Youth Empowerment Services (YES)
System Capacity Analysis Report

January 30, 2017

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Executive Summary

Opportunities to improve outcomes for children, youth, and families in Idaho through the Youth Empowerment Services (YES) Project include providing timely access to a full array of mental health services in the scope, intensity and duration that meets the needs of the target population. A comprehensive analysis of the capacity of Idaho's mental health treatment system to deliver the continuum of mental health services is needed periodically to effectively guide the state's transformation efforts in workforce development to successfully meet this goal.

This initial YES System Capacity Analysis Report is based on the requirements in the Jeff D Agreement and Idaho Implementation Plan. The YES Quality Management Improvement and Accountably (QMIA) Data and Reports Committee completed the initial system capacity assessment. The QMIA Data and Reports Committee is a workgroup, involving representatives from the Idaho Department of Health and Welfare (DHW) Divisions of Behavioral Health (DBH), Medicaid, and Family and Community Services (FACS), along with the Idaho Department of Juvenile Corrections (IDJC) and the State Department of Education (SDE), was formed to develop YES reports that are across the child serving systems.

This capacity analysis has revealed some of the gaps in the current data capture infrastructure that must be addressed to move toward a system in which all the partners are capturing similar data, using the same naming conventions, have the same definitions for variables and then are able to engage in meaningful data sharing. Despite the noted data limitations, the following conclusions were derived from this analysis:

- The proportion of children served in Region 7, exceeds the proportion served in the highest populated region, Region 4 for both DBH and Medicaid.
- The percent of medication management services for Medicaid appears to be higher than the national average despite the affirmed shortage in child and adolescent psychiatrists in Idaho.
- Psychotherapy appears to be accessed significantly less in Idaho than it is accessed nationally.

Over the next one to two (1-2) years more extensive analyses on the system capacity needs for Jeff D Class Members will be conducted and reported. The intent of further study into system capacity will be to uncover more in-depth information about child, youth and family needs, and how the system is able to meet those needs.

Information gleaned from this report will be utilized for system planning, specifically for workforce development. Based on the result of this initial capacity analysis the recommendations for planning for workforce development in order to maintain and enhance system capacity are:

- Continue analyze and assess current capacity and needed capacity on an on-going basis based on an in-depth need-based planning study
- Implement Child and Adolescent Needs and Strengths (CANS) and the Transformational Collaborative Outcomes Management (TCOM) system which will provide useful data about child, youth and family outcomes
- Evaluate the cause of apparent capacity issues by region
- Consider setting recruitment goals by region and by type of service needed
- Provide training on practices that are effective (evidence based, evidence informed and proven practices) but are currently not utilized extensively
- Consider establishing staffing models by program type
- Work with local universities to ensure education is focused on areas of need throughout the state.
- Support primary integration by developing new models of integration and pilot them

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Introduction

The Idaho Department of Health and Welfare (DHW) Divisions of Behavioral Health (DBH), Medicaid, and Family and Community Services (FACS), along with the Idaho Department of Juvenile Corrections (IDJC) and the State Department of Education (SDE) have initiated the Youth Empowerment Services (YES) project. The aim of the YES project is to transform statewide public mental health systems over the next four (4) to seven (7) years to improve outcomes for Idaho's children, youth and families. The goals for this transformation are based on the Jeff D. Settlement Agreement which resulted from the most recent mediation to resolve the lawsuit filed originally in 1980. The steps toward transformation are outlined in Idaho's Youth Empowerment Services (YES) Implementation Plan. (See the YES website at www.youthempowermentservices.idaho.org for copies of the Jeff D. Settlement Agreement and Implementation Plan).

Opportunities to improve outcomes for children, youth, and families in Idaho through YES include providing timely access to a full array of mental health services in the scope, intensity and duration that meets the needs of the target population. A comprehensive analysis of the capacity of Idaho's mental health treatment system to deliver the continuum of mental health services is needed periodically to effectively guide the state's transformation efforts in workforce development to successfully meet this goal.

The YES Quality Management Improvement and Accountably (QMIA) Data and Reports Committee completed an initial system capacity assessment to begin the practice of using cross-system data to assess capacity. The QMIA Data and Reports Committee is a workgroup, involving all five child serving systems noted above, and was formed to develop YES reports that are across the child serving systems. This initial YES System Capacity Analysis Report is based on the requirements in the Jeff D Agreement and Idaho Implementation Plan.

The initial YES System Capacity Analysis is based on the following requirements in the Jeff D Agreement and in the YES Implementation Plans:

Jeff D. Settlement Agreement:

> Section 82. Throughout the sustained performance period, Defendants shall maintain the critical system infrastructure developed during the implementation period and continue to provide the full array of services and supports to Class Members statewide. In order to sustain the children's mental health system of care Defendants shall:
>
> a. Annually update the range of expected Class Member service utilization;
> b. Maintain statewide capacity to timely provide Services and Supports in the appropriate scope, intensity and duration to Class Members for whom it is medically necessary;
> c. Provide the full array of Services and Supports statewide to Class Members for whom it is medically necessary;
> d. Timely provide Class Members with Services and Supports that are appropriate in scope, intensity and duration to meet to his or her individual strengths and need;

YES Implementation Plan:

> Section H. Assess system capacity by January 30, 2017.

1. Develop methodology to assess the current statewide system capacity and estimate the statewide system capacity necessary to provide all of the service and supports statewide to Class Members under the Agreement.

2. Identify metrics to be used to measure current statewide and regional capacity, taking into account historical utilization data.

3. Utilize metrics to measure current statewide and regional capacity for the timely delivery of services and supports.

4. Formulate initial recommendations to inform Workforce and Community Stakeholder Development, to establish and maintain system capacity.

Report Limitations

While not comprehensive this initial analysis will provide baseline information that can be used for decision-making that will support improving system capacity. Due to the complexity of the child mental health serving system and data limitations this initial analysis only addresses outpatient services and does not address timeliness, intensity, or duration. It is notable that there were other limitations that also impacted initial capacity analysis:

- There are variations in reliability of the data which may impact accuracy.
- There were limited resources available to complete the analysis.
- The data needed must be gleaned from several complex systems that operate independently therefore duplication could not be minimized.
- Indicators of system capacity are not currently collected by any of the partner agencies; therefore, the analysis is limited to extrapolation of utilization data from Division of Medicaid and Division of Behavioral Health.

Profile of Children, Youth and Families

The YES Capacity Analysis begins with a broad examination of all children and youth under the age of 18 in Idaho (Section 1) by payer type, and the estimated number of Class Members (Section 2). The capacity analysis then focuses on how current service utilization is distributed across service types, and how patterns of use differ between DBH and Medicaid and across Idaho's seven (7) regions (Sections 3 and 4). This information will assist in understanding the variation between the two systems. This portion of the analysis is based on the most recent data about utilization of outpatient services by the child and youth population that is presumed to meet the criteria to be a Class Member of the Jeff D. lawsuit. The capacity analysis then shifts to focus on assessing capacity needs for the system transformation (Section 5).

1) Total number of Idaho Children and Youth (under the age 18):

Table 1: Idaho's Child and Youth Population by Payer

Column	Year	Population	Medicaid	Privately Insured	Uninsured
1	2014	430,918	188,290	215,407	27,221
2	2015	432,837	201,925	206,211	24,701
3	2016	434,465	208,687	207,794	17,984

Data Source: Medicaid

- Columns 1 and 2: Years 2014 and 2015: Idaho population under age 18, U.S. Census Bureau Annual Population Estimates
- Column 3: 2016: Medicaid estimated Idaho population under age 18

Discussion: It is notable that for the past two (2) years there appears to be trend for an increase in the number of children and youth under the age of 18 who are Medicaid members (+11%) and trend for a decrease in the number of children and youth under the age of 18 who are uninsured (-34%). It is unknown if this trend will impact the system capacity needed to meet the requirements of the Settlement Agreement.

2) Projected number of Jeff D Class Members

Idaho continues to work on finalizing its projection of the numbers of Jeff D. Class Members. There have been three (3) in-depth studies completed, two (2) by Boise State University (BSU) and one (1) by a collaborative group including Medicaid, Optum, and DBH staff. The projection has varied somewhat in each group's analysis as the proxy indicators or "caseness" has varied. The actual number of Class Members will remain an estimate until Idaho has implemented the standardized assessment instrument designated in the Agreement (the Child and Adolescent Strengths and Needs or CANS).

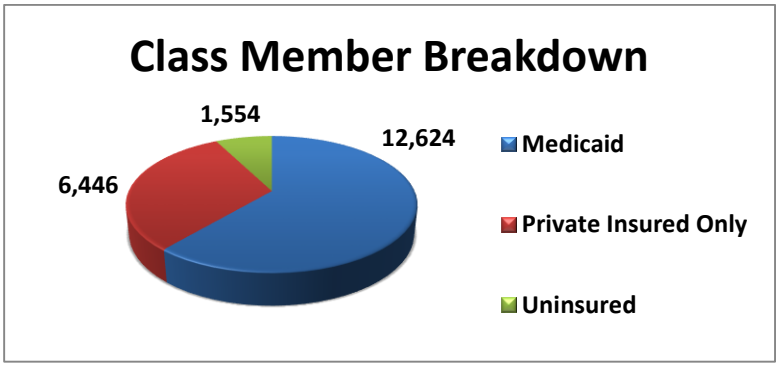
BSU Projection:

The estimate of Idaho's youth populations ages five (5) to 17 who experience SED and have an impairment in functioning severe enough to qualify them for Jeff D services was suggested to be between 17,734 to 23,318 children or youth. The estimate was based on the BSU study "Prevalence of Serious Emotional Disturbance (SED) and Mental Health (MH) Service Utilization in Idaho," conducted on behalf of the YES project. This estimate was based on a meta-analysis of the epidemiological literature on children's mental health in the US published from 1993 to 2015. This is based on a prevalence rate of 6.47% with a confidence interval of 5.59% to 7.35%.

The estimate by the Center for Substance Abuse Treatment (CSAT) committee of 21,000 was within the ranges noted in the BSU estimate and was in fact very close to the number predicted through BSU's meta-analysis (317,248 youth ages 5-17 X 6.47% = 20,526). (Note there was a difference in age groups used (5-17 for BSU), (0-17 for IDHW)

CSAT Projected Total Class Members: 21,000 (Rounded)

Diagram #1:



Data Source: Medicaid

Discussion: DBH is working with BSU and Medicaid to finalize the projected number of Class Members but for purposes of this capacity analysis projection of 21,000 will be utilized. It is notable however that this projection includes 6446 children and youth who are privately insured and that is unknown how many children or youth who are privately insured will choose to utilize the public mental health system for services.

*3) Number of Presumed Class Members** currently served by DBH and Medicaid by Region:*

DBH and Medicaid utilize data in their current systems to try to identify how many children and youth currently being served would potentially be deemed as Class Members. These two systems utilized different proxy indicators as the data collected by each system varies.

DBH used the scores on the Child and Adolescent Functional Assessment Scale (CAFAS) to predict Class Membership. The CAFAS score of 80 matches the definition currently in IDAPA Administrative Code for SED (IDAPA 16.07.37) Additionally a CAFAS score of 80 matches to the expected CANS scores that will be used to determine class membership once the CANS has been implemented.

Medicaid used state fiscal year (SFY) 2016 Idaho Behavioral Health Plan (IBHP) enrollment and claims data and diagnostic information. Medicaid also used the number of services that were delivered within this timeframe. Children that met the criteria for diagnosis and also received 10 or more SED claims were presumed to meet the criteria for Jeff D. Class Membership.

Table 1: Estimated number of children and youth currently served who are Presumed to be Class Members

	DBH			**Medicaid**	
Region	Current Presumed Class Members**	% of Total		Current Presumed Class Members**	% of Total
1	127	10.5%		1,617	11.3%
2	60	4.9%		487	3.4%
3	151	12.4%		3,080	21.5%
4	236	19.4%		3,322	23.1%
5	201	16.6%		1,569	10.9%
6	114	9.4%		1,088	7.6%
7	307	25.3%		3,150	21.9%
Other/Unknown	18	1.5%		41	0.3%
# of Presumed Class Members receiving services**	1,214			14,354**	

**In this report current Presumed Class Members are or may be duplicated within or across regions, and within or across DBH and Medicaid systems. Due to the possible duplication the total number of Presumed Class Members served in this table is not equal the projection of estimated number of Class Members.

Discussion: This analysis demonstrates significant variability across the regions and between DBH and Medicaid. The proportion of children served in Region 7, exceeds the proportion served in the highest populated region, Region 4.

4) Assessing current system capacity:

Several methodologies were used to assess current system capacity to provide services in the scope that meets the needs of children, youth and families.

The first method was focus on what is known about Idaho's capacity to provide mental health services.

Health Provider Shortage Area (HPSA):
There are known shortages in Idaho's capacity to provide mental health services as demonstrated by the states' Health Provider Shortage Area (HPSA) designation. A HPSA is an area designated by the Health Resources &

Services Administration (HRSA) as having a shortage of primary care, dental care or mental health providers. Based on the criteria for mental health providers established by HRSA a score is given to each area based on the population and the number of providers in the region. Although some counties in Idaho are not defined as having shortages in mental service providers (such as Ada County) there are many others that are designated. Based on the number of counties that are designated HRSA considers the state of Idaho overall to be designated as a HPSA state for mental health.

The State Behavioral Health Planning Council noted the following in their 2016 Report to the Governor: "Idaho continues to experience a shortage of child and adolescent psychiatrists. And while this shortage is found nationwide, in Idaho we continue to see families driving up to four hours from their home to access needed psychiatric services."

Substance Abuse Mental Health Services Administration (SAMHSA):
While the comment from the Planning Council is anecdotal there is national data published by SAMHSA which verifies the comment. The SAMHSA data (see Table 2 on page 7) shows that the ratio of child and adolescent psychiatrists to the state's population indicates that there is still a shortage of children's psychiatrists although the number of psychiatrists has increased since 1990.

Discussion: As of 2009 Idaho's rate was 5.0 children's psychiatrists per 100,000 youth. There are only 3 states with rates that re worse than Idaho's rate. It is notable that while the SAMHSA data about Idaho regarding the total number of psychiatrists is useful it is not known if the numbers reflect the number of psychiatrists working in the public mental health system or currently practicing.

Table 2: Idaho's Child and Adolescent Psychiatrists

	Number of Child and Adolescent Psychiatrists			Child and Adolescent Psychiatrists per 100,000 youth		
Year	1990	2000	2009	1990	2000	2009
Number/rate per 100,000	9	17	21	3.0	4.6	5.0

Idaho's Service Utilization Data:
Using current utilization data (SFY 2016) the QMIA Data and Reports Committee evaluated the most commonly used outpatient treatment services by type and geographic distribution of services delivered by DBH (Table 3) and Medicaid (Table 4). A direct comparison between the two systems is not feasible for the following reasons:

1. Services provided by DBH are intended for a target population that is substantially different from the Medicaid population. DBH serves children who are primarily court ordered into services while Medicaid serves primarily those who are voluntary.
2. The top most commonly used services vary by DBH and Medicaid system based on the difference between the populations served.
3. Data contains duplication because of the lack of a common identifier of clients among the partner agencies in the analysis.
4. Terms and definitions across child serving systems differ and therefore data often cannot be compared directly

The metrics used for the assessment of current system capacity were:

- Provider location based on provider address from provider claims
- Scope (types) of outpatient services delivered from provider claims
- Presumed Class Members currently served based on Medicaid proxy criteria
- Services stratified by Region as defined by DBH

Table 3: Count of DBH Services Utilized Most Frequently by Current Presumed Class Members**

Region	Division of Behavioral Health (DBH) Regional Clinics Type of Service							
	CMH Case Mgmt.	Medication Management Services			Parenting With Love and Limits	Wraparound	Total Types of Services	% of Total Services
		Psychiatric Diagnostic Evaluation	Nursing Services	15 Minute Outpatient (99213)				
1	114	37	0	0	23	14	188	10.2%
2	49	8	20	0	20	2	99	5.4%
3	125	53	23	20	35	0	256	13,9%
4	199	101	1	44	29	0	374	18.7%
5	194	5	0	0	22	0	221	11.9%
6	93	52	0	18	31	0	194	10.5%
7	235	210	0	0	36	14	495	26.8%
Other	11	2	1	1	2	0	17	0.9%
Total	1,020	468	45	83	197	30	1844	
Percent	55.3%	25.4%	2.4%	4.5%	10.7%	1.6%		

Data Source: DBH

** Current Presumed Class Members are or may be duplicated across regions, and across multiple services. Due to the possible duplication the total number of Presumed Class Members served in this table is not equal the projection of estimated number of Class Members.

Discussion: There are several observations that can be made based on the estimated number of clients served by DBH and the services they received:

- The proportion of children served in Region 7 exceeds the proportion served in the highest populated region, Region 4.
- Greater than 50% of services provided was Children's Mental Health CMH Case Management which reflects the referral source of the population served (court ordered services under the Idaho Statue 20-511A).
- The total of the three (3) types of medication management services is 596 or 32%.

Table 4: Count of Medicaid Behavioral Health Services Utilized Most Frequently by Presumed Class Members

Regions	Division of Medicaid Behavioral Health Type of Service						
	Individual Therapy by Non-Prescriber	Family Therapy	Medication Management		Mental Health Assessment/ Treatment Plans	Case Mgmt.	Total
			Psychiatric Diagnostic Evaluation	Prescriber Visits			
1	1,273	1,131	1,065	197	679	414	4,759
2	439	335	284	58	217	107	1,440
3	2,732	2,143	2,267	1,067	958	597	9,764
4	2,903	2,304	2,381	987	871	588	10,034
5	1,334	1,158	966	348	327	161	4,294
6	993	799	748	277	430	267	3,514
7	2,932	2,378	2,180	765	1,512	1,351	11,118
Other	35	25	11	6	3	8	88
Total	12,641	10,273	9,902	3705	4,997	3,493	45,011
Percent	28.1%	22.8%	22.0%	8.2%	11.1%	7.8%	

Data Source: Medicaid/Optum

Discussion: There are several observations that can be made based on the estimated number of clients served by DBH and the services they received:

- The proportion of children served in Region 7 exceeds the proportion served in the highest populated region, Region 4.
- Approximately 50% of services are either individual or family therapy.
- Approximately 30% of services are Medication Management services.

5) Estimating System Capacity Needed:

Estimating how many Class Members are not currently receiving services (unmet need):

To estimate the number of Class Members who are not currently accessing services the number of projected Class Members currently receiving services was multiplied by the prevalence rate and compared to the number of presumed Class Members currently being served.

Metrics:

- Estimated number of uninsured and Medicaid members under the age of 18 as of 2016
- Prevalence rate of 6.47% (as noted in the BSU Class Member analysis)
- Number of presumed Class members currently served

The results (See Table 5 on page 9) indicate that it is likely that most of the Class Members may be accessing some type of mental health services. However, this result should not be interpreted as an indication that Class Member needs are being met. The only thing we know is the number of children and youth that currently have some contact with the outpatient mental services is close to the projected numbers who need those services. There needs to be more study of the use of services to assess the amount of service being delivered to individuals. This will include intensity and duration of services. Also as noted previously it is unknown how many of those who are privately insured will access the public mental health system.

Table 5: Population and Expected Need Based on Prevalence and Number Presumed Class Members Currently Served

	DBH (Uninsured)	Medicaid
Total Population	17,984	208,687
# of Projected Class Members	1,164	13,502
# of Presumed Class Members currently served	1150	13,300
Variance	+14	+202

Data Source: DBH, Medicaid/Optum

Type of Services Needed:
Additional analysis regarding the projected need for service was gained by comparing service utilization in Idaho to service utilization nationally. The national statistics for percentage of services in Table 6 were reported in "Examining Children's Behavioral Health Service Utilization and Expenditures" (Faces of Medicaid, Center for Health Care Strategies, Inc., Dec 2013, page 33).

The data analyzed was focused solely on Medicaid as the national data is for Medicaid services. The Medicaid service of "Psychiatric Evaluation" and "Prescriber Visits" were combined to equal the national "Medication Management" category.

The metrics used to estimate system capacity needed were:

- Current utilization of types of services from provider claims
- Percentage of number of Presumed Class Members

Table 6: Comparison of % of Service Utilized Nationally to % of Presumed Class Members Currently Served

	Division of Medicaid Behavioral Health Type of Service				
	Individual Therapy by Non-Prescriber	Family Therapy	Medication Management		MH Assessment/ Tx. Plans	Case Mgmt.
			Psychiatric Diagnostic Evaluation	Prescriber Visits		
National %	53.1%	19.4%	22.3%		8.8%	8.7%
Idaho Medicaid %	28.1%	22.8%	30.2%		11.1%	7.8%
Variance	-25.0%	3.4%	7.9%		2.3%	-0.9%
Potential for Unmet Need	Yes	No	No		No	No

Data Source: Medicaid/Optum

Discussion: There are several observations that can be made based on the estimated number of clients served in Idaho by Medicaid and the services they received:

- The percent of medication management services appears to be higher than the national average despite the affirmed shortage in child and adolescent psychiatrists in Idaho. This suggests that physician extenders are filling the psychiatrist gap for the provision of prescriber services (or medication management).
- Psychotherapy appears to be accessed significantly less in Idaho than it is accessed nationally; therefore, additional analysis is needed to determine if the low use of the service is due to lack of providers, lack of geographical access to the providers that exist, lack of awareness of the service, lack of interest in the service or other determinants.

Conclusions

This analysis has revealed some of the gaps in the current infrastructure that must be addressed to move to a system in which all the partners are capturing similar data, using the same naming conventions, have the same definitions for variables and then are able to engage in meaningful data sharing.

Despite the data limitations the following conclusions are derived from this analysis:

- The proportion of children served in Region 7, exceeds the proportion served in the highest populated region, Region 4 for both DBH and Medicaid.
- The percentage of medication management services for Medicaid appears to be higher than the national average despite the affirmed shortage in child and adolescent psychiatrists in Idaho.
- Psychotherapy appears to be accessed significantly less in Idaho than it is accessed nationally.

The initial capacity analysis has revealed several areas that the Data and Reports Committee recommends should be addressed. Over the next one to two (1-2) years more extensive analyses on the system capacity needs for Jeff D Class Members will be conducted and reported. The intent of further study into system capacity will be to uncover information about child, youth and family needs.

1. Additional analysis needed for comprehensive assessment of current capacity and estimated need to timely provide services and supports in appropriate scope, intensity and duration to Class Members

    - Estimate of need for Child and Family Team (CFT) and Intensive Care Coordination (ICC) services
    - Rates of access by demographics including age, race/ethnicity, diagnosis
    - Gap Analysis by region
    - % spent compared to total healthcare expenditures
    - % spent by level of care
    - Mean $'s spent per person
    - % of change in access to services
    - Analysis of use of other levels of care including but not limited to: peer and family supports, home and community based services, partial hospitalization respite, crisis services hospitalization and residential
    - Analysis of use of psychotropic meds with and without accompanying mental health services
    - Use of services by the foster care and adoptive populations

2. Future analysis may also include solicitation of precise information directly from providers as well. This will provide useful detail regarding provider competencies, interests, scope of practice, specialties, training needs, opportunities for system expansion and other information vital to building a comprehensive network that will meet the needs of the Class Members as described.

3. To further inform system planning the capacity will be further analyzed in terms of how and why various services are being used and which ones were the most effective. To achieve this work Idaho will conduct an in depth need-based planning study of Idaho's current child serving system to identify;

    - How Idaho identifies and serves children and youth with the highest needs and risk behaviors, and how these individuals are linked to outpatient settings.
    - What services are in place now that successfully prevent inpatient hospitalizations.
    - Why children, youth and families do not go to, or stop going to outpatient clinics.
    - Trends in the use of prescribing of psychotropic medications.

Recommendations for Workforce Development:

Based on the result of this initial capacity analysis the initial recommendations for Workforce Development to establish and maintain system capacity are
:

- Continue to analyze and assess current capacity and needed capacity on an ongoing basis based on an in-depth need-based planning study;
- Implement CANS and the TCOM system, which will provide useful data about child, youth and family outcomes;
- Evaluate the cause of apparent capacity issues by region
- Consider setting recruitment goals by region and by type of service needed
- Provide training on practices that are effective (evidence based, evidence informed and proven practices) but not utilized extensively
- Consider establishing staffing models by program type
- Work with local universities to ensure education is focused on areas of need throughout the state and

- Support primary integration by developing new models of integration and pilot them

Glossary:

Caseness: The degree to which the accepted standardized diagnostic criteria for a given condition are applicable to a given patient

Duration: The length of time a person receives services

Intensity: Level of care, amount of intervention, amount of support provided

Outpatient: Psychotherapy and/or skills building offered in an office, school, or other community setting

Prevalence: The expected rate of occurrence of a mental health disorder or behavior

Proxy Indicators: Indirect measure that approximates or represents a phenomenon in the absence of a direct measure

Scope: The focus of a disorder, the treatment plan work, and services to be provided for a child and family team

Timely: An expected duration between receipt of referral and initiation of services that would not cause undo harm or distress to the individual receiving services

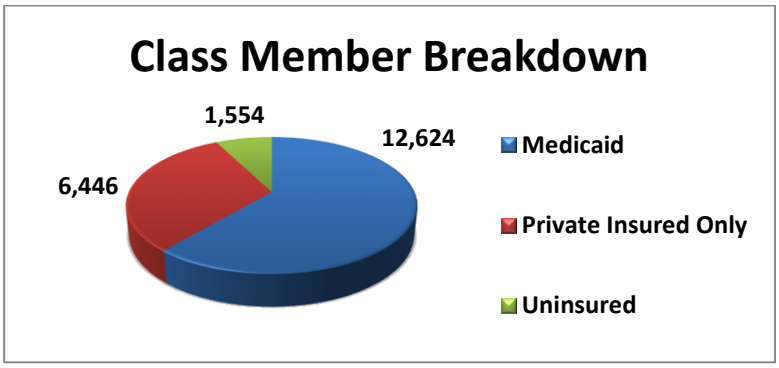
Attachment 1

Jeff D. Projected Class Size

Class Member Defined As:

Children in Idaho, who are under 18 years of age, have a serious emotional disturbance (SED) and a functional impairment.

Projected Total Class Members: 21,000 (Rounded)



Methodology:

Using U.S. Census population estimates and Current Population Survey data along with Medicaid historical claim data (children age 0-17, who had at least a frequency of 10 mental health claims/visits within a year and that had an ICD-9 diagnosis that have generally been considered as diagnoses associated with SED), an estimate of the total number of children (0-17) with Serious Emotional Disturbance (SED) that affected their social functionality (estimated by the frequency of mental health claims/visits) was made based on the population distribution of Idaho children (0-17) of those who had Medicaid insurance, private insurance only, and those who were uninsured. In this statewide estimation it was assumed that children who were uninsured had the same SED + affected functionality prevalence rate as those children that had Medicaid insurance and it was assumed that the children who had private insurance only had half of the SED + affected functionality prevalence rate than that of those who were on Medicaid or uninsured.