

**Improving the Delivery of
Health Care that Supports
Young Children's Healthy
Mental Development**

*Early Accomplishments and Lessons
Learned from a Five-State Consortium*

Neva Kaye

April 2006

Funded by The Commonwealth Fund



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National Academy for State Health Policy

50 Monument Square, Suite 502

Portland, ME 04101

Telephone: (207) 874-6524

Facsimile: (207) 874-6527

E-mail: info@nashp.org

Website: www.nashp.org

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- Penny Knapp, MD; Linda Rudolph, MD, Richard Sun, MD; and Cricket Mitchell of California;
- Anne Marie Murphy, Debbie Saunders, Dedra Markovich, and Carey McCann of Illinois;
- Carrie Fitzgerald, Sally Nadolsky, and Kay DeGarmo of Iowa;
- Glenace Edwall, Antonia Wilcoxon, and Susan Castellano of Minnesota; and
- Julie Olson, Katie Smart, and Lori Smith of Utah.

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Finally, it is important to note that the views presented here are those of the author. Any errors or omissions are mine.

EXECUTIVE SUMMARY

Services that support young children’s healthy mental development can reduce the prevalence of developmental and behavioral disorders that have high costs and long-term consequences for health, education, child welfare, and juvenile justice systems—and for children’s futures. States are interested in improving their support of young children’s healthy mental development and want to learn about ways to do so.

In January 2004, the ABCD II Consortium was formed to provide five states with an opportunity to develop and test strategies for improving the care of young children at risk for or with social or emotional development delays, especially those in need of preventive or early intervention services. Each state is working toward the common goal of improving care, but each of their projects has different objectives and approaches.

State	Objectives
California	<ul style="list-style-type: none"> • Develop a service matrix that will be used to create a “roadmap to care.” • Identify policy and service delivery changes needed to improve access to infant mental health and developmental services. • Develop and implement a quality improvement project in primary care practices in two managed care organizations (MCOs).
Illinois*	<ul style="list-style-type: none"> • Increase the number of young children who receive comprehensive primary care that addresses social and emotional development, by <ul style="list-style-type: none"> ▪ increasing the use of formal screening tools and referrals for intervention services; and ▪ improving pediatric providers’ access to materials on early childhood and perinatal mental health. • Develop mental health and developmental screening and referral guidelines and test them in four pilot communities before implementing them statewide.
Iowa	<ul style="list-style-type: none"> • Establish minimum clinical care standards for preventive and developmental mental health services. • Establish links to community resources to improve access to appropriate follow-up care. • Establish two pilot projects to test the standards and identify policy changes needed to support statewide implementation of the standards.
Minnesota	<ul style="list-style-type: none"> • Support primary care provider efforts to meet the needs of children who are at risk for delays in social or emotional development but do not meet the criteria for receiving services from the children’s mental health system by, among other things, <ul style="list-style-type: none"> ▪ Conducting CME trainings on early childhood mental health; ▪ Increasing the likelihood that children who qualify for care from the children’s mental health system are identified and referred to that system; and ▪ Conducting two pilots to test strategies to improve care. • Modify state policies to increase the identification and referral of children with delays.
Utah	<ul style="list-style-type: none"> • Increase screening for infant mental health concerns as part of EPSDT/well-child visits. • Increase interactions between and among Medicaid providers to ensure that providers direct children and their families to appropriate services. • Increase screening by pediatric practices for maternal depression during the postpartum period. • Increase the capacity of the current mental health system to serve infants and toddlers. • Conduct three learning collaboratives with pediatric practices to achieve these objectives.

*Unlike the other four states in the ABCD II Collaborative, Illinois’ individual project is not funded by the Commonwealth Fund but, rather, by a local funder, the Michael Reese Health Trust.

The five states have not yet completed their projects, but they have accomplished key tasks and learned valuable lessons. The purpose of this paper is to provide an opportunity for other states interested in improving child development services to benefit from the experiences of these five states.

Key Accomplishments

Promoted pediatric provider use of validated screening tools. All five states have identified, with stakeholder participation, a set of tools that they recommend clinicians use and are promoting the tools' use through activities, such as modifying Medicaid provider handbooks and holding training sessions.

Helped primary care providers integrate these tools into their practices. The five states have supported primary care providers in a variety of ways that have included establishing learning collaboratives of practice-based teams, developing training modules for individual pilots and practices, identifying “physician experts” to serve as mentors to primary care providers, and partnering with provider organizations that provide direct support to practices.

Identified and facilitated appropriate referral to follow-up services. The five states have identified resources through activities such as surveys, stakeholder interviews, and review of materials, including state regulations. Further, these states have facilitated referrals to resources through activities such as creating a database of local and statewide resources, providing practices with training including information about local resources, designating a local individual or agency that is familiar with resources for follow-up services to facilitate referrals, and working with primary care practices and representatives of local resource agencies to develop referral pathways. Finally, these states have used the information collected about local resources to identify gaps in the system and begin developing ways to fill those gaps, such as facilitating use of a diagnostic classification system specifically designed for young children.

Identified and addressed policy barriers. All five states have developed a process for identifying and addressing policy barriers based on their ABCD project experience and stakeholder input. These include establishing statewide policy workgroups, producing documents identifying and describing the barriers, presenting the results of the work to state leaders who can act on the information, and developing guiding principles for addressing changes. This work has already enabled the five states to implement policies that better support young children's healthy development—not only in those governing Medicaid, but also in those that govern other programs such as early intervention.

Formed partnerships to achieve project goals. The five states have all established key partnerships that they believe will enable them to meet their project goals. These states have partnered with other state agencies, clinicians, provider organizations, and others. These partnerships have been key not only to developing and implementing the project but to identifying and addressing policy barriers, communicating with clinicians, and improving the quality of care delivered.

Used quality improvement to make progress. Most of the efforts of the ABCD II states are designed to produce and sustain improvement in the delivery of care within existing federal guidelines and funding. These states are fostering change through such mechanisms as better defining Medicaid expectations of clinicians and supporting clinicians in their efforts to improve the quality of care they provide. Also, California, Illinois, and Utah are all working through their Medicaid managed care systems to improve care. These states are undertaking performance improvement projects, working with their external quality review organizations (EQROs) to plan and promote improvements, and developing model quality improvement projects.

Lessons Learned

Screening with a standardized tool for potential social and emotional development delays is an important step in ensuring young children's healthy mental development. There is a clear consensus in the field that pediatric clinicians have both the opportunity and expertise to identify children who are in need of care to support their mental development. There are also indications that physicians often fail to diagnose children with a clearly defined developmental problem. In response, the five ABCD II projects have focused their improvement efforts on encouraging and supporting primary pediatric practices to make periodic use of a validated, standardized screening tool a regular part of the way they deliver care to all children.

Screening does little good without access to follow-up services. All five states have found that efforts to identify and help families and clinicians access resources for assessment and treatment are critical to project success. These follow-up efforts are necessary to ensure that children who are identified with potential needs receive appropriate care. In addition, the ABCD II states have found that pediatric clinicians are often reluctant to adopt (or continue) using a screening tool unless they are confident that the children they identify as potentially needing further care will receive it. As a result, the five ABCD II states have undertaken efforts to identify existing assessment and treatment resources, remove policy barriers to accessing those services, and facilitate referrals to these resources.

States can facilitate access to follow-up care for young children who are identified by pediatric providers as experiencing or being at risk for delays in social or emotional development. States pay for assessment and treatment not only through their Medicaid programs but also through early intervention and children's mental health programs. They have resources available not only to pay for treatment but also to facilitate access to treatment by:

- providing direct assistance;
- improving coordination among programs; and
- helping practitioners to develop links with local resources.

Demonstrations can inspire and test policy change. Each of the ABCD II states has established pilot sites (demonstrations) to test new ideas and delivery mechanisms, test new policies, and/or identify policy barriers. They have found that the pilot sites have proven to be an effective method of not only testing whether new ideas work but of also ensuring that policy changes are grounded in real life experience—an important aspect of making policy work relevant and tangible.

Partnering with pediatric clinicians is critical to improving the care delivered to children.

Active partnerships with clinicians have proved critical to obtaining provider acceptance and support for the projects. Specifically, in all five states, clinicians have played key roles in:

- developing state recommendations for screening tools and effectively communicating those recommendations to clinicians;
- identifying policy changes needed to promote improvement; and
- providing training and assistance to the pilot practices and spreading improvements in practice throughout the state.

Developing successful partnerships with providers takes effort and a willingness to follow as well as lead. Each of the ABCD II states has developed successful partnerships with medical providers. These partnerships have been forged even in states where the Medicaid agency and clinicians have not always worked well together. These partnerships have been built over time as partners recognize what each has to contribute to improving care. The ABCD II states have also found that joining partnerships led and administered by others can be very beneficial.

States can improve care without new funding or legislation. All five ABCD II states have improved (or are on track to improve) the delivery of care to young children. For the most part they have done this without seeking new appropriations, changing state law, or obtaining federal approval. They have accomplished their work by leveraging existing resources and partnering with other stakeholders including their sister agencies, private organizations, and providers.

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INTRODUCTION

Many young children could benefit from improved delivery of services that support healthy mental development. States and society at-large could also benefit from improved delivery of preventive and early intervention services that promote school readiness and prevent the need for more costly interventions at a later date. Two reports released in the last few years summarize the relevant studies:

Research suggests that many mental health problems and disorders in children might be prevented or ameliorated with prevention, early detection, and intervention. Overall, prevention and early intervention efforts targeted to children, youth and their families have been shown to be beneficial and cost-effective and reduce the need for more costly interventions and outcomes such as welfare dependency and juvenile detention.¹

What research tells us is that, for some young children, emotional and behavioral problems serve as a kind of red flag. Without help, evidence suggests that these emotional and behavioral difficulties may stabilize or escalate and negatively affect early school performance. In turn, early school performance is predictive of later school outcomes.²

Evidence also exists that children are not receiving the care they need. As Dr. Neal Halfon has noted: “A majority of problems go unrecognized, and most children do not receive treatment early in their life unless the problems are severe.”³

States, especially Medicaid agencies, play an important role in efforts to ensure young children’s healthy mental development.

- Medicaid serves more than 25 percent of all children in the United States (and more than half of all poor and low-income children).⁴ Children from poor families are at greater risk than those from non-poor families for poorer outcomes, including those related to

¹ Catherine Hess and Karen VanLandeghem, *Children’s Mental Health: An Overview and Key Considerations for Health System Stakeholders, Issue Paper* (Washington, DC: National Institute for Health Care Management, February 2005), 3. Retrieved September 17, 2005. www.nihcm.org/CMHReport-FINAL.pdf.

² C. Cybele Raver and Jane Knitzer, *Ready to Enter: What Research Tells Policymakers about Strategies to Promote Social and Emotional School Readiness among Three- and Four-year-old Children* (New York, NY: National Center for Children in Poverty, 2002). Retrieved September 17, 2005. <http://www.nccp.org/media/pew02c-text.pdf>.

³ U.S. Department of Health and Human Services, *Report of the Surgeon General’s Conference on Children’s Mental Health: A National Action Agenda* (Washington, DC: DHSS, 2000). Retrieved September 17, 2005. <http://www.hhs.gov/surgeongeneral/topics/cmh/childreport.htm>.

⁴ Kaiser Family Foundation, *Health Coverage For Low-Income Children, Fact Sheet*, September 2004. Retrieved September 17, 2005. <http://www.kff.org/uninsured/upload/Health-Coverage-for-Low-Income-Children-September-2004-UPDATE.pdf>.

mental development.⁵ In addition, income may be a more powerful influence on young children's development than on older children's development.⁶

- States also provide services to those children who do not qualify for Medicaid through their Early Intervention and other programs. This further extends the potential influence of states on the delivery of care to support healthy mental development.
- State Medicaid agencies have the flexibility to design benefits and implement policies and billing guidelines that support the identification and treatment of children with or at risk of delay in social and emotional development.⁷

The important role that Medicaid and other state agencies can play in improving the delivery of services that support young children's social and emotional development is confirmed by the experiences of the five states that are participating in the ABCD II Consortium (described below). Even though these five states are only halfway through their three-year projects, they have already accomplished much and learned key lessons. This report examines their early experiences to provide helpful information to other states interested in working to ensure young children's healthy mental development.

⁵ Institute of Medicine, *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Jack P. Shonkoff and Deborah A. Phillips (eds). (Washington, DC: National Academy Press, 2000), 274. Retrieved September 18, 2005. <http://books.nap.edu/books/0309069882/html/index.html>.

⁶Ibid., 279.

⁷ More information on what states can do to support young children's healthy mental development is available from: Kay Johnson and Neva Kaye, *Using Medicaid to Support Young Children's Healthy Mental Development* (Portland, ME: National Academy for State Health Policy, 2003). Available at http://www.nashp.org/Files/CW8_Health_Mental_development.pdf.

THE ABCD II PROGRAM

The ABCD II program is sponsored by the Commonwealth Fund and administered by the National Academy for State Health Policy (NASHP). ABCD II is a three-year initiative designed to strengthen primary health care services and systems that support the healthy mental development of young children, ages 0-3. The program focuses on preventive care of children whose health care is covered by state health care programs, especially Medicaid. The goals of ABCD II are to:

- Create models of service delivery and financing that promote high quality care supporting children's healthy mental development, especially those with less intense needs, i.e., those who need only preventive care and those who are identified as "at risk" or in need of low-level intervention; and
- Develop policies and programs that assure that health plans and pediatric providers serving these children and their parents have the knowledge and skills needed to furnish health care in a manner that supports a young child's healthy mental development.

The ABCD II Consortium

The ABCD II program accomplishes its goals through a state consortium that was established in January 2004.⁸ Five states (California, Illinois, Iowa, Minnesota, and Utah) are participating in this consortium. Each of these five states is implementing an individual project that seeks to achieve the ABCD II program goals within their state. Each project is led by the state's Medicaid agency, and these agencies work in partnership with other stakeholders to achieve their objectives. Each state receives grant funding and technical assistance and shares lessons learned with the other participating states.

The ABCD II Consortium is intended not only to improve the quality of children's health care in the five consortium states but also to assist other states interested in ensuring young children's healthy mental development by providing them with information on the work of the consortium states. The ABCD II initiative is based on the belief that while each state is unique, any state interested in this issue will face barriers similar to those encountered by the consortium states and will be able to benefit from the lessons learned by them.

⁸ The ABCD II Consortium is the second state consortium administered by NASHP and supported by the Commonwealth Fund. For more information on ABCD I, please go to NASHP's Web site at www.nashp.org.

Overview of the State Projects

Each of the five states is implementing projects and policies that:

- identify and foster provider use of formal screening tools that effectively identify social and emotional development concerns;
- identify service gaps that prevent children in need of services to support their mental development from obtaining those services—and fill those gaps;
- examine existing referral and assessment procedures to identify ways to more efficiently get those with a positive screen into the appropriate service system;
- use stakeholder groups to help design their interventions, including developing provider training curricula;
- identify and recommend changes and/or clarifications in state policies, procedures, and billing codes; and
- improve screening for perinatal depression and resources for treatment of this condition—recognizing that young children’s mental development is closely tied to their parents’ mental health.

Each of the ABCD II projects has adopted a similar approach for achieving its objectives. This approach includes:

- designing interventions in conjunction with other stakeholders;
- piloting the interventions in a few practices or communities (these pilots are designed both to test and improve the intervention(s) and to identify any state policy changes needed to support expansion of the intervention); and
- disseminating the findings from the pilots to others and implementing needed policy changes.

Although all five of the state projects are following this general approach they have not always proceeded through these steps in this sequence. For example, many of the states are not waiting until the pilots are complete to implement some needed policy changes identified during the design step.

KEY EARLY ACCOMPLISHMENTS

Although the five states are just completing the second year of their projects, they have already accomplished many important tasks (Table 1). They have moved to improve identification and treatment of young children with or at risk of social or emotional development delays by addressing barriers they have identified within their states. Based on early lessons learned, they have initiated policy changes designed to better support identification and treatment. Finally, they have all relied on partnerships to help them improve the quality of care delivered to young children.

Table 1 Overview of State Project Objectives

State	Objectives
California	<ul style="list-style-type: none"> • Develop a service matrix that will be used to create a “roadmap to care.” • Identify policy and service delivery changes needed to improve access to infant mental health and developmental services. • Develop and implement a quality improvement project in primary care practices in two managed care organizations (MCOs).
Illinois ⁹	<ul style="list-style-type: none"> • Increase the number of young children who receive comprehensive primary care that addresses social and emotional development, by <ul style="list-style-type: none"> ▪ increasing the use of formal screening tools and referrals for intervention services; and ▪ improving pediatric providers’ access to materials on early childhood and perinatal mental health. • Develop mental health and developmental screening and referral guidelines and test them in four pilot communities before implementing them statewide.
Iowa	<ul style="list-style-type: none"> • Establish minimum clinical care standards for preventive and developmental mental health services. • Establish links to community resources to improve access to appropriate follow-up care. • Establish two pilot projects to test the standards and identify policy changes needed to support statewide implementation of the standards.
Minnesota	<ul style="list-style-type: none"> • Support primary care provider efforts to meet the needs of children who are at risk for delays in social or emotional development but do not meet the criteria for receiving services from the children’s mental health system by, among other things, <ul style="list-style-type: none"> ▪ Conducting CME trainings on early childhood mental health; ▪ Increasing the likelihood that children who qualify for care from the children’s mental health system are identified and referred to that system; and ▪ Conducting two pilots to test strategies to improve care. • Modify state policies to increase the identification and referral of children with delays.
Utah	<ul style="list-style-type: none"> • Increase screening for infant mental health concerns as part of EPSDT/well-child visits. • Increase interactions between and among Medicaid providers to ensure that providers direct children and their families to appropriate services. • Increase screening by pediatric practices for maternal depression during the postpartum period. • Increase the capacity of the current mental health system to serve infants and toddlers. • Conduct three learning collaboratives with pediatric practices to achieve these objectives.

⁹ Unlike the other four states in the collaborative, Illinois’s individual project is not funded by the Commonwealth Fund but, rather, by a local funder, the Michael Reese Health Trust.

The remainder of this section of the paper examines key early accomplishments in six major areas.

1. Recommending validated screening tools for pediatric clinician¹⁰ use.
2. Working with primary pediatric clinicians to integrate screening into their practices.
3. Improving the referral process between primary pediatric practices and specialized providers and increasing the availability of treatment services.
4. Identifying and addressing policy barriers.
5. Partnering to achieve goals.
6. Financing improvements in care during difficult times.

Recommending Screening Tools for Use by Pediatric Clinicians

A literature review conducted by NASHP staff found indications that few young children in need of care to support their mental development are identified, even by physicians.¹¹ Several studies also indicate that using a developmental screen “improves the accuracy with which children are identified when compared with decisions based only on clinical judgment.”¹² Further, there are indications that pediatricians do not regularly use standardized tools.¹³ Finally, there is growing consensus on the important role that primary care providers, who see the child on a regular basis and can thus assess development over time, can play in recognizing potential developmental problems, including social and emotional development problems. As the American Academy of Pediatrics (AAP) has noted: “The primary care practitioner's office is the only place where most children younger than five years are seen and is ideal for developmental and behavioral screening.”¹⁴

Early accomplishments in all five of the ABCD II states include identifying validated tools and encouraging providers to use them. In each of the five states, project leaders have drawn clinicians and other stakeholders together to provide input on the tools under consideration and factors that states should consider when selecting tools. To support this effort, NASHP produced

¹⁰ As used in this paper the term *pediatric clinician* means all physicians and nurses who treat young children, including pediatricians, family practitioners, child psychiatrists, pediatric nurses, and pediatric nurse practitioners.

¹¹ David Bergman, *Screening for Behavioral Developmental Problems: Issues, Obstacles, and Opportunities for Change* (Portland, ME: National Academy for State Health Policy, 2004). Two of the studies that support this statement are: (1) Laura Sices, MD, et al., “How do Primary Care Physicians Identify Young Children with Developmental Delays? A National Survey with an Experimental Design,” *Pediatrics* 113, no.2 (Feb. 2004): 274-282 and (2) Kelly J. Kelleher MD, MPH, et al., “Increasing Identification of Psychosocial Problems: 1979-1996,” *Pediatrics* 105(6):2000, 1313-1321.

¹² For example, D. Rydz, et al. “Developmental Screening,” *J Child Neurol.* 2005; 20(1): 4-21.

¹³ U.S. Department of Health and Human Services. *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda* (Washington, DC: DHHS, 2000). Retrieved September 17, 2005. <http://www.hhs.gov/surgeongeneral/topics/cmh/childreport.htm>

¹⁴ American Academy of Pediatrics, “Developmental Surveillance and Screening of Infants and Young Children.” *Pediatrics* 2001; 108(1):192-195. Retrieved October 6, 2005. <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;108/1/192>.

a technical assistance paper that summarized the factors states might want to consider in assessing tools. The paper also provided relevant information about the tools used most often to screen for potential delays in mental development.

As part of the review process, each of five states sought to identify tools that would:¹⁵

- identify those children who may need behavioral developmental care;
- be accurate enough to avoid mislabeling many children;
- differentiate between those in need and those not in need of follow-up services;
- be quick and inexpensive to administer; and
- provide information that could lead to action.

In all five states, the decision about which tool(s) to recommend was not made at a single meeting or by an individual. In all cases, the screening tools were selected by consensus among the members of standing committees that were formed to support the ABCD II effort. These committees were made up primarily of state project staff and clinicians. ABCD II states felt that heavy clinician involvement in the process was necessary not only to produce the best decision but also to improve the likelihood that providers would follow the recommendations.

As Table 2 illustrates, most of the recommended tools are completed by the parent. The Ages and States Questionnaire (ASQ), Ages and Stages Questionnaires: Social-Emotional (ASQ:SE), Brief Infant-Toddler Social and Emotional Assessment (BITSEA), Child Development Review, Infant Development Inventory, Parent's Evaluation of Developmental Status (PEDS), and Temperament and Atypical Behavior Scale (TABS) are all designed to elicit information from the parent rather than through observation by the clinician. These states were attracted to parent-completed tools for several reasons. First, they are completed by parents either before the appointment or while waiting to see the child's doctor. This means that administering and scoring these tools takes little of the physician's (or other staff member's) time. In addition, some physicians who have used tools that elicit information from the parent report that these tools can help parents identify and raise concerns and can lead to a productive discussion between parent and provider.¹⁶

Four of the five states (Illinois, Iowa, Minnesota, and Utah) have all begun some efforts to communicate these recommendations to providers other than those involved in their pilot projects. It is significant that ABCD II program staff in these four states have included clinicians—usually those involved in selecting tools for recommendation—in state efforts to convey the resulting recommendations to pediatric clinicians. These states have relied on clinicians to review provider handbook and Web site language, send out letters supporting and reinforcing the recommendations, and otherwise present information on the recommendations to their colleagues. These states found that clinicians were able to help the states communicate more effectively to a clinician audience than the states could on their own.

¹⁵ For more information about selecting a screening tool, see David Bergman, [Screening Children for Developmental Disabilities and Behavioral Problems](#) (Portland, ME: National Academy for State Health Policy, 2004).

¹⁶ Julie Olson. "The ABCD's of Promoting Children's Healthy Mental Development: Lessons and Accomplishments." Presentation at NASHP's Annual State Health Policy Conference. August 8, 2005.

Table 2 Screening Tool Recommendations

State	Recommended Tool(s)	How recommendation is communicated to providers
California ¹⁷	<ul style="list-style-type: none"> • Ages and Stages Questionnaires (ASQ) • Ages and Stages Questionnaires: Social-Emotional (ASQ:SE) 	On-site training for pilot sites (conducted in Winter 2005, with Continuing Medical Education credits planned)
Illinois	Will reimburse for administration of 21 different screening tools, but recommends: <ul style="list-style-type: none"> • ASQ • ASQ:SE 	<ul style="list-style-type: none"> • Medicaid provider handbook • Letter to providers from the Illinois Chapter of the American Academy of Pediatrics (AAP) • Website: www.hfs.illinois.gov/handbooks/chapter200.html#cmh200 • Training for pilot sites
Iowa	Iowa Health Maintenance Clinical Notes (IHMCN) ¹⁸ or <ul style="list-style-type: none"> • ASQ:SE • Brief Infant-Toddler Social and Emotional Assessment (BITSEA) • Child Development Review • Infant Development Inventory 	<ul style="list-style-type: none"> • Training for pilot sites • Website: www.iowaepsdt.org/ScreeningResources/Standards.htm <p><i>Iowa does not plan to undertake more intensive efforts to promote use of the recommended tools until the pilots conducted as part of their ABCD II project are completed.</i></p>
Minnesota	ASQ:SE	<ul style="list-style-type: none"> • On-site CME course for pilot sites • As part of other trainings conducted by the state and other organizations on related topics • Website: www.health.state.mn.us/divs/fh/mch/devscrm
Utah	<ul style="list-style-type: none"> • ASQ • ASQ:SE • Parent's Evaluation of Developmental Status (PEDS) • Temperament and Atypical Behavior Scale (TABS) 	<ul style="list-style-type: none"> • Medicaid provider handbook • Letter to providers from Medicaid • Learning Collaborative conducted by UPIQ (clinician-led stakeholder group described later in this document)

¹⁷ California recommends that the pilot sites use these tools and has not yet considered statewide recommendations. The other four states are recommending these tools to the pilot sites and other clinicians.

¹⁸ The IHMCN is a state-developed tool that is designed to identify children who have developmental delays or are at risk for such delays. As part of its ABCD II project, Iowa has revised the IHMCN to better address social and emotional development issues and is testing these forms during the pilot to determine their effectiveness compared with other tools.

State example

Illinois: Partnering to promote use of screening tools

State agencies (especially Medicaid agencies) have sometimes found it difficult to encourage providers to use validated screening tools. This is due, in part, to a perception among providers that Medicaid is a funding source, not a source of information on best practices in providing care. To overcome this barrier, Illinois Medicaid developed active partnerships with the Illinois Chapter of the American Academy of Pediatrics (ICAAP) and the Illinois Academy of Family Physicians (IAFP) to encourage primary care providers to use screening tools. Illinois Medicaid invited these provider organizations to be an integral part of policy development. In addition, these organizations helped the Medicaid agency effectively inform clinicians of the new policies and supported clinicians in implementing new practices in response to the policies.

In February 2004, Illinois's Medicaid agency sent providers a notice clarifying that they could bill for conducting a screen in addition to a well-child exam—and offering guidance about the specific tools for which providers could receive reimbursement. ICAAP provided the agency with input on the provider notice, was identified in the notice as a resource for more information and technical assistance on developmental screening or risk assessment, and published an article in its Spring 2004 newsletter supporting the policy change (www.illinoisap.org/spring.html#oral). ICAAP reported that as a result of this notice it provided technical assistance to many providers regarding billing, developmental screening tools, and referral resources for children with developmental concerns.

In November 2004, Illinois's Medicaid agency released a provider notice clarifying its coverage of screening for maternal depression (an issue it is addressing as part of its ABCD II project). In conjunction with the agency's release of the provider notice, ICAAP, the American College of Obstetricians and Gynecologists (ACOG), and the IAFP sent a letter to all their members endorsing the use of the screening tool and containing information about the policy clarification (www.hfs.illinois.gov/mch/letter.html). Illinois reports that the endorsement was a very effective method for encouraging providers to adopt maternal depression screening. The ICAAP also created a Web page on maternal depression and social-emotional resources to complement this effort (www.illinoisap.org/DevelopmentalScreening.htm).

Although the Illinois partnership was successful, other states seeking to develop similar partnerships with provider organizations may face difficulties, especially in states where these organizations are not active or where the Medicaid agency has no history of working collaboratively with such organizations.

Lessons learned about recommending screening tools to primary care providers

The experiences of the ABCD II states suggest that certain strategies can help to increase the likelihood that providers will attend to recommendations to use a validated screening tool.¹⁹ The lessons states have learned and the strategies they have implemented include the following items.

- Clinicians are more likely to follow the recommendations when they are consulted in their development, both about what tools to recommend and the language used to make the recommendation.
- Practices are more likely to use tools that are inexpensive and take little staff time to complete and score—and that they believe are valid and accurate.
- Clinicians are more likely to use tools they see doing more than screening, for example tools that help parents organize questions prior to an appointment or that help parents learn more about child development.
- Providers are more likely to follow recommendations if they are aware of them—and not all providers read Medicaid handbooks or other communications from the agency.
- Clinicians are more likely to listen to recommendations from their peers or recognized clinical experts than to heed recommendations from a state agency.
 - An endorsement of the agency’s recommendations by the professional organizations that represent physicians increases the likelihood that clinicians will adopt, implement, and sustain the recommended changes.
 - Active collaboration with state professional societies to develop and implement recommendations may be even more effective than an endorsement as these societies can offer additional venues for informing, help ensure that recommendations are stated in effective language, and offer technical assistance to members. All of these activities help demonstrate to providers the importance that their professional peers place on taking the recommended actions.

Working with Clinicians to Integrate the Tools into their Practices

The five ABCD II states have all recognized that simply identifying tools and communicating these recommendations to primary care providers does not, by itself, increase pediatric clinician use of validated tools. Providers are faced with numerous demands on their time and may have to conduct other screens. Even though they recognize the value of using a validated tool, many may not do so because they believe that they do not have enough time.²⁰ The ABCD II states

¹⁹ For a more in-depth discussion on this topic, see Helen Pelletier, *How States Are Working With Physicians to Improve the Quality of Children’s Health Care* (Portland, ME: National Academy for State Health Policy, April 2006.)

²⁰ States also report that some providers are reluctant to identify issues that they may not be able to address. This issue is addressed in the section starting on page 13.

have found that provider practices need support to redesign office systems and/or practice flow to incorporate a new service and that making these changes requires time and expertise. Most of the ABCD II states have found ways to connect practices with experts outside their agencies, but as will be described later in this section, in Iowa the public health agency has taken on much of this role itself.²¹

ABCD II states are already implementing several types of actions to help providers integrate screening into their practices. Although many of these early actions are focused on helping practices in the pilot sites, they are applicable for broader use. In addition, physicians participating in the pilots can serve as role models for other practices. It is the hope of the ABCD states that these pilots will, among other things, demonstrate not only that providers can integrate a validated screening tool into their practice without a major increase in administrative costs—but that doing so also improves patient care.

- California has contracted with both a physician who has experience in integrating screening tools into a large pediatric practice and with the California Institute for Mental Health to develop curriculum materials that will be tested in the pilot sites and designed to provide ongoing individual technical assistance to the sites.
- Illinois's ICAAP and IAFP have taken the lead in helping providers integrate screening into their practices. Their representatives co-chair the Illinois ABCD II project's Provider Information, Curriculum, and Training Committee. They worked with the Medicaid agency to develop and conduct initial training for each pilot site on screening and also offer ongoing assistance to these practices. These groups plan to modify the training based on the pilot experience and will offer it to other practices.
- Minnesota is directly addressing the time concern through technology. This state worked with a private company to develop a version of the ASQ:SE that is administered electronically on a hand-held device. The pilot sites are currently using this device. Parents complete the screen on the device while waiting to see their child's primary care provider. The device is then docked into a station that scores the screen. The device can print the results to paper or send them to an electronic medical record. The print-out also offers the provider suggestions for anticipatory guidance and (if needed) follow-up.
- Utah has already completed the learning session components of two provider learning collaboratives that are designed to improve screening for young children. The state is now providing ongoing, individualized technical assistance to the practices that are participating in the collaboratives. The monthly measurement activities undertaken by each participating practice indicate that improvements are already being made in the

²¹ Several organizations (outside of ABCD II) are training and working with practices to modify processes of care. These include the National Initiative for Children's Health Care Quality (NICHQ) and the North Carolina Center for Children's Health Improvement. The results of these efforts should prove valuable to states seeking to improve the care delivered to children.

amount of screening being conducted by each practice. (This approach is discussed in more detail on page 20.)²²

State example

Iowa: Supporting change within primary care practices

Providers frequently mention that limited resources—of both time and referral options—can be a significant barrier to using a validated screening tool. As part of its ABCD II project, Iowa has undertaken a comprehensive effort to work directly with providers to help them address these barriers. The Bureau of Family Health within the Department of Public Health²³ is leading this effort under a contract with the Medicaid agency. As part of the effort, Iowa’s ABCD II project required each pilot site to identify both a physician (physician champion) and a nurse or office manager to lead the pilot. Iowa ABCD team members then support these leaders as they integrate screening (and referral/treatment) into their practices.

The physician champion is responsible for leading the staff involved in the project and supporting the overall effort. These champions sign a memorandum of agreement outlining their and their practice’s responsibilities in the pilot. Each physician champion is supported by a physician mentor who is a member of the committee that planned the pilots and has experience in using screening tools in a primary care setting. The mentors provide both consultation and support to the physician champions as they work to change systems and spread that change in their practices. Project staff report that the mentor physician volunteers about four to six hours per month to this activity. They also report that this structure is most effective when the two physicians have the same specialty (e.g., a champion with a specialty in pediatrics is mentored by a pediatrician and a champion with a specialty in family practice is mentored by a family practitioner). Iowa’s ABCD II staff report that physicians of the same specialty “speak the same language and have shared experiences” and “understand office cultures and what is needed for change.”

The nurse/office manager serves as the lead for many of the operational tasks needed to support routine screening in the practice such as scheduling trainings, identifying and implementing changes to filing procedures and paperwork, facilitating the evaluation of the pilot, maintaining contact with the ABCD II team, and working with community partners. The nurse/office manager does not necessarily conduct all of these tasks, but is responsible for seeing that they get done. The nurse/office manager is supported by staff employed by the Bureau of Family Health. The state staff provide training and are available to consult and problem solve on a daily basis.

Iowa’s Department of Public Health has also tasked the local coordinator of the state’s Early and Periodic Screening Diagnosis and Treatment (EPSDT) services with helping practices identify and access local resources that can provide services that are beyond the scope of the primary care

²² For more information on the Illinois and Utah provider education efforts, see Helen Pelletier, *Working with Physicians to Improve the Quality of Children’s Healthcare* (Portland, ME: National Academy for State Health Policy, April 2006.)

²³ In Iowa, the Medicaid agency also contracts with the public health agency to assure children have access to EPSDT services.

practitioner. EPSDT care coordinators are employees of local agencies under contract with the Iowa Department of Public Health to perform informing and care coordination activities to support the EPSDT program. Many of these activities and much of the knowledge needed to support the EPSDT program are ideal for supporting the ABCD II efforts. Among other activities the EPSDT care coordinator may help set up another level of screening or assessment, child or family specific services, transportation to services, additional medical appointments, and child care. Anyone from the practice may call the EPSDT coordinator (as can parents).

Lessons learned about helping primary care providers integrate use of a screening tool into their practices

The experience of the ABCD II states suggest that several elements are important in helping primary care providers integrate screening into practice.

- A physician needs to lead the effort in the practice, and the support of other physicians in the practice is critical to widespread adoption of the new procedures. Gaining physician support for these changes is likely to depend on the perceived benefits—both to the child and to the practice.
- In some practices, staff other than physicians will conduct the screening, and in all practices administrative and nursing staff are critical to identifying and implementing changes to office procedures to help ensure that screening becomes routine. These staff need as much support and training as the physicians.
- Physicians listen better to other physicians, so a professional organization’s endorsement of routine screening with a validated tool is effective in promoting change. Direct communication between a physician who is considering implementing routine screening and a physician who has done so successfully appears to be even more effective.
- It is important to offer ongoing support—not just a one-time training session. As practices implement screening, they are likely to encounter unforeseen problems. Having access to someone who can help them work through those problems and concerns will encourage them to do so instead of giving up on screening.

Improving Referrals and Access to Follow-up Services

The five ABCD II states all recognize that lack of follow-up services (full assessments and interventions) is a barrier to ensuring young children’s healthy mental development. States report that clinicians may be reluctant to screen children because they are not familiar with the resources available for treatment or how to access those resources once a need is identified. This is particularly true for those children with less intense needs.

Key early accomplishments in the ABCD II states include implementing tasks designed to:

- support primary care providers in providing treatment;
- identify and fill gaps in the treatment service system;
- improve the process for obtaining services; and
- improve provider knowledge of how to access care.

State examples

Two strategies for facilitating referrals: Utah and Illinois

The ABCD II states report that they have found that even when community services are available providers may not refer children to these resources. These states report that providers may not make these referrals for a number of reasons related to lack of knowledge about what resources are available and how to access them. The ABCD II states have taken two approaches to facilitating referrals. These approaches are exemplified by Utah and Illinois.

Utah

Utah has used its provider learning collaboratives as a venue for both increasing provider awareness of treatment resources and facilitating the development of referral systems between the participating practices and local resources. Specifically, the second half of each of the day-long sessions that initiate a learning collaborative is devoted to planning for referrals to care. In this half of the meeting, the participating pediatric practice staff are joined by representatives of local resource agencies, including the local mental health agency and Early Intervention service providers. State staff provide an overview of all the local resources available and whom to contact. Then each practice meets with staff members from multiple local resources to develop referral pathways. The practice plans for screening and referral are then presented to all collaborative participants at the end of the session. Utah's ABCD project staff report that the personal connection developed during these in-person meetings between the representatives of the practices and the resource agencies are important to facilitating referrals.

State and UPIQ²⁴ staff members continue to support these developing relationships by meeting with the practices on a regular basis to discuss the referral process and how it could be improved. They are also working with some of the local resource agencies to change some of their practices that discourage referrals, such as failing to report back to the practice on the outcome of all (or sometimes any) referrals.

Illinois

Illinois has established a partnership between each of its ABCD II pilot sites²⁵ and the local Early Intervention intake office (referred to as Child and Family Connections, or CFC). The CFC in each of the pilot communities facilitates the provision of further assessment services to all

²⁴ The Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ) is a broad partnership that, among other things, convenes learning collaboratives in Utah. (Please see page 20 for more information on UPIQ.)

²⁵ Illinois's pilots are defined as communities. Each site is composed of multiple practices and other local stakeholders.

children who do not pass a screen conducted by an ABCD pilot site. They are directly providing treatment to those families whose children are eligible for Early Intervention services, and will connect those with less intense needs to other resources in the local community. In addition, the CFC does not typically rescreen a child who does not pass an ASQ:SE; instead, at follow-up visits, a CFC staff member simply reviews the existing screen with the parent, eliminating the need for the parent to fill out the form a second time.

Minnesota: Creating early childhood mental health services in the community

The ABCD II states report that one of the barriers to treating young children with delays in social or emotional development is that the services do not exist or there is a lack of mental health providers qualified to treat young children. In addition, children, especially young children with less intense needs, may not qualify for the services that do exist. Minnesota has developed a multi-faceted approach to address these concerns.

Increasing the capacity of primary care practices

Both of Minnesota's pilot sites are co-locating mental health providers within the primary care practice. Any child who is identified with a possible delay in social, emotional, or mental development is seen by the mental health provider during the well-child visit. In one site, the mental health professional is a psychiatric nurse and in the other it will be a licensed mental health professional, such as a family therapist or nurse. Minnesota believes that this approach will not only facilitate access to care from the mental health professional but enable the primary care providers to consult with the provider and offer more effective care for those children with less intense needs.

Improving diagnosis

Children must have a diagnosis, usually a DSM-IV or ICD9²⁶ diagnosis, to qualify for most treatment services. However, according to Nancy Seibel of the organization ZERO TO THREE: "Existing systems do not adequately reflect or describe disorders of infancy and toddlerhood (especially developmental and relational issues)."²⁷ Therefore, children who may need care may be prevented from accessing that care because they are not diagnosed. The ZERO TO THREE organization has developed a diagnostic classification specifically designed for young children (the DC: 0-3). As part of its ABCD II project, Minnesota's Medicaid agency adopted a policy that allows providers to use the DC: 0-3 to diagnose young children and then to crosswalk these diagnoses to the DSM-IV and ICD9 codes that are accepted for billing. Minnesota's Children's Mental Health Agency has reinforced these efforts by training over 306 clinicians and others in the use of the diagnosis codes and crosswalk.

²⁶ The *Diagnostic and Statistical Manual of Mental Disorders-IV* (DSM-IV) is produced by the American Psychiatric Association and the *International Statistical Classification of Diseases and Related Health Problems* (ICD) is produced by the World Health Association. They are the major diagnostic classification systems in use by health professionals.

²⁷ Nancy Seibel, "DC: 0-3, Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood," presentation to the ABCD II Collaborative via conference call, January 19, 2005.

Implementing a new benefit

In 2003, Minnesota Medicaid was authorized to implement a new benefit, Children's Therapeutic Services and Supports (CTSS). Minnesota's ABCD II staff guided the implementation of this benefit. CTSS is available to children who have been diagnosed with an emotional disturbance of any severity and includes a wide range of mental health services, including skill building services for the child and the child's family. CTSS services can be provided both by traditional mental health providers and a variety of approved social service agencies, including Head Start.

Lessons learned about improving access to referral and follow-up services

Based on the experiences of these states, the following actions can improve access to treatment services.

- States can identify and inform primary care providers about existing resources and give them an opportunity to meet with representatives of the local agencies that provide treatment.
- Identifying an individual, either external or internal to the practice, to facilitate referral improves the process and helps address clinician concerns that the children they identify with potential needs will be able to access assessment and follow-up services.
- States can inform resource agencies about what they can do to encourage primary care providers to make referrals to the agency, such as report back to primary care providers on the result of a referral. This is even more effective when primary care providers communicate this information directly to the agency.
- States can use Medicaid to create services for children with less intense needs.

Identifying and Addressing Policy Barriers

The ABCD II states have already found that some existing Medicaid policies discourage identification and treatment of young children with or at risk for delay in social or emotional development. Each anticipates that it will identify more policy barriers through its pilot experience.

This outcome is not unexpected. Promoting policy change is an important element of the ABCD initiative. These state projects were designed to test tools and strategies for improving young children's healthy mental development *and* to identify and address state policy barriers. The first ABCD initiative found that it was changes in state policy that facilitated broad change and sustained changes after the project ended.²⁸

²⁸ For information about the work of the ABCD I initiative, see Helen Pelletier and Melinda Abrams, [*ABCD: Lessons from a Four-State Consortium*](#) (Portland, ME: National Academy for State Health Policy, December 2003).

Although we anticipate that most policy change activities will occur in the final year of the state projects (and continue after the projects end), several of the ABCD II states have already changed and clarified policy. They have also established formal methods for continuing to identify and make needed changes. Most of these changes were identified during pilot development, and several have already been described. In addition:

- Illinois has established a policy committee as part of its ABCD II project. This committee is charged with reviewing the pilot experience and other sources of information to develop recommendations for changing state program policies to better promote young children's healthy mental development. Illinois has already made the following changes in addition to the perinatal screening policies described in more detail later in this section.
 - Clarified Medicaid policies to encourage physicians to bill separately for developmental screening and assessment (instead of including these services as part of a bundled rate) to improve tracking of these services and allow better measurement of performance.
 - Clarified Early Intervention policies on eligibility. The Early Intervention System has stated that it considers major depression within the first year postpartum to be a "severe mental disorder" as described in Early Intervention eligibility criteria, thus qualifying a child whose mother has been diagnosed with post partum depression for Early Intervention services.
- Utah has initiated several policy changes to support young children's healthy mental development.
 - Changing its EPSDT provider manual to recommend a menu of screening tools (ASQ, ASQ:SE, PEDS, TABS) for use during EPSDT well-baby/child visits. The provider manual also includes a recommended screening schedule.
 - Clarifying inconsistencies in Medicaid and Division of Substance Abuse and Mental Health policies. Medicaid billing policies had allowed community mental health centers to provide the services children needed to treat or ameliorate a condition identified in an EPSDT screen without the presence of DSM-IV diagnoses. However, the mental health agency's audit policies had required the presence of a DSM-IV diagnosis for treatment of all clients. As a result, the centers were not serving some children who qualified for Medicaid services. Once this inconsistency was identified, Utah's mental health agency clarified its audit policies to conform with Medicaid billing policies.
- California, Illinois, Iowa, and Minnesota have already or are in the process of adopting crosswalks that allow providers to diagnose young children using the DC: 0-3 and to then match these diagnoses to the DSM-IV codes required for claims payment.

State example

Iowa's process for identifying needed Medicaid policy changes

Iowa has established a Medicaid Barriers workgroup as part of its ABCD II project. The workgroup membership consists mostly of Medicaid staff and clinicians who were involved in the ABCD II project's development and pilot site planning. The workgroup has developed a Medicaid barriers document that begins with a set of guiding principles for acting on any barriers that current Medicaid policies create to implementation of the statewide system for identifying and treating young children with or at risk for delay in social or emotional development. The document then describes each barrier identified during ABCD II planning, as well as the Medicaid agency's initial thoughts on how to respond to the barrier.

The workgroup has identified three types of barriers.

1. *Those that require changes to current Medicaid policies.* For example, in Iowa, the Medicaid agency will not allow a clinician to submit a claim for a well-child visit conducted on the same day as a sick visit. The Medicaid Director is now considering changing this policy.
2. *Those that require clarification of existing policies.* For example, Iowa Medicaid is considering changing its written billing policies to clearly specify that primary care providers should use procedure code 99420 (Administration and Interpretation of Health Risk Assessment Instrument) to bill for screens conducted using the Iowa Health Maintenance Clinical Notes or other approved screening tool.
3. *Those that are a misperception of current Medicaid policy.* For example, many primary care providers were unaware that they could bill Medicaid for conducting a developmental screen. Iowa plans to offer providers training to improve their understanding of Medicaid policy in this area.

Illinois: Improving identification of maternal depression within existing authority

As part of its ABCD II project, Illinois's Medicaid agency made several important changes to its provider manuals that should improve identification of maternal depression. These changes were within the existing authority of the Medicaid agency; they did not require the approval of new funding or of an amendment to the State Plan. Specifically, in December 2004 Illinois's Medicaid agency issued a provider notice informing primary care providers, including pediatricians, that they could be reimbursed for conducting risk assessments for maternal depression with one of a list of approved tools that include the Edinburgh Postnatal Depression Scale, the Beck Depression Inventory, and the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire. Providers may use other tools if they receive pre-approval from the Medicaid agency. Further:

- If the woman is pregnant or in a postpartum period up to a year after birth and a Medicaid beneficiary, the provider is instructed to bill Medicaid under the mother's ID number.

- If the mother is not herself a Medicaid beneficiary but her child is a beneficiary who is less than one year old, the provider is instructed to bill Medicaid for a risk assessment under the child's number. The state has adopted this policy because research has shown that maternal depression often results in poor health or developmental outcomes for the child.

As previously mentioned, the Illinois Chapter of the American Academy of Pediatrics (ICAAP) and the Illinois Association of Family Practitioners (IAFP) are participating as partners in the Illinois ABCD II project. These organizations have played an important role in implementing and publicizing this policy clarification—at little or no cost to the state. These agencies (and the Illinois chapter of the American College of Obstetricians and Gynecologists, or ACOG) sent a joint letter to their members explaining the policy and expressing their support for maternal depression screening by primary care providers. These provider organizations are also providing technical assistance to providers who are conducting screens about why to use a standardized screening tool, how to document its use, resources for treatment, and other billing issues.

Lessons learned about identifying and resolving policy barriers

The ABCD II states have identified a number of factors that improve efforts to identify and resolve policy barriers. They include:

- a focus on solving problems;
- an effort to solicit input on barriers from clinicians and others who interact with the system;
- a recognition that processes designed to identify and resolve Medicaid policy barriers are more likely to result in policy change when led by the Medicaid agency—and when there is a clear process (and time) for involving the Medicaid director in the decision-making. The director does not necessarily need to lead the process but the process should lead to the director;
- a willingness to give clinicians a specific response to each barrier raised. This helps to create a process that is focused on solving problems—even when the response is no—as long as there is an explanation of why not;
- the establishment of guiding principles (informed by stakeholders) for deciding how to respond to each barrier; and
- a willingness to describe each barrier's impact on the delivery of care, on why it is in both the clinician's and payor's interest to address the barrier.

Partnering to Achieve Project Goals

Each ABCD II project is a partnership of multiple state agencies and others interested in ensuring young children's healthy mental development. One of the keys to these projects' early success has been the partnership among agencies. Project staff recognize that they will most effectively achieve project goals by building partnerships with clinicians and private organizations. Many of these public and private partnerships have already been discussed. In addition:

- California has partnered with the First Five agencies²⁹ in the pilot counties.
 - In Alameda County, the First Five agency has identified referral resources and assists children who have screened positive for social or emotional developmental problems.
 - In Riverside County, the Inland Empire Health Plan has an agreement with an agency partially funded through the local First Five agency to receive referrals for children with positive screens.

- Illinois’s chapters of the American Academy of Pediatrics and the Academy of Family Physicians have developed and are piloting a peer training curriculum and toolkit about screening and referrals for early childhood mental health and maternal depression to complement the state’s training. Illinois’s early intervention program is also assisting with assessment and referral in the pilot communities.

- Minnesota project staff, the state’s AAP chapter, and the Minnesota Department of Health have agreed on a strategy and preliminary steps for improving the quality of well-child visits in Minnesota, focused particularly on improving developmental and mental health assessment and anticipatory guidance.

- Utah has partnered with its medical home project to develop information on social-emotional development for inclusion on the medical home project Web site and to use this Web site (<http://medhome.med.utah.edu/>) to disseminate lessons learned and tools developed by the pediatric practices participating in the ABCD learning collaboratives. Utah’s Medicaid agency has posted the same information, or links to the medical home project Web site, on its Web pages.

State examples

Utah: Broad partnership to improve care

As previously discussed, Utah is fostering improvement in the identification and treatment of young children through a series of learning collaboratives for pediatric practices. These collaboratives are convened by the Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ). The UPIQ is a partnership of the Intermountain Pediatric Society; University of Utah School of Medicine, Division of General Pediatrics; Utah Department of Health’s Division of Health Care Financing and Division of Community and Family Health Services; HealthInsight; and Intermountain Health Care, Physician’s Division—in other words, state agencies, provider professional organizations, a large multi-specialty group, and a state university. Utah Medicaid staff describe UPIQ as “a collaborative effort to promote evidence based best practices and assist providers to institute quality improvement at the practice level.” Or, as one of the physicians on the steering committee put it: “It helps bridge the gap from what doctors know are the best practices to implementing those best practices.”

²⁹ First Five agencies are county-based agencies created and funded through a tobacco tax to provide health-related services to children under five.

UPIQ has one dedicated part-time staff person who is employed by the University of Utah. Most of the work of organizing and operating the collaboratives is donated by staff from the partner agencies. The cost of a collaborative has ranged from about \$15,000 to \$23,000. Each collaborative consists of a:

- pre-assessment and/or other data collection within the practice;
- one-day learning session;
- monthly chart audits;
- ongoing technical assistance including:
 - monthly conference calls; and
 - at least two site visits by the UPIQ coordinator during the six to twelve months following the learning session; and
- closing session to recognize success and steps to continue and spread the changes.

Utah is winding up the first ABCD II Learning Collaborative. Early results show that:

- Only two practices reported using any screening tool in the pre-assessment, but:
 - three months into the collaborative, nine practices documented using one of the recommended tools as part of a well-baby (EPSDT) visit; and
 - six months into the collaborative, 58 percent of the 400 children eligible to be screened were screened using a standard tool. Of the children screened, 2.8 percent have been referred for additional assessment and 1 percent are receiving ongoing services;
- One of the physicians from this learning collaborative stated: “I’ve picked up on delays in seven children I would have missed without using the ASQ.”

According to Utah Medicaid staff members, the agency pursued this partnership because it offers them the opportunity to develop relationships with providers and advocates that advance program goals and to access expertise which they do not have within their staff or among contractors. They acknowledge encountering a number of challenges in establishing this partnership. Among them: some potential provider partners view Medicaid not as a partner but as a source of payment, and this can complicate efforts designed to be collaborative. In addition, a Medicaid agency’s responsibility to wisely spend the public’s money and adhere to federal regulations can sometimes make it difficult to find ways to reach common goals.³⁰

California: Clarifying privacy laws to promote partnering between primary care providers and treating providers

One of the barriers to primary care providers, local agencies that offer treatment, and state staff working together to serve a family with a child experiencing or at risk for delays in mental, social, or emotional development is concern that they may violate privacy laws by sharing information about a family, information that can be critical to coordinating care. Sharing

³⁰ See Helen Pelletier, *How States Are Working With Physicians to Improve the Quality of Children’s Health Care* (Portland, ME: National Academy for State Health Policy, April 2006).

information among agencies presents special challenges because each agency must not only follow its own policies and rules but must also respect those of their partnering agencies.

To address this barrier, California's ABCD II project has worked with the National Center for Youth Law (NCYL) to develop confidentiality guidelines. The NCYL reviewed agency confidentiality policies and state/federal requirements and regulations. Based on the information gathered in this review, the NCYL prepared a report that identified:

- The information that managed care plans, the Medicaid agency, providers and other agencies that provide services to children with special health care needs can share with each other in order to accomplish four specific tasks:
 - monitoring and improving quality of care;
 - enhancing care coordination;
 - preventing duplication of services; and
 - improving administration of Medicaid benefits.
- The information that cannot be shared, even when needed to accomplish the four identified tasks, and what laws and procedures prevent that sharing.
- Suggested changes in procedure or state law that could facilitate information sharing.

The NCYL also developed a privacy agreement that facilitates partnerships and collaboration by showing legal guidelines for information sharing.

Lessons learned about building successful partnerships to achieve project goals

The experiences of the ABCD II states demonstrate that both state- and physician-led partnerships can produce improvements in care, especially when:

- The purpose of the partnership, how it benefits all involved, and what each partner can contribute is clear.
- Partners recognize that developing a partnership takes time and effort. Particularly difficult are partnerships between providers and state agencies that have a history of antagonism.

A final important lesson from these states' experience is that a state agency does not have to lead a partnership to benefit from it. Utah Medicaid benefits greatly from UPIQ, which is led by the Intermountain Pediatric Society and administered through the University of Utah. In Iowa, the Healthy Mental Development Panel (which brings together a range of stakeholders in partnership to develop standards for identification and treatment that will ensure young children's healthy mental development) is chaired by Dr. Alfred Healy, who is a widely respected pediatrician.

Using Quality Improvement to Make Progress Even in Difficult Economic Times

Each of the ABCD II states face the same funding constraints as other states, among them growing Medicaid costs and recovery from several years of declining or stagnating revenue. As a result, most of the efforts of the ABCD II states are designed to produce and sustain improvement without requiring new appropriations or even, in most cases, any changes to their Medicaid State Plan.³¹ Instead, these state projects have focused on improving the quality of the care delivered within existing federal guidelines and funding through such mechanisms as better defining Medicaid expectations of clinicians and supporting clinicians in their efforts to improve the quality of care they provide.

In addition, California, Illinois, and Utah are all working through their Medicaid-contracted managed care organizations (MCOs) to improve the identification and treatment of young children with or at risk for delays in social, emotional, or mental development.

State example

Utah: Improving quality through managed care

The Utah Medicaid agency contracts with managed care organizations (MCOs) to deliver physical health services and has separate managed care contracts to deliver mental health services. Utah is using these contracts to support its ABCD II project goals. In the first year of the ABCD II project, the state Medicaid agency's peer review organization (HealthInsight) reviewed the charts of adults and children likely to be served in both the medical system and the community mental health system. Less than 15 percent of the charts reviewed showed any coordination between mental health and medical providers. Medicaid staff presented these findings and models of care coordination to their contracted health plans and then gave all of the plans the same process improvement project (PIP) for the three-year period: improve the coordination of care, both plan to plan and clinician to clinician. Utah has not dictated how the plans are to improve coordination, only that they will do so. These PIPs will be validated by the External Quality Review Organization.

Because federal law classifies Utah's largest "plan" (Intermountain Health Care or IHC) as a primary care case management³² provider, IHC is not required to complete PIPs. Coincidentally, IHC is working on a project for its commercial line of business to place mental health

³¹The state Medicaid plan is the official document that defines how each state will operate its Medicaid program within federal guidelines. The state plan addresses the areas of state program administration, Medicaid eligibility criteria, service coverage, and provider reimbursement. (Source: CMS *State Medicaid Plans and Plan Amendment Web sites*. Retrieved September 15, 2005. <http://www.cms.hhs.gov/medicaid/stateplans/default.asp>.)

³² Primary care case management is a form of managed care used by Medicaid agencies in which (usually) a primary care provider or group of providers agrees to serve as the medical home and gatekeeper for Medicaid beneficiaries who are enrolled with the provider. In return, the provider receives fee-for-service payments for all services delivered to enrolled beneficiaries plus a small monthly case management fee for each beneficiary.

professionals on site in some of its larger contracted clinics. ABCD II project staff in Utah have worked with IHC to present this model to the Medicaid-contracted mental health plans, and two mental health plans are now working with these larger clinics to facilitate referrals for children enrolled in Medicaid.

Lessons learned about improving the quality of care.

The ABCD II states have identified a number of strategies for improving the care delivered to young children, even in tough economic times.

- Medicaid agencies can improve the care delivered to young children and sustain that improvement without new funding, changes to state law, or changes to Medicaid policy that require federal approval. But doing so requires effort, creativity, and support at high levels within the Medicaid agency.
- Partnering with other agencies, advocates, and providers offers opportunity for improvement. These partners can bring both resources and support to the table.
- Medicaid agencies can leverage existing resources and requirements, such as the federal requirement to conduct quality improvement projects in managed care programs, to improve identification and treatment of young children with or at risk for delays in social and emotional development.
- Testing potential strategies in pilot sites can build a strong case for broader quality improvement.

SUMMARY OF LESSONS LEARNED

The experiences of the ABCD II states in six key areas offer several important lessons for states interested in improving the delivery of services to support young children’s healthy mental development. Although these are important lessons, it is important to note that they reflect state experience at the halfway mark in the projects. We anticipate that more will be learned as these states continue to work on their projects and collect data. The final lessons learned and the quantitative data each state is now collecting will be reported in a final report from the ABCD II collaborative in 2007.

Screening With a Standardized Tool for Potential Social and Emotional Development Delays is an Important Step in Ensuring Young Children’s Healthy Mental Development

There is a clear consensus in the field that pediatric clinicians have both the opportunity and expertise to identify children in need of care to support their mental development. As the American Academy of Pediatrics notes, pediatric clinicians are the only clinicians who see most children under five on a regular basis—making the primary pediatric clinician an ideal candidate for conducting the ongoing surveillance needed to identify developmental problems. In recognition of the critical role played by pediatric providers, all five state projects began with a focus on improving the identification of young children with social and emotional development by pediatric clinicians.

There are also clear indications that physicians often fail to diagnose children with a clearly defined developmental problem, that few physicians use a standardized developmental screen, and many do not identify children with developmental problems.³³ As the AAP has noted: “the use of standardized developmental screening tools at periodic intervals will increase accuracy” and “pediatricians should consider using standardized developmental screening tools that are practical and easy to use in the office setting.”³⁴ Thus, the five projects have focused their improvement efforts on encouraging and supporting primary pediatric practices to make periodic use of a validated, standardized screening tool a regular part of the way they deliver care to all children.

These five states have found that the federal Early and Periodic Screening Diagnosis and Treatment (EPSDT) requirements provide an important base for improving identification. Among other things, EPSDT requires periodic screening, a requirement that four of the five states have already used as a platform for recommending the use of standardized, validated screening tools to providers.

³³ David Bergman, *Screening for Behavioral Developmental Problems: Issues, Obstacles, and Opportunities for Change* (Portland, ME: National Academy for State Health Policy, 2004).

³⁴ American Academy of Pediatrics. “Developmental Surveillance and Screening of Infants and Young Children.” *Pediatrics* 2001; 108(1):192-195.

Screening Does Little Good Without Access to Follow-up Services

Early in the design of these projects it became clear that although improved screening of young children for potential social and emotional development problems was essential to ensuring young children's healthy mental development, it was also insufficient. All five states found that efforts to identify and help families and clinicians access resources for assessment and treatment were critical to project success. Not only are these efforts necessary for ensuring that children identified with potential needs receive appropriate care, but the ABCD II states found that pediatric clinicians were reluctant to adopt (or continue) using a screening tool unless they were confident that the children they identified as potentially needing further care would receive appropriate care. Thus, the five states also undertook efforts to identify existing assessment and treatment resources, remove policy barriers to accessing those services, and facilitate referrals to these resources. Minnesota has also taken steps to increase the resources available for assessment and treatment.

Federal EPSDT requirements also provide an important base for this aspect of the state projects. EPSDT requires states to provide eligible children with any service needed to "correct or ameliorate defects and physical and mental illnesses and conditions discovered by the [EPSDT] screening services" even if the state has chosen not to cover those services under other conditions.³⁵ Several ABCD II states have used this requirement as a basis for covering innovative services, such as conducting a risk assessment for perinatal depression (Illinois) and specialized services targeted to treat children with less intense needs than normally covered (Minnesota).

States Can Facilitate Access to Follow-up Services

States can facilitate access to follow-up care for young children identified by pediatric providers as experiencing or being at risk for delays in social or emotional development. States pay for assessment and treatment not only through their Medicaid programs but also through early intervention and children's mental health programs. They have resources available to not only pay for treatment but to facilitate access to treatment by providing direct assistance, by improving coordination among programs, and by helping practitioners to develop links with local resources.

- *Direct assistance.* Iowa's EPSDT coordinators (who work for local agencies contracted to the state public health agency) and Illinois's Child and Family Connections (which contract with the state's Early Intervention program) will both accept referrals from practitioners in the pilot sites and are committed to helping the families of children identified with potential delays obtain needed care.

³⁵ § 1905(r)(5) of the Social Security Act. Retrieved September 27, 2005.
www.ssa.gov/OP_Home/ssact/title19/1905.htm

- *Improved coordination among programs.* Illinois’s early intervention program changed its policies to clarify that children of mothers with maternal depression qualified for early intervention services, and Utah’s Medicaid agency and Division of Substance Abuse and Mental Health resolved inconsistencies between their billing and audit policies that were discouraging some local mental health agencies from treating some children with less intense needs.
- *Helping practitioners develop links with local resources.* Part of each learning collaborative session in Utah is devoted to helping practitioners develop relationships with and referral pathways to local resource agencies.

Demonstrations Can Inspire and Test Policy Change

Each of the ABCD II states has established pilot sites (demonstrations) to:

- test new ideas and delivery mechanisms;
- test new policies; and/or
- identify policy barriers.

The ABCD II states have found that the pilot sites have proven to be an effective method of not only testing whether new ideas work but of also ensuring that policy changes are grounded in real life experience—an important aspect of making policy work relevant and tangible.

Partnering With Pediatric Clinicians is Critical to Improving the Care Delivered to Children

Active partnerships with clinicians have been critical to obtaining provider acceptance and support for the ABCD II projects. In all five states clinicians have played key roles in:

- developing state recommendations for screening tools and effectively communicating those recommendations to clinicians;
- identifying policy changes needed to promote improvement; and
- providing training and assistance to the pilot practices and spreading improvements in practice throughout the state.

Developing Successful Partnerships with Providers Takes Effort and a Willingness to Follow as well as Lead.

Each of the ABCD II states has developed successful partnerships with medical providers. These partnerships have been forged even in states where the Medicaid agency and clinicians have not always worked well together. These partnerships have been built over time as partners recognize what each has to contribute to improving care. The ABCD II states have also found

that joining partnerships that they do not lead can be very beneficial. Utah's learning collaboratives, for example, are led by providers and have opened up important new avenues for state efforts to improve the care delivered to children.

States Can Improve Care Without New Funding or Legislation

All five ABCD II states have improved (or are on-track to improve) the delivery of care to young children. For the most part, they have done so without seeking new appropriations, changing state law, or obtaining federal approval. They have accomplished this by leveraging existing resources and partnering with other stakeholders including their sister agencies, private organizations, and providers.

The ABCD II states have found federal EPSDT provisions to be particularly important to their efforts to leverage existing resources and partner with other stakeholders. The flexibility provided by EPSDT has enabled these states to complete the following tasks without a waiver or changes to their Medicaid state plan:

- promote providers' use of standardized screening tools (all five states);
- establish a system for supporting treatment referrals that relies on local EPSDT care coordinators (Iowa); and
- use primary pediatric providers to conduct risk assessments for perinatal depression (Illinois).

In addition, EPSDT has enabled Minnesota to create a Medicaid benefit designed for all children diagnosed with an emotional disturbance and to expand the types of providers that can deliver parts of that benefit.

Some of these states have found that two other provisions of federal Medicaid law were also important factors in enabling them to improve care, especially in difficult financial times.

- Illinois and Utah have both made use of federally required external quality reviews to work with MCOs on efforts that would, among other things, support young children's healthy mental development. Illinois's efforts were focused on child development services and Utah's on improving coordination between the mental health and physical health systems (plan to plan and clinician to clinician).
- Illinois reported that its ability to use local funding to claim federal matching funds for Medicaid administrative costs has been an important factor in garnering the support of other stakeholders.

Appendix

Profiles of State Projects

State Profile: California

Project: California's BEST-PCP: Behavioral, Developmental, Emotional Screening and Treatment by Primary Care Providers

Agency: Medi-Cal Managed Care, California Department of Health Services

Project Directors: Penny Knapp, MD
Medical Director
Children's Services
California Department of Mental Health
1600 9th Street, Suite 151
Sacramento, CA 95814
phone: 916-654-2309
penny.knapp@dmh.ca.gov

Richard Sun, MD
Medical Consultant
Medi-Cal Managed Care Division
California Department of Health Services
PO Box 997413, MS 4404
Sacramento, CA 95899
phone: 916-449-5020
rsun@dhs.ca.gov

Background

According to project leaders, California's decentralized service delivery system is ill-designed to meet the needs of children at-risk for mental, emotional, and developmental problems. Project leaders cite a dearth of screening tools, a lack of culturally sensitive materials, and a shortage of children's mental health providers as particular challenges.

Project Overview

The goal of the BEST-PCP project is to improve outcomes for young children at risk for the development of serious mental or behavioral health or developmental problems through improved identification and linkage to available and appropriate resources for prevention and early intervention services. The BEST-PCP project focuses on improving access to state-funded and community-based early mental/emotional/developmental (M/E/D) services by addressing structural and policy constraints that influence the ability of providers to appropriately find and refer children in need. The project is also working to develop model to implement change at the provider practice level.

The project has three specific objectives:

1. To develop a matrix of agency responsibilities for mental health and developmental services delivery for children enrolled in Medi-Cal managed care.
2. To identify policy and process changes to improve access to and enhance funding of mental and developmental health services.
3. To implement a model quality improvement project (including training and toolkit) in two counties to help providers improve identification of children ages 0-3 in need of prevention or early intervention services for mental health or developmental disorders using a standardized screening tool, and to improve utilization of existing agency and community resources, incorporating the matrix and proposed policy and process changes.

Major Accomplishments in Years 1 and 2 (2004 and 2005):

- Identified two pilot sites and partner agencies: The Inland Empire Health Plan and the Alameda Alliance for Health. A training curriculum for the two pilots has been developed, procedural decisions have been made, trainings have been held, and screening schedules have been determined.
- Identified the ASQ-SE and two depression screening questions (to test for maternal depression) as a recommended tool for use in the pilot projects.
- Initiated standardized screening and referral protocols in the practices recruited within the BEST-PCP project sites.
- Developed a matrix framework identifying roles and responsibilities of state and local agencies regarding the healthy mental development of children under age 4. Established and populated a database for the matrix.
- Worked with an outside organization to analyze federal and state privacy laws that may inhibit or facilitate collaboration among agencies and stakeholders. Produced a document on confidentiality constraints and, based upon its findings, trained professionals confidentiality issues.
- Convened policy stakeholder group to review opportunities to encourage screening, education, and referral for children and families with social and emotional developmental issues.

Summary of Plans for Year 3 (2006)

- Sustain standardized screening and referral protocols in the practices recruited within the BEST-PCP project sites.
- Create mechanisms for BEST-PCP standardized screening and referral protocols to be spread to other providers/practices within the pilot counties.
- Create mechanisms for BEST-PCP standardized screening and referral protocols to be spread to other health plans within the state.
- Produce policy and process recommendations to improve access to and enhance funding of M/E/D services.
- Assess and disseminate evaluation results to facilitate project sustainability and expansion.

State Profile: Illinois

Illinois's ABCD II project focuses on the role of the state Medicaid program and primary care providers in promoting the social-emotional health of children under age three. The project's goals include:

1. Increasing social-emotional and perinatal depression screening and referral by primary care providers;
2. Improving the provision of mental health-related services to Medicaid eligible women and their children under age three; and
3. Providing lessons learned that will lead to changes in statewide policy and practice in Illinois.

Major Accomplishments in Years 1 and 2 (2004 and 2005)

- Implemented three pilots using a coordinated community model and a fourth pilot that integrates screening and referral into its outreach program. As part of this implementation project staff:
 - identified referral resources for primary care providers by conducting an assessment of statewide prevention, early intervention and treatment resources and an assessment of the pilot communities; and
 - trained eight primary care practices on social-emotional developmental screening, including screening for perinatal depression. (This same training was provided to all local health departments.)
- Clarified and changed policy:
 - Clarified the state's Medicaid reimbursement policy for developmental screenings. By clarifying and encouraging the use of "unbundled services," the Illinois Department of Healthcare and Family Services (IDHFC) has been able to monitor trends in screening and referral services and to reiterate the importance of periodic objective developmental screening among primary care providers serving young children.
 - Medicaid began paying primary care clinicians for using a validated screening tool to screen the mothers of all infants covered by Medicaid for perinatal depression. (A detailed overview of this new policy is available.) The screening occurs as a part of the risk assessment during the infant's well-child or episodic visit. If the infant's mother is not covered by Medicaid, the provider may bill for the service under the infant's Medicaid ID number.
 - Worked with the Illinois Department of Human Services to allow the use of other developmental and social-emotional screening tools for infants in the Adverse Pregnancy Outcomes Reporting System (APORS), instead of the Denver II.
 - Worked with the Bureau of Early Intervention to clarify that an infant whose mother has been diagnosed with postpartum depression is eligible for Part C services.
- Required that Medicaid contracted Managed Care Organizations (MCOs) develop a performance improvement project to evaluate the content and quality of care provided to young children. Medical record abstractions have been completed and analysis is currently underway. MCOs are also required to implement a perinatal depression initiative for screening, referral, and treatment.
- Developed an evaluation plan, compiled baseline data on the primary care practices, compiled results from training sessions, developed and distributed evaluation tools to the pilot practices, performed periodic interviews with leadership team members for lessons learned, and performed evaluation of changes in social and emotional screening, referral, and treatment practices.

Summary of Plans for Year 3 (2006)

During year 3, the ABCD II project plans to:

- Continue the four pilot projects and complete the evaluation of their efforts.
- Provide technical assistance to the pilot primary care practices that have struggled to implement the screening and referral processes into their well-child visit structure.
- Modify the training curriculum developed for the pilot primary care practices in order to deliver social-emotional and perinatal depression training to an additional 40 practices.
- Expand the data match model used by the Chicago Department of Public Health outreach initiative in ABCD II.
- Continue to analyze Medicaid policy for clarification and changes as needed.
- Collaborate with the Enhancing Developmentally Oriented Primary Care Project, Evanston Northwestern Health Care (ENH), and the University of Illinois at Chicago, to ensure a sustainable, statewide perinatal depression training program.
- Work with the Illinois Children's Mental Health Partnership's Early Childhood Committee to increase the use of the assessment tool, DC: 0-3, and develop a crosswalk to ICD-9 codes for billing purposes.

The Illinois project is being supported by grants from the Michael Reese Health Trust, with support also from the Chicago Community Trust during the first year of the three-year initiative.

State Profile: Iowa

Project Summary

Iowa has established three levels of services:

- Level 1: Preventive services, including screening, assessment, family risk factors, counseling, and care coordination, for all Medicaid eligible children;
- Level 2: Developmental services, such as problem-based counseling and coordination of care for all Medicaid eligible children identified at risk for developmental or emotional problems; and
- Level 3: Intensive developmental or mental health services for those children identified in need of therapy.

The state's ABCD II project is intended to:

- Build the capacity of Iowa primary health care providers to provide developmental surveillance and assessment, family risk assessment, and anticipatory guidance for the healthy mental development of all Medicaid eligible children birth to age three.
- Build the capacity of Iowa's public and private health systems to promote healthy mental development through the enhancement of the delivery of Level Two services and improved linkages with Iowa hospitals and other service providers.
- Define clinical care standards for Level One and Level Two services, including surveillance, family risk assessment and care coordination
- Conduct two pilot projects—one urban and one rural—to test the application of Level One system standards and linkages to Level Two services.

Major Accomplishments in Years 1 and 2 (2004 and 2005)

- Established the Healthy Mental Development Panel, made up of various stakeholders, to guide the state's ABCD II project in its development of a comprehensive system.
- Implemented two pilots to test and refine minimum standards for Level One services and linkages to existing Level Two services. Pilot implementation has included initial training and ongoing support by a team that includes physicians and state staff. These pilots are also testing the use of screening tools and other materials developed to support the practices' efforts to identify and refer young children with mental development needs.
- Defined a referral process, using local EPSDT coordinators, that assures all children are referred to and connected with appropriate services. This approach is being tested in the pilot sites, and information from the EPSDT coordinators in the pilots is being used to identify gaps in the system.
- Identified and analyzed Medicaid barriers related to screening and identification as a step toward policy improvement; began work to identify barriers related to intervention services.
- An Iowa EPSDT health provider Web site reflecting the standards and definitions of the three levels and other information about using a standardized screening tool was designed and went online in June 2005.
- Developed a training proposal to cover topics including: the proposed identification standards, best practices in developmental screening, autism screening, family risk assessment, and healthy mental development.
- Featured ABCD at the "Off to a Good Start: Framing Policy for Early Childhood Systems Integration" conference in October 2005 for leaders in Iowa's health programs and for state legislators. The purpose of this conference was to begin developing (and developing support for) a children's health agenda in Iowa.

Summary of Plans for Year 3 (2006)

During year 3, the ABCD II project plans to:

- Assess outcomes from demonstration sites.
- Revisit and adapt proposed EPSDT healthy mental development standards, tools and processes based on the demonstration site outcomes. Revised standards, tools, and processes will be taken to the Board for its review and approval.
- Obtain endorsement of revised healthy mental development standards, tools, and processes by participating health provider associations
- Complete evaluation of Medicaid barriers to implementation of the standards, tools, services, and processes and make recommendations to the Medicaid director who will respond by the end of the project period.
- Disseminate the adopted healthy mental development standards, tools, and processes by meeting with participating health provider associations to ascertain their needs; developing plans and materials to address these needs including making necessary changes to the EPSDT health provider web site; initiating training on the standards and recommended tools through the Medical Home initiative's quality improvement learning collaborative; developing a plan to enhance linkages between private health providers and EPSDT care coordinators across the state; training local Title V agency staff including the EPSDT care coordinators in the use of the standards, tools, and processes; revising current EPSDT care coordination policies and procedures to encourage enhancement of partnerships with private practices; and revising the EPSDT section of the Iowa Medicaid Provider manual to reflect revised standards, tools, and process.
- Identify gaps in and barriers to the provision of Level 2 services by working with the pilot sites. A report with recommendations about further developing Level 2 services in Iowa will be developed and shared with key state policymakers.

State Profile: Minnesota

Project Summary

Minnesota's ABCD II project set the following goals:

1. Introduce mental health screening of parents.
2. Expand early childhood mental health screenings in several venues and establish a separate billing mechanism.
3. Test and establish a new Medicaid benefit for at-risk children who do not meet current diagnostic criteria.
4. Test and adopt a new diagnostic framework (DC:0-3) for use with young children.
5. Train primary pediatric practices to assist in infant mental health integration.

Major Accomplishments in Years 1 and 2 (2004 and 2005)

During the first two years, the ABCD II project:

- Updated the state's EPSDT provider training manual to more directly address early childhood and children's mental health.
- Completed review of developmental screening instruments and posted a new Web site presenting those instruments recommended by the Minnesota Department of Health, endorsed by the Minnesota Department of Human Services, and approved for use by the Minnesota Department of Education for the Early Childhood Screening Program.
- Began significant collaborations with Head Start and Early Head Start, organizations that have identified improving early childhood mental development as a new strategic goal. Local Head Start agencies have made progress in implementing screening tools in the target language of the families served. Instruments will be translated and back-translated for accuracy in Hmong, Somali, and Spanish. The agencies have also purchased handheld tablets with screening tools already installed for easy use and adaptation.
- Started screening children at one partner site with the other pilot expected to launch its screening program in January 2006. The site has compiled a list of initial challenges based on its initial experience in using the ASQ:SE as part of a well-child exam and is now working with project staff to address those challenges. These sites are also testing the utility of a potential new Medicaid service specifically tailored for children whose mental health development is at risk but who do not have diagnosable disorders.
- Minnesota legislature enacted legislation to provide postpartum depression education and information to new mothers and fathers departing from hospitals and other health care facilities.
- Began implementing use of the DC: 0-3 classification system; trained mental health providers on the DC: 0-3 system and the crosswalk to ensure that those children who now qualify for the service receive it; and worked to increase the number of providers certified to provide the Children's Therapeutic Services and Supports (CTSS) benefit.

Summary of Plans for Year 3 (2006)

In the third year, Minnesota's ABCDII initiative will work to:

- Arrange for routine consistent training of both physicians and mental health providers.
- Work with the stakeholder partnership as well as the Minnesota Mental Health Action Group (MMHAG) to configure a new targeted prevention benefit. This benefit would fill a gap in the

service continuum by serving children who are identified by screening as being at risk for mental health problems but whose conditions do not fall into a diagnosable range.

- If feasible, expand the MN Health Care Program benefit to include screening of children and parents, and targeted prevention.
- Disseminate and provide technical assistance on use of the CTSS benefit for young children, including developmentally and culturally appropriate interventions.
- Serve as lead in adopting the DC: 0-3 diagnostic criteria and work with the Minnesota Department of Health, the Harris Center, and other training venues to assure adequate training in use of DC: 0-3 to all providers of CTSS to young children.
- Expand the number of clinics utilizing the Great Start MN model. Minnesota's AAP chapter is actively supporting this effort.
- Work with educational institutions to prepare the early childhood mental health workforce, by developing an Infant Mental Health Certificate.

State Profile: Utah

Project Summary

The Utah Department of Health, Division of Health Care Financing proposed a multi-pronged project to increase the number of children enrolled in Medicaid who receive developmental screenings, including a focus on mental health concerns, as part of regular well-child visits as well as appropriate treatment when indicated. The Division planned to build on efforts already under way and to collaborate with partners who also serve children enrolled in Medicaid.

Utah's objectives are to:

1. Increase screening for infant mental health concerns as part of the EPSDT well-child visits;
2. Increase interactions between and among Medicaid providers to ensure that providers direct children and their families to appropriate services;
3. Increase screening for maternal depression within pediatric practices and as part of the postpartum follow up visits; and
4. Increase the capacity of the current mental health system to serve infants in a variety of appropriate settings.

Major Accomplishments in Years 1 and 2 (2004 and 2005)

The Utah ABCD II project has:

- Selected preferred developmental and social-emotional screening tools for infants and toddlers and updated the Medicaid CHEC provider manual to recommend that clinicians use them. (The preferred tools are ASQ, ASQ:SE, PEDS, and TABS.)
- Conducted two learning collaboratives on social-emotional development—one for infants and a second for toddlers. The collaboratives were developed through the Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ). Ten pediatric practices participated in the first collaborative and an additional ten participated in the second. Early results from the first collaborative show increased use of a standardized screening tool by pediatricians and improvements in identifying children. One of the physicians from this learning collaborative stated: "I've picked up on delays in seven children I would have missed without using the ASQ."
- Conducted chart reviews that documented that less than 15 percent of the charts showed any coordination between mental health providers and medical providers. Presented findings to contracting health plans along with models of care coordination and gave all managed care plans the same process improvement project to improve the coordination of care—plan to plan and provider to provider.
- Conducted two systems capacity surveys and report of the state system capacity that indicate a sharp decline in the number of mental health providers employed and contracted by community mental health centers while the number of children served continues to rise.

Summary of Plans for Year 3 (2006)

During year 3, the ABCD II project plans to:

- Hold a third learning collaborative on maternal depression and take it to rural areas of the state.
- Partner with the Children's Mental Health Institute to get information about the importance of identifying maternal depression and getting mothers and families into appropriate services through regularly scheduled conferences.

- Share information on the learning collaboratives, and progress made by the participating practices, with Intermountain Pediatric Society members, HealthInsight (QIO), and the medical directors of all health plans in Utah.
- Continue to work with primary care practices as well as local mental health centers to identify and pilot projects that will improve coordination of care between the mental health and medical providers.
- Expand on the Systems Capacity Survey to analyze trends in third year, collaborate with UPIQ in providing feedback/technical assistance for collaborative participants needing it, and collaborate with Maternal and Child Health to develop and implement an “Infant Mental Health Training Needs” survey. Develop target training from the results.