Arizona Health Care Cost Containment System (AHCCCS)
AHCCCS Complete Care (ACC), Children's Medical and Dental Program (CMDP), Division of Developmental Disabilities (DDD), and KidsCare
Performance Improvement Project:

Back to Basics

Creation Date: May 2019
Implementation Date: October 1, 2019

Background:
Well-care and annual dental visits for children and adolescents aim to promote optimal health and development. Ensuring that children and adolescents receive regular well-care and dental visits is critically important in disease prevention, early detection, and treatment. It is equally important in evaluating a child's developmental milestones, addressing parental concerns, and assessing a child or adolescent's psychological and social development.

There are many benefits of well-child/well-care visits. Well-child visits benefits include disease prevention, tracking growth and development, raising concerns, and establishing a team approach to assist with the development of optimal physical, mental, and social health of a child[1]. Adolescence is a critical stage of development during which physical, intellectual, emotional, and psychological changes occur[2]. Adolescence is generally considered a healthy stage of life; however, during this stage, individuals begin making lifestyle choices and develop behaviors that can impact their current and future health. Adolescent well-care visits assist with the promotion of healthy choices and behaviors, preventing risky behaviors, and the early detection of conditions that can inhibit an adolescent's development.

Maintaining good oral health is an essential component in the overall health of infants, children, and adolescents. Oral health addresses several disease prevention and health promotion topics including dental caries, tooth decay, and periodontal health. Tooth decay (or cavities) is one of the most common chronic conditions of childhood in the United States[3]. If untreated, tooth decay can lead to pain and infections that cause children and adolescents to experience problems with playing, learning, eating, and speaking. About 1 of 5 children aged 5 to 11 years have at least one untreated decayed tooth, and 1 of 7 adolescents aged 12 to 19 years have at least one untreated decayed tooth[3]
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Due to a decline in the rates between CYE 2015 and CYE 2016 for the Well-Child Visits in the First 15 Months of Life (W15); Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34); Adolescent Well-Care Visits (AWC); and Annual Dental Visits (ADV) performance measures, AHCCCS has identified these measures as areas of opportunity and improvement for the overall well-being of children and adolescents. Increasing the rates for these measures also impacts other measures and focus areas including, but not limited to, childhood and adolescent immunizations, dental sealants for children at elevated caries risk, and developmental screenings.

Purpose:
The purpose of this performance improvement project is to increase the number of child and adolescent well-child/well-care visits, as well as increase the number of children and adolescents receiving annual dental visits.

AHCCCS Goal:
The goal is to demonstrate a statistically significant increase in the number and percentage of child and adolescent well-child/well-care visits, as well as a statistically significant increase in the number and percentage of children and adolescents receiving an annual dental visit, followed by sustained improvement for one consecutive year.

Measurement Period:

Baseline Measurement	October 1, 2018 through September 30, 2019
Intervention Year	October 1, 2019 through September 30, 2020
First Re-measurement	October 1, 2020 through September 30, 2021
Second Re-measurement	October 1, 2021 through September 30, 2022

Study Question:
What is the number and percent, overall and by Contractor, of AHCCCS-enrolled children and adolescents receiving well-child visits and children and adolescents receiving at least one annual dental visit?

Eligible Population:
- Children and adolescents who are continuously enrolled with no more than one gap in enrollment of up to 45 days during the measurement period

Population Exclusions:
- Children and adolescents who do not meet the continuous enrollment criteria as described in the indicator's associated technical specifications
- Children and adolescents with more than one gap in enrollment during the measurement period
- Children and adolescents with a gap in enrollment of more than 45 days during the measurement period
- Children and adolescents enrolled in hospice or utilizing hospice services

Population Stratification:
The population will be stratified by Contractor.

Sample Frame:
All members that meet the eligibility criteria will be evaluated to determine the indicator rates.

Sample Selection:

Not applicable, as the included indicators shall be collected and measured via administrative data only.

Indicator Criteria:

Indicator 1: Well-Child Visits in the First 15 Months of Life (CMS Child Core - W15)

Indicator 1: Percentage of children who turned 15 months old during the measurement year and who had six or more well-child visits with a primary care practitioner (PCP) during their first 15 months of life. *(Not applicable for CMDP or DDD)*	**Numerator:** The total number of children receiving six or more well-child visits, on different dates of service, with a PCP during their first 15 months of life.
	Denominator: The total number of eligible children who turn 15 months during the measurement period.

Seven separate numerators will be calculated which correspond to the number of children who received 0, 1, 2, 3, 4, 5, or 6 or more well-child visits in the timeframe; however, performance will be measured by the percentage of children who had six or more well-child visits.

Indicator 2: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (CMS Child Core - W34)

Indicator 2: Percentage of children ages 3 years to 6 years who had one or more well-child visits with a primary care practitioner (PCP) during the measurement period.	**Numerator:** The total number of children receiving at least one well-child visit with a PCP during the measurement period.
	Denominator: The total number of eligible children who are ages 3 years to 6 years as of the end of the measurement period.

Indicator 3: Adolescent Well-Care Visits (CMS Child Core - AWC)

Indicator 3: Percentage of adolescents ages 12 to 21 who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetric/gynecologic (OB/GYN) practitioner during the measurement period.	**Numerator:** The total number of adolescents receiving one or more comprehensive well-care visits with a PCP or OB/GYN practitioner during the measurement period.
	Denominator: The total number of eligible adolescents who are ages 12 years to 21 years as of the end of the measurement period.

Indicator 4: Annual Dental Visits (NCQA HEDIS® - ADV)

Indicator 4: Percentage of children and	**Numerator:** The total number of children and

adolescents ages 2 years to 21 years who received at least one dental visit during the measurement period.	adolescents receiving at least one dental visit during the measurement period.
	Denominator: The total number of eligible children and adolescents who are ages 2 years to 20 years as of the end of the measurement period.

Data Sources:
AHCCCS administrative data will be used to identify indicator data.

Data Collection:
This study will be conducted via administrative review for Indicators 1-3 in alignment with the Centers for Medicare and Medicaid Services (CMS) technical specifications developed for the *Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)*.

The study will be conducted via administrative review for Indicator 4 in alignment with NCQA HEDIS® technical specifications.

Confidentiality Plan:
AHCCCS and its Contractors maintain compliance with the Health Insurance Portability and Accountability Act (HIPAA) requirements. Only AHCCCS employees who analyze data for this project will have access to study data. Requested data are used only for the purpose of performing health care operations, oversight of the health care system, or research. Member names are never identified or used in reporting.

Quality Assurance Measures:
Data files will be thoroughly reviewed prior to detailed validation to ensure that all study perimeters are accurate and complete. Once rates have been established, AHCCCS will track and trend data to ensure consistency with internal data and similar aligned initiatives. Additionally, external reports will be evaluated to determine rate alignment for comparative purposes.

Data Validation:
The Data Validation Studies for the Well-Child Visits in the First 15 Months of Life (W15); Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34); Adolescent Well-Care Visits (AWC); and Annual Dental Visits (ADV) indicators examine professional encounters and facility encounters. These studies compare paid and denied encounters sent to AHCCCS by the Contractors. The studies produce an overall accuracy rate based on receipt, accuracy, and timeliness.

Analysis Plan:
The data will be analyzed in the following ways:

- The numerator will be divided by the denominator to determine the indicator rate.
- Results will be analyzed as a statewide aggregate and by individual Contractor.
- Results will be analyzed by urban and rural county groups.

- Results may be analyzed by member race/ethnicity; i.e. Caucasian, African American, Hispanic, Asian/Pacific Islander, Native American/American Eskimo, and Other/Unknown, as well as any other stratifications deemed appropriate.

Comparative Analysis:
For the purpose of comparative analyses, the following will be considered when applicable and meaningful to future improvement:

- Results will be compared with prior years to identify changes and trends.
- Rural and urban area results will be compared to identify any significant disparities in geographic area types.
- Individual Contractor results will be compared with each other, the statewide aggregate, and the AHCCCS goal [Minimum Performance Standard (MPS)].
- Results may be compared by other stratifications, as deemed appropriate (i.e. age, race/ethnicity, gender, subpopulation).
- Results will be compared to the results of any other comparable studies, if available.
- In the future, differences between overall baseline study results and overall re-measurement results will be analyzed for statistical significance and relative change.

Limitations:
None noted at this time.

Works Cited

1. AAP Schedule of Well-Child Care Visits. (2017, June 27). Retrieved from https://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx
2. Adolescence: Preparing for Lifelong Health and Wellness. (2018). Retrieved from https://www.cdc.gov/grand-rounds/pp/2015/20150818-adolescent-wellness.html
3. Children's Oral Health | Division of Oral Health | CDC. (2018). Retrieved from https://www.cdc.gov/oralhealth/children_adults/child.htm

For general questions regarding this methodology, please contact Jakenna Lebsock, AHCCCS Clinical Administrator, at Jakenna.Lebsock@azahcccs.gov. For technical questions regarding this methodology, please contact Jamie Robin, AHCCCS Quality Improvement Manager, at jamie.robin@azahcccs.gov.