

FIRST THINGS FIRST

Pascua Yaqui Tribe Region



2022 Needs and Assets Supplemental Report:

Children's Access to and Use of Public Health Services

Report Prepared by:

Center for Health Information & Research

Arizona State University

502 E. Monroe St, Suite C320

Phoenix, AZ 85004

(602) 496-2009 | chir@asu.edu / chs.asu.edu/chir

Project Team

- Molly Loughran, MS, Data Science Specialist
- Varnika Angampally, MS, Statistical Programmer
- Nishanth Prathap, MS, Data Science Specialist
- Tameka Sama, MBA, CRA, Center Administrator
- Sruthi Kommareddy, Database Analyst
- Gevork Harootunian, MS, Data Science Consultant
- Meghan Morris, MD, Clinical Consultant
- Anita Murcko, MD, Clinical Consultant

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EXECUTIVE SUMMARY

Under the direction of First Things First (FTF), the Arizona State University Center for Health Information & Research (CHiR) conducted a regional network analysis of children from birth to age 5 to determine the health assets and health needs in the Pascua Yaqui Tribe Region. The main data source was claims data from the Arizona Health Care Cost Containment System (AHCCCS), Arizona’s Medicaid agency; therefore, the results presented in this report were for children and mothers who were enrolled in AHCCCS from 2017 to 2019.¹ This population was denoted as AHCCCS children or AHCCCS women.

CHiR and representatives from the FTF Regions, Programs, and Evaluation teams determined priority indicators for this report. AHCCCS children’s health was measured in the following categories: primary care and well-child visits, health care workforce, screening for lead poisoning, weight assessment and counseling, developmental health, behavioral health, vision, hearing, oral health, immunizations, maternal prenatal and postpartum care, and health plan performance. Many of the reported indicators were from the Healthcare Effectiveness Data and Information Set (HEDIS)². HEDIS is a performance improvement tool whereby health plans, health care organizations and government agencies submit data on specific health measures. HEDIS uses the collected data to calculate national performance statistics and benchmarks and set standards for measures. HEDIS specifications were applied to the AHCCCS population for each region. Non-HEDIS indicators, which do not have associated benchmarks, were compared to state and national data when possible. The results were displayed by gender, age, race, ethnicity, tribal affiliation³, provider type, and health plan when the data was available and within data suppression guidelines. The results of the analyses are summarized below. When possible, the results are grouped by 1) indicators that met or were above the state average or national HEDIS standards and 2) indicators that did not meet or were below the state average or national HEDIS standards. Other notable findings are also presented that do not have comparison data.

Population and Demographics of Children Enrolled in AHCCCS

There were 234,616 children from birth to age 5 enrolled in AHCCCS statewide from 2017 to 2019. In the Pascua Yaqui Tribe Region there were 305 children enrolled in AHCCCS in 2017, 285 children enrolled in 2018 and 271 children enrolled in 2019. In 2017, 51% of AHCCCS children were male, but in 2018 and 2019 51% of AHCCCS children were female. Regionally, there were 10% more preschoolers than infants and toddlers in 2017, with the difference dropping to 7% more in 2018 and increasing to 13% more in 2019. By race, the percentage of Native American AHCCCS children in the region dropped from 86% in 2017 to

¹ Data used in this report covers all AHCCCS members in Arizona, including members living in FTF tribal regions and subregions. Reports for tribal regions and subregions were carried out with specific approval from each tribe. For those tribal regions and subregions who did not give approval, data is included only in aggregate totals for Arizona, and—in the case of a tribal subregion—aggregate totals for the region.

² See <https://www.ncqa.org/hedis/>

³ Tribal affiliation refers to whether an individual is a member of a federally recognized Arizona tribe and is displayed as a flag (Yes/No) in this report. This information is captured during enrollment in AHCCCS.

82% in 2019. There were no Asian/Pacific Islander AHCCCS children in the region, so this race was not reported beyond this section.

The data was suppressed for Black AHCCCS children in the region throughout this report due to counts <6. The percentage of AHCCCS children who were reported as Hispanic or Latino in the region decreased from 27% in 2017 to 24% in 2018 and 2019. Affiliation with a tribal community was reported by 93-94% of AHCCCS children in the region.⁴ Nearly three-quarters of AHCCCS children in the region were enrolled in three health plans from 2017 - 2019: American Indian Health Plan (39-45%), Mercy Care Plan (11-21%) and UnitedHealthcare (13-15%). Annual health claims were submitted mostly by Physicians (15-21%), followed by Federally Qualified Health Centers (17-20%), Behavioral Health Outpatient Clinics (14-22%) and Pharmacy (8-12%).

Health Care Workforce

The supply of physicians in the United States is tracked by the Association of American Medical Colleges biennially. Arizona had 160 hospitals individually licensed by the state which were subtyped as children, critical access, long term, short term, psychiatric, rehabilitation, transplant and non-participating. The Pascua Yaqui Tribe Region did not show any medical facilities that were licensed by the state.

The rate of available primary care physicians per 1,000 AHCCCS children in the region was 13 in 2017, 4 in 2018 and 18 in 2019 compared to the statewide rate of 23-24 per 1,000 AHCCCS children. For primary care physicians accepting AHCCCS patients, the regional rate of physicians per 1,000 AHCCCS children was 3 in 2017, 2 in 2018 and 7 in 2019. For dentists accepting AHCCCS patients, the regional rate was 3-4 dentists per 1,000 AHCCCS children compared to 16-17 dentists per 1,000 AHCCCS children statewide.

We compared the distance that regional and statewide AHCCCS children needed to travel to the nearest provider type to assist in determining whether the population in the region may have access to care issues based on travel distance. A unique feature of the Pascua Yaqui Tribe Region was its small size. The region was only 2.2 square miles and only had one zip code. Although many regional AHCCCS children did not have exact addresses in the distance analysis, no matter where the children lived in the zip code, the nearest provider was close by for most provider types, either in the region or a neighboring region. The nearest primary care physician, dentist and behavioral health provider was no more than one mile away from 96-100% of AHCCCS children in the region compared to 56-65% of AHCCCS children statewide. The nearest pharmacy was up to five miles away for all regional AHCCCS children versus 64% of AHCCCS children statewide. Regional AHCCCS children traveled the farthest to visit a hospital as the nearest hospital for all children was 5-10 miles away whereas 80-81% of AHCCCS children statewide traveled five miles or less to the nearest hospital.

⁴ Tribal affiliation refers to whether an individual is a member of a federally recognized Arizona tribe and is displayed as a flag (Yes/No) in this report. This information is captured during enrollment in AHCCCS.

Primary Care and Well-Child Visits

Access to primary care is important for the health and well-being of children. Primary care practitioners (PCPs) provide appropriate screenings, treatment and preventive services. When children regularly visit a PCP, they are less likely to visit the emergency department for non-urgent care. Well-child visits are PCP visits scheduled at designated age intervals where a child's growth and development are measured and tracked according to national guidelines. PCPs examine a child holistically for physical, mental, emotional and social/environmental health during a well-child visit.

Regionally, 69-78% of AHCCCS children had at least one PCP visit compared to 85-86% of AHCCCS children statewide and 86-87% of Medicaid children nationally. The regional rates were below the AHCCCS Minimum Performance Standard (MPS)⁵ of 84% from 2017 to 2019. AHCCCS children ages 1-2 (71%) were more likely to have annual PCP visits than ages 3-5 (69%) in 2017; however, ages 3-5 (70-79%) were more likely to have annual PCP visits in 2018 and 2019 than ages 1-2 (67-74%). All AHCCCS children in the region who were not affiliated with a tribe were more likely to have an annual PCP visit than tribally affiliated AHCCCS children (67-76%). Hispanic or Latino AHCCCS children (79-90%) were more likely to have annual PCP visits than Non-Hispanic or Latino AHCCCS children (65-74%) in the region. By race, all Caucasian/White AHCCCS children in the region were more likely to have annual PCP visits than Native American AHCCCS children (64-73%).

Regionally, 36-40% of AHCCCS children birth to 15 months had six or more well-child visits compared to 53-60% of AHCCCS children statewide and 63-66% of Medicaid children nationally from 2017 to 2019. The region and state rates were below the AHCCCS MPS of 65% (2017 and 2018) and 62% (2019) for this indicator. Hispanic or Latino AHCCCS children in the region (58-60%) were more likely to have an annual well-child visit compared to Non-Hispanic or Latino AHCCCS children (27-32%) in 2018 and 2019. For AHCCCS children ages 3-5, 49-53% of regional children had an annual well-child visit compared to 62-65% of statewide children and 72-74% of Medicaid children ages 3-6 nationally. The region did not meet the AHCCCS MPS of 66% for this indicator from 2017 to 2019. Hispanic or Latino AHCCCS children (62-71%) were more likely to have an annual well-child visit compared to Non-Hispanic or Latino AHCCCS children (42-47%).

Screening for Lead Poisoning

Lead poisoning is a silent killer because often there are no symptoms. Exposure to lead can cause irreversible damage to the brain and other vital organs in children, as well as intellectual and behavioral deficits. To detect abnormal blood lead levels in children, screenings are conducted via a blood lead test. According to the Arizona Department of Health Services (ADHS), children who live in areas designated as high-risk for lead poisoning should receive a blood lead test at 12 and 24 months of age, and older children

⁵ Minimum Performance Standard (MPS) is the minimal expected level of performance by AHCCCS Contractors. AHCCCS-reported rates are the official rates used to determine Contractor compliance with performance requirements. If a Contractor does not achieve the MPS, they will be required to submit a corrective action plan and may be subject to sanctions for each deficient measure.

who have not been previously tested should receive the blood lead test.⁶ For AHCCCS children being screened for lead poisoning one or more times by their second birthday, the regional rate was 39% in 2017, 31% in 2018 and 33% in 2019 compared to AHCCCS statewide rates which increased from 32% in 2017 to 35% in 2019.

Weight Assessment and Counseling

Childhood obesity has both short-term and long-term effects, so it is important for primary care practitioners (PCPs) to monitor weight problems in children and provide guidance for maintaining a healthy weight and lifestyle. The prevalence of obesity among children aged 2–5 years in 2015-2016 was 14% according to a national survey. For this report, we focused on AHCCCS children ages 3-5.

The regional rates for weight assessment and counseling showed AHCCCS children in the Pascua Yaqui Tribe Region were assessed for weight at rates of 8% in 2017, 12% in 2018 and 37% in 2019 compared to 9-19% for AHCCCS children statewide. Rates for nutrition counseling were suppressed at the regional level versus 4-5% at the state level for AHCCCS children. Physical activity assessments in the region were suppressed whereas AHCCCS children statewide were assessed <1-1%.⁷ The national HEDIS Medicaid rates included children ages 3-17, and therefore, were not strictly comparable to the region or state rates for AHCCCS children ages birth to 5.

Developmental Screening and Delay

During early childhood, children grow and develop at a rapid pace physically and cognitively. Although children develop skills at different times, there are guidelines that define the period when an average child should meet certain developmental milestones. National pediatric guidelines recommend developmental screenings during well-child visits for all children ages 9 months, 18 months, 2 years and 2.5 years. Developmental delay occurs when a child does not demonstrate mastery of developmental milestones. Developmental delays have been found to occur in 10-15% of preschool children nationwide.

Rates of developmental screenings in AHCCCS children birth to age 5 increased over the report period although still well below the AHCCCS median rates of 42% in 2017 and 32% in 2018. At the regional level, rates increased from 2-5% compared to statewide AHCCCS rates of 10-14% from 2017 to 2019.⁸ Rates of diagnosing developmental delay in AHCCCS children were 3-4% at the regional level compared to 3-5% at the state level for AHCCCS children in 2018 and 2019. Of those AHCCCS children who were diagnosed with developmental delay, 58% of regional and statewide AHCCCS children received behavioral health services in 2019.

⁶ <https://www.azdhs.gov/preparedness/epidemiology-disease-control/lead-poisoning/index.php#high-risk-zip-codes-home>

⁷ Physical Activity Counseling includes sports physicals which are not provided to children in the early childhood age group.

⁸ Due to the limited capture of developmental screenings in claims data alone, these rates should be interpreted with caution.

Behavioral Health

The social-emotional development and adaptive functioning of a young child is as important as their physical health. Negative early childhood events can lead to behavioral and physical health problems in adulthood if behavioral health intervention services are not provided at the infant and toddler stages. For young children, behavioral health services⁹ would likely include day programs, crisis services, rehabilitation services, health promotion, mental health counseling, psychiatric and psychologist services, and various support services. Of AHCCCS children in the Pascua Yaqui Tribe Region, 14-22% received behavioral health services compared to 11-16% of AHCCCS children statewide from 2017 to 2019. Male AHCCCS children in the region were more likely to receive behavioral health services (16-23%) compared to female AHCCCS children (13-20%).

Vision¹⁰

Visual impairment affects a child's development, performance, and quality of life. Fortunately, most vision problems are successfully treated when detected early through regular visits to primary care practitioners (PCPs), and well-child visits should include a vision screening. It has been estimated that 20% of preschool children in the United States have eye or vision problems. Arizona's Eyes on Learning Vision Coalition recommends a vision screening beginning at age one. Children ages 3-5 should have at least one vision screening by a PCP or trained screener, and annual screenings should be provided to children in kindergarten through fourth grade.

In the Pascua Yaqui Tribe Region, 18-22% of AHCCCS children received an annual vision screening or well-child visit compared to 43-47% of AHCCCS children statewide from 2017 to 2019. AHCCCS children ages 3-5 (21-28%) were more likely to receive an annual vision screening or well-child visit than ages 1-2 (21-24%). AHCCCS children who were Hispanic or Latino (19-29%) were more likely to receive an annual vision screening or well-child visit than Non-Hispanic or Latino AHCCCS children (16-19%). Eye exams were conducted much less frequently, ranging 4-6% annually at the regional and state levels for AHCCCS children. Follow-up eye exams were conducted on AHCCCS children statewide at rates of 4-5%, and regional rates were suppressed. AHCCCS children with visually significant eye conditions received treatment at a rate of 58% regionally in 2018 compared to 54-60% statewide from 2017 to 2019.

⁹ For more detail on AHCCCS behavioral health services, visit

<https://www.azahcccs.gov/Members/AlreadyCovered/coveredservices.html>

¹⁰ Per the AHCCCS Medical Policy Manual, AHCCCS children should receive hearing and vision screenings during their well-child visits according to the periodicity schedule. Claims data does not specify each service provided during a well-child visit; thus, we cannot verify whether these screenings were provided according to the schedule. The rates in this report should be interpreted with caution.

Hearing¹⁰

Most children begin hearing sounds at birth and learn to speak over time by imitating the sounds around them. However, it is reported that around two or three out of every 1,000 children are born deaf or hard-of-hearing in the United States, and more lose their hearing later in childhood. For children diagnosed with hearing loss, early detection, intervention and treatment would provide each child with the opportunity to develop better language and communication skills. Arizona strives to screen all infants before one month of age. Infants who do not pass the initial hearing screen and a rescreening, should be evaluated further to confirm or diagnose hearing loss before 3 months of age. Infants diagnosed with permanent hearing loss should receive intervention services before 6 months of age.

Nearly 99% of all Arizona infants received a newborn hearing screening in 2017 which was slightly higher than the national rate of 98%. Less than 1% of all Arizona infants were diagnosed with permanent hearing loss, and of those, 42% were diagnosed before three months of age. Nationally, 10% of infants were diagnosed with permanent hearing loss, and of those, approximately 74% were diagnosed before three months of age. Additional audiology services were provided to 15% of regional AHCCCS children under age one in 2017 compared to 11% of AHCCCS children statewide in 2017 and 9% of children in 2019. Hearing screenings were provided to 4% of regional AHCCCS children ages 1-5 in 2019 compared to 28% of AHCCCS children statewide. Statewide AHCCCS children's rates for additional audiology services for ages 1-5 decreased from 68% to 57% from 2017 to 2019, and regional rates were suppressed for this indicator.

Oral Health

Oral health is a key indicator of overall health, well-being and quality of life. Access to dental care is necessary to maintain good oral health. Two preventative care dental visits are recommended annually for children. For young children, the application of fluoride varnish to primary and permanent teeth biannually is also recommended to prevent cavities.

In the Pascua Yaqui Tribe Region, 36-48% of AHCCCS children had at least one annual dental visit compared to 51-53% of AHCCCS children statewide from 2017 to 2019. Neither the region nor the state met the AHCCCS MPS of 60% for annual dental visits for ages 2-20. Most dental claims were submitted by dentists in 2017 (74%) and 2018 (63%), but in 2019, Federally Qualified Health Centers submitted the most dental claims (62%). AHCCCS children ages 3-5 (43-52%) were more likely to have at least one annual dental visit than ages 1-2 (23-38%). Hispanic or Latino AHCCCS children (51-56%) were more likely to have at least one annual dental visit in 2017 (41%) and 2019 (49%), and Non-Hispanic or Latino AHCCCS children were more likely to have at least one annual dental visit in 2018 (40%).

Two preventative care dental visits are recommended annually for children. Regionally, 9-10% of AHCCCS children in 2017 and 2018, and 4% of children in 2019, received the biannual preventative care dental visits compared to 18-20% of AHCCCS children statewide. Fluoride varnish was applied to 29-37% of

¹⁰ ibid

AHCCCS children in the region compared to 47-49% of AHCCCS children statewide. Regional AHCCCS children ages 3-5 (33-39%) were more likely to have a fluoride varnish application than ages 1-2 (22-32%) from 2017 to 2019.

Maternal Prenatal and Postpartum Care

The health of women before pregnancy and after delivery significantly impacts their health and the health of their babies. Thus, it is important to focus on women's prenatal and postpartum care. Prenatal care involves regular visits to a health care provider to monitor the mother's health and health of the developing fetus. Women should have at least one prenatal visit in the first trimester of pregnancy. The period of up to 60 days following childbirth is called the postpartum period. Preexisting health conditions, social determinants, and newly developed conditions contribute to maternal morbidity and mortality during this period so at least one postpartum visit is recommended.

In the region, 53% of pregnant women in 2017, 64% in 2018 and 60% in 2019 began prenatal care in the first trimester compared to 84-86% of AHCCCS women statewide. The region did not meet the Healthy People 2030 target rate of 81%¹¹. For postpartum care, 68% of regional AHCCCS women in 2017, 45% in 2018 and 60% in 2019 had at least one postpartum visit compared to 88-89% of AHCCCS women statewide and 64-75% of Medicaid women nationally.

Health Plan Performance

This section provided a selection of health indicators to compare results among AHCCCS children enrolled in each of the AHCCCS health plans available in the region. All regional health plans exceeded the AHCCCS statewide aggregate performance and Minimum Performance Standard for primary care practitioner visits for ages 1-5 for all years that were not suppressed, except for the American Indian Health Program which did not meet this performance metric in any year. For at least one well-child visit in the first 15 months, all regional health plans performed well, ranging from 86% for UnitedHealthcare in 2017 to 89% for Steward Health Choice AZ in 2018 to 100% for all other health plans and years that were not suppressed. Four regional health plans met or exceeded the AHCCCS statewide aggregate performance and MPS for one or more annual well-child visits for ages 3-5: Banner University Family Care (from 2017 to 2019), Mercy Care Plan (2017 and 2018), Steward Health Choice AZ (2017 and 2018), and UnitedHealthcare (from 2017 to 2019). Arizona Complete Care exceeded the AHCCCS statewide aggregate performance for one or more annual well-child visits for ages 3-5 in 2019. Banner University Family Care (2017) and Care 1st (2019) exceeded the AHCCCS statewide aggregate health plan performance and MPS

¹¹ Healthy People 2030 Prenatal Care Objective - <https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/increase-proportion-pregnant-women-who-receive-early-and-adequate-prenatal-care-mich-08>

or preventative care dental visits for ages 1-5, and Banner University Family Care met the MPS for this indicator in 2018.¹²

Conclusion

From 2017 to 2019, the Pascua Yaqui Tribe Region showed strong performance on the following AHCCCS children's and women's health indicators: access to care, newborn hearing screenings and acute health plan performance on primary care practitioners (PCP) visits and well-child visits. These achievements contributed to good health outcomes throughout the region. The areas where needs were identified for AHCCCS women and children in the region included: PCP and well-child visits, lead poisoning screenings, developmental screenings, vision screenings and treatment for significant visual conditions, oral health, and prenatal and postpartum care. The information in this report can be combined with other available information to create a more comprehensive view of young children and women in the region for regional council planning.

¹² The AHCCCS statewide indicator for preventative care dental visits includes ages 2-20 which incorporates a significantly larger number of AHCCCS children than our reporting on ages birth to 5, so the rates should be compared with caution.

INTRODUCTION

THE IMPORTANCE OF EARLY CHILDHOOD HEALTH

Under the direction of First Things First (FTF), the Arizona State University Center for Health Information & Research (CHiR) conducted a regional analysis of children from birth to age 5 to explore the health assets and needs in the FTF Pascua Yaqui Tribe Region. This report provides detailed health utilization and access to services for children birth through 5, along with prenatal and postpartum women, who were enrolled in the Arizona Health Care Cost Containment System (AHCCCS). Additional information is provided via medical board licensing data to further describe access to medical professionals and services contracted under AHCCCS. The goal is for the FTF Regional Partnership Councils to utilize the findings in this report when conducting regional planning discussions, as an additional resource and tool to the Regional Needs and Assets base report.

DEFINITIONS

Access to Care

This term refers to making health care services readily available when needed and removing all barriers.

Age Groups

- Age is defined as the age of the patient on Dec. 31 of each given year. The age for a patient is constant through the report year. Special age breakdowns are listed for certain indicators that have an associated milestone.
- Infants: less than 1 year of age
- Toddlers: greater than or equal to 1 year of age to less than 3 years of age
- Preschooler: greater than or equal to 3 years of age to less than 6 years of age

Assets

An asset is a finding where young children or women appear to be faring well regarding utilization of or access to health care.

Behavioral Health

To determine whether children are receiving behavioral health services, we used the following definition: category of service on claim equals mental health services (category of service = 47) or primary diagnosis is a behavioral health diagnosis as listed in the AHCCCS Behavioral Health Services Matrix <https://www.azahcccs.gov/PlansProviders/MedicalCodingResources.html>.

Children

Unless noted otherwise, all references to children denote children, ages birth to 5, who are AHCCCS members.

CMS Median

The Centers for Medicare & Medicaid Services (CMS) annually collects and reports state performance rates on a standardized set of care quality measures for Medicaid and Children’s Health Insurance Program beneficiaries, called the Child and Adult Core Set. The CMS Median is the average performance among reporting states for each measure.

Habilitation

Training in independent living skills or special developmental skills, sensory-motor development, orientation and mobility and behavior intervention.

Healthcare Effectiveness Data and Information Set

The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool produced by the National Committee for Quality Assurance (NCQA) that is used by most U.S. health plans to measure performance and quality in health care. HEDIS® contains over 90 measures under six domains of care: effectiveness of care, access/availability of care, experience of care, utilization and risk adjusted utilization, health plan descriptive information, and measures reported using electronic clinical data systems. The national committee collects HEDIS® survey results from health plans and Preferred Provider Organizations through the Healthcare Organization Questionnaire and collects non-survey data through the Interactive Data Submission System. HEDIS measures are specifically defined to make comparisons among health plans. The measurement set is reviewed annually. CHiR uses the AHCCCS claims within HEDIS. HEDIS measures have complicated numerator and denominator calculations, and therefore, are expressed and interpreted as rates.

Health Plans

Health plan categories include acute care, Children’s Rehabilitative Services, Comprehensive Medical and Dental Program, Developmental Disability/Department of Economic Security, Long Term Care, and Fee-For-Service American Indian health plans.

Minimum Performance Standard

Minimum Performance Standard (MPS) is the minimal expected level of performance by AHCCCS Contractors. AHCCCS-reported rates are the official rates used to determine Contractor compliance with performance requirements. If a Contractor does not achieve the MPS, they will be required to submit a corrective action plan and may be subject to sanctions for each deficient measure.

Needs

A need is an area where it appears that access or utilization of health care is low.

Postpartum Period

The AHCCCS postpartum period begins the day the pregnancy terminates and continues for 60 days following pregnancy termination.

Primary Care Physician Specialties

Physicians included in the primary care specialty include Family Practitioner, General Practitioner, Internal Medicine and Pediatrician.

Race/Ethnicity

Race and ethnicity are grouped and reported in the following manner.

- Race
 - Asian/Pacific Islander
 - Black
 - Caucasian/White
 - Native American
 - Other/Unknown
- Ethnicity
 - Hispanic or Latino
 - Not Hispanic or Latino
 - Unknown

Up until 2017, AHCCCS only collected one race/ethnicity variable and used the Hispanic value to denote Hispanic or Latino origin. As of 2017, AHCCCS began collecting race and ethnicity as separate variables. Hispanic is retained as a race variable, but AHCCCS is phasing out its use; therefore, the decrease in the use of Hispanic in the race variable correlates to the increase in reporting of Unknown in the race variable. Ethnicity is reported separately beginning in 2018 and notes on its use in this report are below.

- Individuals who reported “Not Hispanic, Latino, Spanish” are not Hispanic or Latino origin.
- To denote those of Hispanic or Latino origin, we combine Mexican, Mexican American, Chicano, Puerto Rican, Cuban, Other Hispanic/Latino Origin, and Hispanic or Latino Unknown.
- All individuals who reported a race/ethnicity of Hispanic prior to 2017 were assigned a race of other/unknown and an ethnicity of Hispanic or Latino origin
- Ethnicity Unspecified refers to individuals who did not answer or were not provided the opportunity to give this information.
- Ethnicity Unknown means the individual chose to be unknown. AHCCCS started phasing out this category in October 2018.
- Data on multiracial individuals is not collected.

Tribal Affiliation

Tribal affiliation refers to whether an individual is a member of a federally recognized Arizona tribe and is displayed as a flag (Yes/No) in this report. This information is captured during enrollment in AHCCCS. This is based on AHCCCS-stated affiliation, not residential location.

Well-Child Visits

Children enrolled in AHCCCS receive well-child visits under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program. The EPSDT program provides comprehensive treatment and preventive health care services for children under age 21. The services include dental, physical, behavioral health, developmental, vision, hearing, screenings and other specialty services. EPSDT visits are all-inclusive, meaning one payment is made for all services rendered during the visit. Only certain services are billed

separately when conducted by qualified health care providers, and those are: nutritional assessments, developmental screenings, immunizations, fluoride varnish and ocular photo screening.

Women

Unless noted otherwise, all references to women denote women who were AHCCCS members.

APPROACH

CHiR and representatives from the FTF Regions, Programs, and Evaluation teams determined priority indicators for this report. FTF provided the regional and subregional boundaries. The main data source was claims data from the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency; therefore, the results presented in this report were for children and mothers who were enrolled in AHCCCS from 2017 to 2019. This population was denoted as AHCCCS children or AHCCCS women.

AHCCCS children's health was measured in the following categories: primary care, well-child visits, health care workforce, screening for lead poisoning, weight assessment and counseling, developmental screening and delay, behavioral health, vision, hearing, oral health, immunizations, maternal prenatal and postpartum care, and health plan performance.

Many of the reported indicators were from the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is a performance improvement tool whereby health plans, health care organizations and government agencies submit data on specific health measures. HEDIS used the collected data to calculate national performance statistics and benchmarks and set standards for measures. HEDIS specifications were applied to the AHCCCS population for each region. The denominators were listed within each indicator and are available on the National Committee for Quality Assurance website at <https://www.ncqa.org/hedis/>. Inclusion generally required a child to have continuous enrollment for the reporting year with no more than one gap smaller than 45 days allowed. Some indicators also required enrollment in a period preceding the reporting year.

Non-HEDIS denominators were derived from the children who met the AHCCCS inclusion criteria for the region. The AHCCCS inclusion criteria were children ages 0-5 ($0 \leq \text{age} < 6$) who were enrolled in AHCCCS in 2017, 2018, or 2019 and residing in Arizona regions defined by First Things First. Health claims were for paid services in 2017, 2018, or 2019. Additional AHCCCS enrollment requirements were indicator-based. The complete population of children covered by AHCCCS were not included due to the limitations on AHCCCS enrollment gaps which were not met by all children.

For the distance analysis that was reported in the health care workforce section, all AHCCCS-enrolled children were assigned coordinates on a map related to their residential address on file. Health providers were also assigned coordinates from their address on file or public address, if available. Each child's address was analyzed to determine the distance in miles to the closest provider for each provider type. The children were then grouped into distance ranges as percentages. The region and state percentages were listed side-by-side to compare totals and determine if the population in the region may have access to care issues due to the distance required to travel for health services.

Data used in this report covered all AHCCCS members in Arizona, including members living in FTF tribal regions and subregions. Report creations for tribal regions and subregions was carried out with specific

approval from the tribe. As required by a Memorandum of Understanding previously established between FTF and the Pascua Yaqui Tribe, FTF notified the Pascua Yaqui Tribe in writing in December 2020 that work would begin on this report, and the work was approved by the Pascua Yaqui Tribe. For those tribal regions who did not give approval, data was included only in aggregate totals for Arizona. In the case of a tribal subregion, only aggregate totals for Arizona and the region were included.

REPORTING

There were 13 health topics discussed in this report. Each section began with context on the importance of the health topic before discussing the results from the AHCCCS claims data.

The AHCCCS results were presented at the regional level with state and national benchmarks provided for comparison, where available. When possible, the results are grouped by 1) indicators that met or were above the state average or national HEDIS standards and 2) indicators that did not meet or were below the state average or national HEDIS standards. Other notable findings were also presented that do not have comparison data. Most results were presented as percentages for standardization purposes and ease of comparison with benchmarks. The terms rate and percent were used interchangeably.

After reporting the general regional demographics, the results were displayed by gender, age group, race, ethnicity, tribal affiliation, provider type, and/or health plan when the data was available and within the data suppression guidelines stated below. Each section contained maps to display the results at the subregional level, when possible. The maps had a color gradient which compared the performance among the subregions for each indicator. A darker color denoted a higher percentage of individuals in the subregion who were included in the indicator. The Pascua Yaqui Tribe Region did not have subregions, so no maps are reported. Percentages over 1% were rounded to the nearest whole number. Percentages less than 1% were denoted as "<1%".

A brief conclusion summarized how well the region was doing with regards to access and utilization of health care services and provided areas where the regional councils may want to focus during their regional planning conversations.

The Executive Summary was designed to provide the main findings and takeaways for the report. A definitions section explained the lesser-known terms. The data sources were detailed in the Appendix which follows the references. The report was hyperlinked for ease of navigating from the Table of Contents and the text to the associated topics, figures and tables.

To protect the confidentiality of program participants, the First Things First Data Dissemination and Suppression Guidelines preclude our reporting data related to health or developmental delay if the count is less than six. Throughout this report, information which was not available because of suppression guidelines will be indicated by entries of "<6" for counts or "DS" (data suppressed) for percentages. Data were sometimes not available for particular regions, either because a particular program did not operate in the region or because data were only available at a higher level (i.e., county, state, etc.). Cases where data were not available will be indicated by an entry of "N/A." For the Pascua Yaqui Tribe Region, there were no AHCCCS children of Asian/Pacific Islander race, and the data for Black children was suppressed.

DATA LIMITATIONS

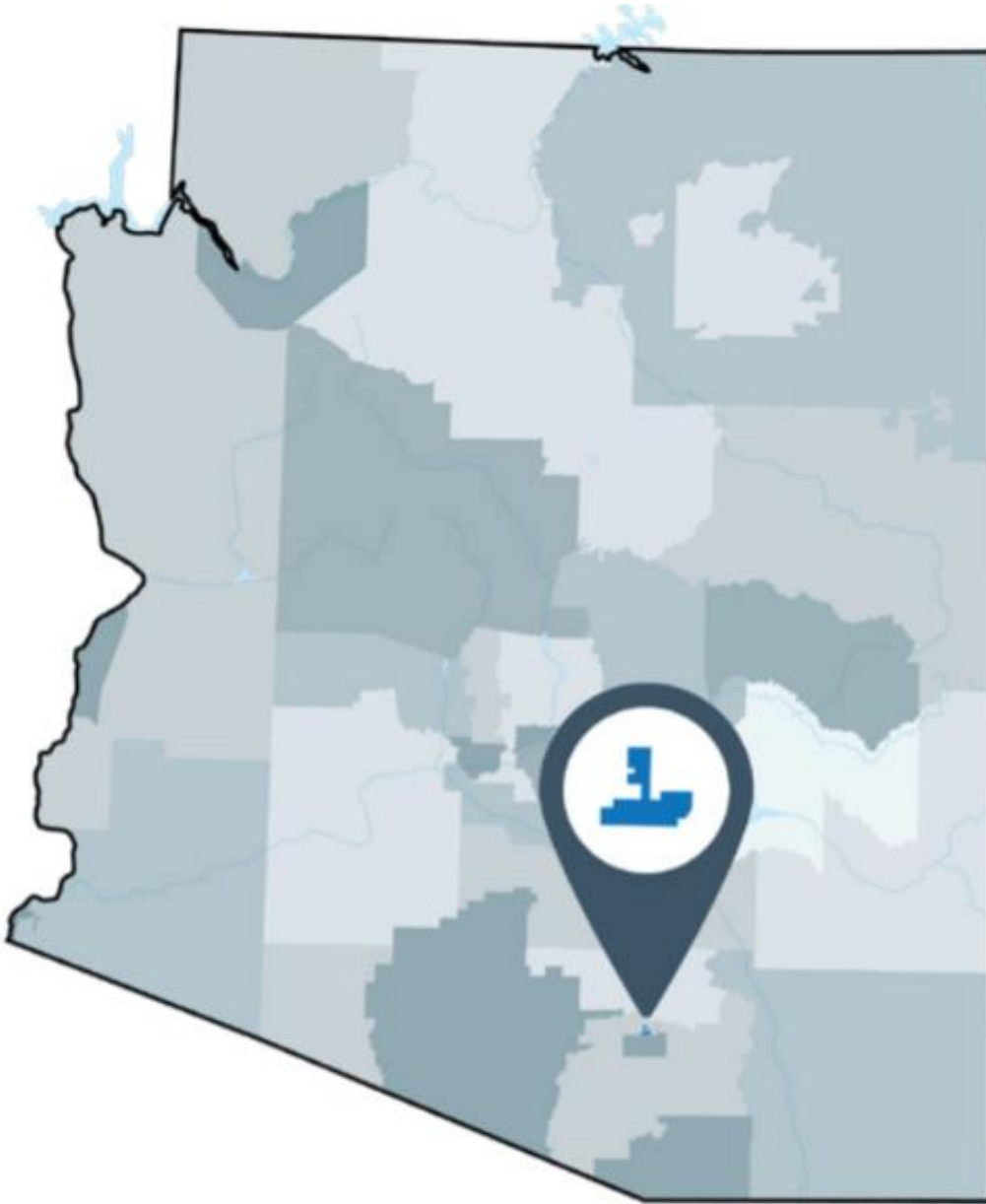
Most of the results in this report used AHCCCS claims and encounter data. While being limited to the population of children enrolled in Arizona Medicaid, this data source was also subject to coding errors and missing data for some indicators.

To best capture the full picture of childhood immunizations, a combination of data from claims, electronic health records, paper medical records and registry data was needed. AHCCCS used a combination of AHCCCS claims, Arizona State Immunization Information System (ASIIS) registry data and medical record data from its contractors to measure immunization rates internally. For this report, we used only AHCCCS claims as we did not have access to the other data sources. Since the AHCCCS claims data only included a subset of the immunizations of Arizona's children, our results showed substantially lower immunization rates than AHCCCS officially reports.

Per the AHCCCS Medical Policy Manual, AHCCCS children should receive hearing and vision screenings during their well-child visits according to the periodicity schedule. Claims data does not specify each service provided during a well-child visit; thus, we cannot verify whether these screenings were provided according to the schedule. The rates in this report should be interpreted with caution.

This report did not include data on all children birth to age five in the Pascua Yaqui Tribe Region as some children may have received medical services from other health insurance plans.

PASCUA YAQUI TRIBE REGIONAL RESULTS



POPULATION AND DEMOGRAPHICS OF CHILDREN ENROLLED IN AHCCCS

AHCCCS exists to make care affordable to the individuals and families it enrolls, including the approximately 235,000 children birth to age 5 who were enrolled in AHCCCS statewide from 2017 to 2019.

Of children in the Pascua Yaqui Tribe Region birth to age 5, 305 were enrolled in AHCCCS in 2017, 285 were enrolled in 2018 and 271 were enrolled in 2019.

(AHCCCS Claims Data, 2021)

In 2017, 51% of AHCCCS children birth to age 5 in the Pascua Yaqui Tribe Region were male, but in 2018 and 2019 51% of AHCCCS children were female in Table 1. In Table 2, there were 10% more preschoolers than infants and toddlers in 2017, with the difference dropping to 7% more in 2018 and increasing to 13% more in 2019.

By race, the percentage of Native American AHCCCS children in the region dropped from 86% in 2017 to 82% in 2019 in Figure 1. There were no Asian/Pacific Islander AHCCCS children in the region, so this race was not reported beyond this section. The data was suppressed for Black AHCCCS children in the region throughout this report due to counts <6. The percentage of AHCCCS children who were reported as Hispanic or Latino in the region decreased from 27% in 2017 to 24% in 2018 and 2019 (Figure 2). Affiliation with a tribal community was reported by 93-94% of AHCCCS children in the region in Figure 3.¹³ In Figure 4, nearly three-quarters of AHCCCS children in the region were enrolled in three health plans: American Indian Health Plan (39-45%), Mercy Care Plan (11-21%) and UnitedHealthcare (13-15%).

Annual health claims from 2017 to 2019 were submitted mostly by Physicians (15-21%), followed by Federally Qualified Health Centers (17-20%), Behavioral Health Outpatient Clinics (14-22%) and Pharmacy (8-12%) (Table 3).

Table 1. Number of Regional AHCCCS Children Birth to Age 5 by Year and Sex

Year	Female	Male	Total of AHCCCS-Enrolled Children
2017	149	156	305
2018	145	140	285
2019	139	132	271

Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

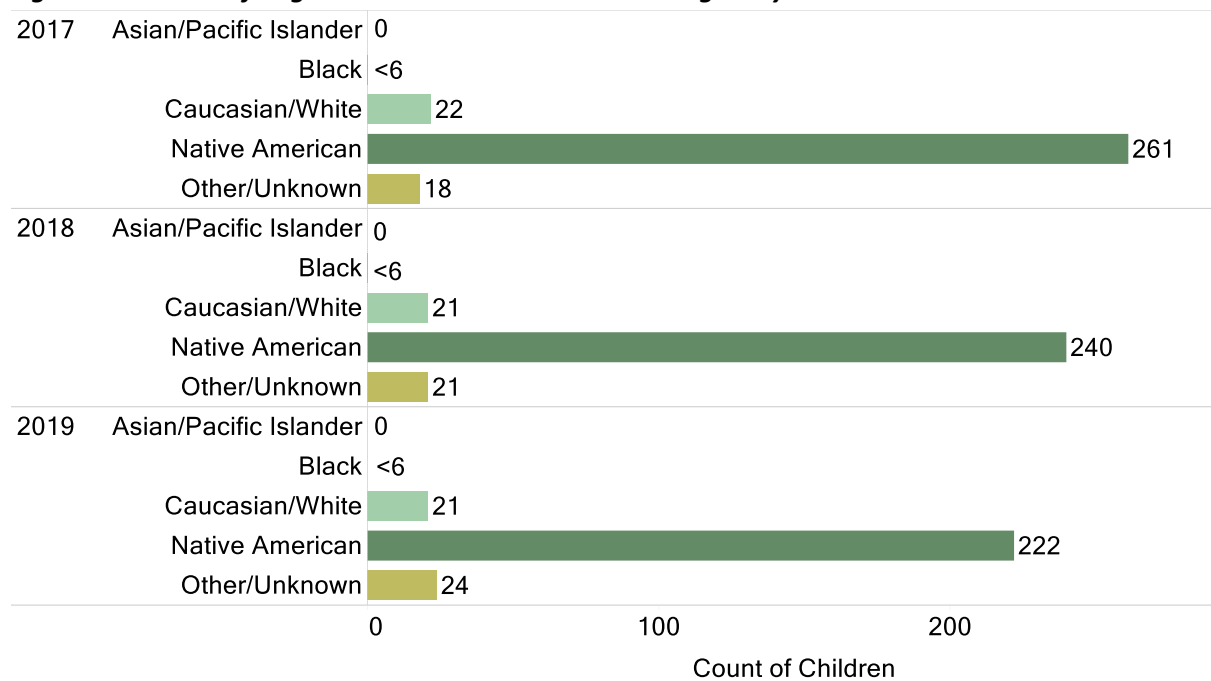
¹³ Tribal affiliation refers to whether an individual is a member of a federally recognized Arizona tribe and is displayed as a flag (Yes/No) in this report. This information is captured during enrollment in AHCCCS.

Table 2. Number of Regional AHCCCS Children Birth to Age 5 by Year and Age Group

Year	Infant (under 1)	Toddler (1-2)	Preschooler (3-5)
2017	47	90	168
2018	46	87	152
2019	49	69	153

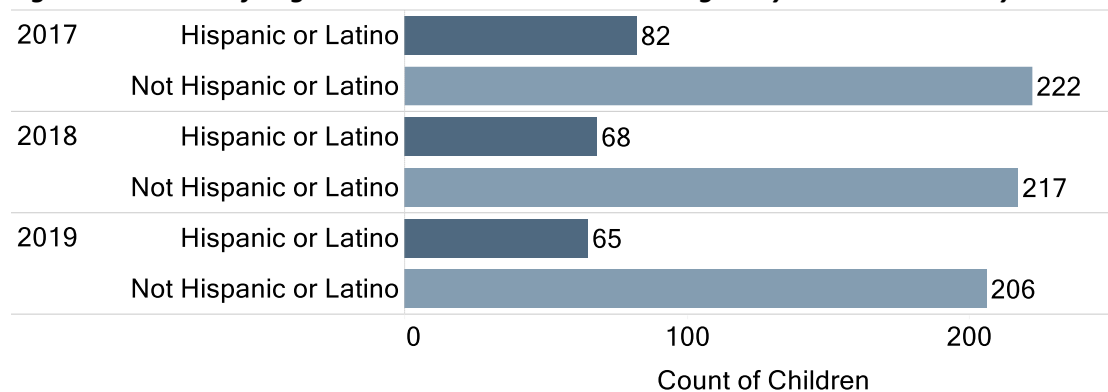
Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

Figure 1. Number of Regional AHCCCS Children Birth to Age 5 by Year and Race



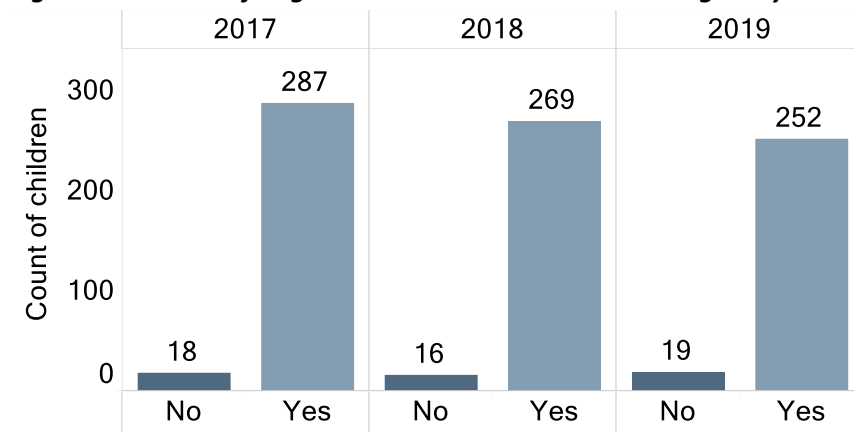
Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

Figure 2. Number of Regional AHCCCS Children Birth to Age 5 by Year and Ethnicity



Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

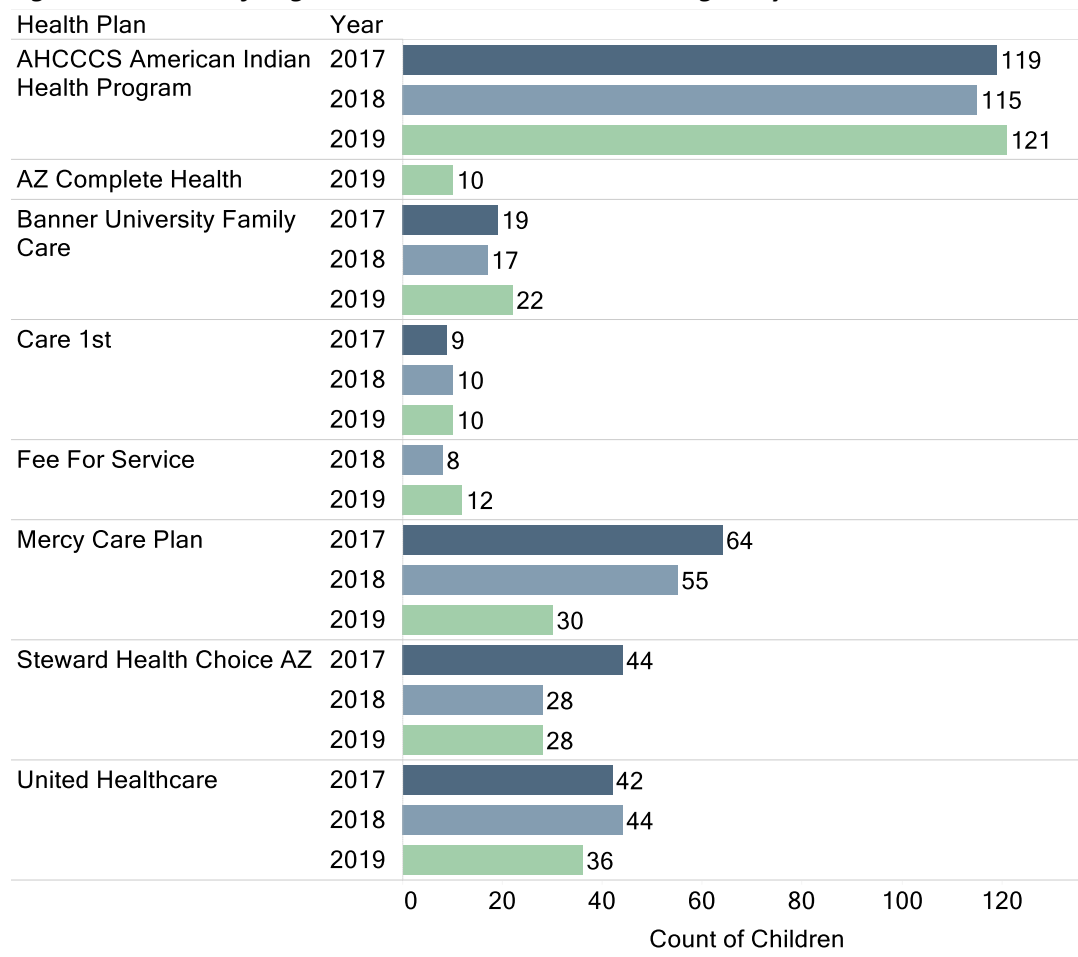
Figure 3. Number of Regional AHCCCS Children Birth to Age 5 by Year and Tribal Affiliation



Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

Note: Tribal affiliation refers to whether an individual is a member of a federally recognized Arizona tribe and is displayed as a flag (Yes/No) in this report. This information is captured during enrollment in AHCCCS.

Figure 4. Number of Regional AHCCCS Children Birth to Age 5 by Year and Health Plan



Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

Table 3. Number of Regional AHCCCS Claims for Children Birth to Age 5 by Provider Type (Billing Entity), 2017-2019

Provider Type	2017		2018		2019	
	Claims Count	Percent of Total	Claims Count	Percent of Total	Claims Count	Percent of Total
Behavioral Health Outpatient Clinic	640	14%	1,038	22%	627	16%
Dentist	132	3%	115	2%	70	2%
Durable Medical Equipment Supplier	36	1%	35	1%	38	1%
Federally Qualified Health Center (FQHC)	834	18%	818	17%	801	20%
Habilitation Provider*	<6	DS	91	2%	16	<1%
Home Health Agency	<6	DS	10	<1%	<6	DS
Hospital	367	8%	266	6%	220	5%
Integrated Clinics**	39	1%	62	1%	70	2%
Laboratory	91	2%	123	3%	118	3%
Non-Emergency Transportation Providers	85	2%	81	2%	86	2%
Occupational Therapist	47	1%	51	1%	53	1%
Pharmacy	448	10%	389	8%	495	12%
Physical Therapist	7	<1%	9	<1%	<6	DS
Physician – MD/DO	962	21%	706	15%	655	16%
Physician Assistant	60	1%	79	2%	61	2%
Registered Nurse Practitioner	157	3%	139	3%	108	3%
Speech Language Pathology	<6	DS	9	<1%	11	<1%
Speech/Hearing Therapist	65	1%	214	4%	279	7%
Other***	605	13%	563	12%	295	7%

Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

Notes: * Habilitation is training in independent living skills or special developmental skills, sensory-motor development, orientation and mobility and behavior intervention.

** An Integrated Clinic is a provider licensed by the Arizona Department of Health Services as an Outpatient Treatment Center which provides both behavioral health services and physical health services.

*** Other represents any other provider not included in the named provider types above.

HEALTH CARE WORKFORCE

Currently, Arizona has 160 hospitals individually licensed by the state which are subtyped as children, critical access, long term, short term, psychiatric, rehabilitation, transplant and non-participating (Arizona Department of Health Services, 2021). The Pascua Yaqui Tribe Region did not show any medical facilities that were licensed by the state (Arizona Department of Health Services, 2021).

The rate of available primary care physicians per 1,000 AHCCCS children in the region was 13 in 2017, 14 in 2018 and 18 in 2019 (Table 5) compared to the statewide rate of 23-24 per 1,000 AHCCCS children (Table 4). This meant that for every 1,000 AHCCCS children in the region, there were 13-18 primary care physicians available to provide care versus 23-24 primary care physicians available to provide care for AHCCCS children statewide from 2017 to 2019. For primary care physicians accepting AHCCCS patients, the regional rate of physicians per 1,000 AHCCCS children was 3 in 2017, 2 in 2018 and 7 in 2019. For dentists accepting AHCCCS patients, the regional rate was 3-4 dentists per 1,000 AHCCCS children compared to 16-17 dentists per 1,000 AHCCCS children statewide.

In Table 6, we compared the distance that regional and statewide AHCCCS children needed to travel to the nearest provider type to assist in determining whether the population in the region may have access to care issues based on travel distance. A unique feature of the Pascua Yaqui Tribe Region was its small size. The region was only 2.2 square miles and only had one zip code. Although many regional AHCCCS children did not have exact addresses in the distance analysis, no matter where the children lived in the zip code, the nearest provider was close by for most provider types, either in the region or a neighboring region. The nearest primary care physician, dentist and behavioral health provider was no more than one mile away from 96-100% of AHCCCS children in the region compared to 56-65% of AHCCCS children statewide. The nearest pharmacy was up to five miles away for all regional AHCCCS children versus 64% of AHCCCS children statewide. Regional AHCCCS children traveled the farthest to visit a hospital as the nearest hospital for all children was 5-10 miles away whereas 80-81% of AHCCCS children statewide traveled five miles or less to the nearest hospital.

Table 4. Supply of Key Health Professionals in Arizona per 1,000 AHCCCS Children Birth to Age 5, 2017-2019

Provider Type	2017		2018		2019*	
	Number	Rate	Number	Rate	Number	Rate
Total Active Physicians	16,345	70	17,356	74	N/A	N/A
Active Primary Care Physicians¹	5,396	23	5,598	24	N/A	N/A
Pediatricians⁴	1,214	5	1,257	5	1,293	6
Active Registered and Practical Nurses²	N/A	N/A	101,599	433	104,434	445
Dentists³	3,796	16	3,903	17	4,012	17

Source: ¹ (Association of American Medical Colleges, 2017). (Association of American Medical Colleges, 2019). ² (National Council of State Boards of Nursing, 2021). ³ (American Dental Association, 2021). ⁴ (American Board of Pediatrics, 2020); (American Board of Pediatrics, 2019); (American Board of Pediatrics, 2018).

Notes: The rate was calculated using the Arizona population of AHCCCS children birth to age 5 (N = 234,616). National data on pediatricians excluded those who were over age 70 to better control for those who may have been deceased in recent years. ¹ Data were from the 2017 and 2019 AMA Physician Masterfiles. Active physicians were federal and non-federal with an Arizona state license who worked at least 20 hours per week. *Data on active physicians was not available for 2019.

Table 5. Supply of Key Health Professionals in the Region per 1,000 AHCCCS Children Birth to Age 5, 2017-2019

Provider	2017		2018		2019	
	Num	Rate	Num	Rate	Num	Rate
Primary Care						
Primary Care – All Licensed Primary Care Physicians ²	4	13	4	14	5	18
Physicians accepting AHCCCS ^{1,2} – Total	1	3	2	2	2	7
Physicians accepting AHCCCS – Pediatrics	1	3	1	1	1	4
Physicians accepting AHCCCS – Primary Care	N/A	N/A	1	1	1	4
Behavioral Health – AHCCCS¹						
Behavioral Health Physician Specialty or Allied Health Professional	14	46	20	70	24	89
Primary Care with Behavioral Health Services*	1	3	1	4	1	4
Other						
Dentist – accepting AHCCCS ²	1	3	1	4	1	4
Hospital ^{1,3}	N/A	N/A	N/A	N/A	N/A	N/A
Pharmacy ^{1,4}	N/A	N/A	N/A	N/A	N/A	N/A

Source: ¹AHCCCS Claims Data, 2021. ²Arizona Medical Board and Arizona Board of Osteopathic Medical Examiners in Medicine and Surgery, 2021. ³(Arizona Department of Health Services, 2021). ⁴RXOpen dataset, accessed from data.gov, 2020. CHiR was the source for all processing of the AHCCCS and Workforce data.

Notes: The rate was calculated using the regional population of AHCCCS children birth to age 5 in 2019 (N = 305 for 2017, N = 285 for 2018 and N = 271 for 2019). Pharmacies that were co-located with clinics were not captured in the data.

*This includes Federally Qualified Health Clinics and Integrated Clinics. These facilities provide both behavioral health services and physical health services.

Table 6. Percent of Regional and Statewide AHCCCS Children Birth to Age 5 Grouped by Travel Distance Between Provider and Child’s Residence by Provider Type, 2017-2019

Provider Type/Miles	Year	0-1 Miles		1-5 Miles		5-10 Miles		10+ Miles	
		Region	AZ	Region	AZ	Region	AZ	Region	AZ
Behavioral Health Specialty or Primary Care with Behavioral Health Services*	2017	100%	62%	<1%	30%	<1%	3%	<1%	2%
	2018	100%	64%	<1%	27%	<1%	3%	<1%	2%
	2019	100%	65%	<1%	27%	<1%	3%	<1%	2%
Dentist	2017	97%	62%	3%	29%	<1%	3%	<1%	4%
	2018	96%	63%	4%	29%	<1%	3%	<1%	3%
	2019	97%	63%	3%	28%	<1%	3%	<1%	3%
Hospital	2017	<1%	11%	<1%	69%	100%	9%	<1%	10%
	2018	<1%	12%	<1%	69%	100%	9%	<1%	11%
	2019	<1%	12%	<1%	69%	100%	9%	<1%	11%
Pharmacy	2017	<1%	64%	100%	26%	<1%	3%	<1%	7%
	2018	<1%	64%	100%	26%	<1%	3%	<1%	7%
	2019	<1%	64%	100%	26%	<1%	3%	<1%	7%
Primary Care Physician	2017	97%	56%	3%	34%	<1%	4%	<1%	4%
	2018	96%	56%	4%	35%	<1%	3%	<1%	4%
	2019	97%	57%	3%	34%	<1%	3%	<1%	4%

Source: ¹ (AHCCCS Claims Data, 2021). ² (Arizona Medical Board and Arizona Board of Osteopathic Medical Examiners in Medicine and Surgery, 2021). CHIR was the source for all processing of the AHCCCS and Workforce data.

Notes: See the Approach section for details on this methodology. Pharmacies that were co-located with hospitals or clinics were not captured in the data. Historic data on Hospital and Pharmacy were not available, so all numbers are based on the most recent data available. *Behavioral Health providers includes primary care providers that offer behavioral health services. **The Unknown column captured children who did not have an exact-match address, so the number of miles to the nearest provider could not be accurately calculated.

PRIMARY CARE

Access to primary care is important for the health and well-being of children. Primary care practitioners (PCPs) provide appropriate screenings, treatment and preventive services. When children regularly visit a PCP, they are less likely to visit the emergency department for non-urgent care (Transforming Clinical Practice Initiative, 2019) (Piehl, Clemens, & Joines, 2000).

The inclusion criteria for this indicator were children enrolled in the previous 12 months who had at least one claim with a primary care provider, which includes primary care physicians, nurse practitioners and physician assistants.

Regionally, 69-78% of AHCCCS children ages 25 months to six years had at least one annual PCP visit from 2017 to 2019.

(Arizona Health Care Cost Containment System, July 2021)

Regionally, 69-78% of AHCCCS children had at least one PCP visit compared to 85-86% of AHCCCS children statewide in Table 7 and 86-87% of Medicaid children nationally. The regional rates did not meet the AHCCCS Minimum Performance Standard (MPS)¹⁴ of 84%.

In Figure 5, regional AHCCCS children ages 1-2 (71%) were more likely to have annual PCP visits than ages 3-5 (69%) in 2017; however, ages 3-5 (70-79%) were more likely to have annual PCP visits in 2018 and 2019 than ages 1-2 (67-74%). All AHCCCS children in the region who were not affiliated with a tribe were more likely to have an annual PCP visit than tribally affiliated AHCCCS children (67-76%). Hispanic or Latino AHCCCS children in the region (79-90%) were more likely to have annual PCP visits than Non-Hispanic or Latino AHCCCS children (65-74%). By race, all Caucasian/White AHCCCS children in the region were more likely to have annual PCP visits than Native American AHCCCS children (64-73%).

Table 7. Regional and Statewide AHCCCS Rates for PCP Visits, 2017-2019

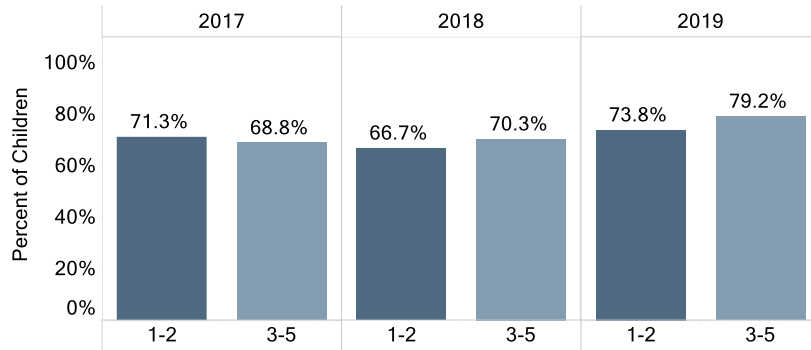
Indicator/Year	2017		2018		2019	
	Region	Arizona	Region	Arizona	Region	Arizona
Access to Primary Care	70%	85%	69%	85%	78%	86%

Source: AHCCCS Claims Data, 2021. CHIR is the source for all processing of the AHCCCS data.

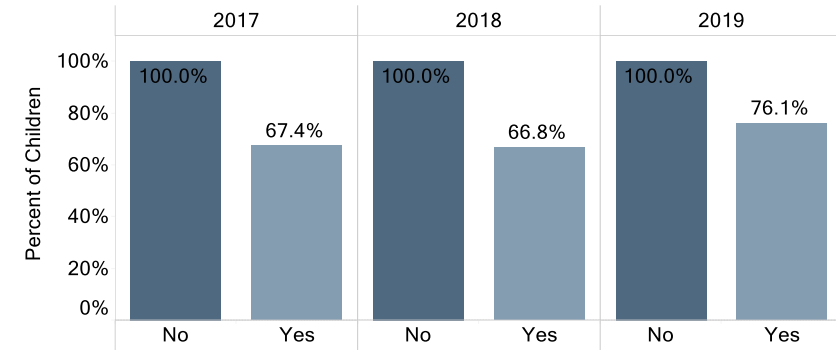
¹⁴ Minimum Performance Standard (MPS) is the minimal expected level of performance by AHCCCS Contractors. AHCCCS-reported rates are the official rates used to determine Contractor compliance with performance requirements. If a Contractor does not achieve the MPS, they will be required to submit a corrective action plan and may be subject to sanctions for each deficient measure.

Figure 5. Percent of Regional AHCCCS Children Ages 1 – 5 with a Visit to PCP by Age Group, Tribal Affiliation, Ethnicity, Race and Year

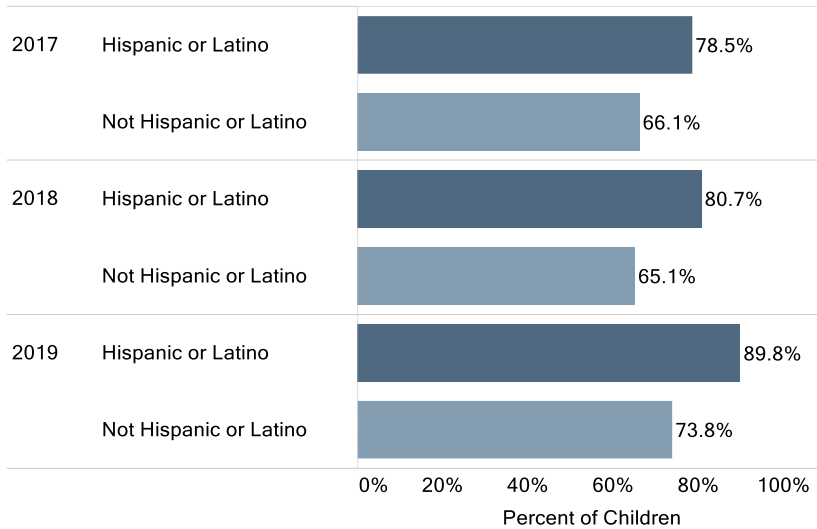
Percent of children with a visit to primary care practitioner ages 1 - 5 by age group



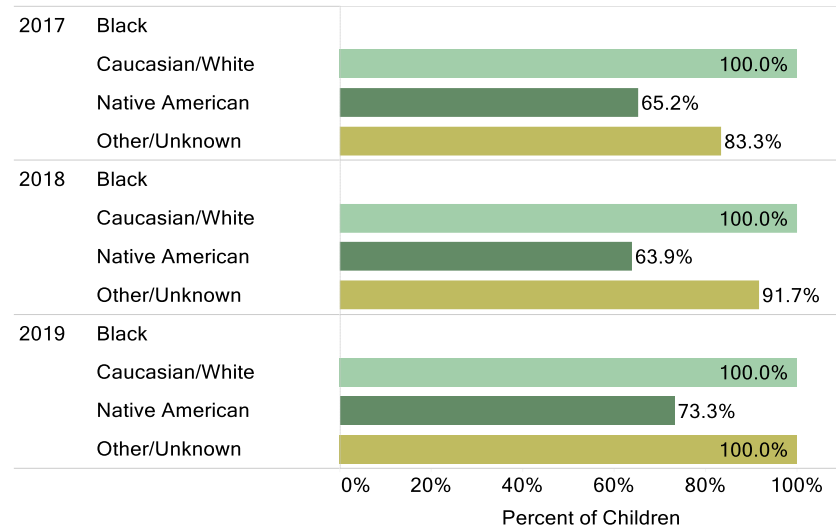
Percent of children with a visit to primary care practitioner ages 1 - 5 by tribal affiliation



Percent of children with a visit to primary care practitioner ages 1 - 5 by ethnicity



Percent of children with a visit to primary care practitioner ages 1 - 5 by race



Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

Note: Tribal affiliation refers to whether an individual is a member of a federally recognized Arizona tribe and is displayed as a flag (Yes/No) in this report. This information is captured during enrollment in AHCCCS.

WELL-CHILD VISITS

Well-child visits provide an opportunity for primary care practitioners (PCPs) to examine a child holistically for physical, mental, emotional and social/environmental health. A child's growth and development are tracked during a well-child visit. Screenings, counseling and immunizations take place at well-child visits. PCPs can instill healthy behaviors in children by reinforcing their importance during well-child visits. Parents and caregivers can team up with PCPs to address concerns. Creating a trusted relationship between the PCP and child is important as the child ages and develops, so these visits are beneficial to everyone involved (Moreno, 2018); (Sturgeon, 2015).

This HEDIS indicator assesses whether children who turned 15 months old during the measurement year had one or more well-child visits since birth, categorized by number of visits from one to six or more. A separate HEDIS indicator assesses whether children ages 3-5 had an annual well-child visit.

Regionally, 36-40% of AHCCCS children birth to 15 months had six or more well-child visits compared to 53-60% of AHCCCS children statewide from 2017 to 2019 (Table 8) and 63-66% of Medicaid children nationally. The region and state rates were below the AHCCCS MPS of 65% (2017 and 2018) and 62% (2019) for this indicator. In Figure 6, Hispanic or Latino AHCCCS children (58-60%) were more likely to have an annual well-child visit compared to Non-Hispanic or Latino AHCCCS children (27-32%) in 2018 and 2019.

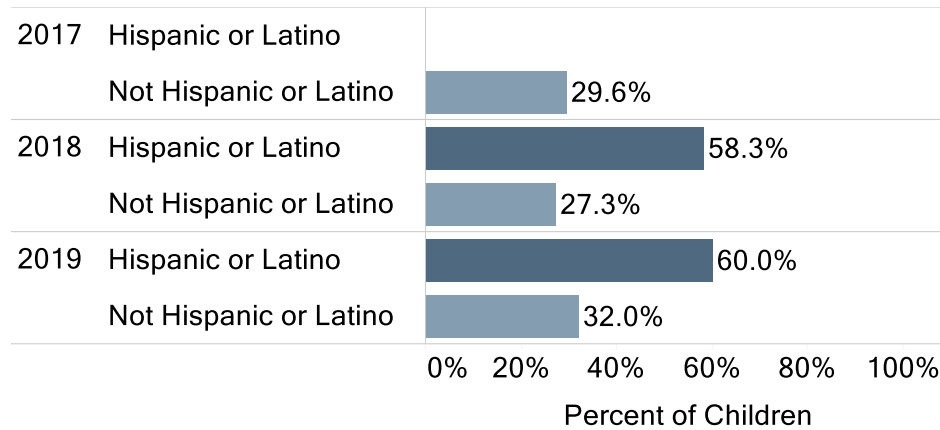
For AHCCCS children ages 3-5 in Table 8, 49-53% of regional children had an annual well-child visit compared to 62-65% of statewide children and 72-74% of Medicaid children ages 3-6 nationally. The region did not meet the AHCCCS MPS of 66% for this indicator. In Figure 7, Hispanic or Latino AHCCCS children (62-71%) were more likely to have an annual well-child visit compared to Non-Hispanic or Latino AHCCCS children (42-47%).

Table 8. Regional and Statewide AHCCCS Rates for Well-Child Visits, 2017-2019

Indicator/Year	2017		2018		2019	
	Region	Arizona	Region	Arizona	Region	Arizona
Six or More Well-Child Visits in First 15 Months of Life	37%	53%	36%	58%	40%	60%
Annual Well-Child Visit, Ages 3-5	49%	62%	53%	63%	49%	65%

Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

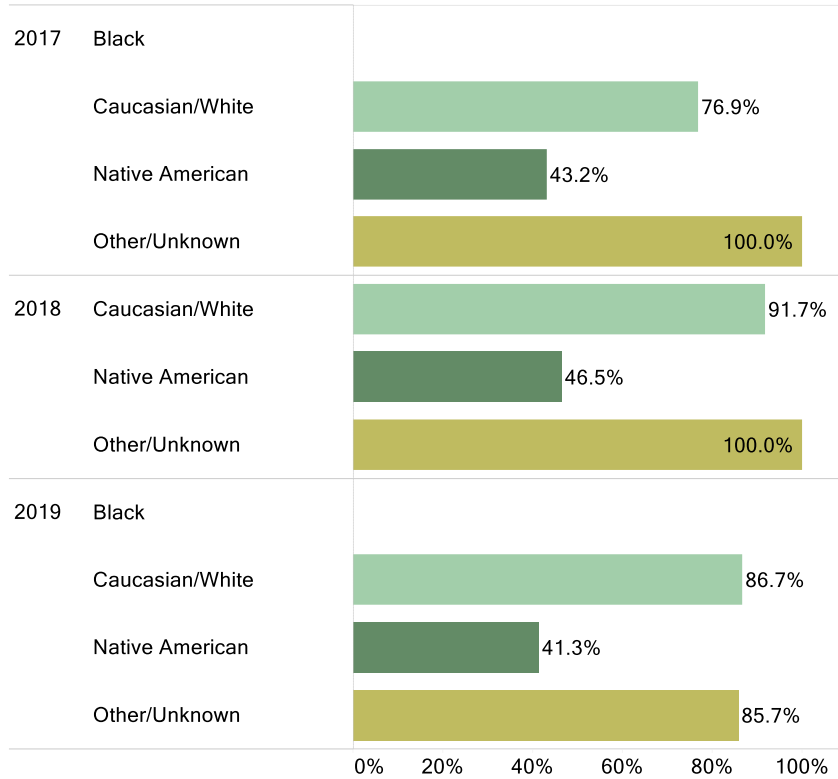
Figure 6. Percent of Regional AHCCCS Children Who Had Six or More Well-Child Visits During Their First 15 Months of Life by Ethnicity and Year



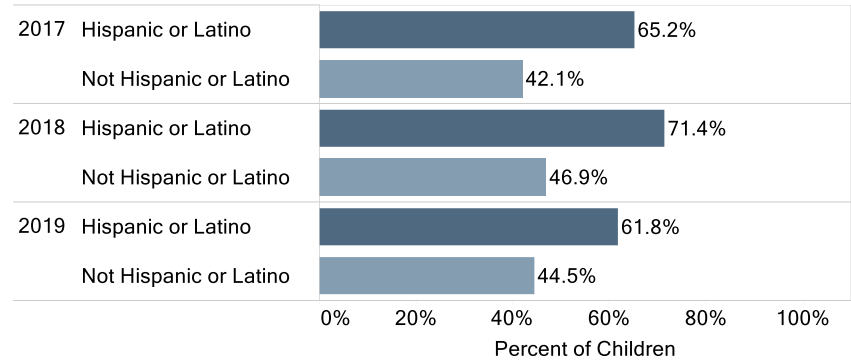
Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data. Data was suppressed for Hispanic or Latinos in 2017.

Figure 7. Percent of Regional AHCCCS Children Ages 3-5 with a Well-Child Visit by Race, Ethnicity, Tribal Affiliation and Year

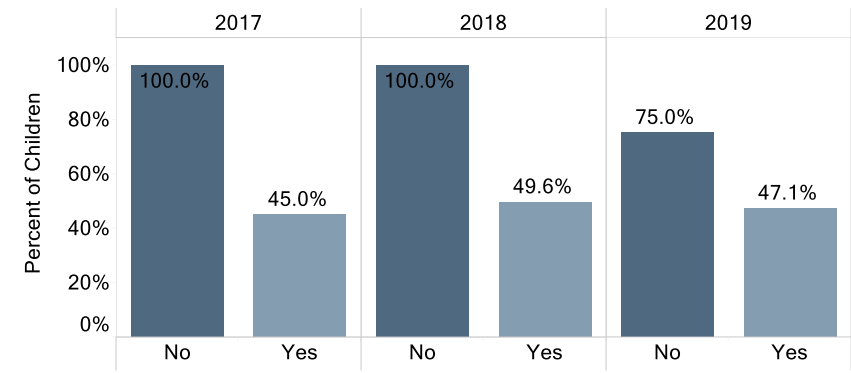
Percent of children ages 3-5 with well-child visit by race



Percent of children ages 3-5 with well-child visit by ethnicity



Percent of children ages 3-5 with a well-child visit by tribal affiliation



Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

Note: Tribal affiliation refers to whether an individual is a member of a federally recognized Arizona tribe and is displayed as a flag (Yes/No) in this report. This information is captured during enrollment in AHCCCS.

SCREENING FOR LEAD POISONING

Exposure to lead can cause damage to the brain and other vital organs, as well as intellectual and behavioral deficits. Because children who are exposed to lead often have no obvious symptoms, lead poisoning often goes unrecognized. Screening for lead via a capillary or venous lead blood test is an easy way to detect an abnormal blood lead level in children. There is no safe blood lead level. If not found early, exposure to lead and high blood lead levels can lead to irrevocable effects on a child’s physical and mental health (Arizona Department of Health Services, 2006); (Arizona Department of Health Services, 2003); (National Center for Environmental Health, 2020).

In Arizona, blood lead results are reportable to the Arizona Department of Health Services (ADHS) for children less than six years old. According to ADHS, children who live in areas designated as high-risk¹⁵ for lead poisoning should receive a blood lead test at 12 and 24 months of age, and older children who have not been previously tested should receive a blood lead test. ADHS reported 61,391 children statewide under age six (14% of children under age 5) were screened in 2019, and 40,773 (66%) of those children lived in high-risk areas. Of the children living in high-risk areas, 29% were screened at 12 months of age, and 19% were screened at 24 months of age. Only 10% of children were screened at both intervals (Arizona Department of Health Services, 2021).

For AHCCCS children being screened for lead poisoning one or more times by their second birthday in Table 9, the regional rate was 39% in 2017, 31% in 2018 and 33% in 2019 compared to AHCCCS statewide rates which increased from 32% in 2017 to 35% in 2019.

Table 9. Regional and Statewide AHCCCS Rates for Lead Poisoning Screening, 2017-2019

Indicator/Year	2017		2018		2019	
	Region	Arizona	Region	Arizona	Region	Arizona
One or More Tests for Lead Poisoning by Second Birthday	39%	32%	31%	34%	33%	35%

Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

¹⁵ Interactive map of Arizona neighborhoods to identify those considered to be high-risk is online at <http://www.azhealth.gov/leadmap>

WEIGHT ASSESSMENT AND COUNSELING¹⁶

Childhood obesity has both short-term and long-term effects, so it is important for primary care practitioners (PCPs) to monitor weight problems in children and provide guidance for maintaining a healthy weight and lifestyle. The prevalence of obesity among children aged 2–5 years in 2015-2016 was 14% according to the National Health and Nutrition Examination Survey (Hales, Carroll, Fryar, & Ogden, 2017). For this report, we focused on regional AHCCCS children ages 3-5.

The regional rates for weight assessment¹⁷ and counseling are in Table 10. AHCCCS children in the Pascua Yaqui Tribe Region were assessed for weight at rates of 8% in 2017, 12% in 2018 and 37% in 2019 compared to 9-19% for AHCCCS children statewide. Rates for nutrition counseling were suppressed at the regional level versus 4-5% at the state level for AHCCCS children. Physical activity assessments in the region were suppressed whereas AHCCCS children statewide were assessed <1-1%.¹⁸

The national HEDIS Medicaid rates reported in Table 11 included children ages 3-17, and therefore, were not strictly comparable to the region or state rates for AHCCCS children ages birth to 5.

Table 10. Regional and Statewide AHCCCS Rates for Weight Assessment and Counseling, 2017-2019

Indicator/Year	2017		2018		2019	
	Region	Arizona	Region	Arizona	Region	Arizona
BMI Assessment	8%	9%	12%	12%	37%	19%
Nutrition Counseling	DS	4%	DS	5%	DS	5%
Physical Activity Counseling	DS	<1%	DS	1%	DS	1%

Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

Note: Each of the three items above is a different indicator. Because BMI norms for youth vary with age and sex, this indicator evaluates whether BMI percentile is assessed, rather than an absolute BMI value. The regional rates include AHCCCS children ages 3-5 only, and the statewide rates include ages birth to 5. Data was suppressed for Nutrition Counseling and Physical Activity Counseling.

¹⁶ There was limited reporting of these indicators in claims data as this information was most likely collected in the medical record, so these rates should be interpreted with caution.

¹⁷ Under HEDIS, the rates for weight assessment are an evaluation of whether Body mass index (BMI) percentile is accessed and does not determine the absolute BMI value. The diagnosis codes for pediatric BMI included: Z68.51 (< 5th percentile for age), Z68.52 (5th percentile to < 85th percentile for age), Z68.53 (85th percentile to < 95th percentile for age) and Z68.54 (≥ 95th percentile for age).

¹⁸ Physical Activity Counseling includes sports physicals which are not provided to children in the early childhood age group.

Table 11. National Medicaid HEDIS Rates for Weight Assessment and Counseling, Ages 3-17 Years, 2017-2019

Indicator/Year	2017	2018	2019
BMI Assessment	73%	74%	77%
Nutrition Counseling	67%	67%	68%
Physical Activity Counseling	61%	62%	64%

Source: (National Committee for Quality Assurance, 2021).

DEVELOPMENTAL SCREENING AND DELAY

During early childhood, children grow and develop at a rapid pace physically and cognitively. Although children develop skills at different times, there are guidelines that define the period when an average child should meet certain developmental milestones. The American Academy of Pediatrics recommends developmental screenings during well-child visits for all children ages 9 months, 18 months, 2 years and 2.5 years (Centers for Disease Control and Prevention). Parents may also notice concerns they have about their child's development and discuss them with their child's health care provider.

Developmental delay occurs when a child does not demonstrate mastery of developmental milestones, and the delay can range from mild to severe. Developmental delays have been found to occur in 10-15% of preschool children (Choo, Agarwal, How, & Yeleswarapu, 2019). The National Health Interview Survey found that from 2015-2018, 18% of U.S. children ages 3-17 years had at least one developmental disability (Zablotsky & Black, 2020). After being diagnosed with a developmental delay, children should be referred to appropriate behavioral health services.

AHCCCS PCPs use developmental screening tools during 9-month, 18-month and 24-month well-child visits. Developmental screenings are assessed in claims data using billing code CPT 96110. AHCCCS has an active Performance Improvement Project to increase the number of screenings in its eligible populations (Arizona Health Care Cost Containment System, 2021). AHCCCS analyzed its own performance on developmental screenings using several data sources and reported 26% (Median = 42%) of eligible members in acute care screened in 2017 and 30% (Median = 33%) screened in 2018 statewide. Rates for AHCCCS children in foster care were 34% and 38% for the same years, respectively. AHCCCS also analyzed the 2018 data for disparities and found disparities in five of Arizona's 15 Counties: Apache, Gila, Navajo, Santa Cruz and Yavapai. Racial disparity was also demonstrated for the American Indian population.

Table 12 showed rates of developmental screenings in AHCCCS children birth to age 5 increased over the report period although still well below the AHCCCS median rates. At the regional level, rates increased from 2-5% compared to statewide AHCCCS rates of 10-14%.¹⁹ Rates of diagnosing developmental delay in AHCCCS children were 3-4% at the regional level compared to 3-5% at the state level for AHCCCS children

¹⁹ Due to the limited capture of developmental screenings in claims data alone, these rates should be interpreted with caution.

in 2018 and 2019. Of those AHCCCS children who were diagnosed with developmental delay, 58% of regional and statewide AHCCCS children received behavioral health services in 2019.

Table 12. Regional and Statewide AHCCCS Rates for Developmental Screenings and Delay, 2017-2019

Indicator/Year	2017		2018		2019	
	Region	Arizona	Region	Arizona	Region	Arizona
Developmental Screening, Ages Birth to 5	2%	10%	2%	11%	5%	14%
Diagnosing Developmental Delay, Ages Birth to 5*	DS	3%	3%	4%	4%	5%
Developmental Delay and Behavioral Health Services, Ages 3-5	DS	49%	DS	47%	58%	58%

Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

* This indicator uses diagnosis code R62.50: Unspecified lack of expected normal physiological development in childhood.

Table 13. Percent of Claims by Provider Type for Regional AHCCCS Children Receiving Developmental Screenings, 2017-2019

Provider Type	2017		2018		2019	
	Claims Count	Percent of Total	Claims Count	Percent of Total	Claims Count	Percent of Total
Federally Qualified Health Center (FQHC)	<6	DS	<6	DS	9	64%
Physician – MD/DO	6	86%	6	67%	<6	DS

Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

Note: Providers in other categories are not shown, percents do not sum to 100%

Table 14. Percent of Claims by Provider Type for Regional AHCCCS Children with a Diagnosed Developmental Delay Who Have Received Behavioral Health Services, 2017-2019

Provider Type	2017		2018		2019	
	Claims Count	Percent of Total	Claims Count	Percent of Total	Claims Count	Percent of Total
Behavioral Health Outpatient Clinic	<6	DS	59	87%	32	68%
Other	N/A	N/A	9	13%	15	32%

Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

BEHAVIORAL HEALTH

During the early years of life, the social-emotional development and adaptive functioning of a child changes rapidly and profoundly as their developing brains encounter experiences (National Scientific Council on the Developing Child, 2004). The Adverse Childhood Experiences studies demonstrate how negative early childhood events such as neglect, violence and trauma can lead to behavioral and physical health problems in adulthood like chronic disease, mental illness, and substance abuse (Centers for Disease Control and Prevention, n.d.). However, these effects can be mitigated with proper intervention at the infant and toddler stages by behavioral health services (Arizona Health Care Cost Containment System, 2018). For young children, behavioral health services²⁰ would likely include day programs, crisis services, rehabilitation services, health promotion, mental health counseling, psychiatric and psychologist services, and various support services.

Pediatric behavioral health providers screen AHCCCS children from birth to age five for emotional, behavioral, and/or developmental needs. A national screening tool assists providers in coordinating services based on the intensity of need and formulating an integrated treatment plan (American Academy of Child and Adolescent Psychiatry, 2006).

Of AHCCCS children birth to age 5 in the region, 14% of children received behavioral services in 2017, 16% of children in 2018 and 22% of children in 2019.

According to Table 15, 14-22% of AHCCCS children in the Pascua Yaqui Tribe Region received behavioral health services compared to 11-16% of AHCCCS children statewide. In Figure 8, male AHCCCS children in the region were more likely to receive behavioral health services (16-23%) compared to female AHCCCS children (13-20%).

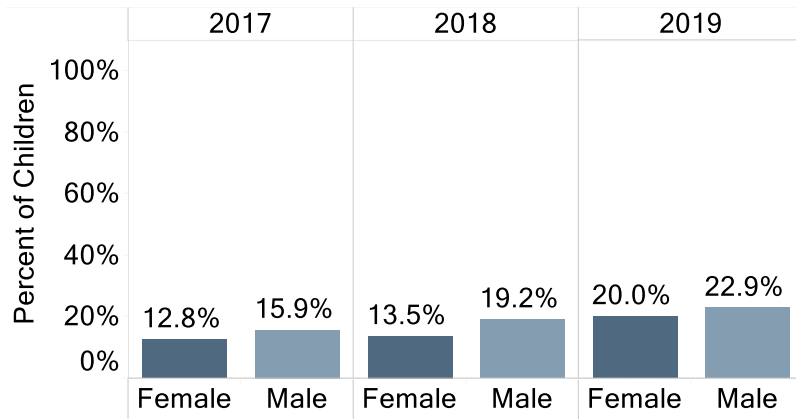
Table 15. Regional and Statewide AHCCCS Rates for Behavioral Health Services, Ages 3-5, 2017-2019

Indicator/Year	2017		2018		2019	
	Region	Arizona	Region	Arizona	Region	Arizona
Behavioral Health Services, Ages 3-5	14%	11%	16%	12%	22%	16%

Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

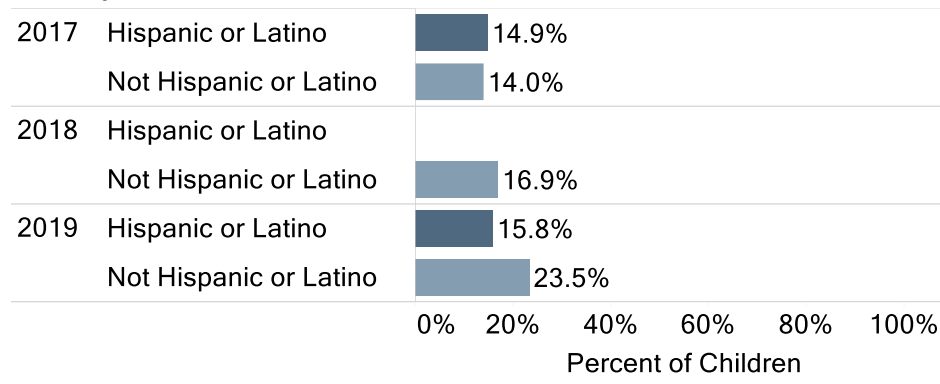
²⁰ For more detail on AHCCCS behavioral health services, visit <https://www.azahcccs.gov/Members/AlreadyCovered/coveredservices.html>

Figure 8. Percent of Regional AHCCCS Children Ages 3-5 Receiving Behavioral Health Services by Sex and Year



Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

Figure 9. Percent of Regional AHCCCS Children Ages 3-5 Receiving Behavioral Health Services by Ethnicity and Year



Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

Note: Data was suppressed for Hispanic or Latino in 2018.

Table 16. Percent of Claims by Provider Type for Regional AHCCCS Children Ages 3-5 Receiving Behavioral Health Services, 2017-2019

Provider Type	2017		2018		2019	
	Claims Count	Percent of Total	Claims Count	Percent of Total	Claims Count	Percent of Total
Behavioral Health Outpatient Clinic	499	85%	703	91%	546	73%
Hospital	<6	DS	11	1%	22	3%
Integrated Clinics	<6	DS	<6	DS	7	DS
Occupational Therapist	<6	DS	<6	DS	14	2%
Physician – MD/DO	10	2%	<6	DS	<6	DS
Speech/Hearing Therapist	46	8%	43	6%	97	13%
Other	24	4%	16	2%	55	7%

Source: AHCCCS Claims Data, 2021. CHIR is the source for all processing of the AHCCCS data.

VISION

Health conditions such as vision problems are detected through regular visits to primary care practitioners (PCPs). The American Public Health Association estimates that 20% of preschoolers have eye or vision problems (American Public Health Association, 2019). Vision screenings check the appearance of the eyes and detect potential eye problems. Most vision problems are successfully treated when detected early, but many children do not receive adequate vision screenings. A lack of vision care at younger ages can mean higher rates of undetected vision problems, leading to visual impairments that affect a child's development, performance, and quality of life.

*Of all Arizona children 0-5 years old, 35% received a vision screening 2019-2020.
(Child and Adolescent Health Measurement Initiative)*

Arizona's Eyes on Learning Vision Coalition recommends a vision screening as early as age one during a well-child visit. Other settings that provide vision screening include pediatrician offices, educational settings and community settings. Children ages 3-5 should have at least one vision screening by a PCP or trained screener during this timeframe. Annual screenings should be provided to children in kindergarten through fourth grade. A vision screening is not necessary for children with certain developmental delays that cause difficulties with language and speech, motor skills, behavior, memory, learning, or other neurological functions. Instead, eye doctors recommend that all children with these types of delays receive a comprehensive eye exam. (Eyes on Learning, n.d.)

Vision screenings are typically included in AHCCCS' well-child visits according to their vision periodicity schedule and as medically necessary (Arizona Health Care Cost Containment System, 2021). However, the vision screening is not billed as a separate claim when completed during a well-child visit. Therefore, to capture the population of children who received a vision screening, we assumed that AHCCCS children were screened at their annual well-child visit, or they received a separately billable vision screening. Additional analysis showed that there were very few children who received a vision screening and not a

well-child visit annually. Given that the claims data did not specify that a vision screening occurred during the well-child visit, these rates should be interpreted with caution and may be an overestimation of actual vision screenings.

Eye exams are completed by optometrists or ophthalmologists, so we captured those using procedure codes for ophthalmological services. We designated the eye exam as a follow-up eye exam if the visit occurred within six months of a vision screening or well-child visit. If a child was diagnosed with a visually significant eye condition during an eye exam and received treatment or additional visits to an optometrist or ophthalmologist for eyeglasses, surgery or other procedures, the rate of treatment was reported under “visually significant eye conditions who receive treatment”. To calculate the rate for visually significant eye conditions who receive treatment, the denominator was all AHCCCS children who received an eye exam and had a diagnosis of strabismus, refraction and accommodation, amblyopia, or other eye disorders; and of those AHCCCS children with an eye condition, the numerator included children who were treated for the eye condition.

In the Pascua Yaqui Tribe Region, 18-22% of AHCCCS children received an annual vision screening or well-child visit compared to 43-47% of AHCCCS children statewide (Table 17). AHCCCS children ages 3-5 (21-28%) were more likely to receive an annual vision screening or well-child visit than ages 1-2 (21-24%) in Figure 10. AHCCCS children who were Hispanic or Latino (19-29%) were more likely to receive an annual vision screening or well-child visit than Non-Hispanic or Latino AHCCCS children (16-19%).

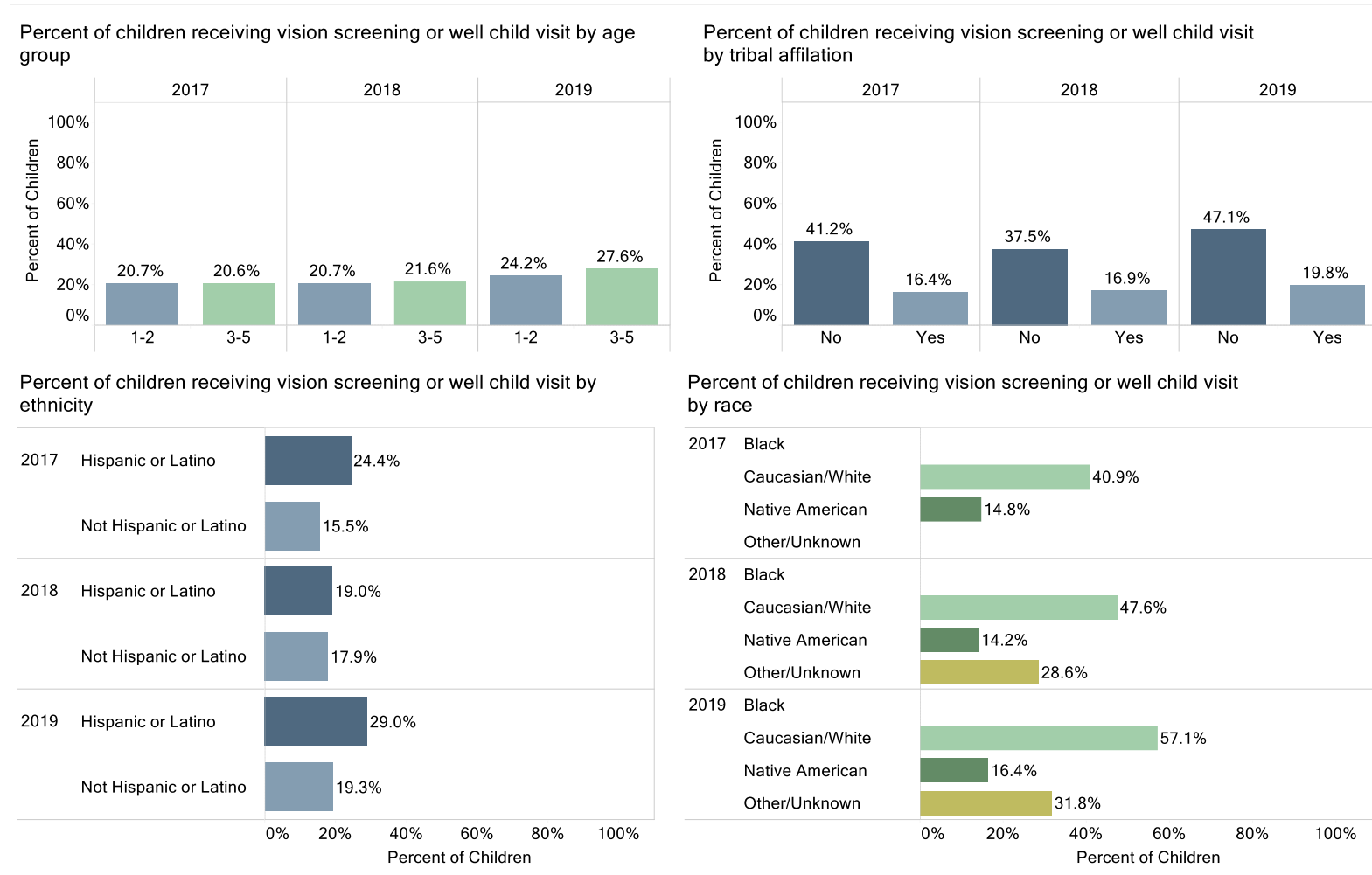
Eye exams were conducted much less frequently, ranging 4-6% annually at the regional and state levels for AHCCCS children. Follow-up eye exams were conducted on AHCCCS children statewide at rates of 4-5%, and regional rates were suppressed. AHCCCS children with visually significant eye conditions received treatment at a rate of 58% regionally in 2018 compared to 54-60% statewide from 2017 to 2019 (Table 17).

Table 17. Regional and Statewide AHCCCS Rates for Vision, 2017-2019

Indicator/Year	2017		2018		2019	
	Region	Arizona	Region	Arizona	Region	Arizona
Vision Screening or Well-Child Visit	18%	44%	18%	43%	22%	47%
Eye Exams	4%	4%	6%	4%	5%	5%
Eye Exams after Vision Screening or Well-Child Visit	DS	4%	DS	5%	DS	4%
Visually Significant Eye Conditions Who Receive Treatment	DS	54%	58%	56%	DS	60%

Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

Figure 10. Percent of Regional AHCCCS Children Receiving Vision Screening or Well-Child Visit by Age Group, Tribal Affiliation, Ethnicity, Race and Year



Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

Note: Tribal affiliation refers to whether an individual is a member of a federally recognized Arizona tribe and is displayed as a flag (Yes/No) in this report. This information is captured during enrollment in AHCCCS.

HEARING

Most children begin hearing sounds at birth and learn to speak over time by imitating the sounds around them (NIDCD Information Clearinghouse, 2011). The National Institute on Deafness and Other Communication Disorders reports that around two or three out of every 1,000 children are born deaf or hard-of-hearing in the United States, and more lose their hearing later in childhood (NIDCD Information Clearinghouse, 2011). To detect hearing loss early, every state conducts universal newborn hearing screenings before a baby is discharged from a hospital or birthing center. If hearing loss is indicated, parents will be referred to an audiologist to conduct more comprehensive hearing testing and determine appropriate intervention services. For children diagnosed with hearing loss, early intervention helps children develop better language and communication skills.

Arizona strives to screen all infants before 1 month of age. Infants who do not pass the initial hearing screen and a rescreening, should be evaluated further to confirm or diagnose hearing loss before 3 months of age. Infants diagnosed with permanent hearing loss should receive intervention services before 6 months of age (Arizona Department of Health Services, n.d.). This report included available data on hearing screenings along with comprehensive hearing testing, evaluation and assessment which were termed “additional audiology services”.

Around 99% (82,035) of all Arizona infants received a newborn hearing screening in 2017 (Arizona Health Care Cost Containment System, 2018) which was slightly higher than the national rate of 98% (National Center on Birth Defects and Developmental Disabilities, 2019). Less than 1% of all Arizona infants were diagnosed with permanent hearing loss, and of those, 42% were diagnosed before three months of age (Arizona Health Care Cost Containment System, 2018). Nationally, 10% of infants were diagnosed with permanent hearing loss, and of those, approximately 74% were diagnosed before three months of age (National Center on Birth Defects and Developmental Disabilities, 2019).

Additional audiology services were provided to 15% of regional AHCCCS children under age one in 2017 compared to 11% of AHCCCS children statewide in 2017 and 9% of children in 2019 (Table 18). Hearing screenings were provided to 4% of regional AHCCCS children ages 1-5 in 2019 compared to 28% of AHCCCS children statewide. Statewide AHCCCS children’s rates for additional audiology services for ages 1-5 decreased from 68% to 57% from 2017 to 2019, and regional rates were suppressed for this indicator.

Table 18. Percent of Regional and Statewide AHCCCS Statewide and Regional Hearing Results, 2017-2019

Indicator / Year	2017		2018		2019	
	Region	Arizona	Region	Arizona	Region	Arizona
Additional Audiology Services Under Age One	15%	11%	DS	12%	DS	9%
Hearing Screening Ages 1-5	DS	20%	DS	22%	4%	28%
Additional Audiology Services for those Screened, Ages 1-5	DS	68%	DS	66%	DS	57%

Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

ORAL HEALTH

Oral health concerns our teeth, gums, and oral-facial system that includes the ability to smile, speak, chew and other senses. Daily brushing and flossing of our teeth and gums demonstrates good oral hygiene, but it is not enough to maintain good oral health. We also need good nutrition, proper management of other health conditions, access to dental care, and extra help when there is a genetic predisposition to oral health conditions or special health care needs.

Oral health is a key indicator of overall health, well-being and quality of life.

Unfortunately, tooth decay has become a chronic disease in children. The CDC reports that 20% of children ages 5-11 have at least one untreated cavity, and children in low-income families are twice as likely to have cavities than children in higher-income families (Dye, Xianfen, & Beltrán-Aguilar, 2012). Cavities can be prevented by applying a fluoride varnish to primary and permanent teeth, drinking fluoridated tap water, brushing with a fluoride toothpaste, and applying dental sealants. Children should have regular visits to the dentist, beginning before their first birthday, for early identification and management of problems (Enany, n.d.). This report focuses on dental visits for ages 1-5.

In the Pascua Yaqui Tribe Region, 36-48% of AHCCCS children had at least one annual dental visit compared to 51-53% of AHCCCS children statewide in Table 19. Neither the region nor the state met the AHCCCS MPS of 60% for annual dental visits for ages 2-20 (Table 20). Most dental claims were submitted by dentists in 2017 (74%) and 2018 (63%), but in 2019, Federally Qualified Health Centers submitted the most dental claims (62%) in Table 21.

Regional AHCCCS children ages 3-5 (43-52%) were more likely to have at least one annual dental visit than ages 1-2 (23-38%) in Figure 11. Hispanic or Latino AHCCCS children (51-56%) were more likely to have at least one annual dental visit in 2017 (41%) and 2019 (49%), and Non-Hispanic or Latino AHCCCS children were more likely to have at least one annual dental visit in 2018 (40%).

Two preventative care dental visits are recommended annually for children. In Table 19, 9-10% of regional AHCCCS children in 2017 and 2018, and 4% of children in 2019, received the biannual preventative care dental visits compared to 18-20% of AHCCCS children statewide.

In Table 19, fluoride varnish was applied to 29-37% of AHCCCS children in the region compared to 47-49% of AHCCCS children statewide from 2017 to 2019. Regional AHCCCS children ages 3-5 (33-39%) were more likely to have a fluoride varnish application than ages 1-2 (22-32%) in Figure 13.

Table 19. Percent of Regional and Statewide AHCCCS Children Oral Health Visits for Ages 1-5, 2017-2019

Type of Visit / Year	2017		2018		2019	
	Region	Arizona	Region	Arizona	Region	Arizona
Any Annual Dental Visit	36%	51%	39%	52%	48%	53%
Preventative Care Dental Visit Twice Annually	9%	18%	10%	19%	4%	20%
Fluoride Varnish Application	29%	47%	33%	48%	37%	49%

Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

Table 20. Statewide AHCCCS Contractor Rate of Performance on Annual Dental Visits for Ages Two to 20 Years, 2017-2019

Contractor	2017	2018	2019	Minimum Performance Standard
AHCCCS Complete Care	61%	61%	60%	60%
Comprehensive Medical and Dental Program	74%	75%	60%	60%
KidsCare	74%	74%	76%	60%

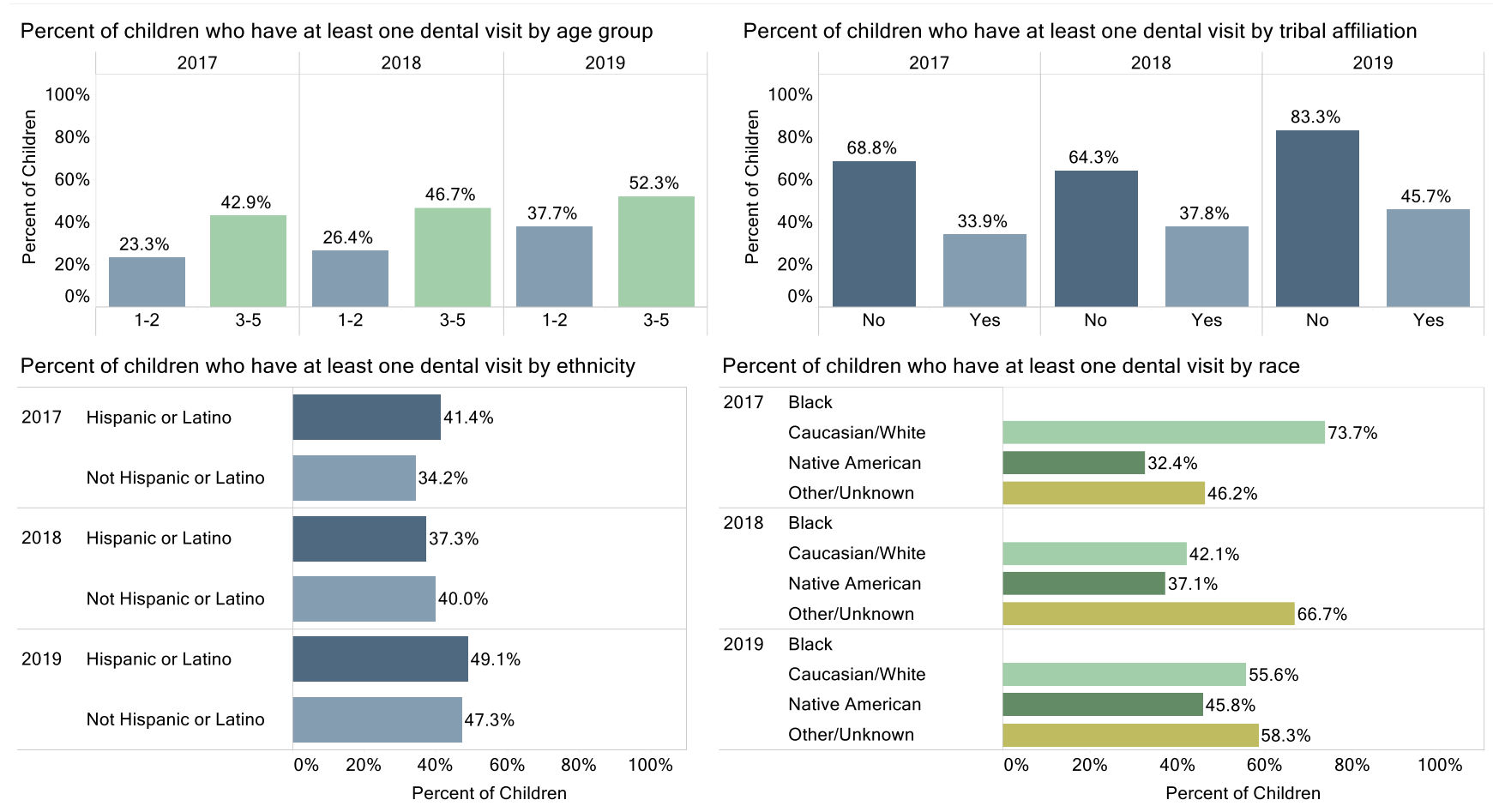
Source: (Health Services Advisory Group, 2021); (Health Services Advisory Group, 2019) (Health Services Advisory Group, 2020).

Table 21. Percent of Regional AHCCCS Claims by Provider Type for Children Ages 1-5 With at Least One Annual Dental Visit, 2017-2019

Provider Type	2017		2018		2019	
	Claims Count	Percent of Total	Claims Count	Percent of Total	Claims Count	Percent of Total
Dentist	132	74%	115	63%	70	38%
Federally Qualified Health Center (FQHC)	46	26%	68	37%	114	62%

Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

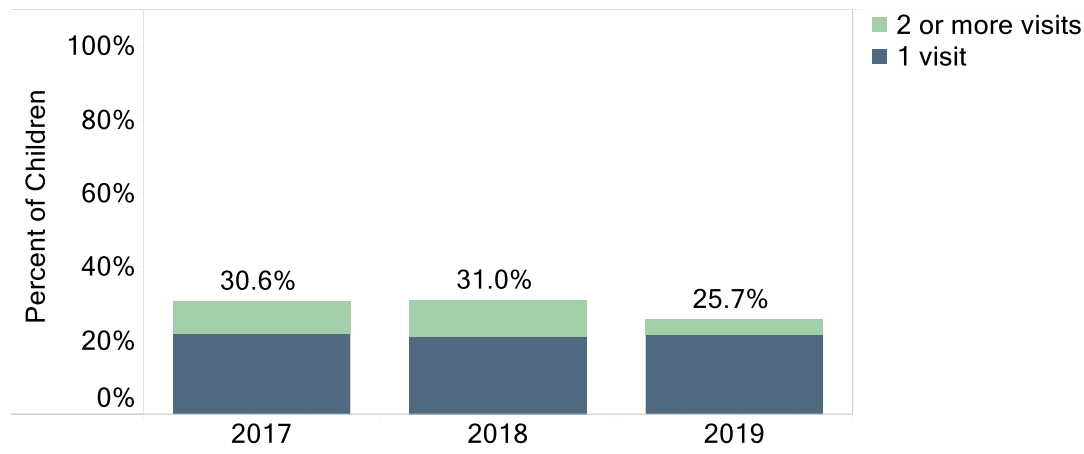
Figure 11. Percent of Regional AHCCCS Children Ages 1-5 With at Least One Annual Dental Visit by Age Group, Tribal Affiliation, Ethnicity, Race and Year



Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

Notes: This indicator includes any claim with an associated dental procedure code (CDT). Tribal affiliation refers to whether an individual is a member of a federally recognized Arizona tribe and is displayed as a flag (Yes/No) in this report. This information is captured during enrollment in AHCCCS.

Figure 12. Percent of Regional AHCCCS Children Ages 1-5 With One and Two Preventative Care Dental Visits in a Year



Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

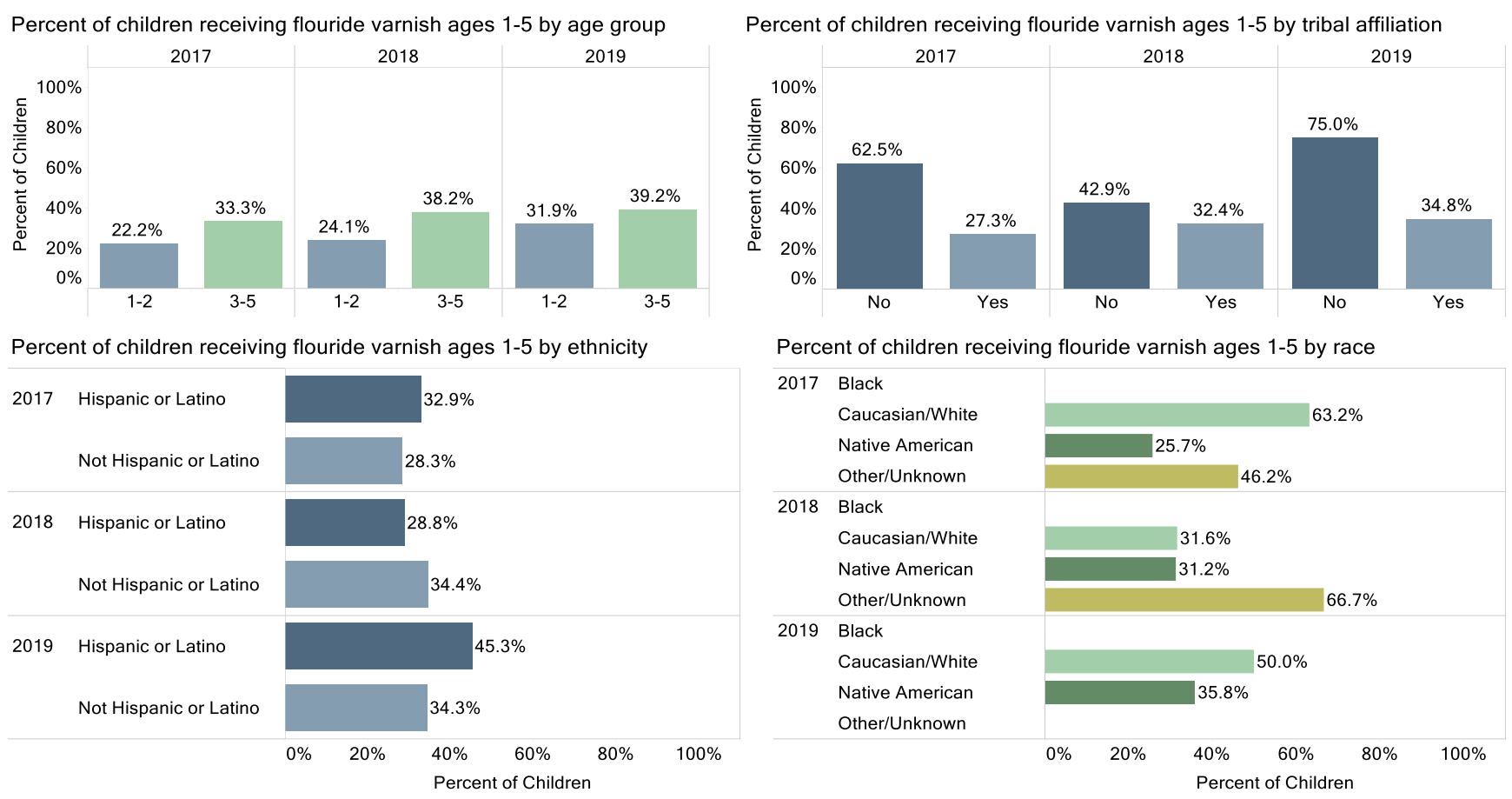
Notes: This indicator is called a preventative care dental visit and includes the following procedures: D0120 periodic oral evaluation, D0150 comprehensive oral evaluation and D0145 oral evaluation for patient under 3 years of age and counseling with primary caregiver.

Table 22. Percent of Claims by Provider Type for Regional AHCCCS Children Ages 1-5 Receiving Fluoride Varnish, 2017-2019

Provider Type	2017		2018		2019	
	Claims Count	Percent of Total	Claims Count	Percent of Total	Claims Count	Percent of Total
Dentist	76	78%	68	63%	38	35%
Federally Qualified Health Center (FQHC)	21	22%	40	37%	71	65%

Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

Figure 13. Percent of Regional AHCCCS Children Ages 1-5 Receiving Fluoride Varnish by Age Group, Tribal Affiliation, Ethnicity, Race and Year



Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

Note: Tribal affiliation refers to whether an individual is a member of a federally recognized Arizona tribe and is displayed as a flag (Yes/No) in this report. This information is captured during enrollment in AHCCCS.

IMMUNIZATIONS

Childhood vaccines protect children from many serious and potentially life-threatening diseases such as diphtheria, measles, meningitis, polio, tetanus and whooping cough, at a time in their lives when they are most vulnerable to disease. Approximately 300 children in the United States die each year from vaccine preventable diseases (HHS Office of Disease Prevention and Health Promotion, 2021). Immunizations are essential for disease prevention and are a critical aspect of preventable care for children. Vaccination coverage must be maintained to prevent a resurgence of vaccine-preventable diseases.

The Centers for Medicare and Medicaid Services measures the quality of immunizations through a core indicator of childhood immunization status which is also used by HEDIS. The measure calculates a rate for certain vaccines recommended by a child's second birthday (National Quality Forum, 2017):

- Percent of children who have completed the following schedules: four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); two influenza (flu).
- Percent of children who have completed all vaccine courses combined: Combo 10.
- Percent of children who have completed Combo 3: four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV).

AHCCCS measures childhood immunization completion rates with each of its contractors biennially using the core measure. AHCCCS children's immunization status in Table 24 is the percent of regional and statewide AHCCCS children who have completed each indicated vaccine course by their second birthday, recorded in AHCCCS claims only. These rates were substantially lower than AHCCCS' published statistics in Table 23 due to the limitation of claims data and should be interpreted with caution. AHCCCS declared that claims data does not have the greatest level of detail as claims are not always reported for immunizations, particularly in school settings. To accurately capture immunization rates in AHCCCS' published statistics, AHCCCS uses data from medical records and from the Arizona State Immunization Information System (ASIIS), which is maintained by the Arizona Department of Health Services.

AHCCCS reported that statewide childhood immunization completion rates met or exceeded the national mean rates for three immunizations: DTaP, Hep A and Combo 3 (Arizona Health Care Cost Containment System, 2018) in Table 23. Several barriers to immunizations remained, such as the spread of misinformation about vaccines and parental hesitancy. The rate of exemptions from immunizations increased statewide as nearly 6% of kindergarteners had a Personal Beliefs Exemption in place since the 2017-2018 school year (Arizona Department of Health Services, 2021).

Table 23. AHCCCS Statewide Aggregate Immunization Completion Rates by Two Years Old, FFY 2016

Immunizations	FFY 2016 (period ending 9/30/2017)	HEDIS Medicaid Mean	AHCCCS Minimum Performance Standard
DTaP	79%	77%	85%
Polio	88%	89%	91%
MMR	89%	90%	91%
HiB	87%	88%	90%
Hep B	87%	88%	90%
VZV	88%	89%	88%
PCV	76%	77%	82%
Hep A	88%	84%	40%
RV	61%	69%	60%
Flu	40%	45%	45%
Combo 3	71%	70%	68%

Source: (Arizona Health Care Cost Containment System, 2018).

Note: The rows shaded green are the childhood immunization rates that met or exceeded the national median rates.

Table 24. Percent of Statewide and Regional AHCCCS Children Immunization Status, from AHCCCS Claims Data Only, 2017-2019

Immunizations	2017		2018		2019	
	Region	Arizona	Region	Arizona	Region	Arizona
DTaP	37%	30%	27%	38%	36%	52%
Polio	53%	40%	40%	51%	42%	66%
MMR	55%	57%	40%	72%	47%	76%
HiB	53%	44%	40%	56%	39%	69%
Hep B	50%	13%	36%	18%	36%	21%
VZV	55%	57%	42%	72%	47%	76%
PCV	26%	18%	22%	31%	33%	52%
Hep A	58%	65%	49%	75%	47%	78%
RV	53%	31%	40%	39%	39%	51%
Flu	34%	19%	33%	31%	33%	34%
Combo 3	24%	4%	18%	10%	31%	15%
Combo 10	18%	2%	18%	4%	22%	7%

Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

Notes: Rates only include immunizations recorded in AHCCCS claims, this is likely an undercount of immunization rates. Rows shaded pink are for comparing with Table 23.

MATERNAL PRENATAL AND POSTPARTUM CARE

Research has shown that the health of women before pregnancy and after delivery significantly impacts the health of their babies; therefore, it is important to focus on women’s preconception health, prenatal care, postpartum care and beyond (Healthy People 2030).

Women who do not seek prenatal care are three times as likely to deliver a low birth weight infant.

(NICHD - Eunice Kennedy Shriver National Institute of Child Health and Human Development, 2017)

For pregnant women, prenatal care is essential for a healthy pregnancy and reducing the complications that can lead to poor birth outcomes for mother and child. Prenatal care involves regular visits to a health care provider to monitor the mother’s health and health of the developing fetus, and this care should begin as early as possible in the pregnancy and continue until delivery. Prenatal care can identify

problems or complications and take steps to manage them (NICHD - Eunice Kennedy Shriver National Institute of Child Health and Human Development, 2017). The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists recommend that a woman with an uncomplicated pregnancy be examined at least once in the first trimester for prenatal care. Appropriate perinatal services and education are crucial components of a healthy birth.

The period of up to 60 days following childbirth is called the postpartum period. Preexisting health conditions, social determinants, and newly developed conditions contribute to maternal morbidity and mortality during this period. Health care providers consider the postpartum period to be critical to the health and well-being of both mother and child, so postpartum care should not be considered as optional. Yet, research has shown that nearly 40% of women in the United States have gone without a single postpartum visit (American College of Obstetricians and Gynecologists, 2018).

In the region, 53% of pregnant women in 2017, 64% in 2018 and 60% in 2019 began prenatal care in the first trimester compared to 84-86% of AHCCCS women statewide in Table 25. The region did not meet the Healthy People 2030 target rate of 81%²¹. For postpartum care, 68% of regional AHCCCS women in 2017, 45% in 2018 and 60% in 2019 had at least one postpartum visit compared to 88-89% of AHCCCS women statewide and 64-75% of Medicaid women nationally.

Table 25. Percent of All Regional and Statewide AHCCCS Women Who Received Timely Prenatal and Postpartum Care, 2017-2019

Type of Care	2017		2018		2019	
	Region	Arizona	Region	Arizona	Region	Arizona
Prenatal Care	53%	84%	64%	86%	60%	85%
Postpartum Care	68%	88%	45%	89%	60%	89%

Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

²¹ Healthy People 2030 Prenatal Care Objective - <https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/increase-proportion-pregnant-women-who-receive-early-and-adequate-prenatal-care-mich-08>

HEALTH PLAN PERFORMANCE

This section provided a selection of health indicators to compare results among the AHCCCS health plans.

Table 27 provided a snapshot of service utilization for regional AHCCCS children enrolled in each AHCCCS health plan. All regional health plans exceeded the AHCCCS statewide aggregate performance and MPS for primary care practitioner (PCP) visits for ages 1-5 for all years that were not suppressed, except for the American Indian Health Program which did not meet this performance metric in any year.

For at least one well-child visit in the first 15 months, all regional health plans performed well, ranging from 86% for UnitedHealthcare in 2017 to 89% for Steward Health Choice AZ in 2018 to 100% for all other health plans and years that were not suppressed. Four regional health plans met or exceeded the AHCCCS statewide aggregate performance and MPS for one or more annual well-child visits for ages 3-5: Banner University Family Care (all years), Mercy Care Plan (2017 and 2018), Steward Health Choice AZ (2017 and 2018), and UnitedHealthcare (all years). Arizona Complete Care exceeded the AHCCCS statewide aggregate performance for one or more annual well-child visits for ages 3-5 in 2019.

Banner University Family Care (2017) and Care 1st (2019) exceeded the AHCCCS statewide aggregate health plan performance and MPS for preventative care dental visits for ages 1-5.²² In 2018, Banner University Family Care met the MPS for this indicator.

Table 26. Statewide AHCCCS Aggregate Health Plan Performance and Minimum Performance Standards, 2017-2019

Year/Indicator	One or More Annual PCP Visits, Ages 1-6 (MPS)	Six or More Well-Child Visits in First 15 Months (MPS)*	One or More Annual Well-Child Visits, Ages 3-6 (MPS)	One or More Annual Preventative Care Dental Visits, Ages 2-20 (MPS)
2017	83% (84%)	60% (65%)	61% (66%)	61% (60%)
2018	84% (84%)	62% (65%)	61% (66%)	61% (60%)
2019	84% (87%)	64% (62%)	63% (66%)	60% (60%)

Source: (Health Services Advisory Group, 2019); (Health Services Advisory Group, 2020); (Health Services Advisory Group, 2021); (Health Services Advisory Group, 2021); (Health Services Advisory Group, 2019); (Health Services Advisory Group, 2020).

Note: *AHCCCS did not measure health plan performance for the indicator of at least one PCP visit by 15 months of age.

²² The AHCCCS statewide indicator for preventative care dental visits includes ages 2-20 which incorporates a significantly larger number of AHCCCS children than our reporting on ages birth to 5, so the rates should be compared with caution.

Table 27. Select Regional Indicators by AHCCCS Health Plan, 2017-2019

Health Plan	Year	One or More PCP Visits, Ages 1-5	At Least One Well-Child Visit in First 15 Months	One or More Well-Child Visits,	One or More Preventative Care Dental Visits,
				Ages 3-5	Ages 1-5
AHCCCS American Indian Health Program	2017	25%	100%	DS	28%
	2018	30%	DS	DS	31%
	2019	52%	DS	DS	48%
AZ Complete Health	2019	97%	100%	64%	DS
Banner University Family Care	2017	100%	DS	82%	71%
	2018	100%	DS	91%	60%
	2019	100%	100%	74%	43%
Care 1st	2017	DS	DS	DS	DS
	2018	100%	DS	DS	DS
	2019	DS	DS	DS	70%
Mercy Care Plan	2017	90%	100%	76%	39%
	2018	90%	DS	71%	43%
	2019	DS	DS	DS	43%
Steward Health Choice AZ	2017	97%	DS	70%	49%
	2018	85%	89%	70%	54%
	2019	DS	DS	DS	50%
United Healthcare	2017	87%	86%	67%	30%
	2018	88%	DS	70%	39%
	2019	100%	100%	79%	38%

Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

Notes: All data was suppressed for six or more well-child visits in first 15 months. Cells shaded green indicate the rate met or exceeded the AHCCCS statewide performance by health plan (Table 28); cells shaded blue indicate the health plan met or exceeded the AHCCCS statewide aggregate performance; cells shaded pink indicate the health plan met or exceeded the MPS; and cells shaded purple indicate the health plan met or exceeded both the MPS and statewide aggregate performance (see Table 26).

Table 28. Select Statewide AHCCCS Indicators by Health Plan, 2017-2019

Health Plan	Year	One or More PCP Visits, Ages 1-6	Well-Child Visits in First 15 Months Six or More Visits	One or More Well-Child Visits, Ages 3-6	One or More Preventative Care Dental Visits, Ages 2-20
AZ Complete Health	2017	N/A	N/A	N/A	N/A
	2018	82%	61%	59%	48%
	2019	82%	64%	61%	55%
Banner University Family Care	2017	N/A	N/A	N/A	N/A
	2018	84%	62%	60%	54%
	2019	83%	64%	61%	53%
Care 1st	2017	83%	66%	64%	62%
	2018	86%	67%	67%	65%
	2019	84%	71%	64%	63%
Magellan Complete Care	2017	N/A	N/A	N/A	N/A
	2018	N/A	N/A	N/A	N/A
	2019	67%	N/A	47%	37%
Mercy Care Plan	2017	85%	63%	62%	64%
	2018	86%	66%	63%	64%
	2019	87%	65%	65%	63%
United Healthcare	2017	83%	59%	60%	61%
	2018	84%	61%	61%	62%
	2019	86%	66%	67%	62%

Source: (Health Services Advisory Group, 2019); (Health Services Advisory Group, 2020); (Health Services Advisory Group, 2021); (Health Services Advisory Group, 2021); (Health Services Advisory Group, 2019); (Health Services Advisory Group, 2020).

Notes: Cells that did not have available data for that year and/or the health plan was not contracted for that year are indicated by "N/A". Cells shaded blue indicate the rate met or exceeded the AHCCCS statewide aggregate health plan performance rate; cells shaded purple indicate the rate met or exceeded both the AHCCCS statewide aggregate health plan performance rate and the AHCCCS MPS (see Table 26). AHCCCS did not measure health plan performance for the indicator of at least one PCP visit by 15 months of age.

CONCLUSION

The physical, mental, and emotional health of young children lays the foundation for the rest of their life. The Pascua Yaqui Tribe Region had several assets contributing to better health outcomes for young children and women enrolled in AHCCCS from 2017 to 2019, including access to care, newborn hearing screenings and acute health plan performance on primary care practitioner (PCP) visits and well-child visits. These achievements contributed to good health outcomes throughout the region. The areas where needs were identified for AHCCCS women and children included: PCP and well-child visits, lead poisoning screenings, developmental screenings, vision screenings and treatment for significant visual conditions, oral health, and prenatal and postpartum care.

The information in this report can be combined with other available information to create a more comprehensive view of young children and women in the region for regional council planning.

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APPENDIX: DATA SOURCES

The source of data in all tables, graphs, reports, presentations, and other publications is the Arizona Health Care Cost Containment System (AHCCCS) (2021) unless otherwise noted. CHiR is the source of the calculations, analysis and/or processing of the data.

AHCCCS health claims and encounters data. AHCCCS is the state Medicaid provider. The data include health care transactions (paid claims) on all members, patients receiving inpatient, emergency department or other outpatient care in the state. The data layout is already at the individual patient level when received and requires no further manipulation to standardize variables or match patients.

AHCCCS System

In October 2018, AHCCCS enacted major changes to its care delivery system to integrate physical and behavioral health care under designated health plans for its eligible populations, called AHCCCS Complete Care. Integrated care would result in better coordination among providers in the same network and better health outcomes for AHCCCS enrollees. Under AHCCCS Complete Care, the choice of health plans varies by geographic area, but affected members have the same array of covered services and access to a network of providers (Arizona Health Care Cost Containment System, 2018).

Table 29. AHCCCS Complete Care Health Plans by Geographic Service Area

Geographic Service Area	AHCCCS Complete Care Health Plans
North (Apache, Coconino, Mohave, Navajo and Yavapai Counties)	Care 1st and Health Choice Arizona
Central (Maricopa, Gila and Pinal Counties)	Banner University Family Care, Care 1st, Health Choice Arizona, Arizona Complete Health, Magellan Complete Care, Mercy Care, UnitedHealthcare Community Plan
South (Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz and Yuma Counties)*	Banner University Family Care, Arizona Complete Health, UnitedHealthcare Community Plan (Pima County only)

*Zip codes 85542, 85192, 85550 are in the South geographic service area.

Other health plans serve specialty populations. AHCCCS members with developmental disabilities who are enrolled in the Department of Economic Security/Division of Developmental Disabilities (DES/DDD) with a Children’s Rehabilitative Services designation receive integrated care through their assigned DDD health plan. Arizona Long Term Care members receive services through program contractors.

American Indian members have the choice of enrolling in an AHCCCS Complete Care managed care plan or the American Indian Health Program (AIHP fee-for-service) for integrated care or switch enrollment between the two at any time. AIHP members can also choose care coordination through a Tribal Regional Behavioral Health Authority when available (secondary health plan). American Indian members can receive services at any time from an Indian Health Service facility, or a tribally owned or operated organization (i.e., Tribal 638 providers or Urban Indian Health providers).

American Indian members determined to have a Serious Mental Illness receive behavioral health services from a Regional Behavioral Health Authority but have the option to choose the American Indian Health Program or AHCCCS Complete Care for physical health services.

Arizona Health Care Workforce- Physicians. For the provider indicators, we capture the supply of Arizona physicians by specialty using the Arizona Health Care Workforce data set. This data set includes administrative data collected from the Arizona Medical Board and the Arizona Board of Osteopathic Examiners in Medicine and Surgery, the licensing agencies for physicians.