ArizonaLEND

COMMUNITY NEEDS ASSESSMENT REPORT

2026

EXECUTIVE SUMMARY

The Arizona Leadership Education in Neurodevelopmental and Related Disabilities (ArizonaLEND) program conducted a **statewide community needs assessment** to better understand the experiences of families of children with neurodevelopmental and related disabilities and the perspectives of service providers across Arizona. The purpose of this assessment was to identify **gaps in access to care**, **workforce capacity**, and **training needs** to inform program planning and workforce development initiatives.

Findings reveal pronounced geographic concentration of both families and providers in the Tucson and Phoenix metropolitan areas, with comparatively limited representation in rural, frontier, and tribal regions. These patterns reflect broader statewide workforce maldistribution and medically underserved area designations, suggesting that **structural access inequities persist across Arizona's neurodevelopmental care system**. Rapid population growth in counties such as Pinal may further strain diagnostic and specialty care capacity if workforce expansion does not keep pace.

The assessment also highlights the **complexity of care** required by many families, with **high rates of co-occurring diagnoses and multi-domain service utilization** across medical, developmental, behavioral, and educational systems. While families generally reported positive perceptions of provider knowledge and family-centered care, variability in early screening practices and transition-to-adult-care support suggests **opportunities to strengthen continuity across the lifespan**.

Together, these findings underscore the need for **coordinated strategies** that address geographic workforce disparities, strengthen early identification pathways, improve interdisciplinary care coordination, and support structured transition planning. ArizonaLEND is positioned to leverage these insights to advance targeted workforce development efforts that promote more equitable and integrated systems of care statewide.

BACKGROUND AND PURPOSE

ArizonaLEND is an interdisciplinary leadership training program focused on **improving systems of care for children with neurodevelopmental and related disabilities and their families**. The program emphasizes family-centered care, interdisciplinary collaboration, and workforce development across clinical, community, and policy settings.

A community needs assessment is a core component of ArizonaLEND's mission, as it enables the integration of both family and provider perspectives when identifying priorities for training and systems improvement. Children with disabilities and special health care needs frequently encounter barriers related to access, geographic location, and the availability of trained providers, with these challenges often amplified in rural, frontier, and tribal communities.

The objectives of this needs assessment were to:

- Describe parent and guardian experiences accessing diagnostic and therapeutic services
- Characterize provider workforce capacity and training needs
- Identify geographic patterns in service availability and access
- Inform ArizonaLEND program planning and future workforce development initiatives.

METHODS + DATA COLLECTION

SURVEY DESIGN

A **cross-sectional needs assessment survey** was developed and administered using Qualtrics. The survey employed a convenience sampling strategy through established professional and family networks and was not designed to generate a representative statewide sample. Separate survey logic was used for parent/guardian respondents and service provider/professional respondents to allow for parallel, role-specific questions addressing access to care, service utilization, workforce capacity, and training needs. The survey was available in both English and Spanish.

PARTICIPANTS

Parent/guardian respondents were individuals caring for one or more children with disabilities or special health care needs. **Service provider/professional respondents** included clinicians and other professionals such as psychologists, board certified behavior analysts, audiologists, etc., all of whom are involved in the diagnosis, treatment, education, or support of children with neurodevelopmental and related disabilities. Although the survey was available in Spanish, all respondents completed the English-language version.

DATA COLLECTION

The survey was disseminated between **May and August 2025** to a total of **260 agencies, disability organizations, ArizonaLEND alumni, service providers affiliated with local and rural health centers, and members of parent/guardian support networks across Arizona**. Participation was voluntary and anonymous. Respondents self-reported demographic characteristics, geographic location, and experiences related to service access and utilization, workforce training, and care delivery practices.

METHODS + DATA COLLECTION

ANALYTIC APPROACH

Survey responses were analyzed descriptively. Frequencies and distributions were examined separately for parent/guardian and service provider respondents, and responses were compared across groups for questions with overlapping content. ZIP codes were grouped into approximate service areas (i.e., Phoenix metropolitan area, Tucson region, and northern/rural regions) and by county to assess geographic patterns of family need and provider workforce distribution.

LIMITATIONS

This assessment has several limitations. Data were self-reported and may be subject to recall bias, response bias, or differences in interpretation of survey items. Geographic representation was uneven, with a greater concentration of responses from Pima and Maricopa Counties and fewer responses from rural, frontier, and tribal regions. Although the survey was intentionally distributed broadly, including outreach to ArizonaLEND alumni, local and regional health systems, rural health centers, and family support networks, response rates from certain geographic areas and practice settings were limited. The lower response representation from some regions likely reflects challenges in survey reach and engagement rather than the absence of need.

In addition, participation was voluntary and based on convenience sampling, which may limit the representativeness of the findings. Analyses were descriptive and non-inferential; therefore, results should be interpreted as indicative of patterns within the responding sample rather than definitive estimates of statewide prevalence, workforce capacity, or service access. While the findings provide valuable insight into family and provider experiences, they may not fully capture the perspectives of all communities served by ArizonaLEND.

RESULTS

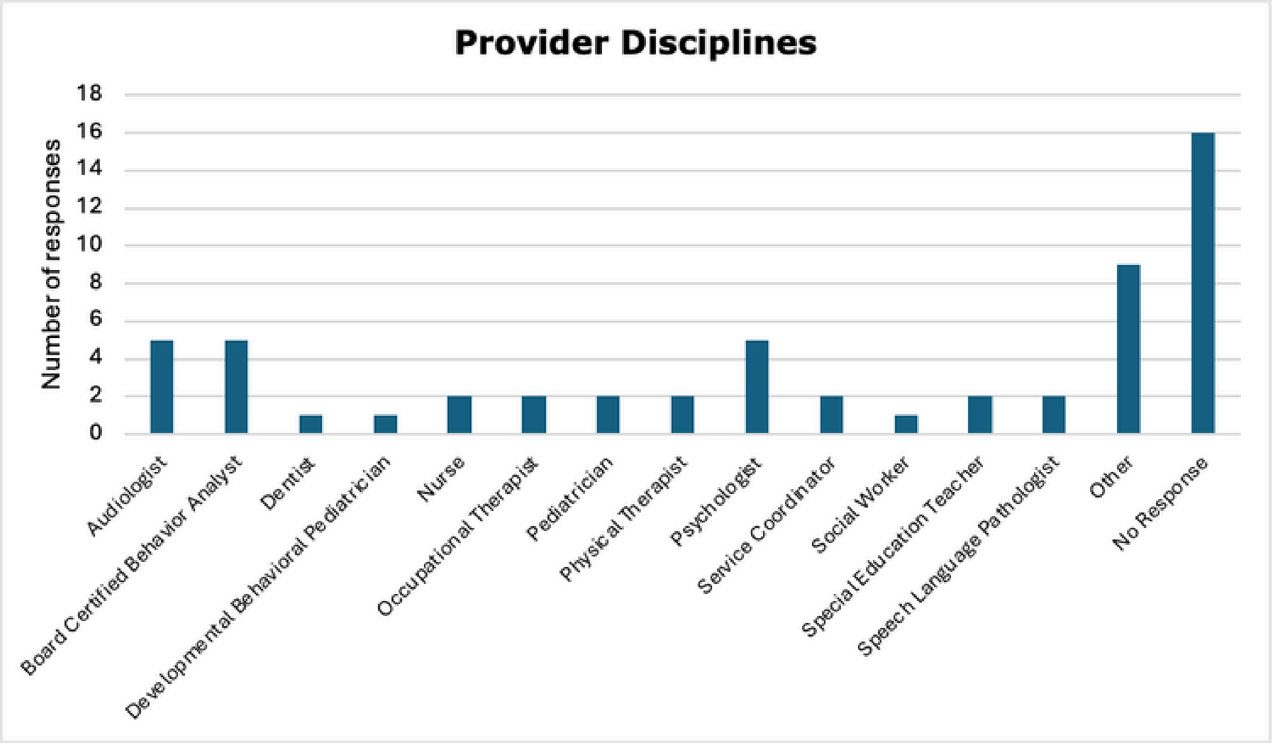
RESPONDENT CHARACTERISTICS

Among the 94 parent/guardian respondents who answered this item, the majority reported caring for one child with a disability or special health care need (n = 66, 70.2%). Sixteen respondents (17.0%) reported caring for two children, and eight respondents (8.5%) reported caring for three children with disabilities. A small number of respondents reported caring for four children (n = 1, 1.1%) or five or more children (n = 3, 3.2%) with disabilities or special health care needs.

Overall, while most respondents reported caring for a single child with special health care needs, approximately 30% of responding families reported caring for two or more children with disabilities, indicating a substantial caregiving burden among a subset of families represented in this assessment.

Service provider respondents represented a wide range of professional disciplines, practice settings, and geographic service areas. Disciplines included psychologists, board-certified behavior analysts, audiologists, physical and occupational therapists, social work, and other health and education professionals (Figure 1). Among the 42 provider respondents, 24 reported to provide diagnostic services for children with neurodevelopmental and related disabilities.

Figure 1. Professional Disciplines Represented Among Service Provider Respondents



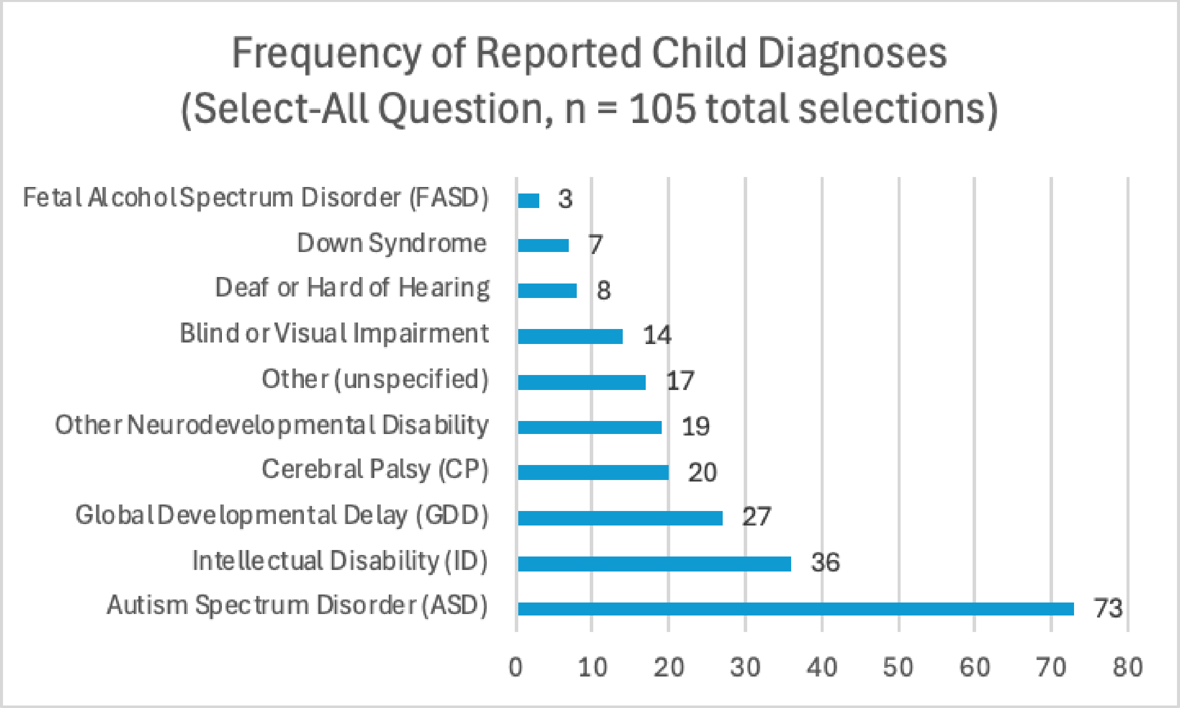
RESULTS

CHILD DIAGNOSES

Across 105 total diagnosis selections, parent/guardian respondents reported a broad range of neurodevelopmental and related conditions (Figure 2), with many indicating multiple co-occurring diagnoses. Autism spectrum disorder was the most frequently reported condition (n = 73, 69.5%), followed by intellectual disability (n = 36, 34.3%), global developmental delay (n = 27, 25.7%), and cerebral palsy (n = 20, 19.0%). Other neurodevelopmental disabilities (n = 17, 16.2%) were also commonly reported. Sensory impairments, including blind or visual impairment (n = 14) and deaf or hard of hearing (n = 8), were present among a subset of children, and additional diagnoses included Down syndrome and fetal alcohol spectrum disorder.

A substantial proportion of respondents selected more than one diagnosis, reflecting the high prevalence of co-occurring developmental, cognitive, and sensory conditions within the population represented. This diversity and overlap indicate that many children require ongoing, multidisciplinary support across medical, developmental, behavioral, and educational systems, underscoring the complexity of care coordination and service delivery needs identified in this assessment.

Figure 2. Frequency of Reported Child Diagnoses
(Select-All Question, n = 105 total selections)



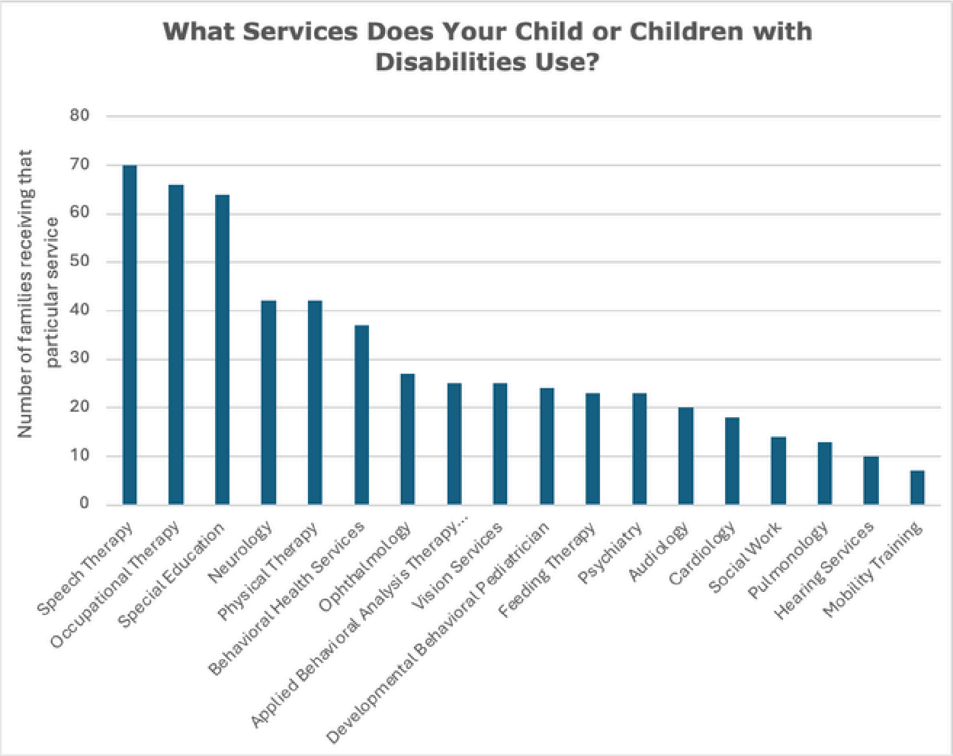
SERVICE UTILIZATION

PARENT/GUARDIAN PERSPECTIVE

Parents reported utilization of a wide array of services to support their children's developmental, medical, behavioral, and educational needs, most often concurrently. The most commonly utilized services included speech therapy, occupational therapy, special education services, physical therapy, neurology, and behavioral health services. Many families also reported accessing developmental-behavioral pediatrics, applied behavioral analysis (ABA) therapy, psychiatry, and feeding therapy, highlighting the complexity of care needs. Sensory and communication-related services, such as audiology, hearing services, vision services, and ophthalmology, were also frequently reported.

In addition, families described use of medical specialty care (including cardiology and pulmonology), as well as social work and mobility training services. Service utilization varied across families, with an average of five services per family (range: 1–18). The diversity of services utilized underscores the intensity of support required by many children and points to substantial care coordination demands placed on families. These patterns are consistent with national findings from the National Survey of Children's Health, which identify children and youth with special health care needs as having elevated use of medical, mental health, educational, and specialized therapeutic services such as speech, occupational, and physical therapy (Minnaert et al., 2025).

Figure 3. Services Utilized by Children with Disabilities Reported by Parent/Guardian Respondents



GEOGRAPHIC DISTRIBUTION OF NEED AND SERVICES

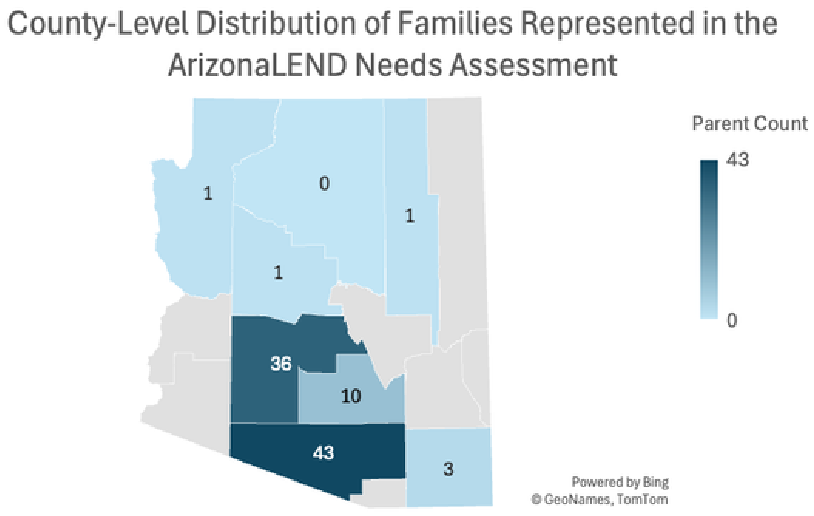
To better understand structural access patterns, geographic distribution of both parent (Table 1) and provider (Table 2) respondents was examined at the county level.

Among the 95 parent/guardian respondents who provided a ZIP code, the largest proportion resided in Pima County (n = 43, 45.3%), followed by Maricopa County (n = 36, 37.9%). Pinal County accounted for 10 respondents (10.5%). Smaller numbers of respondents were located in Cochise County (n = 3, 3.2%), Yavapai County (n = 1, 1.1%), Mohave County (n = 1, 1.1%), and Navajo County (n = 1, 1.1%).

Pima County responses were concentrated in Tucson-area ZIP codes (i.e., 85701, 85705, 85706, 85712, 85716, 85745, 85750, 85755) and surrounding communities including Vail (85641), Marana (85653), and Sahuarita (85629). Maricopa County respondents were distributed across central Phoenix, East Valley, and West Valley ZIP codes (i.e., 85023, 85044, 85205, 85297, 85374). Pinal County responses included rapidly growing communities such as 85140, 85142, and 85143.

Overall, parent respondents were heavily concentrated in Pima and Maricopa Counties (83.2% combined), with comparatively limited representation from rural and northern counties (Figure 4A).

Figure 4A. Parent/Guardian Respondents by County



GEOGRAPHIC DISTRIBUTION OF NEED AND SERVICES

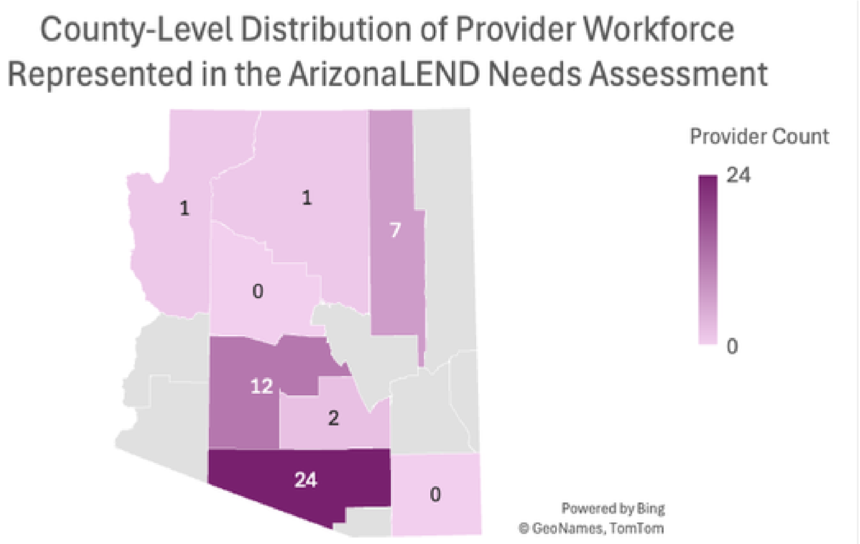
Among the 59 provider respondents who reported a practice ZIP code (Figure 4B), the majority practiced in Pima County (n = 24, 40.7%) and Maricopa County (n = 12, 20.3%). Additional providers practiced in Navajo County (n = 7, 11.9%), Cochise County (n = 3, 5.1%) Pinal County (n = 2, 3.4%), Coconino County (n = 1, 1.7%), and Mohave County (n = 1, 1.7%). Nine respondents (15.3%) reported practicing out of state or indicated they were not currently practicing.

Pima County provider ZIP codes were concentrated in Tucson and surrounding areas (i.e., 85701, 85712, 85716, 85719, 85721, 85755). Maricopa County providers practiced across central Phoenix and surrounding communities (i.e., 85013, 85016, 85250, 85281, 85374). Providers in Navajo County reported serving multiple northern Arizona ZIP codes (i.e., 85901–85941, 86025), reflecting regional service coverage.

Several provider respondents reported practicing in or serving multiple ZIP codes. In these cases, providers were counted once per reported practice location for geographic distribution purposes, reflecting the multi-county service areas commonly observed in rural and specialty practice settings.

This distribution suggests that while workforce density is greatest in urban centers, families residing in Pinal County and more rural or northern regions may face increased travel burden and reduced access to diagnostic and specialty services.

Figure 4B. Provider Respondents by County



ACCESS TO DIAGNOSTIC AND THERAPEUTIC SERVICES

PARENT/GUARDIAN PERSPECTIVE

Parents were asked to evaluate provider knowledge, family-centered care, and support for transition to adult healthcare across four related survey items.

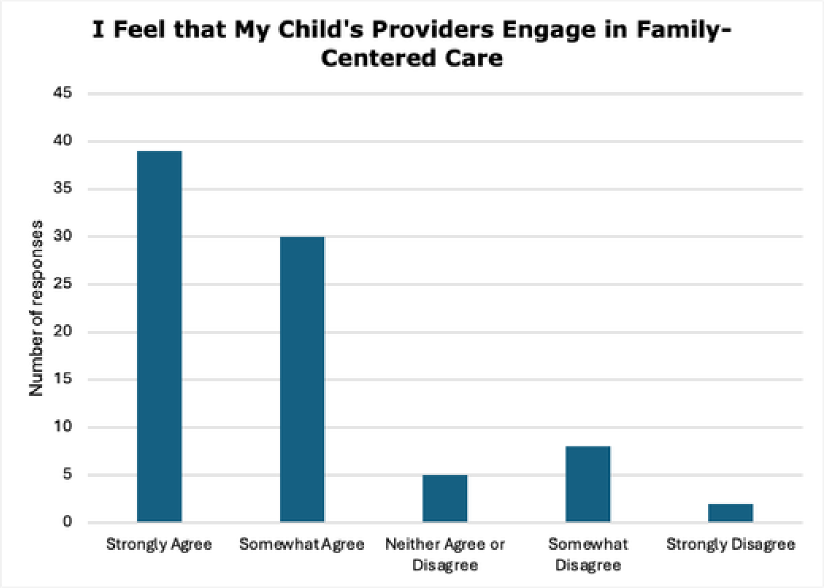
PROVIDER KNOWLEDGE AND CLINICAL SKILLS

Among 105 parent/guardian respondents, perceptions of provider knowledge and skill were largely positive. Sixty-eight respondents (64.8%) either strongly agreed (n = 34) or somewhat agreed (n = 34) that their child's provider is knowledgeable about their child's diagnosis and skilled in their treatment approach. Eight respondents (7.6%) neither agreed nor disagreed, while a small proportion expressed dissatisfaction (somewhat disagree n = 3; strongly disagree n = 4). Although the majority of responses were favorable, approximately one-quarter of respondents did not indicate strong agreement, suggesting some variability in perceived provider expertise.

FAMILY-CENTERED CARE

Similarly, responses regarding family-centered care were predominantly positive. Sixty-nine respondents (65.7%) strongly agreed (n = 39) or somewhat agreed (n = 30) that their child's providers deliver care that is family-centered. Five respondents (4.8%) neither agreed nor disagreed, and ten respondents (9.5%) expressed some level of disagreement (somewhat disagree n = 8; strongly disagree n = 2). While most families perceived care as family-centered, a meaningful subset did not report strong agreement, indicating potential opportunities to strengthen shared decision-making and family engagement practices.

Figure 5. Parent/Guardian Perceptions of Family-Centered Care Provided by Their Child's Providers



ACCESS TO DIAGNOSTIC AND THERAPEUTIC SERVICES

PARENT/GUARDIAN PERSPECTIVE

TRANSITIONAL SUPPORT

In contrast, responses related to transition to adult healthcare demonstrated greater variability. Fifty-six responses appeared to be non-applicable or left unanswered, likely reflecting families whose children were not between the ages of 14 and 21. Among applicable responses, only 21 respondents (20.0%) expressed agreement that their child's providers are able to support transition (strongly agree n = 4; somewhat agree n = 17). Twelve respondents (11.4%) neither agreed nor disagreed, while fifteen respondents (14.3%) expressed dissatisfaction (somewhat disagree n = 10; strongly disagree n = 5).

Taken together, responses indicate that **parents generally perceive providers as knowledgeable and skilled and largely view care as family-centered**. However, **perceptions of transition-related support were notably less positive** and more variable. Compared to items assessing clinical competency and family engagement, **transition planning and support showed lower levels of agreement and higher proportions of neutral or dissatisfied responses.**

Figure 6. Parent/Guardian Perceptions of Provider Ability to Support Healthcare Transition

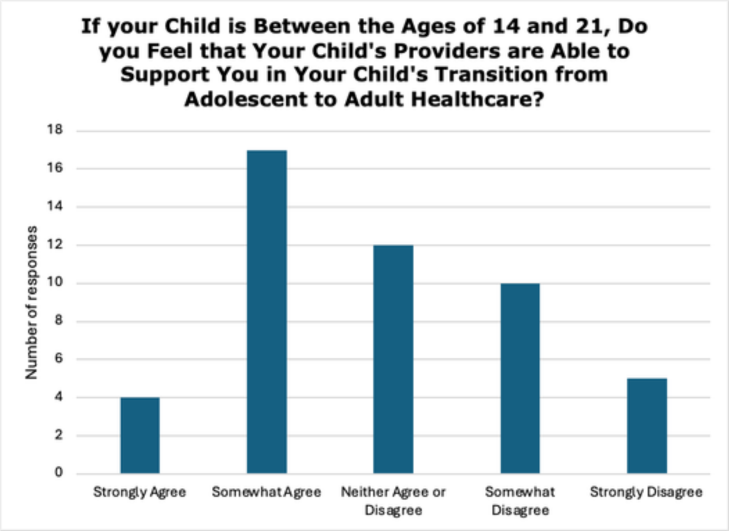
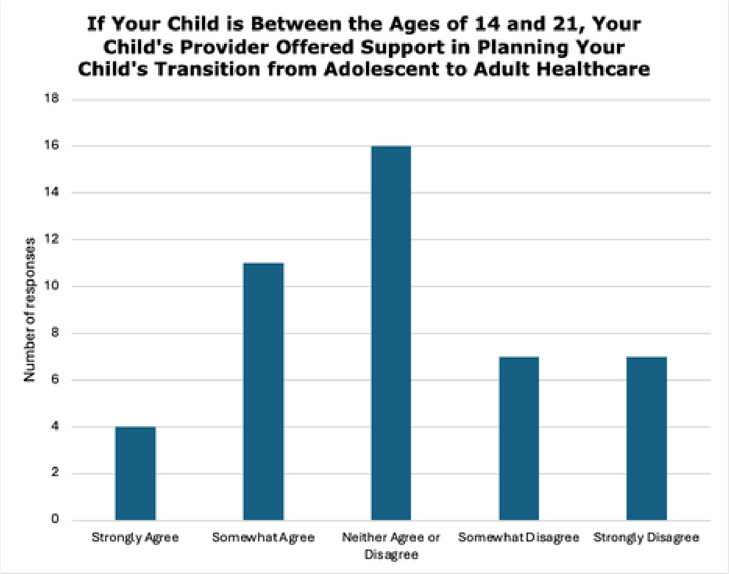


Figure 7. Parent/Guardian Reports of Provider Support for Transition Planning



This pattern suggests that while core pediatric care practices are generally perceived as strong, **transition planning for adolescents and young adults with neurodevelopmental and related disabilities remains an area where families report more variability and unmet need.**

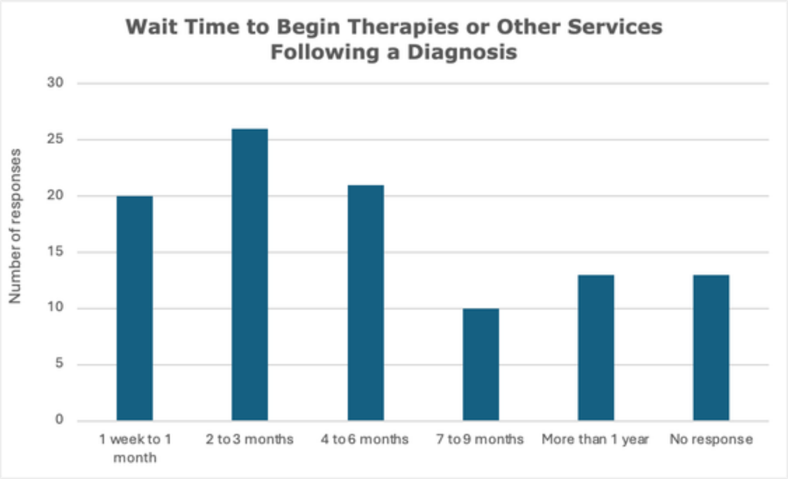
ACCESS TO DIAGNOSTIC AND THERAPEUTIC SERVICES

PROVIDER WORKFORCE CAPACITY AND ACCESS

PARENT/GUARDIAN PERSPECTIVE

Parents reported a wide range of wait times for initiating therapies or services following a diagnosis. The most commonly reported wait times were two to three months and four to six months, though some families reported waiting seven months or longer and a smaller number reported waiting more than one year. These findings suggest that delays in accessing recommended therapies remain a significant challenge for many families.

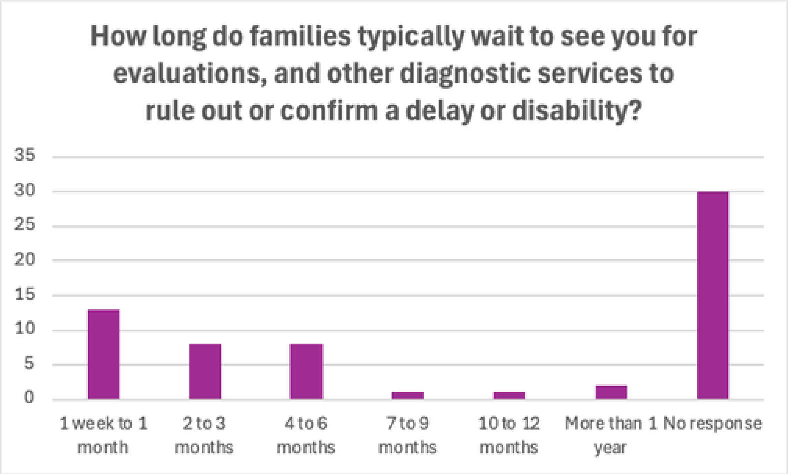
Figure 8. Parent/Guardian Reported Wait Time to Initiate Therapies Following Diagnosis



SERVICE PROVIDER PERSPECTIVE

Among 42 service providers who answered this question, 24 respondents (57.1%) reported providing diagnostic services for children with neurodevelopmental and related disabilities. Providers commonly reported maintaining waitlists, with most indicating typical diagnostic wait times of one week to three months and some reporting waits of four to six months or longer.

Figure 9. Provider-Reported Wait Times for Diagnostic Evaluations



These estimates were shorter than those reported by parents. This difference may reflect how timelines are experienced and measured; providers often report time from scheduling to evaluation, while families experience the entire process from initial concern through referral, insurance authorization, waitlist placement, and diagnostic evaluation.

WORKFORCE TRAINING AND DEVELOPMENT NEEDS

Providers reported **variable levels of training in behavioral health integration, complex care, and support for children with multiple or co-occurring diagnoses.** While some providers indicated substantial training and experience, others reported limited exposure in these areas. This variability is important because **children with neurodevelopmental and related disabilities frequently require coordinated services across medical, behavioral health, educational, and therapeutic systems**. National data from the National Survey of Children's Health indicate that children with special health care needs often require elevated levels of medical care, mental health services, educational supports, and specialized therapies such as speech, occupational, and physical therapy, highlighting the complexity of care required for this population.

Survey findings also suggest variability in the use of standardized developmental screening tools. Of the 29 service provider respondents who answered the screening item, **only five reported utilizing the Modified Checklist for Autism in Toddlers Revised with Follow-Up (M-CHAT-R/F)** in their practice. Additionally, six of the 36 service provider respondents reported utilizing the Parents' Evaluation of Developmental Status (PEDS) screening tool, and **sixteen of the 29 respondents indicated that they had not received training on the PEDS screening tool.**

These findings are notable given that the **American Academy of Pediatrics recommends routine developmental surveillance at every well-child visit and standardized developmental screening at specific intervals during early childhood**, including autism-specific screening at 18 and 24 months (Lipkin et. al., 2020). Limited familiarity with validated screening tools may contribute to delays in identification, referral, and access to early intervention services.

Many providers expressed interest in additional training related to autism spectrum disorder, intellectual and developmental disabilities, fetal alcohol spectrum disorder, complex care, and care coordination. Respondents also indicated interest in multiple training modalities, including in-person sessions, virtual trainings, and asynchronous online modules, suggesting opportunities for workforce development programs to expand accessible and flexible training opportunities.

DISCUSSION

This assessment highlights structural inequities in access to neurodevelopmental services across Arizona. The concentration of both families and providers in Pima and Maricopa Counties mirrors the distribution of major health systems and aligns with statewide medically underserved area designations identifying **persistent workforce shortages in rural and tribal regions** (Arizona Department of Health Services [ADHS], 2024). The limited representation from northern and frontier communities likely reflects barriers to care rather than absence of need. Statewide workforce analyses indicate that many **rural counties have lower provider-to-population ratios and greater travel distances to specialty care**, contributing to medically underserved designations across large portions of the state (ADHS, 2024). National research similarly demonstrates that children with special health care needs living in rural communities experience greater difficulty accessing specialty services and often travel longer distances to obtain diagnostic and therapeutic care (Skinner & Slifkin, 2007). For families outside urban centers, **diagnostic delays and service fragmentation** therefore reflect broader **structural workforce and infrastructure gaps** rather than isolated clinical barriers, particularly for children with complex developmental needs who require coordinated services across multiple health, behavioral, and educational systems.

The clustering of prolonged diagnostic timelines among families of children with autism spectrum disorder is particularly significant. **National research consistently demonstrates delays between early developmental concerns and confirmed autism diagnosis, with median diagnosis often occurring at four to five years of age** despite reliable identification being possible by age two (Shaw et al., 2020; van 't Hof et al., 2021). The American Academy of Pediatrics recommends universal developmental surveillance and autism-specific screening at 18 and 24 months (Lipkin et al., 2020), yet provider-reported screening utilization in this assessment suggests variability in implementation. Diagnostic delays therefore represent not only workforce shortages, but also gaps in screening practices, referral efficiency, and coordination following initial concern. Because early access to intervention is associated with improved cognitive, language, adaptive, and social-communication outcomes (Lipkin et al., 2020), reducing time to diagnosis has direct implications for long-term developmental trajectories.

DISCUSSION CONT.

The **high frequency of co-occurring diagnoses and extensive multi-domain service utilization** further underscores the **complexity of care r**equired by this population. Families are often navigating developmental, behavioral, specialty medical, and educational systems simultaneously. Without coordinated infrastructure, this **complexity increases the risk of fragmentation and caregiver burden.** These patterns align with priorities outlined in the **Arizona Division of Developmental Disabilities (DDD) Strategic Plan**, which emphasizes **strengthening provider network capacity, improving care coordination, and addressing workforce sustainability challenges statewide** (Arizona Department of Economic Security [ADES], 2025). Workforce development efforts must therefore move beyond specialty training alone and **incorporate interdisciplinary collaboration, behavioral health integration, and system navigation competencies.**

Although parents largely perceived providers as knowledgeable and family-centered, perceptions of transition-to-adult-care support were notably more variable. This distinction suggests that while core pediatric care practices may be strong, structured transition processes may not be systematically embedded across settings. **Transition planning requires early, proactive coordination across pediatric and adult systems.** Inconsistent implementation may contribute to care disruptions during a vulnerable developmental period, particularly for youth with complex, co-occurring conditions.

Overall, these findings suggest that improving access and outcomes for children with neurodevelopmental and related disabilities in Arizona will require coordinated strategies that address **geographic workforce distribution, strengthen early identification pathways, expand diagnostic capacity,** and **enhance cross-system integration.** ArizonaLEND is positioned to contribute to these efforts by advancing interdisciplinary training, leadership development, and partnerships that align clinical practice with statewide workforce priorities.

RECOMMENDATIONS

SHORT-TERM OPPORTUNITIES

1. Strengthen Early Identification and Screening Practices

2. Enhance Diagnostic Pathway Navigation and Care Coordination Training

3. Develop Family Navigation and Transition Support Resources

MEDIUM-TERM OPPORTUNITIES

4. Expand Diagnostic Capacity Through Interdisciplinary Training and Mentorship

5. Scale Telehealth Consultation and Rural Workforce Support Models

6. Improve Cross-System Coordination

LONG-TERM OPPORTUNITIES

7. Invest in Workforce Pipeline Development and Retention

8. Build Integrated Early Identification-to-Intervention Infrastructure

9. Establish Ongoing Data Monitoring and Evaluation Mechanisms

RECOMMENDATIONS

SHORT-TERM OPPORTUNITIES (1-2 YEARS)

1. Strengthen Early Identification and Screening Practices

Develop and expand targeted training modules for primary care and early childhood providers focused on autism spectrum disorder, intellectual and developmental disabilities, and use of validated screening tools (i.e., M-CHAT-R/F, PEDS). Given variability in screening tool utilization and training exposure identified in this assessment, increasing adherence to recommended developmental surveillance and screening practices may help reduce time from first concern to diagnosis.

2. Enhance Diagnostic Pathway Navigation and Care Coordination Training

Provide education for providers on streamlined referral pathways, insurance navigation, interdisciplinary coordination, and proactive responses to parental developmental concerns. Training should emphasize reducing bottlenecks between screening, referral, evaluation, and service initiation.

3. Develop Family Navigation and Transition Support Resources

Create or disseminate accessible tools to support families in navigating diagnostic and therapeutic systems, including visual referral maps, care coordination guides, and structured transition planning resources for adolescents. These tools may help mitigate fragmentation and reduce uncertainty during prolonged wait periods.

RECOMMENDATIONS

MEDIUM-TERM OPPORTUNITIES (3-5 YEARS)

4. Expand Diagnostic Capacity Through Interdisciplinary Training and Mentorship

Strengthen workforce capacity by supporting interdisciplinary diagnostic training models, including mentorship programs for providers in high-demand and underserved regions such as Pinal County and northern Arizona. Expanding the number of trained evaluators may reduce prolonged diagnostic timelines reported by families.

5. Scale Telehealth Consultation and Rural Workforce Support Models

Leverage telehealth consultation networks and remote specialist support to assist providers practicing in rural, frontier, and tribal communities. Telehealth-based diagnostic consultation, mentorship, and continuing education can help mitigate geographic workforce disparities identified in both this assessment and statewide medically underserved area designations (Arizona Department of Health Services, 2024).

6. Improve Cross-System Coordination

Facilitate collaboration between medical, behavioral health, early intervention, educational systems, and service providers to improve continuity of care. Aligning efforts across care systems may strengthen system efficiency and reduce fragmentation across service domains.

RECOMMENDATIONS

LONG-TERM OPPORTUNITIES

7. Invest in Workforce Pipeline Development and Retention

Support long-term recruitment and retention strategies for professionals trained in neurodevelopmental and related disabilities, with particular attention to geographic shortages identified in medically underserved areas. Strategies may include interdisciplinary leadership training, rural training tracks, loan repayment incentives, and partnerships with state workforce initiatives.

8. Build Integrated Early Identification-to-Intervention Infrastructure

Promote system-level integration that links developmental screening, diagnostic evaluation, early intervention services, and ongoing care coordination. Creating a more seamless pathway from initial concern to service delivery may reduce disparities in age at diagnosis and improve developmental outcomes.

9. Establish Ongoing Data Monitoring and Evaluation Mechanisms

Develop mechanisms for routine assessment of diagnostic timelines, screening implementation, transition planning practices, and family experience. Continuous evaluation will allow ArizonaLEND and partner organizations to track progress, identify emerging gaps, and align with evolving state-level strategic priorities.

CONCLUSION

This community needs assessment provides a comprehensive snapshot of the experiences of families and providers supporting children with neurodevelopmental and related disabilities across Arizona. The findings reveal patterns of diagnostic delay, service intensity, geographic workforce concentration, and variability in transition support that reflect both localized challenges and broader statewide structural inequities. In particular, the intersection of prolonged diagnostic timelines, inconsistent screening practices, rapid population growth in certain counties, and workforce shortages in medically underserved areas underscores the need for coordinated, systems-level responses.

By integrating family perspectives with provider insights and aligning findings with statewide workforce and strategic planning priorities, this assessment offers actionable direction for strengthening early identification, expanding diagnostic capacity, improving care coordination, and enhancing transition planning. ArizonaLEND has the opportunity to leverage these findings to advance interdisciplinary training, support workforce development in underserved regions, and promote more equitable, efficient, and family-centered systems of care across the state.

Sustained collaboration among healthcare providers, educational systems, behavioral health services, and state agencies will be essential to translating these findings into measurable improvements in access and outcomes for children and families. Continued evaluation and partnership-driven implementation will ensure that workforce development efforts remain responsive to evolving community needs.

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APPENDIX

Table 1. Parent/Guardian Respondents by County (Based on ZIP Code of Residence)

County	Representative ZIP Codes Included	Number of Parent Respondents (n)
Pima County	85701, 85705, 85706, 85708, 85710, 85712, 85714, 85716, 85730, 85745, 85750, 85755, 85641, 85653, 85629, 85747, 85749	43
Maricopa County	85023, 85027, 85028, 85032, 85041, 85044, 85048, 85050, 85051, 85053, 85203, 85205, 85206, 85286, 85297, 85304, 85306, 85361, 85374, 85379, 85383	36
Pinal County	85140, 85142, 85143, 85138, 85128	10
Cochise County	85615, 85630, 85643	3
Yavapai County	86301	1
Mohave County	86401	1
Navajo County	85929	1
Total Parent Respondents	—	95

APPENDIX

Table 2. Provider Respondents by County (Based on Practice ZIP Code)

County	Representative ZIP Codes Included	Number of Provider Respondents (n)
Pima County	85701, 85705, 85712, 85713, 85716, 85719, 85721, 85741, 85755, 85629	24
Maricopa County	85013, 85014, 85016, 85249, 85250, 85255, 85281, 85308, 85338, 85350, 85374, 85382	12
Pinal County	85147, 85623	2
Coconino County	86004	1
Navajo County	85901, 85928, 85929, 85935, 85937, 85941, 86025	7
Mohave County	86426	1
Pima/Frontier Multi-Region Reporting	85607, 85620, 85643	3
Out-of-State / Not Currently Practicing	90027, 92618, 92663, 12550, 02115, 09180, 80212, 28806, 53590	9
Total Provider Respondents	—	59

APPENDIX

Table 3. County-Level Difference Between Parent and Provider Representation

County	Parent Count	Provider Count	Gap
Pima	43	24	19
Maricopa	36	12	24
Pinal	10	2	8
Cochise	3	0	3
Yavapai	1	0	1
Mohave	1	1	0
Navajo	1	7	-6
Coconino	0	1	1

Figure 4C. Difference Between Parent and Provider Representation by County