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STATUS OF MENTAL HEALTH CARE BLUEPRINT RECOMMENDATIONS

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You asked for the status of recommendations from the 2010 mental health care blueprint for Connecticut's children, a report by the joint child mental health task force.

SUMMARY

In 2010, the Joint Task Force of the Connecticut Chapter of the American Academy of Pediatrics and the Connecticut Chapter of the American Academy of Child and Adolescent Psychiatry issued a mental health care "blueprint" for Connecticut's children.

This proposal, developed at the state child advocate's request, makes recommendations to improve mental health access and control mental health care costs for children while maintaining health care quality. These recommendations included:

1. creating a regionalized, integrated system of care that includes outpatient mental health and primary care providers, child guidance centers, school- and home-based programs, mobile crisis teams, and partial and inpatient hospitalization programs;

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2. increasing resource allocation to pediatric, day care, and school settings for mental health prevention and early detection initiatives;

3. improving timely access to high quality, appropriate intervention; and

4. preserving a centralized, high quality, long term, inpatient treatment center for the entire state at Riverview State Hospital (now the Albert J. Solnit Children's Center South Campus).

In addition, the proposal called for implementing a model similar to the Connecticut Behavioral Health Partnership (BHP), the state's public mental health system, for privately insured children. The BHP contracts with a national managed behavioral health care company, to serve as its administrative services organization. The contractor's payment is tied to performance benchmarks. To fund the change, the proposal recommended establishing a fund using money paid by the state's health insurers. It would replace the money insurers currently pay for mental health care, similar to the insurance assessment levied on certain health insurers to pay for the state's childhood immunization program.

Most of the blueprint's recommendations have not been implemented. Some of those that have been implemented or otherwise addressed by legislation include (1) creating a regional behavioral health consultation and care coordination program for primary care providers, (2) expanding school-based health centers, and (3) maintaining long-term beds at facilities capable of delivering a high level of care, such as therapeutic group homes.

Below, we describe legislative action that fully or partially implements recommendations in the report. We also list those recommendations (1) that appear not to have been implemented and (2) whose implementation status we are unable to determine.

RECOMMENDATIONS IMPLEMENTED IN FULL OR PART

Create Access for Connecticut's Children of Every Socio-Economic Status – for Mental Health (ACCESS-MH) Program to Provide Primary Care Clinicians with Mental Health Capacity

The report recommended creating a system, based on the Massachusetts Child Psychiatry Access Project (MCPAP), to increase collaboration between mental health and primary care providers to screen, treat, and refer children for mental health services. MCPAP is a

regional system of children's mental health consultation teams that help primary care providers serving children with mental health conditions, regardless of their insurance status. (For more information on MCPAP, see OLR Report 2013-R-0011.)

PA 13-3 (§ 69) requires the children and families (DCF) commissioner, by January 1, 2014, to establish and implement a regional behavioral health consultation and care coordination program for primary care providers who serve children. The program must provide these primary care providers with:

1. timely access to a consultation team that includes a child psychiatrist, social worker, and care coordinator;

2. patient care coordination and transitional services for behavioral health care; and

3. training and education on patient access to behavioral health services.

The act required the DCF commissioner to submit a program plan by October 1, 2013 to the Appropriations, Children, Human Services, and Public Health committees. It allows the commissioner to contract for services and adopt regulations to administer the program.

Additionally, DCF's FYs 14-15 budget increased by $3.5 million to expand trauma-focused cognitive behavioral therapy (TF-CBT) to supplement the initiatives established above. It is expected that $2 million of this supplemental amount will be used to expand TF-CBT access to children ages four to 18 who are experiencing anxiety, depression, or trauma or who have conduct disorders. Most of the balance will be used to support TF-CBT in public schools in the south-central region of the state, with a smaller amount going to Bridgeport public schools for this purpose.

Finally, the biennial budget includes $2 million additionally for DCF to expand the Intensive In-home Child and Adolescent Psychiatric Services (IICAPS) program, which is a program designed to stabilize children while keeping them in their home community and out of acute or chronic inpatient care.

Expand and Standardize the "Medical Home" Model

There have been a few legislative initiates since 2010 to expand the use of the "Medical Home" model in Connecticut. Under this model, a primary care provider coordinates care for the patient.

PA 11-44 (§ 110), codified at CGS § 17b-263c, allowed the social services (DSS) commissioner to establish medical homes as a model for delivering care to recipients of DSS-administered medical assistance programs. The model, as defined by federal law, is for people eligible for Medicaid or a Medicaid waiver who have (1) two chronic conditions, (2) one chronic condition with a risk of developing a second, or (3) a serious and persistent mental health or substance abuse condition. Its components include, among other things, comprehensive case management and care coordination. A full summary of this section is available here. For information on person-centered medical homes, see http://www.huskyhealthct.org/pathways_pcmh/pathways_pcmh.html.

PA 11-58 (§ 2) requires the comptroller to consult with the Health Care Cost Containment Committee to develop and implement patient-centered medical homes for the state employee plan and partnership plans that will reduce these plans' costs.

PA 13-178 requires DCF to develop a comprehensive implementation plan across agency and policy areas for meeting the mental, emotional, and behavioral needs of all children in the state and preventing or reducing the long-term negative impact of such health issues on children. Among numerous other things, the plan must include strategies to enhance early interventions, consumer input, and public information and accountability by increasing family and youth engagement in medical homes, in collaboration with the Department of Public Health (DPH).

Expand School-Based Health Centers

There have been a number of public acts since 2010 concerning school-based health centers (SBHCs), including some to increase the number of SBHCs or the services they can offer.

For example, PA 13-247 (§ 193) allows all SBHCs to:

1. extend their hours,

2. expand the health care services they provide,

3. service students who live outside of their school district,

4. provide behavioral health services,

5. conduct community outreach, and

6. receive reimbursement for services from private insurance.

The act also requires such services to be provided in accordance with DPH licensure terms.

PA 12-116 (§ 8) required the DPH commissioner, for the 2012-13 school year, to establish or expand at least 20 SBHCs, in alliance districts (the 30 lowest-performing districts as identified by the education commissioner).

PA 10-118 requires each Connecticut-licensed health insurer, at the request of one or more SBHCs, to offer to contract with the center or centers to reimburse enrollees for covered health services. This offer must be made on terms and conditions similar to contracts offered to other health care service providers.

The FYs 14-15 budget reflects an increase of over $1 million in funding for SBHCs in each of the next two years, which is roughly 20% more than FY 11 funding for these centers.

Other relevant legislation includes:

1. PA 11-242 (§§ 44 & 97), which established a SBHC advisory committee to help the DPH commissioner develop recommendations for statutory and regulatory changes to improve health care through access to SBHCs;

2. PA 12-1, June 12, 2012 SS (§ 96), which requires SBHCs that receive operational funding from DPH to enter into an agreement with the local or regional board of education to establish minimum standards for the frequency and content of communications between the health center and school nurses or nurse practitioners;

3. PA 13-178, which requires emergency mobile psychiatric service providers to collaborate with SBHCs to (a) improve coordination and communication in order to promptly identify and refer children with mental, emotional, or behavioral health issues to the appropriate treatment program and (b) plan for any appropriate follow-up with the child and family; and

4. PA 13-287, which requires the SBHC advisory committee to advise the DPH commissioner on matters relating to minimum standards for providing services in SBHCs to ensure that high quality health care services are provided.

On the other hand, the report recommended that BHP and ultimately the proposed I-BHP/BHP Joint Oversight Council oversee school-based mental health services (see below under unimplemented recommendations for information on I-BHP). It also recommended the establishment of a task force, including DPH, SBHC administrators, DCF behavioral health administrators, key SDE administrators, and a legislative "champion" to review the successes and failures of previous and ongoing school based mental health interventions so that a bank of effective interventions can be available to practitioners. It appears that neither recommendation has been implemented to date.

Preserve Riverview Hospital

When the report was being drafted, the administration had proposed closing Riverview Hospital, which provides long-term inpatient treatment for severely mentally ill patients. The hospital, renamed Solnit Center - South Campus, remains open.

Therapeutic Group Homes (TGH)

The report recommended that the state maintain long-term beds at facilities capable of delivering a high level of care, such as therapeutic group homes (TGH). In fact DCF has increased funding for such homes. DCF began a "right-sizing" and redesign of its congregate care service continuum in 2011. This was done to ensure that children are placed in congregate care only when appropriate and in a setting that meets their needs. It also reflected DCF's policy to not place children under age six in congregate care whenever possible. This included implementing procedures to better manage the lengths of stay in TGHs in order to return children to their families more quickly.

Co-location

The report recommended the expansion of grant- and insurance-based co-location models that place mental health providers in a setting that also has primary care providers. There has been a limited expansion of co-location, but it is unclear to what extent this has included mental health providers.

Provider Training

The report recommended that the BHP add more clinical training links and other material to its website, citing MCPAP as a model. The BHP website currently provides links to training programs on topics such as the DSS spend-down requirements under Medicaid and dealing with transgender youths. It also provides links to webinars and the program's provider newsletters.

Case Management Codes

The report recommended that case management codes be included for all insurers and reflect parity between mental health and other health services, as required by federal and state law. The BHP website notes that the American Medical Association (AMA) has introduced a series of changes to the Current Procedural Terminology codes to reflect current behavioral health practices, to improve health outcomes and reduce long-term healthcare costs. In addition, the AMA added evaluation and management and add-on codes to help document details such as duration of therapy sessions and the complexity of interaction. To support providers through this transition, the BHP has updated its covered services table and authorization schedules on its website to reflect the new codes. Similarly, DSS has posted information pertaining to reimbursement rates for these services on its website, www.CTDSSMAP.com.

Funding for Prevention

The report recommended the establishment of ongoing, secure funding for prevention efforts such as the Head Start and Nurturing Families Network (NFN) Home Visiting programs. The NFN home visitation program continued to grow. According to the program's results-based accountability report card for 2013, the number of in-home visits grew from 563 in 2006 to 743 in 2011 and the number of participants almost doubled (1,201 to 2,034) during this period. According to the report card, a study focusing on child outcomes from in-home visits was to start in February 2013.

UNIMPLEMENTED RECOMMENDATIONS

It appears that the following recommendations have not been implemented.

1. Create a regionalized integrated system of care, based on home address, in which outpatient mental health and primary care providers, child guidance centers, school-based programs, in-home programs, mobile crisis teams, partial hospitalization programs, and inpatient programs are linked in one system of care.

2. Develop an insurance company-based Behavioral Health Partnership (I-BHP), modeled on the (a) state's vaccination program for children and (b) existing HUSKY mental health payment system, BHP.

3. Make intensive in-home services a staple of the regional BHP/I-BHP programs.

4. Use I-BHP to fund mental health evaluation and treatment for children and families with private insurance. Eliminate for-profit subcontractors of the commercial managed care companies for commercially insured families and replace them with the BHP model of not-for-profit managed care, with guidance from and accountability to a professional oversight council.

5. Expand intensive services as part of I-BHP regional services.

6. Increase funding for office rounds attended by both mental health and primary care providers through I-BHP to make attendance reimbursable and required for primary care clinicians.

7. More generally, provide reimbursement for collaboration between providers.

8. Create an I-BHP/BHP joint venture oversight council to ensure that the needs of all patient populations are being met.

9. Begin an initiative of statewide communication, possibly through I-BHP/BHP and ACCESS-MH, to coordinate private and public agencies, foundations, and providers that care for and advocate for children.

10. Have the oversight council and its sub-committees communicate at least quarterly with all child mental health providers to create common practice goals.

11. Regionalize beds used to provide acute care to keep patients close to their homes and use the regionalized network to provide continuity of care for these patients upon reintegration.

12. Establish regionalized oversight of prevention efforts, especially for preschoolers, in order to establish level of needs and interventions required.

13. Expand and improve the statewide network of child guidance centers.

14. Extend the licenses for these centers to entire school districts, rather than individual schools.

15. Expand access to these centers for all state residents by increasing their funding.

16. Use the centers as the major hub of the regionalized service system within the I-BHP/BHP model.

17. Create intradistrict teams of mental health providers to provide treatment and prevention services in schools. In most cases, child guidance centers would be the lead agency of these teams.

18. The school-mental health services collaborative should pursue all potential funding possibilities, including the reallocation of existing resources as well as: (a) fully implementing the Medicaid Rehabilitation Option with children to make it easier to locate community providers in the schools and access Medicaid funding for services, (b) expanding the practice of having SBHCs serve as satellites of Community Health Centers, and (c) encouraging private health insurers to reimburse for services provided in the school by licensed mental health providers.

19. School districts should work with their respective community collaboratives to expand the local system of care to include school based programs.

20. Draw skilled child behavioral health practitioners (including those from the private sector) into the initiatives recommended in the report through (a) loan forgiveness programs for all disciplines, (b) waiver or subsidization of license fees for doctors and mental health clinicians, and (c) other financial incentives.

21. Identify communities that lack care options as high demand areas and provide correspondingly higher incentives for clinicians to work in those areas.

22. Standardize practice and level of care guidelines across the state so that providers, government agencies, and insurance companies are all speaking the same language.

23. Engage the state attorney's office (presumably the attorney general's office) to develop malpractice awareness seminars and services for providers.

24. Provide public service announcements about social services, funding, and revenue cuts affecting children's health care.

We have not found information on the implementation status of the following recommendations.

1. Increase allocation of resources to pediatric, day care, and school settings for the prevention and early detection of mental health problems in children.

2. Local boards of education should conduct a needs assessment to determine what mental health resources are needed by their student population.

3. Include a three- to six-month 'No Harm or No Risk' clause for agencies that uncover and report problems in providing mental health care that might otherwise affect their clinic status designation.

4. Hire care managers with the goal of educating primary care clinicians and the public on how to make timely mental health referrals.

5. Include best practice guidelines and training for clinicians in statewide initiatives to meet the demands of our population.

6. Review acuity and level of care criteria with outpatient providers before they discharge patients from higher levels of care.

7. Standardize procedures for discharge or referral of problem clients and clients who fail to show.

8. Provide incentives with set expectations of the length of service expected (or payback requirements) for clinicians in high-volume programs such as child guidance centers, who are offered financial incentives to go elsewhere.

9. Prioritize the publication and updating of information regarding services and providers in regional catchment areas for use by local area collaboratives.

10. Enhance local systems of care and invite community members to offer resources for children.

11. All agencies will track length of waitlists or waiting times for the commercially insured and those who are not insured.

12. Implement a statewide tracking process to track down no-shows, who are potentially people who fall through the cracks and suffer most.

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