THE SOCIAL AND EMOTIONAL HEALTH OF CHILDREN DURING COVID-19

YTFG, April 2020
BEFORE COVID-19 THERE WAS A CHILDREN’S MENTAL HEALTH CRISIS

Increase in inpatient visits for suicide, suicidal ideation and self injury for children ages 1-17 years old, and 151% increase for children ages 10-14

Increase in mental health hospital days for children between 2006 and 2014

Increase in the rate of self-reported mental health needs since 2005

California ranks low in the country for providing behavioral, social and development screenings that are key to identifying early signs of challenges
COVID-19 is disrupting access to care for children and families...

School closures disrupt access to care

95% of the state’s 6 million children in public schools

40%-50% of CA youth receiving mental health access at or through their school

Social distancing impacts clinical settings

State and local social distancing requirements are limiting access to traditional outpatient settings

Lack of coordination between levels of government has been a historical challenge in CA - exacerbated by recent policy actions including 2011 realignment

It is further strained by the rapidly changing landscape created by covid-19
EVIDENCE OF THE DISRUPTION AND DESTABILIZATION

Mental Health America is reporting a 20% increase in mental health utilization.

“According to our screening data, we experienced a 19% increase in screening for clinical anxiety in the first weeks of February, and a 12% percent increase in the first two weeks of March.”

CBHA Provider survey found precipitous decreases in access and utilization.

“Contract behavioral health providers report a 58% decrease in provision of services, and a 42% reduction in provider staff productivity”

Sharp increases in teletherapy/crisis line utilization:

• AbleTo, a teletherapy platform that counts over 700 clinicians across the US reports utilization increased by 25%

• Talkspace, reports volume is up 25% since last month, which they attribute to coronavirus fears

• Wellspace Health’s Suicide Prevention and Crisis line from across California increased by 40 percent between February and March amid the coronavirus crisis,
COMMUNITY-BASED PROVIDERS ARE ESSENTIAL TO THE CHILD-SERVING SAFETY NET

California’s Health and Human Services safety net is in the midst of a fundamental transformation from a publicly provided delivery system to a privately purchased delivery systems.

Like other public utilities – power and waste management – an increasing number of services are being provided by community-based organizations.

Nowhere is this truer than in children’s mental health. 90% of Alameda’s children health system is contracted out to non-public community- based organizations.
AND THE IMPACT OF COVID-19 IS DESTABILIZING THE FRAGILE NETWORK OF PROVIDERS THAT SERVE CHILDREN

Revenue loss:

- Reimbursement is tied to units of service in traditional face-to-face modalities
- Contracts are designed and administered at the county level – counties vary dramatically in their capacity to respond to the crisis quickly

Workforce challenges:

- Providers face challenges accessing their own workforce and transforming practice to technology enabled modalities

Governor Newsom’s clarification of essential workforce:

“Behavioral health workers (including mental and substance use disorder) responsible for coordination, outreach, engagement, and treatment to individuals in need of mental health and/or substance use disorder services."
CALIFORNIA’S CHILD SERVING SYSTEMS ARE TRANSFORMING AT LIGHT SPEED...

Tech-enabled services are approved modalities for behavioral health. State and Federal guidance has increased access to services and supports delivered remotely.

But local jurisdictions are struggling to adopt and implement this guidance and change their contracts to ensure reimbursement.

The children’s mental health system will see a dramatic decrease in outpatient capacity and it must quickly adapt to tech-enabled modalities.
...WITH REVISED POLICY AND NEW RESOURCES FROM BOTH THE FEDS AND STATE

Federal suspension of HIPAA compliance. Guidance provides examples of services that are acceptable (Google Meet, Zoom for health care, etc.) and those that are not (Facebook).

DHCS encourages counties and providers to take all appropriate and necessary measures to ensure beneficiaries can access all medically necessary services while minimizing community spread. This includes:

• Behavioral health services via telephone and telehealth
• Minimize administrative burden and waive any additional county oversight and administrative requirements that are above and beyond DHCS and/or federal requirements.
THE TRUST HAS WORKED WITH PARTNERS ON FOUR KEY POINTS TO RESPOND TO THE CRISIS.

1. **Equivalency.** Speed the adoption of technology modalities by reimbursing them at the same rate as face-to-face. Expand the definition of therapeutic practice to place a higher value on client contact and engagement.

2. **1/12th contracting.** Follow the lead of San Francisco County to stabilize provider cash flow at 1/12 payments at actual costs.

3. **Rate adjustments with caps.** Adjust Medi-Cal rates to account for short-term loss of productivity within existing contract allocations.

4. **Prepare for increased demand.**
CAN THE FEDERAL RELIEF PACKAGE HELP?

There’s money (FMAP), but it’s not enough and it’s unclear how much will go to child-serving systems. Children have historically been last in line to receive funds, and because of the design of the children’s system (contracted) it is uniquely vulnerable.

• **SAMHSA: $425 Million Emergency Allocation – Approximately $40 Million to CA.** But how much for children’s mental health?

• **Coronavirus Relief Fund: $150 billion – Approximately $15 billion to CA.** But how much for children’s mental health?

• **Public Health and Social Services Emergency Fund: $100 billion – Approximately $10 billion to CA.** But how much for children’s mental health?
WHERE CAN PHILANTHROPY HAVE THE BIGGEST IMPACT?

1. **Support existing grantees** - relax reporting requirements so providers can do what they need to do at this time.

2. **Provide stabilization funding for NPOs with thin margins that are facing financial crisis.**

3. **Fund the recording of best practices and long-term benefits of short-term crisis activity** to help ensure the system doesn’t return to “business as usual” after the crisis.

4. **Fund just-in-time advocacy and technical assistance** to ensure safety net providers and systems can act quickly and effectively to take advantage of opportunities as they appear.

5. **Organize a response at scale and develop new collaborative response models.**
WHAT’S NEXT?

1. **100% FOR KIDS** - Propose FMAP increases for EPSDT Mental Health—preferable for all children’s mental health services. Consider targeted models (Foster Care, Schools, Provider Classifications).

2. **Restructure State MediCaid Plans and Reimbursement Practices to promote “Equivalency”** Focus on TA/Advocacy at the Payor level (health plans and systems).

3. **Prepare for Increased Demand as Economic Downturn Impacts Acuity and Safety Net Revenues.** Schools and FMAP again. Just when you need it most, the economic viability of safety net program is most challenged.

4. **Dedicated financing for adoption of Peer to Peer and Social Model Programs** Use next round of stimulus to prioritize system transformation.