ACCESSING THE CONTINUUM OF CARE OUTPATIENT SERVICES

SUCCESSES, CHALLENGES AND RECOMMENDATIONS

Parent Story

Child Health and Development Institute (CHDI)

Vision: All children will grow up healthy and thrive.

Mission: Advance effective, integrated health and behavioral health systems, practices, and policies that result in equitable and optimal health and well-being for children, youth, and families.

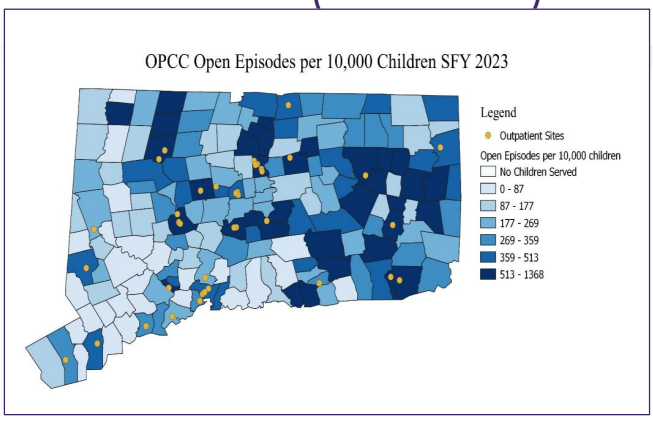
Our Strategy: We identify, demonstrate, support and promote effective health and behavioral health care innovations that will result in sustainable change, working in partnership with providers, policymakers, academic institutions and state agencies.

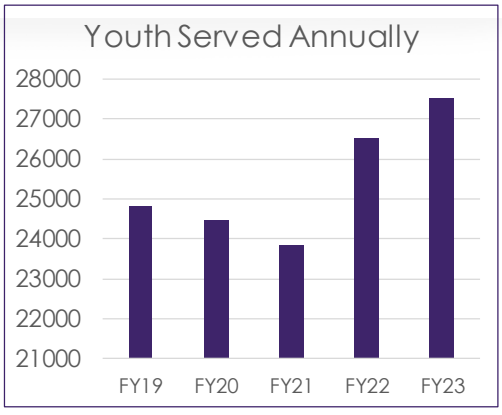
Our Core Values: Anti-racism, respect, accountability, collaboration, and equitable action.

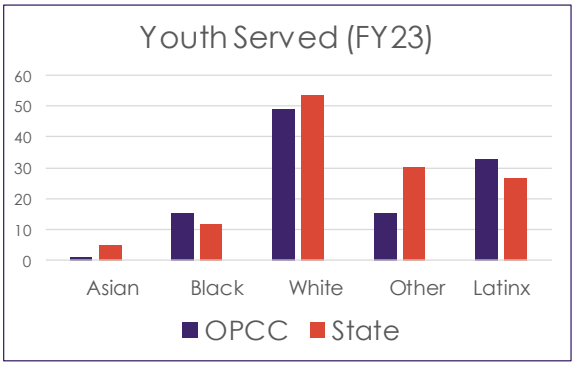
Jason Lang, Ph.D.
Chief Program Officer

Child Health and Development Institute

OPCC Data (22 clinics)

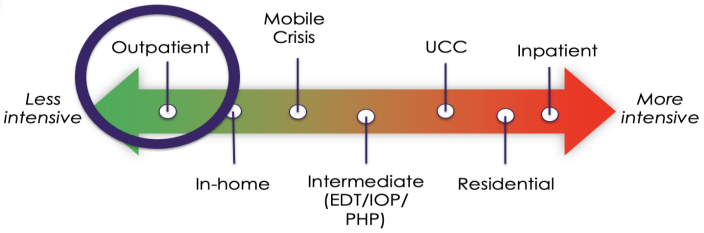






- Average 20 sessions
- 55-60% significantly improve
- Almost half receive an EBT
- 1/3 sessions telehealth
- Caseload average 60-80 youth (!!!)

What are "Outpatient" Children's Mental Health Services?



- Most widely used and available service; broad population
- Talk therapy - often 50 minutes, every week or two; child/family/group
- May include medication management
- Generally clinic- or office-based (or telehealth)
- Types of Outpatient Providers
  - ??? Group & private practices
  - ~110 Community-based licensed OPCCs (~637 sites)
    - ~24 DCF grant-funded OPCCs
  - Other

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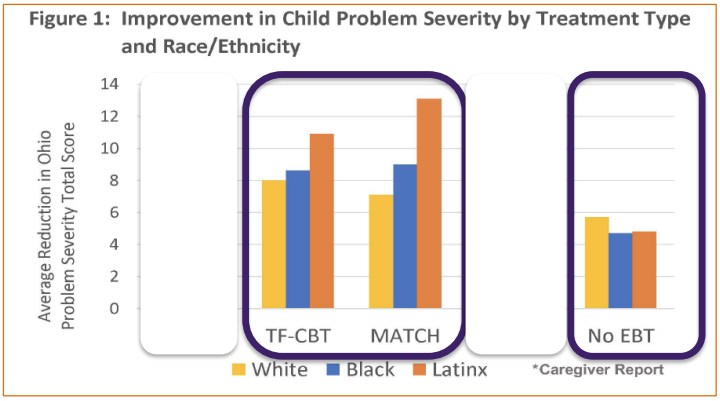
Evidence-Based Treatments (EBTs)

- EBTs are treatments shown to be highly effective
- Two state-supported EBTs for anxiety, depression, conduct, trauma
  - 14,000+ children served (1500+ in FY23)
- Twice as effective as routine outpatient therapy
- Reduce disparities



Evidence-Based Treatment Cost Savings

14,000 CT children served **X** $29,700 Benefits per child served* **=** **$414,800,000** Total Benefits

- Estimated benefits of receiving a trauma-focused EBT, inflation adjusted through 2023; WA State Institute for Public Policy (www.wsipp.wa.gov)

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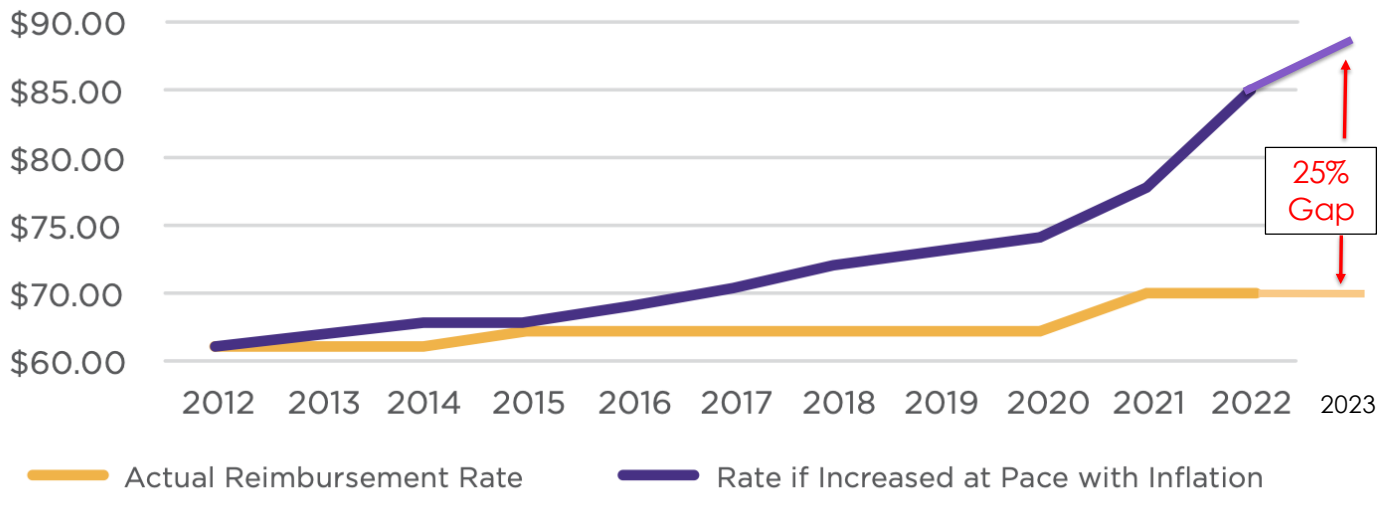
Fig. 1: Actual Medicaid Reimbursement Rate vs. Rate if Increased Proportionally to Inflation (45 minute outpatient therapy session)



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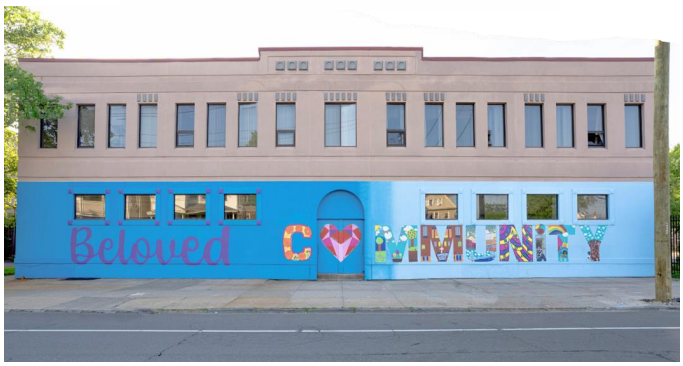
ACCESSING CHILDREN'S BEHAVIORAL HEALTH CARE

LifeBridge Community Services

Edith Boyle, LCSW, President & CEO



LifeBridge is a leading non-profit behavioral health organization located in both Bridgeport and Fairfield, supporting adults, children, and adolescents through mental health and substance use recovery.

As a member of Urban Trauma Provider Network, we provide trauma-informed and evidence-based interventions to address urban, racial, and other forms of trauma.

Services:

- Individual and Family Therapy
- Adolescent and Parent Support Groups
- NEW! Clinical Art Therapy
- Medication Management

Insurance:

- Medicaid
- Commercial insurance plans

Payment ability

- Discounted/sliding fee schedule available

LIFEBRIDGE: CHALLENGES IN THE BRIDGEPORT CHILDREN'S MENTAL HEALTH SYSTEM

Many Bridgeport children face significant challenges:

- Poverty
- Underperforming schools
- Trauma
- Living in fragile home situations

Bridgeport's community health needs are rooted in systemic inequities, including historical trauma, poverty, violence, and educational and economic inequality.

Wellbeing Disparities:

- Average poverty rate in Fairfield County is only 2% (compared to 10% for the state and 15% nationwide), Bridgeport's poverty rate is over ten times as high at 21%, with one in three children living in poverty (3)
- Median household income in Bridgeport is $45,441 compared to wealthier neighboring towns like Weston ($219,083) and Darien ($210,51) (4)
- Fairfield County is 59.8% White (64.6% statewide), while over 80% of Bridgeport's population is non-White (4)
- 30% of Bridgeport residents are foreign-born; 22% of the population aged 5 or older are linguistically isolated (5)
- Languages other than English are spoken in 48.5 % of Bridgeport homes (5)

Mental Health Services:

- High-quality mental health services are urgently needed in Bridgeport (6)
- In 2019, only 30% of Bridgeport residents had regular access to mental and behavioral health services (7)
- Bridgeport's violent crime rate is 75% higher than the national average (1)
- Statewide, 18.4% of hospital child/youth behavioral health emergency department visits result in inpatient admission, compared to 43.6% for Bridgeport's St. Vincent's Medical Center (8)

ACCESSING CHILDREN'S BEHAVIORAL HEALTH CARE

Mid-Fairfield Community Care Center

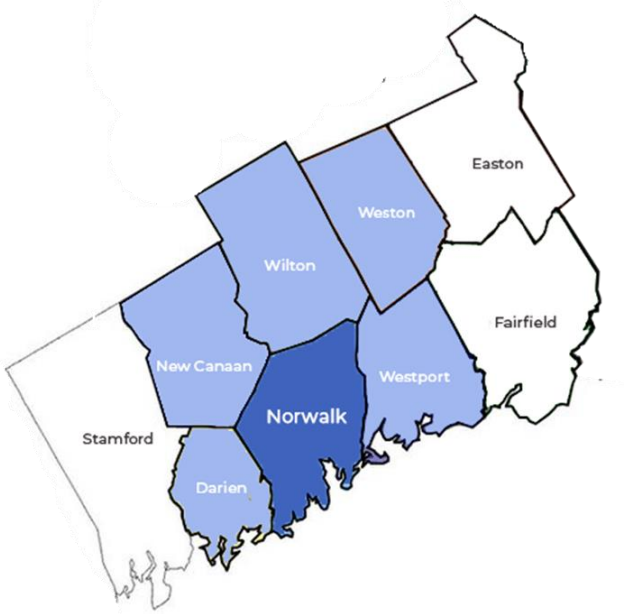
Marissa Mangone, Senior Officer of Development and Community Partnerships

We occupy four buildings adjacent to each other at 98 and 100 East Avenue, Norwalk, CT

- Non-profit established in 1956
- Community safety net for families unable to access and/or afford private mental health services
- From prenatal/birth through early adulthood, our programs/services promote optimal mental health and help ensure a successful transition into adulthood
- Client symptoms and diagnoses include depression, anxiety, posttraumatic stress disorder (PTSD), attention deficit hyperactivity disorder (ADHD)
- Our practices are family-centered, trauma-focused, culturally responsive and evidence-based
- Evidence-Based Practices: Trauma Focused Cognitive Behavioral Therapy (TFCBT),Dialectical Behavior Therapy (DBT), MATCH-ADTC), Cognitive Behavioral Intervention for Trauma In Schools (CBITS), Bounce Back, Eye Movement Desensitization Reprocessing Therapy (EMDR)
- Primary provider of comprehensive bilingual/bicultural mental health services (Spanish, Haitian-Creole)
- Outpatient services include individual, family, and group therapy, care coordination, psychiatry (evaluation and medication management), parent support, and advocacy
- We accept Medicaid, commercial insurance, and offer sliding scale
- Affiliate of Clifford Beers Community Health Partners

Mid-Fairfield Community Care Center
Clifford Beers Community Health Partners

SNAPSHOT OF NEED IN MID-FAIRFIELD SERVICE



Norwalk Youth Survey October 2022
(Positive Directions for The Norwalk Partnership)

- **3,969 (69% of total student body)** Norwalk Public School (NPS) students in grades 7 – 12 were surveyed
- **27% (n=1,076)** of NPS students surveyed experienced high levels of anxiety
- **23% (n=913)** of NPS students surveyed reported symptoms of depression
- **17% (n=678)** of NPS students surveyed reported both depression and anxiety
- **6.4% (n=254)** of NPS students surveyed reported they attempted suicide within the past year

Note: Subset sample (69%) valid for application against total NPS student body of 5,781 students

Mid-Fairfield Community Care Center
Clifford Beers Community Health Partners

ACCESSING CHILDREN'S BEHAVIORAL HEALTH CARE

REAL LIFE. REAL HOPE.

Community Health Resources

Jennifer Nadeau, LCSW, Senior Vice President of Child & Family Services

CHR is a leading nonprofit behavioral healthcare provider in Connecticut, offering a wide range of personalized services for children, families, and adults affected by mental illness, addiction, and trauma.

CHR offers outpatient and community-based behavioral healthcare services throughout central and eastern Connecticut.

Outpatient Services Include:

- Clinical and psychiatric assessments
- Crisis intervention
- 24-hour on call emergency professional coverage
- Evaluation, treatment recommendations and medication management
- Treatment of depression, anxiety and other psychological problems
- Treatment of co-occurring problems (mental illness and chemical dependency)
- Individual, family and group therapy
- Crisis support, short and long-term therapy
- Collaboration and coordination with other community resources (i.e. schools, pediatricians)
- Parent support
- Evidence Based Treatments such as TF-CBT and MATCH-ADTC
- Spanish speaking therapy

SNAPSHOT OF NEEDS IN THE CHR SERVICE AREA

Demographic Details:

Based on 2015 US Census projections, the region is home to over 1.16 million people, 24% of whom are under 18 years old.

- More than 65% of youth are low-income, as evidenced by factors below including, poverty levels, Medicaid eligibility, and free lunches.

Wellbeing Disparities:

High rates of exposure to trauma among youth in the CHR service area, along with concerns about the impact of the COVID-19 pandemic, demonstrate the need for an expanded array of trauma-focused, evidence-based services for children, teens, and families.

- Currently, 37% of youth being served in CHR's outpatient-based settings have endorsed an exposure to trauma.
- The extent of the problem mirrors data from the National Children's Traumatic Services Network (NCTSN), showing 2/3 of all children in the US experience a traumatic event by age 16.

Growing concern about the number of youth and families who report that vaping/smoking and marijuana use is not problematic.

- In 2021, CHR started screening each teen for vaping behavior and providing education using the InDepth model.
- Around 12% of all admissions result in a positive screen, yet youth and families are resistant to vaping education.
- CT's marijuana legalization led to attitude shift among youth and parents, prompting more education and safe storage practices in our interventions.

CHANGES IN CHILD BEHAVIORAL HEALTH NEEDS AND ACCESS STATEWIDE (2020-2023)

Needs of Families

Transportation to treatment
- State transport issues
- Avoidance due to Medicaid problems
- Limited transportation options

Equitable access and health equity
- Lack of access and poor outcomes

Language barriers
- Shortage of bilingual clinicians
- Need for BIPOC staff
- Communication barriers with parents and services

Socioeconomic Challenges
- Poverty and hunger
- Community violence and trauma
- Unemployment
- Wages vs. Basic Needs
  - E.g. Affordability challenges in Bridgeport:
    - Median household income: $45,441
    - Cost of living: $73,084
    - Cost of housing: 53% of income
    - Single-parent households: 48.4%
    - Cost-burdened households: 53%

*Affordable housing is a huge concern in Bridgeport, where a two-bedroom apartment is nearly 70% of a full-time income before taxes.

Needs of Children

Higher acuity in children
- Self-harming behaviors
- Suicidal ideation (ages 6-12)

Social and Emotional Issues
- Isolation
- Impact of social media
- Eating disorders
- Bullying
- Anxieties about returning to school

Systemic Challenges
- Structural racism
- Post-pandemic truancy
- Legal issues (theft, weapons, larceny)

SYSTEM CHALLENGES FOR OUTPATIENT PROVIDERS

Intake Challenges:
- High referrals to outpatient settings make engaging families before their first appointment challenging.
- No statewide funding to support pre-service engagement with families. Non-billable (initial phone screening, collecting information, scheduling appointments, running insurance authorizations) work not reimbursed if the family no shows.

Delivery of Services
- The ability to promptly connect has increased waiting lists for other Husky-covered services, such as autism screenings and in-home care.
- Non-DCF involved higher levels of care or in-home services that accept Husky are inaccessible or have long waitlists.

Higher Levels of Care Needed
- High acuity cases need a different level of care than outpatient care, which is not equipped for their needs and often leads to treatment failure
- Challenges include "holding" a client at the outpatient level of care while waiting for a more appropriate (IICAPs or other in-home) level of care to be able to treat higher acuity cases.

Referrals
- Other providers have waitlists or may even be closed for referrals.
- Families may decline referrals due to strong connections with their outpatient providers.
- Due to the lack of resources, clinical providers spend much non-billable time managing cases and collaborating with other providers to support families.
- Unmet basic needs make it difficult for families to engage in any service.

System Challenges & Needs

- Existing services are underfunded and services are built by
  - Inadequate reimbursement rates/flat-funded grants
  - Private insurance limitations in coverage/access and low rates

- Lack of data about most services (outside of DCF-funded)
  - For public about access/availability
  - Accountability and system improvements

- Staffing and workforce – chronic underfunding is pushing clinicians to private practice/telehealth and widening disparities for underserved
  - Limited capacity to provide high-quality services (EBTs)
  - Limited capacity for specialized populations (young children, autism/DD, substance use, etc.)
  - Limited Spanish-speaking clinicians/diversity

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FINANCIAL BARRIERS FOR OUTPATIENT PROVIDERS

Administrative and Regulatory Challenges

- Multiple requirements/documentation required by insurance/funders
- Licensing requirements for outpatient clinics (26+ pages of regulations)
- Licensing requirements for child psychiatrists to serve as Medical Directors is challenging due to workforce shortages and cost prohibitive

Financial Sustainability

- Lack of adequate funding
- The issue is less about the need for "additional" services, but instead the need for added financial support to provide "existing" services adequately and effectively

Workforce and Recruitment Issues

- Licensed clinician recruitment/retention is impacted by competing with telehealth providers or for-profit settings
- Clinicians are leaving their current positions for better opportunities, which offer higher salaries, smaller caseloads, and less acute or case management needs
- Nonprofit organizations serving high-need clients rely on Medicaid reimbursement rates to offer competitive salaries
- Schools refer for medication management needs; however, community providers are incurring financial loss when employing prescribers (e.g., APRNs, Psychiatrists)
- Families come with mental and social needs but, case management is not reimbursed by Medicaid. Clinicians addressing these needs, lead to burnout.

Policy Recommendations

- Adequately fund the existing network of outpatient services
  - Increase reimbursement rates and grant funding to cover costs of quality care and a fair wage for clinicians (inclusive of training, EBTs, data reporting, administrative requirements., etc.) and case management/care coordination
  - Funding should account for inflation
  - Strengthen and enforce parity laws for behavioral health

- Implement data collection standards across all providers for public access and accountability
  - Consider reimbursement incentives for data reporting, meeting benchmarks, equity, EBTs

- Identify and remove unnecessary/duplicative administrative requirements that impede delivery of services

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RECOMMENDATIONS FOR SOLUTIONS

Medicaid Reimbursement and Access Enhancement Initiatives

- Increase Medicaid reimbursement rates and reimburse at higher rates using CMS' Case Mix Index, a metric that reflects the diversity, complexity, and severity of the patients treated – treatment for populations who have historically experienced inequity in access to quality services (BILPOC), and/or who have more complex or severe issues receive higher reimbursement rates.
- Due to the challenges in finding APRNs and Psychiatrists who prescribe for children, increase Medicaid reimbursement rates for medication management.
- Revise regulation to allow Medical Doctors (MDs) to serve as Medical Directors instead of requiring expensive and hard to find Psychiatrists to serve in the role.
- Currently, CT does not certify Certified Community Behavioral Health Centers at this time. CCBHCs provide a higher standard of client-centered care, inclusive of case management and care coordination – Certify CCBHCs and provide a higher reimbursement rate for care provided by CCBHCs as an incentive to provide high quality, coordinated care.
- Allow clinicians to bill Medicaid for case management services they're providing to clients (e.g., support in finding housing, transportation, connecting clients to primary care/medical homes, etc.).

School-Based Recommendations

- Resource guides provided to school personnel to increase awareness of community behavioral health services available to children and families.
- Funding is needed for non-DCF after-school or in-home therapy programs.
- Not all schools have school-based health centers - allow outpatient clinics to provide counseling services in schools (e.g., individual and group sessions) reimbursed by Medicaid – currently, caregivers must bring the child to the outpatient clinic, encountering many barriers in accessing care (e.g., transportation, parents' work schedules, child missing school).

Delivering Quality of Care

- Evidence Based Treatments should be the standard for outpatient care. The cost of providing EBTs is higher than treatment as usual so the reimbursement should be higher.
- Outpatient programs are seeing a high volume of youth and the acuity is higher than ever before. Care coordination supports within the outpatient setting could provide additional support to help families access those services.

THOUGHTS? **QUESTIONS?**