FIRST THINGS FIRST

Pima South 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 Pima South Region. Pima South consisted of eight subregions: Ajo, Amado, Drexel Heights, Rita Ranch, Sahuarita, Sunnyside, Three Points and Vail. The main data source was claims data from the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency; therefore, the results presented in this report were for children and mothers who were enrolled in AHCCCS from 2017 to 2019.[1] This population was denoted as AHCCCS children or AHCCCS women.

CHiR and representatives from the FTF Regions, Programs, and Evaluation teams determined priority indicators for this report. AHCCCS children's health was measured in the following categories: primary care and well-child visits, health care workforce, screening for lead poisoning, weight assessment and counseling, developmental health, behavioral health, vision, hearing, oral health, immunizations, maternal prenatal and postpartum care, and health plan performance. Many of the reported indicators were from the Healthcare Effectiveness Data and Information Set (HEDIS)[2]. HEDIS is a performance improvement tool whereby health plans, health care organizations and government agencies submit data on specific health measures. HEDIS uses the collected data to calculate national performance statistics and benchmarks and set standards for measures. HEDIS specifications were applied to the AHCCCS population for each region. Non-HEDIS indicators, which do not have associated benchmarks, were compared to state and national data when possible. The results were displayed by gender, age, race, ethnicity, tribal affiliation[3], 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 Pima South Region, there were 12,015 children enrolled in AHCCCS in 2017, 11,285 children enrolled in 2018 and 10,826 children enrolled in 2019. Of these, male AHCCCS children outnumbered females by 3%. There were 12% more infants and toddlers than preschoolers in 2017, with the difference dropping to 6% more in 2018 and 1% more in 2019.

[1] Data used in this report covers all AHCCCS members in Arizona, including members living in FTF tribal regions and subregions. Reports for tribal regions and subregions were carried out with specific approval from each tribe. For those tribal regions and subregions who did not give approval, data is included only in aggregate totals for Arizona, and—in the case of a tribal subregion—aggregate totals for the region.
[2] See https://www.ncqa.org/hedis/
[3] Tribal affiliation refers to whether an individual is a member of a federally recognized Arizona tribe and is displayed as a flag (Yes/No) in this report. This information is captured during enrollment in AHCCCS.

Of the AHCCCS children in Pima South Region, 81% lived in two subregions: Drexel Heights and Sunnyside. By race, there were 57-60% of AHCCCS children reported as Caucasian/White, 5-6% as Black, 1% as Asian/Pacific Islander and 6-7% as Native American. There were 58-61% of AHCCCS children in this region reported as Hispanic or Latino. Affiliation with a tribal community was reported by 8% of AHCCCS children annually. [4] Around 80% of AHCCCS children in the region were enrolled in four health plans: UnitedHealthcare (30-34%), Banner University Family Care (17-20%), Steward Health Choice AZ (13-19%) and Mercy Care Plan (10-14%). Most claims for AHCCCS children in the region were submitted by physicians (29-32%), pharmacies (15%), hospitals (9%) and Federally Qualified Health Centers (FQHCs) (8%).

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. Of those hospitals. Pima South Region had one short-term hospital, Northwest Sahuarita Hospital, and four Federally Qualified Health Center sites and five outpatient treatment centers. The rate of available primary care physicians in the region was 11-12 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 7-9 physicians per 1,000 AHCCCS children. For dentists accepting AHCCCS patients, the regional rate was 3-5 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 and dentist, 33-40% of AHCCCS children in Pima South Region traveled up to one mile for services compared to 56-63% of AHCCCS children statewide. Another 50-59% of regional AHCCCS children traveled up to five miles to visit these providers versus 28-35% of statewide AHCCCS children. The nearest pharmacy and behavioral health provider were one mile away or less for 42-47% of regional AHCCCS children versus 62-65% of AHCCCS children statewide. Another 43-51% of regional AHCCCS children traveled up to five miles to visit these providers versus 26-30% of statewide AHCCCS children. To visit the nearest hospital, 58-59% of regional AHCCCS children traveled up to five miles compared to 80-81% of AHCCCS children statewide.

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

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

tracked according to national guidelines. PCPs examine a child holistically for physical, mental, emotional and social/environmental health during a well-child visit.

Regionally, 89% of AHCCCS children had at least one PCP visit compared to 85-86% of AHCCCS children statewide and 86-87% of Medicaid children nationally. All rates exceeded the AHCCCS Minimum Performance Standard (MPS)[5] of 84%. All subregions met or exceeded the AHCCCS statewide rates and MPS for annual PCP visits in all years, except for Ajo (no years) and Amado (2017 and 2018). Regional AHCCCS children who had annual PCP visits were more likely to be ages 1-2 (93-94%) than ages 3-5 (86-87%), Hispanic and Latino (90-91%) versus Non-Hispanic or Latino (86-87%), and Asian/Pacific Islander (93-95%) than other races in 2018 and 2019.

Regionally, 58-70% of AHCCCS children birth to 15 months had six or more well-child visits compared to 53-60% of AHCCCS children statewide and 63-66% of Medicaid children nationally. In 2018 and 2019, the region met the AHCCCS MPS of 65% (2017 and 2018) and 62% (2019) for this indicator. The subregions who met or exceeded the AHCCCS statewide rate and MPS for six or more well-child visits for AHCCCS children birth to 15 months were Amado (2019), Drexel Heights (2019), Rita Ranch (2018 and 2019), Sahuarita, Sunnyside (2018 and 2019), Three Points (2018 and 2019) and Vail (2019). Regional AHCCCS children birth to 15 months with six or more well-child visits were more likely to be Hispanic or Latino (61-74%) than Non-Hispanic or Latino (55-63%). For AHCCCS children ages 3-5, 68-70% 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 exceeded the AHCCCS MPS of 66% for this indicator. The subregions who met or exceeded the AHCCCS statewide rates and MPS for annual well-child visits for AHCCCS children ages 3-5 were Drexel Heights (all years), Rita Ranch (2017), Sahuarita (2019), Sunnyside (all years), Three Points (all years) and Vail (all years). Regional AHCCCS children ages 3-5 with an annual well-child visit were more likely to be Hispanic or Latino (69-73%) than Non-Hispanic or Latino (63-66%), and Asian/Pacific Islander (71-75%) in 2018 and 2019 than other races.

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.[6]

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

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

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[7] 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.

For AHCCCS children being screened for lead poisoning one or more times by their second birthday, the regional rates increased 38-42% compared to AHCCCS statewide rates which increased from 32% in 2017 to 35% in 2019. The subregions who met or exceeded the AHCCCS statewide rates for one or more blood lead screenings for lead poisoning by the second birthday were Amado (2018), Drexel Heights (all years), Rita Ranch (2017 and 2018), Sahuarita (2019), Sunnyside (all years), and Three Points (2017 and 2018). Regional AHCCCS children screened for lead poisoning by their second birthday were more likely to be Hispanic or Latino (40-45%) than Non-Hispanic or Latino (34-38%), and Asian/Pacific Islander (53-61%) in 2018 and 2019 than other races.

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 and counseling showed AHCCCS children in Pima South were assessed for weight at 7-35% compared to AHCCCS children statewide who were assessed at rates of 9-19%. Rates for nutrition counseling were 2-4% at the regional level versus 4-5% at the state level for AHCCCS children. Physical activity assessments in the region were <1-2% while AHCCCS children statewide were assessed <1-1%.[8]

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.

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

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

Rates of developmental screenings in AHCCCS children birth to age 5 increased over the report period although still well below the AHCCCS median rates. At the regional level, rates increased 9-14% compared to statewide AHCCCS rates of 10-14%.[9] Developmental screenings were conducted most often in physician offices (69-78%). Developmental screenings for AHCCCS children ages 1-2 were most likely to be conducted in the following subregions: Rita Ranch (37-49%), Vail (25-48%) and Drexel Heights (26-39%), Sunnyside (22-34%), and Three Points (27-28%). Regional AHCCCS children receiving developmental screenings were more likely to be ages 1-2 (23-35%) than age 0 (4-8%) and ages 3-5 (1-3%), and Black (31-40%) in 2017 and 2019 than other races.

Rates of diagnosing developmental delay in AHCCCS children were 2-4% at the regional level compared to 3-5% at the state level for AHCCCS children. Regional AHCCCS children were more likely to be diagnosed with a developmental delay in Rita Ranch and Vail. Regional AHCCCS children diagnosed with developmental delay were more likely to be ages 3-5 (3-5%) than age 0 (1%) and ages 1-2 (3-4%) and male (3-5%) than female (2-3%). Of those AHCCCS children who were diagnosed with developmental delay, 53-62% of regional AHCCCS children received behavioral health services compared to 47-58% of AHCCCS children statewide. The subregions where regional AHCCCS children were more likely to receive behavioral health services after a diagnosis of developmental delay were Drexel Heights (62-69%), Rita Ranch (35-67%) and Vail (55-64%). Regional AHCCCS children diagnosed with developmental delay who received behavioral health services were more likely to be ages 3-5 (57-69%) than age 0 (41%) and ages 1-2 (44-53%), affiliated with a tribal community (67%) than unaffiliated (58-61%) in 2017 and 2019, Black (71-90%) than other races, and male (58-64%) than female (46-58%).

Behavioral Health

The social-emotional development and adaptive functioning of a young child is as important as their physical health. Negative early childhood events can lead to behavioral and physical health problems in adulthood if behavioral health intervention services are not provided at the infant and toddler stages. For young children, behavioral health services[10] would likely include day programs, crisis services, rehabilitation services, health promotion, mental health counseling, psychiatric and psychologist services, and various support services.

Fourteen to seventeen percent of AHCCCS children in Pima South Region received behavioral health services compared to 11-16% of AHCCCS children statewide. All subregions provided behavioral health services at rates higher than the AHCCCS statewide rates in at least one year. Regional AHCCCS children who received behavioral health services were more likely to be male (17-21%) than female (10-13%) and Asian (24%) in 2019 than other races.

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

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

Vision[11]

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 Pima South Region, 38-44% of AHCCCS children received an annual vision screening or well-child visit compared to 43-47% of AHCCCS children statewide. Regional AHCCCS children who received an annual vision screening or well-child visit at rates equal or higher than the AHCCCS statewide rates were in Rita Ranch (all years), Three Points (2017) and Vail (all years). Regional AHCCCS children who received an annual vision screening or well-child visit were more likely to be ages 1-2 (44-60%) than ages 3-5 (44-51%), Hispanic or Latino (39-47%) than Non-Hispanic or Latino (37-40%), and Black (50-54%) than other races. Eye exams were conducted much less frequently, ranging 4-5% annually at the regional and state levels for AHCCCS children. Regional AHCCCS children receiving an eye exam were more likely to be ages 3-5 (6-7%) than ages 1-2 (2-4%) and Asian/Pacific Islander (5-9%) than other races. Follow-up eye exams were conducted on AHCCCS children in the region and statewide at rates of 4-5%. AHCCCS children with visually significant eye conditions received treatment at rates of 50-54% regionally compared to 54-60% statewide.

Hearing[11]

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.

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%

[11] 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.
[11] ibid

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 4-7% of AHCCCS children under age one in Pima South compared to 9-12% of AHCCCS children statewide. Hearing screenings were provided to 5-6% of AHCCCS children ages 1-5 in the region compared to 20-28% of AHCCCS children statewide. The provision of additional audiology services to regional AHCCCS children ages 1-5 increased from 67% in 2017 to 84% in 2019 while statewide AHCCCS children's rates decreased from 68% to 57% over the same period. The subregional rates for AHCCCS children receiving additional audiology services were Drexel Heights (59-79%), Rita Ranch (75%) in 2018, Sahuarita (75-90%) in 2018 and 2019, Sunnyside (60-91%), and Vail (100%) in 2017 and 2018. Regional AHCCCS children ages 1-5 who received additional audiology services were more likely to be ages 3-5 (67-97%) than age 1-2 (64-73%), tribally affiliated (100%) than unaffiliated (82%) in 2019, and Hispanic or Latino (83-91%) than Non-Hispanic or Latino (76-80%) in 2018 and 2019.

Oral Health

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

In Pima South Region, 54-59% 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. Drexel Heights and Sunnyside subregions met or exceeded the AHCCCS MPS in 2019. Regional AHCCCS children with at least one annual dental visit were more likely to be ages 3-5 (63-67%) than ages 1-2 (39-47%) and Hispanic or Latino (57-62%) than Non-Hispanic or Latino (49-54%).

Two preventative care dental visits are recommended annually for children. In the region, 18-20% of AHCCCS children received the biannual preventative care dental visit compared to 18-20% of AHCCCS children statewide; and almost half of regional AHCCCS children had at least one preventative care dental visit per year. Fluoride varnish was applied to 47-53% of AHCCCS children in the region compared to 47-49% of AHCCCS children statewide. The subregions that met or exceeded the AHCCCS statewide rates for AHCCCS children having received a fluoride varnish application were Drexel Heights (all years), Rita Ranch (2018), Sahuarita (2019) and Sunnyside (all years). Regional AHCCCS children who had a fluoride varnish application were more likely to be ages 3-5 (54-59%) than ages 1-2 (38-44%) and Hispanic or Latino (50-56%) than Non-Hispanic or Latino (43-49%).

Maternal Prenatal and Postpartum Care

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

In Pima South Region, 82-83% of pregnant women began prenatal care in the first trimester compared to 84-86% of AHCCCS women statewide, which are both above the Healthy People 2030 target rate of 81%[12]. All subregions met or exceeded the Healthy People 2030 target rate for timely prenatal care in a least one year. Regional AHCCCS children who received timely prenatal care were more likely to be Hispanic or Latino (84%) than Non-Hispanic of Latino (79-81%) and adult (83%) than teens (77-81%). For postpartum care, 84-88% of regional AHCCCS women had at least one postpartum visit compared to 88-89% of AHCCCS women statewide and 64-75% of Medicaid women nationally. The subregions that met or exceeded the AHCCCS statewide rates for postpartum care were Amado (2018), Drexel Heights (2017), Rita Ranch (all years), Sahuarita (all years), Three Points (2017), and Vail (all years). Adult regional AHCCCS women (85-88%) were more likely to have a postpartum visit than teens (78%).

Health Plan Performance

This section provided a selection of health indicators to compare results among AHCCCS children enrolled in each of the AHCCCS health plans available in the region. All regional health plans met or exceeded the AHCCCS statewide aggregate performance and MPS for PCP visits for ages 1-5 in at least one year, ranging 87-97%. For at least one well-child visit in the first 15 months, all reporting regional health plans performed very well, ranging 97-100%. Six regional health plans met or exceeded the AHCCCS statewide aggregate performance and MPS for six or more well-child visits in the first 15 months: AZ Complete Care (2019), Banner University Family Care (2018 and 2019), Care 1st (2017 and 2018), Mercy Care Plan (2017 and 2018), Steward Health Choice AZ (2017 and 2018), and UnitedHealthcare (2017 and 2018). The following health plans met or exceeded the AHCCCS statewide aggregate performance and MPS for annual well-child visits for ages 3-5: AZ Complete Care (2019), Banner University Family Care (all years), Care 1st (all years), Comprehensive Medical and Dental Program (2018), Mercy Care Plan (2017 and 2018), Steward Health Choice AZ (all years) and UnitedHealthcare (all years). Care 1st (2019), Mercy Care Plan (2019),

[12] 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

Steward Health Choice AZ (2019) and UnitedHealthcare (2019) exceeded the AHCCCS statewide aggregate performance for preventative care dental visits for ages 1-5.[13]

Conclusion

From 2017 to 2019, Pima South showed strong performance on the following AHCCCS children's and women's health indicators: annual PCP visits, access to care, newborn hearing screenings, immunizations (DTap, Hep A and Combo 3), and prenatal and postpartum care. These achievements contributed to good health outcomes throughout the region. The areas where needs were identified for AHCCCS women and children included the supply of health care professionals, well-child visits, lead poisoning screenings, developmental screenings, vision screenings, hearing screenings for ages 1-5, and oral health. 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.

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

INTRODUCTION

THE IMPORTANCE OF EARLY CHILDHOOD HEALTH

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

DEFINITIONS

Access to Care

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

Age Groups

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

Assets

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

Behavioral Health

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

Children

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

CMS Median

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

Habilitation

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

Healthcare Effectiveness Data and Information Set

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

Health Plans

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

Minimum Performance Standard

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

Needs

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

Postpartum Period

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

Primary Care Physician Specialties

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

Race/Ethnicity

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

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

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

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

Tribal Affiliation

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

Well-Child Visits

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

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

Women

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

APPROACH

CHiR and representatives from the FTF Regions, Programs, and Evaluation teams determined priority indicators for this report. FTF provided the regional and subregional boundaries. Pima South Region consisted of eight subregions: Ajo, Amado, Drexel Heights, Rita Ranch, Sahuarita, Sunnyside, Three Points and Vail. 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 <= 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. For those tribal regions who did not give approval, data was included only in aggregate totals for Arizona. In the case of a tribal subregion, only aggregate totals for Arizona and the region were included.

REPORTING

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

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

After reporting the general regional demographics, the results were displayed by gender, age group, race, ethnicity, tribal affiliation, provider type, and/or health plan when the data was available and within the data suppression guidelines stated below. Each section contained maps to display the results at the subregional level. 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.”

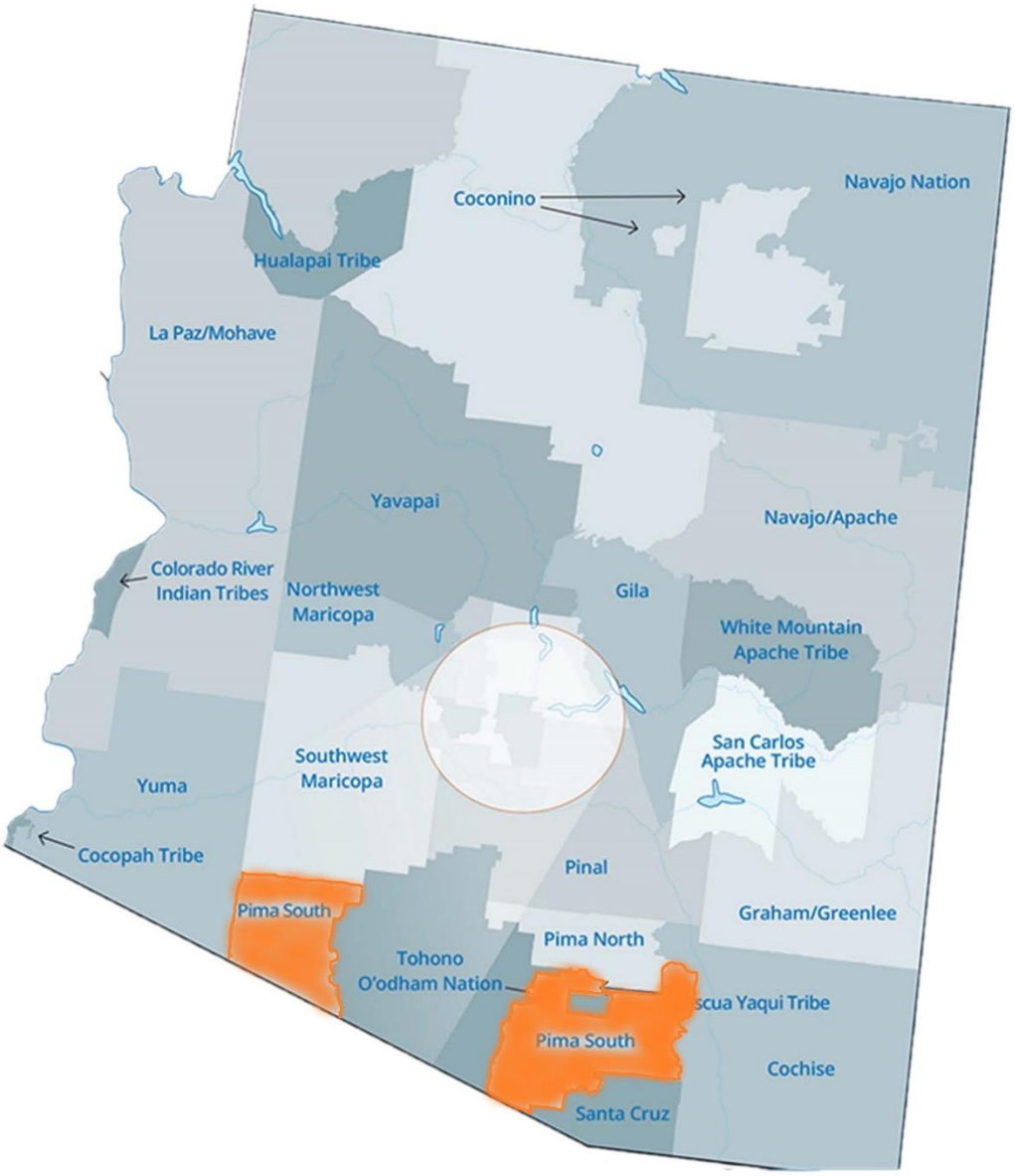
DATA LIMITATIONS

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

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

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

PIMA SOUTH 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 Pima South Region there were 12,015 children enrolled in AHCCCS in 2017, 11,285 children enrolled in 2018 and 10,826 children enrolled in 2019. Of these, male AHCCCS children outnumbered females by 3% (Table 1). In Table 2, there were 12% more infants and toddlers than preschoolers in 2017, with the difference dropping to 6% more in 2018 and 1% more in 2019.

Of the AHCCCS children in Pima South Region, 81% lived in two subregions: Drexel Heights and Sunnyside (Figure 1). By race in Figure 2, there were 57-60% of AHCCCS children reported as Caucasian/White, 5-6% as Black, 1% as Asian/Pacific Islander and 6-7% as Native American. There were 58-61% of AHCCCS children in this region reported as Hispanic or Latino in

Figure 3. Affiliation with a tribal community was reported by 8% of AHCCCS children annually.[14] In Figure 5, around 80% of AHCCCS children in the region were enrolled in four health plans: UnitedHealthcare (30-34%), Banner University Family Care (17-20%), Steward Health Choice AZ (13-19%) and Mercy Care Plan (10-14%). In Table 3, most claims for AHCCCS children in the region were submitted by physicians (29-32%), pharmacies (15%), hospitals (9%) and Federally Qualified Health Centers (FQHCs) (8%).

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

Year	Female	Male	Total of AHCCCS-Enrolled Children
2017	5,819	6,196	12,015
2018	5,452	5,833	11,285
2019	5,257	5,569	10,826

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

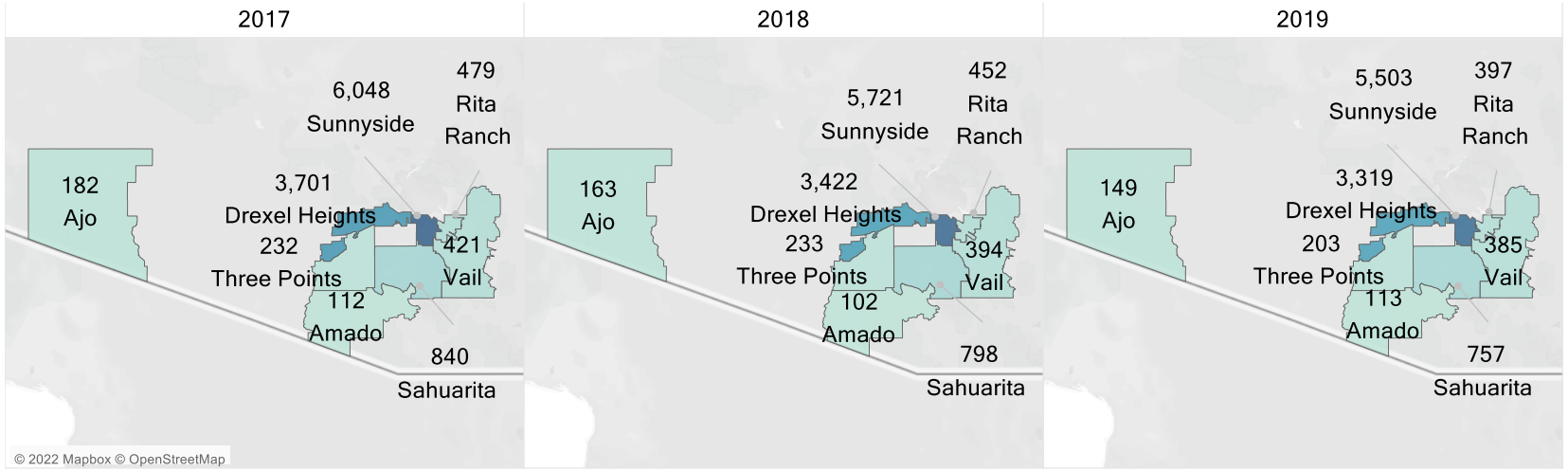
[14] Tribal affiliation refers to whether an individual is a member of a federally recognized Arizona tribe and is displayed as a flag (Yes/No) in this report. This information is captured during enrollment in AHCCCS.

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

Year	Infant (under 1)	Toddler (1-2)	Preschooler (3-5)
2017	2,493	3,860	5,662
2018	2,271	3,546	5,468
2019	2,098	3,348	5,380

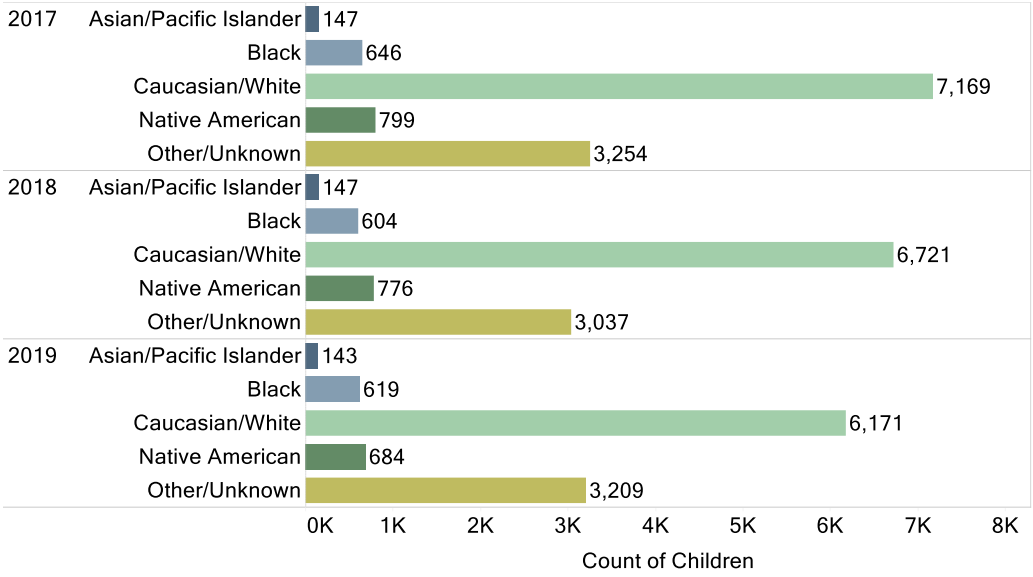
Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

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



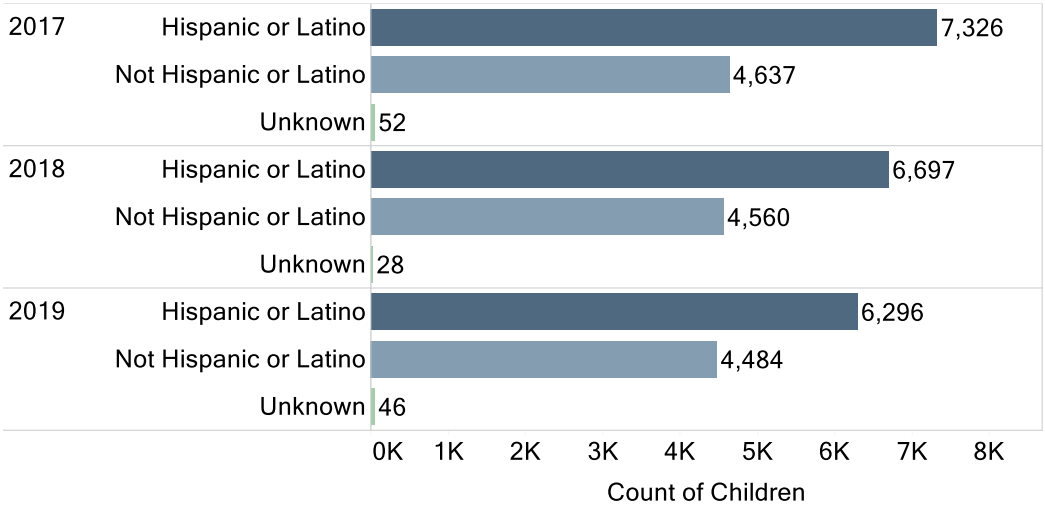
Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

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



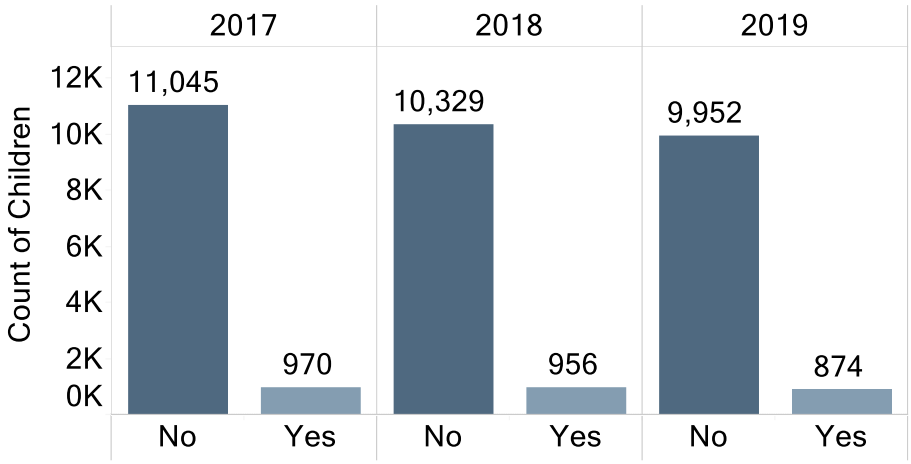
Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

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



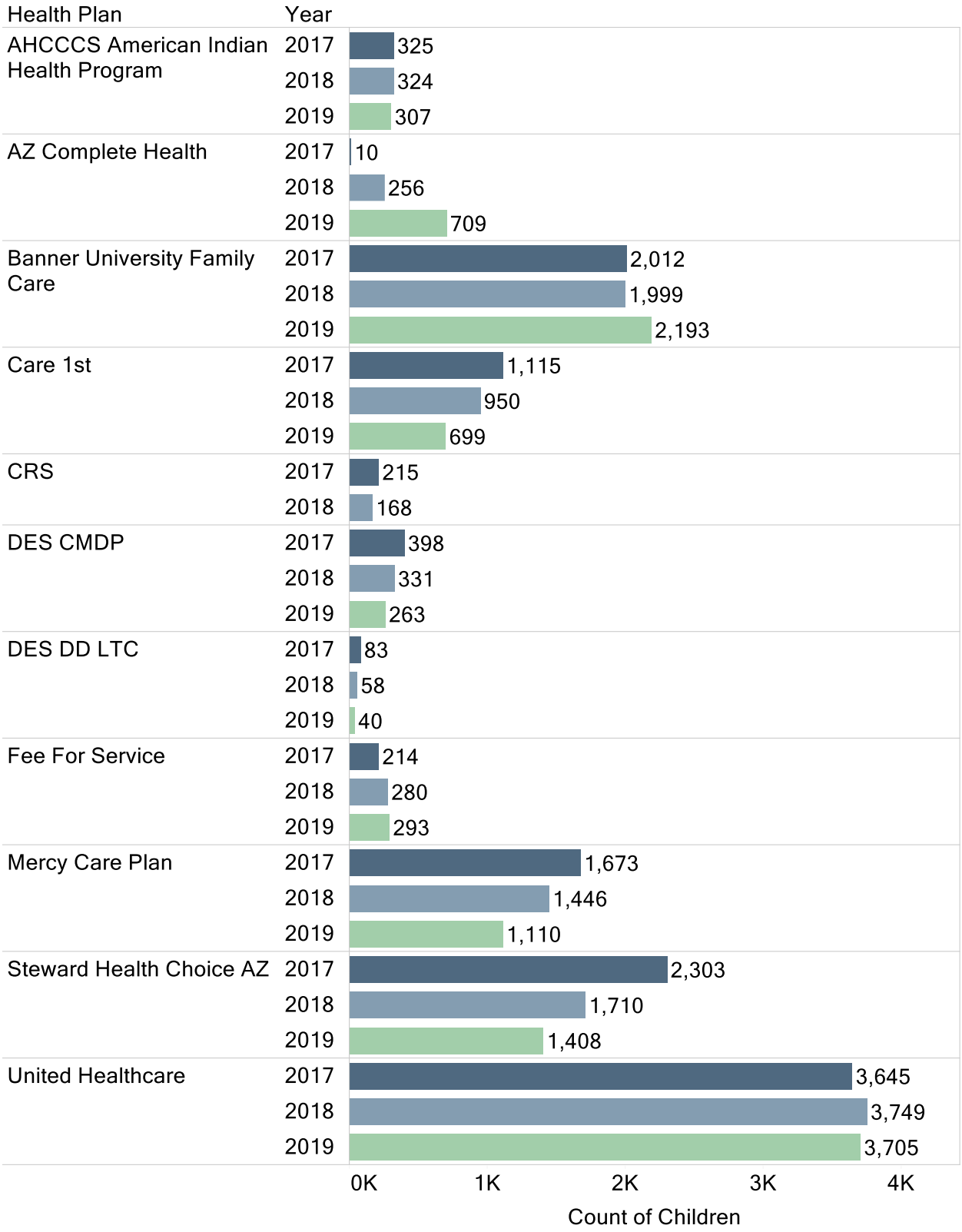
Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

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	28,579	5%	18,096	3%	16,494	3%
Dentist	34,001	5%	31,223	5%	29,349	5%
Durable Medical Equipment Supplier	8,840	1%	9,218	2%	9,675	2%
Federally Qualified Health Center (FQHC)	51,112	8%	47,290	8%	48,720	8%
Habilitation Provider*	21,122	3%	22,632	4%	28,869	5%
Home Health Agency	4,884	1%	5,553	1%	4,766	1%
Hospital	57,077	9%	53,509	9%	55,829	9%
Integrated Clinics**	6,863	1%	11,880	2%	12,544	2%
Laboratory	21,896	3%	19,355	3%	18,547	3%
Non-Emergency Transportation Providers	6,684	1%	5,249	1%	4,644	1%
Occupational Therapist	8,815	1%	11,839	2%	15,681	3%
Pharmacy	94,840	15%	87,489	15%	90,321	15%
Physical Therapist	5,872	1%	6,376	1%	6,963	1%
Physician – MD/DO	200,243	32%	185,461	31%	180,993	29%
Physician Assistant	22,909	4%	21,117	4%	19,789	3%
Registered Nurse Practitioner	23,507	4%	25,181	4%	28,448	5%
Speech Language Pathology	2,637	0%	4,203	1%	5,470	1%
Speech/Hearing Therapist	22,652	4%	27,819	5%	35,433	6%
Other	10,625	2%	7,915	1%	7,486	1%

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

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). Pima South Region had one short-term hospital, Northwest Sahuarita Hospital, and four Federally Qualified Health Center sites and five outpatient treatment centers (Arizona Department of Health Services, 2021).

The rate of available primary care physicians in the region was 11-12 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 7-9 physicians per 1,000 AHCCCS children. For dentists accepting AHCCCS patients, the regional rate was 3-5 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 and dentist, 33-40% of AHCCCS children in Pima South Region traveled up to one mile for services compared to 56-63% of AHCCCS children statewide. Another 50-59% of regional AHCCCS children traveled up to five miles to visit these providers versus 28-35% of statewide AHCCCS children. The nearest pharmacy and behavioral health provider were one mile away or less for 42-47% of regional AHCCCS children versus 62-65% of AHCCCS children statewide. Another 43-51% of regional AHCCCS children traveled up to five miles to visit these providers versus 26-30% of statewide AHCCCS children. To visit the nearest hospital, 58-59% of regional AHCCCS children traveled up to five miles compared to 80-81% of AHCCCS children statewide.

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
Total Active Physicians	16,345	70	17,356	74	N/A	N/A
Active Primary Care Physicians[1]	5,396	23	5,598	24	N/A	N/A
Pediatricians[4]	1,214	5	1,257	5	1,293	6
Active Registered and Practical Nurses[2]	N/A	N/A	101,599	433	104,434	445
Dentists[3]	3,796	16	3,903	17	4,012	17

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

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

Table 5. Supply of Key Health Professionals in Pima South Region per 1,000 AHCCCS Children, 2017-2019

Provider	2017		2018		2019	
	Num	Rate	Num	Rate	Num	Rate
Primary Care						
Primary Care – All Licensed Primary Care Physicians[2]	131	11	136	12	130	12
Physicians accepting AHCCCS[1,2] – Total	90	7	99	9	91	8
Physicians accepting AHCCCS – Pediatrics	29	2	30	3	25	2
Physicians accepting AHCCCS – Primary Care	61	5	69	6	66	6
Physicians with ≥250 AHCCCS patients per year (all ages)	36	3	35	3	32	3
Behavioral Health – AHCCCS[1]						
Behavioral Health Physician Specialty or Allied Health Professional	42	3	47	4	40	4
Primary Care with Behavioral Health Services*	12	1	15	1	15	1
Other						
Dentist – accepting AHCCCS[2]	40	3	46	4	50	5
Hospital[1,3]	2	0	2	0	2	0
Pharmacy[1,4]	24	2	24	2	24	2

Source: [1]AHCCCS Claims Data, 2021. [2]Arizona Medical Board and Arizona Board of Osteopathic Medical Examiners in Medicine and Surgery, 2021. [3] (Arizona Department of Health Services, 2021). [4]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 = 12,015 for 2017, N = 11,285 for 2018 and N = 10,826 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
Behavioral Health Specialty or Primary Care with Behavioral Health Services*	2017	42%	62%	51%	30%	5%	3%	<1%	2%	1%	4%
	2018	44%	64%	48%	27%	7%	3%	<1%	2%	1%	3%
	2019	43%	65%	48%	27%	7%	3%	<1%	2%	1%	4%
Dentist	2017	33%	62%	59%	29%	5%	3%	2%	4%	1%	2%
	2018	35%	63%	55%	29%	5%	3%	2%	3%	2%	3%
	2019	35%	63%	56%	28%	5%	3%	2%	3%	2%	3%
Hospital	2017	1%	11%	57%	69%	30%	9%	12%	10%	<1%	<1%
	2018	1%	12%	57%	69%	30%	9%	12%	11%	<1%	<1%
	2019	1%	12%	58%	69%	30%	9%	11%	11%	<1%	<1%
Pharmacy	2017	46%	64%	44%	26%	6%	3%	4%	7%	<1%	<1%
	2018	46%	64%	43%	26%	7%	3%	4%	7%	<1%	<1%
	2019	47%	64%	43%	26%	7%	3%	4%	7%	<1%	<1%
Primary Care Physician	2017	36%	56%	55%	34%	5%	4%	3%	4%	1%	3%
	2018	37%	56%	54%	35%	5%	3%	2%	4%	1%	3%
	2019	40%	57%	50%	34%	6%	3%	3%	4%	1%	3%

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

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

PRIMARY CARE

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

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

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, 89% of AHCCCS children had at least one PCP visit compared to 85-86% of AHCCCS children statewide (Table 7) and 86-87% of Medicaid children nationally. All rates exceeded the AHCCCS Minimum Performance Standard (MPS)[15] of 84%. In Table 8, all subregions met or exceeded the AHCCCS statewide rates and MPS for annual PCP visits in all years, except for Ajo (no years) and Amado (2017 and 2018).

In Figure 6, regional AHCCCS children who had annual PCP visits were more likely to be ages 1-2 (93-94%) than ages 3-5 (86-87%), Hispanic and Latino (90-91%) versus Non-Hispanic or Latino (86-87%), and Asian/Pacific Islander (93-95%) than other races in 2018 and 2019.

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	89%	85%	89%	85%	89%	86%

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

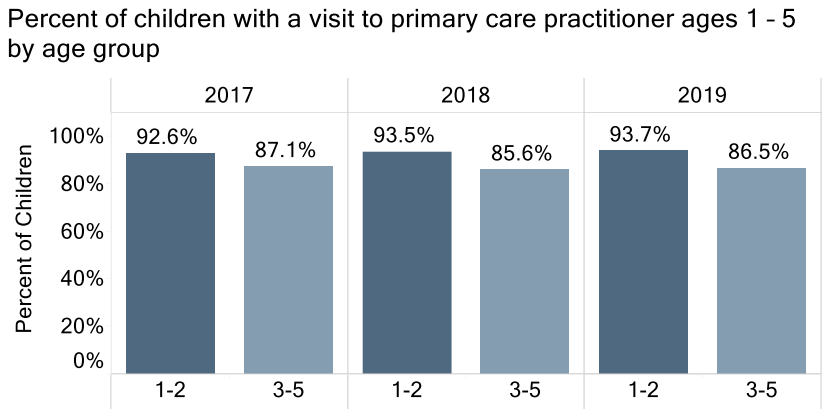
[15] Minimum Performance Standard (MPS) is the minimal expected level of performance by AHCCCS Contractors. AHCCCS-reported rates are the official rates used to determine Contractor compliance with performance requirements. If a Contractor does not achieve the MPS, they will be required to submit a corrective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

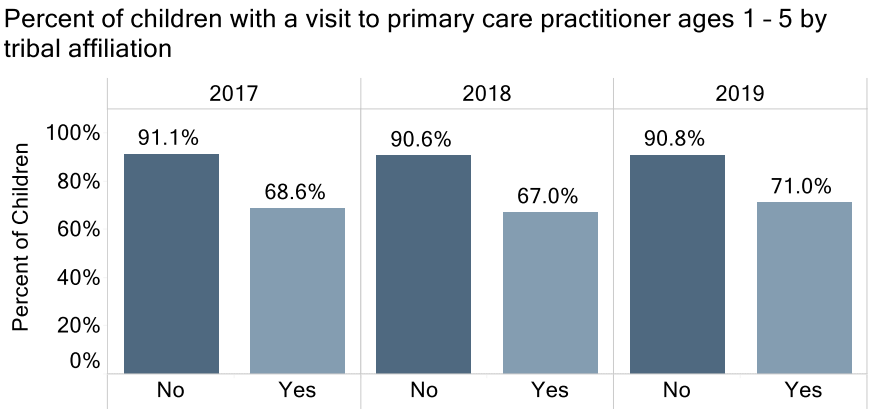
Table 8. Percent of AHCCCS Children Ages 1 – 5 with a Visit to PCP by Subregion, 2017-2019

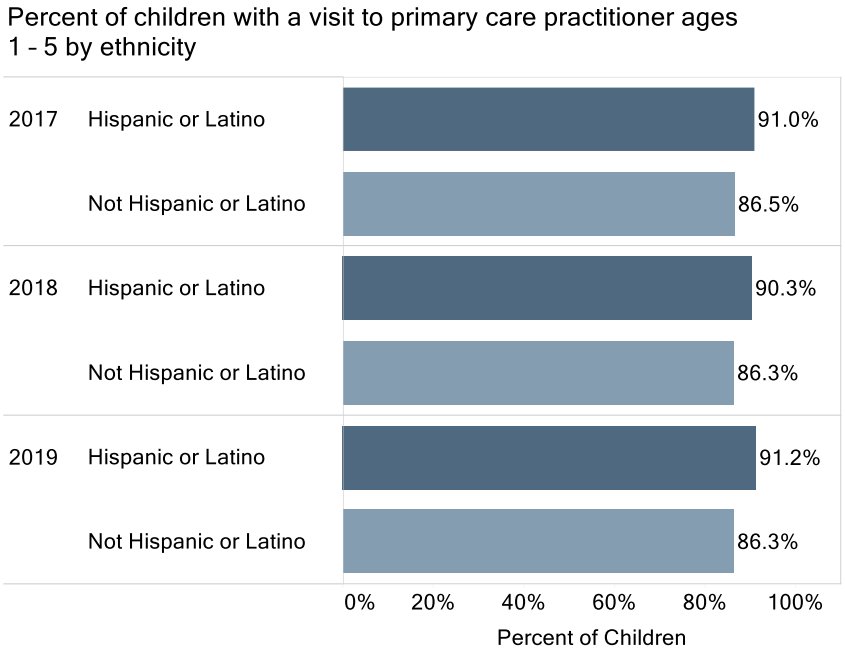
Subregion	2017	2018	2019
Ajo	48%	47%	56%
Amado	88%	87%	80%
Drexel Heights	90%	90%	91%
Rita Ranch	89%	90%	91%
Sahuarita	90%	89%	90%
Sunnyside	90%	89%	89%
Three Points	90%	87%	88%
Vail	88%	91%	89%

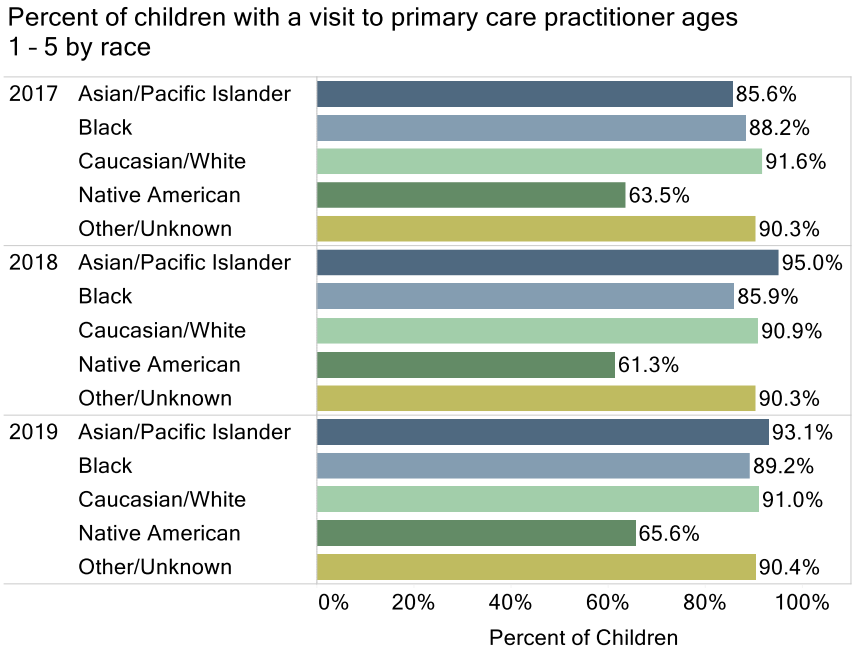
Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

Figure 6. Percent of AHCCCS Children Ages 1 – 5 with a Visit to PCP 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.

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, 58-70% of AHCCCS children birth to 15 months had six or more well-child visits compared to 53-60% of AHCCCS children statewide (Table 9) and 63-66% of Medicaid children nationally. In 2018 and 2019, the region met the AHCCCS MPS of 65% (2017 and 2018) and 62% (2019) for this indicator.

In Table 10, the subregions who met or exceeded the AHCCCS statewide rate and MPS for six or more well-child visits for AHCCCS children birth to 15 months were Amado (2019), Drexel Heights (2019), Rita Ranch (2018 and 2019), Sahuarita, Sunnyside (2018 and 2019), Three Points (2018 and 2019) and Vail (2019). In Figure 8, regional AHCCCS children birth to 15 months with six or more well-child visits were more likely to be Hispanic or Latino (61-74%) than Non-Hispanic or Latino (55-63%).

For AHCCCS children ages 3-5 in Table 9, 68-70% 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 exceeded the AHCCCS MPS of 66% for this indicator.

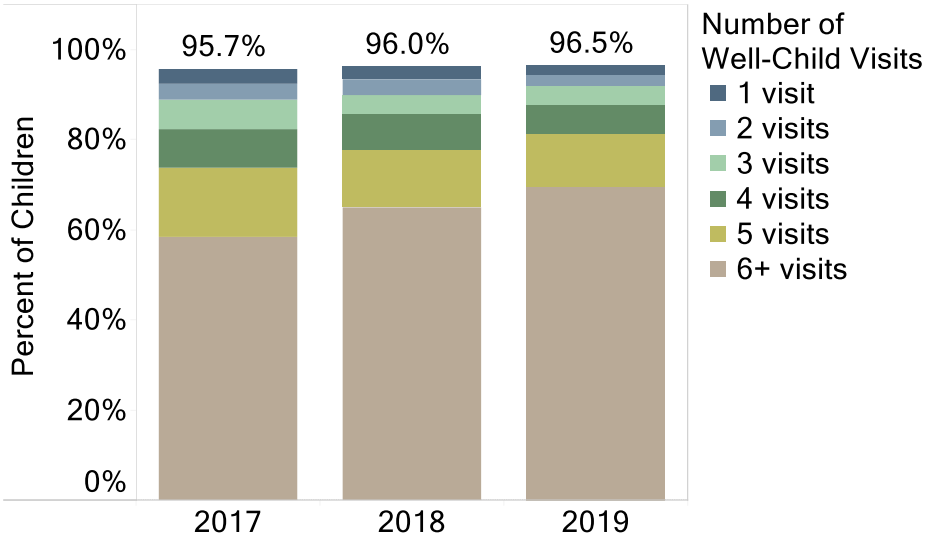
In Table 11, the subregions who met or exceeded the AHCCCS statewide rates and MPS for annual well-child visits for AHCCCS children ages 3-5 were Drexel Heights (all years), Rita Ranch (2017), Sahuarita (2019), Sunnyside (all years), Three Points (all years) and Vail (all years). In Figure 9, regional AHCCCS children ages 3-5 with an annual well-child visit were more likely to be Hispanic or Latino (69-73%) than Non-Hispanic or Latino (63-66%), and Asian/Pacific Islander (71-75%) in 2018 and 2019 than other races.

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

Indicator/Year	2017		2018		2019	
	Region	Arizona	Region	Arizona	Region	Arizona
Six or More Well-Child Visits in First 15 Months of Life	58%	53%	65%	58%	70%	60%
Annual Well-Child Visit, Ages 3-5	68%	62%	68%	63%	70%	65%

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

Figure 7. Percent of Regional AHCCCS Children by Number of Well-Child Visits Completed During Their First 15 Months by Number of Visits and Year



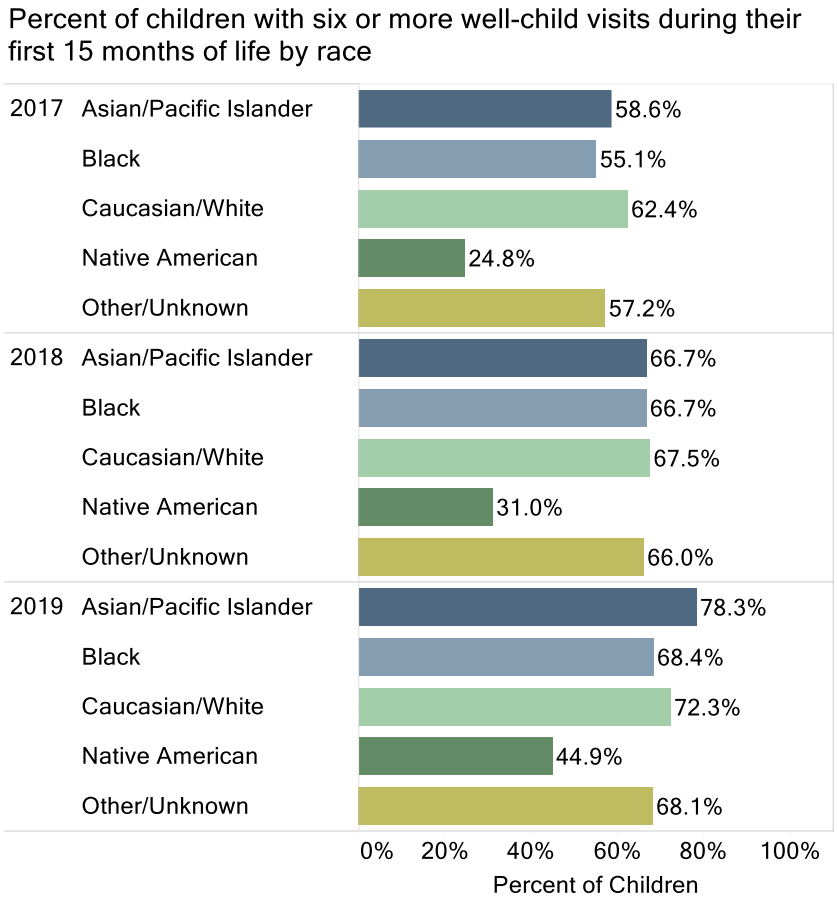
Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

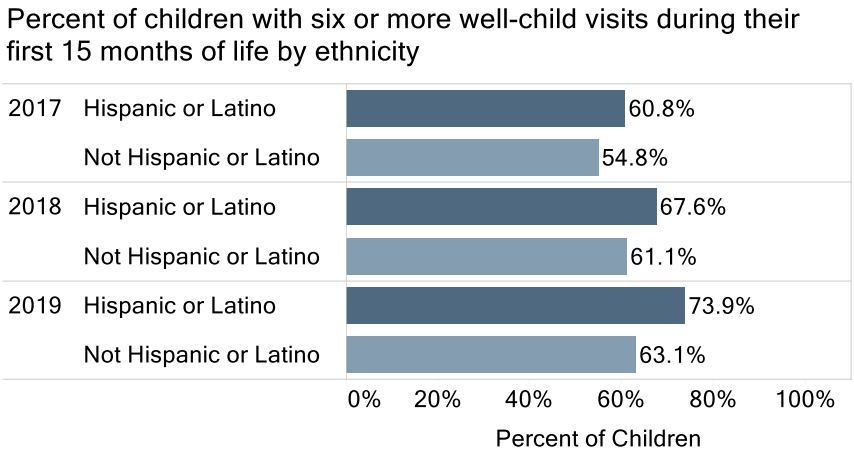
Table 10. Percent of AHCCCS Children Who Had Six or More Well-Child Visits During Their First 15 Months of Life by Subregion, 2017-2019

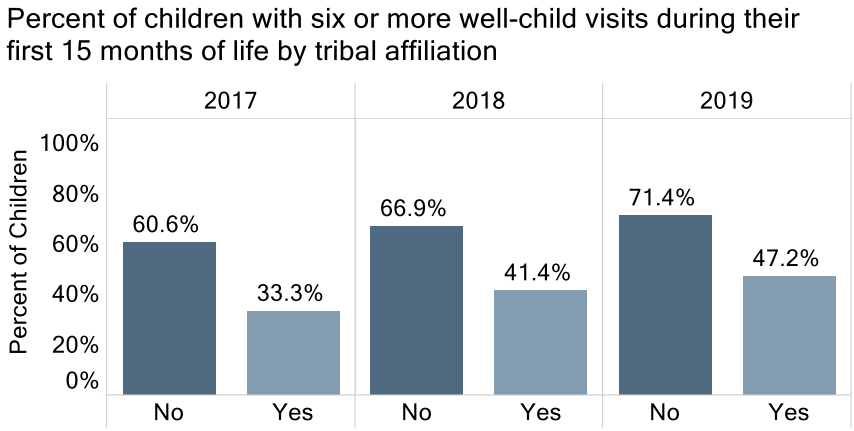
Subregion	2017	2018	2019
Ajo	DS	DS	37%
Amado	64%	40%	62%
Drexel Heights	59%	64%	69%
Rita Ranch	61%	75%	69%
Sahuarita	56%	61%	64%
Sunnyside	59%	66%	71%
Three Points	61%	65%	86%
Vail	54%	63%	76%

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

Figure 8. Percent of AHCCCS Children Who Had Six or More Well-Child Visits During Their First 15 Months of Life by Race, Ethnicity, Tribal Affiliation and Year







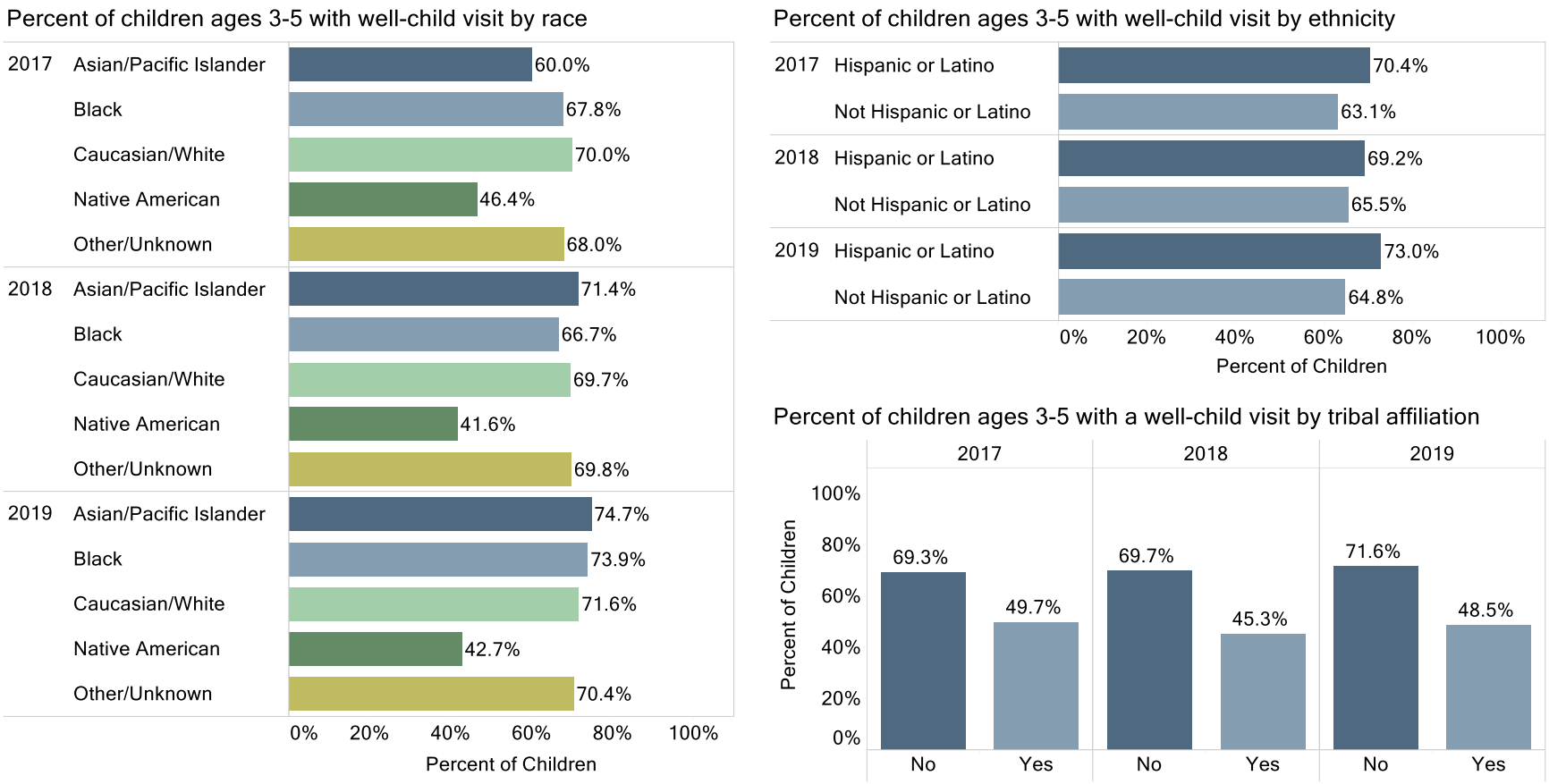
Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

Table 11. Percent of AHCCCS Children Ages 3-5 with a Well-Child Visit by Subregion, 2017-2019

Subregion	2017	2018	2019
Ajo	29%	31%	36%
Amado	62%	60%	53%
Drexel Heights	68%	69%	71%
Rita Ranch	66%	63%	64%
Sahuarita	63%	64%	68%
Sunnyside	70%	69%	71%
Three Points	67%	69%	69%
Vail	66%	69%	70%

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

Figure 9. Percent of AHCCCS Children Ages 3-5 with a Well-Child Visit by Race, Ethnicity, 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[16] 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 12, the regional rates increased 38-42% compared to AHCCCS statewide rates which increased from 32% in 2017 to 35% in 2019.

In Table 13, the subregions who met or exceeded the AHCCCS statewide rates for one or more blood lead screenings for lead poisoning by the second birthday were Amado (2018), Drexel Heights (all years), Rita Ranch (2017 and 2018), Sahuarita (2019), Sunnyside (all years), and Three Points (2017 and 2018).

In Figure 10, regional AHCCCS children screened for lead poisoning by their second birthday were more likely to be Hispanic or Latino (40-45%) than Non-Hispanic or Latino (34-38%), and Asian/Pacific Islander (53-61%) in 2018 and 2019 than other races.

Table 12. 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	38%	32%	41%	34%	42%	35%

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

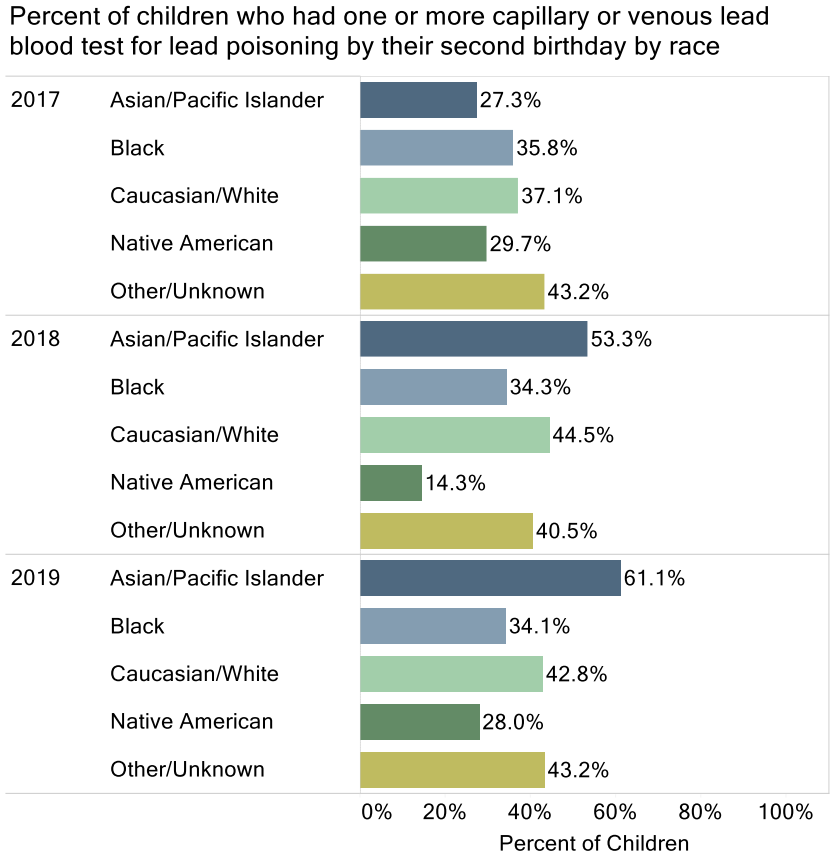
[16] Interactive map of Arizona neighborhoods to identify those considered to be high-risk is online at http://www.azhealth.gov/leadmap

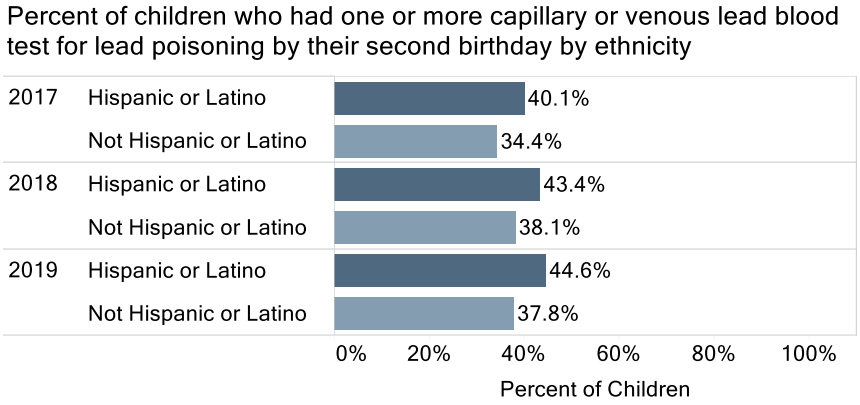
Table 13. Percent of AHCCCS Children Who Had One or More Tests for Lead Poisoning by Their Second Birthday by Subregion, 2017-2019

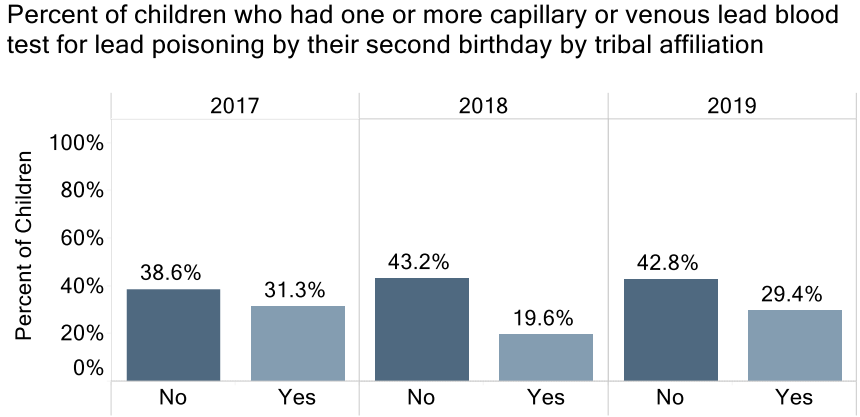
Subregion	2017	2018	2019
Amado	DS	38%	DS
Drexel Heights	35%	40%	40%
Rita Ranch	33%	40%	33%
Sahuarita	25%	28%	36%
Sunnyside	44%	46%	46%
Three Points	45%	51%	33%
Vail	27%	23%	23%

Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.
Note: Data was suppressed for Ajo subregion.

Figure 10. Percent of AHCCCS Children Who Had One or More Tests for Lead Poisoning by Their Second Birthday by Race, Ethnicity, Tribal Affiliation and Year







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

WEIGHT ASSESSMENT AND COUNSELING[17]

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[18] and counseling in Figure 11 showed AHCCCS children in Pima South were assessed for weight at 7-35% compared to AHCCCS children statewide (Table 14) who were assessed at rates of 9-19%. Rates for nutrition counseling were 2-4% at the regional level versus 4-5% at the state level for AHCCCS children. Physical activity assessments in the region were <1-2% while AHCCCS children statewide were assessed <1-1%.[19]

The national HEDIS Medicaid rates were reported in Table 15; 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 14. 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 15. 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%

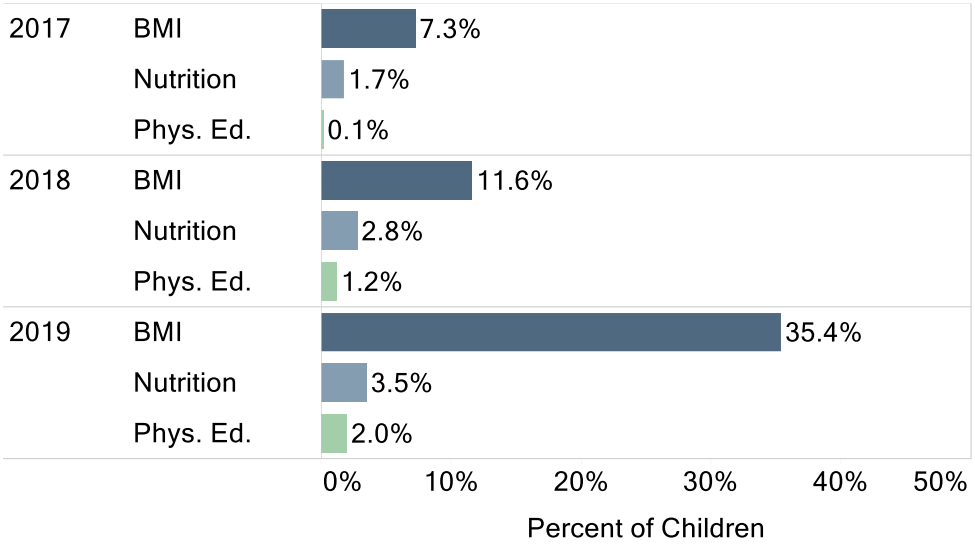
Source: (National Committee for Quality Assurance, 2021).

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

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

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

Figure 11. Percent of AHCCCS Children Ages 3-5 Who Had Weight Assessment and Counseling by Year



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

Notes: Each of the three items above is a different indicator. Because BMI norms for youth vary with age and sex, this indicator evaluates whether BMI percentile is assessed, rather than an absolute BMI value.

DEVELOPMENTAL SCREENING AND DELAY

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

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

AHCCCS PCPs use developmental screening tools during 9-month, 18-month and 24-month well-child visits. Developmental screenings are assessed in claims data using billing code CPT 96110. AHCCCS has an active Performance Improvement Project to increase the number of screenings in its eligible populations (Arizona Health Care Cost Containment System, 2021). AHCCCS analyzed its own performance on developmental screenings using several data sources and reported 26% (Median = 42%) of eligible members in acute care screened in 2017 and 30% (Median = 33%) screened in 2018. Rates for AHCCCS children in foster care were 34% and 38% for the same years, respectively. AHCCCS also analyzed the 2018

data for disparities and found disparities in five of Arizona's 15 Counties: Apache, Gila, Navajo, Santa Cruz and Yavapai. Racial disparity was also demonstrated for the American Indian population.

Table 16 rates of developmental screenings in AHCCCS children birth to age 5 increased over the report period although still well below the AHCCCS median rates. At the regional level, rates increased 9-14% compared to statewide AHCCCS rates of 10-14%.[20] Developmental screenings were conducted most often in physician offices (69-78%) in Table 17. Developmental screenings for AHCCCS children ages 1-2 were most likely to be conducted in the following subregions: Rita Ranch (37-49%), Vail (25-48%) and Drexel Heights (26-39%), Sunnyside (22-34%), and Three Points (27-28%) in Table 18. In Figure 12, regional AHCCCS children receiving developmental screenings were more likely to be ages 1-2 (23-35%) than age 0 (4-8%) and ages 3-5 (1-3%), and Black (31-40%) in 2017 and 2019 than other races.

Rates of diagnosing developmental delay in AHCCCS children were 2-4% at the regional level compared to 3-5% at the state level for AHCCCS children in Table 16. Regional AHCCCS children were more likely to be diagnosed with a developmental delay in Rita Ranch and Vail in Table 19. In Figure 13, regional AHCCCS children diagnosed with developmental delay were more likely to be ages 3-5 (3-5%) than age 0 (1%) and ages 1-2 (3-4%) and male (3-5%) than female (2-3%).

Of those AHCCCS children who were diagnosed with developmental delay, 53-62% of regional AHCCCS children received behavioral health services compared to 47-58% of AHCCCS children statewide (Table 16). The subregions where regional AHCCCS children were more likely to receive behavioral health services after a diagnosis of developmental delay were Drexel Heights (62-69%), Rita Ranch (35-67%) and Vail (55-64%) in Table 20. In Figure 14, regional AHCCCS children diagnosed with developmental delay who received behavioral health services were more likely to be ages 3-5 (57-69%) than age 0 (41%) and ages 1-2 (44-53%), affiliated with a tribal community (67%) than unaffiliated (58-61%) in 2017 and 2019, Black (71-90%) than other races, and male (58-64%) than female (46-58%).

Table 16. 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	9%	10%	9%	11%	14%	14%
Diagnosing Developmental Delay, Ages Birth to 5	2%	3%	3%	4%	4%	5%
Developmental Delay and Behavioral Health Services, Ages 3-5	58%	49%	53%	47%	62%	58%

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

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

Table 17. Percent of Claims by Provider Type for AHCCCS Children Receiving Developmental Screenings, 2017-2019

Provider Type	2017		2018		2019	
	Claims Count	Percent of Total	Claims Count	Percent of Total	Claims Count	Percent of Total
Federally Qualified Health Center (FQHC)	465	10%	418	8%	874	13%
Physician – MD/DO	3,741	78%	3,685	74%	4,789	69%
Physician Assistant	273	6%	399	8%	489	7%
Registered Nurse Practitioner	304	6%	475	10%	763	11%

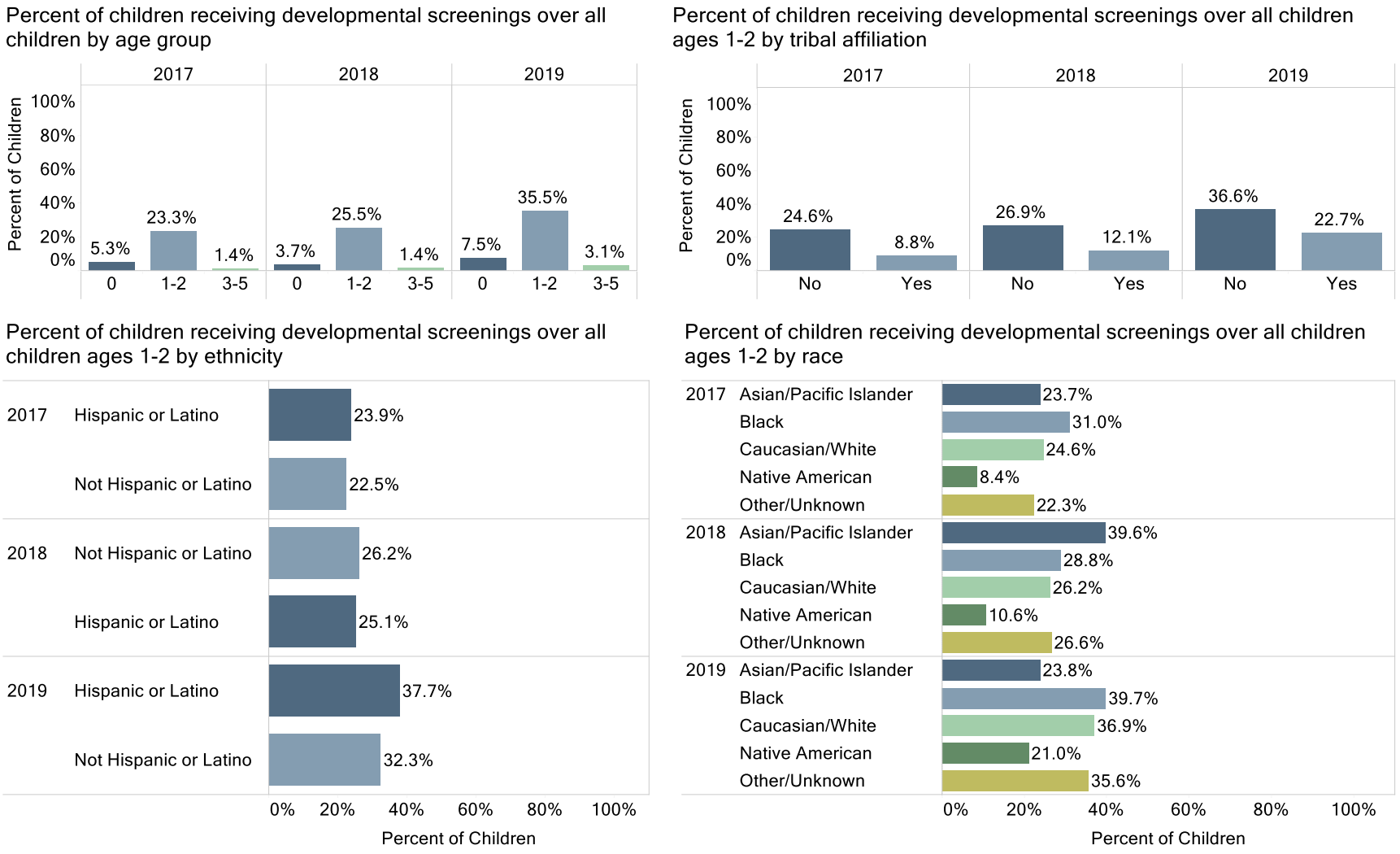
Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

Table 18. Percent of AHCCCS Children Receiving Developmental Screenings, Age 1-2, by Subregion, 2017-2019

Subregion	2017	2018	2019
Ajo	DS	DS	16%
Drexel Heights	26%	29%	39%
Rita Ranch	38%	37%	49%
Sahuarita	13%	18%	27%
Sunnyside	22%	24%	34%
Three Points	28%	27%	28%
Vail	25%	38%	48%

Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.
Note: Data was suppressed for Amado subregion.

Figure 12. Percent of AHCCCS Children Receiving Developmental Screenings 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.

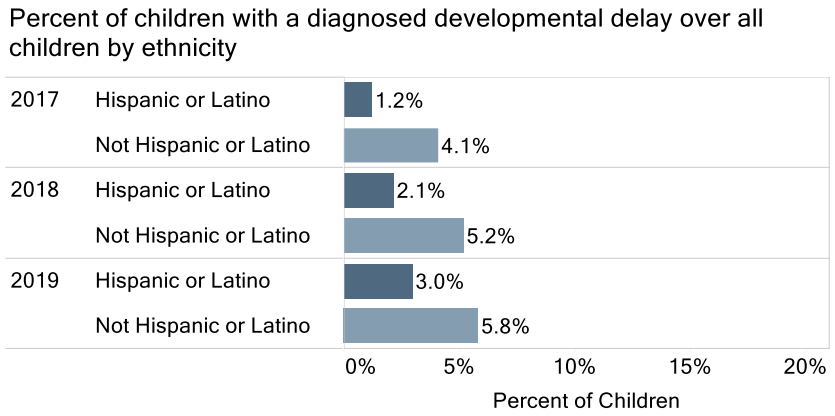
Notes: Since developmental delay screenings are more likely to take places for those ages 1-2, the other analyses focus on that age group.

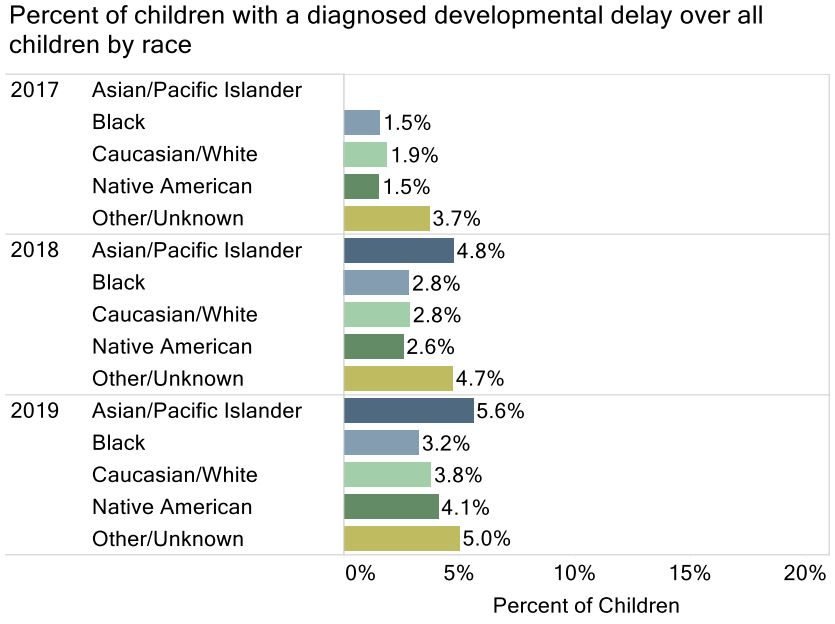
Table 19. Percent of AHCCCS Children with a Diagnosed Developmental Delay by Subregion, 2017-2019

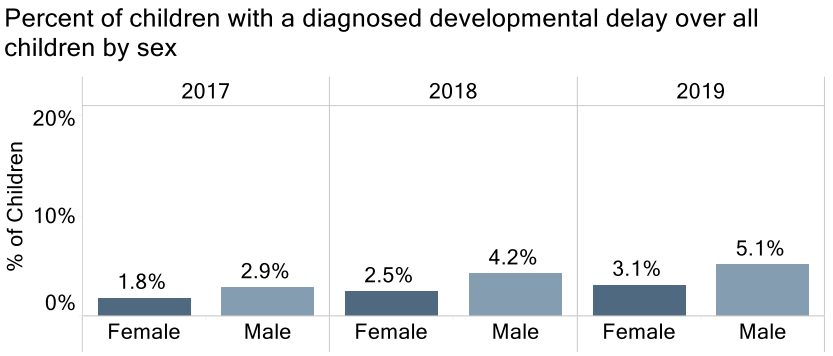
Subregion	2017	2018	2019
Drexel Heights	2%	3%	4%
Rita Ranch	5%	7%	9%
Sahuarita	3%	5%	4%
Sunnyside	2%	3%	4%
Three Points	DS	3%	3%
Vail	6%	7%	9%

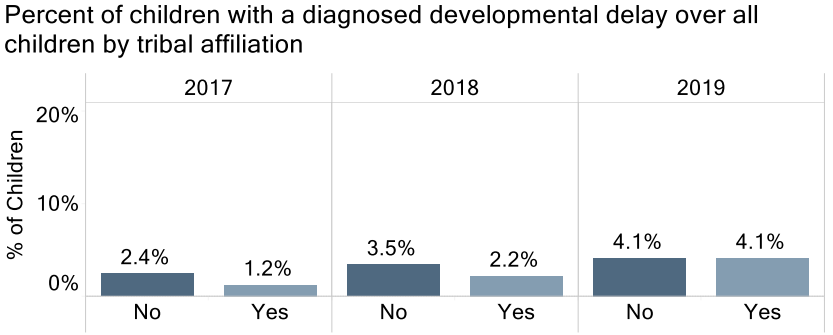
Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.
Note: Data was suppressed for Ajo and Amado subregions.

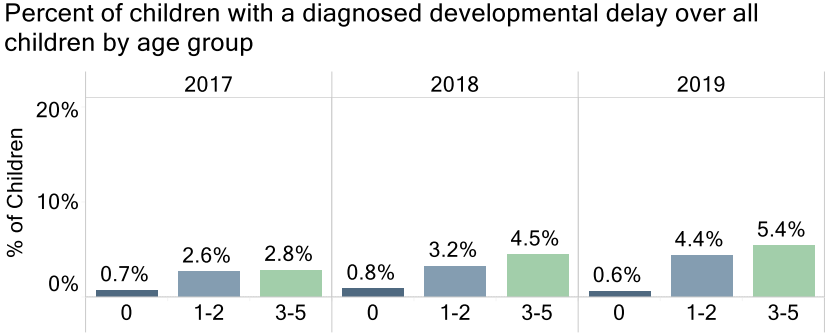
Figure 13. Percent of AHCCCS Children with a Diagnosed Developmental Delay by Ethnicity, Race, Sex, Tribal Affiliation, Age Group and Year











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

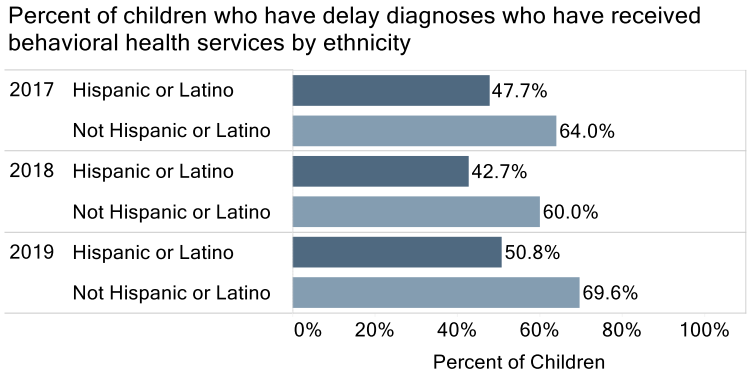
Note: Data was suppressed for Asian/Pacific Islander in 2017.

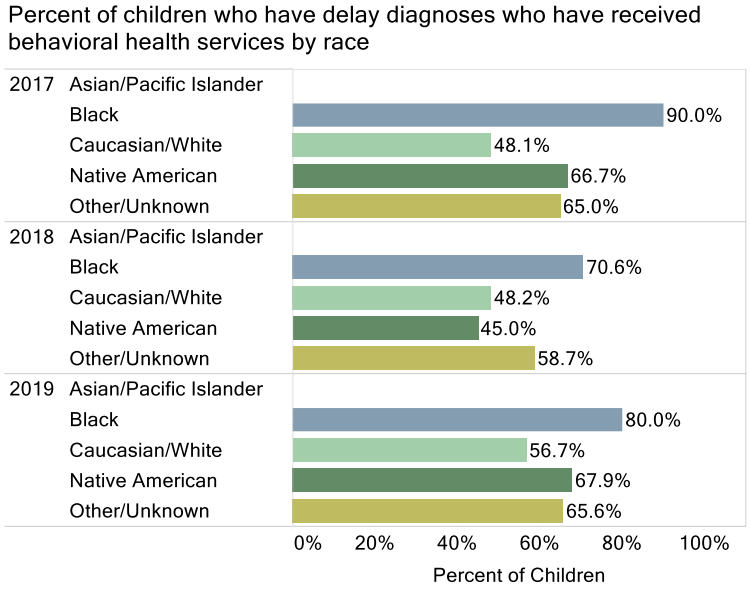
Table 20. Percent of AHCCCS Children with a Diagnosed Developmental Delay Who Have Received Behavioral Health Services by Subregion, 2017-2019

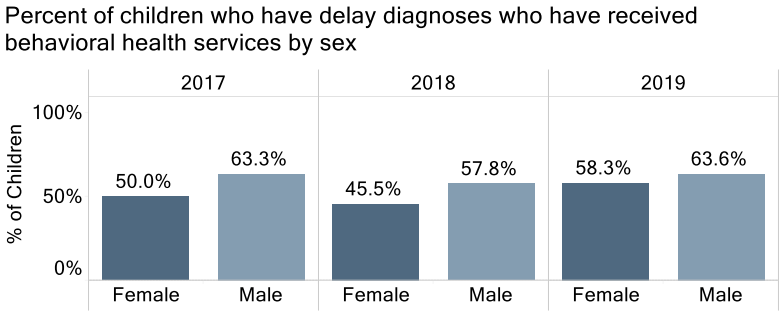
Subregion	2017	2018	2019
Drexel Heights	62%	62%	69%
Rita Ranch	50%	35%	67%
Sahuarita	57%	56%	56%
Sunnyside	54%	50%	57%
Vail	63%	55%	64%

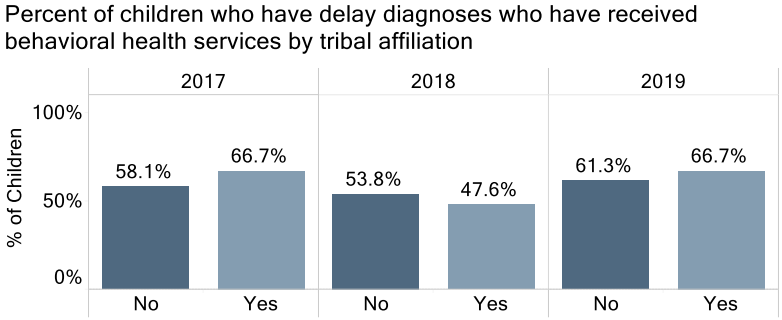
Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.
Note: Data was suppressed for Ajo, Amado and Three Points subregions.

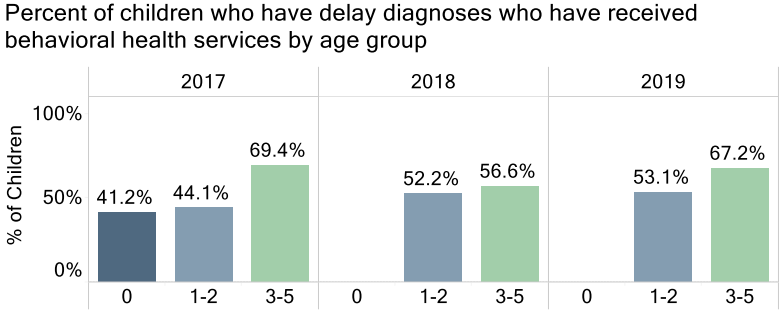
Figure 14. Percent of AHCCCS Children with a Diagnosed Developmental Delay Who Have Received Behavioral Health Services by Ethnicity, Race, Sex, Tribal Affiliation, Age Group and Year











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. Data was suppressed for Asian/Pacific Islander (all years) and age 0 (2018 and 2019).

Table 21. 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	4,224	34%	3,878	24%	4,788	22%
Board Certified Behavior Analysts (BCBA)	<6	DS	<6	DS	191	1%
Durable Medical Equipment Supplier	364	3%	449	3%	579	3%
Habilitation Provider	1,136	9%	1,777	11%	1,833	8%
Hospital	129	1%	186	1%	286	1%
Integrated Clinics	1,134	9%	1,785	11%	2,150	10%
Occupational Therapist	740	6%	1,075	7%	1,974	9%
Physical Therapist	81	1%	283	2%	558	3%
Physician – MD/DO	328	3%	269	2%	392	2%
Speech Language Pathology	126	1%	375	2%	783	4%
Speech/Hearing Therapist	3,690	30%	5,585	35%	7,677	35%
Other	355	3%	350	2%	682	3%

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[21] would likely include day programs, crisis services, rehabilitation services, health promotion, mental health counseling, psychiatric and psychologist services, and various support services.

[21] For more detail on AHCCCS behavioral health services, visit https://www.azahcccs.gov/Members/AlreadyCovered/coveredservices.html

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 22, 14-17% of AHCCCS children in Pima South Region received behavioral health services compared to 11-16% of AHCCCS children statewide. In Table 23, all subregions provided behavioral health services at rates higher than the AHCCCS statewide rates in at least one year. In Figure 15, regional AHCCCS children who received behavioral health services were more likely to be male (17-21%) than female (10-13%) and Asian (24%) in 2019 than other races.

Table 22. 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	14%	11%	14%	12%	17%	16%

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

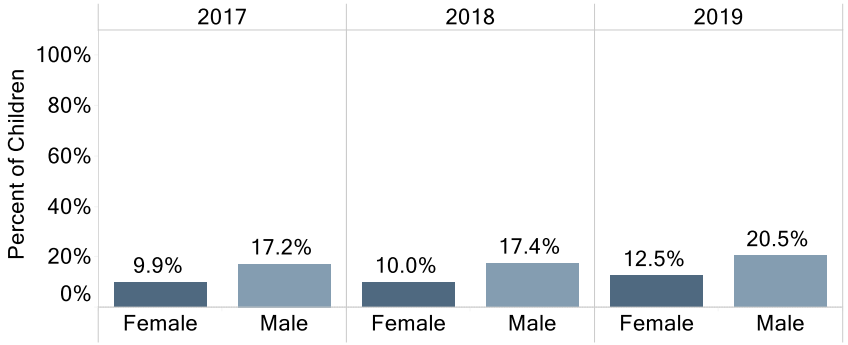
Table 23. Percent of AHCCCS Children Ages 3-5 Receiving Behavioral Health Services by Subregion, 2017-2019

Subregion	2017	2018	2019
Amado	11%	DS	DS
Drexel Heights	15%	14%	18%
Rita Ranch	18%	19%	24%
Sahuarita	16%	16%	14%
Sunnyside	13%	13%	16%
Three Points	11%	12%	13%
Vail	18%	21%	20%

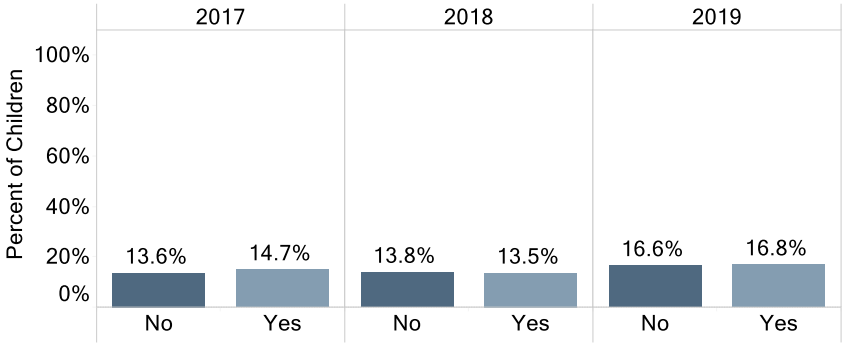
Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.
Note: Data was suppressed for Ajo.

Figure 15. Percent of AHCCCS Children Ages 3-5 Receiving Behavioral Health Services by Sex, Tribal Affiliation, Ethnicity, Race and Year

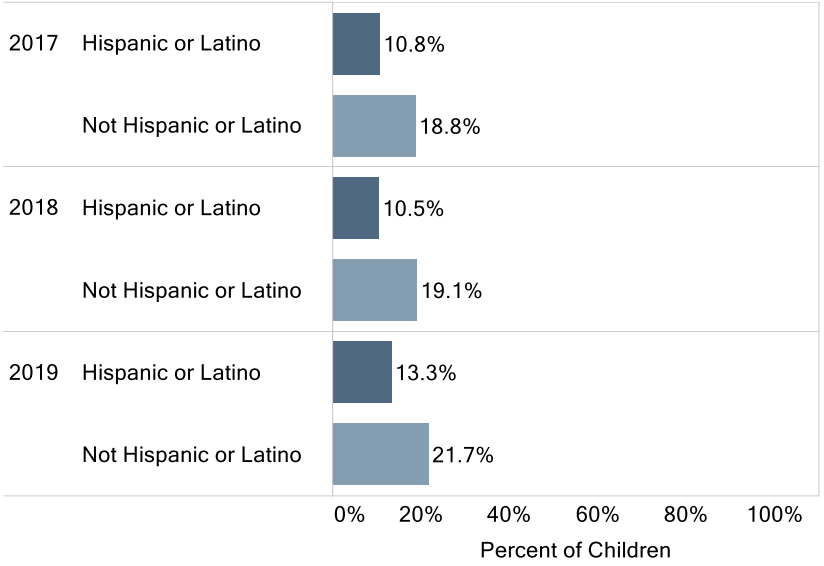
Percent of children who are receiving behavioral health services of all children ages 3-5 by sex



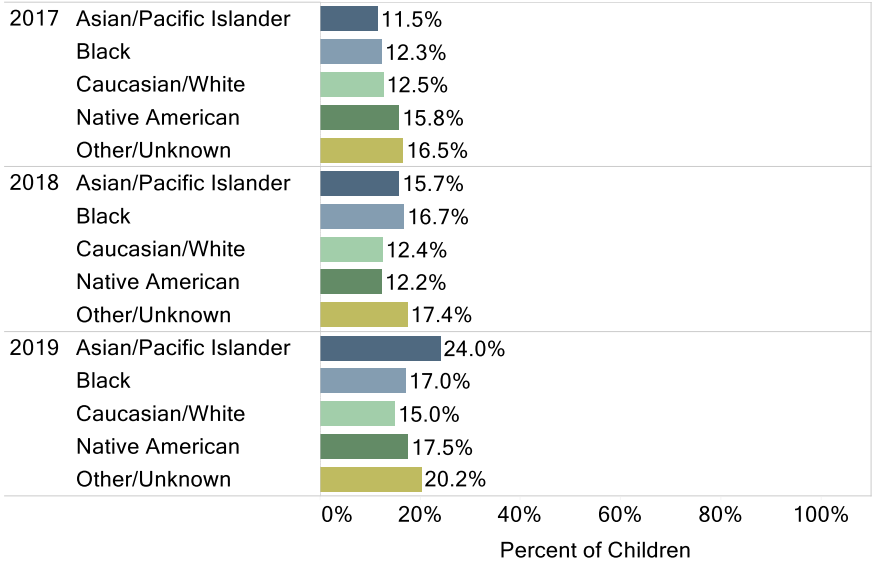
Percent of children who are receiving behavioral health services of all children ages 3-5 by tribal affiliation



Percent of children who are receiving behavioral health services of all children ages 3-5 by ethnicity



Percent of children who are receiving behavioral health services of all children ages 3-5 by race



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

Table 24. 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	20,803	43%	14,302	31%	14,335	27%
Durable Medical Equipment Supplier	472	1%	502	1%	635	1%
Habilitation Provider	2,988	6%	3,258	7%	2,209	4%
Hospital	346	1%	404	1%	538	1%
Integrated Clinics	5,048	10%	7,247	16%	7,282	14%
Occupational Therapist	1,545	3%	1,876	4%	2,625	5%
Physical Therapist	427	1%	539	1%	685	1%
Physician – MD/DO	872	2%	801	2%	960	2%
Speech Language Pathology	326	1%	757	2%	1,374	3%
Speech/Hearing Therapist	13,832	29%	15,351	33%	20,273	38%
Other	1,430	3%	1,082	2%	1,881	4%

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 Pima South Region, 38-44% of AHCCCS children received an annual vision screening or well-child visit compared to 43-47% of AHCCCS children statewide in Table 25. In Table 26, regional AHCCCS children who received an annual vision screening or well-child visit at rates equal or higher than the AHCCCS statewide rates were in Rita Ranch (all years), Three Points (2017) and Vail (all years). In Figure 16, regional AHCCCS children who received an annual vision screening or well-child visit were more likely to be ages 1-2 (44-60%) than ages 3-5 (44-51%), Hispanic or Latino (39-47%) than Non-Hispanic or Latino (37-40%), and Black (50-54%) than other races.

Eye exams were conducted much less frequently, ranging 4-5% annually at the regional and state levels for AHCCCS children in Table 25. In Figure 17, regional AHCCCS children receiving an eye exam were more likely to be ages 3-5 (6-7%) than ages 1-2 (2-4%) and Asian/Pacific Islander (5-9%) than other races.

Follow-up eye exams were conducted on AHCCCS children in the region and statewide at rates of 4-5% in Table 25. AHCCCS children with visually significant eye conditions received treatment at rates of 50-54% regionally compared to 54-60% statewide.

Table 25. 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	39%	44%	38%	43%	44%	47%
Eye Exams	4%	4%	4%	4%	5%	5%
Follow-up Eye Exams after Vision Screening or Well-Child Visit	4%	4%	4%	5%	4%	4%
Visually Significant Eye Conditions Who Receive Treatment	50%	54%	54%	56%	54%	60%

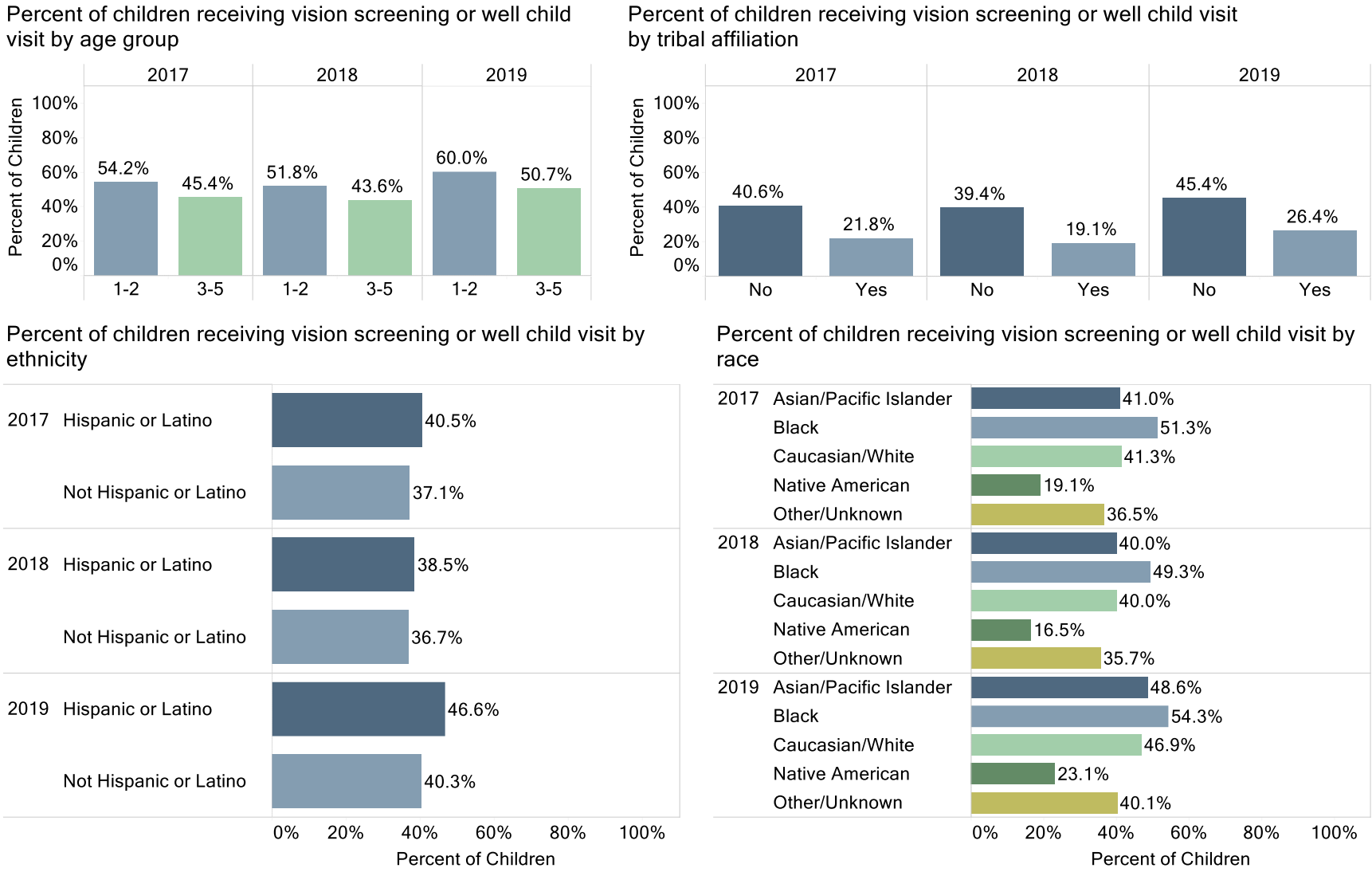
Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

Table 26. Percent of AHCCCS Children Receiving Vision Screening or Well-Child Visit by Subregion, 2017-2019

Subregion	2017	2018	2019
Ajo	14%	12%	17%
Amado	17%	14%	26%
Drexel Heights	40%	40%	45%
Rita Ranch	56%	53%	56%
Sahuarita	31%	29%	35%
Sunnyside	38%	37%	44%
Three Points	45%	34%	46%
Vail	50%	52%	54%

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

Figure 16. Percent of AHCCCS Children Receiving Vision Screening or Well-Child Visit by Age Group, Tribal Affiliation, Ethnicity, Race and Year



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

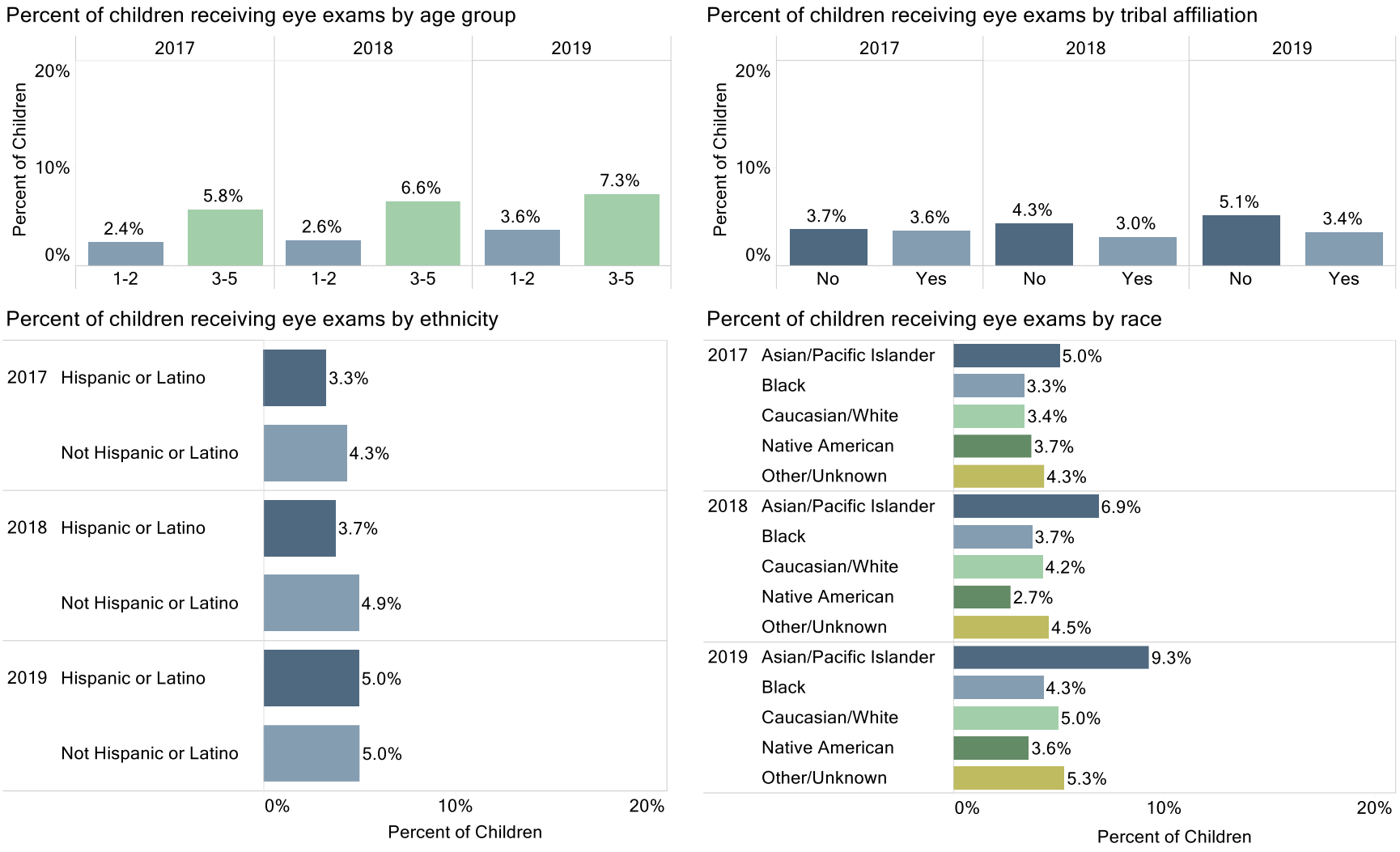
Table 27. Percent of AHCCCS Children Receiving Eye Exams by Subregion, 2017-2019

Subregion	2017	2018	2019
Ajo	DS	DS	DS
Amado	DS	DS	DS
Drexel Heights	4%	4%	5%
Rita Ranch	5%	8%	8%
Sahuarita	5%	6%	4%
Sunnyside	3%	4%	5%
Three Points	3%	DS	DS
Vail	5%	5%	7%

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

Note: Data was suppressed for Ajo and Amado.

Figure 17. Percent of AHCCCS Children Receiving Eye Exams 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: Eye exams are performed by an optometrist or ophthalmologist.

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 4-7% of AHCCCS children under age one in Pima South compared to 9-12% of AHCCCS children statewide in Table 28.

Hearing screenings were provided to 5-6% of AHCCCS children ages 1-5 in the region compared to 20-28% of AHCCCS children statewide in Table 28. The provision of additional audiology services to regional AHCCCS children ages 1-5 increased from 67% in 2017 to 84% in 2019 while statewide AHCCCS children’s rates decreased from 68% to 57% over the same period. In Table 33, the subregional rates for AHCCCS children receiving additional audiology services were Drexel Heights (59-79%), Rita Ranch (75%) in 2018, Sahuarita (75-90%) in 2018 and 2019, Sunnyside (60-91%), and Vail (100%) in 2017 and 2018. In Figure 20, regional AHCCCS children ages 1-5 who received additional audiology services were more likely to be ages 3-5 (67-97%) than age 1-2 (64-73%), tribally affiliated (100%) than unaffiliated (82%) in 2019, and Hispanic or Latino (83-91%) than Non-Hispanic or Latino (76-80%) in 2018 and 2019.

Table 28. Percent of AHCCCS Statewide and Regional Hearing Results, 2017-2019

Indicator / Year	2017		2018		2019	
	Region	Arizona	Region	Arizona	Region	Arizona
Audiology Services Under Age One	6%	11%	7%	12%	4%	9%
Hearing Screening Ages 1-5	6%	20%	5%	22%	6%	28%
Audiology Services for those Screened, Ages 1-5	67%	68%	78%	66%	84%	57%

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

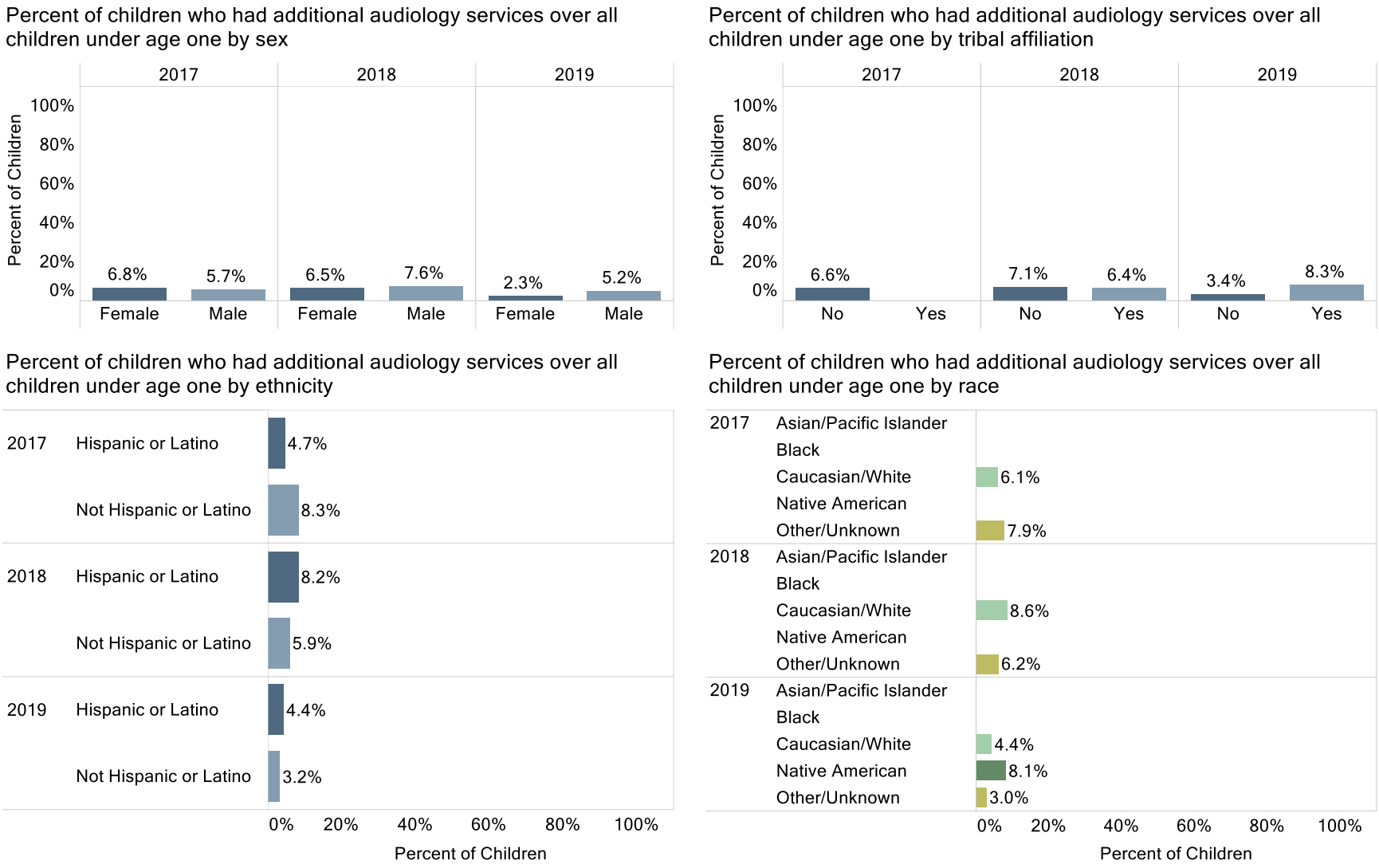
Table 29. Percent of AHCCCS Children Under Age One Who Had Audiology Services of All Children by Subregion, 2017-2019

Subregion	2017	2018	2019
Drexel Heights	5%	5%	5%
Rita Ranch	9%	DS	DS
Sahuarita	9%	9%	DS
Sunnyside	6%	9%	4%
Vail	14%	DS	DS

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

Note: Data was suppressed for Ajo, Amado and Three Points subregions.

Figure 18. Percent of AHCCCS Children Under 1 Year of Age Who Had Audiology Services by Sex, 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 tribal affiliation in 2017, Asian/Pacific Islander (all years), Black (all years), and Native American (2017 and 2018).

Table 30. Percent of Claims by Provider Type for AHCCCS Children Under Age One Who Had Audiology Services, 2017-2019

Provider Type	2017		2018		2019	
	Claims Count	Percent of Total	Claims Count	Percent of Total	Claims Count	Percent of Total
Audiologist	65	35%	82	39%	32	26%
Physician – MD/DO	115	62%	108	52%	78	64%
Other	6	3%	18	9%	12	10%

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

Table 31. Percent of Claims by Provider Type for AHCCCS Children Ages 1-5 Receiving Hearing Screening Tests, 2017-2019

Provider Type	2017		2018		2019	
	Claims Count	Percent of Total	Claims Count	Percent of Total	Claims Count	Percent of Total
Audiologist	418	34%	399	26%	326	17%
Federally Qualified Health Center (FQHC)	168	13%	315	21%	729	37%
Integrated Clinics	<6	DS	<6	DS	18	1%
Physician – MD/DO	614	49%	743	49%	838	43%
Physician Assistant	10	1%	22	1%	11	1%
Registered Nurse Practitioner	35	3%	32	2%	49	2%

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

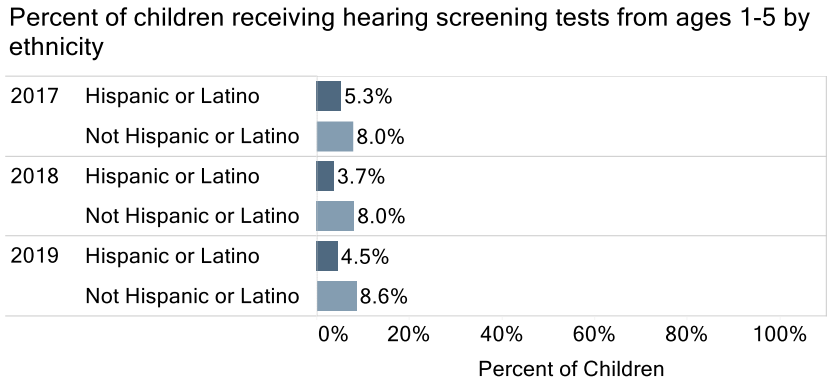
Table 32. Percent of AHCCCS Children Ages 1-5 Receiving Hearing Screening Tests by Subregion, 2017-2019

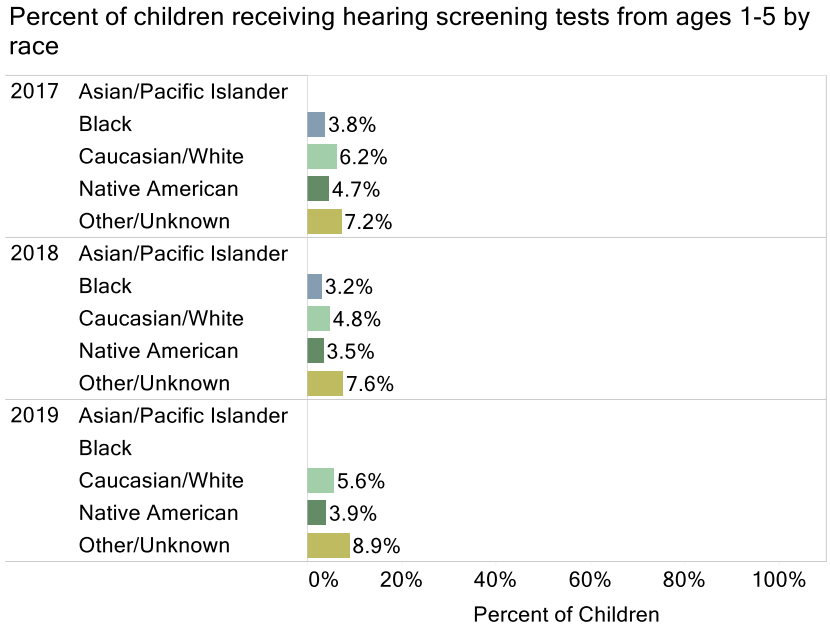
Subregion	2017	2018	2019
Drexel Heights	7%	6%	8%
Rita Ranch	5%	11%	4%
Sahuarita	4%	8%	7%
Sunnyside	6%	4%	5%
Three Points	6%	DS	DS
Vail	8%	10%	5%

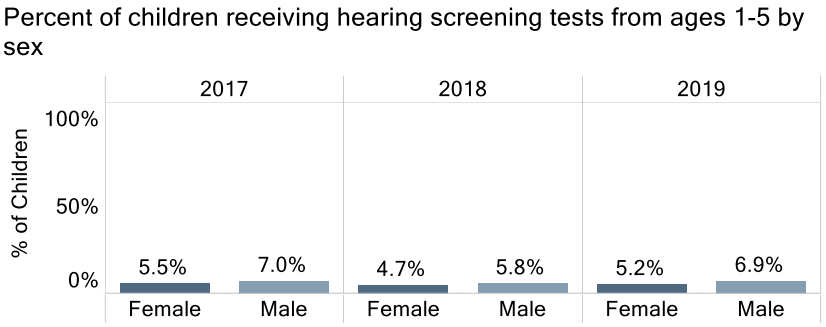
Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

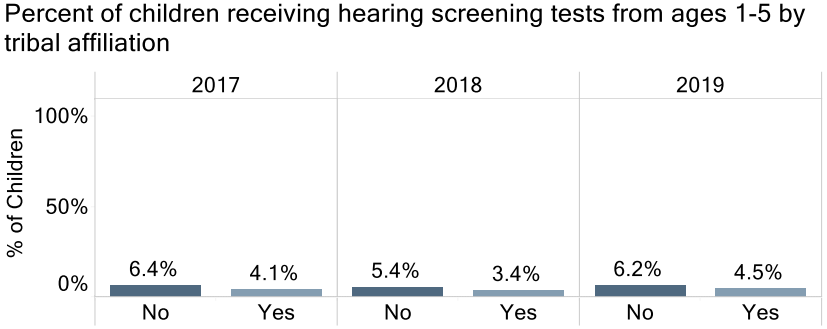
Note: Data was suppressed for Ajo and Amado subregions.

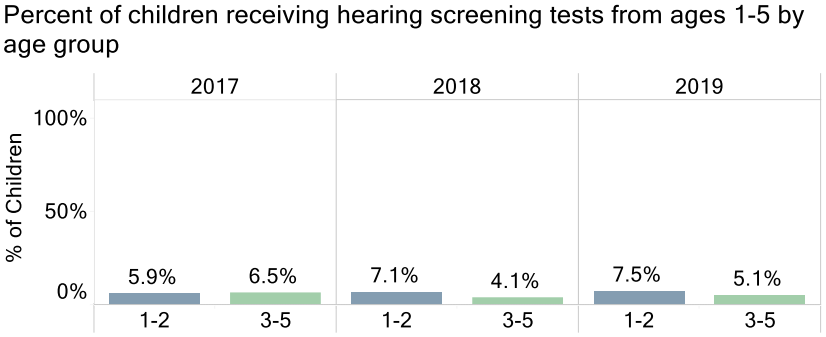
Figure 19. Percent of AHCCCS Children Ages 1-5 Receiving Hearing Screening Tests by Age Group, Tribal Affiliation, Ethnicity, Race, Sex and Year











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

Note: Data was suppressed for Asian/Pacific Islander (all years) and Black (2019).

Table 33. Percent of AHCCCS Children Ages 1-5 Screened for Hearing and Who Had Additional Audiology Services by Subregion, 2017-2019

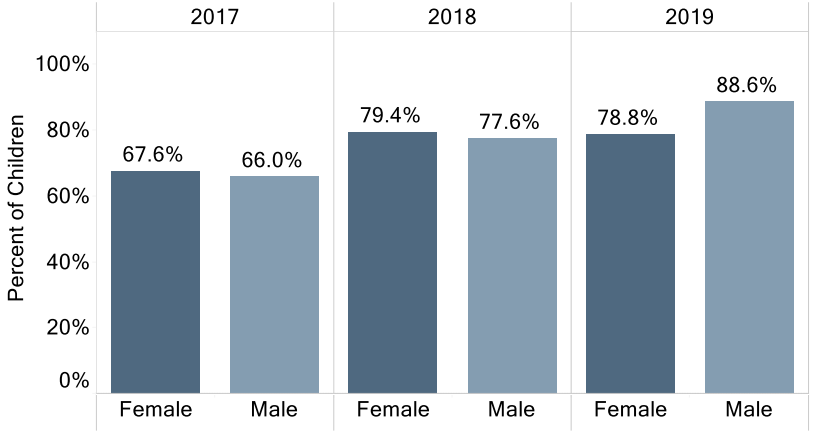
Subregion	2017	2018	2019
Drexel Heights	59%	68%	79%
Rita Ranch	DS	75%	DS
Sahuarita	DS	90%	75%
Sunnyside	60%	77%	91%
Vail	100%	100%	DS

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

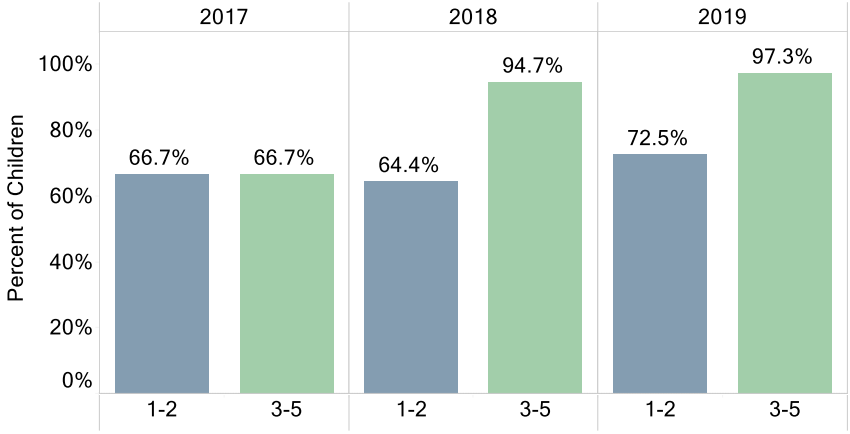
Note: Data was suppressed for Ajo, Amado and Three Points subregions.

Figure 20. Percent of AHCCCS Children Ages 1-5 Screened for Hearing and Who Had Additional Audiology Services by Age Group, Tribal Affiliation, Ethnicity, Race, Sex and Year

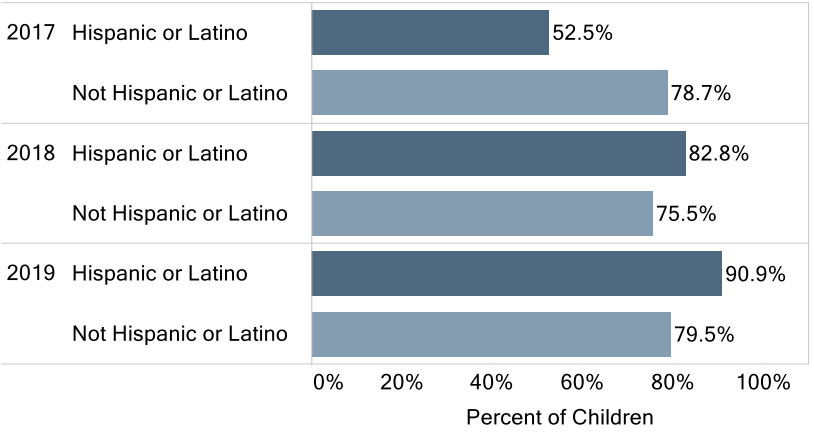
Percent of children screened ages 1-5 who had additional audiology services by sex



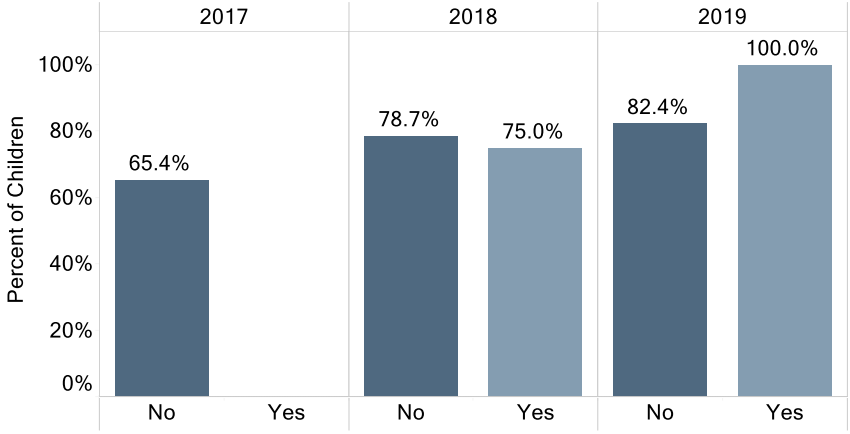
Percent of children screened ages 1-5 who had additional audiology services by age group



Percent of children screened ages 1-5 who had additional audiology services by ethnicity



Percent of children screened ages 1-5 who had additional audiology services by tribal affiliation



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

Note: Data was suppressed for tribal affiliation in 2017.

Table 34. Percent of Audiology Service Claims by Provider Type for AHCCCS Children Ages 1-5 Screened for Hearing and Who Had Additional Audiology Services, 2017-2019

Provider Type	2017		2018		2019	
	Claims Count	Percent of Total	Claims Count	Percent of Total	Claims Count	Percent of Total
Audiologist	536	46%	472	35%	390	29%
Federally Qualified Health Center (FQHC)	49	4%	72	5%	67	5%
Integrated Clinics	<6	DS	31	2%	39	3%
Physician – MD/DO	577	49%	751	56%	814	61%
Other	8	1%	11	1%	18	1%

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 Pima South Region, 54-59% of AHCCCS children had at least one annual dental visit compared to 51-53% of AHCCCS children statewide in Table 35. Neither the region nor the state met the AHCCCS MPS of 60% for annual dental visits for ages 2-20 in Table 36. Drexel Heights and Sunnyside subregions met or exceeded the AHCCCS MPS in 2019 in Table 37. In Figure 21, regional AHCCCS children with at least one annual dental visit were more likely to be ages 3-5 (63-67%) than ages 1-2 (39-47%) and Hispanic or Latino (57-62%) than Non-Hispanic or Latino (49-54%).

Two preventative care dental visits are recommended annually for children. In the region, 18-20% of AHCCCS children received the biannual preventative care dental visit compared to 18-20% of AHCCCS

children statewide (Table 35); and almost half of regional AHCCCS children had at least one preventative care dental visit per year in Figure 22.

In Table 35, fluoride varnish was applied to 47-53% of AHCCCS children in the region compared to 47-49% of AHCCCS children statewide. In Table 39, the subregions that met or exceeded the AHCCCS statewide rates for AHCCCS children having received a fluoride varnish application were Drexel Heights (all years), Rita Ranch (2018), Sahuarita (2019) and Sunnyside (all years). In Figure 23, regional AHCCCS children who had a fluoride varnish application were more likely to be ages 3-5 (54-59%) than ages 1-2 (38-44%) and Hispanic or Latino (50-56%) than Non-Hispanic or Latino (43-49%).

Table 35. 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
Any Annual Dental Visit	54%	51%	55%	52%	59%	53%
Preventative Care Dental Visit Twice Annually	18%	18%	19%	19%	20%	20%
Fluoride Varnish Application	47%	47%	50%	48%	53%	49%

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

Table 36. 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).

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	33,648	90%	30,846	87%	29,096	86%
Federally Qualified Health Center (FQHC)	3,655	10%	4,463	13%	4,418	13%
Other	248	1%	200	1%	219	1%

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

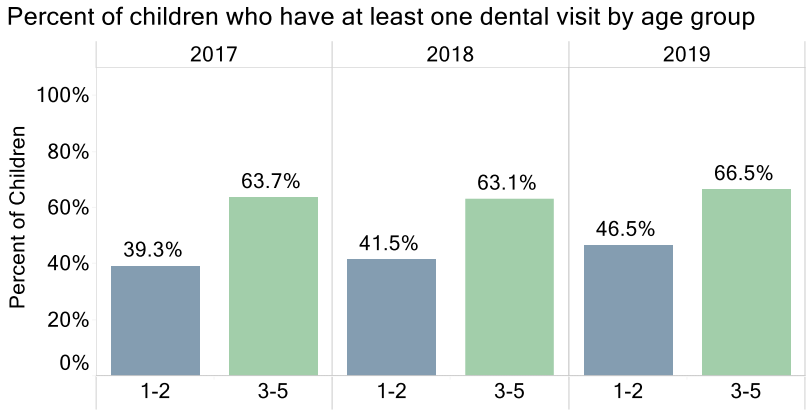
Table 37. Percent of AHCCCS Children Ages 1-5 With at Least One Annual Dental Visit by Subregion, 2017-2019

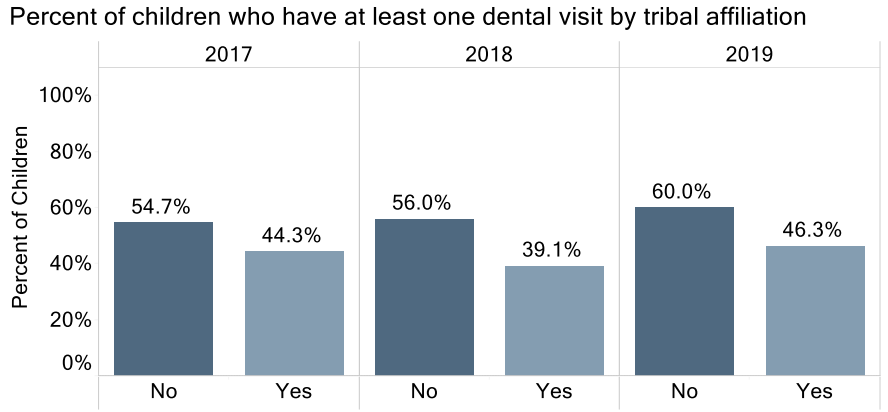
Subregion	2017	2018	2019
Ajo	33%	29%	19%
Amado	50%	52%	45%
Drexel Heights	54%	55%	60%
Rita Ranch	42%	49%	50%
Sahuarita	49%	50%	58%
Sunnyside	58%	57%	61%
Three Points	44%	46%	51%
Vail	45%	47%	45%

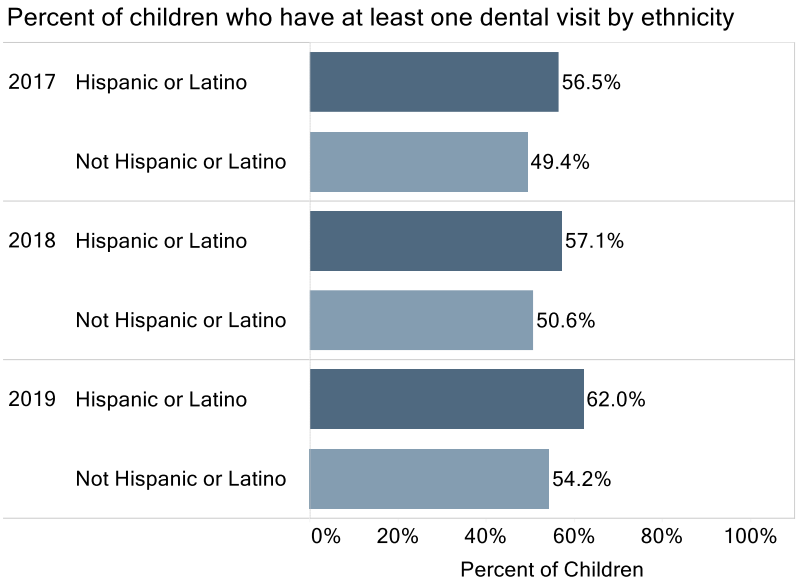
Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

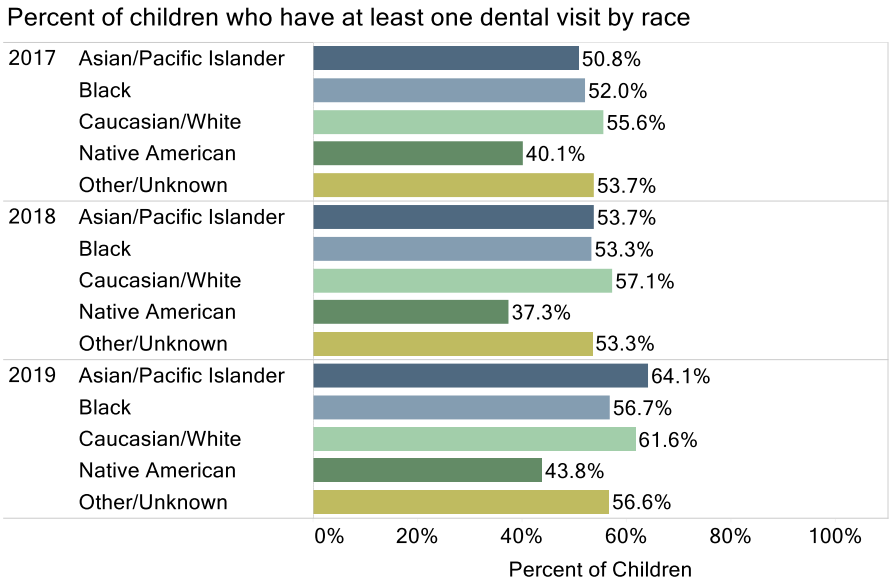
Notes: This indicator includes any claim with an associated dental procedure code (CDT).

Figure 21. Percent of AHCCCS Children Ages 1-5 With at Least One Annual Dental Visit by Age Group, Tribal Affiliation, Ethnicity, Race and Year





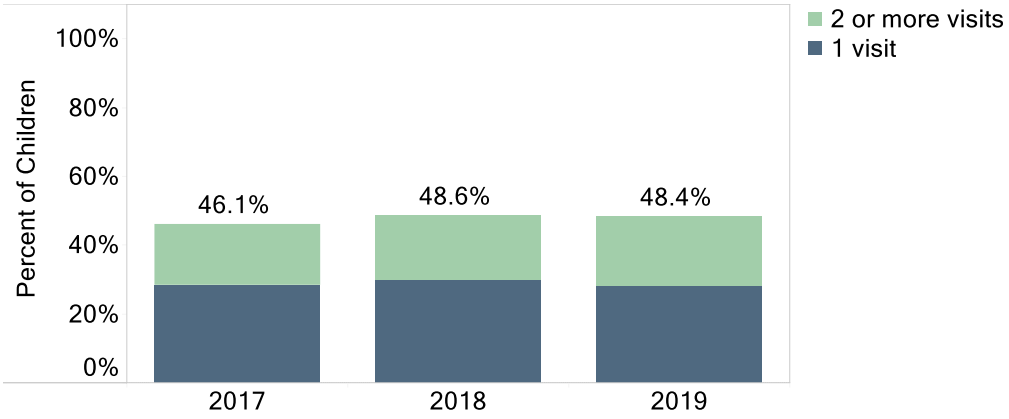




Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

Notes: This indicator includes any claim with an associated dental procedure code (CDT).

Figure 22. 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 38. 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	21,675	90%	20,196	90%	19,390	88%
Federally Qualified Health Center (FQHC)	660	3%	611	3%	980	4%
Physician – MD/DO	1,510	6%	1,365	6%	1,346	6%
Other	348	1%	379	2%	421	2%

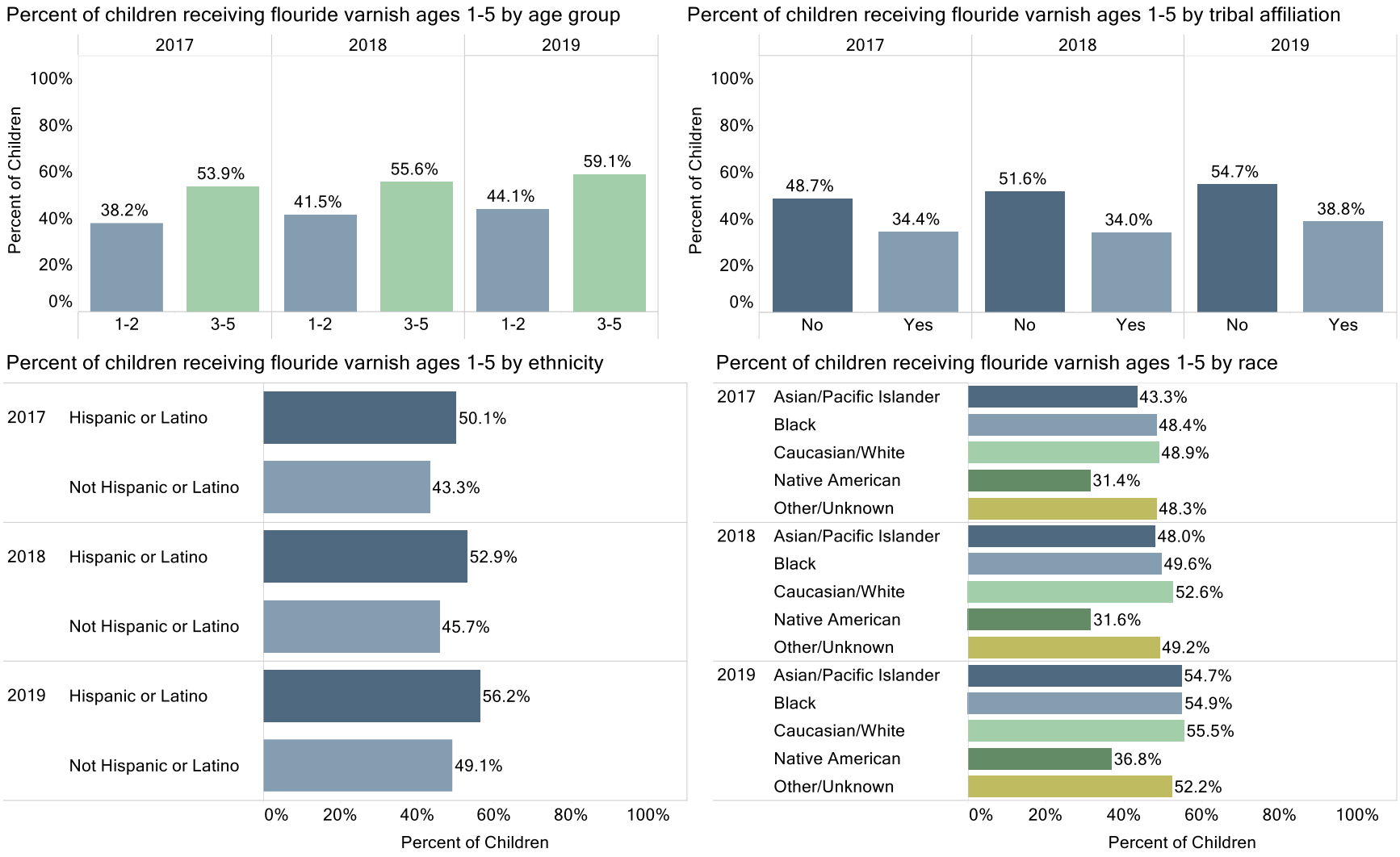
Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

Table 39. Percent of AHCCCS Children Ages 1-5 Receiving Fluoride Varnish by Subregion, 2017-2019

Subregion	2017	2018	2019
Ajo	17%	18%	11%
Amado	30%	47%	41%
Drexel Heights	48%	50%	54%
Rita Ranch	39%	48%	47%
Sahuarita	37%	43%	49%
Sunnyside	52%	53%	56%
Three Points	39%	41%	42%
Vail	42%	45%	42%

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

Figure 23. 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.

IMMUNIZATIONS

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

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

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

AHCCCS measures childhood immunization completion rates with each of its contractors biennially using the core measure. AHCCCS children's immunization status in Table 41 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 40 due to the limitation of claims data and should be interpreted with caution. AHCCCS declared that claims data does not have the greatest level of detail as claims are not always reported for immunizations, particularly in school settings. To accurately capture immunization rates in AHCCCS' published statistics, AHCCCS uses data from medical records and from the Arizona State Immunization Information System (ASIIS), which is maintained by the Arizona Department of Health Services.

AHCCCS reported that statewide childhood immunization completion rates met or exceeded the national mean rates for three immunizations: DTaP, Hep A and Combo 3 (Arizona Health Care Cost Containment System, 2018) (Table 40). 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 40. AHCCCS Statewide Aggregate Immunization Completion Rates by Two Years Old, FFY 2016

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

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

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

Table 41. Percent of Statewide and Regional AHCCCS Children Immunization Status, from AHCCCS Claims Data Only, 2017-2019

Immunizations	2017		2018		2019	
	Region	Arizona	Region	Arizona	Region	Arizona
DTaP	33%	30%	44%	38%	61%	52%
Polio	41%	40%	53%	51%	74%	66%
MMR	60%	57%	80%	72%	82%	76%
HiB	45%	44%	60%	56%	76%	69%
Hep B	29%	13%	40%	18%	51%	21%
VZV	60%	57%	79%	72%	81%	76%
PCV	15%	18%	34%	31%	63%	52%
Hep A	71%	65%	82%	75%	83%	78%
RV	35%	31%	47%	39%	66%	51%
Flu	28%	19%	50%	31%	53%	34%
Combo 3	9%	4%	23%	10%	41%	15%
Combo 10	6%	2%	14%	4%	26%	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 40.

MATERNAL PRENATAL AND POSTPARTUM CARE

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

> *Women who do not seek prenatal care are three times as likely to deliver a low birth weight infant.*
>
> *(NICHD - Eunice Kennedy Shriver National Institute of Child Health and Human Development, 2017)*

For pregnant women, prenatal care is essential for a healthy pregnancy and reducing the complications that can lead to poor birth outcomes for mother and child. Prenatal care involves regular visits to a health care provider to monitor the mother's health and health of the developing fetus, and this care should begin as early as possible in the pregnancy and continue until delivery. Prenatal care can identify problems or complications and take steps to manage them (NICHD - Eunice Kennedy Shriver National Institute of Child Health and Human Development, 2017). The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists recommend that a woman with an uncomplicated pregnancy be examined at least once in the first trimester for prenatal care. Appropriate perinatal services and education are crucial components of a healthy birth.

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

In Pima South Region, 82-83% of pregnant women began prenatal care in the first trimester compared to 84-86% of AHCCCS women statewide in Table 42, which are both above the Healthy People 2030 target rate of 81%[22]. In Table 43, all subregions met or exceeded the Healthy People 2030 target rate for timely prenatal care in a least one year. In Figure 24, regional AHCCCS children who received timely prenatal care were more likely to be Hispanic or Latino (84%) than Non-Hispanic of Latino (79-81%) and adult (83%) than teens (77-81%).

For postpartum care, 84-88% of regional AHCCCS women had at least one postpartum visit compared to 88-89% of AHCCCS women statewide (Table 42) and 64-75% of Medicaid women nationally. In Table 44, the subregions that met or exceeded the AHCCCS statewide rates for postpartum care were Amado (2018), Drexel Heights (2017), Rita Ranch (all years), Sahuarita (all years), Three Points (2017), and Vail (all years). In Figure 25, adult regional AHCCCS women (85-88%) were more likely to have a postpartum visit than teens (78%).

[22] 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 42. 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	82%	84%	83%	86%	83%	85%
Postpartum Care	88%	88%	84%	89%	84%	89%

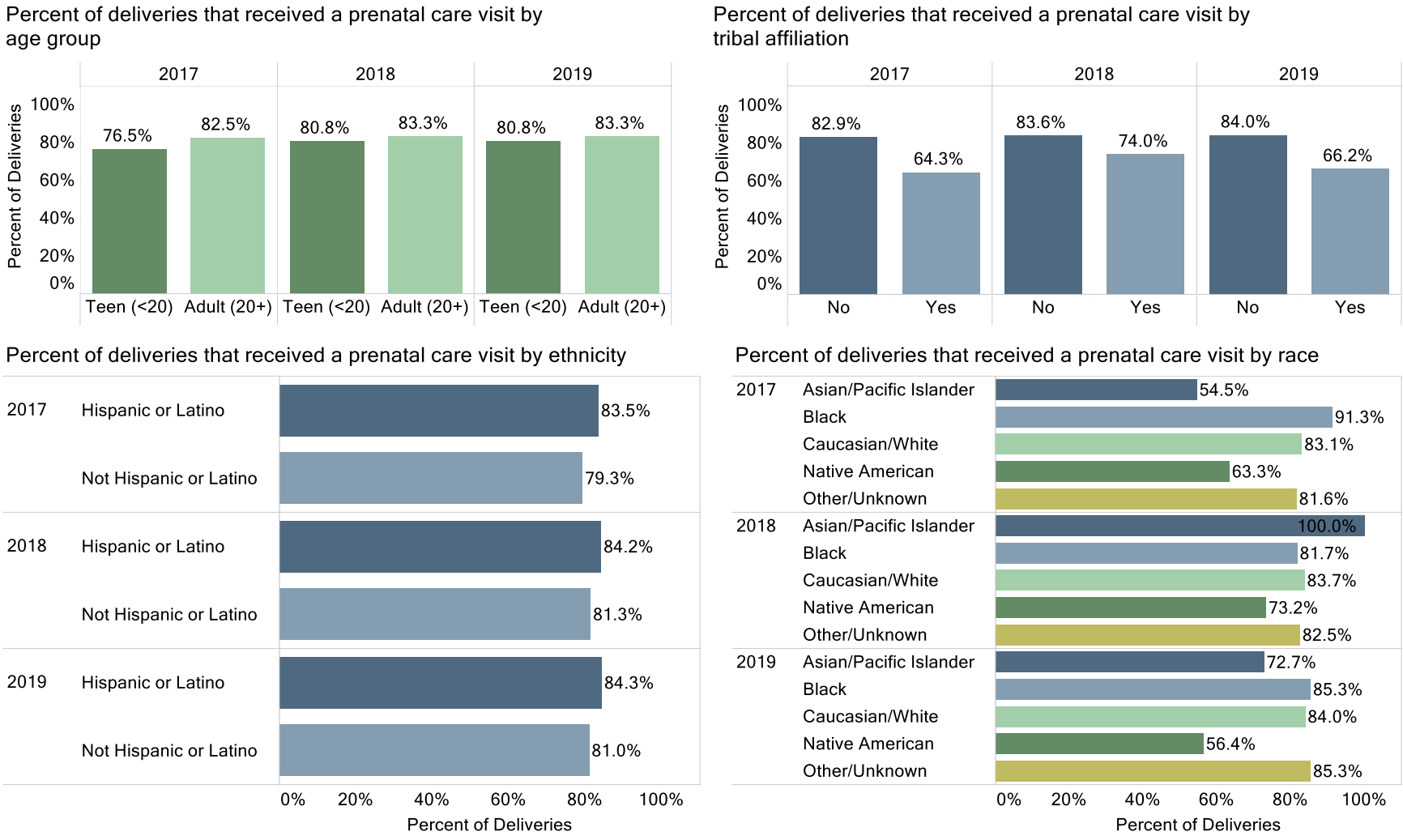
Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

Table 43. Percent of Deliveries That Received a Prenatal Care Visit While Enrolled in AHCCCS in the First Trimester, on the Enrollment Start Date or Within 42 Days of Enrollment in AHCCCS by Subregion, 2017-2019

Subregion	2017	2018	2019
Ajo	54%	79%	83%
Amado	77%	93%	86%
Drexel Heights	84%	83%	85%
Rita Ranch	87%	85%	91%
Sahuarita	93%	93%	85%
Sunnyside	79%	82%	82%
Three Points	88%	78%	73%
Vail	93%	84%	76%

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

Figure 24. Percent of Deliveries That Received a Prenatal Care Visit While Enrolled in AHCCCS in the First Trimester, on the Enrollment Start Date or Within 42 Days of Enrollment in AHCCCS by Age Group, Tribal Affiliation, Ethnicity, Race and Year



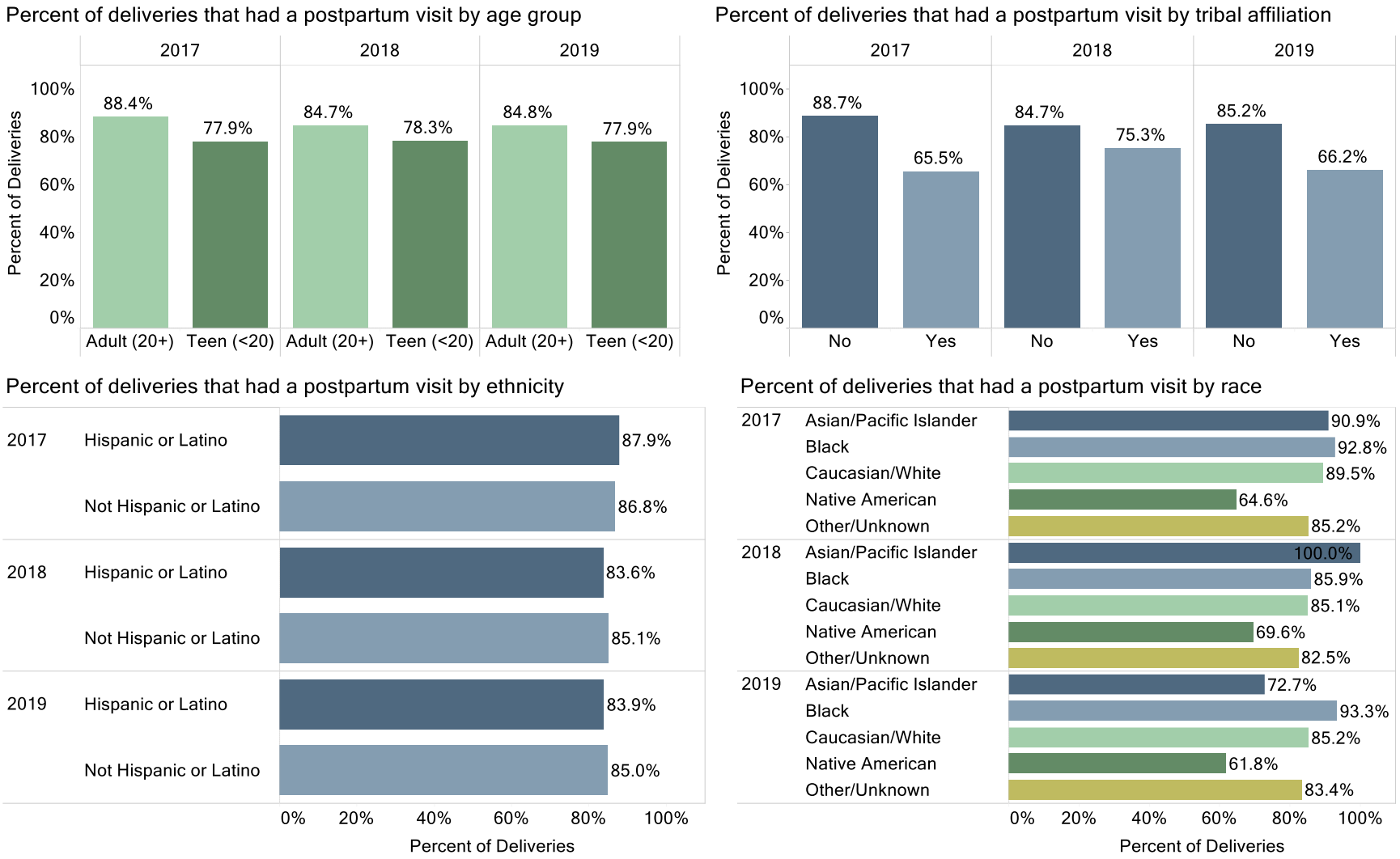
Source: AHCCCS Claims Data, 2021. CHiR is the source for all processing of the AHCCCS data.

Table 44. Percent of AHCCCS Deliveries That Had a Postpartum Visit After Delivery by Subregion, 2017-2019

Subregion	2017	2018	2019
Ajo	71%	79%	75%
Amado	85%	93%	86%
Drexel Heights	89%	83%	85%
Rita Ranch	94%	93%	95%
Sahuarita	97%	94%	94%
Sunnyside	85%	83%	81%
Three Points	91%	80%	77%
Vail	98%	93%	93%

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

Figure 25. Percent of AHCCCS Deliveries That Had a Postpartum Visit After Delivery by Age Group, Race, Ethnicity, Tribal Affiliation and Year



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

HEALTH PLAN PERFORMANCE

This section provided a selection of health indicators to compare results among the AHCCCS health plans. Table 46 provided a snapshot of service utilization for regional AHCCCS children enrolled in each AHCCCS health plan. All regional health plans met or exceeded the AHCCCS statewide aggregate performance and MPS for PCP visits for ages 1-5 in at least one year, ranging 87-97%. For at least one well-child visit in the first 15 months, all reporting regional health plans performed very well, ranging 97-100%. Six regional health plans met or exceeded the AHCCCS statewide aggregate performance and MPS for six or more well-child visits in the first 15 months: AZ Complete Care (2019), Banner University Family Care (2018 and 2019), Care 1st (2017 and 2018), Mercy Care Plan (2017 and 2018), Steward Health Choice AZ (2017 and 2018), and UnitedHealthcare (2017 and 2018). The following health plans met or exceeded the AHCCCS statewide aggregate performance and MPS for annual well-child visits for ages 3-5: AZ Complete Care (2019), Banner University Family Care (all years), Care 1st (all years), Comprehensive Medical and Dental Program (2018), Mercy Care Plan (2017 and 2018), Steward Health Choice AZ (all years) and UnitedHealthcare (all years). Care 1st (2019), Mercy Care Plan (2019), Steward Health Choice AZ (2019) and UnitedHealthcare (2019) exceeded the AHCCCS statewide aggregate performance for preventative care dental visits for ages 1-5.[23]

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

Table 45. AHCCCS Statewide Aggregate Health Plan Performance and Minimum Performance Standards, 2017-2019

Year/Indicator	Health Plan Type	One or More Annual PCP Visits, Ages 1-6 (MPS)	Six or More Well-Child Visits in First 15 Months (MPS)	One or More Annual Well-Child Visits, Ages 3-6 (MPS)	One or More Annual Preventative Care Dental Visits, Ages 2-20 (MPS)
2017	**Acute**	83% (84%)	60% (65%)	61% (66%)	61% (60%)
	CMDP	92% (84%)	75% (65%)	75% (66%)	74% (60%)
	CRS	93% (84%)	49% (65%)	66% (66%)	67% (60%)
	DES DD	89% (84%)	N/A (65%)	53% (66%)	57% (60%)
2018	**Acute**	84% (84%)	62% (65%)	61% (66%)	61% (60%)
	CMDP	93% (84%)	N/A (65%)	73% (66%)	75% (60%)
	CRS	92% (84%)	47% (65%)	64% (66%)	68% (60%)
	DES DD	87% (84%)	N/A (65%)	55% (66%)	57% (60%)
2019	**Acute**	84% (87%)	64% (62%)	63% (66%)	60% (60%)
	CMDP	92% (87%)	N/A (62%)	75% (72%)	75% (60%)
	CRS	N/A (87%)	N/A (62%)	N/A (66%)	N/A (60%)
	DES DD	89% (87%)	N/A (62%)	58% (66%)	53% (60%)

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

Notes: There was no MPS for DES/DDD for six or more well-child visits in the first 15 months. Cells for which data was not available are indicated by "N/A". AHCCCS did not measure health plan performance for the indicator of at least one PCP visit by 15 months of age.

Table 46. Select Regional Indicators by AHCCCS Health Plan, 2017-2019

Health Plan	Year	One or More PCP Visits, Ages 1-5	Well-Child Visits in First 15 Months		One or More Well-Child Visits, Ages 3-5	One or More Preventative Care Dental Visits, Ages 1-5
			At Least One Visit*	Six or More Visits		
AZ Complete Health	2017	89%	DS	DS	DS	DS
	2018	DS	DS	DS	DS	DS
	2019	90%	99%	74%	71%	43%
Banner University Family Care	2017	89%	97%	55%	67%	51%
	2018	89%	100%	70%	67%	52%
	2019	90%	98%	71%	72%	55%
Care 1st	2017	91%	98%	68%	67%	58%
	2018	90%	98%	67%	69%	54%
	2019	90%	100%	DS	64%	63%
Children's Rehabilitative Services (CRS)	2017	97%	100%	39%	74%	65%
	2018	97%	100%	56%	72%	64%
DES Comprehensive Medical and Dental Program (CMDP)	2017	95%	97%	34%	73%	60%
	2018	95%	99%	56%	77%	62%
	2019	94%	100%	62%	68%	65%
DES Developmental Disability (DD) Long Term Care (LTC)	2017	90%	DS	DS	61%	51%
	2018	87%	DS	DS	55%	52%
	2019	81%	DS	DS	43%	36%
Mercy Care Plan	2017	91%	97%	66%	68%	56%
	2018	90%	98%	67%	69%	55%
	2019	81%	100%	DS	58%	63%
Steward Health Choice AZ	2017	91%	97%	66%	71%	54%
	2018	90%	98%	68%	70%	55%
	2019	82%	DS	DS	70%	64%
United Healthcare	2017	91%	98%	58%	71%	55%
	2018	91%	98%	66%	70%	58%
	2019	92%	98%	73%	73%	60%

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

Notes: The American Indian Health Program was excluded due to low enrollment numbers (6% of AHCCCS children in the region). Cells shaded green indicate the rate met or exceeded the AHCCCS statewide performance by health plan (Table 45); cells shaded blue indicate the health plan met or exceeded the AHCCCS statewide aggregate performance, cells shaded pink indicate the health plan met or exceeded the MPS, and cells shaded purple indicate the health plan met or exceeded both the MPS and statewide aggregate performance (see Table 47). AHCCCS did not measure health plan performance for the indicator of at least one PCP visit by 15 months of age.

Table 47. Select AHCCCS Statewide Indicators by Health Plan, 2017-2019

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

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

Notes: Cells that did not have available data for that year and/or the health plan was not contracted for that year are indicated by "N/A". Cells shaded blue indicate the rate met or exceeded the AHCCCS statewide aggregate health plan performance rate; cells shaded purple indicate the rate met or exceeded both the AHCCCS statewide aggregate health plan performance rate and the AHCCCS MPS (see Table 45). AHCCCS did not measure health plan performance for the indicator of at least one PCP visit by 15 months of age.

CONCLUSION

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

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 48. 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.