ACCESSING THE CONTINUUM OF CARE OUTPATIENT SERVICES

SUCCESES, 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.

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**Jason Lang, Ph.D., Chief Program Officer**

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**OPCC Data (22 clinics)**

**Youth Served Annually**

- 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

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

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

\[
\text{14,000 CT children served} \times \text{\$29,700 Benefits per child served}^* = \text{\$414,800,000 Total Benefits}
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Fig. 1: Actual Medicaid Reimbursement Rate vs. Rate if Increased Proportionally to Inflation (45 minute outpatient therapy session)
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

- 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

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

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
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 (ICAPs 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

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

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?