

Assuring Better Child Health and Development II

Enhancing Utah's Capacity to Support Children's Healthy Mental Development

A Report on System Capacity in Utah
Completed for Utah's ABCD II Project

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Introduction

Over the past three decades, the science of child development, including an understanding of the impact of early experiences on later social, emotional and cognitive development, has grown dramatically. In turn, there has been increasing interest and concern about the quality of the infant's earliest experiences and how the experiences shape later development (Zeanah, Stafford, Nagle and Rice, 2005). Healthy social and emotional development of infants and toddlers provides the framework for the healthy development of young children and adolescents and can better insure school readiness and a decrease in involvement in the criminal justice system.

It is crucial then that the child care system including physicians, mental health professionals, Early Intervention and Head Start, step up to the plate to insure that children and families receive the most appropriate level of care possible. The first step in addressing the complex needs of the developing child, is to understand the meaning of the term "Infant Mental Health (IMH)." IMH was defined in 2001 by the Zero to Three Infant Mental Health Task Force Steering Committee as *"the developing capacity of the child from birth to three to: experience, regulate, and express emotions; form close interpersonal relationships; and explore the environment and learn—all in the context of family, community, and cultural expectations for young children. Infant mental health is synonymous with healthy social and emotional development."* (Zeanah, Stafford, Nagle, and Rice, 2005).

Researchers have found that more than one of ten children in the United States suffer from mental health problems that affect their lives (Jellineck, Murphy, Little et. al., 1999). In 1999, the Surgeon General called on pediatricians to improve screening and referral for children's mental illness (U. S. Department of Health and Human Services, 1999). This was followed by the President's New Freedom Commission on Mental Health and the American Academy of Pediatrics recommendation that pediatric providers screen patients for mental health issues as part of regular medical care (New Freedom Commission on Mental Health, 2003 and American Academy of Pediatrics, 2000). Unfortunately, mental health issues continue to go unrecognized and very few children receive any services. In fact, the capacity of the system to provide care is largely unknown.

ABCD II Project Overview-

In an effort to address the question of system capacity as it relates to providing care for children, the Utah Department of Health, Division of Health Care Financing, Bureau of Managed Health Care, identified system capacity as an area of focus for its ABCD II Project. The project, Enhancing Utah's Capacity to Support Children's Healthy Mental Development, seeks to increase the number of children enrolled in Medicaid who receive a screening for social/emotional delay during the well-child visit and to assess and increase the capacity of the system to provide care to children identified with a mental health issue. The project is funded by a grant from the Commonwealth Fund in conjunction with the National Academy for State Health Policy (NASHP).

As screening for healthy mental development in infants and toddlers increases, so will the identification of problems. Many concerns related to healthy mental development can and will be addressed in the primary care setting. There will be children who will need the services of a mental health professional and others who may be referred to Early Intervention or other community services. A comprehensive review of the infant and toddler mental health system involves providing a definition of the system and those authorized to provide the care.

Utah Mental Health System

Utah State Law Governing Mental Health Practice-

The Utah State Legislature determines specific guidelines and laws governing professionals authorized to provide mental health specific services. Utah Code 58-60-102 provides definitions included in the Utah Mental Health Professional Practice Act. Those authorized to practice under the Act are listed in 58-60-103. For a detailed explanation, please refer to Appendix A.

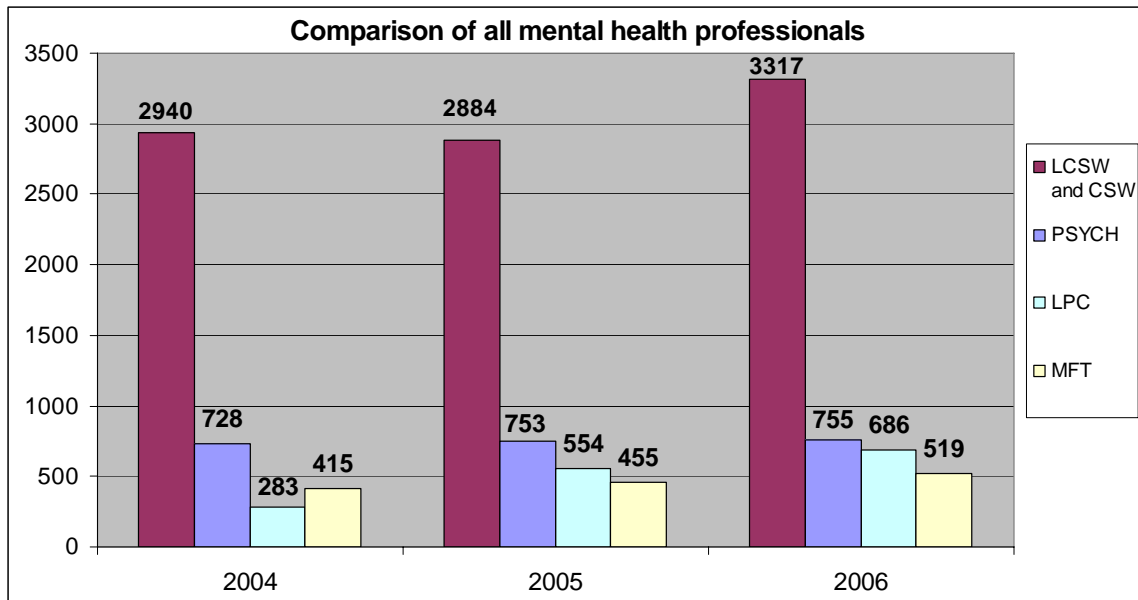
The State of Utah requires that all individuals providing mental health specific therapeutic services be properly trained and licensed. Individual, family, and group therapy require licensing at the Master's or higher degree level. Mental Health assessment can only be completed by a Master's or higher clinical level. Case management, education and support can be provided by an individual trained at the Bachelor's level but these individuals must also be licensed at the level of Social Service Worker. The licensing body is within the Utah Department of Commerce, Division of

Occupational and Professional Licensing (DOPL). Occupational licensing requires that all professional licenses be renewed every two years. Licensed professionals are listed for public review on the Department of Commerce website which is updated daily. The complete list of professionals and the total number licensed for the study period may be found in Table 1 in Appendix C.

The data shows that the number of licensed mental health professionals remained relatively stable increasing by only 20% over the three-year period. Individually, Marriage and Family Therapist (MFT), and Psychologists remained consistent. Licensed Clinical Social Workers (LCSW) and Certified Social Workers (CSW) dropped slightly between 2004 and 2005 but rose again in 2006 and the number of Licensed Professional Counselors (LPC) increased by 42% over the three years.

Chart 1 reflects the overall stability of the profession over the three years. It further points out the large numbers of social workers, as compared to other professions. It should be noted that many Psychologists, Social Workers and MFT’s are dually licensed. This is likely the primary reason there appears to be such an overwhelming number of social workers.

Chart 1: Comparison of all licensed mental health professionals



Mental Health System Capacity Survey

As part of the original ABCD II grant application, Utah proposed to complete a study and report outlining the capacity of the mental health system to provide care to infants, toddlers and mothers with maternal depression.

Study Methodology-

A preliminary inquiry into system capacity was made in March of 2004. Each Community Mental Health Center, Medical MCO, and Early Intervention site was contacted by telephone requesting numbers of professionals qualified to provide services to infants and toddlers from birth to age three. This information was used to determine an initial baseline which in turn led to a decision that additional information was needed in order to obtain a clearer picture of capacity numbers. This was accomplished by completing surveys of each mental health center, medical MCO and Early Intervention sites each year of the grant.

The survey tool was designed to review and determine the number of professionals qualified to provide services to infants and toddlers from birth to age three. Questions on the tool include numbers of professionals employed and contracted by the various organizations, developmental/social/emotional screening practices, resources used, and participation in specialized training programs. The professional disciplines reviewed included:

- Pediatrician
- Pediatric Psychiatrist
- Developmental Pediatrician
- Psychologist
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker (CSW)
- Licensed Professional Counselor (LPC)
- Marriage and Family Therapy (LMFT)
- Advanced Practice Registered Nurse (APRN)
- Other

The tool was mailed via email and postal to the mental health centers, medical practices participating in Medicaid and Early Intervention sites.

Data analysis was completed on each area of focus: mental health centers, Medical MCO and Early Intervention. Reporting of the analysis takes into consideration the uniqueness of each group. For example, the survey included Advanced Practice Registered Nurses (APRN) as part of the number of staff employed and contracted, as they are qualified to provide mental health care. However, after further review of the definition and APRN practice in Utah, it was determined to not include this discipline in

the final community mental health center and Early Intervention comparison as it is impossible to determine if they provide a mental health or general nursing role. The report on APRN's is included in the medical data and report section.

The same survey tool was used each year with the exception of the section on training. The rationale for changing the training section is explained in Part V: Training. Please refer to Appendix B for a review of the survey tool. Due to the large amount of information from the survey the data tables are located in Appendix C of the report. Graph charts will be used throughout the report to provide explanation of the data. It should be noted that aside from Early Intervention which only works with children birth to five, there is no mechanism to break down the number of staff limited to working with infants and toddlers. Therefore, this report lists the target group as children.

Utah Community Mental Health Centers

In accordance with the Social Security Act, Utah law restricts Medicaid enrollees living in specific counties to obtain mental health services from a community mental health center under contract with Utah Medicaid. There are nine community mental health centers contracted with Utah Medicaid to provide service under a capitated plan known as Prepaid Mental Health Plans (PMHPs). Two centers remain as fee-for-service centers. They provide services to Medicaid enrollees however due to low numbers have opted out of the pre-paid plan. The Utah Department of Health, Division of Health Care Financing, Bureau of Managed Health Care provides fiscal oversight of the community mental health centers.

Of the nine pre-paid plans, four are urban: Davis, Salt Lake, Wasatch and Weber. These four provide care to the area known locally as "The Wasatch Front." The majority, about 78%, of Utah's population resides along the Wasatch Front. The remainder of the population lives in rural or frontier areas of the state. Five pre-paid plans and two fee-for-service centers provide care in rural areas that stretch from Utah's northern border to the east, west and southern borders. The complete list of mental health centers and the counties they serve are located in Appendix C. Any solution to providing adequate infant and children's mental health services must take into account and recognize the realities of providing services in Utah's most sparsely populated areas.

Public Mental Health Center Survey Results-

The initial survey of the public mental health centers was completed in March 2004. Eleven surveys were sent via email and postal, ten centers responded. There were no refusals. This survey provided the baseline for comparison over the three years of the study.

A second survey was completed in March 2005. Eleven surveys were mailed, nine centers responded, there were no refusals. This survey was designed to provide information to be used to compare any changes in numbers since 2004.

The final system capacity survey was completed in October 2006. Eleven surveys were mailed and six centers responded, three from the urban area and three rural. This survey was designed to provide information to be used to compare changes over the three years of the ABCD II Project. Comparison will be made using the data received. Information specific to the rural centers is statistically questionable due to the low number of respondents. It is included in the report because it provides some insight into the capacity in the rural areas and the unique challenges faced by rural centers.

Center Staffing-

Review of the data indicates a reduction of 270 mental health professionals available to provide care over the three-year study period. This is approximately a 52% reduction in the total number of staff employed or contracted by the mental health centers over the three-year period.

Urban centers have lost 66% of their staff over the three-year period and rural centers have reduced staff by 49% during the same time frame. The most significant reduction came between 2004 and 2005 when urban centers reduced the number of contract staff by 59%.

The reduction in available clinicians is a cause for concern given the 20% increase in the number of newly licensed mental health professionals during that same time frame. This would suggest that the increase in licensed mental health professionals provides mental health centers with the ability to increase their staff yet this has not happened. The reason for the reduction in staff is not specifically known. The general belief is that financial restrictions are the primary reason.

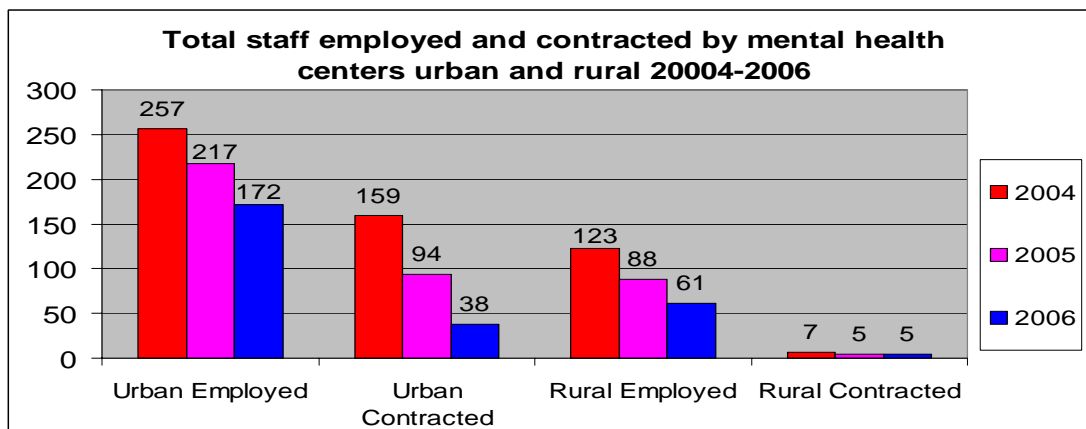
Urban centers have been more likely to use both full-time staff and contract

employees to provide mental health services. This is likely because there are a large number of private providers available along the urban corridor to provide contract services. Rural centers do not have the luxury of high numbers of private providers therefore they rely upon staff employed by the centers to provide mental health treatment. None of this is particularly concerning if taken at face value. The concern is raised when numbers are compared across years where the reductions appear and when compared with the number of children enrolled in Medicaid served by the community health centers.

The data tables located in Appendix C reflect the total number of staff employed and contracted by the mental health centers from 2004 through 2006. Table 3 reflects the number of staff employed and contracted by the mental health centers. Table 4 is a side by side comparison of the number of professionals combined. Tables 5-7 indicate the breakdown of professionals by urban and rural for each year. Table 8 is a side-by-side comparison of the total number of professionals combined urban vs. rural.

Chart 2 listed below, points out two compelling issues. The first is the significant decline in staff employed and contracted in the urban centers. As previously stated, this is concerning because of the high number of clients reporting to urban centers. Secondly, the chart points out the disparity between staffing levels in the urban vs. the rural centers. While the differences in population size may counter this difference, it is still a concern. Further discussion of this point is included in the section titled “Number of Children Served” that follows. The data show that Medicaid customers in the rural areas of the state are faced with a difficult task when attempting to access mental health services.

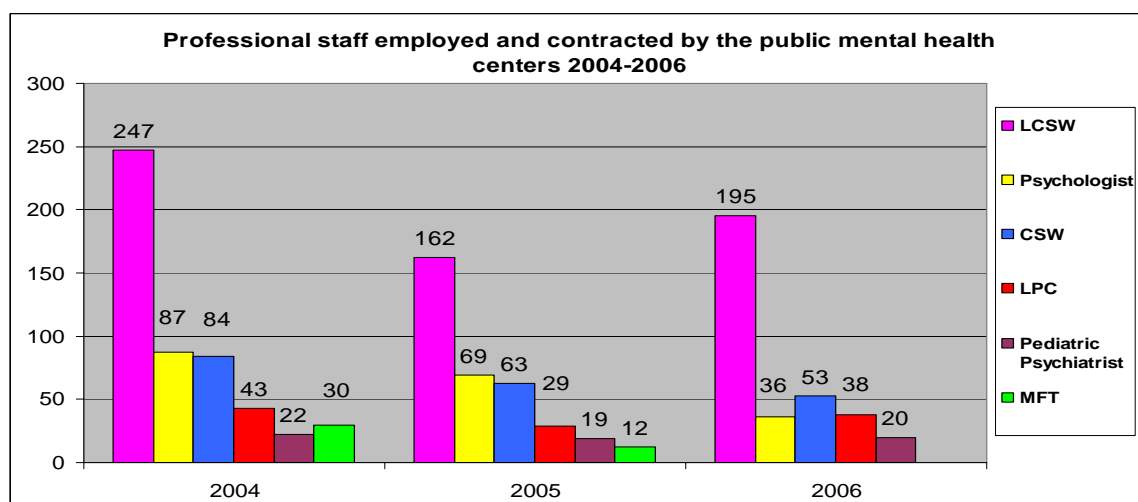
Chart 2: Staff employed and contracted by mental health centers urban and rural 2004-2006:



Note: 2006 Numbers reflect six of 11 centers responding, -three from each focus area. Therefore, rural numbers should be viewed with caution.

Chart 3 presents the total number of staff employed by the mental health centers over the three-year study period. The reader can clearly see that since 2004, there has been a decrease across disciplines. It should be noted that for the purposes of this report only disciplines with ten or more staff members were included. This chart illustrates the decrease in the number of clinicians available within the community mental health system to provide intervention with children and their families and provides further evidence of the challenge faced by those enrolled in Medicaid when they seek mental health intervention.

Chart 3: Professional staff employed and contracted by mental health centers 2004-2006:



The data in the preceding section emphasize the overall reduction in staff employed and contracted by the mental health centers over the study time frame. Concern regarding the reduction is discussed in the section titled “Number of Children Served”.

Centers were queried on the availability of 24-hour psychiatrist coverage. The information from the centers suggests that only about 50% of the centers provide this service. Centers are more likely to provide emergency coverage or referral by using their existing clinical staff or making referral to a 24-hour emergency hotline.

Number of Children Served-

The number, or potential number, of children served by the mental health centers is a critical factor when examining system capacity. For the purposes of this report, the number of children enrolled in Medicaid that received care from a mental health center

was determined by reviewing the grievance reports submitted by each pre-paid mental health plan. Centers enrolled in the plan are required to submit semi-annual reports outlining the number of grievances filled and investigated (fee for service mental health centers are not required to submit grievance reports and are not included in the data presented). As part of the report, the centers are asked for a total of children served. This information was used to determine the numbers for this report. The reports do not separate infants and toddlers birth to five from other youth; the numbers listed are total number of children served birth to twenty for the study time period.

The tables located in Appendix C report on the number of children enrolled in Medicaid that received care from the mental health centers during the years 2004 through 2006. Table 9 reflects the total number of Medicaid children/youth served by the centers from 2004-2006. The data is further broken down in Table 10 which provides a side-by-side comparison of the numbers across the study time frame. Tables 11 and 12 look at the numbers of children served by area and compares with the numbers of clinicians available to provide care.

Review of the data reveals that the number of children served during 2004 through 2006 has increased by 250%. The increase was largely in the number of urban children served, where there was an increase of over 7200 children served over the three year period. The number of children in the rural areas receiving care doubled during this same time.

Chart 4 highlights the increase in the number of children enrolled in Medicaid who have received services in the public mental health system. Medicaid enrollment numbers declined during the study time frame, resulting in a decrease in revenue to the mental health centers. At the same time the centers provided care to significantly more children. This means the Mental Health Centers are literally doing more for less.

Chart 4: Children enrolled in Medicaid who received mental health services from 2004 to 2006:

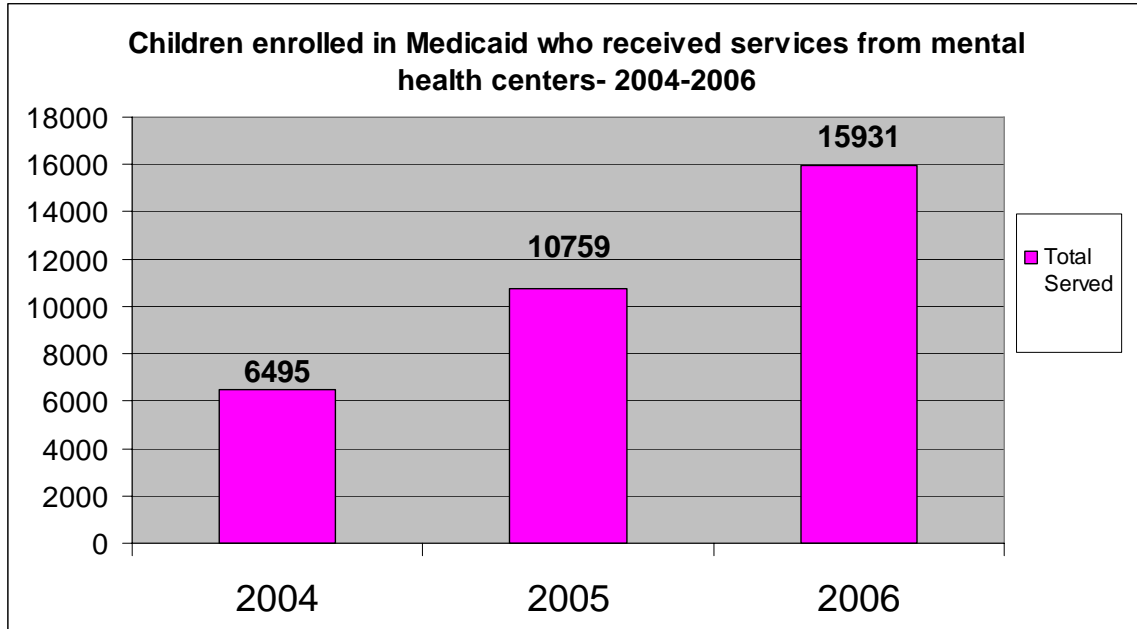
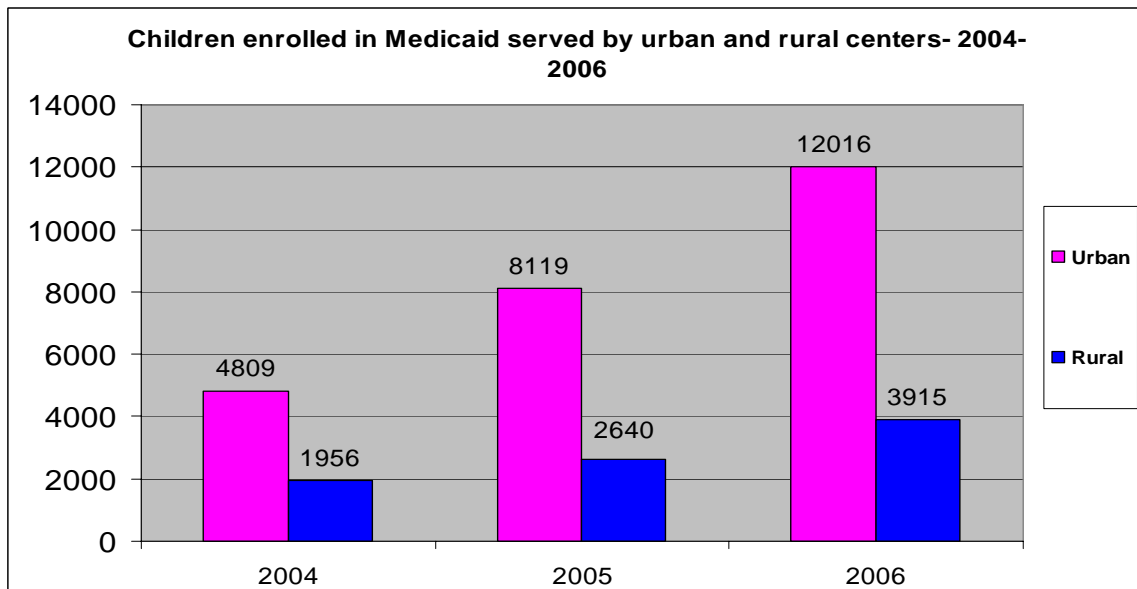


Chart 5 provides a side-by-side comparison of urban and rural children served. This chart highlights the differences in the number of children served by the urban vs. rural centers and again highlights the overall increase in children served over the study period. The chart further points out the relative stability of the population in rural centers as opposed to the fluctuation in the number of children served by urban centers. The fluctuation could be a result of rural families seeking treatment for difficult cases in the urban centers.

Chart 5: Children enrolled in Medicaid served by urban and rural from 2004 to 2006:



The increase in the number of children served has been surprising, given the decrease in the number of staff available to provide care to the most vulnerable clients. For example, in 2006, urban centers employed and contracted 210 licensed mental health providers who in turn provided services to 5761 children (27 clients per provider). The 2006 rural numbers show 66 staff serving 2147 clients, or 32 clients per provider.

Charts 6 and 7 emphasize the disparity between the number of children served and the number of clinicians available to provide the care. The charts are broken down by urban and rural with a combination of all children served over the study period. This breakdown allows the reader to clearly see the increase in the number of children served and the decline in the number of professionals available to provide care.

Chart 6: Comparison of children enrolled in Medicaid and the number of urban providers:

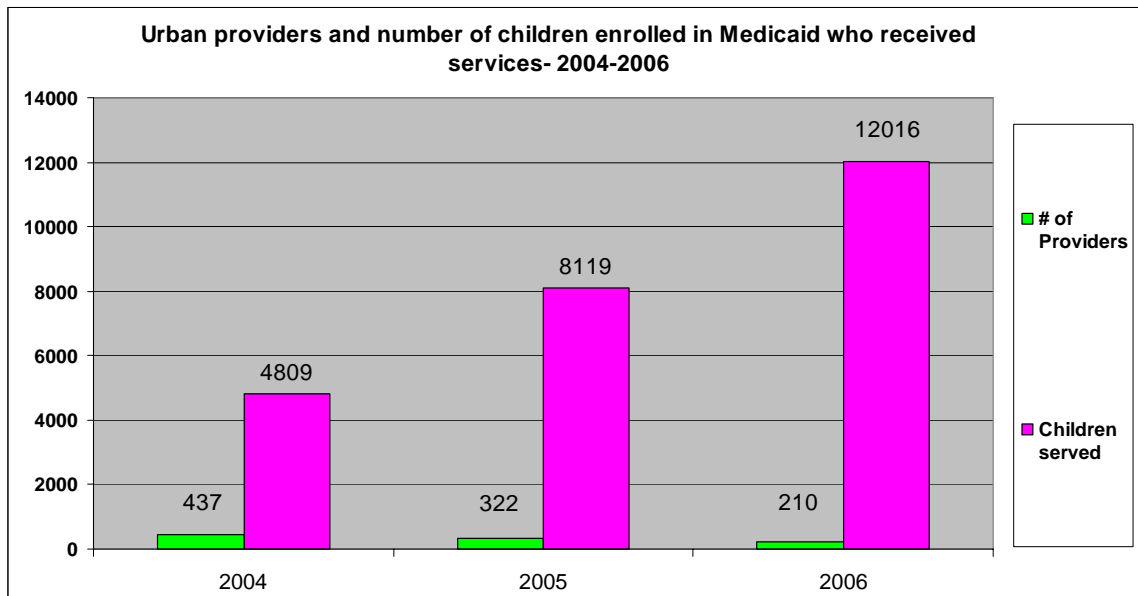
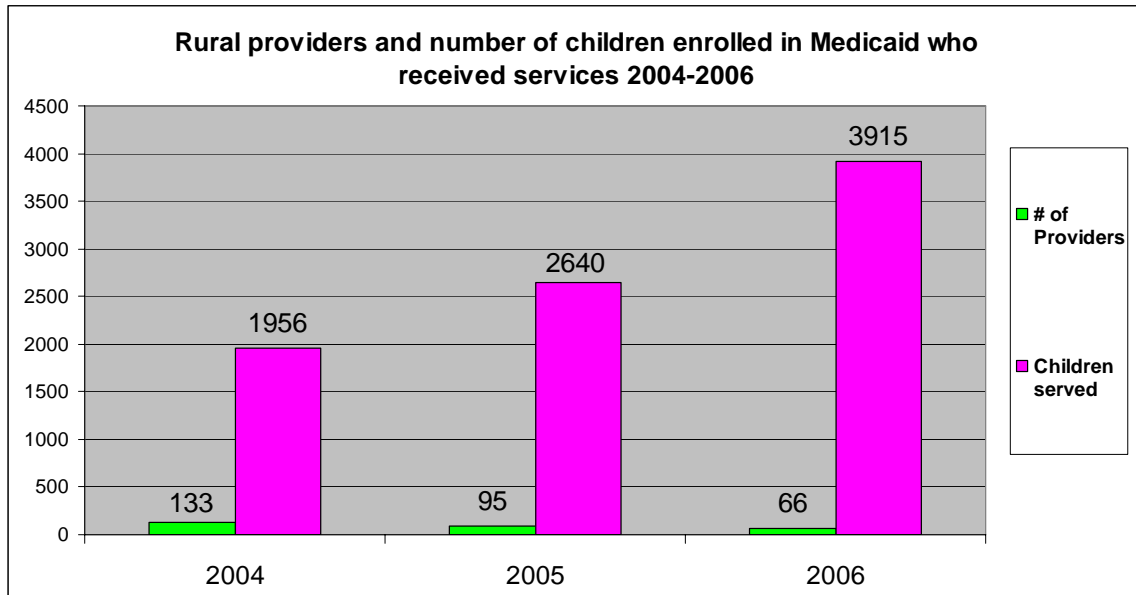


Chart 7: Comparison of the number of children enrolled in Medicaid and the number of rural providers:



Summary-

There are eleven community mental health centers serving the twenty-nine counties throughout the state. Nine provide services through a capitated arrangement (Pre-Paid) and two are fee-for-service. In 2004, when the Assuring Better Child Health and Development (ABCD) project began, there was a total of 380 licensed mental health providers employed by the centers and 165 contract providers. The 545 providers working in or for the centers served nearly 6,800 children/youth enrolled in Medicaid statewide during calendar year 2004.

The 2005 survey indicated that there were 305 licensed mental health providers employed by the centers and 93 contract providers. This reflects a 35% reduction in the number of licensed providers available. The 404 providers working in or for the centers served 10,759 children/youth statewide during 2005. This indicates a 71% increase over the previous year. Further calculations reflect a 68% increase in the number of children receiving services in the urban areas and a 34% increase in the rural areas. The data from 2006 indicates 150% increase in the number of children served. A possible explanation for the increase is the activity generated by the ABCD II Project.

In 2006, only six surveys (of eleven) were returned: three each from urban and rural centers. Urban centers employed a total of 172 staff reflecting a 49% reduction in full-time staff. The urban centers contracted with only 38 providers, a reduction of 153

since 2004, representing a 43% reduction in contract employees over the study period. Rural centers employed 61 full-time staff in 2006, a reduction of 48% over the study period. The number of contract providers working with the rural centers stayed even over the three years.

Most centers provide some level of 24-hour psychiatrist coverage. Most centers use full-time staff for emergency on-call coverage, or refer callers to the emergency room, or other crisis hot-lines.

Over the three years of the study, the number of Master's level licensed mental health providers statewide grew by 20% each year. What is important about this information is the comparison of the total number of mental health providers licensed in the state and the number working in community mental health centers. Of the 5,277 licensed mental health providers in Utah, 276 are employed by mental health centers. Clearly there is a rich resource of experienced mental health providers that is untapped.

The number of children enrolled in Medicaid who received mental health services has risen dramatically over the past three years. From 2004 to 2006 there was a 250% increase in the number of children served. In response to the increased importance placed on children's mental health, the Utah Department of Health increased its capacity to support the mental health centers and private providers with programming and training. In July 2005, the Child and Adolescent School Health Program (CASH) in the Bureau of Maternal and Child Health (MCH) within the Division of Community and Family Health Services (DCFHS) hired a full-time Children's Mental Health Promotion Specialist. The position focuses on children's mental health issues including; screening infants and toddlers, youth mental health, youth suicide prevention, adolescent substance abuse, domestic violence, child abuse and neglect and screening and treatment of maternal depression. The creation of this position will significantly contribute to the overall improvement of system capacity because it will involve another partner in the broader ABCD II Project. The sustainability of the ABCD II Project will fall within this position as it shifts its focus to prevention by continuing to encourage routine screening for social/emotional delay.

Utah Medicaid Health Plans

Utah Medicaid provides Medicaid-covered services through managed care health plans and fee-for-service. Enrollment for non-institutional Medicaid recipients is mandatory in the four counties along the Wasatch Front. In these counties, the Utah Department of Health, Division of Health Care Financing contracts with two medical managed care plans and one preferred provider network. Rural Medicaid residents in nine counties outside the Wasatch Front may choose either a managed care health plan or a fee-for-service arrangement with health care providers who agree to see Medicaid enrollees. Residents in the remaining sixteen counties receive the fee-for-service arrangement.

In 2004, Utah had 224 community pediatric health care providers with 114 practicing along the Wasatch Front and 110 working in the outlying areas. As of October 2006, the number had increased to 1,339 with 1,225 practicing in the urban area and 114 in the rural clinics. The most significant increase was in the Molina product which saw a 43% rise in the number of contracted pediatric providers from 2005 to 2006. Data indicates that of the 1,339 community Pediatricians, 764 are contracted with the Utah Medicaid MCO program. The data indicates that 75% of the Pediatricians in Utah are enrolled as Medicaid fee-for-service providers.

Of the three plans, Molina is the only product serving Medicaid enrollees exclusively. Healthy U is part of the University of Utah health system and serves University employees as well as Medicaid. The Division of Health Care Financing (DHCF) has a contract with Intermountain Healthcare that allows Medicaid enrollees to access the Select Access network. Select Access is not contracted as a Medicaid MCO. Rather, the DHCF provides all claims payment, prior authorizations, payment policy, etc. for enrollees. It should be noted that many Pediatric health care providers are included on the panels of all three plans. Table 13 in Appendix C provides a breakdown of the number of pediatric health care providers by Medicaid medical plan.

Survey results-

An initial system capacity survey of the medical practices providing services to infants and toddlers was conducted in 2004. Clinic managers throughout the state were queried on the number of pediatricians, mental health professionals, nurses, screenings

completed, referral resources and specialized training completed (please refer to pages 28 and 29 for information on screenings completed tools used and referral sources). Clinic managers were targeted to answer the survey because they often have the necessary information and may be in a better position to take the time to answer the questions as opposed to the pediatricians themselves. Attempts were made to contact 71 practices by telephone. A total of 51 contacts were completed. Five practices refused because office staff were too busy and we were unable to contact 14 practices either because the telephone number had changed or the office manager was unavailable. It is important to note that of the 71 practices listed, 29 were affiliated with all three medical plans.

In 2005, 87 surveys were mailed to clinic office managers. Twenty-seven were returned completed with no refusals. Although it may appear that there was a lower response rate from the previous year, there was actually a higher number of pediatric practices represented. That is because the survey reached a number of large pediatric practices with many pediatricians but only one office manager. For example, Wasatch Pediatrics, which is located in Salt Lake County, has an office manager that works with 45 clinics.

The 2006 survey was mailed to 30 practices - none were returned. It is unknown why there were no responses; however changes in ABCD II staff may be the primary contributing factor.

Although a comparison of the data may suggest a decline in number of staff employed by the medical practices, this may be misleading. The process of determining the number of staff employed by the practices has been a particular challenge. Practices are extremely busy and have been reluctant to complete telephone interviews or paper surveys. Therefore, the data presented should be reviewed with caution in consideration of the limitations of the survey process.

In addition, data collection specific to mental health practitioners within the medical practices is difficult. Most medical practices do not employ mental health professionals or provide any mental health intervention. Practices that have indicated the availability of mental health practitioners are likely involved in the Intermountain Healthcare Mental Health Integration Project. The Intermountain project focuses on integrating mental health with physical health within the medical clinic. The project is currently underway in a limited number of clinics in Salt Lake County and provides

mental health intervention to primarily older children and adult patients. Intermountain researchers have found that this approach is useful as a cost-saving measure and in reduction of chronic mental illness.

Table 14, located in Appendix C, presents data obtained from the 2004 and 2005 system capacity surveys. It should be noted that this information was valid as of December 2005 and may or may not have changed over the past year.

Medicaid Children Served-

In order to obtain a complete picture of system capacity, it is necessary to review the number of children birth to three enrolled in Medicaid served by the medical practices. The determination of number served was taken from Medicaid billing of CPT Codes (99381, 99382, 99392, 99432 and 96110) for well-child visits focusing specifically on preventive medicine including screening for developmental and social/emotional delays. Data was taken from years 2003 (used for baseline information) through 2006.

The data reveals that there has been a steady increase in the number of children served statewide during the study period. Specifically, urban areas experienced a 23% increase over the three years and rural areas felt a 40% increase.

Chart 8 provides a breakdown of the total number of Medicaid children birth to five served statewide during the years 2003 through 2006. This chart is useful in a year to year comparison of the raw totals. Please refer to Table 16 located in Appendix C for a complete listing by individual counties.

Chart 8: Birth to Five Children Served 2003- 2006:

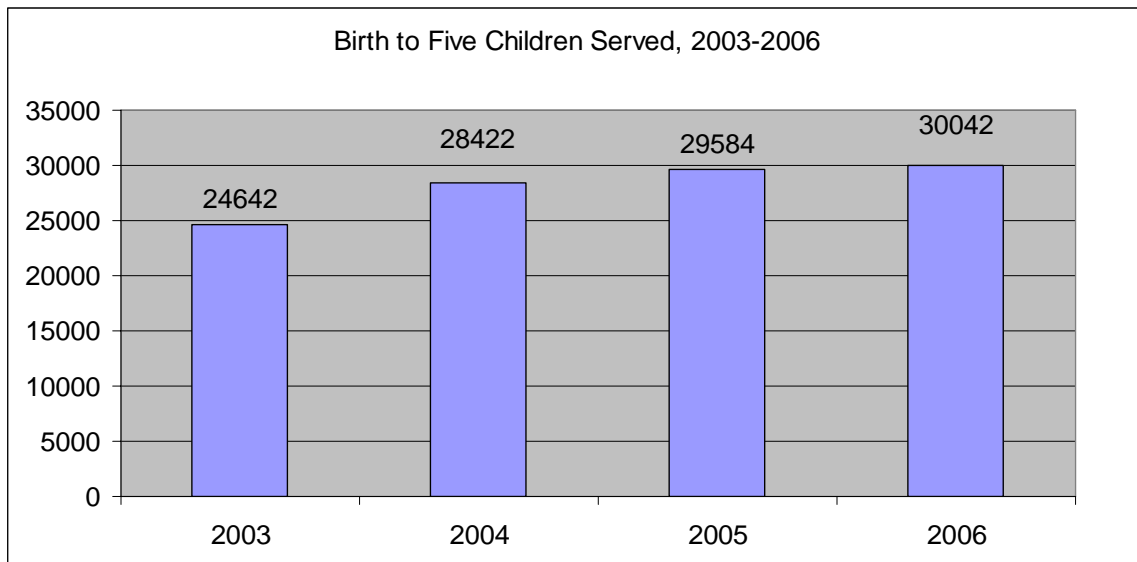


Chart 9 provides a breakdown in the number of urban and rural children served and the number of providers available to see children living in these areas. The information contained in the chart is important in further emphasizing the challenges that are present for rural enrollees as well as providers. It should be noted that in rural Utah, families often are required to travel long distances to obtain treatment and are offered fewer mental health, medical and early intervention resources. Chart 9 further emphasizes the disparity in the numbers of children served between urban and rural providers.

Chart 10 is the final chart in this series. It offers a visual comparison of one year of the study project and reflects the disparities in the urban vs. rural areas of the state. The chart shows the number of children served and the number of physicians available to provide the service. There was no mechanism in place prior to 2006 to provide accurate data on the number of urban vs. rural providers. Therefore, there are no comparison charts for 2003 through 2005.

Overall, the data reflects that the state has experienced a steady increase in the number of children birth to three that have received services since 2003. The most significant increase appears to have occurred in Washington County which experienced a 63% increase in the number of Medicaid children birth to five receiving services over the three-year period. Washington County, located in the deep southwest portion of the state, is experiencing a significant population boom and the growth in numbers is likely a result of the overall growth of the county. Review of the remaining counties indicates that the majority experienced growth but not to the degree of Washington County.

Chart 9: Urban vs. Rural birth to five children served:

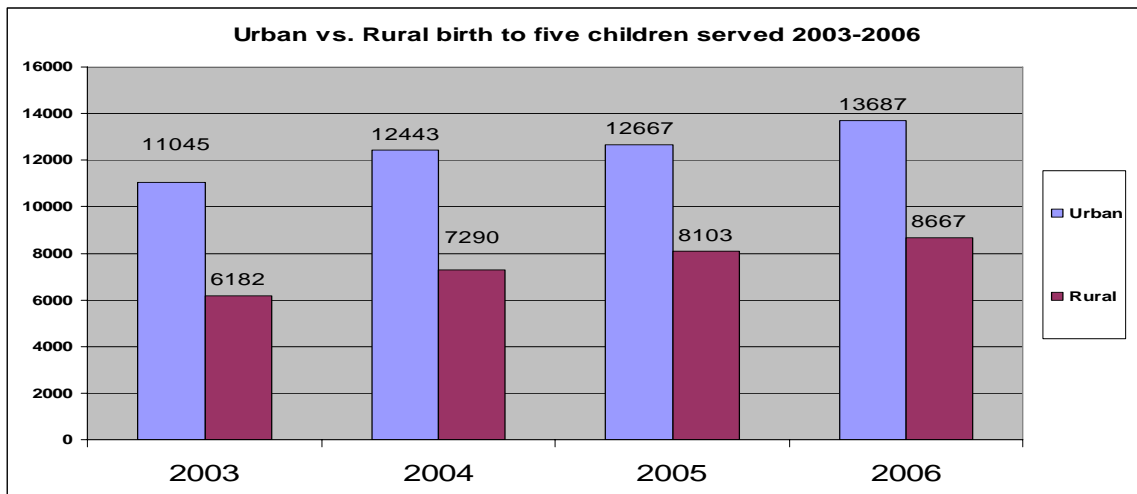
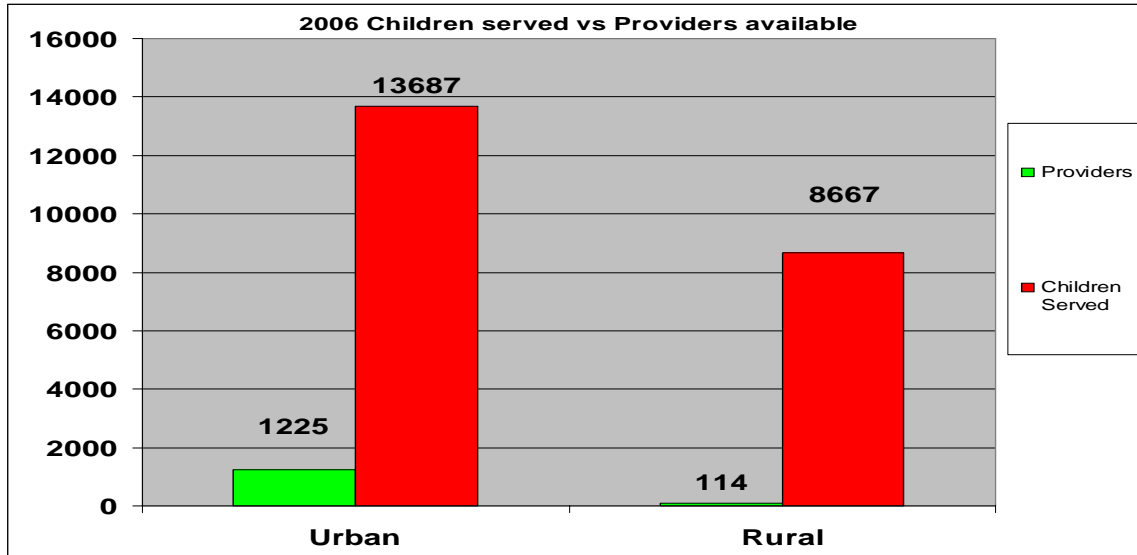


Chart 10: Medicaid children served in urban and rural areas vs. number of providers available in the areas, 2006:



Complete data tables on this information are located in Appendix C. Data Table 15 outlines the county by county numbers. Table 16 provides a breakdown by urban vs. rural.

Screening for Developmental and Social/Emotional Delay-

As increased focus is placed on early child development and recognition of delay the need for behavioral and developmental surveillance also rises. With this, comes the challenge of how to determine if a child is delayed. In July 2001, the American Association of Pediatrics (AAP) issued a directive recommending routine administration of a validated accurate developmental screening test at each well-child visit.

The Utah Department of Health responded to this directive by engaging in the Assuring Better Child Health and Development (ABCD) Project funded by a grant from the Commonwealth Fund with oversight and technical assistance provided by The National Academy for State Health Policy (NASHP). Utah was fortunate to participate in two ABCD projects.

ABCD I identified that the Utah Department of Health had no systematic process to access child development. As a result, Utah’s Medicaid agency instituted a Targeted Case Management (TCM) Program for infants, using home visits conducted by local public health nurses as the vehicle for providing the case management. The program was developed in collaboration with the Bureau of Maternal and Child Health and Local

Public Health Departments. The service is designed to facilitate the identification of health and developmental issues in infants, to improve immunization rates among children enrolled in Medicaid, and to increase the use of well-child care and the number of children linked with a primary care provider.

In addition, Utah's ABCD I Project was responsible for the creation of the Utah Pediatric Partnership to Insure Health Care Quality (UPIQ). UPIQ is a direct outgrowth of the connections forged during ABCD I between Utah ABCD participants and leaders of Vermont's Child Health Improvement Program (VCHIP). UPIQ was established in 2003 to improve children's health "by assisting pediatric and family medicine practices to deliver the highest possible quality of care to their infant, child, and adolescent patients." UPIQ partners include Intermountain Pediatric Society - Utah's AAP affiliate, University of Utah Health Department of Pediatrics, Utah Department of Health's Division of Health Care Financing, Utah Department of Health's Division of Community and Family Health Services, HealthInsight, and Intermountain Healthcare Primary Care Clinical Program.

Utah's original ABCD II grant proposal outlined a plan designed to increase the number of infants and toddlers, birth to three, enrolled in Medicaid to receive regular screening for developmental and social/emotional delay, as part of regular well-child visits and receive appropriate treatment when indicated. The final step of the plan is to increase screening for maternal depression. The initial step in implementing this project was to research the history of screening and provide scientific rationale to support the recommendation to screen.

Why Conduct Pediatric Screening?

In April 2003, Frances Glascoe, PhD and Michelle Macias, MD outlined several reasons for conducting screening in the pediatric practice. Dr.'s Glascoe and Macias related the following reasons for routine screening:

- Research on early brain development revealed the need to identify and address emerging problems during pre-school years as the brain is developing.
- Reauthorization of the Individuals with Disabilities Education Act (IDEA) mandates and expands intervention services for young children and their families.

- Studies have shown that early intervention can immediately benefit patients and has long-term effects in intellectual, social, and behavioral functioning; improves high school graduation rate; improves employability and decreases criminality.
- A recent survey from the Commonwealth Fund has shown that fewer than 50% of families receive developmental screening, promotion, and counseling from their primary care provider. The study further indicated that families want these services and are willing to pay for them.
- Families who receive developmental services are more satisfied with the care and tend to demonstrate positive parenting practices.
- Most pediatricians use either an informal method with unproven sensitivity and specificity or screening tests that are too long for the primary care visit. Tools that are too long result in screening the symptomatic rather than the asymptomatic child. Well-normed and validated parent questionnaires are more accurate than directly administered screening tests.
- Fewer than 30% of children with a behavioral problem are detected and referred before they enter kindergarten—eliminating all hope for early intervention and contributing significantly to school failure and disenfranchisement.
- Twenty-eight states have been sued in class-action lawsuits for failure in the delivery of developmental/behavioral screening and referral.

Pediatricians are in a unique position to influence children’s healthy development. Barbara Howard, MD explained it best in her article, *The Pediatrician as Therapist II*. She indicated that pediatricians are able to detect risk factors early before they have taken their full toll. In addition, they can assist the family in obtaining community resources to deal with the problems, provide referral for mental health or other services, and help the family build support systems. In addition, they can advocate for community-based resources to be sensitive to the developmental needs of children.

The Utah Child Health Evaluation and Care (CHEC) Program, Utah’s Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, has instructed medical practices to screen infants and toddlers for social/emotional delay and post-partum mothers for maternal depression as part of the well-child visit. The provider manual lists recommended screening tools for use by practices.

Tool choices were based on review of scientifically validated screening tools recommended for use in the primary care setting. Tools were chosen based on the specificity and validity rating, ease of use—i.e. can a parent self-administer the tool and

time it takes to complete the tool- and ease of scoring. Determination was further made using a standard of screening, assessment and/or surveillance. Screening is viewed as a brief activity used to quickly determine delay. If a delay is identified, an assessment may be ordered. Assessments are generally more in-depth and administered by a professional. Surveillance is the ongoing follow-up either in the medical setting, Early Intervention site or mental health center.

Recommended tools for infant and toddler screening:

- Ages and Stages Questionnaire (ASQ)
- Ages and Stages Questionnaire: Social/Emotional (ASQ:SE)
- Parent's Evaluation of Developmental Status (PEDS)
- Temperament and Atypical Behavior Scale (TABS)

Recommended tools for maternal depression screening:

- Patient Health Questionnaire 2 question screener (PHQ2)
- Patient Health Questionnaire 9 (PHQ9)
- Edinburgh
- Beck Depression Inventory II (BDI- II)
- Family Psychosocial Screener (FPS)

Specific instructions for screening may be found in the CHEC Provider Manual. Please refer to: <http://health.utah.gov/medicaid/pdfs/chec.PDF>.

In an effort to increase the capacity of the system to provide care to infant and toddlers birth to three, the Utah ABCD II Project proposed to present information on screening for developmental and social/emotional delay to medical practices. This information was presented in the form of a Learning Collaborative. The ABCD II Project contracted with UPIQ to develop and administer the Learning Collaboratives which are focused on improving the quality of early child mental health and development services for low-income children. Specific information related to the Learning Collaborative is included in the training portion of this report.

Survey Screening and Referral Results-

The Utah Department of Health system capacity survey queried respondents on the number of practices screening for developmental and social/emotional delay on a regular basis during the well-child visit. Practices were also queried as to the type of screening tool administered and the community resources used when a problem is identified.

The survey results indicated that during 2004 and 2005, thirteen clinics reported that screening was taking place on a regular basis and 36 of the centers were unsure if screenings occurred. There is no data available from 2006 since no surveys were returned.

From 2004 through the end of 2006 the Utah Department of Health and the Utah Pediatric Partnership to Improve Health Care Quality (UPIQ) presented Learning Collaboratives focusing on screening infants and toddlers for social/emotional delay and screening post-partum mothers for maternal depression. As a result of the collaboratives, 24 clinics were conducting regular screening during the study time frame. In addition, UPIQ presented a Learning Collaborative focusing on screening for developmental delay which resulted in eleven practices screening infants and toddlers for developmental delay. It is likely that there are duplicate numbers between the survey and Learning Collaborative participants and that the survey is likely not a good representation of the actual number of practices screening. In reality, during the study period there were approximately 36 practices screening on a regular basis and likely many more that were underrepresented. In addition, reports from the practices that participated in the Learning Collaborative suggest a large spread factor occurring among the practices. Spread factor refers to practices that participate in a Learning Collaborative and upon returning to the office share information with practice partners who in-turn initiates regular screening. It is impossible to determine the actual number of spread practices. Anecdotal stories suggest that of the 36 practices that have participated, it is estimated that an additional 14 pediatricians have begun screening.

Practices listed a variety of screening tools that are typically used to screen for developmental and social/emotional delay. The survey results indicated that the most commonly used tools were:

- Ages and Stages (ASQ)
- Ages and Stages: Social/Emotional (ASQ:SE)
- Bailey
- Connors
- Denver
- Other

It should be noted that participants in the Learning Collaboratives were given a choice of four tools and overwhelmingly chose the Ages and Stages (ASQ) as a primary developmental and social/emotional screening tool. The Ages and Stages Social/Emotional (ASQ:SE) was chosen as a secondary tool in the event of a more complicated concern specific to social/emotional delay. Two other tools were offered, the Parents Evaluation of Developmental Status (PEDS) as a primary tool for developmental screening and the Temperament and Atypical Behavior Scale (TABS) was offered to be used specifically with temperament or behavioral issues.

Increased screening for developmental and social/emotional delays will likely result in the increased need for referral to community resources. Anecdotal reports indicate that while there has not been a sharp increase in the number of children identified with social/emotional delay, medical practices are increasing their referrals for other developmental delays. Data from two Learning Collaboratives indicates that 6% of the children screened required additional assessment or treatment. Of those 90% were treated in the pediatric office. Local resources have been provided to the practices to use when needed. Most practices indicated that they often refer to multiple resources. The most common resources used by medical practices were:

- The Children's Center (either by direct referral or via referral from the community mental health center)
- The Community Mental Health Center
- Children with Special Health Care Needs (CSHCN)
- Early Intervention
- Other Local Hospital
- Primary Children's Medical Center (PCMC)
- Other Private Provider
- University of Utah Neo-Natal
- Other

Summary-

Utah Medicaid recipients may receive care through three medical plans or through fee-for-service. The Division of Health Care Financing contracts with two medical managed care plans (Healthy U and Molina) and one preferred provider network (Select Access).

According to the 2004 provider lists, there were 209 pediatricians contracted with Healthy U, 201 with Molina Healthcare, and 213 with Select Access. In 2004, there were

a total of 224 licensed professionals within the three plans. This included pediatricians, pediatric psychiatrists, developmental pediatricians, psychologists, LCSW, RN, APRN and other professionals. There were no clinics offering 24-hour coverage.

The 2005 provider lists indicate that there were 101 pediatricians contracted with Healthy U, 197 with Molina Healthcare and 201 with Select Access. Within each plan, there were a total of 164.5 licensed professionals offering pediatric, pediatric psychiatry, developmental pediatrics, psychologists, LCSW, RN, APRN and other specialty services.

In 2006, there were 148 pediatricians with Healthy U, 480 with Molina and 136 with Select Access. There are no numbers available for other licensed providers in the pediatric practices for 2006.

The total number of infants/toddlers, birth through age 4, served by the medical practices gradually rose from 24,642 in 2003 to 30,042 in 2006. Over three years of the study period, the percentage of children receiving services through Medicaid increased by approximately 21% overall (comparing 2006 numbers with 2003).

Pediatric clinics use a variety of standardized tools for developmental and social/emotional screening. The most common standardized tool used has been the Denver. This is consistent with what had previously been recommended in the Utah Medicaid CHEC Provider Manual. The manual has been updated with the recommendation to use a menu of tools other than the Denver. The rationale for this change relates to the ease of use offered by other screening tools. The tools recommended are all scientifically validated and take only about 5-10 minutes to complete and can be completed by the parent. This approach eases the stress of the busy pediatric clinic by not requiring a nurse or medical assistant to administer the tool. Since 2004, there has been a marked increase in the number of practices choosing to use the Ages and Stages Questionnaire (ASQ). The practices that participated in two social/emotional screening Learning Collaboratives all used the ASQ as their primary tool with the Ages and Stages Questionnaires: Social-Emotional (ASQ:SE) used as a secondary tool. There continues to be a number of practices using their own tool, while others rely upon the developmental guidelines established by the AAP.

Most clinics surveyed indicated that they refer children to outside resources on a regular basis. The most common referral is the local Early Intervention Program. This

was followed by referral to the local mental health center, Primary Children's Medical Center, private insurance, and other medical care providers.

The data clearly shows a need to continue to increase the number of clinics offering regular developmental and social/emotional screening of infants/toddlers. There has been a marked increase in the number of screenings as a result of physician practice, attendance at Learning Collaboratives and use of other resources to give information. Other resources would include the regular Medicaid Information Bulletin (MIB), training within the Intermountain Pediatric Society (IPS) and articles in the IPS newsletter. The Utah Department of Health will continue its collaboration with UPIQ in developing and providing quality improvement trainings designed specifically to increase the number of primary care practices offering regular screening for social/emotional and developmental delay and maternal depression. In addition, the Utah Department of Health is researching alternatives to the Learning Collaborative in an effort to increase outreach to rural providers with the goal of providing training and technical assistance in the implementation of regular screening.

As clinics increase the number of children screened the need for additional resources will increase as well. The solution to this is not a simple answer. Tight budgets and ongoing challenges with private insurance will not result in staffing increases. The Utah Department of Health is working closely with local community resources and private providers to develop a training resource designed to increase the number of qualified providers and thereby ease the congestion caused by increased referrals.

In addition, there may still be reluctance on the part of medicine to welcome mental health professionals into the medical setting. Nationally, there is a marked increase in the number of states interested in the idea of mental health co-location. Intermountain Healthcare is currently engaging in a project to integrate mental health into the primary care setting. The Intermountain Mental Health Integration Project currently places mental health providers in a select number of medical clinics located throughout the Wasatch Front. Preliminary analysis of this project indicates that the clinics are beginning to see the value in a mental health provider on sight. The Utah Department of Health is following this project closely and has offered technical assistance support to help build and expand the project into clinics that typically provide care to the

underserved population. The Utah Department of Health strongly supports this project and is researching avenues in which other partnerships focusing on mental health co-location may occur.

Early Intervention

Early Intervention providers operate under the regulations provided in Part C of the Individuals with Disabilities Education Act (IDEA). Early Intervention clinics provide a wide-range of services spanning educational, case management, screening and direct care. Often the medical practice screening will identify an issue that may be unclear whether it should fall into mental health or Early Intervention, and usually refer to Early Intervention in these types of cases. Under Utah law, unless the Early Intervention clinic has qualified staff to provide mental health specific services, they must refer to a licensed mental health provider. In the event the service is educational, case management, screening or physical in nature, the Early Intervention program may choose to provide this service itself. Individuals providing these services should receive special training to address infant social/emotional needs.

Utah's Early Intervention centers operate under the guidance of the Utah Department of Health Division of Community and Family Health Services Baby Watch Program. Baby Watch contracts with 16 programs statewide to provide services to qualified children and families (please refer to Table 17 in Appendix C for a complete list of all sites statewide). In addition, they contract for deaf, blind, hearing and vision services with the School for the Deaf and the Blind. The Child Development Clinic (CDC) located in the Utah Department of Health Bureau of Children with Special Health Care Needs (CSHCN) provides assessment and evaluation throughout the state through satellite clinics.

The services provided in the Early Intervention include:

- Assessment of a child's current health and development status
- Service coordination among providers, programs and agencies
- Strategies to build on family concerns, priorities and resources
- Developmental services including:
 - Occupational therapy
 - Physical therapy
 - Speech and language therapy

These services are provided through the coordinated effort of parents, community agencies, and a variety of professionals. Assessment and follow-up is provided at Early Intervention centers, in the home, and in community settings. Services are provided to

children from birth to three years who meet or exceed the definition of developmental delays. In the course of delivering family-centered services, Early Intervention providers are frequently in a unique position to identify a mental health need. Early Intervention emphasizes the importance of infusing mental health into all services. Unfortunately, providers have often found that mental health services for infants and toddlers are unavailable. In an effort to reduce this difficulty, Early Intervention programs are encouraged to form collaborations with the local community mental health agencies. For example, The Learning Center for Families, located in Washington County, has a working interagency agreement with Southwest Mental Health. They work closely to provide assessment, referral, and treatment of children in Early Intervention in the area.

Staffing Survey Results-

An initial Early Intervention system capacity survey was completed in 2004 in an effort to determine the capacity of Early Intervention to provide mental health specific services. Early Intervention sites were queried on the number of licensed professionals available to provide care, screenings completed, tools used, referral sources, and participation in specialized training.

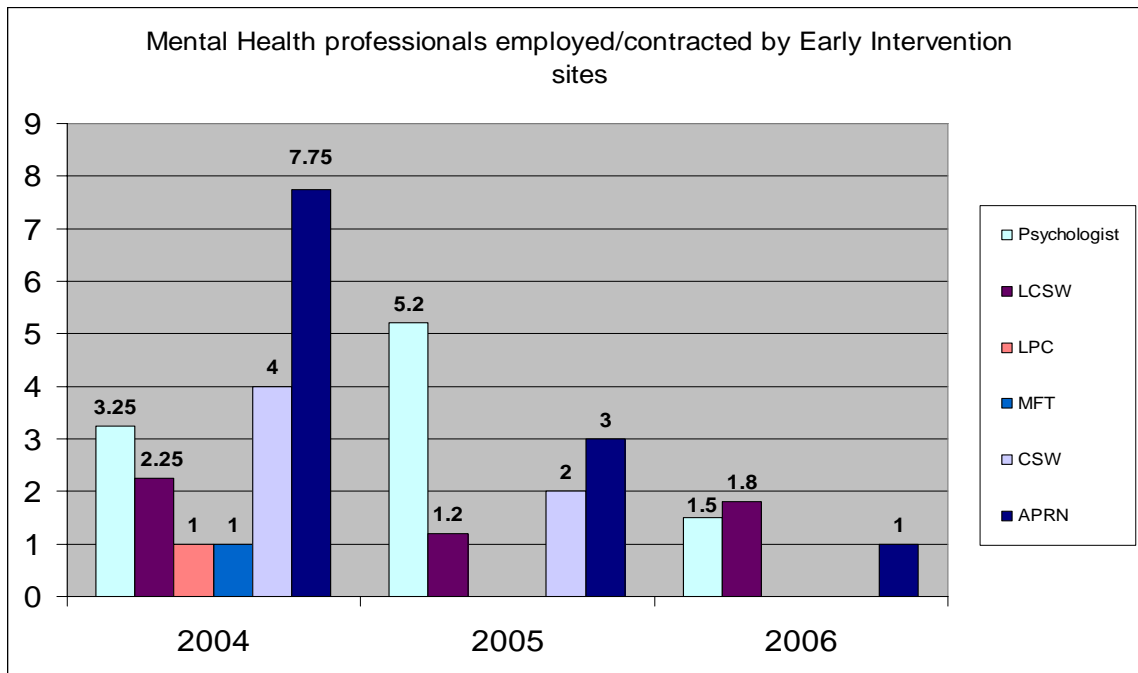
In 2004, sixteen surveys were mailed and sent electronically. Twelve were returned completed. The 2005 survey was mailed to sixteen centers, eleven were returned completed. The Utah School for the Deaf and Blind refused to complete the survey because they did not feel it pertained to their services.

In 2006, sixteen surveys were mailed, six were returned completed. It should be noted that of the six returned, two were from the urban area, and four were from rural centers. The reason for the low response rate is unknown but may be related to changes in ABCD II staff.

The data reveals that during 2004 and 2005 the Early Intervention programs have maintained a stable workforce with only a slight reduction of staff. Urban sites remained very stable while rural sites cut staff by 50%. While data from 2006 is incomplete, it is believed that little change has occurred since 2005. The reductions in staff are not necessarily a concern as Early Intervention programs primarily employ staff qualified to provide services other than mental health and generally refer to other community resources if mental health intervention is warranted. Chart 11 provides a list of the

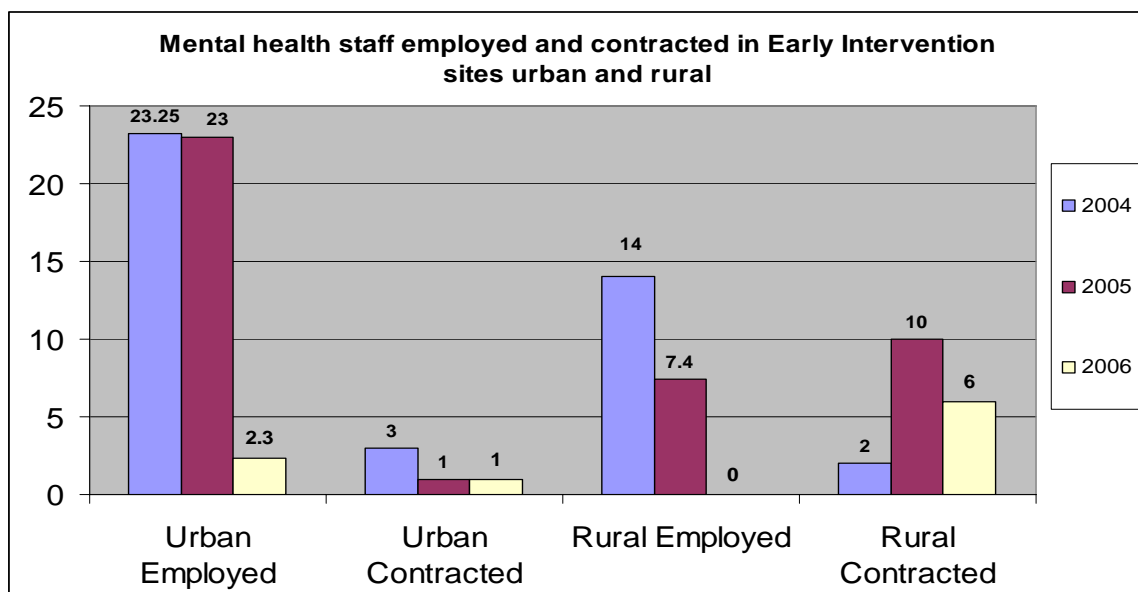
number of mental health professionals employed/contracted at the Early Intervention sites. Chart 12 provides an overview of the breakdown between urban and rural employed and contracted. It further highlights the relative stability of the Early Intervention sites. Tables 18 and 19 located in Appendix C reflect the number of professionals employed and contracted statewide, and urban vs. rural for the study period.

Chart 11: Mental health professionals employed and contracted by Early Intervention 2004 to 2006



Note: 2006 data is included for reference purposes only and due to low response rate should be viewed with caution.

Chart 12: Mental health professionals employed and contracted urban and rural 2004 to 2006



Note: 2006 data is included for reference purposes only and due to low response rate should be viewed with caution.

Screening Survey Results-

Developmental screening within the Early Intervention programs has been a basic service for many years. Recently, the programs have expanded the service to include screening for social/emotional delay. While each center may prefer one tool over another, most use very similar tools when administering a screening. Often a variety of tools are used, in concert with one another. Screening tools used in Early Intervention sites are generally assessment oriented rather than brief screening, however; many centers are now using the Ages and Stages on a more regular basis. Over the three years of the study, Early Intervention sites increased use of the Ages and Stages Questionnaire by 75% and the Ages and Stages Questionnaire: Social/emotional by 66% making them the most widely used tools. The eight most commonly used tools in Early Intervention are:

- Ages and Stages Questionnaire
- Ages and Stages: Social/emotional
- Battelle Developmental Inventory
- ELAP
- HELP Checklist
- Infant Developmental Assessment
- Infant Toddler Sensory Checklist
- Temperament and Atypical Behavior Scales

Early Intervention programs rarely employ licensed mental health professionals and therefore, rely upon community resources to perform follow-up mental health treatment. Survey data indicates that the referral to the local community mental health center increased by 22% over the course of the study period. The most common community resources used by Early Intervention are:

- The Children's Center (either through referral from private insurance or community mental health)
- Community Mental Health Center
- Children with Special Health Care Needs
- Family Support Center
- Other Private Mental Health Provider
- Primary Children's Medical Center

Summary-

There are sixteen Early Intervention sites throughout the state of Utah. Sites perform a wide-range of services to children birth to five including screening for

developmental and social/emotional delay to providing direct services in the form of occupational therapy, physical therapy, speech, etc.

While Early Intervention rarely provides mental health intervention, they are in a unique position to serve as a conduit for screening and referral of infants and toddlers with social/emotional needs. Although they focus primarily on developmental issues, they have the ability to form collaborations with the CMHCs to provide seamless transition of these children into care.

As with the CMHCs, Early Intervention programs are often under-funded and, in the past, have suffered low employee retention. This trend seems to be improving as evidenced by the stability shown during 2004 and 2005.

Providers of Infant and Toddler Social/emotional Care

The role of mental health centers, medical clinics, and Early Intervention providers, including who they are, where they are located, and what their capacity is have each been discussed. The following matrix outlines the various activities involved in the screening and treatment of the healthy mental development of infants and toddlers. It can be used to help explain the levels of care, activities involved, and who should provide the care.

Level	Activities	Who
Promotion	Screening Education/anticipatory guidance Appropriate referral	Primary Care Provider Early Intervention programs Targeted Case Management Nurses Licensed Mental Health Therapists
Prevention	Education Referral Facilitate access to necessary services Coordination of services	Targeted Case Management Nurses Early Intervention programs Primary Care Provider Licensed Mental Health Therapists
Treatment	Assessment Care-plan Educate/consultation to primary care and prevention providers Coordination of services	Licensed Mental Health Therapists

Review of the matrix emphasizes the need for training to insure that an appropriate level of care is provided to infant and toddlers with social/emotional delay. As has been argued in the preceding chapters, the need to treat infant, toddlers and their families is increasing while funding and available resources continues to shrink. The recommended response to these needs is to insure that professionals providing mental health specific treatment (and to a lesser degree those who provide any direct level of care) are trained to properly respond to the needs of these children and families.

The subject of Infant Mental Health (IMH) is burgeoning with several states implementing specialized IMH certificate programs. Researchers in Utah have looked into these programs and while they offer very valuable information they are not being recommended at this time.

The following is offered as a brief overview on the history of infant/toddler mental health training. It provides a framework to the importance of providing information specific to a focus on infant/toddler social/emotional development.

Specialized Infant/Toddler Mental Health Training

In October 2000, Deborah Weatherston, Ph.D., of the Merrill-Palmer Institute/Wayne State University, Detroit, Michigan authored *The Infant Mental Health Specialist*. The paper outlined the history of the Infant Mental Health movement beginning more than a century ago when Selma Fraiberg, one of the founding board members of ZERO TO THREE, and her colleagues in Ann Arbor, Michigan developed the original practice of Infant Mental Health. In their practice, social workers, psychologists, nurses, psychiatrists, and student interns developed a home visiting Infant Mental Health program. These individuals were trained in a psychodynamic or relationship-based approach to mental health treatment for adults and children that they adapted to meet the needs of infants, toddlers, and their parents.

Since the days of Ms. Fraiberg and the work of Ms. Weatherston, there has been a broadening of the field into a more interdisciplinary approach. IMH professionals come from many disciplines including social work, child welfare, education, speech and language, occupational and physical therapy, child and family development, psychology, nursing, pediatrics, and psychiatry. Training programs now focus on shifting from a

therapeutic approach directed at the individual to one that focuses on the parent-child dyad (Zeanah, Stafford, Nagle, and Rice, 2005).

Professionals are trained at many different levels including academic, professional in-service programs of specialized study, or professional conferences. Specialized training includes the development of a knowledge base and competencies that are specific to the optimal development of infants and toddlers. Specific training has included attachment theory, infant and family observation for the purpose of assessment and care, identification of disorders in infancy, and strategies for intervention with the parent and child.

There are a number of specialized training programs available to professionals in Utah. These programs include: the University of Utah Graduate School of Social Work Summer Institute; Critical Issues in Children's Mental Health; Bridging the Gap: Clinical Application of Attachment Theory and Research; courses offered by the National Association of Social Work (NASW) and the American Psychological Association (APA); and courses sponsored by a variety of community programs.

System Capacity Training Survey

In 2004, mental health agencies, early intervention sites and medical practices were asked to list the number of staff that had received specialized training in infant mental health. Without adequate record keeping in place, many of the agencies and practices were only able to estimate the numbers. In many cases, there were names but no record of where they worked or if they were professionally licensed. In other cases, there were duplicate listings causing an inability to determine which training the individual had attended.

The 2005 and 2006 survey tool provided a list of workshops that had been offered during the time frame from 2003 through 2006. In addition, there was an opportunity to list trainings that were not on the form. Many agencies listed numerous workshops with many staff attending. Respondents were asked to provide the number of staff that had attended each of the trainings. The numbers are likely duplicated but indicate a wide variety of available training opportunities with a large number of staff participating in the training events.

Review of the data from the surveys indicates that mental health centers and early intervention staff have attended the largest number of trainings. It is impossible however, to determine an exact number due to the likelihood that numbers may be duplicate. There does not appear to be a simple mechanism to determine the total number of staff attending any given seminar. An additional concern is that there has been no attempt to survey the larger mental health community about gaps in training, needs, interests or concerns.

Learning Collaboratives-

The number of medical professionals participating in infant/toddler or post-partum depression training is easier to measure. A focal point of the Utah ABCD II Project is the training offered to medical professionals through the Utah Pediatric Partnership to Improve Health Care Quality (UPIQ) Learning Collaborative Quality Improvement model.

There have been five separate Learning Collaboratives focusing on developmental and social/emotional issues from May 2004 to September 2006. The Collaboratives had a total of 51 practice teams. A practice team consists of a Physician, Nurse and Office Manager. Some practices will involve additional nursing or medical assistants in the process. There was at least one duplicate practice in each collaborative and some practices did not participate with a full team. However, there was always a physician or physician assistant in attendance. Duplicate practices are those that have attended more than one of the collaboratives. Taking this into consideration, training has been provided to 105 Pediatricians, Family Practice and nurse practitioners.

The Learning Collaborative begins with an intensive learning session. The learning session involves bringing practice teams together to hear experts in the field make the case for screening, referral and treatment. The expert presents information about the importance of screening and offers information about selected validated screening tools. Practice teams also learn the basics of quality improvement using the Plan, Do, Study, Act Cycle and have an opportunity to discuss plans for implementing the change in their practices. Practice teams are offered the opportunity to collaborate with Early Intervention, local health department and mental health providers' from their

area and learn about services available outside the medical office. This has been an extremely valuable exercise as it is one of the few opportunities that medical providers have to speak directly with outside resources. This also provides the outside resources the opportunity to learn about the importance of screening in the primary care practice and how to engage in collaborative relationships. A total of 25 outside resource representatives attended at least one initial learning session. Perhaps the greatest value of the learning session is the opportunity to collaborate with other practice teams and spend time with national experts in the field.

Collaboratives focusing on screening infants and toddlers (years one and two) were presented to seventeen practice teams. The teams were from the Wasatch Front (Utah, Salt Lake and Weber Counties) and Logan. Data from the infant and toddler Learning Collaboratives indicates that prior to participation in a collaborative; few practices used a standardized screening tool. After participation in a collaborative, the use of a tool increased by 76% to 84% for each collaborative. Further, the charts indicate that 62% to 77% of those screened required additional assessment or intervention. Of those 10% to 36% were referred outside the pediatric office for additional mental health services. In 2005, the participants were given the option of following borderline children (for the purposes of this report borderline is defined as an infant/toddler who may score high on the screening but the pediatrician feels that it may be an issue that will resolve without referral and chooses to follow the child in the office) in the practice. Of those who participated, 90% were treated within the primary care practice office. Complete measurement results for the Learning Collaboratives focusing on screening for social/emotional delay are attached as Appendix D.

Anecdotal evidence suggests that frontier areas feel a sense of under-representation in training programs and treatment options. As a result, the Learning Collaborative focusing on maternal depression was targeted to include rural practices and recruitment efforts were made to ensure their participation. Members of the Community Health Centers (CHC's) were invited to the initial learning session. In turn, this brought more involvement with Family Practice physicians, Physician Assistants and Nurse Practitioners to the learning session. Although the majority of the practices were from urban areas, one rural practice did participate in the Learning Collaborative. There

were 7 practice teams, including one family practice team and one team from a Community Health Center (CHC). The initial learning session was held in September 2006. Data analysis will be available in mid-2007.

As a result of interest expressed from health department partners in the community, an additional maternal depression screening training session was added that was less structured and did not involve follow-up data collection. The additional training was attended by 40 medical and mental health professionals and resulted in increased collaboration between service providers and increased interest in quality improvement projects focusing on screening.

An additional measurement issue to consider when looking at the Learning Collaborative is the spread effect. This refers to other providers in the practices adopting the screening processes after learning about the process during staff meetings with the UPIQ-trained providers. It is estimated that 18 additional practices have begun regular screening during well-child visits as a result of training provided during the two collaboratives focusing on screening infants and toddlers. For example, one clinic that had two pediatricians trained, reported that two additional pediatricians in that clinic started using the same screening process even though they did not go to the UPIQ training. In addition, providers report feeling more comfortable administering the screening as a result of the training and were confident that their patients were receiving a higher quality of care.

A final measurement issue is customer satisfaction. In this case, the customer is not the practice but the parent of the child. There are many stories about improved communication with the parents and improved parent satisfaction with the visit. Parents report feeling more assured that their child is developing appropriately and that they feel more prepared to participate in anticipatory guidance activities at home.

Summary-

Each year the system capacity survey has queried staff from the mental health centers, Early Intervention, and the medical clinics about participation in infant/toddler mental health training. The process of data analysis has been difficult in part due to poor record keeping and an inability to differentiate duplicate numbers. The simple analysis

found that mental health and early intervention providers are attending training on a regular basis. Physicians attend some of the same training seminars, however, the largest growth in physician training has resulted from participation in the Utah Department of Health/Utah Pediatric Partnership to Improve Health Care Quality (UPIQ) quality improvement Learning Collaborative.

Although all licensed mental health clinicians should have some degree of expertise as a generalist provider, it is important that they continue to receive training in specialized treatment to further hone their skills. Staff working within the public mental health centers may find it difficult to attend training due to the reluctance of the center to pay for training. While there have been a number of training opportunities, little is known about the views of the larger mental health community.

Given the difficulties in gathering data specific to participation in training events by mental health providers and incomplete information about available training opportunities, it is recommended that additional studies be conducted to determine the interest level, actual availability and needs of all mental health providers. A study of this nature will more adequately address the needs, make recommendation to fill any gaps and provide quantitative information about what is or is not available.

Recommendations-

The system capacity picture in Utah is becoming clearer. Numbers of licensed professionals employed across the system have been reviewed with some areas of concern. The community mental health system is suffering from financial cutbacks as a result of changes in Medicaid and has been forced to reduce the number of staff employed and contracted by the centers. While the number of licensed mental health professionals has grown, the number employed and contracted by the centers has fallen. At the same time, the number of children treated continues to grow. The community mental health system has been reluctant to increase the number of staff without increased funding. Training has been limited and often underutilized due to cost or travel involved. The challenges of the broader mental health community are unknown as they have never been included in any capacity studies.

The Early Intervention system has remained steady throughout the course of the

study. However, it is important to support specialized training as a capacity building tool in this area as Early Intervention may often be the referral system of choice for physicians. Early Intervention providers often serve as the “front-line” workers in early childhood and therefore, must have an advanced level of expertise in order to properly assess and make referral.

The challenges of the medical profession are great when it comes to providing care to children. They are clearly overburdened by the sheer number of office visits and the increasing difficulties children are presenting. While it is not expected that medical professionals will provide direct mental health care, it is crucial that the providers have an understanding of children’s mental health and the issues that may be presented.

Recommendation 1:

- Utah’s ABCD II project under the direction of the Bureau of Maternal and Child Health create an organized training program in children’s mental health (including maternal depression).

This will be accomplished by:

- Completing a professional mental health needs assessment to determine the gaps in training for children’s mental health and maternal depression

Rationale:

Since 2003, there have been a large number of workshops or conferences offered that provided training specific to children’s mental health. Poor record keeping has made it difficult to determine the number of staff attending these programs and the broader mental health community have never been included in any studies. It appears that more information is warranted to determine the most efficient direction to take regarding training. In addition, there has never been a comprehensive needs assessment of the larger mental health community. This study will provide information that will assist mental health centers, governmental agencies, private training planners and individuals interested in training needs.

The needs assessment will be completed by the Utah Department of Health, Bureau of Maternal and Child Health. Query will be made of all licensed mental health professionals in the state as to available training opportunities in children’s mental health and maternal depression and levels of interest and need.

Recommendation 2:

- Complete a study of Early Intervention, Head Start and medical practice training needs.

This will be accomplished by:

- A collaborative effort between the Utah Department of Health and University students seeking study for graduate or doctoral thesis/dissertation opportunities.

Rationale:

In creating a comprehensive system of care, it is imperative that all parts of the system are included in improvements. Early Intervention, Head Start and medical practices are crucial in providing care to children experiencing mental health issues. The capacity of these agencies requires additional study to determine ability to provide care. This study could be in the form of a formal survey or a series of focus groups with a similar goal of determining gaps in training geared to the specific group. This offers the opportunity for community partners to feel included in the development of a training program and could aid the system in the creation of an organized program that may increase participation.

Recommendation 3:

- Training programs created specific to fit the need.

This will be accomplished by:

- Thorough review of training needs assessment, reports on focus group and research into national programs designed specifically to provide intensive training in children's mental health.
- Local and national trainings featuring nationally recognized experts in the field of children's mental health.
- Train the trainer, tele-training or regionally focused training programs.

Rationale:

Improving system capacity relies upon the ability of the system to respond to the mental health needs of children and their families. Proper workforce development is crucial in promoting healthy development, prevention of problems and treatment of the issues as they arise. An understanding of the complexities of early childhood development is imperative in guaranteeing that the needs of children and families are

adequately met. Medical, mental health, Early Intervention and Head Start providers need the knowledge, skills and resources to most effectively support early social and emotional development and child mental health development. The most effective and efficient way to increase capacity is by increasing the number of individuals qualified to provide care.

Recommendation 4:

- Collaborate with the local graduate schools of social work in creating a child care consultations project or mental health co-location program in a Head Start or Early Intervention program, a medical home site or other interested primary care practice.

This will be accomplished by:

- A student intern would become part of a Head Start child care program, Early Intervention home visiting team or a medical practice.
- The intern would perform social/emotional screening and assessment; provide appropriate referral, parenting education, and screening for maternal depression; and, when appropriate, provide ongoing counseling.

Rationale:

In addition to specialized training, the best way to build the capacity of the system to address children's healthy mental development is the creation of integration projects into early childhood or children's services programs. Integration can provide a seamless coordination of care between the crucial providers and can insure collaboration and communication between providers. The integrated mental health provider serves as the link between the multiple programs and providers.

This approach would provide a long-range increase in infant mental health expertise by giving students the opportunity to learn by the "hands-on" approach. Addressing the needs of system capacity in this manner provides an increase in proper screening and treatment for social/emotional needs including referral for maternal depression. Over the long-term, this would improve treatment outcomes for children with social/emotional issues, reduce the number of children involved in the juvenile justice system, and offer the system a way to quickly identify family issues as they arise.

Appendix A-

58-60-102. Definitions.

In addition to the definitions in Section 58-1-102, as used in this chapter:

(1) "Client" or "patient" means an individual who consults or is examined or interviewed by a mental health therapist acting in his professional capacity.

(2) "Confidential communication" means information, including information obtained by the mental health therapist's examination of the client or patient, which is:

(a) (i) transmitted between the client or patient and a mental health therapist in the course of that relationship; or

(ii) transmitted among the client or patient, the mental health therapist, and individuals who are participating in the diagnosis or treatment under the direction of the mental health therapist, including members of the client's or patient's family; and

(b) made in confidence, for the diagnosis or treatment of the client or patient by the mental health therapist, and by a means not intended to be disclosed to third persons other than those individuals:

(i) present to further the interest of the client or patient in the consultation, examination, or interview;

(ii) reasonably necessary for the transmission of the communications; or

(iii) participating in the diagnosis and treatment of the client or patient under the direction of the mental health therapist.

(3) "Hypnosis" means, regarding individuals exempted from licensure under this chapter, a process by which one individual induces or assists another individual into a hypnotic state without the use of drugs or other substances and for the purpose of increasing motivation or to assist the individual to alter lifestyles or habits.

(4) "Individual" means a natural person.

(5) "Mental health therapist" means an individual licensed under this title as:

(a) a physician and surgeon, or osteopathic physician engaged in the practice of mental health therapy;

(b) an advanced practice registered nurse, specializing in psychiatric mental health nursing;

(c) a psychologist qualified to engage in the practice of mental health therapy;

(d) a clinical social worker;

(e) a certified social worker;

(f) a marriage and family therapist; or

(g) a professional counselor.

(6) "Mental illness" means a mental or emotional condition defined in an approved diagnostic and statistical manual for mental disorders generally recognized in the professions of mental health therapy listed under Subsection (5).

(7) "Practice of mental health therapy" means treatment or prevention of mental illness, including:

(a) conducting a professional evaluation of an individual's condition of mental health, mental illness, or emotional disorder consistent with standards generally recognized in the professions of mental health therapy listed under Subsection (5);

(b) establishing a diagnosis in accordance with established written standards generally recognized in the professions of mental health therapy listed under Subsection (5);

(c) prescribing a plan for the prevention or treatment of a condition of mental illness or emotional disorder; and

(d) engaging in the conduct of professional intervention, including psychotherapy by the application of established methods and procedures generally recognized in the professions of mental health therapy listed under Subsection (5).

(8) "Unlawful conduct" is as defined in Sections 58-1-501 and 58-60-109.

(9) "Unprofessional conduct" is as defined in Sections 58-1-501 and 58-60-110, and may be further defined by division rule.

58-60-103. Licensure required.

(1) An individual shall be licensed under this chapter; Chapter 67, Utah Medical Practice Act, or Chapter 68, Utah Osteopathic Medical Practice Act; Chapter 31b, Nurse Practice Act; Chapter 61, Psychologist Licensing Act; or exempted from licensure under this chapter in order to:

(a) engage in or represent he will engage in the practice of mental health therapy, clinical social work, certified social work, marriage and family therapy, or professional counseling; or

(b) practice as or represent himself as a mental health therapist, clinical social worker, certified social worker, marriage and family therapist, professional counselor, psychiatrist, psychologist, or registered psychiatric mental health nurse specialist.

(2) An individual shall be licensed under this chapter or exempted from licensure under this chapter in order to:

(a) engage in or represent that he is engaged in practice as a social service worker; or

(b) represent himself as or use the title of social service worker.

(3) An individual shall be licensed under this chapter or exempted from licensure under this chapter in order to:

(a) engage in or represent that he is engaged in practice as a licensed substance abuse counselor; or

(b) represent himself as or use the title of licensed substance abuse counselor.

(4) Notwithstanding the provisions of Subsection 58-1-307(1)(c), an individual shall be certified under this chapter, or otherwise exempted from licensure under this chapter in order to engage in an internship or residency program of supervised clinical training necessary to meet the requirements for licensure as:

- (a) a marriage and family therapist under Part 3; or
- (b) a professional counselor under Part 4.

58-60-107. Exemptions from licensure.

(1) Except as modified in Section 58-60-103, the exemptions from licensure in Section 58-1-307 apply to this chapter.

(2) (a) In addition to the exemptions from licensure in Section 58-1-307, the following may engage in acts included within the definition of practice as a mental health therapist, subject to the stated circumstances and limitations, without being licensed under this chapter:

(b) the following when practicing within the scope of the license held:

(i) a physician and surgeon or osteopathic physician and surgeon licensed under Chapter 67, Utah Medical Practice Act, or Chapter 68, Utah Osteopathic Medical Practice Act;

(ii) an advanced practice registered nurse, specializing in psychiatric mental health nursing, licensed under Chapter 31b, Nurse Practice Act; and

(iii) a psychologist licensed under Chapter 61, Psychologist Licensing Act;

(3) a recognized member of the clergy while functioning in his ministerial capacity as long as he does not represent himself as or use the title of a license classification in Subsection 58-60-102(5);

(4) an individual who is offering expert testimony in any proceeding before a court, administrative hearing, deposition upon the order of any court or other body having power to order the deposition, or proceedings before any master, referee, or alternative dispute resolution provider;

(5) an individual engaged in performing hypnosis who is not licensed under this title in a profession which includes hypnosis in its scope of practice, and who:

(a) (i) induces a hypnotic state in a client for the purpose of increasing motivation or altering lifestyles or habits, such as eating or smoking, through hypnosis;

(ii) consults with a client to determine current motivation and behavior patterns;

(iii) prepares the client to enter hypnotic states by explaining how hypnosis works and what the client will experience;

(iv) tests clients to determine degrees of suggestibility;

(v) applies hypnotic techniques based on interpretation of consultation results and analysis of client's motivation and behavior patterns; and

(vi) trains clients in self-hypnosis conditioning;

(b) may not:

(i) engage in the practice of mental health therapy;

(ii) represent himself using the title of a license classification in Subsection 58-60-102(5); or

(iii) use hypnosis with or treat a medical, psychological, or dental condition defined in generally recognized diagnostic and statistical manuals of medical, psychological, or dental disorders;

(6) an individual's exemption from licensure under Subsection 58-1-307(1)(b) terminates when the student's training is no longer supervised by qualified faculty or staff and the activities are no longer a defined part of the degree program;

(7) an individual holding an earned doctoral degree or master's degree in social work, marriage and family therapy, or professional counseling, who is employed by an accredited institution of higher education and who conducts research and teaches in that individual's professional field, but only if the individual does not engage in providing or supervising professional services regulated under this chapter to individuals or groups regardless of whether there is compensation for the services;

(8) an individual in an on-the-job training program approved by the division while under the supervision of qualified persons;

(9) an individual providing general education in the subjects of alcohol or drug use or abuse, including prevention; and

(10) an individual providing advice or counsel to another individual in a setting of their association as friends or relatives and in a nonprofessional and noncommercial relationship, if there is no compensation paid for the advice or counsel.

Appendix B-

ABCDII System Capacity Survey

Agency/Clinic Name: _____
 Agency/Clinic Location: _____
 Name and Title of person completing survey: _____

This survey is designed to measure the capacity of the mental health, Early Intervention, medical, and Early Head Start system in Utah to provide social/emotional intervention to infants/toddlers birth to three.

Instructions: Please, complete the information, and e-mail the completed questionnaire by May 31, 2005 to Lori Smith, LCSW at losmith@utah.gov or mail to 288 North 1460 West- P.O. Box 143108, Salt Lake City, Utah 84114-3108.

The following questions are designed to determine the number of mental health professionals currently employed or contracted by your agency.

1. Between March 2004 and the current date how many of the following professionals does your agency/clinic employ?* (Please specify the number in the box next to the applicable position, indicate which clinic location the employee generally practices and indicate the number of new staff over the past year).

Position	# Employed	Agency/clinic address and telephone
PEDIATRICIAN		
PEDIATRIC PSYCHIATRIST		
DEVELOPMENTAL PEDIATRICIAN		
PSYCHOLOGIST		
LICENSED CLINICAL SOCIAL WORKER (LCSW)		
LICENSED PROFESSIONAL COUNSELOR (LPC)		
LICENSED MARRIAGE AND FAMILY THERAPIST (LMFT)		
CERTIFIED SOCIAL WORKER (CSW)		
ADVANCED PRACTICE REGISTERED NURSE (APRN)		
OTHER		

**If more than one location, please indicate the number employed at each.*

2. Between March 2004 and the current date how many of the following professionals does your agency/clinic retain on contract? (Please specify the number in the box next to the applicable position, indicate which clinic location the employee generally practices and number of new contracts over the past year)

Position	# Contracted	Agency/Clinic address and telephone
PEDIATRICIAN		
PEDIATRIC PSYCHIATRIST		
DEVELOPMENTAL PEDIATRICIAN		
PSYCHOLOGIST		
LICENSED CLINICAL SOCIAL WORKER (LCSW)		
LICENSED PROFESSIONAL COUNSELOR (LPC)		
LICENSED MARRIAGE AND FAMILY THERAPIST (LMFT)		
CERTIFIED SOCIAL WORKER (CSW)		

ADVANCED PRACTICE REGISTERED NURSE (APRN)		
OTHER		

**If more than one location, please indicate the number employed at each.*

The following questions are designed to determine mental health emergency coverage.

3. Does your agency/clinic provide 24 hour Psychiatrist coverage? *(Please mark applicable box)*
 YES NO
- 3a. If yes, is the coverage provided by a general Psychiatrist or a Child Psychiatrist? *(Please mark applicable box)*
 General Psychiatrist Child Psychiatrist
4. If you do not employ a Psychiatrist (General or Child) how do you deal with after hour emergency needs?
(Please mark the appropriate box).
- Provide crisis line referral
 Refer to local hospital
 Other (please list)_____

The following question is designed to determine the availability of and demand for additional specialized training in infant mental health. Please review the question and indicate the number of staff who have attended the specific training.

5. Have any of your staff attended any of the following infant mental health training programs? YES
 No

Title of training	Number of staff attending	Date of training
Infusing Infant Mental Health Strategies Presented by The Harris Center and sponsored by The Children's Center		
Supporting Healthy Social/emotional Development- 2003 Summer Institute		
Bridging the Gap 2004		
Critical Issues 2004		
2004 Maternal Depression- Sponsored by UAIMH		
Infant Parent Psycho Therapy- Natalie Roth CSHCN		
Georgetown Institutes- San Francisco- 2004		
Attachment Disorders- IOTI training sponsored by The Children's Center		
Zero to Three Institutes- Sacramento- 2004		
Reflective Supervision presented by Nick Tsandes		
Coping Styles of Children with Special Needs Observation, Assessment & Intervention presented by The Children's Center		
Bridging the Gap- 2005		
Mutual Competence presented by Adrienne Akers		
Children's Emotional Responses to Illness Injury and Health Care. Coping with Medical Trauma presented by Primary Children's Medical Center		
21 st Summer Institute in the Human Services		

Other- Please list on a separate sheet of paper		
---	--	--

If you have had staff attend the Touchpoints training please indicate the number of staff attending, date of training and location of training in the appropriate box

Touchpoints 2003, 2004, 2005	Number of staff attending	Date of Training	Location of training

The following questions are designed to determine information about the use of standardized screening tools and the types of tools used.

6. Does your agency administer infant developmental and/or social/emotional screening?
 YES NO

6a. If yes, what screening tools do you use? *(Please list all tools used.)*

The following questions are designed to determine information about referral, and resources used.

7. Does your agency provide referral for infant and early childhood developmental or mental health concerns?
 YES NO

7a. If yes, where? *(Please list all resources used.)*

7b. If no, what other action do you take?

The following questions are designed to determine if you provide on-site mental health counseling and the types of professionals performing the services.

8. Do you provide any on-site mental health counseling?
 YES NO

8a. If yes, please list licensure qualifications of those individuals providing the counseling.

*** THANK YOU FOR YOUR TIME!!! ***

Appendix C-

System Capacity Survey Data sets listed by table number.

Table 1: Licensed mental health professionals in the state:

Profession	2004	2005	2006
Psychologist	728	753	755
Social Work (includes LCSW and CSW)	2940	2884	3317
Marriage and Family Therapy (MFT)	415	455	519
Licensed Professional Counselor (LPC)	283	554	686
TOTAL	4366	4646	5277

Table 2: Mental Health Centers currently under contract and counties covered:

<p>Bear River Mental Health</p> <ul style="list-style-type: none"> • Box Elder • Cache • Rich
<p>Central Utah Mental Health Center, Counseling and Substance Abuse Center</p> <ul style="list-style-type: none"> • Piute • Juab • Wayne • Millard • Sanpete • Sevier
<p>Davis Behavioral Health</p> <ul style="list-style-type: none"> • Davis
<p>Four Corners Community Behavioral Health</p> <ul style="list-style-type: none"> • Carbon • Emery • Grand
<p>Northeastern Counseling Center</p> <ul style="list-style-type: none"> • Duchesne • Uintah • Daggett
<p>Southwest Mental Health</p> <ul style="list-style-type: none"> • Beaver • Garfield • Iron • Kane • Washington
<p>Valley Mental Health</p> <ul style="list-style-type: none"> • Salt Lake • Tooele • Summit
<p>Wasatch Mental Health</p> <ul style="list-style-type: none"> • Utah
<p>Weber Human Services</p>

- Weber
- Morgan

Fee-for-Service community mental health centers:

- | |
|--|
| Heber Valley Counseling <ul style="list-style-type: none"> • Wasatch |
| San Juan Counseling Center <ul style="list-style-type: none"> • San Juan |

Table 3: Professionals employed and contracted by the mental health centers statewide:

Position	Employed in 2004	Contracted in 2004	2004 Total	Employed in 2005	Contracted in 2005	2005 Total	Employed in 2006	Contracted in 2006	2006 Total
Pediatrician	4	4	8	4	0	4	1	0	1
Pediatric Psychiatrist	12	10.5	22.5	15	4.12	19.12	12	8	20
Developmental Pediatrician	0	1	1	0	0	0	0	0	0
Psychologist	42	45	87	37	32	69	20	16	36
LCSW	178	69	247	129	33	162	178	17	195
LPC	36	7	43	28	1	29	36	2	38
MFT	24	6	30	9	3	12	7	0	7
CSW	70	14	84	47	16	63	51	2	53
Other	14	9	23	36	10	46	2	0	2
Totals	380	165.5	545.5	305	99.12	404.12	307	45	352

Table 4: Total by profession 2004, 2005 and 2006:

Position	2004 Total	2005 Total	2006 Total
Pediatrician	8	4	1
Pediatric Psychiatrist	22.5	19.12	20
Developmental Pediatrician	1	0	0
Psychologist	87	69	36
LCSW	247	162	195
LPC	43	29	38
MFT	30	12	7
CSW	84	63	53
Other	23	46	2
Totals	545.5	404.12	352

Table 5: Professionals employed and contracted in urban and rural centers for 2004:

Position	2004 Urban Employed	2004 Urban Contracted	Urban Total	2004 Rural employed	2004 Rural Contracted	Rural Total	2004 Total
Pediatrician	4	4	8	0	0	0	8

Pediatric Psychiatrist	11	7	18	1	3.5	4.5	22.5
Developmental Pediatrician	0	1	1	0	0	0	1
Psychologist	27	45	72	15	0	15	87
LCSW	127	66	193	51	3	54	247
LPC	18	7	25	18	0	18	43
MFT	12	6	18	12	0	12	30
CSW	55	14	69	15	0	15	84
Other	3	9	12	11	0	11	23
TOTAL	257	159	416	123	6.5	129.5	545.5

Table 6: professionals employed and contracted in urban and rural centers for 2005:

Position	2005 Urban Employed	2005 Urban Contracted	Urban Total	2005 Rural Employed	2005 Rural Contracted	Rural Total	2005 Total
Pediatrician	4	0	4	0	0	0	4
Pediatric Psychiatrist	13	3	16	2	1.12	3.12	19.12
Developmental Pediatrician	0	0	0	0	0	0	0
Psychologist	26	31	57	11	1	12	69
LCSW	90	30	120	39	3	42	162
LPC	15	1	16	13	0	13	29
MFT	4	3	7	5	0	5	12
CSW	36	16	52	11	0	11	63
Other	29	10	39	7	0	7	46
TOTAL	217	94	311	88	5.12	93.12	404.12

Table 7 professionals employed and contracted in urban and rural centers for 2006:

Position	2006 Urban Employed	2006 Urban Contracted	Urban Total	2006 Rural Employed	2006 Rural Contracted	Rural Total	2006 Total
Pediatrician	1	0	1	0	0	0	1
Pediatric Psychiatrist	12	7	19	0	1	1	20
Developmental Pediatrician	0	0	0	0	0	0	0
Psychologist	12	14	26	4	1	5	31
LCSW	87	13	100	44	2	46	146
LPC	18	2	20	8	0	8	28
MFT	3	0	3	2	0	2	5
CSW	38	2	40	2	0	2	42
Other	1	0	1	1	1	2	3
TOTAL	172	38	210	61	5	66	276

Note: Only three of seven rural centers responded to the survey making the statistical relevance questionable, however the information is included and used for comparison. It should be further noted that of the rural centers responding one is a center in an area that will likely be considered urban in the next census.

Table 8 staff employed and contracted 2004, 2005 and 2006:

Year	Urban Employed	Urban Contracted	Rural Employed	Rural Contracted	Total
2004	271	166	127	6.5	570.5
2005	225	97	90	5.12	417.12
2006	172	38	61	5	276

Table 9 Medicaid children/youth served by center 2004-2006 as reported by the centers:

Center	Total Served in 2004	Total served in 2005	Total served in 2006
Bear River Mental Health	449	784	885
Central Utah Counseling and Substance Abuse Center	504	271	505
Davis Behavioral Health	301	772	1263
Four Corners Mental Health	262	443	575
Northeastern Counseling Center	255	281	406
Southwest Center	486	861	1544
Wasatch Mental Health	1055	1453	3034
Weber Human Services	491	1853	1941
Valley Mental Health	2962	4041	5778
TOTAL	6765	10759	15931

Table 10 total number children served by year urban and rural:

Year	Urban	Rural	Total
2004	4809	1956	6765
2005	8119	2640	10759
2006	12016	3915	15931

Table 11 total urban children served compared to total number of clinicians:

Year	Providers	Children served
2004	437	4809
2005	322	8119
2006	210	12016

Table 12 total rural children served compared to total number of clinicians:

Year	Providers	Children served
2004	133.5	1956
2005	95.12	2640
2006	3915	2147

Table 13 number of Pediatric health care providers by Medicaid medical plan

Year	Healthy U	Molina	Select Access
2004	209	201	213
2005	101	197	201
2006	148	480	136

Table 14 total number of specialists employed/contracted by the clinics:

Position	2004 Total	2005 Total
Pediatrician	160	134.5
Pediatric Psychiatrist	1	0
Developmental Pediatrician	4	2
Psychologist	2	2
LCSW	1	1
LPC	0	0
MFT	0	0
CSW	0	0
APRN	20	15
Other (includes RN)	36	10
TOTAL	224	164.5

Table 15 Medicaid Children birth to five by county:

County	2003	2004	2005	2006
Beaver	14	21	23	17
Box Elder	421	482	486	532
Cache	1,550	1,809	2,129	2,295
Carbon	428	408	339	405
Daggett	3	3	1	3

Davis	987	1,095	1,108	1,196
Duchesne	185	203	172	177
Emery	97	98	124	173
Garfield	19	26	23	19
Grand	167	159	202	172
Iron	577	772	935	736
Juab	82	98	78	115
Kane	28	25	10	8
Millard	143	143	133	162
Morgan	23	28	30	41
Piute	5	7	12	14
Rich	13	22	19	15
Salt Lake	3,951	4,597	4,592	4,887
San Juan	225	236	192	152
Sanpete	254	318	309	399
Sevier	174	194	203	243
Summit	212	294	311	292
Tooele	543	561	546	544
Uintah	250	289	311	289
Utah	4,292	4,874	5,052	5,500
Wasatch	143	147	168	214
Washington	614	925	1,338	1,617
Wayne	12	22	9	13
Weber	1,815	1,877	1,915	2,164
Total	24642	28422	29584	30042

Table 16: Urban vs. Rural birth to five children served:

Year	Urban	Rural
2003	11045	6182
2004	12443	7290
2005	12667	8103
2006	13687	8667

Table 17 Early Intervention Programs and the counties covered:

<p>Central Utah Health Department</p> <ul style="list-style-type: none"> • Juab • Millard • Sanpete • Sevier • Piute • Wayne
<p>Family Enrichment Center</p> <ul style="list-style-type: none"> • Davis
<p>DDI VANTAGE</p> <ul style="list-style-type: none"> • Salt Lake/Granite School District • Tooele • Duchesne

Up to 3
<ul style="list-style-type: none"> • Cache • Rich • Box Elder
Deaf/Blind Services
<ul style="list-style-type: none"> • Statewide
Parent Infant Program
<ul style="list-style-type: none"> • Statewide
Child Development Center
<ul style="list-style-type: none"> • Jordan School District
Kids On The Move
<ul style="list-style-type: none"> • Alpine School District in Utah County
Kids Who Count
<ul style="list-style-type: none"> • Nebo School District in Nebo County
Provo Early Education Program
<ul style="list-style-type: none"> • Provo School District in Utah County
Southeastern Utah Health Dept
<ul style="list-style-type: none"> • Carbon • Emery • Grand
San Juan School District Early Intervention
<ul style="list-style-type: none"> • San Juan
Summit County Health Dept. Early Intervention
<ul style="list-style-type: none"> • Summit • Wasatch
Southern Utah University Early Intervention
<ul style="list-style-type: none"> • Beaver • Iron • Garfield • Kane
The Learning Center for Families
<ul style="list-style-type: none"> • Washington County
PrimeTime 4 Kids
<ul style="list-style-type: none"> • Uintah • Daggett
Weber School District Early Intervention
<ul style="list-style-type: none"> • Weber • Morgan

Table 18 EI professionals employed and contracted statewide 2004, 2005, 2006:

Position	Employed in 2004	Contracted in 2004	2004 Total	Employed in 2005	Contracted in 2005	2005 total	Employed in 2006 *	Contracted in 2006 *	2006 total *
Pediatrician	0	0	0	0	0	0	0	0	0
Pediatric Psychiatrist	0	0	0	0	0	0	0	0	0
Developmental Pediatrician	0	0	0	0	0	0	0	0	0
Psychologist	5.25	0	3.25	5.2	2	5.2	0.5	1	1.5
LCSW	0.25	2	2.25	0.2	1	1.2	0.8	1	1.8
LPC	0	1	1	0	0	0	0	0	0
MFT	0	1	1	0	0	0	0	0	0
CSW	4	0	4	2	0	2	0	0	0

APRN	6.75	1	7.75	3	0	3	1	0	1
Other	21	0	21	20	8	28	0	7	6
TOTAL	37.25	5	42.25	30.4	11	41.4	2.3	9	12..3

* total respondents for 2006 survey less than 50%, results should be carefully considered as they may not be statistically valid.

Table 19 breakdown of professionals employed and contracted in urban and rural sites for the 2004-2006:

	Urban Employed	Urban Contracted	Rural Employed	Rural Contracted
2004	23.25	3	14	2
2005	23	1	7.4	10
2006	2.3	1	0	6

Note: total respondents for 2006 survey less than 50%, results should be carefully considered as they may not be statistically valid.

Appendix D-

Learning Collaborative Measurement results

ABCD II Common Measures: Overview of Utah's Results

Practices participating in the UPIQ Learning Collaboratives were asked to conduct monthly chart audits to measure progress related to improving developmental screening and referral during well-child visits. Audits were conducted for the 12 months following participation in the Learning Session. Ten practices participated in each Learning Collaborative, for a total of 20 practices. Nine hundred fifty charts were reviewed over the course of both Learning Collaboratives.

A brief overview of the results of the chart audits can be found below. A more detailed explanation of the results can be found in the subsequent pages of this report under the headings "Learning Collaborative 1 (age birth to 12 months)" and "Learning Collaborative 2 (age 12 months to 36 months)".

Measure 1: Percent of charts indicating screening was completed during well child visit.	
Social/emotional Screening- Infants	76%
Social/emotional Screening- Toddlers	84%
Measure 2: Percent of charts indicating child was referred for additional services (of those children who were identified to be in need of referral).	
Social/emotional Screening- Infants	62%
Social/emotional Screening- Toddlers	77%
Measure 3A: Percent of charts indicating child was followed in the PCP office (of those children who were identified to be in need of referral).	
Social/emotional Screening- Infants	Information on follow-up by PCP not collected as part of Learning Collaborative 1.
Social/emotional Screening- Toddlers	64% ¹
Measure 3B: Percent of charts indicating report verifying receipt of additional services was received by the PCP (of those charts indicating child was referred for additional services).	
Social/emotional screening- Infants-	10%
Social/emotional Screening- Toddlers	36%

¹ See notes on the limitations of this measure under Learning Collaborative 2 section.

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Learning Collaborative 1 (age birth to 12 months)

Part One of Monthly Audit Form:

Practices were asked to pull a sample of 5 charts of children age birth to 12 months that had a well child visit in the past month to evaluate:

- Completion of developmental screening
- Need for further assessment / services
- Referral for further assessment / services

Part Two of Monthly Audit Form:

Practices were asked to pull a sample of 5 different charts of children age birth to 12 months that had a well child visit in the past month that resulted in referral or other services to evaluate:

- Report of assessment / services received
- Receiving services
- Medical records sent to agency or provider
- Report of intervention result received

Measure 1: Number of children screened / number of children who should have been screened

Number of charts indicating screening was completed during the well-child visit	401
Number of charts audited	526
Percent of charts indicating screening was completed during the well-child visit	76%

Measure 2: Number of children referred for services / number of children who should have been referred

Number of charts indicating child was referred for services / assessment	13
Number of charts indicating need for referral	21
Percent of charts indicating child was referred for services / assessment (of those children who were identified to be in need of referral)	62%

Measure 3A: Number of children who received treatment services from the PCP who conducted the screening / number of children who were screened and whose screening results indicated that they should receive treatment services provided by the PCP

The monthly audit tool for Learning Collaborative 1 did not collect information pertaining to the provision of treatment services by the PCP who conducted the developmental screening. See Monthly Audit Form for Learning Collaborative 1.

Measure 3B: Number of children who received referral for treatment services from a non-PCP and a report verifying the receipt to those services was received by the PCP / number of children who received referral for treatment services from a non-PCP

Number of charts indicating child received referral from PCP to a non-PCP for assessment or other services and a report of those services was received by the PCP	9
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Number of charts indicating child received referral from PCP to a non-PCP for assessment or other services	79
Percent of charts indicating report verifying receipt of services was received by the PCP	10%

Learning Collaborative 2 (age 12 months to 36 months)

Part One of Monthly Audit Form:

Practices were asked to pull a sample of 5 charts of children age 12 months to 36 months that had a well child visit in the past month to evaluate:

- Type of health insurance
- Completion of developmental screening tool
- Need for additional intervention
- Intervention provided in medical office
- Referred to non-PCP for further intervention

Part Two of Monthly Audit Form:

Practices were asked to pull a sample of 5 different charts of children age 12 months to 36 months that had a well child visit in the past month that resulted in referral or other services to evaluate:

- Report of assessment received by non-PCP
- Report indicated child not eligible for services
- Child receiving ongoing services from non-PCP
- Report of intervention result received

Note: Type of health insurance coverage was not collected in Part Two of the Monthly Audit.

Measure 1: Number of children screened / number of children who should have been screened

	Medicaid	Non-Medicaid	Overall
Number of charts indicating screening tool was completed during well-child visit	60	150	210
Number of charts audited	73	178	251
Percent of charts indicating screening tool was completed during well-child visit	82%	84%	84%

Measure 2: Number of children referred for services / number of children who should have been referred

	Medicaid	Non-Medicaid	Overall
Number of charts indicating child was referred to Non-PCP	2	15	17
Number of charts indicating need for referral	2	20	22
Percent of charts indicating child was referred to Non-PCP (of those identified to be in need of referral)	100%	75%	77%

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Measure 3A: Number of children who received treatment services from the PCP who conducted the screening / number of children who were screened and whose screening results indicated need for referral

	Medicaid	Non-Medicaid	Overall
Number of charts indicating child was provided intervention in the PCP office	7	7	14
Number of charts indicating need for referral	2	20	22
Percent of charts that were followed in the PCP office	350%*	35%	64%

*Note: Some children whose score did not indicate a need for additional intervention were provided intervention in the PCP office resulting in a value of over 100%.

Measure 3B: Number of children who received referral for treatment services from a non-PCP and a report verifying the receipt of those services was received by the PCP / number of children who received referral for treatment services from a non-PCP

Number of charts indicating child received referral from PCP to a non-PCP for treatment services and a report of those services was received by the PCP	46
Number of charts indicating child received referral from PCP to a non-PCP for treatment services	82
Percent of charts indicating report verifying receipt of services was received by the PCP	36%

*Note: Type of health insurance was not collected for these measures (see Monthly Chart Audit Tool for Learning Collaborative 2).

Notes regarding Common Measures Matrix

- 1) Type of Screening Tool Used. Information on the type of screening tool used by practices was not collected in either Learning Collaborative. As such, findings could not be stratified by the tool used as described in the measures matrix.
- 2) Medicaid status. Information on Medicaid status was not collected as part of Learning Collaborative 1. The measures matrix indicates that the percent of Medicaid children within each practice will be determined and applied to the chart audit results. However, because the chart audit results are only a sample of the total number of children who were actually screened, applying the percent of Medicaid patients within each practice to the chart audit results would only estimate the total number of Medicaid charts that were reviewed compared to the total number of Non-Medicaid charts that were reviewed. Because this method would not provide an estimate of the percent of Medicaid children that were screened compared to the percent of non-Medicaid children that were screened, it was not included.
- 3) Learning Collaborative 3: Maternal Depression: Sufficient data from the third Learning Collaborative is not available at this time for inclusion in the report.

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