishing its mission, the SMAC will, whenever practicable, recommend issues and/or policies for inclusion on the SMAC agenda in order to allow for consideration prior to implementation. SMAC membership may also request background information and/or policy papers in advance of SMAC meetings, allowing for a deliberative discussion of the issues with AHCCCS Senior Management during the SMAC meeting.

AUTHORITY

The SMAC operates in accordance with 42 CFR 431.12 and the State Medicaid Plan.

DEFINITIONS

“AHCCCS” or “Administration” means the Arizona Health Care Cost Containment System defined in Arizona Revised Statutes (A.R.S.) §§ 36-2901, -2931, -2971 and -2981.

“SMAC” means the State Medicaid Advisory Committee, as appointed by the Director.

“Director” means the Director of AHCCCS as specified in A.R.S. §§ 36-2901, -2931, -2971 and -2981.

SMAC COMPOSITION

The SMAC shall include the AHCCCS Director or designee, the Director of the Arizona Department of Health Services (ADHS) or a designee, and the Director of the Department of Economic Security (DES) or a designee. The remaining authorized members shall be no less than seventeen (17), as follows: eight (8) health care providers or professionals with a direct interest in the AHCCCS program; and nine (9) members of
the public (e.g. a Medicaid recipient, a consumer advocate, a representative of a tribal community, or a representative of the educational community, etc.).

**APPOINTMENT PROCESS AND LENGTH OF TERM**

The AHCCCS Director or a designee, the ADHS Director or a designee, and the DES Director or a designee positions are ex officio (i.e. permanent position by virtue of the position with their respective State agency). The remaining seventeen (17) committee members shall be appointed by the AHCCCS Director. A term shall last for two years from the date of appointment and no member shall serve more than three terms. After serving as a member for three consecutive terms, a member may be appointed again after a waiting period of 24 months.

The AHCCCS Director or a designee is the SMAC chairperson and is responsible for setting meeting agendas. Special meetings of the SMAC may be called by the chairperson. Written notice of a special meeting shall be given at least five (5) days before the meeting, specifying the date, time and purpose of the meeting. The chairperson shall preside at all meetings, and shall facilitate discussion by the members.

Any vacancy shall be filled by the AHCCCS Director. The SMAC shall submit to the Director a list of nominees for expiring terms. The Director may solicit or receive nominations from other sources. The appointment process will occur annually in October. At that time, new appointments will be made for seats for members who have served the maximum of three, two-year terms. Any appointed member of the SMAC may resign by giving written notice to the SMAC, SMAC chairperson or SMAC Liaison. Any such resignation shall take effect at the time specified therein, or, if not specified therein, upon its receipt.

Any SMAC member appointed by the Director may be removed by the SMAC or the Director whenever it is deemed to be in the best interest of the SMAC and AHCCCS.

**STAFF ASSISTANCE**

Staff assistance from the Administration shall be available to the SMAC at the request of the chairperson or the committee as a whole. The designated SMAC Liaison shall provide staff assistance. Independent technical assistance shall be available at the request of the SMAC, if determined necessary by the Director and appropriate funds are available.

**MEETINGS**
SMAC meetings are open to the public. The meetings shall be held quarterly on the 2nd Wednesday of January, April, July and October or otherwise as the Director deems appropriate.

A member may participate in a meeting by tele-conference or online, so long as that method does not detract from other participants’ ability to communicate with one another. Participating in this manner shall constitute in person attendance. If a SMAC member is unable to attend a meeting, that member is requested to notify the SMAC Liaison of their absence prior to the date of the meeting. Members are encouraged to send a representative to meetings they are unable to attend. Members are requested to notify the SMAC Liaison with the name of the individual who will be attending on their behalf.

MEETING MATERIALS

When available, handouts for the current agenda will be mailed two weeks in advance of the meeting. Members shall bring all mailed handouts to the meeting to facilitate discussion.

If a member is unable to attend the meeting and is sending a representative, please forward the handouts to the representative to bring to the meeting.

FEDERAL FINANCIAL PARTICIPATION

Medicaid recipient members shall be reimbursed for necessary costs, such as transportation and childcare, to facilitate their attendance at committee meetings.

If determined necessary and available by the AHCCCS Director, Federal financial participation at 50 percent shall be secured for expenditures for the participation of the Medicaid recipient members and for committee activities, including independent technical assistance costs.

AMENDMENT

These Bylaws may be altered, amended or repealed and new or revised bylaws may be adopted by a majority of the SMAC at any regular meeting or special meeting, provided that at least ten (10) days written notice is given of intention to alter, amend, or repeal or to adopt new Bylaws at such meeting.
42 Code of Federal Regulations (CFR)

Part 431-State Administration
   Subpart A-Single State Medicaid Agency

42 CFR 431.12 § 431.12 Medical care advisory committee.

(a) Basis and purpose. This section, based on section 1902(a)(4) of the Act, prescribes State plan requirements for establishment of a committee to advise the Medicaid agency about health and medical care services.

(b) State plan requirement. A State plan must provide for a medical care advisory committee meeting the requirements of this section to advise the Medicaid agency director about health and medical care services.

(c) Appointment of members. The agency director, or a higher State authority, must appoint members to the advisory committee on a rotating and continuous basis.

(d) Committee membership. The committee must include –

   (1) Board-certified physicians and other representatives of the health professions who are familiar with the medical needs of low-income population groups and with the resources available and required for their care;

   (2) Members of consumers' groups, including Medicaid recipients, and consumer organizations such as labor unions, cooperatives, consumer-sponsored prepaid group practice plans, and others; and

   (3) The director of the public welfare department or the public health department, whichever does not head the Medicaid agency.

(e) Committee participation. The committee must have opportunity for participation in policy development and program administration, including furthering the participation of recipient members in the agency program.

(f) Committee staff assistance and financial help. The agency must provide the committee with –
(1) Staff assistance from the agency and independent technical assistance as needed to enable it to make effective recommendations; and

(2) Financial arrangements, if necessary, to make possible the participation of recipient members.

(g) Federal financial participation. FFP is available at 50 percent in expenditures for the committee's activities.

*Excerpts from SMAC Bylaws Rev. 5/2018*
I ____________________________ (please print name) affirm to commit to attending all quarterly State Medicaid Advisory Committee meetings during the 2018 – 2019 calendar years. When I am unable to attend a meeting(s), I will send a delegate who can represent the views of the constituency I represent.

If I am unable to meet this commitment as a member of the SMAC, I will notify the AHCCCS Director’s Office immediately to allow a new committee individual to be appointed to my committee slot.

____________________________  ________________
(Signature)        (Date)

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January 10, 2019
April 11, 2019
July 11, 2019
October 18, 2019
AHCCCS Update
Organizational Structure

Reaching across Arizona to provide comprehensive quality health care for those in need
AHCCCS Organizational Structure

Reaching across Arizona to provide comprehensive quality health care for those in need
2019 Strategic Plan

Reaching across Arizona to provide comprehensive quality health care for those in need
### AHCCCS Strategic Plan

<table>
<thead>
<tr>
<th>Goals</th>
<th>Goal Performance Indicator(s)</th>
<th>Objectives FY 2019</th>
</tr>
</thead>
</table>
| 1: AHCCCS must pursue and implement long term strategies that bend the cost curve while improving member health outcomes. | Percentage of Health Plan spend in alternative payment models  
Number of regulatory flexibilities approved  
Number of members receiving a Medicaid behavioral health service in schools | a) 47% of Health Plan spend in alternative payment models  
b) 3 regulatory flexibilities approved  
c) Increase the number of members receiving a Medicaid behavioral health service in a school by 10% |
| 2: AHCCCS must pursue continuous quality improvement | Percent of measures which exceed the National Committee for Quality Assurance (NCQA) mean  
Number of facilities achieving medical home status  
Overall number of prescribed opioids | a) 50% of measures exceed the NCQA mean  
b) 8 facilities achieve medical home status  
c) 13% reduction in overall number of opioids prescribed |
| 3: AHCCCS must reduce fragmentation driving towards an integrated sustainable healthcare system | Percent of AHCCCS enrollees served in a fully integrated health plan  
Percent of Targeted Investment (TI) participants retained  
Number of provider organizations participating in the Health Information Exchange (HIE)  
Percent of members who receive at least one BH service per month during their first six months of CMDP enrollment  
Percent of pre-release inmates who receive a service within 3 months of release from incarceration | a) 98% of AHCCCS enrollees served in a fully integrated health plan by October 1, 2018  
b) Retain 95% of TI participants  
c) Increase number of provider organizations participating in the HIE to 580  
d) Increase percent of members who receive at least one service per month during their first six months of CMDP enrollment from 76% to 80%  
e) Increase percent of pre-release inmates who receive a service within 3 months of release from 43% to 50% |
| 4: AHCCCS must maintain core organizational capacity, infrastructure and workforce planning that effectively serves AHCCCS operations | AHCCCS Overall Employee Engagement Score  
ADOA system security evaluation score | a) Increase engagement score to 9  
b) Increase ranking on the ADOA system security evaluation score to 725 |
2019 Legislative Initiatives

Reaching across Arizona to provide comprehensive quality health care for those in need
AHCCCS Legislation

• SMI Housing Trust Fund Flexibility
  o Sen. Carter bill will allow AHCCCS to use the SMI Housing Trust Fund for rental assistance

• DCW-Assisted Living Caregiver Training Alignment
  o Arizona Leading Age is running a bill to align the training requirements for assisted living caregivers and DCWs
Other Legislation

- KidsCare
- Dental Benefit for Pregnant Women
- Telemedicine
- Chiropractic Services
- HIE Clean Up
- Diabetes Education Services
On the Horizon

Reaching across Arizona to provide comprehensive quality health care for those in need
Medicaid Innovation Challenge

• Partnership with Adaptation Health and the Centers for Healthcare Strategies
• Brings the State Medicaid Office and MCOs together with healthcare innovators who can provide novel and sustainable solutions for addressing specific needs
• Applications due by 02/15/19
• Medicaid Innovation Challenge to take place on 03/29/19
Medicaid Innovation Challenge

• Areas of focus
  o Social determinants of health
    ▪ Assess member risk, share/house SDOH data, identify/aggregate referral options, referral feedback
  o Digital member engagement
    ▪ Technologies to assist individuals in better managing their care, accessing appropriate services, and empowering them to adopt healthier behaviors

Reaching across Arizona to provide comprehensive quality health care for those in need
Questions

Reaching across Arizona to provide comprehensive quality health care for those in need
SHA Presentation
Arizona State Health Assessment
January 9, 2019

Presenting to
State Medicaid Advisory Committee (SMAC)

Sheila Sjolander, MSW  |  Assistant Director
Carla Berg, MHS  |  Chief Strategy Officer
STATE HEALTH ASSESSMENT BACKGROUND
Assessment Framework

Assess Health Needs

Assess Capacity

Match Needs & Capacity

Set priorities & performance objectives

Further in-depth studies of specific needs

Strategic plan and allocation of resources
Arizona Health Improvement Plan 2016
First Edition of the AzHIP Published in 2016, included:

- Asthma & Chronic Lower Respiratory Diseases (CLRD)
- Cancer
- Diabetes
- Healthcare Associated Infections (HAI)

- Heart Disease & Stroke
- Maternal & Child Health
- Obesity
- Oral Health
- Tobacco
- Unintentional Injury
Arizona Health Improvement Plan
AzHIP Additions Released in 2017, included:

2 Health Priorities
• Suicide
• Substance Abuse

4 Cross-Cutting Issues
• Worksite Wellness
• Access to Care
• Built Environment
• School Health
2017/2018 Update

www.azhealth.gov/azhip/
Healthy People, Healthy Communities

✓ Healthy People
✓ Outcomes Across the Lifespan
  • Maternal, Child, and Adolescent Health
  • Healthy Adults
  • Healthy Aging
✓ Healthy Communities
  • Neighborhood Impact
  • Social Influences
  • Tribal Health
✓ Opportunities for Health
Main Data Sources

• ADHS Vital Records:
  Birth and death certificates filed with ADHS and filed in other states but affecting AZ residents.
Pregnancies are the sum of live births, spontaneous terminations of pregnancy and induced terminations of pregnancy.
• Behavioral Risk Factor Surveillance System (BRFSS):
  Annual Random selection telephone survey initiated in 1984 that collects data from Arizonan adults aged 18 and older. Results are used to monitor selected public health objectives related to general health status, health-related quality of life and well-being, determinants of health and disparities. Since BRFSS is used nationwide, comparisons can be made to other states and to the national average.
• Youth Risk Behavior Surveillance System (YRBSS):
  National school-based survey developed in 1990. Monitors six categories of health-related behaviors that contribute to the leading causes of death, disability, and social problems among youth and adults. Survey is completed every 2 years (recent years 2013, 2015, and 2017).
Arizona’s population is the 6th fastest growing in the United States. Since 2010, the average population growth rate is 1.4%.

U.S. Census Bureau, National Population by Characteristics: 2010-2017
Between 2010 – 2017, the largest population growth (36.3%) has been among residents ages 65 and older. Arizona’s population has decreased among infants by 2.2%.
The largest percentage of Arizonans are between 20 – 44 years of age. 32.7% of residents are within 20 and 44 years of age with 24.1% between ages 45 and 64.
More than 85% of Arizonans are **White** or **Hispanic/Latino**.

- **White**: 54.9%
- **Hispanic**: 31.4%
- **Black**: 4.3%
- **Asian**: 3.3%
- **American Indian and Alaska Native**: 4.0%
- **Multiracial**: 2.0%
- **Native Hawaiian and Other Pacific Islander**: 0.2%

U.S. Census Bureau, National Population by Characteristics: 2010-2017
Over 75% of Arizonans reside in Maricopa and Pima counties.
OUTCOMES ACROSS THE LIFESPAN
Leading cause of death by age group in 2017

<table>
<thead>
<tr>
<th>Rank</th>
<th>&lt;1Y</th>
<th>1-14Y</th>
<th>15 - 19Y</th>
<th>20-44Y</th>
<th>45-64Y</th>
<th>65+Y</th>
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<tbody>
<tr>
<td>1</td>
<td>Congenital Anomalies</td>
<td>Unintentional Injury</td>
<td>Unintentional Injury</td>
<td>Unintentional Injury</td>
<td>Cancer</td>
<td>Heart Disease</td>
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<tr>
<td></td>
<td>92</td>
<td>76</td>
<td>107</td>
<td>1,219</td>
<td>2,727</td>
<td>10,171</td>
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<tr>
<td>2</td>
<td>Short Gestation</td>
<td>Cancer</td>
<td>Suicide</td>
<td>Suicide</td>
<td>Heart Disease</td>
<td>Cancer</td>
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<td></td>
<td>64</td>
<td>30</td>
<td>62</td>
<td>514</td>
<td>1,853</td>
<td>8,850</td>
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<td>3</td>
<td>Maternal Complications</td>
<td>Suicide</td>
<td>Homicide</td>
<td>Cancer</td>
<td>Unintentional Injury</td>
<td>Chronic Lower Respiratory Disease</td>
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<td>31</td>
<td>16</td>
<td>32</td>
<td>301</td>
<td>1,175</td>
<td>3,293</td>
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<td>4</td>
<td>Unintentional Injury</td>
<td>Congenital Anomalies</td>
<td>Cancer</td>
<td>Homicide</td>
<td>Liver Disease</td>
<td>Alzheimer's Disease</td>
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<td></td>
<td>23</td>
<td>13</td>
<td>8</td>
<td>268</td>
<td>591</td>
<td>2,997</td>
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<td>SIDS</td>
<td>Homicide</td>
<td>Heart Disease</td>
<td>Heart Disease</td>
<td>Diabetes</td>
<td>Stroke</td>
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<td></td>
<td>14</td>
<td>10</td>
<td>*</td>
<td>248</td>
<td>545</td>
<td>2,292</td>
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<tr>
<td>6</td>
<td>Intrauterine hypoxia</td>
<td>Influenza &amp; Pneumonia</td>
<td>Abnormal Findings</td>
<td>Liver Disease</td>
<td>Chronic Lower Respiratory Disease</td>
<td>Unintentional Injury</td>
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<tr>
<td></td>
<td>11</td>
<td>*</td>
<td>*</td>
<td>149</td>
<td>460</td>
<td>1,485</td>
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<td>7</td>
<td>Homicide</td>
<td>Chronic Lower Respiratory Disease</td>
<td>Diabetes</td>
<td>Suicide</td>
<td>Diabetes</td>
<td></td>
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<tr>
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<td>77</td>
<td>413</td>
<td>1,411</td>
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<tr>
<td>8</td>
<td>Respiratory Distress</td>
<td>Asthma</td>
<td>Obesity</td>
<td>Stroke</td>
<td>Hypertension</td>
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<td>6</td>
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<td>45</td>
<td>304</td>
<td>850</td>
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<tr>
<td>9</td>
<td>Influenza &amp; Pneumonia</td>
<td>*</td>
<td>Stroke</td>
<td>Hypertension</td>
<td>Parkinson's Disease</td>
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<td>44</td>
<td>149</td>
<td>737</td>
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<td>HIV</td>
<td>Influenza &amp; Pneumonia</td>
<td>Influenza &amp; Pneumonia</td>
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<td></td>
<td></td>
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<td>20</td>
<td>125</td>
<td>697</td>
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</table>

ADHS Vital Records 2017

All age group rank

1 2 3 4 5
The 3 leading causes of death by both count and years of potential life lost (YPLL) are heart disease, cancer and unintentional injury.

<table>
<thead>
<tr>
<th>Cause of Death (count)</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Heart disease</td>
<td>12,285</td>
</tr>
<tr>
<td>2. Cancer</td>
<td>11,917</td>
</tr>
<tr>
<td>3. Unintentional injury</td>
<td>4,085</td>
</tr>
<tr>
<td>4. Chronic lower respiratory diseases</td>
<td>3,779</td>
</tr>
<tr>
<td>5. Alzheimer's disease</td>
<td>3,050</td>
</tr>
<tr>
<td>6. Cerebrovascular diseases</td>
<td>2,647</td>
</tr>
<tr>
<td>7. Diabetes</td>
<td>2,037</td>
</tr>
<tr>
<td>8. Suicide</td>
<td>1,304</td>
</tr>
<tr>
<td>9. Chronic liver disease &amp; cirrhosis</td>
<td>1,122</td>
</tr>
<tr>
<td>10. Essential (primary) hypertension &amp; hypertensive renal disease</td>
<td>1,018</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cause of death (YPLL)</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Unintentional injury</td>
<td>89,604</td>
</tr>
<tr>
<td>2. Cancer</td>
<td>82,697</td>
</tr>
<tr>
<td>3. Heart disease</td>
<td>56,505</td>
</tr>
<tr>
<td>4. Suicide</td>
<td>35,206</td>
</tr>
<tr>
<td>5. Chronic liver disease &amp; cirrhosis</td>
<td>18,741</td>
</tr>
<tr>
<td>6. Diabetes</td>
<td>16,485</td>
</tr>
<tr>
<td>7. Homicide</td>
<td>16,275</td>
</tr>
<tr>
<td>8. Chronic lower respiratory diseases</td>
<td>14,133</td>
</tr>
<tr>
<td>9. Cerebrovascular diseases</td>
<td>10,060</td>
</tr>
<tr>
<td>10. Influenza &amp; pneumonia</td>
<td>4,690</td>
</tr>
</tbody>
</table>
For 2018, Arizona ranked 30th according to America’s Health Ranking Annual Report.

Top Positive Impacts:
- Cancer Deaths
- Preventable Hospitalizations
- Smoking

Top Negative Impacts:
- Violent Crime
- Air Pollution
- High School Graduation

Positive impact includes measures where Arizona is standard deviations from the national average.
Infant births over the last 10 years have decreased from more than 102,000 to 81,664.
In 2017, the infant (less than 1) mortality rate was lower than the national average. Black, American Indian/Alaska Native, and Hispanic Arizonans are disproportionately impacted.

Arizona and U.S.
infant mortality rate, per 1,000 live births
In 2017,

Congenital malformations, deformations and chromosomal abnormalities were the leading cause of infant deaths.
A Snapshot of Preconception Health
Women ages 18-45 were included in this analysis.

Less than half of women have received advice about ways to prepare for healthy pregnancy.

3 in 10 women prepare for healthy pregnancy with daily folic acid.
Between 2014 – 2017, 8 in 10 pregnant women in AZ received adequate prenatal care.

Percent receiving intermediate or adequate prenatal care by race/ethnicity

- American Indian or Alaska Native: 68.1%
- Asian or Pacific Islander: 81.2%
- Black or African American: 71.1%
- Hispanic or Latino: 81.2%
- White non-Hispanic: 63.8%

ADHS Vital Records 2014 – 2017
Rates of maternal mortality are on the rise both in Arizona and nationally. Based on the most recent Maternal Mortality Review, American Indian or Alaska Native women had the highest rate at 284 per 100,000 live births.
Since 2012, Neonatal Abstinence Syndrome (NAS) rates in Arizona have more than doubled.
Breastfeeding rates in Arizona follow national trends. 82.7% of Arizona’s infants born in 2015 were breastfed with 26.3% exclusively breastfed at 6 months.

In 2017, Unintentional injury was the leading cause of death among children and adolescents.

Unintentional injury was the leading cause of death among children and adolescents.
Tooth decay is the #1 chronic disease in Arizona children.

More than 6 out of 10 children are affected by tooth decay.

Almost 2 in 3 3rd grade children in Arizona are affected by tooth decay.

2015 Healthy Smiles Healthy Bodies Survey
Non-medical exemption rates for childhood immunizations have increased across age groups. In the event of an outbreak, over 5,000 Arizona kindergarteners would be at risk for measles.
71.2% of Arizona’s adolescents ages 12 to 17 completed a preventive medical visit in past year compared to 78.7% nationally. Half of those adolescents without a preventive medical visit were insured.

2016 – 2017 National Survey for Children’s Health
Among Arizona’s children with a special healthcare need, 36.6% have a medical home. (Arizona vs. U.S.)
Arizona ranks last in the country as the state with the highest proportion of children ages 0 – 17 who have experienced 2 or more ACEs at 30%.
Parental separation or divorce and economic hardship are the most common ACEs in Arizona.

- Saw or heard adult violence: 11%
- Parent/guardian served time in jail: 13%
- Lived with someone who had problem with alcohol or drugs: 16%
- Hard to cover basics like food or housing: 27%
- Parent/guardian divorced or separated: 32%
36.4% of students report feeling sad or hopeless almost every day for 2 weeks or more in a row so that they stopped doing some usual activities. Additionally, more than 1 in 10 Arizona youth indicating attempting suicide with 4.7% requiring medical treatment as a result of a suicide attempt. (AZ vs. U.S.)
Fewer teens reported smoking in 2017 compared to 2013.

- **Ever tried cigarette smoking**
  - **AZ**: 2013: 43.9%, 2015: 29.9%, 2017: 20.1%
  - **U.S.**: 2013: 41.1%, 2015: 21.0%, 2017: 9.5%

- **Currently smoke cigarettes or cigars**
  - **AZ**: 2013: 43.9%, 2015: 29.9%, 2017: 20.1%
  - **U.S.**: 2013: 41.1%, 2015: 21.0%, 2017: 9.5%
While 1 in 2 teens have ever used an electronic vapor product, 16.1% report current use. Current use of electronic vapor products has decreased from 27.5% in 2015. (AZ vs. U.S.)
Arizona’s teen pregnancy rate has decreased to a low at **13.8**.
Teen pregnancies accounted for 6.7% of pregnancies in the state in 2016 with a greater impact on American Indian/Alaska Native, Hispanic, and Black/African American female teens.
HEALTHY ADULTS
In 2017, Unintentional deaths was the leading cause of death among adults ages 20 – 44. Cancer was the leading cause of death among adults ages 45 – 64.

ADHS Vital Records 2017
Unintentional injury-related mortality rates are on the rise both in Arizona and nationally with rates more than 2.5 times higher among American Indian Arizonans.
Suicide mortality rates in Arizona remain higher than national rates. Suicide deaths accounted for the loss of 1,304 Arizonans in 2017 with more than half identifying firearm as the injury type.
Males accounted for more than 75% of the suicide deaths in Arizona last year. The highest rates are seen among men ages 55 to 64 and over 75. (Male vs. Female)
The invasive cancer incidence rate from 2011 to 2015 impacted an average of 29,943 people each year. Arizona’s incidence rate remains lower than the national rate.

<table>
<thead>
<tr>
<th>Year</th>
<th>Invasive Cancer Incidence Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>465.4</td>
</tr>
<tr>
<td>2012</td>
<td>406.8</td>
</tr>
<tr>
<td>2013</td>
<td>406.8</td>
</tr>
<tr>
<td>2014</td>
<td>406.8</td>
</tr>
<tr>
<td>2015</td>
<td>406.8</td>
</tr>
</tbody>
</table>

U.S. Cancer Statistics, CDC and National Cancer Institute
Cancer mortality rates in Arizona remain lower than national rates.
The Arizona age-adjusted mortality rate for heart disease, the state’s leading cause of death, has remained below the U.S. rate over the last 5 years.
The Arizona diabetes mortality rate was 23.8 deaths per 100,000 population in 2017 with rates ranging from 16.5 to 60.2 by county.
In 2017, heart disease was the leading cause of death among Arizonans ages 65 and older.
3,780 Arizonans died due to Chronic Lower Respiratory Disease (CLRD) in 2017. The 2017 CLRD mortality rate was 43 deaths per 100,000 residents.
Over the last 5 years, the stroke mortality rate in Arizona has increased.
Behavioral Risk Factors

HEALTHY ADULTS
Arizona continues to follow the national average for healthy weight, overweight, and obesity. (Arizona vs. U.S.)

<table>
<thead>
<tr>
<th>Year</th>
<th>Adults at a healthy weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>35.8%</td>
</tr>
<tr>
<td>2014</td>
<td>33.4%</td>
</tr>
<tr>
<td>2015</td>
<td>32.9%</td>
</tr>
<tr>
<td>2016</td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td></td>
</tr>
</tbody>
</table>
Over the last 5 years, the percentage of Arizonans who reported currently smoking has remained below the national average.

- 2013: 16.3%
- 2014: 17.1%
- 2015: 15.6%
- 2016: 15.6%
- 2017: 17.1%

The national average (U.S.) was 17.1% in 2013, which decreased to 19.0% in 2017.

The map shows the percentage of adult smokers in Arizona and its counties for 2017. The colors indicate the percentage of smokers: < 11%, 11% - 15%, 15% - 20%, and > 20%.
Disparities in income and race/ethnicity exist for smoking prevalence in the state. **28.6%** of Arizonans with an income less than $15,000 and **17.8%** of African American Arizonans are current smokers.
5.3% of Arizonan adults use e-Cigarettes.

Use of eCigarettes was initially captured in the 2016 BRFSS.
15.2% of Arizonans report binge drinking which has been below the national average for the last 5 years with pending 2017 national results.

Graph showing the trend from 2013 to 2017 for Arizona and the U.S., with Arizona having a lower percentage than the U.S. overall.

Map of Arizona showing the percentage of adult binge drinking by county, with different colors representing different percentage ranges.
Arizona has been facing an opioid epidemic leading to hundreds of death each year.
Heroin and oxycodone were the opiate drugs most commonly noted in overdoses determined to be due to opioids during review June 15, 2017 - November 29, 2018.
Verified Fatal Opioid Overdoses by Age and Gender:
June 15, 2017-June 14, 2018

ADHS 5-day Opioid Surveillance System
Chronic pain was the most common pre-existing condition for non-fatal overdoses determined to be due to opioids during review June 15, 2017 - November 29, 2018.
While 1 in 5 Arizonans ages 18 to 25 had any mental illness in the past year, only 1 in 10 received mental health services during that same time. For adults over age 26, 17% had a mental illness and 12.1% received services.

Percent with any mental illness and percent receiving services

<table>
<thead>
<tr>
<th>Age</th>
<th>Mental Illness (%)</th>
<th>Services (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-25Y</td>
<td>20.7</td>
<td>10.4</td>
</tr>
<tr>
<td>26+Y</td>
<td>17.0</td>
<td>12.1</td>
</tr>
</tbody>
</table>

2015 and 2016 NSDUH
18.8% of Arizonans report ever being told they have a form of depression. Frequent mental distress is reported at a higher percentage among American Indians/Alaska Natives in the state.
STD cases have tripled since 2000 with 2016 rates indicating distribution statewide.

*2016 - Darker shades indicate higher rates.

Arizona Department of Health Services, 2017 STD Dashboard
The majority of people with hepatitis C are baby boomers. While rates of hepatitis C are increasing both in AZ and nationally, rates are higher among Arizonans.
TRIBAL HEALTH
35% of American Indian/Alaskan Native Arizonans are living below the poverty level. American Indian/Alaskan Native Arizonans report the lowest percentage of very good or excellent health.

U.S. Census Bureau, 2012 – 2016 American Community Survey 5-year period estimates and BRFSS 2016
In 2016, the leading cause of death among American Indian/Alaska Natives by gender and residence is **unintentional injury** for almost all groups with rates exceeding 12 deaths per 100,000 residents.

<table>
<thead>
<tr>
<th>Rank</th>
<th>Female, resided on reservation</th>
<th>Female, resided off reservation</th>
<th>Male, resided on reservation</th>
<th>Male, resided off reservation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Unintentional injury 12.4</td>
<td>Cancer 13.3</td>
<td>Unintentional injury 20.2</td>
<td>Unintentional injury 19.3</td>
</tr>
<tr>
<td>2</td>
<td>Heart disease 11.8</td>
<td>Heart disease 12.5</td>
<td>Heart disease 12.0</td>
<td>Heart disease 12.6</td>
</tr>
<tr>
<td>3</td>
<td>Cancer 10.5</td>
<td>Liver disease 10.2</td>
<td>Liver disease 8.8</td>
<td>Liver disease 9.6</td>
</tr>
<tr>
<td>4</td>
<td>Liver disease 8.5</td>
<td>Diabetes 7.8</td>
<td>Diabetes 8.4</td>
<td>Cancer 8.2</td>
</tr>
<tr>
<td>5</td>
<td>Diabetes 8.1</td>
<td>Unintentional injury 6.6</td>
<td>Cancer 7.3</td>
<td>Diabetes 6.4</td>
</tr>
</tbody>
</table>
Among American Indian/Alaska Natives in Arizona, unintentional injury is the leading cause of death with a mortality rate of **139** per 100,000 persons. The motor vehicle-related injury mortality rate for the same year was **54.3**.
The average life expectancy in Arizona is **79.5** years.

Six of the state’s counties fall below the nation average life expectancy of **78.6** years.
A 13 mile distance could mean a difference in 14 years of life.

Virginia Commonwealth University, Center on Society and Health
13.5% of Arizonans report an education level less than high school degree compared to 12.7% nationally.

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U.S. Census Bureau, 2013 - 2017 American Community Survey 5-year period estimates
17% of Arizonans are living below the federal poverty level.

U.S. Census Bureau, 2013 – 2017 American Community Survey 5-year period estimates
4.6% of Arizonans are unemployed.
Among Arizonans reporting a good overall health status, higher percentages were identified among those with at least a high school degree and those with an income over $15,000.
Almost 1 in 4 of Arizona’s children are living below the federal poverty level and 30.3% of children are living in households with public assistance including SSI, cash public assistance or SNAP benefits.

U.S. Census Bureau, 2013 – 2017 American Community Survey 5-year period estimates
Since 2012, Arizona has seen an increase in residents with health insurance, however, we remain below the national average.

U.S. 88.3%
AZ 86.4%

83.0%
85.1%
88.3%


U.S. Census Bureau, 2012 – 2016 American Community Survey 5-year period estimates
Arizona suffers from a disproportionate distribution of providers evident by a total of 546 federally designated Health Professional Shortage Areas (HPSAs).

Primary Care: 187
Dental: 183
Mental Health: 176

ADHS Health Systems Development, Health Resources and Services Administration
14.9% of households in Arizona face food insecurity.

Low food access areas include areas where people lack access to healthy food and fresh produce. This negatively affects the health of low-income individuals because they lack the means to travel to obtain healthier foods.

USDA, Economics of Food, Farming, Natural Resources, and Rural America and 2015 USDA ERS Food access by census tract
The 2017 Point in Time survey identified an estimated 8,947 sheltered and unsheltered homeless individuals statewide. *(Unsheltered vs. Sheltered)*

Between 2016 and 2017, the total number of homeless individuals increased by 3%.
1 in 2 Arizonans pay a gross rent of 30% or more of their household income.

U.S. Census Bureau, 2012 – 2016 American Community Survey 5-year period estimates
Fewer of Arizona’s adults believe their children live in a supportive neighborhood compared to nationally.

58.8% definitely agree their children live in a safe neighborhood.

Supportive Neighborhood

- AZ: 45.3%
- U.S.: 55.4%

Safe Neighborhood

- Definitely agree: 58.8%
- Somewhat agree: 32.4%
- Somewhat or definitely disagree: 8.8%

2016 – 2017 Combined National Survey of Children’s Health
Social vulnerability index (SVI) ranks communities by social factors and estimates readiness or vulnerability in the event of an emergency. The closer to **1** indicates the highest risk.

### Socioeconomic Status
- Below Poverty
- Unemployed
- Income
- No High School Diploma

### Household Composition & Disability
- Aged 65 or Older
- Aged 17 or Younger
- Civilian with a Disability
- Single-Parent Households

### Minority Status & Language
- Minority
- Speak English “Less than Well”

### Housing & Transportation
- Multi-Unit Structures
- Mobile Homes
- Crowding
- No Vehicle
- Group Quarters

ATSDR Social Vulnerability Index, 2016
In 2017, 3 of Arizona’s counties ranked in the top 10 worst according to EPA’s Air Quality Index (AQI).

<table>
<thead>
<tr>
<th>Rank</th>
<th>County</th>
<th>State</th>
<th>Median AQI</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hawaii</td>
<td>HI</td>
<td>146</td>
</tr>
<tr>
<td>2</td>
<td>Riverside</td>
<td>CA</td>
<td>87</td>
</tr>
<tr>
<td>3</td>
<td>Gila</td>
<td>AZ</td>
<td>84</td>
</tr>
<tr>
<td>4</td>
<td>Kern</td>
<td>CA</td>
<td>84</td>
</tr>
<tr>
<td>5</td>
<td>San Bernardino</td>
<td>CA</td>
<td>84</td>
</tr>
<tr>
<td>6</td>
<td>Tulare</td>
<td>CA</td>
<td>80</td>
</tr>
<tr>
<td>7</td>
<td>Los Angeles</td>
<td>CA</td>
<td>77</td>
</tr>
<tr>
<td>8</td>
<td>Pinal</td>
<td>AZ</td>
<td>75</td>
</tr>
<tr>
<td>9</td>
<td>Fresno</td>
<td>CA</td>
<td>74</td>
</tr>
<tr>
<td>10</td>
<td>Maricopa</td>
<td>AZ</td>
<td>71</td>
</tr>
</tbody>
</table>
Arizona has $50 per person dedicated for public health from state and federal dollars directed by the CDC and HRSA, falling well below the national average of $86 per person with a public health funding ranking of 47\textsuperscript{th} in the country.

OPPORTUNITIES FOR HEALTH
Health priorities identified by Arizona’s County Health Improvement Plans

- Substance Abuse
- Mental Health
- Chronic Disease
- Heart Disease
- Diabetes
- Safe Neighborhoods
- Injury Prevention
- Obesity
- Health Lifestyles
- Nutrition & Physical Activity
- Access to Care
- Health Literacy
- Maternal & Child Health
- Teen Pregnancy
- Maternal & Child Health
- Teen Pregnancy
Impact of different factors on risk of premature death

Schroeder, SA (2007). We Can Do Better – Improving the Health of the American People. NEJM. 357:1221-8
Healthy People Healthy Communities: Moving Towards Health Equity

[Diagram showing the difference between Equality and Equity]

Discussion

• What takeaways do you have from this snapshot?

• Would additional analysis be useful in understanding the health of Arizonans?

• How do we use this data to take action?

• How would you prioritize resources and activities?
THANK YOU

AzHIP@azdhs.gov  |  602-364-3143

azhealth.gov

@azdhs

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