

# # FIRST THINGS FIRST

Tohono O'odham Nation Region



2022 Needs and Assets Supplemental Report:

## **Children's Access to and Use of Public Health Services**

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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 Tohono O’odham Nation Region. Tohono O’odham Nation Region consists of the following subregions: Baboquivari District, Chukut Kuk District, Gu Achi District, Gu Vo District, Hickiwan District, Pisinemo District, San Lucy District, San Xavier District, Schuk Toak District, Sells District, Sif Oidak District. 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.<sup>1</sup> 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)<sup>2</sup>. 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 affiliation<sup>3</sup>, 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 Tohono O’odham Nation Region there were 725 children enrolled in AHCCCS in 2017, 692 children enrolled in 2018 and 653 children enrolled in 2019. Of these, male AHCCCS children outnumbered females

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<sup>1</sup> 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.

<sup>2</sup> See <https://www.ncqa.org/hedis/>

<sup>3</sup> 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.

by 3-5%. There were slightly more infants and toddlers than preschoolers in 2017 and 2018, and 4% more preschoolers in 2019. Of the AHCCCS children in the region, 72-76% lived in Sells District subregion and 16-18% lived in San Xavier District subregion.<sup>4</sup> By race, 3% of AHCCCS children reported as Caucasian/White and 91-93% as Native American. Of these, 5-6% of AHCCCS children were Hispanic or Latino. Affiliation with a tribal community was reported by 94-96% of AHCCCS children<sup>5</sup> and 77-81% were enrolled in the American Indian Health Program. Most annual health claims were submitted by hospitals (38-43%), physicians (14-18%), other providers (11-15%), and non-emergency transportation (10-13%).

### **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 Tohono O’odham Nation Region had one hospital and other medical facilities available in the Region.

The rate of available primary care physicians in the region was 17-26 primary care physicians per 1,000 AHCCCS children compared to the statewide rate of 23-24 per 1,000 AHCCCS children. For primary care physicians accepting AHCCCS patients, the regional rate was 14-17 physicians per 1,000 AHCCCS children. For dentists accepting AHCCCS patients, the regional rate was 0-18 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. To visit the nearest primary care physician, behavioral health provider or dentist, 19-26% of AHCCCS children in the region traveled up to five miles for services compared to 56-65% of AHCCCS children statewide traveling up to one mile and another 27-35% traveling up to five miles. Due to inexact addresses, distance to the nearest primary care physician, behavioral health provider or dentist could not be calculated for 67-71% of regional AHCCCS children. The nearest pharmacy was more than 10 miles away for 82-84% of regional AHCCCS children compared to 64% of statewide AHCCCS children who traveled one mile or less and 26% who traveled up to five miles. Nearly one-third of regional AHCCCS children traveled one mile to the nearest hospital and 14-17% traveled five to ten miles. For AHCCCS children statewide, 11-12% traveled one mile to the hospital and 69% traveled up to five miles.

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<sup>4</sup> Three subregions had fewer than six AHCCCS children in all years (Chukut Kuk District, Pisinemo District and Sif Oidak District) and four subregions had no children (Gu Achi District, Gu Vo District, Hickiwan District and Schuk Toak District); therefore, the rates were suppressed for all indicators in these subregions.

<sup>5</sup> 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, 17-22% 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 region and the subregions were below the AHCCCS Minimum Performance Standard (MPS)<sup>6</sup> of 84%. Regional AHCCCS children having annual PCP visits were more likely to be ages 1-2 (18-25%) than ages 3-5 (16-20%) and Hispanic and Latino (67-68%) than Non-Hispanic or Latino (14-19%).

Regionally, 17-25% of AHCCCS children birth to 15 months had at least one well-child visit compared to 93-94% of statewide AHCCCS children. Of these, 10-13% of regional AHCCCS children had six or more well-child visits compared to 53-60% of statewide AHCCCS children 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. For AHCCCS children ages 3-5, 7-9% 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 was below the AHCCCS MPS of 66% for this indicator. Hispanic or Latino AHCCCS children ages 3-5 (40-46%) were more likely to have an annual well-child visit than Non-Hispanic or Latino AHCCCS children (4-7%).

### **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 who have not been previously tested should receive the blood lead test.<sup>7</sup>

ADHS reported 61,391 children 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. For AHCCCS children being screened for lead poisoning one or more times by

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<sup>6</sup> 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.

<sup>7</sup> <https://www.azdhs.gov/preparedness/epidemiology-disease-control/lead-poisoning/index.php#high-risk-zip-codes-home>



their second birthday, the regional rates were suppressed due to low numbers of screenings. The AHCCCS statewide rates 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 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, nutrition counseling and physical activity counseling were suppressed for AHCCCS children in Tohono O’odham Nation Region. AHCCCS children statewide were assessed at rates of 9-19% for weight assessment, 4-5% for nutrition counseling, and <1-1% for physical activity assessments.<sup>8</sup> 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 were 1-2% in 2017 and 2019 compared to statewide AHCCCS rates of 10-14%.<sup>9</sup> These screening rates were based on 10 claims in 2017 and 14 claims in 2019 from provider types of Federally Qualified Health Center (FQHC), Physician – MD/DO, and Registered Nurse Practitioner. Rates of diagnosing developmental delay in AHCCCS children were 1-2% at the regional level compared to 3-5% at the state level for AHCCCS children. Of those AHCCCS children who were diagnosed with developmental delay, 73% of regional AHCCCS children in 2019 received behavioral health services compared to 58% of AHCCCS children statewide.

### **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

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<sup>8</sup> Physical Activity Counseling includes sports physicals which are not provided to children in the early childhood age group.

<sup>9</sup> Due to the limited capture of developmental screenings in claims data alone, these rates should be interpreted with caution.

young children, behavioral health services<sup>10</sup> would likely include day programs, crisis services, rehabilitation services, health promotion, mental health counseling, psychiatric and psychologist services, and various support services. Five to nine percent of AHCCCS children in the region received behavioral health services compared to 11-16% of AHCCCS children statewide. Male AHCCCS children in the region were more likely to receive behavioral health services (5-10%) than females (4-9%).

### **Vision<sup>11</sup>**

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 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 Tohono O’odham Nation Region, 4-5% of AHCCCS children received an annual vision screening or well-child visit compared to 43-47% of AHCCCS children statewide. By subregion, the rates for annual vision screening or well-child visits were San Xavier District (15-19%) and Sells District (2-3%). The regional rate for eye exams in AHCCCS children was 1-2% compared to 4-5% at the state level. The regional rates for follow-up eye exams and treatment of visually significant eye conditions were suppressed in all years. The statewide rates for AHCCCS children receiving follow-up eye exams were 4-5% and 54-60% for treatment of visually significant eye conditions.

### **Hearing<sup>11</sup>**

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.

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<sup>10</sup> For more detail on AHCCCS behavioral health services, visit <https://www.azahcccs.gov/Members/AlreadyCovered/coveredservices.html>

<sup>11</sup> 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.

<sup>11</sup> *ibid*

Around 99% (82,035) 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 5% of AHCCCS children under age one in Tohono O’odham Nation Region in 2018 compared to 12% of AHCCCS children statewide in the same year. Hearing screenings were provided to 1-2% of AHCCCS children ages 1-5 in the region compared to 20-28% of AHCCCS children statewide. Of these, the rates for additional audiology services for regional AHCCCS children ages 1-5 were suppressed while statewide AHCCCS children’s rates decreased from 68% in 2017 to 57% in 2019; the claim count in the region was 6-9 claims annually over the period.

### **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 is also recommended to prevent cavities.

In Tohono O’odham Nation Region, 14% of AHCCCS children had at least one annual dental visit compared to 51-53% of AHCCCS children statewide. Neither the region nor the state met the AHCCCS MPS of 60% for annual dental visits for ages 2-20. The subregional rates for at least one annual dental visit were San Xavier District (28-32%) and Sells District (9-13%). Regional AHCCCS children receiving at least one annual dental visit were more likely to be ages 3-5 (17-23%) than ages 1-2 (5-9%) and Hispanic or Latino (32-56%) than Non-Hispanic or Latino (12-14%).

Two preventative care dental visits are recommended annually for children. Regionally, 2-4% of AHCCCS children received the biannual preventative care dental visit compared to 18-19% of AHCCCS children statewide. Fluoride varnish was applied to 9-11% of AHCCCS children in the region compared to 47-49% of AHCCCS children statewide. The subregional rates for a fluoride varnish application were San Xavier District (23-31%) and Sells District (6-10%). Regional AHCCCS children who had a fluoride varnish application were more likely to be ages 3-5 (12-17%) than ages 1-2 (5-7%) and Hispanic or Latino (25-48%) than Non-Hispanic or Latino (9-12%).

### **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 for AHCCCS women. 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 Tohono O’odham Nation Region, 44-55% of pregnant women began prenatal care in the first trimester compared to 84-86% of AHCCCS women statewide. The Healthy People 2030 target rate

was 81%<sup>12</sup>. Rates for regional AHCCCS women who had at least one postpartum visit were 38% in 2017, 73% in 2018 and 43% in 2019 compared to 88-89% of AHCCCS women statewide and 64-75% of Medicaid women nationally. In 2018, AHCCCS women affiliated with a tribal community were more likely to have a postpartum visit (77%) than those unaffiliated (67%).

### **Conclusion**

From 2017 to 2019, Tohono O’odham Nation Region showed strong performance on the following AHCCCS children’s and women’s health indicators: newborn hearing screenings, immunizations (DTaP, Hepatitis A and Combo 3), and supply of health care professionals. These achievements contributed to good health outcomes throughout the region. The areas where needs were identified for AHCCCS women and children included PCP visits, well-child visits, developmental screenings, lead poisoning screenings, vision screenings, hearing screenings for ages 1-5, 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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<sup>12</sup> 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>

## INTRODUCTION

### THE IMPORTANCE OF EARLY CHILDHOOD HEALTH

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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 Tohono O’odham Nation 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

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#### 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

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CHiR and representatives from the FTF Regions, Programs, and Evaluation teams determined priority indicators for this report. FTF provided the regional and subregional boundaries. Tohono O’odham Nation Region consists of the following subregions: Baboquivari District, Chukut Kuk District, Gu Achi District, Gu Vo District, Hickiwan District, Pisinemo District, San Lucy District, San Xavier District, Schuk Toak District, Sells District, Sif Oidak District. 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 Resolution previously established between FTF and the FTF Tohono O’odham Nation Region, FTF notified the Tohono O’odham Nation Region in writing that work would begin on this report, and the work was approved by the region. 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

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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. 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. 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.”

## DATA LIMITATIONS

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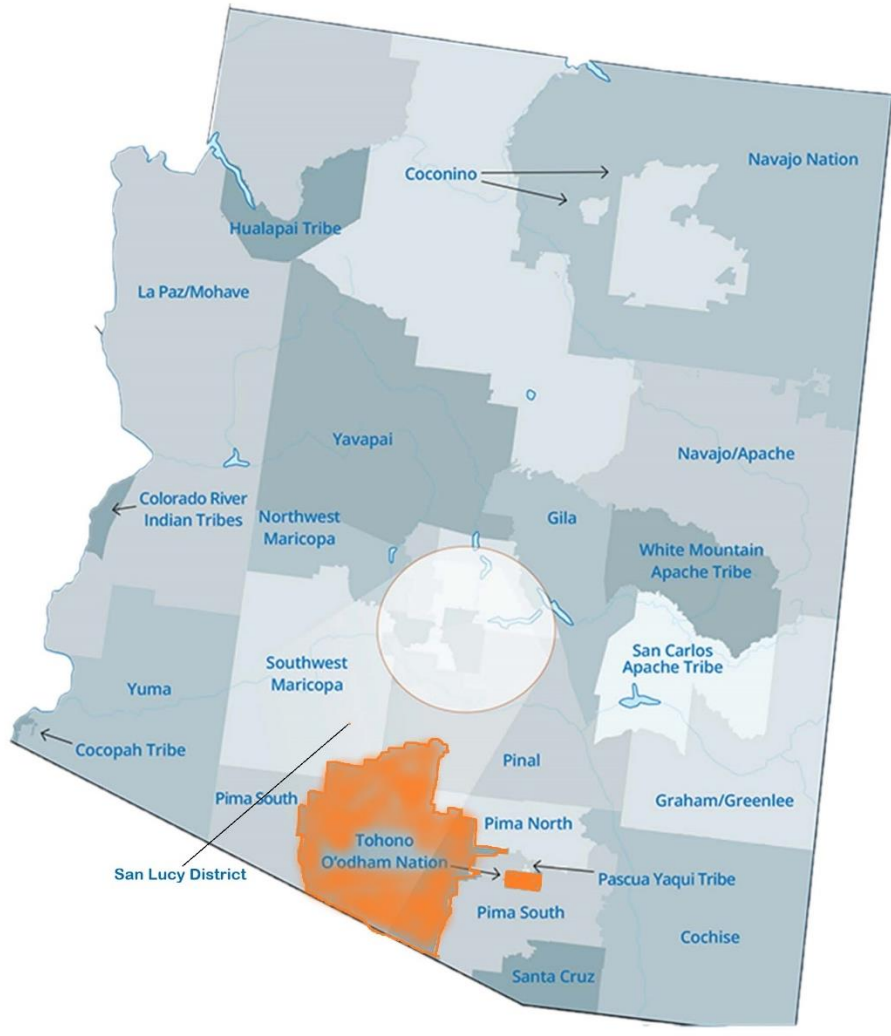
Most of the results in this report used AHCCCS claims and encounter data. While being limited to the population of children enrolled in Arizona Medicaid, this data source was also subject to coding errors and missing data for some indicators.

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 (ASIS) 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.



# TOHONO O'ODHAM NATION 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 from 2017 to 2019.

*There were 234,616 children from birth to age 5 enrolled in AHCCCS statewide from 2017 to 2019.*  
*(AHCCCS Claims Data, 2021)*

In Tohono O’odham Nation Region, there were 725 children enrolled in AHCCCS in 2017, 692 children enrolled in 2018 and 653 children enrolled in 2019. Of these, male AHCCCS children outnumbered females by 3-5% (Table 1). In Table 2, there were slightly more infants and toddlers than preschoolers in 2017 and 2018, and 4% more preschoolers in 2019.

In Figure 1, 72-76% of AHCCCS children in the region lived in Sells District subregion and 16-18% lived in San Xavier District subregion.<sup>13</sup> By race, 3% of AHCCCS children reported as Caucasian/White and 91-93% as Native American (Figure 2). Of these, 5-6% of AHCCCS children were Hispanic or Latino in Figure 3. Affiliation with a tribal community was reported by 94-96% of AHCCCS children annually (Figure 4).<sup>14</sup> Of AHCCCS children in the region, 77-81% were enrolled in the American Indian Health Program (Figure 5). In Table 3, most annual health claims were submitted by hospitals (38-43%), physicians (14-18%), other providers (11-15%), and non-emergency transportation (10-13%).

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

Year	Female	Male	Total of AHCCCS-Enrolled Children
2017	352	373	725
2018	330	362	692
2019	312	341	653

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

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

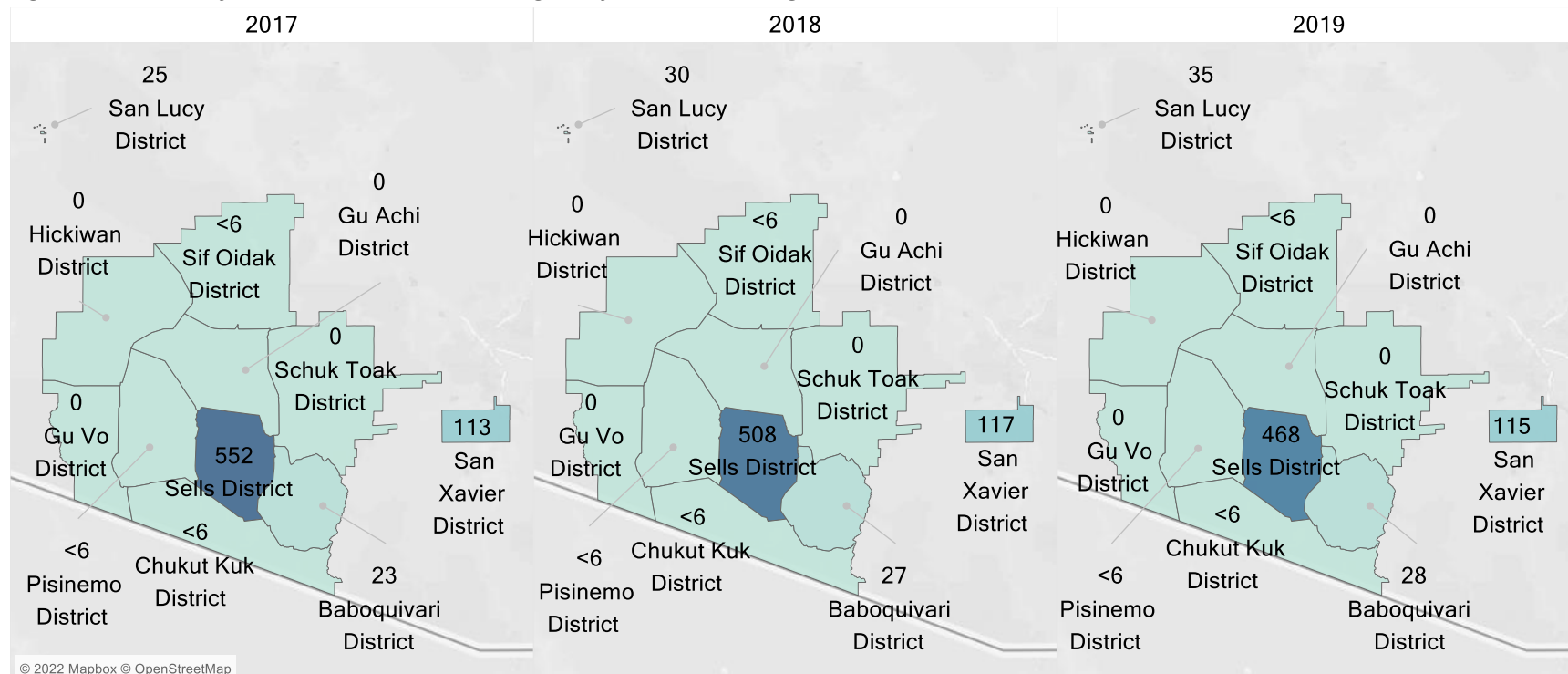
Year	Infant (under 1)	Toddler (1-2)	Preschooler (3-5)
2017	130	234	361
2018	127	224	341
2019	114	198	341

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

<sup>13</sup> Three subregions had fewer than six AHCCCS children in all years (Chukut Kuk District, Pisinemo District and Sif Oidak District) and four subregions had no children (Gu Achi District, Gu Vo District, Hickiwan District and Schuk Toak District); therefore, the rates were suppressed for all indicators in these subregions.

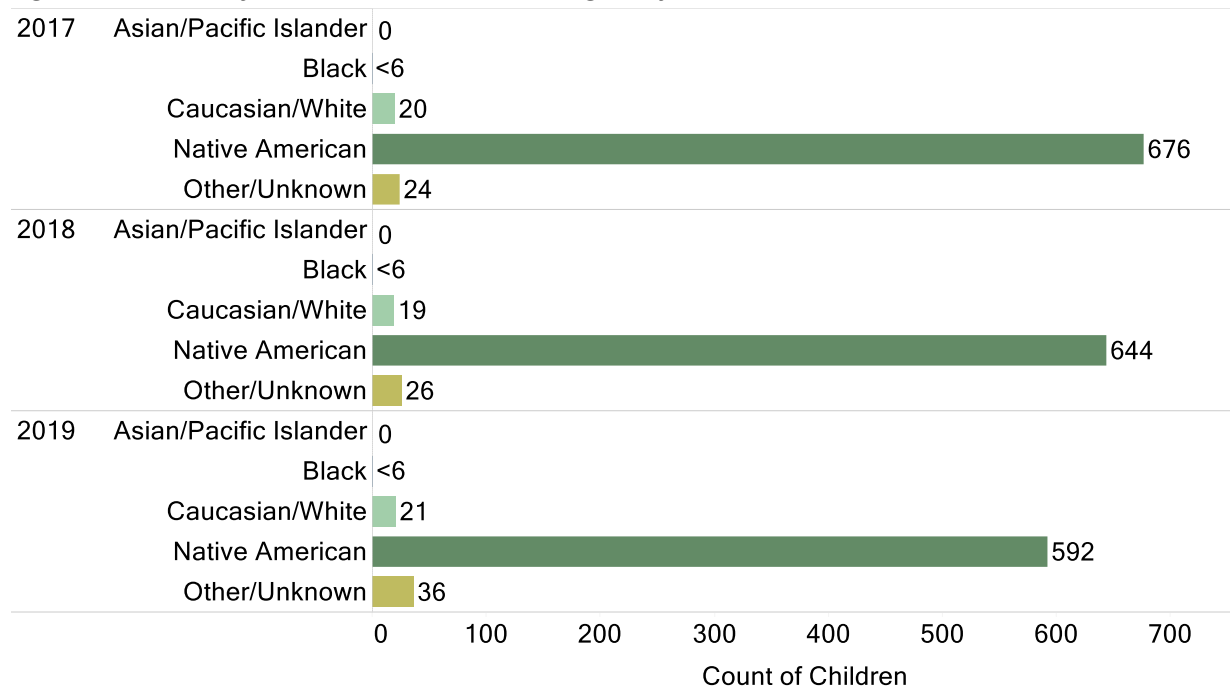
<sup>14</sup> Tribal affiliation refers to whether an individual is a member of a federally recognized Arizona tribe and is displayed as a flag (Yes/No) in this report. This information is captured during enrollment in AHCCCS.

**Figure 1. Number of AHCCCS Children Birth to Age 5 by Year and Subregion**



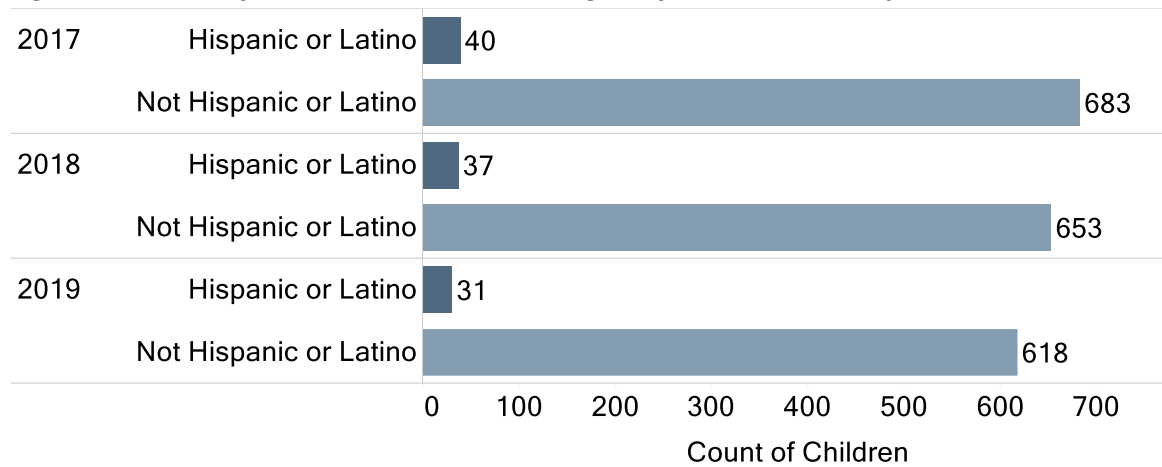
Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

**Figure 2. Number of AHCCCS Children Birth to Age 5 by Year and Race**



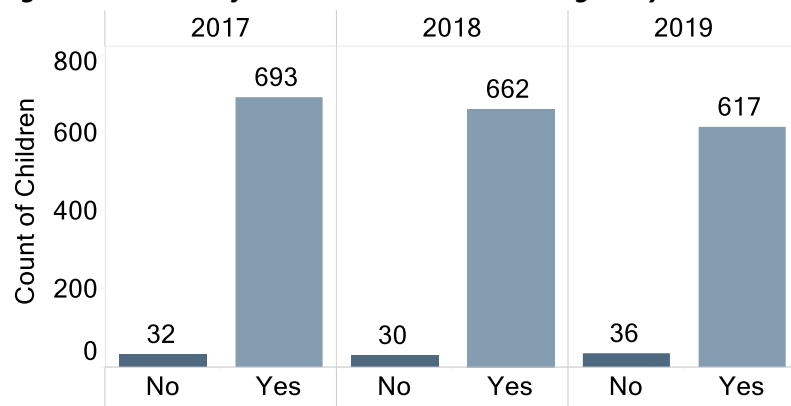
Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

**Figure 3. Number of AHCCCS Children Birth to Age 5 by Year and Ethnicity**



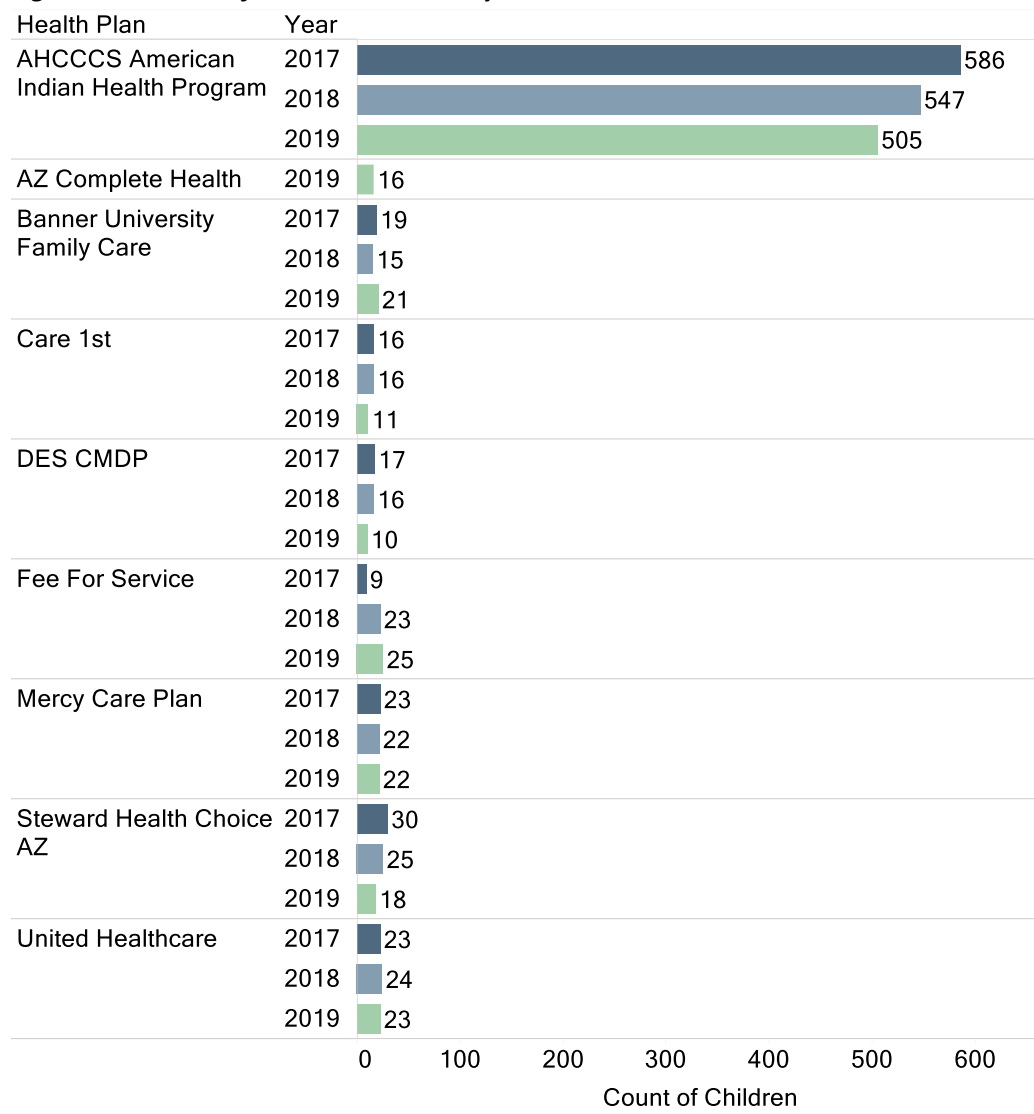
Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

**Figure 4. Number of 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.

**Figure 5. Number of AHCCCS Children 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 AHCCCS Claims 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	341	4%	186	2%	336	4%
Dentist	171	2%	164	2%	137	2%
Durable Medical Equipment Supplier	100	1%	71	1%	72	1%
Federally Qualified Health Center (FQHC)	123	1%	139	2%	173	2%
Hospital	3,403	38%	3,260	39%	3,848	43%
Integrated Clinics**	99	1%	181	2%	161	2%
Laboratory	52	1%	54	1%	55	1%
Non-Emergency Transportation Providers	855	10%	1,040	13%	935	10%
Occupational Therapist	23	<1%	41	<1%	<6	DS
Pharmacy	287	3%	230	3%	251	3%
Physical Therapist	34	<1%	45	1%	25	<1%
Physician – MD/DO	1,589	18%	1,193	14%	1,581	18%
Physician Assistant	98	1%	83	1%	69	1%
Registered Nurse Practitioner	334	4%	296	4%	270	3%
Speech Language Pathology	7	<1%	13	<1%	<6	DS
Speech/Hearing Therapist	45	1%	78	1%	39	<1%
Other	1,290	15%	1,223	15%	966	11%

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.

## HEALTH CARE WORKFORCE

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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 Tohono O’odham Nation Region had one hospital and other medical facilities available in the Region.

The rate of available primary care physicians in the region was 17-26 primary care physicians per 1,000 AHCCCS children (Table 5) compared to the statewide rate of 23-24 per 1,000 AHCCCS children (Table 4). For primary care physicians accepting AHCCCS patients, the regional rate was 14-17 physicians per 1,000 AHCCCS children. For dentists accepting AHCCCS patients, the regional rate was 0-18 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. To visit the nearest primary care physician, behavioral health provider or dentist, 19-26% of AHCCCS children in the region traveled up to five miles for services compared to 56-65% of AHCCCS children statewide traveling up to one mile and another 27-35% traveling up to five miles. Due to inexact addresses, distance to the nearest primary care physician, behavioral health provider or dentist could not be calculated for 67-71% of regional AHCCCS children.

The nearest pharmacy was more than 10 miles away for 82-84% of regional AHCCCS children compared to 64% of statewide AHCCCS children who traveled one mile or less and 26% who traveled up to five miles. Nearly one-third of regional AHCCCS children traveled one mile to the nearest hospital and 14-17% traveled five to ten miles. For AHCCCS children statewide, 11-12% traveled one mile to the hospital and 69% traveled up to five miles.

**Table 4. Supply of Key Health Professionals in Arizona per 1,000 AHCCCS Children, 2017-2019**

Provider Type	2017		2018		2019*	
	Number	Rate	Number	Rate	Number	Rate
<b>Total Active Physicians</b>	16,345	70	17,356	74	N/A	N/A
<b>Active Primary Care Physicians<sup>1</sup></b>	5,396	23	5,598	24	N/A	N/A
<b>Pediatricians<sup>4</sup></b>	1,214	5	1,257	5	1,293	6
<b>Active Registered and Practical Nurses<sup>2</sup></b>	N/A	N/A	101,599	433	104,434	445
<b>Dentists<sup>3</sup></b>	3,796	16	3,903	17	4,012	17

Source: <sup>1</sup> (Association of American Medical Colleges, 2017). (Association of American Medical Colleges, 2019). <sup>2</sup> (National Council of State Boards of Nursing, 2021). <sup>3</sup> (American Dental Association, 2021). <sup>4</sup> (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. <sup>1</sup> 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 Tohono O’odham Nation Region per 1,000 AHCCCS Children, 2017-2019**

Provider	2017		2018		2019	
	Num	Rate	Num	Rate	Num	Rate
<b>Primary Care</b>						
Primary Care – All Licensed Primary Care Physicians <sup>2</sup>	12	17	14	20	17	26
Physicians accepting AHCCCS <sup>1,2</sup> – Total	10	14	11	16	11	17
Physicians accepting AHCCCS – Pediatrics	2	3	3	4	2	3
Physicians accepting AHCCCS – Primary Care	8	11	8	12	9	14
Physicians with ≥250 AHCCCS patients per year (all ages)	1	1	1	1	1	2
<b>Behavioral Health – AHCCCS<sup>1</sup></b>						
Behavioral Health Physician Specialty or Allied Health Professional	3	4	3	4	3	5
Primary Care with Behavioral Health Services*	0	0	0	0	0	0
<b>Other</b>						
Dentist – accepting AHCCCS <sup>2</sup>	0	0	6	9	12	18
Hospital <sup>1,3</sup>	1	1	1	1	1	2
Pharmacy <sup>1,4</sup>	2	3	2	3	2	3

Source: <sup>1</sup>AHCCCS Claims Data, 2021. <sup>2</sup>Arizona Medical Board and Arizona Board of Osteopathic Medical Examiners in Medicine and Surgery, 2021. <sup>3</sup>(Arizona Department of Health Services, 2021). <sup>4</sup>RXOpen 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 = 725 for 2017, N = 692 for 2018 and N = 653 for 2019). Pharmacies that were co-located with hospitals or clinics were not captured in the data. Hospital, and pharmacy historic data was not available, so all numbers are based on most recent data available.

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

**Table 6. Percent of AHCCCS Children Grouped by Travel Distance Between Provider and Child’s Residence by Provider Type for Region and Arizona, 2017-2019**

Provider Type/Miles	Year	0-1 Miles		1-5 Miles		5-10 Miles		10+ Miles		Unknown**	
		Region	AZ	Region	AZ	Region	AZ	Region	AZ	Region	AZ
<b>Behavioral Health Specialty or Primary Care with Behavioral Health Services*</b>	2017	1%	62%	23%	30%	2%	3%	3%	2%	71%	4%
	2018	1%	64%	25%	27%	2%	3%	3%	2%	69%	3%
	2019	DS	65%	26%	27%	2%	3%	4%	2%	67%	4%
<b>Dentist</b>	2017	<1%	62%	19%	29%	<1%	3%	81%	4%	<1%	2%
	2018	1%	63%	25%	29%	2%	3%	3%	3%	69%	3%
	2019	2%	63%	25%	28%	2%	3%	4%	3%	67%	3%
<b>Hospital</b>	2017	71%	11%	5%	69%	14%	9%	10%	10%	<1%	<1%
	2018	69%	12%	4%	69%	16%	9%	10%	11%	<1%	<1%
	2019	67%	12%	4%	69%	17%	9%	12%	11%	<1%	<1%
<b>Pharmacy</b>	2017	2%	64%	14%	26%	<1%	3%	84%	7%	<1%	<1%
	2018	2%	64%	15%	26%	<1%	3%	83%	7%	<1%	<1%
	2019	2%	64%	16%	26%	<1%	3%	82%	7%	<1%	<1%
<b>Primary Care Physician</b>	2017	1%	56%	19%	34%	2%	4%	7%	4%	71%	3%
	2018	1%	56%	20%	35%	2%	3%	8%	4%	69%	3%
	2019	2%	57%	20%	34%	2%	3%	9%	4%	67%	3%

Source: <sup>1</sup> (AHCCCS Claims Data, 2021). <sup>2</sup> (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.

Data was suppressed for Behavioral Health Services, 2019, 0-1 miles due to low numbers.

**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.

*Statewide, 85-86% 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, 17-22% of AHCCCS children had at least one PCP visit compared to 85-86% of AHCCCS children statewide and 86-87% of Medicaid children nationally in Table 7. The region and the subregions (Table 8) were below the AHCCCS Minimum Performance Standard (MPS)<sup>15</sup> of 84%. Regional AHCCCS children having annual PCP visits were more likely to be ages 1-2 (18-25%) than ages 3-5 (16-20%) and Hispanic and Latino (67-68%) than Non-Hispanic or Latino (14-19%) in Figure 6.

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

Indicator/Year	2017		2018		2019	
	Region	Arizona	Region	Arizona	Region	Arizona
Access to Primary Care	17%	85%	18%	85%	22%	86%

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

**Table 8. Percent of AHCCCS Children Ages 1 – 5 with a Visit to PCP by Subregion, 2017-2019**

Subregion	2017	2018	2019
San Lucy District	DS	69%	65%
San Xavier District	31%	35%	45%
Sells District	14%	12%	13%

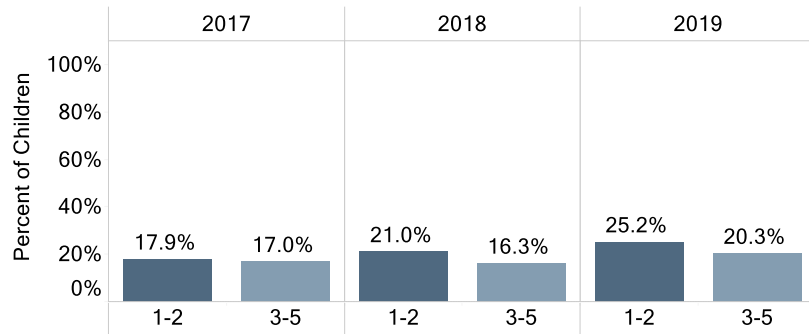
Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

Note: Data was suppressed for Baboquivari District.

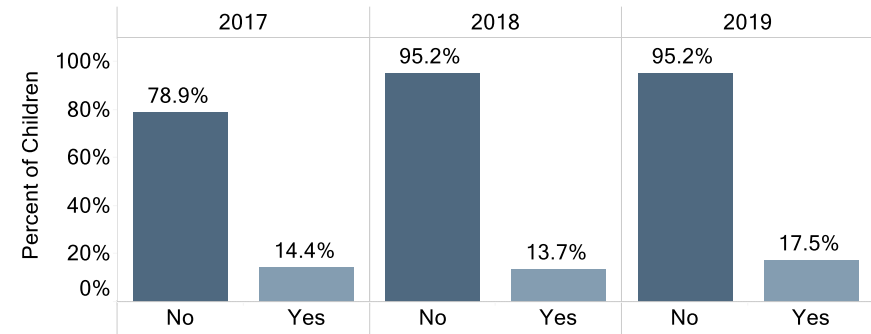
<sup>15</sup> Minimum Performance Standard (MPS) is the minimal expected level of performance by AHCCCS Contractors. AHCCCS-reported rates are the official rates used to determine Contractor compliance with performance requirements. If a Contractor does not achieve the MPS, they will be required to submit a corrective action plan and may be subject to sanctions for each deficient measure.

**Figure 6. Percent of AHCCCS Children Ages 1 – 5 with a Visit to PCP by Age Group, Tribal Affiliation, Ethnicity, Race and Year**

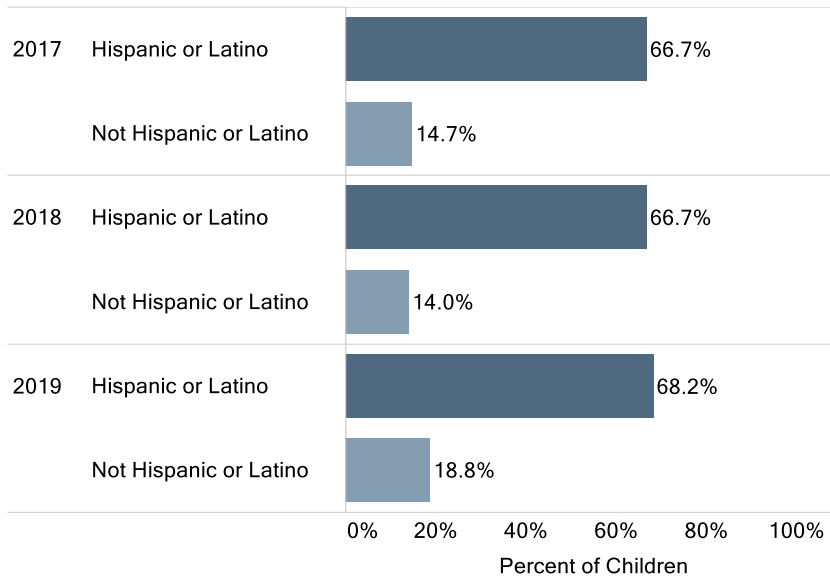
Percent of children with a visit to primary care practitioner ages 1 - 5 by age group



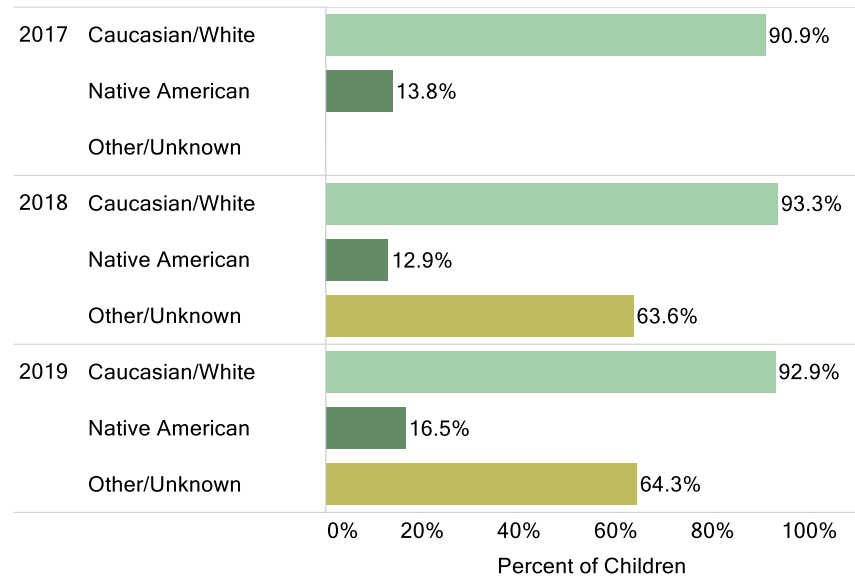
Percent of children with a visit to primary care practitioner ages 1 - 5 by tribal affiliation



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: Data was suppressed for Other/Unknown race in 2017.



## WELL-CHILD VISITS

Well-child visits provide an opportunity for 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 in Table 9, 17-25% of AHCCCS children birth to 15 months had at least one well-child visit compared to 93-94% of statewide AHCCCS children. Of these, 10-13% or regional AHCCCS children had six or more well-child visits compared to 53-60% of statewide AHCCCS children 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.

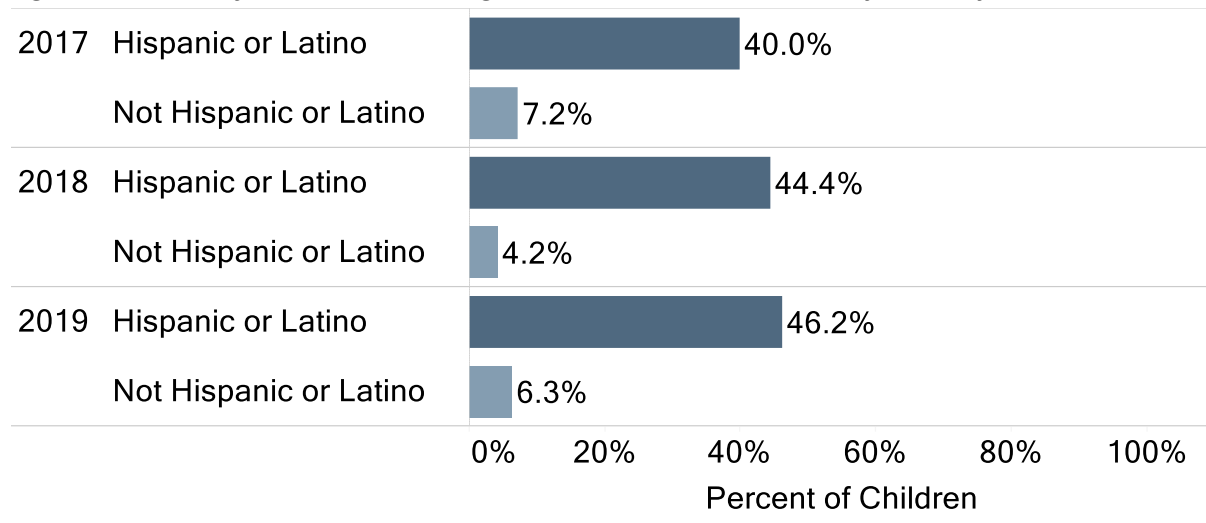
For AHCCCS children ages 3-5 in Table 9, 7-9% of regional children had an annual well-child visit compared to 62-65% of statewide children and 72-74% of Medicaid children ages 3-6 nationally. The region was below the AHCCCS MPS of 66% for this indicator. In Figure 7, Hispanic or Latino AHCCCS children ages 3-5 (40-46%) were more likely to have an annual well-child visit than Non-Hispanic or Latino AHCCCS children (4-7%).

**Table 9. Arizona and Regional AHCCCS Rates for Well-Child Visits, 2017-2019**

Indicator/Year	2017		2018		2019	
	Region	Arizona	Region	Arizona	Region	Arizona
At Least One Well-Child Visit in First 15 Months of Life	23%	93%	25%	94%	17%	94%
Six or More Well-Child Visits in First 15 Months of Life	10%	53%	13%	58%	DS	60%
Annual Well-Child Visit, Ages 3-5	9%	62%	7%	63%	8%	65%

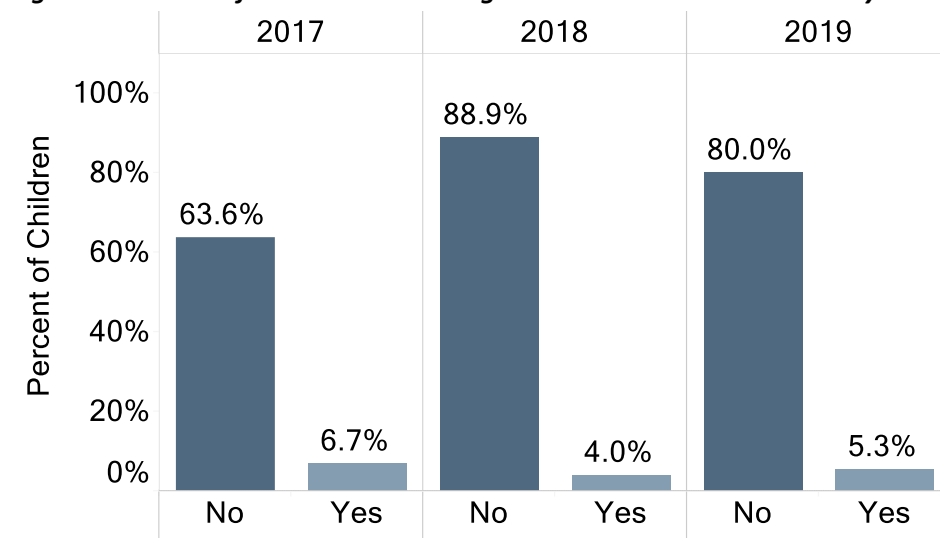
Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

**Figure 7. Percent of AHCCCS Children Ages 3-5 with a Well-Child Visit by Ethnicity and Year**



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

**Figure 8. Percent of AHCCCS Children Ages 3-5 with a Well-Child Visit by Tribal Affiliation and Year**



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

**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-risk<sup>16</sup> 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 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 10, the regional rates were suppressed due to low numbers of screenings. The AHCCCS statewide rates increased from 32% in 2017 to 35% in 2019.

**Table 10. Arizona and Regional 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	DS	32%	DS	34%	DS	35%

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

<sup>16</sup> Interactive map of Arizona neighborhoods to identify those considered to be high-risk is online at <http://www.azhealth.gov/leadmap>

## WEIGHT ASSESSMENT AND COUNSELING

Childhood obesity has both short-term and long-term effects, so it is important for 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 AHCCCS children ages 3-5.

The regional rates for weight assessment<sup>17</sup>, nutrition counseling and physical activity counseling were suppressed for AHCCCS children in Tohono O’odham Nation Region. In Table 11, AHCCCS children statewide were assessed at rates of 9-19% for weight assessment, 4-5% for nutrition counseling, and <1-1% for physical activity assessments.<sup>18</sup> The national HEDIS Medicaid rates were reported in Table 12; these 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.

**Table 11. Arizona AHCCCS Rates for Weight Assessment and Counseling, Ages Birth to 5, 2017-2019**

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

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

**Table 12. 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).

<sup>17</sup> Under HEDIS, the rates for weight assessment are an evaluation of whether Body mass index (BMI) percentile is assessed 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).

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

## DEVELOPMENTAL SCREENING AND DELAY

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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. 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.

Rates of developmental screenings in AHCCCS children birth to age 5 were 1-2% in 2017 and 2019 compared to statewide AHCCCS rates of 10-14% (Table 13).<sup>19</sup> These screening rates were based on 10 claims in 2017 and 14 claims in 2019 from provider types of Federally Qualified Health Center (FQHC), Physician – MD/DO, and Registered Nurse Practitioner. Rates of diagnosing developmental delay in AHCCCS children were 1-2% at the regional level compared to 3-5% at the state level for AHCCCS children. Of those AHCCCS children who were diagnosed with developmental delay, 73% of regional AHCCCS children in 2019 received behavioral health services compared to 58% of AHCCCS children statewide.

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

**Table 13. Arizona and Regional 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	1%	10%	DS	11%	2%	14%
Diagnosing Developmental Delay, Ages Birth to 5*	1%	3%	1%	4%	2%	5%
Developmental Delay and Behavioral Health Services, Ages 3-5	DS	49%	DS	47%	73%	58%

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

Notes: \*The indicator uses diagnosis code R62.50: Unspecified lack of expected normal physiological development in childhood. The count of claims for developmental screenings was 10 claims in 2017, 7 claims in 2018 and 14 claims in 2019.

**Table 14. Percent of Claims by Provider Type for 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	20	77%	64	70%
Other	<6	DS	6	23%	27	30%

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 services<sup>20</sup> 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 statewide, 11% of children received behavioral services in 2017, nearly 12% of children in 2018 and nearly 16% of children in 2019.*

According to Table 15, 5-9% of AHCCCS children in Tohono O’odham Nation Region received behavioral health services compared to 11-16% of AHCCCS children statewide. In Figure 9, male AHCCCS children in the region were more likely to receive behavioral health services (5-10%) than females (4-9%).

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

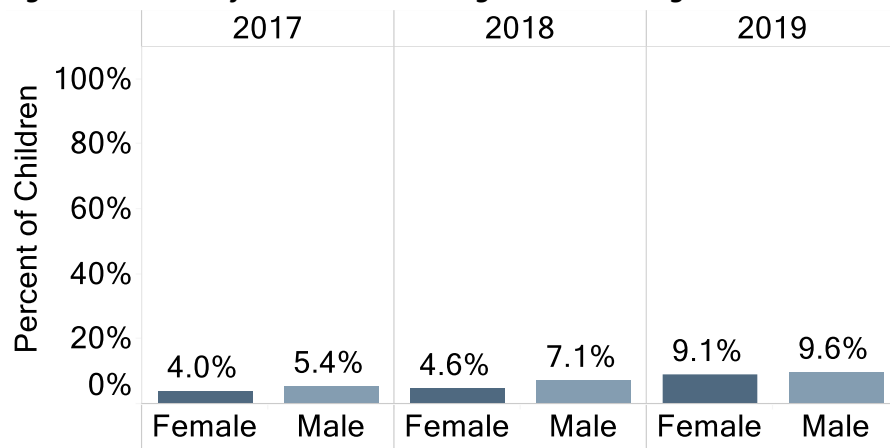
Indicator/Year	2017		2018		2019	
	Region	Arizona	Region	Arizona	Region	Arizona
Behavioral Health Services, Ages 3-5	5%	11%	6%	12%	9%	16%

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

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



**Figure 9. Percent of 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.

**Table 16. Percent of Claims by Provider Type for 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	208	91%	96	86%	313	82%
Hospital	<6	DS	<6	DS	13	3%
Integrated Clinics	<6	DS	<6	DS	18	5%
Speech/Hearing Therapist	10	4%	<6	DS	18	5%
Other	6	3%	10	9%	18	5%

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 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 Tohono O’odham Nation Region, 4-5% of AHCCCS children received an annual vision screening or well-child visit compared to 43-47% of AHCCCS children statewide (Table 17). By subregion in Table 18, the rates for annual vision screening or well-child visits were San Xavier District (15-19%) and Sells District (2-

3%). The regional rate for eye exams in AHCCCS children was 1-2% compared to 4-5% at the state level (Table 17). The regional rates for follow-up eye exams and treatment of visually significant eye conditions were suppressed in all years. The statewide rates for AHCCCS children receiving follow-up eye exams were 4-5% and 54-60% for treatment of visually significant eye conditions.

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

Indicator/Year	2017		2018		2019	
	Region	Arizona	Region	Arizona	Region	Arizona
Vision Screening or Well-Child Visit	5%	44%	4%	43%	5%	47%
Eye Exams	2%	4%	1%	4%	2%	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%	DS	56%	DS	60%

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

**Table 18. Percent of AHCCCS Children Receiving Vision Screening or Well-Child Visit by Subregion, 2017-2019**

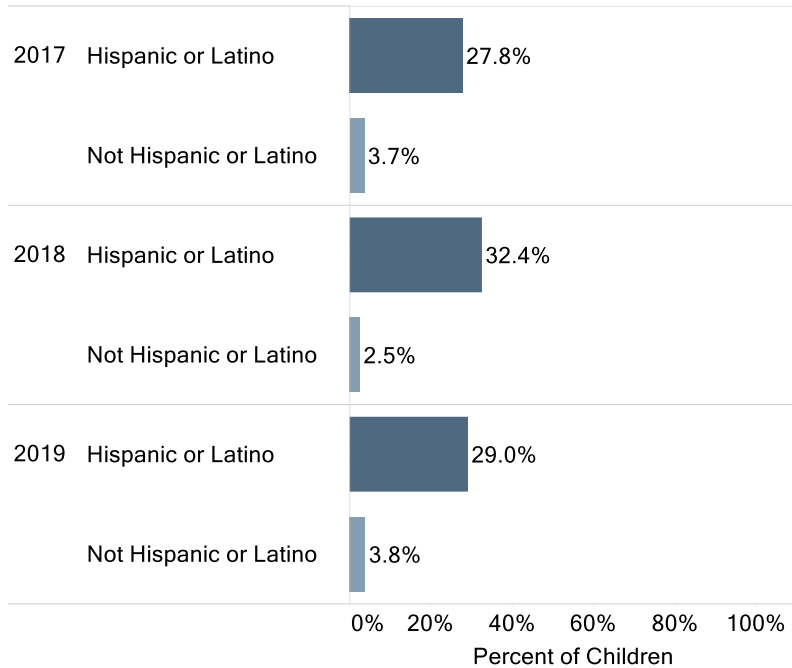
Subregion	2017	2018	2019
San Xavier District	15%	15%	19%
Sells District	3%	2%	2%

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

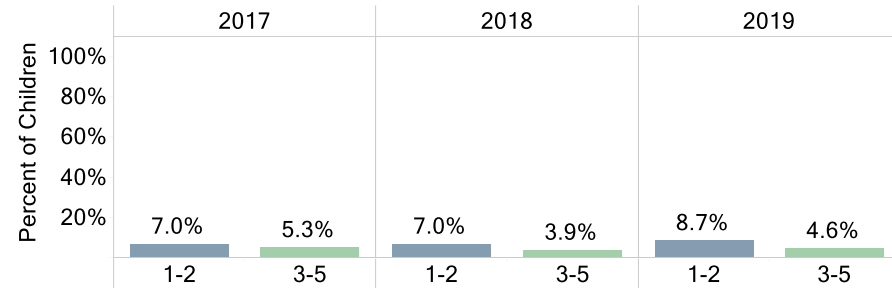
Note: Data was suppressed for Baboquivari and San Lucy Districts.

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

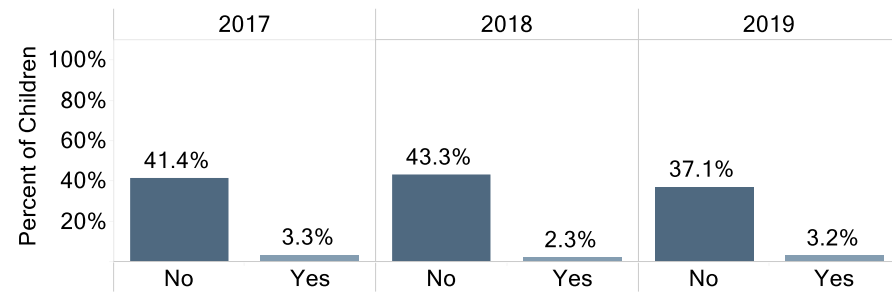
Percent of children receiving vision screening or well child visit by ethnicity



Percent of children receiving vision screening or well child visit by age group



Percent of children receiving vision screening or well child visit by tribal affiliation



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

## 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 5% of AHCCCS children under age one in Tohono O’odham Nation Region in 2018 compared to 12% of AHCCCS children statewide in the same year (Table 19). Hearing screenings were provided to 1-2% of AHCCCS children ages 1-5 in the region compared to 20-28% of AHCCCS children statewide. Of these, the rates for additional audiology services for regional AHCCCS children ages 1-5 were suppressed while statewide AHCCCS children’s rates decreased from 68% in 2017 to 57% in 2019; the claim count in the region was 6-9 claims 2017-2019.

**Table 19. Percent of 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	DS	11%	5%	12%	DS	9%
Hearing Screening Ages 1-5	2%	20%	2%	22%	1%	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 Tohono O’odham Nation Region, 14% of AHCCCS children had at least one annual dental visit compared to 51-53% of AHCCCS children statewide in Table 20. Neither the region nor the state met the AHCCCS MPS of 60% for annual dental visits for ages 2-20 in Table 21. The subregional rates for at least one annual dental visit were San Xavier District (28-32%) and Sells District (9-13%) in Table 23. Regional AHCCCS children receiving at least one annual dental visit were more likely to be ages 3-5 (17-23%) than ages 1-2 (5-9%) and Hispanic or Latino (32-56%) than Non-Hispanic or Latino (12-14%) in Figure 11.

Two preventative care dental visits are recommended annually for children. Regionally, 2-4% of AHCCCS children received the biannual preventative care dental visit compared to 18-19% of AHCCCS children statewide (Table 20). Fluoride varnish was applied to 9-11% of AHCCCS children in the region compared to 47-49% of AHCCCS children statewide. The subregional rates for a fluoride varnish application were San Xavier District (23-31%) and Sells District (6-10%) in Table 25. Regional AHCCCS children who had a fluoride varnish application were more likely to be ages 3-5 (12-17%) than ages 1-2 (5-7%) and Hispanic or Latino (25-48%) than Non-Hispanic or Latino (9-12%) in Figure 13.

**Table 20. Percent of Statewide and Regional AHCCCS Children Oral Health Visits for Ages 1-5, 2017-2019**

Type of Visit / Year	2017		2018		2019	
	Region	Arizona	Region	Arizona	Region	Arizona
<b>Any Annual Dental Visit</b>	14%	51%	14%	52%	14%	53%
<b>Preventative Care Dental Visit Twice Annually</b>	2%	18%	2%	19%	4%	20%
<b>Fluoride Varnish Application</b>	9%	47%	9%	48%	11%	49%

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

**Table 21. AHCCCS Statewide 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 22. Percent of 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	170	93%	164	95%	136	83%
Federally Qualified Health Center (FQHC)	13	7%	8	5%	26	16%

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

**Table 23. Percent of AHCCCS Children Ages 1-5 With at Least One Annual Dental Visit by Subregion, 2017-2019**

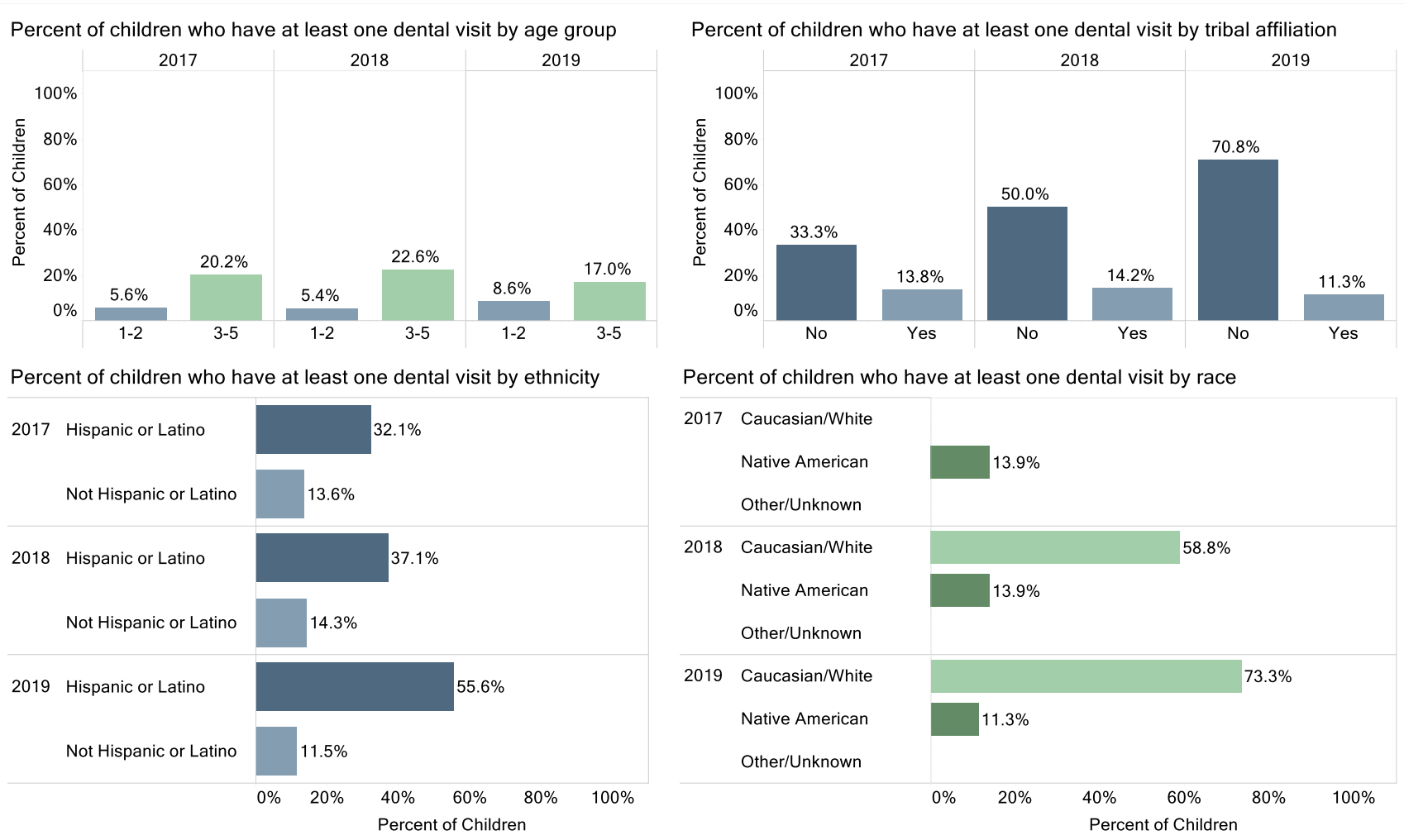
Subregion	2017	2018	2019
San Xavier District	28%	29%	32%
Sells District	12%	13%	9%

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). Data was suppressed for Baboquivari District and San Lucy District.



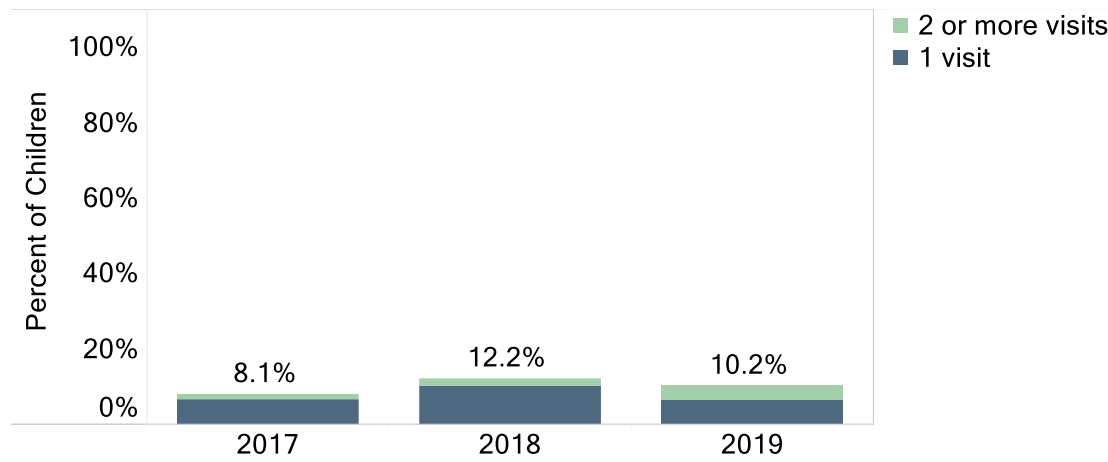
**Figure 11. Percent of AHCCCS Children Ages 1-5 With at Least One Annual Dental Visit by Age Group, Tribal Affiliation, Ethnicity, Race and Year**



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). Data was suppressed for Caucasian/White in 2017 and Other/Unknown in all years.

**Figure 12. Percent of 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 24. Percent of Claims by Provider Type for 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	58	92%	76	90%	69	80%
Other	<6	DS	8	10%	17	20%

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

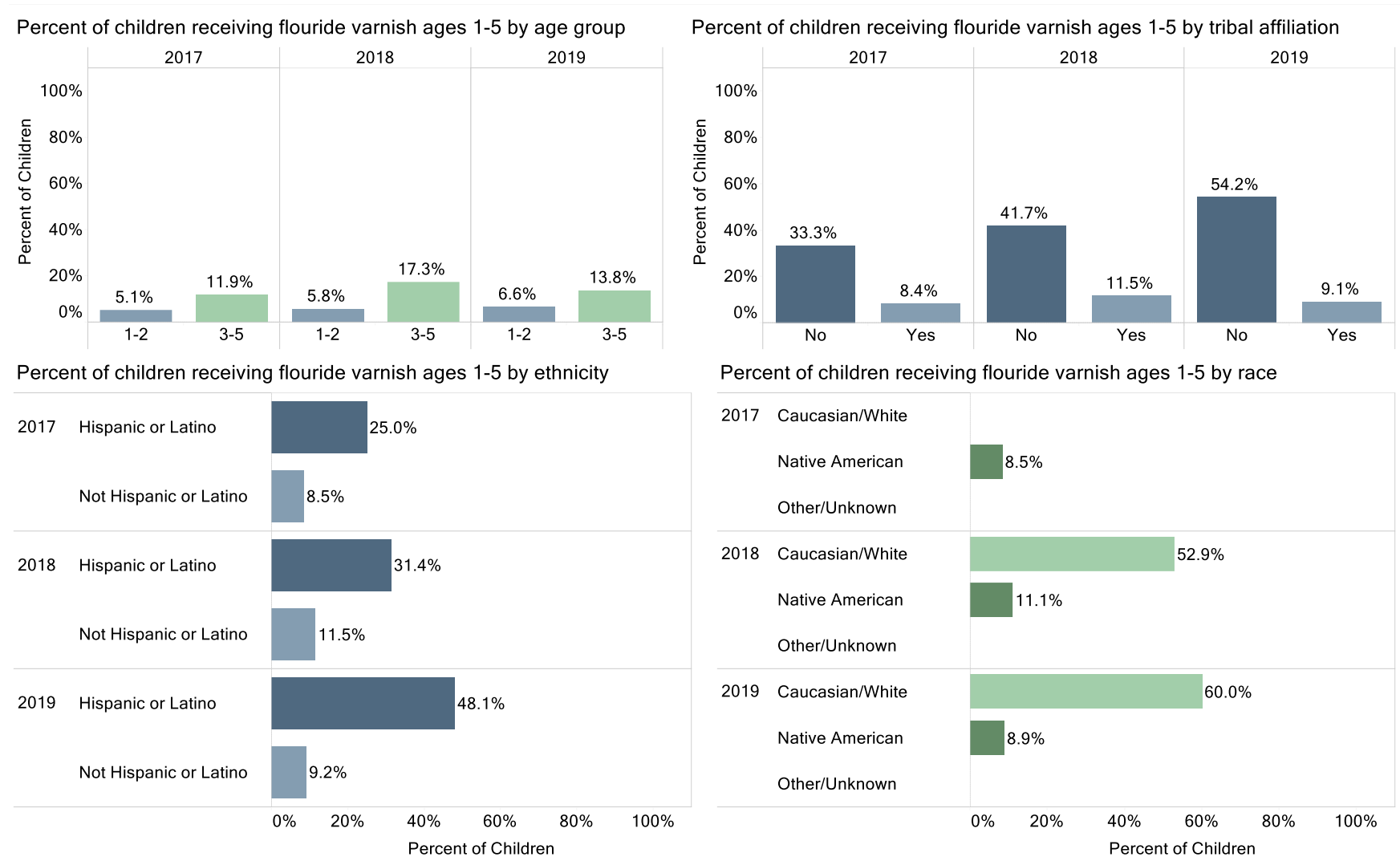
**Table 25. Percent of AHCCCS Children Ages 1-5 Receiving Fluoride Varnish by Subregion, 2017-2019**

Subregion	2017	2018	2019
San Xavier District	23%	28%	31%
Sells District	7%	10%	6%

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

Note: Data was suppressed for Baboquivari District and San Lucy District.

**Figure 13. Percent of 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: Data was suppressed for Caucasian/White in 2017 and Other/Unknown in all years.

## IMMUNIZATIONS

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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 27 is the percent of 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 26 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 (ASIS), 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) (Table 26). 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 26. 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
<b>DTaP</b>	79%	77%	85%
<b>Polio</b>	88%	89%	91%
<b>MMR</b>	89%	90%	91%
<b>HiB</b>	87%	88%	90%
<b>Hep B</b>	87%	88%	90%
<b>VZV</b>	88%	89%	88%
<b>PCV</b>	76%	77%	82%
<b>Hep A</b>	88%	84%	40%
<b>RV</b>	61%	69%	60%
<b>Flu</b>	40%	45%	45%
<b>Combo 3</b>	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 27. 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
<b>DTaP</b>	3%	30%	11%	38%	9%	52%
<b>Polio</b>	3%	40%	11%	51%	10%	66%
<b>MMR</b>	6%	57%	15%	72%	18%	76%
<b>HiB</b>	3%	44%	11%	56%	15%	69%
<b>Hep B</b>	3%	13%	8%	18%	12%	21%
<b>VZV</b>	6%	57%	15%	72%	18%	76%
<b>PCV</b>	DS	18%	11%	31%	7%	52%
<b>Hep A</b>	8%	65%	16%	75%	15%	78%
<b>RV</b>	2%	31%	10%	39%	7%	51%
<b>Flu</b>	2%	19%	11%	31%	9%	34%
<b>Combo 3</b>	DS	4%	8%	10%	6%	15%
<b>Combo 10</b>	DS	2%	4%	4%	4%	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 26.

## MATERNAL PRENATAL AND POSTPARTUM CARE

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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 Tohono O’odham Nation Region, 44-55% of pregnant women began prenatal care in the first trimester compared to 84-86% of AHCCCS women statewide in Table 28. The Healthy People 2030 target rate was 81%<sup>21</sup>. Rates for regional AHCCCS women who had at least one postpartum visit were 38% in 2017, 73% in 2018 and 43% in 2019 compared to 88-89% of AHCCCS women statewide and 64-75% of Medicaid women nationally. In 2018, AHCCCS women affiliated with a tribal community were more likely to have a postpartum visit (77%) than those unaffiliated (67%) in Figure 14.

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<sup>21</sup> 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>

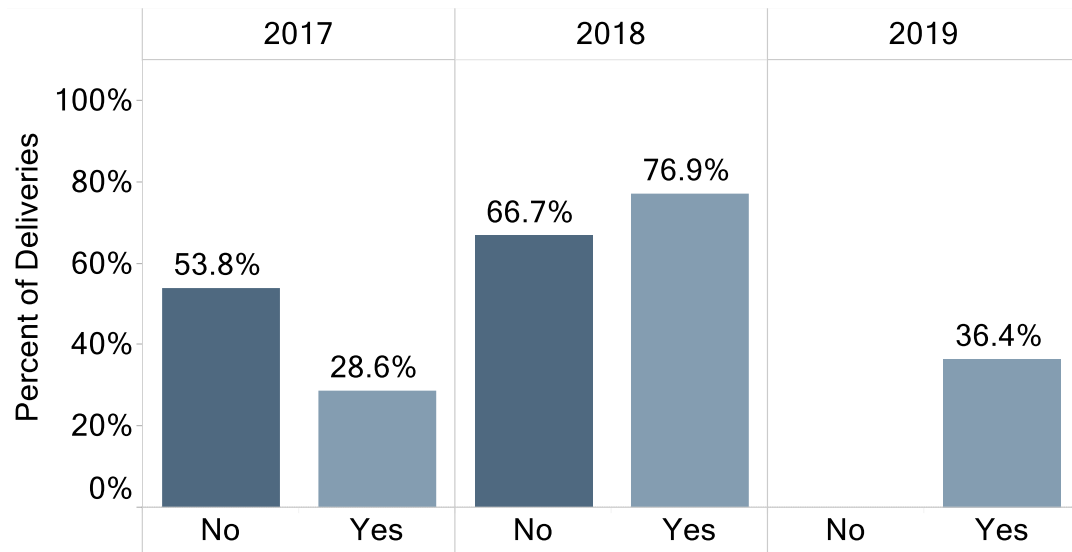


**Table 28. Percent of All AHCCCS Women Who Received Timely Prenatal and Postpartum Care, 2017-2019**

Type of Care	2017		2018		2019	
	Region	Arizona	Region	Arizona	Region	Arizona
Prenatal Care	44%	84%	55%	86%	46%	85%
Postpartum Care	38%	88%	73%	89%	43%	89%

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

**Figure 14. Percent of AHCCCS Deliveries That Had a Postpartum Visit After Delivery by Tribal Affiliation and Year**



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

Note: Data was suppressed for non-affiliated AHCCCS children in 2019.

## CONCLUSION

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The physical, mental, and emotional health of young children lays the foundation for the rest of their life. Tohono O’odham Nation Region had several assets contributing to better health outcomes for young children and women enrolled in AHCCCS from 2017 to 2019, including newborn hearing screenings, immunizations (DTaP, Hepatitis A and Combo 3), and supply of health care professionals. These achievements contributed to good health outcomes throughout the region. The areas where needs were identified for AHCCCS women and children included PCP visits, well-child visits, developmental screenings, lead poisoning screenings, vision screenings, hearing screenings for ages 1-5, 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.