



# IMPROVING BEHAVIORAL HEALTH CARE FOR CHILDREN IN CALIFORNIA

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## A Call to Action

### Executive Summary

Half of all lifetime cases of mental illness begin by age 14 and three-quarters begin by the age of 24.<sup>1</sup> In other words, mental illness is a disease of youth — one with profound long-term implications for children,<sup>2</sup> their families and their communities. And it is an increasingly common condition among California's children. In fact, as many as 1.8 million California children may be living with a behavioral health diagnosis — a number that exceeds the entire population of West Virginia. Yet, California currently lacks a coherent, outcomes-driven approach to addressing their needs. To a large extent, the system includes a patchwork of programs driven more by fiscal incentives than the needs of children and families. As a result, many children lack access to care when they need it.

California's children's hospitals have a unique perspective on the state's behavioral health system, including its shortcomings. Across the socioeconomic spectrum, emergency departments are treating an increasing number of children in crisis. Sometimes these children have had no previous interaction with a behavioral health provider, despite their symptomatology. They may also face significant barriers to obtaining outpatient or residential treatment even after their emergency department visit or psychiatric inpatient stay.

In the fall of 2018, the California Children's Hospital Association (CCHA) convened a workgroup of our hospital behavioral health leaders to discuss this emerging crisis and brainstorm potential strategies to address the lack of adequate behavioral health care for California children. The group has been meeting periodically for over a year, and this

document is an outgrowth of that work. What follows is our perspective on the scope of the problem and specific recommendations the state can take to more effectively meet children’s behavioral health needs. It is our hope that, if adopted, these recommendations would not only mitigate the disease burden on children and their families, but also make a substantial, cost-effective investment in the future health and well-being of all Californians.

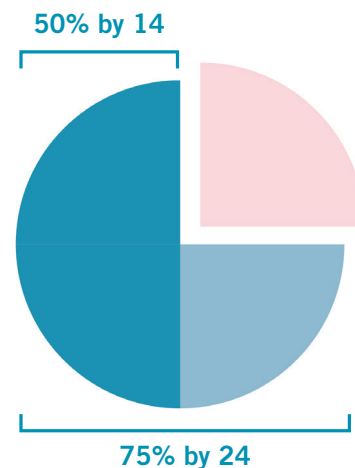
### Recommendations:

#### Specifically, based on our observations and discussions, CCHA recommends that the state:

- Develop consistent behavioral health goals for children that are aligned across agencies in order to guide policymaking and hold organizations accountable for how children are faring.
- Ensure that state and federal laws designed to promote appropriate access to pediatric behavioral health services are being implemented and enforced through better oversight, reducing burdensome paperwork requirements, and providing easier to understand information to families.
- Provide sustained investments in effective community-based prevention and early intervention programs that support healthy child development and/or identify and treat behavioral health problems early.
- Address gaps in the services available to children by requiring counties to cover all types of evidence-based treatments when appropriate, streamlining the state and local facility licensing process, and increasing Medi-Cal rates to providers.
- Implement models that better coordinate the physical health and behavioral health needs of children. This includes making it easier for pediatric primary care providers to obtain support from behavioral health specialists — through means of teleconsultation, for example. It also includes supporting models that co-locate or integrate primary care and behavioral health care services at one location.

- Improve services for children with comorbid chronic health or developmental conditions, by piloting models of care coordination designed specifically for these children, incentivizing better coordination of services among state and local agencies, and requiring the California Children’s Services Program to cover all evidence-based treatment modalities for children with CCS conditions who also have behavioral health diagnoses.
- Provide more funding to address long-standing, severe pediatric behavioral health workforce shortages.
- Encourage local interagency collaboration and incentivize approaches that improve the behavioral health of children.

### 50% OF ALL LIFETIME CASES OF MENTAL ILLNESS BEGIN BY AGE 14 AND 75% BEGIN BY AGE 24.



Source: Arch Gen Psychiatry

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## Background: The Scope of the Problem is Significant and Growing

California is in the grip of a growing behavioral health crisis among children. The rate of self-reported mental health needs among California adolescents has increased by 23 percent since 2005.<sup>3</sup> The percentage of California teens reporting a major depressive episode in 2016-17 was over 13 percent,<sup>4</sup> which exceeds the national average; less than 1/3 of these youth obtain access to needed care.<sup>5</sup> Suicide rates have been rising steadily in California over the past two decades and suicide is now the second leading cause of death for California youth between the ages of 10 and 24.<sup>6</sup> National estimates put the prevalence of behavioral health disorders among children at between 13 and 20 percent.<sup>7</sup> This means that as many as 1.8 million children in California are living with a behavioral health condition — a number that exceeds the entire population of West Virginia.

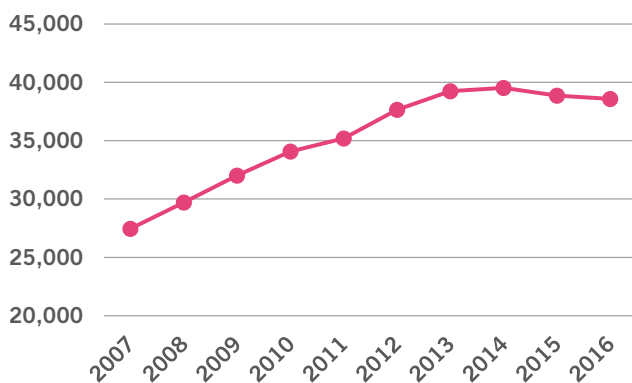
The behavioral health delivery system in California falls short for both adults and children. But the shortfalls in the pediatric delivery system present unique and pressing challenges, for two reasons. First, access to behavioral health services is demonstrably worse for children than it is for adults. For example, Mental Health America periodically ranks states, based on both the prevalence of behavioral health conditions among a state's residents and the ability of residents with behavioral health issues to obtain treatment. States who rank better (with a ranking of number one being best) have a lower prevalence of behavioral health conditions and a higher proportion of residents who are able to obtain treatment. Based on these criteria, Mental Health America ranks California 15th among states for adults but 39th for children.<sup>8</sup> Many counties in California lack inpatient services for children and California is ranked by the American Academy of Child and Adolescent Psychiatry as having a "severe" shortage of providers.<sup>9</sup>

Second, left untreated, behavioral health needs that manifest themselves in childhood and adolescence can lead to lifelong challenges, increased mortality and morbidity, and long-term costs for individuals, their families and their communities. According to the National Alliance on Mental Illness, these costs include:

- Lower educational attainment. According to NAMI, high school students with significant symptoms of depression are more than twice as likely to drop out compared to their peers.<sup>10</sup> This is particularly unfortunate given that recent research found that lifetime earnings quintupled for individuals with serious mental illness when they received more than a high school education, compared to those who did not graduate from high school.<sup>11</sup>
- Increased health care costs due to hospitalizations for untreated or poorly treated serious behavioral health conditions.
- Increased risks of developing other chronic health conditions.
- Reduced life expectancy. Adults in the U.S. living with serious mental illness die on average 25 years earlier than others, largely due to treatable medical conditions.
- Lost earnings. NAMI estimates that serious mental illness results in up to \$193.2 billion in lost earnings per year.<sup>12</sup>

A behavioral health delivery system that truly serves children and their families has the potential to pay significant long-term dividends. It is a cost-effective investment in the future health and wellbeing of California's citizens. But California's behavioral health delivery system falls short. Necessary investments in services are not being made and barriers to access are common. Families struggle to locate services for their children, even when children exhibit symptoms that are unambiguously severe. Data from the Department of Health Care Services suggest the scope of the problem. Recent DHCS data indicate that less than 5 percent of eligible children who are covered by Medi-Cal receive a single mental health service and under 3 percent of children covered by Medi-Cal receive ongoing clinical behavioral health treatment<sup>13</sup> — a number that is far lower than what behavioral health disease prevalence estimates would indicate is appropriate. More disturbingly, these numbers have been declining over the past five years.<sup>14</sup> Even children with private insurance appear to lack access to adequate supports. Among all California adolescents who were identified as experiencing a major depressive episode, less than one-third received treatment.<sup>15</sup>

### California Hospitalizations for Mental Health Issues (Ages 5-18)



Source: www.kidsdata.org

California's children's hospitals, including our affiliated outpatient programs, are on the front lines of this crisis. Over the past decade, hospitalizations for mental health emergencies in California have spiked by more than 40 percent among young people.<sup>16</sup> Our hospitals are serving a growing number of children in acute distress who frequently evidence little or no connection to community behavioral health services and supports before they present in our hospital emergency departments. Our hospitals and affiliated clinics are also the largest providers of specialty care for children in California who have complex and chronic health conditions. These children have particular needs for behavioral health services and supports, because their underlying physical health conditions, such as diabetes, cystic fibrosis and cancer, leave them at increased risk for depression and anxiety. Research has shown that children with multiple chronic conditions have higher incidences of behavioral health conditions, and also exhibit other indicators of poor health, including more school absences and activity limitations.<sup>17</sup> Left untreated, these comorbid behavioral health conditions can negatively impact adherence to medical regimens, creating even more health care complications and increased costs related to more emergency department visits and hospitalizations.<sup>18</sup>

Our observations and experiences lead us to believe that California's pediatric behavioral health delivery system currently fails to meet the needs of many of the state's most vulnerable children and their families. These failures are costly, both financially and socially. We identify the following areas where strong policy action is needed and urge the Governor and legislature to take these critical steps to improve the behavioral health delivery system.

### California Needs a Clearly Articulated Pediatric Behavioral Health Vision, or "North Star"

One of our hospital's behavioral health leaders once described California's pediatric behavioral health system as akin to the Winchester Mystery House, constructed asynchronously and illogically with haphazardly added rooms and doors that lead nowhere. Similar to the famed architectural oddity, behavioral health services for California's children have been built and restructured over time, leading to disconnects between agencies and the absence of a clear set of programmatic goals that relate to how children are actually faring. We believe that all stakeholders need to focus on what would make a demonstrable difference to children and their families and take accountability for those priorities. And we believe that the state of California, which operates the single state agency for Medicaid and the licensing and oversight agencies for private health plans, should articulate those priorities succinctly. When it comes to meeting the behavioral health needs of children, all stakeholders need to be gazing at the same "North Star."

**FOR EVERY 100,000 CHILDREN IN THE STATE, CALIFORNIA HAS ONLY 13 PRACTICING BOARD-CERTIFIED CHILD AND ADOLESCENT PSYCHIATRISTS.**

## Recommendation

**CCHA recommends that the state establish three to five behavioral health goals it wants to achieve for children and their families, and that the state, as payer and regulator, ensure that state and local agencies, private health plans, and other stakeholders take accountability for contributing to these goals. Such goals could include:**

- Reducing the rate of teen suicide to zero.
- Reducing duration of untreated psychosis to four weeks or less.
- Ensuring that all children who have 4 or more Adverse Childhood Events are able to obtain immediate and appropriate follow-up behavioral health and support services.

## California Should Fulfill the Promise of EPSDT and State and Federal Mental Health Parity Laws

In theory, state and federal laws related to the provision of behavioral health services should work to ensure that children obtain the services that they need when they need them. In practice, however, families are frequently confused about how to access behavioral health services for their children and in our experience many services are not accessible, for a variety of reasons. This is true regardless of whether or not children are covered by Medi-Cal or have coverage through private insurance.

### State Compliance with Medi-Cal's EPSDT Mandate for Behavioral Health Services Appears to Fall Short

That children covered by Medi-Cal cannot obtain needed behavioral health services in California is surprising, because federal law provides safeguards that were designed to ensure access to care. Specifically, federal Medicaid law includes a mandated benefit for children under the age of 21, called Early Periodic Screening Diagnosis and Treatment (EPSDT). The EPSDT benefit requires that

Medicaid Programs cover comprehensive screening, diagnosis, treatment and preventive health care services, including behavioral health services, when those services are necessary to “correct or ameliorate any physical or behavioral conditions” or “to prevent disease, disability, and other health conditions or their progression, to prolong life, and to promote physical and mental health and efficiency.”<sup>19</sup> This federal mandate is a different, broader standard for children than the “medical necessity” mandate in state law that applies to adults. Federal law also makes the state Medicaid agency (in this case the Department of Health Care Services) responsible for ensuring compliance with EPSDT.

It appears that California fails to comply with the spirit, and possibly the letter, of the law as it pertains to EPSDT. Certainly California has created a delivery system that makes it very difficult to even determine whether EPSDT is being implemented. In part this is because the state “realigned” most pediatric behavioral health services to county mental health agencies in 2011. In addition, Medi-Cal bifurcates responsibility for behavioral health services between Medi-Cal managed care plans (MCPs) and county mental health plans (MHPs). And to add more complexity to an already highly disjointed system, the division of responsibility for behavioral health services between MCPs and county MHPs is different for adults than for children. MCPs are responsible solely for providing services for “mild to moderate” behavioral health needs for adults while county MHPs are responsible for providing services for adults with “moderate to severe” behavioral health needs. However, unless a child has a developmental disability such as autism, or a behavioral health condition that is the direct result of a physical condition (e.g., psychosis resulting from a brain tumor), county MHPs are the primary providers of EPSDT mental health services for children in Medi-Cal, regardless of whether the child’s behavioral health condition is “mild,” “moderate,” or “severe.” In fact, state law even lists the conditions, such as depression, anxiety, and attention deficit hyperactivity disorders, that county MHPs must treat regardless of their severity.<sup>20</sup> At the same time, MCPs retain specific responsibility for certain behavioral health services for children, including screening to identify potential behavioral health conditions and medication monitoring. MCPs and county MHPs

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are required to have policies and procedures in place to determine how specific functions are to be handled by both parties. In practice, the bifurcation of responsibilities obscures who is accountable for providing care and is profoundly confusing for families and providers, particularly because it differs from the way behavioral health services are provided to adults. It also serves as a barrier to obtaining treatment, as families can face delays in determining who, if anyone, will take responsibility for treating their child.

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## **CALIFORNIA'S PEDIATRIC BEHAVIORAL HEALTH SYSTEM IS AKIN TO THE WINCHESTER MYSTERY HOUSE, CONSTRUCTED ASYNCHRONOUSLY AND ILLOGICALLY WITH HAPHAZARDLY ADDED ROOMS AND DOORS THAT LEAD NOWHERE.**

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Our hospitals — which frequently serve children from multiple counties — report that county MHPs use differing standards to approve behavioral health services and make it difficult and cumbersome for providers to obtain approval to provide these services. Sometimes counties will attempt to enforce utilization review standards that are meant solely for adults, not children. This includes inappropriately attempting to require that providers screen to determine whether a child's condition is “mild to moderate” or “moderate to severe.” Additionally, the bifurcation between MCPs and county MHPs, and between the state and the counties under realignment has fed a growing bureaucracy that bleeds providers dry. County behavioral health plans each require different forms, some of which are on-line and some of which must be filled out by hand. Some counties have EPSDT intake forms that are over 30 pages long.

Our providers tell us that they routinely spend at least 30% to 50% of their time filling out paperwork. Intake paperwork for a new patient can take two hours of a clinician's time to complete. Providers have been reduced to tears by the absurdity of it, and refer to the wastefulness of the situation as “tragic.” Reducing this administrative burden would immediately enable providers to spend more time seeing children, thus improving access to care.

Forms and paperwork are not only extremely burdensome, but the rules established by the bureaucracy produce absurd results. For example, one of our hospitals reports that a county behavioral health department, which — like all county behavioral health departments — requires providers to bill by the minute, would only reimburse for a portion of a case consultation between, for example, a psychiatrist and a psychologist. Specifically, the county would only pay for the time when each provider was speaking to the other, but denied payment associated with the time when each provider was listening to the other. Similarly, after the State Department of Health Care Services issued an informational notice to all county behavioral health directors mandating that counties ensure patients are offered an outpatient psychiatric appointment within 15 business days of a request for services, one county simply added this requirement to its expected agreement with one of our hospitals — in effect requiring the hospital to meet this requirement without providing the hospital with any resources — staffing or financial — to achieve it. The net result of behavioral health realignment is that barriers are being placed, unevenly and inappropriately, that hinder access to care for children, in spite of the EPSDT federal mandate.

As the state has begun work to renew necessary waivers related to Medi-Cal behavioral health services, some observers have questioned whether to eliminate this bifurcation and consolidate responsibility for behavioral health and physical health services either entirely within the purview of Medi-Cal managed care or entirely within the purview of county behavioral health. We are agnostic on the approach the state uses to eliminate or mitigate the bifurcation. We think it matters less which entity is responsible and more that

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some entity truly be responsible for ensuring that a child obtain needed services. It is unconscionable to abandon families of children in crisis to navigate this byzantine system by themselves.

### **Privately Insured Children Also Face Barriers to Care**

Access problems are not unique to children covered by Medi-Cal. Recent news articles have illustrated instances when children with private insurance have had profound difficulty accessing behavioral health services.<sup>21</sup> These stories confirm the experiences of staff in our hospitals, who report that families with private insurance often have a harder time accessing some types of behavioral health services for their children when they have private insurance than children covered by Medi-Cal, particularly when it comes to obtaining access to outpatient services, such as psychiatry and psychotherapy. Families of privately-insured children also face obstacles that are similar to those faced by families whose children are covered by Medi-Cal when they attempt to determine who is responsible for ensuring that their children obtain needed services. Families are sometimes caught between their primary health plan and a separately subcontracted behavioral health plan trying to figure out which is responsible for approving and arranging for care. Still other times, families are denied services for their children on the grounds that they are not medically necessary. Finally, families often have a very difficult time finding a provider willing to accept their insurance, even if a service is determined medically necessary. Whether it is psychotherapy or residential treatment services, California faces a dearth of treatment options for publicly and privately insured families across the continuum of care.

Federal mental health parity law requires that both publicly and privately insured children have access to mental health services that is equal in terms of scope, duration and accessibility to that available to treat physical health conditions. Yet, children and families still struggle to access even routine behavioral health services. In fact, the lack of parity is so glaring and persistent that it has become normalized. For example, it is difficult to find a child psychologist who accepts private insurance rather than cash — whereas it is virtually impossible to find a pediatrician that accepts only cash but not private insurance. Not surprisingly,

our hospitals tell us that many privately insured children who present in our emergency departments in behavioral health crisis have not had any interaction with a behavioral health professional prior their emergency department visit, despite the fact that in many cases these children have likely been exhibiting symptoms of distress for some time prior. They also report incidents where private health plans declined to authorize services for children, even children who were suicidal. Recent media reports document appalling gaps in services to youth in the midst of severe behavioral health crises, leading to suicides and other severe consequences. Staff at our hospitals similarly report instances of families who searched unsuccessfully for months and even in one case over a year for services for a suicidal child.

Our experience and these recent media reports suggest to us that federal and state laws are not being adequately implemented and enforced to ensure that children obtain the services that they need.

### **Recommendation**

**The state must more actively ensure that laws designed to promote appropriate access to pediatric mental health services are being implemented. Specifically, CCHA recommends that:**

- DHCS provide clearer and more consistent guidance to county behavioral health plans and Medi-Cal managed care plans about EPSDT mental health services, and clarify more explicitly that the bifurcation of “mild to moderate/moderate to severe” behavioral health standards for adults do not in many cases apply to children.
- DHCS provide more technical assistance to county behavioral health agencies on how to comply with EPSDT and consider creating a safe harbor for county behavioral health departments that approve clinically appropriate services covered by EPSDT, to discourage defensive fiscal practices that result in needed services being denied.

- DHCS create model EPSDT intake and assessment forms for counties to use, in order to reduce burdensome and inconsistent paperwork requirements on providers.
- DHCS track how long it takes newly diagnosed children to obtain needed behavioral health services, using a “secret shopper” methodology, and hold plans accountable for failing to meet timeliness standards.
- DMHC and CDI step up audit and enforcement activities to ensure that commercial health plans are fully compliant with state and federal law. Among steps these agencies can take is (a) conducting “secret shopper” audits of private health plan provider directories to determine if behavioral health providers listed actually accept patients as well as how long it takes newly diagnosed children to obtain needed care, (b) reviewing plan utilization review criteria to ensure that they are consistent with mental health parity laws, (c) tracking appointment wait times and encounters for services, and (d) ensuring that consumers are aware that Independent Medical Review (IMR) is available to them when a plan denies a behavioral health service.
- The state develop and disseminate easy-to-understand materials to ensure that children and families know when and how they are entitled to behavioral health services and where to go if they have difficulty obtaining care.

## TWO HOSPITALS REPORTED CASES OF YOUTH WITH DEVELOPMENTAL DISORDERS WHO LANGUISHED FOR OVER A YEAR IN THE HOSPITAL AFTER COMPLETING THEIR INPATIENT MEDICAL TREATMENTS BECAUSE THE RESPONSIBLE REGIONAL CENTER WAS UNABLE TO LOCATE AN APPROPRIATE PLACEMENT FOR THESE CHILDREN.

### Create/Expand Programs to Identify Behavioral Health Problems Early

Where children live, eat, sleep, play and learn profoundly affects their emotional health and well-being. If California is to make significant improvements in the way it serves children with behavioral health needs, the state must approach the problem holistically and seek ways to reach and support children and their families well before a crisis has occurred.

This type of approach would:

1. Support families in ways that encourage healthy child development and resiliency, and
2. Build community support systems that are easy for children, youth and families to access in a non-stigmatizing way.

This year the Governor made a down payment on an important type of early intervention strategy, by increasing support for home visitation programs by over \$135 million. Home visiting is a prevention strategy designed to support pregnant moms and new parents, promote infant and child health, foster



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educational development and school readiness, and prevent child abuse and neglect. Research indicates that high-quality home visiting programs can improve outcomes for children and families, particularly those that face added challenges such as teen or single parenthood, maternal depression and lack of social and financial supports.<sup>22</sup>

Other effective early-intervention models include Help Me Grow, a national model that in California is supported by many local First 5 commissions. Help Me Grow is designed to ensure that communities identify vulnerable children early and establish links between families and community-based services. Help Me Grow also empowers families by streamlining access to child development information, assisting families in navigating overlapping and diverse programs to obtain services, collaborating with healthcare providers to ensure children receive appropriate developmental screenings, and identifying gaps in services and opportunities for greater collaboration and systems improvements. The core components of the Help Me Grow system have been shown to decrease medical costs, build family resilience and protective factors, as well as maximize referral and linkage efficiency by creating a pathway to services through a centralized access point.

In addition to prevention strategies that support families of very young children, the state could be doing more to prevent teen suicide and other behavioral health conditions by expanding community-based models that specifically target this age cohort in a non-stigmatizing way.

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**Two models of this approach are:**

1. The San Francisco Wellness Initiative, a partnership of the San Francisco Department of Children, Youth and Their Families, the San Francisco Department of Public Health, and the San Francisco Unified School District that serves 16,000 high school students at 19 campuses around the City. In safe, confidential settings, experts in adolescent health at onsite wellness centers help teens gain the skills they need to cope with complex issues such as stress, trauma, suicide, bullying, depression, self-esteem, drug and alcohol use, sexual health and relationships. Students learn positive, lifelong habits that contribute to their well-being and success, and ultimately, to the health of the communities in which they live.
2. Allcove, a collaboration between Packard Children’s Hospital and the County of Santa Clara which takes its inspiration from a model that originated in Australia in 2006. This model includes the creation of stand-alone, community-based integrated care sites for young people ages 12-25 to access early mental health supports, along with primary care, early addiction treatment, peer support, school-employment support and web-based connectivity. These programs improve young people’s mental, social, and emotional wellbeing through the provision of high quality, integrated, age-appropriate care for teenagers, young adults, and their families who are facing early life challenges—whether they are issues like relationship breakups, bullying, sexual orientation, depression, anxiety, or other health conditions.

Despite data to support the benefits of these types of community-based models, the challenge for many of these programs is finding sustainable financing. For example, First 5 commissions are supported by a declining revenue source (tobacco taxes). Thus, local Help Me Grow programs may need to find other state and local funding sources to sustain their programs over time.

## Recommendation

**CCHA recommends the state provide sustained investments in effective community-based prevention and early intervention programs that support healthy child development and/or identify and treat behavioral health problems early. CCHA also recommends the state seek ways to equitably support these models, via private insurers as well as public payers.**

## Fill In Service Gaps to Ensure a Full Continuum of Care

The behavioral health delivery system for children is at best inadequate and in some cases close to non-existent, depending on where a child lives, regardless of whether that child is privately insured or covered by Medi-Cal. Gaps in the continuum are common and are particularly acute in rural areas of the state. Below are three examples.

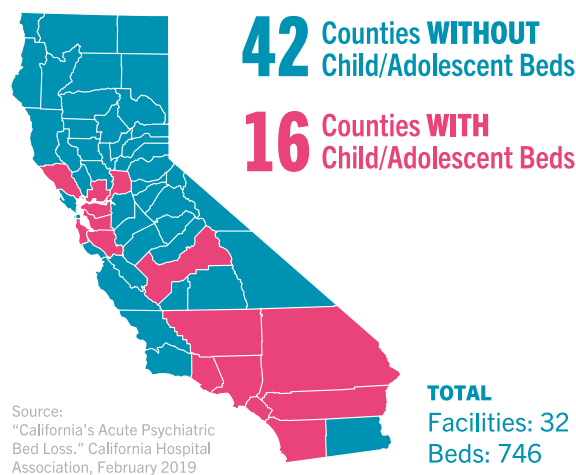
### Lack of Inpatient Psychiatric Beds

Despite the fact that the rate of behavioral health-related hospitalizations for California children ages 5-19 has increased by almost 50 percent since 2007,<sup>23</sup> there are no inpatient psychiatric beds for children in 42 California counties.<sup>24</sup> In fact, between 2005 and 2017, the number of inpatient psychiatric beds for children actually declined.

Building more inpatient capacity is challenging due to the overlapping requirements of federal CMS requirements related to ligature risk, state inpatient licensure rules related to hospital health and safety, and the policies and procedures required to obtain county approval under the Lanterman-Petris-Short (LPS) Act — this latter designation is required in order to enable a facility to provide treatment to a child that is deemed a danger to themselves or others under California law.<sup>25</sup> Our hospitals report that the investment needed to meet all of these requirements is complex, time consuming, and extremely expensive. For example, a facility must be completely operational in order to obtain the accreditation necessary to obtain Medi-Cal reimbursement, but cannot seek

designation as an LPS facility until after accreditation is obtained. This means that a facility must be fully staffed — potentially for months — without any patients being served or reimbursement being received until it receives its LPS designation from the county in which it resides. A facility may lose thousands of dollars per day during this interregnum. To complicate matters, county criteria for approving LPS designation varies and our hospitals report inconsistencies in interpretation of law and regulations. After all approvals are received, a facility is unlikely to receive reimbursement sufficient to offset its operating costs; the default Medi-Cal rate for an intensive care psychiatric bed — that is the rate that a facility will receive for that type of bed unless a county agrees to pay higher — ranges from \$724 in Los Angeles to \$1,550 in the Bay Area.<sup>26</sup>

### Child/Adolescent Acute Care Inpatient Bed Distribution



The overlapping burdens of state and federal rules combined with unreasonably low Medi-Cal reimbursement rates make it infeasible for most hospitals to open pediatric psychiatric beds in California without significant, ongoing assistance from other sources, such as private donors. One staff member estimated that 50 to 70 percent of all reimbursement his psychiatric unit receives goes directly to meeting either insurance costs or federal, state, or county regulatory requirements, rather than direct patient care. With an average patient mix that is 2/3rd Medi-Cal, this is not a sustainable, operational business model for many children's hospitals.

## 45 PERCENT OF THE STATE'S PSYCHIATRISTS ARE OVER THE AGE OF 60 AND WILL LIKELY RETIRE IN THE NEXT TEN YEARS.



Source: Healthforce Center at UCSF

### Shortage of Residential Treatment Options

Similarly, our hospitals report that there are few or no residential treatment beds for children and adolescents in many counties in California, regardless of a family's ability to pay, a problem that some believe has been exacerbated by the state's efforts to reform community care licensing requirements for short term residential treatment programs. This means that many high needs children who require residential, but not hospital inpatient, care will be placed outside of California, far away from any support that their families could provide. It is important to note that treatment out of state means that families cannot participate in treatment — an evidence-based best practice — and learn how to better care for their children upon their return home.

### Access Barriers to Intensive Outpatient and Partial Hospitalization Services

Unlike private insurers, county behavioral health agencies will not approve evidence-based, intensive outpatient or partial hospitalization services for children covered by Medi-Cal, preferring instead to cover what is known as “full-service partnerships” (FSPs). FSPs are funded through California's Mental Health Services Act (also known as Proposition 63) and provide wrap-around outpatient supports for children with behavioral health diagnoses. In theory, “full-service partnerships” can include IOP or PHP services, but in practice no county in California has covered IOP or PHP services in any of our hospitals,

either within an FSP or outside of it. Mostly, counties contract out FSPs to service agencies that provide home-based supports. IOPs and PHPs provide evidence-based therapeutic services and are staffed by licensed professionals. While full-service partnerships are appropriate and beneficial in many circumstances, children with severe behavioral health needs can require more intensive treatment. In these instances, children must have access to a therapeutic milieu and advanced specialists in children's behavioral health treatment who are qualified at identifying and providing the most appropriate interventional treatment modalities.

The reasons for these gaps in the continuum are multifaceted. In some cases, shortages reflect regulatory hurdles that make it difficult for providers to create capacity. In other cases, reimbursement rates are too low (or are in some cases non-existent) to make services viable. Sometimes it is a combination of these two factors. These situations are compounded by a lack of appropriately trained behavioral health professionals at every level.

### Recommendation

**CCHA recommends that the state work to address gaps in behavioral services by:**

- Developing ways to streamline the licensing and accreditation process for inpatient psychiatric beds.
- Increasing the Medi-Cal default reimbursement rate for inpatient and outpatient psychiatric services.
- Developing model criteria for counties to use when approving designation of LPS beds for children, to standardize and streamline the designation process.
- Requiring that county behavioral health agencies provide coverage for evidence-based treatment modalities, such as Intensive Outpatient Programs, and Partial Hospitalization Programs, to serve children with acute behavioral health needs when such services are clinically appropriate.

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## Support Tele-Consultation, Co-location and Care Integration Models That Provide More Support to, and Partner With, Primary Care Providers

We applaud the Governor for including funds in the budget for primary care providers, including pediatricians and family practice doctors, to screen children for exposure to trauma. This is an important first step in early identification of children with behavioral health needs. But more must be done to support the providers on the front lines and ensure that children and families obtain the services that such screening indicates. Primary care providers have regular interactions with their patients and families and are thus in a position to identify early and help to manage many common behavioral health conditions in children, such as depression and anxiety. However, these providers are already burdened with high caseloads and low reimbursement, and burnout is a constant threat. Also, many are not trained in the provision of behavioral health services. Thus, it is not realistic to assume that they can absorb additional work without additional supports. Additionally, screening without ability to refer or consult, is — to borrow a phrase from a recent news article on suicide prevention — “like cutting doorways into an empty building.”<sup>27</sup>

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**BEHAVIORAL HEALTH-RELATED HOSPITALIZATIONS FOR CALIFORNIA CHILDREN AGES 5-19 HAS INCREASED BY ALMOST 50 PERCENT SINCE 2007, BUT THE NUMBER OF INPATIENT PSYCHIATRIC BEDS FOR CHILDREN ACTUALLY DECLINED BETWEEN 2005 AND 2017.**

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Other states are exploring models to help support primary care providers to meet the behavioral health needs of their pediatric patients, including:

- The Massachusetts Child Psychiatry Access Program (MCPAP), which is a system of regional children’s behavioral telehealth consultation teams designed to help primary care providers and their practices to promote and manage the behavioral health of their pediatric patients as a fundamental component of overall health and wellness. MCPAP services are available to all children and families in the state, regardless of insurance. MCPAP services are funded primarily by the Massachusetts Department of Mental Health and in part by major commercial insurance in Massachusetts. MCPAP provides dedicated behavioral health consultation to primary care providers working in the primary care setting as well as other members of the primary care team. The goal of MCPAP is to increase access to behavioral health treatment by making child psychiatry services — a scarce resource — available to PCPs across the state. It is also to improve the capacity of primary care providers to support children with behavioral health issues and their families within their practices, with consistent behavioral health consultation as needed. Each team is staffed with two full-time child and adolescent psychiatrists, independently licensed behavioral health clinicians, resource and referral specialists, and program coordinators. Through consultation and education MCPAP improves the pediatric team’s competencies and comfort with:
  - Screening, identification and assessment;
  - Treating mild to moderate cases of behavioral health disorders according to current evidence-based practices; and in
  - Making effective referrals and coordinating care for patients who need community-based specialty behavioral health services.

- Project ECHO (Extension for Community Health Outcomes), which started in New Mexico, is a model that links expert multidisciplinary specialist teams at an academic “hub” with primary care clinicians in local communities — the “spokes” of the model. Together, they participate in regularly scheduled telehealth consultation and educational clinics, which are like virtual grand rounds, combined with mentoring and patient case presentations and consultations. During teleECHO clinics, primary care clinicians from multiple sites present patient cases to the specialist teams and to each other, discuss new developments relating to their patients, and determine effective treatment. Specialists serve as mentors and colleagues, sharing their medical knowledge and expertise with primary care clinicians. Essentially, the model creates ongoing learning communities where primary care clinicians receive support and develop the skills they need to treat a particular condition, such as depression or anxiety. As a result, they can provide comprehensive, best-practice care to patients with complex health conditions, right where they live.

In addition, many states and providers are exploring ways to co-locate behavioral health and physical health providers or integrate behavioral health and physical health services within a single location, to enable warm hand-offs of patients and improved coordination of care.<sup>28</sup> Several of our hospitals have received grant funding to implement these types of models and report that they have increased levels of family engagement and satisfaction. This approach is supported by Medicare for seniors. Yet in California, this model has not historically received strong support from Medi-Cal or private insurers. The California Department of Health Care Services recently released a draft proposal, “Value Based Payments for Behavioral Health Integration” that may pave the way for improved coordination and integration for children covered by Medi-Cal. The purpose of the draft proposal is to improve physical and behavioral health outcomes through the use of fully integrated care teams. This type of a model may hold considerable promise for all children, particularly for those children with medical complexity.

## Recommendation

### CCHA recommends that California:

- Pursue options that have been used successfully in other states, such as Massachusetts and New Mexico, to expand both telephone and televideo models of consultation and collaboration between primary care providers and behavioral health specialists.
- Explore opportunities to expand models of co-location and integration between mental health professionals and primary care providers to improve treatment and/or case management and support for children with behavioral health needs.
- Mandate that public and private health plans provide financial reimbursement for telephonic consultation between primary care doctors and pediatric behavioral health specialists as well as robust use of care coordination and telehealth consultation models and/or identify mechanisms that would make co-location, integration and tele-consultation models otherwise financially self-sustaining (these models are currently grant-funded).

**PROVIDERS ROUTINELY SPEND 30% TO 50% OF THEIR TIME FILLING OUT PAPERWORK. NEW PATIENT PAPERWORK CAN TAKE A CLINICIAN UP TO TWO HOURS TO COMPLETE.**



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## Establish Programs and Supports Designed Specifically for Children with Behavioral and Comorbid Developmental or Physical Health Conditions

Our hospitals report that there is a disturbingly severe shortage of both inpatient and outpatient services for children who have comorbidities ranging from autism to diabetes. Two of our member hospitals report cases of youth who required inpatient care and also had developmental disorder diagnoses and who, upon completion of their medical treatments, each languished for over *a year* in the hospital, due to the inability of the responsible regional center to locate an appropriate placement for these children. Our hospitals have been confronted with other striking examples of youth who were stranded in a medical inpatient unit, or medical emergency department, for weeks to months, due to the inability of the regional center, child welfare, juvenile justice, and/or medical and mental health care systems to align and effectively work together to find appropriate placements. Long and unnecessary hospitalizations can exacerbate a child's behavioral health condition. More needs to be done to address the needs of children with multiple physical, developmental and behavioral health conditions and to ensure that systems integrate better to meet the needs of children and youth with multiple, comorbid conditions and risk factors.

Some of our hospitals are developing programs to specifically address the needs of children with both special health needs and behavioral health conditions. For example, Loma Linda University Children's Hospital operates a program called MEND that provides intensive outpatient services, three days per week, to children with chronic physical health conditions who are also experiencing behavioral health issues that interfere with the treatment of their chronic condition. The program has shown dramatic improvements in helping children manage their chronic conditions and reduced both school absenteeism for enrolled children as well as work absenteeism among their parents.

### Recommendation

**CCHA recommends that the state invest in building the capacity to support the behavioral health needs of children with chronic health or developmental conditions. This can be accomplished by:**

- Piloting models of care coordination and integration specifically for children with comorbid health conditions, who are at heightened risk for depression, anxiety and other behavioral health conditions, which can negatively affect medical outcomes.
- Incentivizing better coordination among agencies, including regional centers, child welfare agencies, local educational agencies, juvenile justice systems, behavioral health departments, and health plans to ensure that children with comorbid developmental, physical, and behavioral health conditions are case managed appropriately and served in the least restrictive environment possible.
- Requiring the California Children's Services Program (CCS) to cover intensive outpatient services and other evidence-based treatment modalities for children with CCS conditions who also have behavioral health diagnoses.

## Address Pediatric Behavioral Health Workforce Shortages

We are grateful to the Governor for supporting a significant investment in California's health care workforce in the 2019-20 budget, including funding specifically for behavioral health workforce development. Yet, the unmet need in this area is astounding.

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## 42 CALIFORNIA COUNTIES LACK INPATIENT PSYCHIATRIC BEDS FOR CHILDREN.

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California is struggling with an acute shortage of behavioral health providers at every level. This is abundantly clear to anyone anywhere in the state who is seeking to obtain treatment for a child with behavioral health needs. There is a well-documented and severe shortage of child psychiatrists, child psychologists, and family therapists who will accept any sort of insurance, public or private. There are only roughly 8,600 board-certified child psychiatrists and 10,000 child psychologists in the entire United States, and California is disproportionately impacted by these shortages. For example, the American Academy of Child and Adolescent Psychiatry reports that California has only 1,135 practicing board certified child and adolescent psychiatrists (CAPs) in the state, or roughly 13 CAPs for every 100,000 children. This problem is likely to actually worsen in the near future as experts estimate that 45 percent of the state's psychiatrists are over the age of 60 and will likely retire in the next 10 years.<sup>29</sup>

Many providers do not accept Medi-Cal, but even privately insured children struggle to obtain services from licensed behavioral health professionals. The shortage of clinicians is so severe that most will only accept cash, not insurance. Some of the reasons for the shortage are due to the fact that clinicians must acquire additional training in order to be credentialed to treat children, usually by incurring more debt, but are not paid more than providers who treat adults once they complete their training.

It is important to note that there is also a glaring disparity between the racial, ethnic and linguistic make-up of California's children and families and the racial, ethnic, and linguistic availability of behavioral health providers. As severe as the overall shortage is, there is a particularly acute shortage of bilingual providers and providers of color available to treat children in California.

### Recommendation

**To address workforce shortages, CCHA recommends:**

- The state appropriate funding specifically targeted at graduate behavioral health education for clinical social workers, marriage and family therapists, psychologists, addiction specialists and psychiatrists. Support for graduate education needs to go beyond a simple medical model, since many children could be well-served by improved access to therapeutic services provided by qualified behavioral health providers, such as specialized MFT and MSWs — professions that do the bulk of the therapeutic interventions — and child psychologists to add to the provision of assessment and specialized interventions. In addition, funding should support a culturally and linguistically diverse workforce that can meet the diverse needs of California's children and families.
- The state work with providers of behavioral health education to improve the content as it relates specifically to the competencies that should qualify professionals to work with children. This includes trauma-informed and resiliency-informed care models that reduce stigma and are supportive of self-efficacy, include parent and family education and treatment, and address engagement and collaboration to address issues that are the manifestation of larger contexts including school and community violence. This should also include the cultural competencies needed to work effectively with children and families of diverse ethnic and racial backgrounds.
- The state implement loan forgiveness or educational support that targets qualified children's behavioral health specialists where it is needed most.

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## Encourage Local Interagency Collaboration and Incentivize Approaches that Achieve Desirable Outcomes

Many children with behavioral health needs are not identified early because they do not come into contact with professionals who can accurately identify and intervene to assist these children in obtaining needed services. Children spend a large proportion of their time in schools, but schools are frequently disconnected from the behavioral health care delivery system, have their own criteria for serving children with behavioral health needs, and can be simply one more complex bureaucracy that a family must manage in order to attempt to obtain services. While recent investments in school mental health services in California are laudable, more needs to be done to meet effectively the needs of children and youth where they are. This can be accomplished in part by improving partnerships between the agencies that educate children and those that are designed to meet their behavioral health and physical needs.

One model for such interagency collaboration already exists, but it is currently limited to children in foster care or the juvenile justice system. That is, as a result of a settlement between plaintiffs and the state in the *Katie A. v. Bonta* class action lawsuit in 2003, the state of California established what is called the Integrated Core Practice Model.<sup>30</sup> This model is designed specifically to improve the coordination of care between behavioral health and children's services for the purpose of better serving the behavioral health needs of children in the child welfare system, but it can serve as a model for how interagency coordination could and should occur for all children who have behavioral health needs.

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**WHERE CHILDREN LIVE, EAT, SLEEP, PLAY, AND LEARN PROFOUNDLY AFFECTS THEIR EMOTIONAL HEALTH AND WELL-BEING.**

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### Recommendation

#### CCHA recommends that the state:

- Encourage counties that have not already done so to establish interagency agreements with schools, large health care and behavioral health providers, and community based organizations to help identify children with behavioral health needs sooner and provide appropriate supports to them and their families. Provide incentives to facilitate collaboration on training and the provision of services. Incentivize collaboration that prioritizes accountability. For example, set aside a portion of MHSA funds that would be available to local agencies who achieved certain milestones, such as reducing rates of childhood depression.
- Provide incentives to support collaboration among all of the agencies that serve children, including counties, regional centers, the juvenile justice system, children's hospitals, schools, and behavioral health providers to collaborate on training and the provision of services to address social determinants of health, including but not limited to health screening and reducing the impact of poverty and exposure to violence and trauma.

## California Needs Bold Leadership to Address This Crisis

Children and families across California are struggling to obtain needed behavioral health services. The burgeoning crisis in the adult behavioral health system is the result of decades of neglect and a failure to invest in early and timely behavioral health treatment for previous generations. Fixing the shortcomings identified here will require strong leadership and direction but has the potential to pay long-term dividends for California's children, their families, and their communities.

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## Endnotes

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CALIFORNIA  
CHILDREN'S  
HOSPITAL  
ASSOCIATION

## About the California Children's Hospital Association

For over 20 years, the California Children's Hospital Association (CCHA) has been advocating on behalf of the State's eight, private, freestanding children's hospitals. The Association works with state and national leaders to address issues impacting the hospitals' ability to provide the best care possible to the children of California, especially those with special and complex medical conditions.

### **Mission**

Our mission is to advance the well-being of children, promote access to high quality pediatric health care, and ensure the long-term viability of children's hospitals.

### **Vision**

Our vision embraces the ideal that every child should have access to high quality, cost effective primary, preventive and specialty health care services.

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