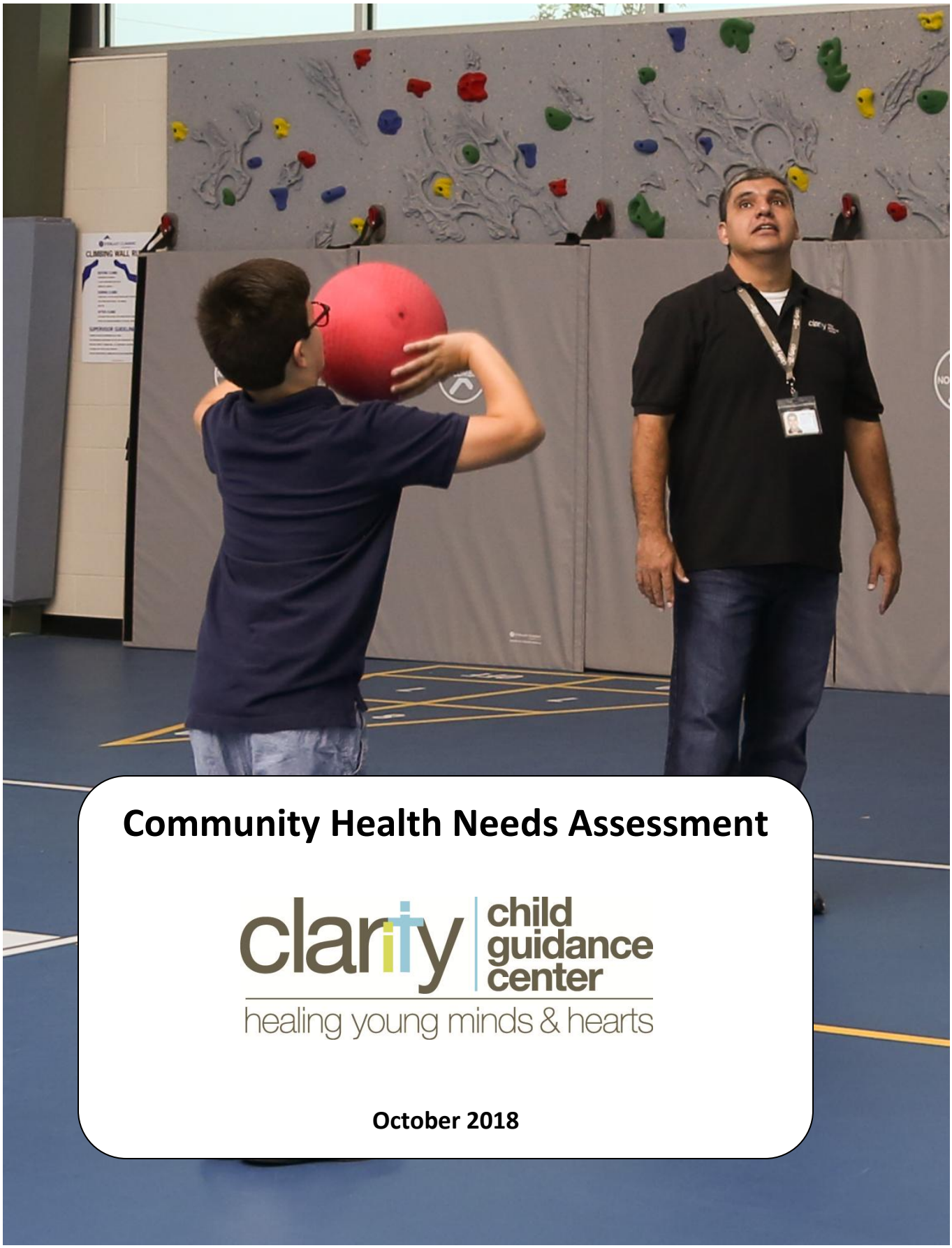

Community Health Needs Assessment

clarity | child guidance center

healing young minds & hearts

October 2018

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Introduction

IRC Section 501(r) requires health care organizations to assess the health needs of their communities and adopt implementation strategies to address identified needs. Per IRC Section 501(r), a byproduct of the Affordable Care Act, to comply with federal tax-exemption requirements, a tax-exempt hospital facility must:

- Conduct a community health needs assessment every three years.
- Adopt an implementation strategy to meet the community health needs identified through the assessment.
- Report how it is addressing the needs identified in the community health needs assessment and a description of needs that are not being addressed with the reasons why such needs are not being addressed.

The community health needs assessment must take into account input from persons who represent the broad interest of the community served by the hospital facility, including those with special knowledge or expertise in public health. The hospital facility must make the community health needs assessment widely available to the public.

The community health needs assessment, which describes both a process and a document, is intended to document Clarity Child Guidance Center's compliance with IRC Section 501 (r). Health needs of the community have been identified and prioritized so that Clarity Child Guidance Center (Clarity CGC) may adopt an implementation strategy to address specific needs of the community.

The process involved:

- Collection and analysis of data specifically related to children's mental health, as we are a unique, specialty care hospital serving the needs of children with severe mental illnesses, representing ages 3 to 17.
- Review of reports including extensive interviews with stakeholders that have specific knowledge and/or responsibility to the well-being of our community in relation to mental health care.
- Circulation of a Community Health research study that gathered information which is contained within this report which was shared with key stakeholders and is widely available to the community.

This document represents a summary of all the available information collected during this newly added IRS requirement. It will serve as a compliance document as well as a resource until the next assessment cycle in 2021.

Both the process and document serve as the basis for prioritizing the community's mental health needs and will aid in planning to meet those needs.

Summary of Community Health Needs

Clarity CGC engaged Core Research to conduct a formal community health needs assessment. Core Research, in business for over 22 years in the San Antonio area, was founded by Dr. Susan Korbel. The last community health needs assessment was conducted in the fall of 2016.

Based on guidance from the treasury and IRS, as well as the expertise from Core Research, the following steps were conducted as part of Clarity CGC's community health needs assessment:

- The "community" served by Clarity CGC was defined by utilizing inpatient and outpatient data regarding patient origin. This process is further described in Community Served by Clarity CGC, but can be summarized as children and adolescents ages 3 to 17, along with their legal guardian who would make decisions on their care.
- Population demographics and socioeconomic characteristics of the community were gathered and reported utilizing various annotated sources.
- An inventory of mental health facilities and resources was prepared and a demand for physician and hospital services was estimated through a third-party resource. This data was then evaluated for unmet needs.
- Community input was provided through the review of recent stakeholders and community studies showing the needs, challenges and opportunities in our region.

  Professionals Research Study
  - The research study was distributed to over 3,500 professional contacts in our community. The sample used for this survey was a mix of several lists: Clarity CGC's email list of professional recipients from our e-news, in addition to lists compiled by Core Research of almost 300 school counselors and social workers (total email: 2,636 contacts). We mailed a hard-copy survey to extend the sample beyond Clarity CGC's contacts. The mailing went to two lists: a purchased mailing list of pediatric/family services, Medical Doctors from the Bexar County Physicians Society (538 contacts) and a random sample of 500 from a list of

licensed therapists downloaded from the Texas State website (3,174 contacts). The result of all the outreach for respondents was 182 completed surveys.

- Among the respondents, 25% were therapists or psychologists, 3% were psychiatrists, 20% were pediatricians or other physicians, 8% were school counselors or nurses. 28% worked in private practice, 19% in schools, 20% in social services.
- Of the 189 respondents to the professional survey, 70% had self-reported living in the San Antonio area for over 10 years. Further, 77% of the respondents had personally referred a child or a teenager with serious mental health problems to a treatment facility in the area.

Parent/Legal Guardian Research Study

- Included in the research study was a separate research effort targeted to parents/legal guardians, with a child under the age of 18 living in the household. We conducted 400 phone interviews within Bexar County and 305 online surveys.
- As a result, our sample was very representative of the community. 60% of respondents were Hispanic, 32% Anglos, 3.5% African American, and 3.8% identified as Other. Respondents aged 18 to 34 represented 27% of the sample, and 35 to 44 represented 43%. 70% of respondents had lived in San Antonio over 5 years. Thanks to the online survey, we were able to have a balanced geographic distribution of the surveys that corresponds to the distribution of the general population. The online survey also collected 39 surveys that came from counties adjoining Bexar County (Seguin, New Braunfels) and we kept them in the totals. 8% completed the survey in Spanish. The proportion of female respondents was 70%.

- Information in the above steps was analyzed and reviewed to identify health issues of uninsured persons, low-income persons and minority groups and the community's mental health needs as a whole. Mental health needs were ranked utilizing a weighting method that considers 1) the ability to evaluate and measure outcomes, 2) the size of the problem, 3) the seriousness of the problem, 4) the prevalence of common themes and 5) the ability for Clarity CGC as a non-profit to address the issues raised from a capability and capacity standpoint.
- Recommendations based on this assessment have been communicated to Clarity CGC's leadership and Board of Directors.

General Description of Hospital

Clarity Child Guidance's mission is to help children, adolescents, and families cope with the disabling effects of mental illness and improve their ability to function successfully at home, at school, and in the community.

Clarity Child Guidance Center's legacy in San Antonio, Texas dates back to 1886 when thirteen caring and industrious women founded an orphanage for children who had been left behind by society. Over the years, the children who most often lived at the orphanage throughout their entire childhood years were children suffering from mental, emotional, and behavioral (MEB) disorders. The agency evolved over decades, eventually merging Southwest Mental Health Center and Child Guidance Center to become Clarity Child Guidance Center, the premiere resource for children in need of mental health treatment.

Clarity CGC's 18-member volunteer board of directors creates the strategies for providing mental health services to the children of Bexar County and the surrounding counties where no care is available. Leadership and staff at Clarity CGC execute the strategies and ensure successful operations. Clarity CGC is staffed with over 300 professionals dedicated to the mission of helping children and families suffering from mental illness. Our treatment team consists of psychiatrists, psychologists, licensed professional counselors, caseworkers, therapeutic recreation specialists, and nurses. Southwest Psychiatric Physicians is our onsite team of doctors providing outpatient and inpatient care. They represent the largest group of psychiatrists specialized in children and adolescents in South Texas as well as the largest group of bilingual psychiatrists in all of Texas.

Internally, we have a Strategic Quality Council made up of our President and CEO, Frederick W. Hines, and the senior officers of the eight departments at Clarity. This group meets weekly to discuss hospital operations and concerns and to ensure we are meeting treatment and development goals. We are Joint Commission Accredited as a hospital and in behavioral health meaning we pass rigorous standards set by the Joint Commission to ensure we offer safe and effective care at the highest quality possible.

Today, Clarity CGC is the only nonprofit providing a continuum of mental health care exclusively for children ages 3-17 in Bexar County. Clarity CGC services include assessments, individual, family and group therapy. Our crisis assessment service added in late 2015 allow people to walk in and be seen by a licensed professional within hours while kept safe until the appropriate level of care is determined. Intensive services day treatment and acute inpatient care take place at our children's 66-bed psychiatric hospital. Case management for families provides wrap

around support during and after inpatient and day treatment. Art, music and play therapy are also integrated into our treatment plans. We never turn away a family regardless of their ability to pay. As a result of our services, we help heal young minds and hearts.

Community Served by Clarity CGC

Clarity CGC is located in San Antonio, Texas, the county seat for Bexar. San Antonio is widely reported as the 7th largest city in the nation, but its population is spread over a wide area, creating rural pockets within a metropolitan base. San Antonio is 75 miles from the state capital in Austin, Texas, 190 miles from Houston and 208 miles from the Dallas/Ft. Worth metroplex.

Defined Community

A community is defined as the geographic area from which a significant number of the patients utilizing hospital services reside. The criteria established to define the community is as follows:

- A zip code area must represent two percent or more of Clarity CGC's total discharges and outpatient visits.
- Clarity CGC's market share in the zip code area must be greater than or equal to 20 percent.
- The area is contiguous to the geographical area encompassing the Hospital.

Based on the patient origin of acute care discharges and outpatient services within our United Way reports (a statistically relevant sampling of patient data) for fiscal year 2018, management has identified the community to include the cities, relevant counties and primary zip codes listed in Exhibit 1. Exhibit 1 presents Clarity CGC's patient origin, which is primarily comprised of San Antonio, Texas (87%). Within the San Antonio area, several zip codes are provided that demonstrate the top 9 areas of service, as well as outlying areas that comprise the remaining share of location service based on patient origin.

Exhibit 1
Clarity CGC Internal Data
Summary of Inpatient Discharges and Outpatient Services by City, County and Zip Code
FY2018

City/County	Discharges (Outpatient & Inpatient Combined)	Percent of Total Discharges
San Antonio (Bexar County)	3917	87%
78245	*203*	*4.51%*
78254	*177*	*3.93%*
78228	*169*	*3.75%*
78250	*164*	*3.64%*
78253	*162*	*3.60%*
78251	*161*	*3.58%*
78249	*123*	*2.73%*
78240	*114*	*2.53%*
78207	*114*	*2.53%*
All other zips	*2530*	*56.18%*
New Braunfels (Comal County)	100	2.22%
Other Texas Zips*	486	11%
Total	4503	100%

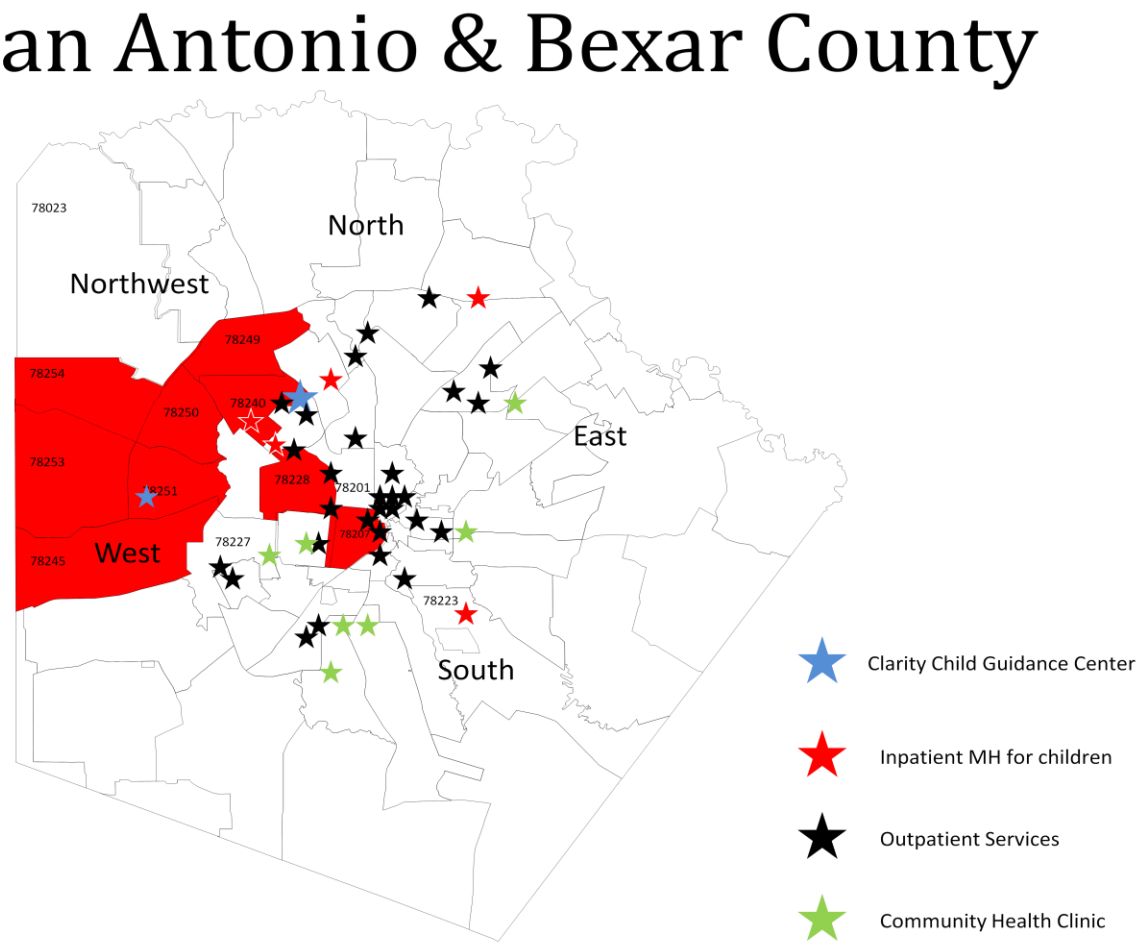
*Comprised primarily of outlying surrounding counties.

Community Details

Identification and Description of Geographical Community

The following map (Exhibit 2) geographically illustrates Clarity CGC's location and other community mental health resources. This visual illustration of mental health services, grouped by category of service demonstrates where gaps in care exist. San Antonio is the county seat and the largest portion of Bexar County, where 87% of our patients reside. The top 9 zip codes are highlighted in red, representing over 31% of where patients reside.

Exhibit 2
Clarity CGC Internal Research and Data
Geographic View of Defined Community, with 87% of Patients Residing in San Antonio



Community Population and Demographics

The U.S. Bureau of Census has compiled population and demographic data based on the 2010 census, while population estimates projections for 2021 were from the Texas State Data Center and other annotated sources.

Exhibit 3 illustrates that the overall population is projected to increase over the five-year period from 2016 to 2021. Also included in Exhibit 3 is a comparison of our projected population growth to that of the State of Texas and the United States for comparison purposes. The data in the table reflects children under the age of 18.

The age category that utilizes our mental health services "Under 18 Years" is projected to increase by 6% in that time period, a stronger growth than that of the US, and a net increase of over 30,000 children and teens in 5 years.

Exhibit 3

Estimated 2015 Children's Population vs. Projected 2021 Population Percent Difference

Area	Estimated 2015	Projection 2016	Projected 2021	Growth 2021/2016
Bexar County	498,631	503,711	533,901	6.0%
Comal County	28,271	28,367	30,034	5.9%
Texas	7,238,604	7,407,636	7,847,455	5.9%
U.S.		77,753,209	80,868,986	4.0%

Sources: Bexar, Comal and Texas: Texas State Data Center http://txsdc.utsa.edu/Data/TPEPP/Estimates/Index.aspx; Source for U.S.: CDC http://wonder.cdc.gov/population-projections.html

While the relative age of the community population can impact community health needs, so can the ethnicity and race of a population. Exhibit 4 shows the children's population of the community by ethnicity along with projected changes by 2021 as compared to the State of Texas. Hispanic children is the largest group in Bexar County by far with 70% of the total. This population has maintained its growth every year since 2009, growing from 293,000 to 345,000 in 2015. The Black population is predicted to grow, a major turn after a consistent decrease from 2009 to 2015 (from 35,000 to 31,000). The Anglo population is also on a turn after a decrease from 100,000 in 2009 to 95,000 in 2014.

Exhibit 4

Projected '16 Population vs. Projected '21 Population Percent Children's Ethnicities

	2016			Projected 2021			Difference		
Ethnicity	Anglo	Hispanic	Black	Anglo	Hispanic	Black	Anglo	Hispanic	Black
Bexar County	99,821	344,451	33,158	104,066	361,326	35,445	4.3%	4.9%	6.9%
Comal County	16,234	10,786	429	16,344	12,185	428	0.7%	13.0%	-0.2%
Texas	2,337,285	3,718,245	834,985	2,337,313	4,055,626	851,892	0.0%	9.1%	2.0%

Sources: Bexar, Comal and Texas: Texas State Data Center http://txsdc.utsa.edu/Data/TPEPP/Estimates/Index.aspx
Source for U.S.: Childstats.gov http://www.childstats.gov/americaschildren/tables.asp

Socioeconomic Characteristics of the Community

The socioeconomic characteristics of a geographic area influence the way residents access mental health care services and perceive the need for services within society. The following exhibits and statistics are a compilation of data that are specifically indicators and factors related to mental health care. Key factors include income levels and poverty, trauma from abuse, children in foster care, single-parent homes and insurance availability.

Income Levels and Poverty Rates

Income levels in Bexar County are consistently below that of Texas, as shown in Exhibit 5. However, the number of children living in poverty in Bexar County has decreased by 16%, from 129,052 to 108,698. Poverty rates among Bexar County children are down by 5.6 points, a significant improvement, and now below the poverty rate of Texas children.

Exhibit 5
Household Income Comparisons

	2016	
Income	**Median**	**Mean**
Bexar County	$ 52,353	$ 71,023
Comal County	$ 69,666	$ 89,816
Texas	$ 54,727	$ 77,585

Source: Source: Annie E. Casey Foundation

Exhibit 6
Poverty Rate Comparisons

	Number of Children under 18		Rate as % of children		Change between 2012 and 2016	
	2012	2016	2012	2016	Number	Percentage points
Bexar County	129,052	108,698	27.6%	22.0%	-15.8%	-5.6%
Comal County	3,895	3,954	15.1%	13.0%	1.5%	-2.1%
Texas	1,771,777	1,616,085	25.8%	22.4%	-8.8%	-3.4%

Source: Source: Annie E. Casey Foundation

Other Critical Factors

Trauma from abuse, obesity, children in foster care without family infrastructure and the stress of single parent homes are also factors that drive the need for mental health care among youth.

Child abuse and neglect is a major factor for mental health problems, as reflected in the fact that 25% of the children who are treated at Clarity CGC are in the foster care system.

Exhibit 7 demonstrates that the policy efforts to prevent child abuse in Bexar County are paying off with a 16.5% decrease in number of victims between 2011 and 2015. The decrease since 2007 is even more dramatic: 27% and a 6 point rate decrease. Conversely, Comal County shows a dramatic increase in incidence of child abuse of 100% since 2007 and a rate almost double that of Texas.

Exhibit 7

Incidence of Child Abuse Comparisons

	Victims		Rate per 1,000 children age 0-17		Change between 2011 and 2015	
Area	2011	2015	2011	2015	Victims	Rate change
Bexar County	5,915	4,941	13.5	9.9	-16.5%	-3.6
Comal County	315	489	12.6	17.5	55.2%	4.9
Texas	65,948	66,706	9.9	9.1	1.1%	-0.8

Source: Annie E. Casey Foundation

The number of Bexar County children in foster care has also decreased but the rates are still higher than the Texas population, as shown in Exhibit 8. Comal County is also showing a strong upward trend for this indicator.

Exhibit 8

Children in Foster Care Comparisons

	Children		Rate per 1,000 children age 0-17		Change between 2013 and 2015	
Area	2013	2015	2013	2015	Children	Rate change
Bexar County	3,473	3,130	7.2	6.3	-9.9%	-0.9
Comal County	146	233	5.4	8.3	59.6%	2.9
Texas	30,740	30,427	4	4.2	-1.0%	0.2

Source: Annie E. Casey Foundation

In Bexar County, the number of single-parent households has grown by 41% between 2000 and 2013. In comparison, between 2000 and 2010, the number of husband-wife households has grown by 14%, far lower than the growth rate of single-parent households. There is more poverty among single-parent families. Single-parent families make up 64% of the Texas households with kids living in poverty (vs. 11% from two-parents families). Poverty comes with a number of potential issues for the child: "Children living in poverty tend to have worse health than children who do not live in poverty. Low-income children also tend to perform less well on standardized tests of math and reading. They are also at higher risk for abuse and neglect." (State of Texas Children 2015 by the Center for Public Policy Priorities).

The rate of children growing up in these more fragile households in Bexar County keeps growing from 34% in 2008-2012 to 35% in 2012-2016, a total growth of 8% in number of kids. The rate is much more dramatic in Comal with a growth of 49% of kids living in this condition.

Exhibit 9
Children Living in Single-Parent Homes Comparison

	Children in single family households		Rate		Change between 2007 and 2011	
Area	2008-2012	2012-2016	2008-2012	2012-2016	Children	Rate change
Bexar County	135,723	146,292	34%	35%	7.8%	1%
Comal County	4,149	6,179	18%	24%	48.9%	6%
Texas	1,814,033	1,897,251	30%	31%	4.6%	0%

Source: Annie E. Casey Foundation

As nutrition and fitness play a role in mental health, the rates of obesity among children can have an effect on the needs for help. During the past 30 years, the number of overweight young people in the United States has more than tripled among children 6 to 11 years old and more than doubled among adolescents 12 to 19 years old. Of children aged 10-17 in Bexar County in 2013, 27 percent of black and Hispanic children are obese, as were 12 percent of white children, according to a report by the Centers for Disease Control and Prevention. These children are more likely to have depression.

Medicaid, CHIP and the Uninsured Children of our Community

While poverty rates are decreasing, the number of uninsured children has decreased dramatically since 2009 from 70,000 to 43,000 in 2016. The number of Bexar County children enrolled in Medicaid has grown from 135,000 in 2006 to almost 230,000 in 2015, and the percentage of children in Medicaid is at 46% compared to 30% in 2006. Children enrolled in CHIP have decreased since 2011 from 37,600 to under 23,000 in 2015, and from a rate of 7.5% to 4.3%. Children in Texas are eligible for either Medicaid or CHIP if their household incomes are up to 201 percent of poverty. Texas has refused to expand Medicaid and instead has been negotiating with CMS to secure funding to cover uncompensated care. Bexar County moved from Traditional Medicaid to STAR or Managed Medicaid in 2016.

Exhibit 10
Children Enrolled in Medicaid Comparison

	Enrollment		% of all children		Change between 2006 and 2010	
Area	2013	2015	2013	2016	Enrollment	Percentage points
Bexar County	203,647	229,751	40.0%	43.6%	12.8%	3.6%
Comal County	7,121	8,249	25.3%	27.4%	15.8%	2.1%
Texas	2,772,479	3,024,502	37.3%	40.7%	9.1%	3.4%

Source: Source: Annie E. Casey Foundation

The table below shows the percentage of uninsured children aged 17 and under in Bexar County as of 2016. The rate in Bexar County is lower than the rate in Texas overall.

Exhibit 11
Uninsured Children Rates Comparison (aged 17 and under)

	Number of uninsured children		% rate of all children		Change between 2009 and 2013	
Area	2013	2016	2013	2016	in # of uninsured	in % rate
Bexar County	52,230	43,779	10.5%	8.4%	-16.2%	-2.1%
Comal County	3,869	3,097	13.6%	9.6%	-20.0%	-4.0%
Texas	975,000	735,079	13.4%	9.7%	-24.6%	-3.7%

Source: Source: Annie E. Casey Foundation

Health Status of the Community

This section of the assessment reviews the mental health status of Bexar County residents with comparisons where possible.

Prevalence of Mental Illness and Treatment Rates

Almost one in five young people have one or more Mental, Emotional or Behavioral (MEB) disorders, and one in 10 youth has mental health problems that are severe enough to impair how they function at home, school, or in the community.

The prevalence of certain severe disorders such as bipolar, MDD (8%, 12-17 yrs, SAMHSA, 2012), ADHD (6.8%, CDC, 2013), autism spectrum disorders (one in 100, 88, 68 children, CDC, 2012, 2013, 2014) have markedly increased in recent years.

Mental Health America's reported the following US data in 2018:

- 11% of people aged 2-17 years old in the U.S. currently have one or more emotional, behavioral, or developmental conditions[1].
- At some point in their lives, half of all adolescents will experience a mental health disorder[2].
- Nearly one-third of adolescents aged 13-18 will experience an anxiety disorder in their lifetime[3].
- 12.8% of the U.S. population aged 12 to 17 (or 3.1 million adolescents) have had at least one major depressive episode in the past year[4].

Athena Health conducted a survey of their providers to measure the change in mental health diagnoses for pediatricians in their network. The rate reported went from 8% of children ages 6-17 diagnosed with a mental health issue in 2009-2010 to 10.5% in 2012-2013, a proportional rise of 29%. The increase was driven by the following diagnostics: ADHD (50%), followed by anxiety, autism, depression and eating disorders.

[1] http://www.nschdata.org/browse/data-snapshots/ nsch-profiles/mental-health?geo=
[2] Merikangas KR, et al. Lifetime prevalence of mental disorders in U.S. adolescents: results from the National Comorbidity Survey Replication--Adolescent Supplement (NCS-A). J Am Acad Child Adolesc Psychiatry. 2010 Oct;49(10):980-9. PMID: 20855043
[3] Kessler RC, Chiu WT, Demler O, Merikangas KR, Walters EE. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry.2005 Jun;62(6):617- 27. PMID: 15939839
[4] 2016 NSDUH: https://www.samhsa.gov/data/ sites/default/files/NSDUH-DetTabs-2016/NSDUHDetTabs- 2016.pdf

The Rep. Four Price House Select Committee on Mental Health Interim Report 2016[5] provides an overview of the Texas State of Mental Health statistics:

- Half of mental health conditions begin by age fourteen, and 75% of mental health conditions develop by age twenty-four
- Nearly 250,000 children have a serious emotional disturbance (SED);
- About one-half of these persons are below the 200 percent poverty level;
- Approximately 26,300 Texas students are receiving special education services with a primary diagnosis of emotional disturbance;
- Approximately 32,000 children are in Department of Family Protective Services (DFPS) conservatorship, and it is estimated that over fifty percent of those children have a diagnosed mental illness;
- Approximately 50 percent of youth in the juvenile justice system have been identified with need for mental health treatment; and
- Approximately 80 percent of state committed youth have a need for alcohol or drug use treatment.

Applying the one in five ratio to the Bexar county population results in an estimated 100,000 children 0-17 suffering from MEB problems in our county. Based on population growth estimate, the number could grow to 106,000 by 2021.

Among the current 100,000, an estimated 42,000 youth fall into the Serious Emotional Disturbance (SED) category, which mean that their condition prevents them from functioning at home or school. About half of these (21,483) live under 200% of the poverty rate[6].

The 2015 Mental Health America report shows that 40% of Texas children who needed services received it. However, the Meadows Mental Health Policy Institute 2017 study of needs in Bexar County reports that only 22% of the children with SED and in poverty are being helped by the two main community / public mental health providers for such services.

“While a very low level of service overall, of equal concern is the fact that relatively few children receive the intensity and level of care necessary in the community, with less than 5% of children in need of intensive, community-based supports able to receive such care through

[5] https://house.texas.gov/_media/pdf/committees/reports/84interim/Mental-Health-Select-Committee-Interim-Report-2016.pdf
[6] 2016 Bexar County Mental Health Systems Assessment by Meadows Mental Health Policy Institute and Methodist Healthcare Ministry.

CHCS or community providers, leading to an overreliance on juvenile justice, child welfare, and specialty school placements."

Lack of education and awareness

In a 2015 presentation, the Meadows Mental Health Policy Institute[7] reported that 9 in 10 people they interviewed were not comfortable discussing mental health, and 31% would not know where to turn to. The stigma and lack of awareness is even greater for children's mental health. Notable differences exist between ethnic / race groups and education levels. Access to care among low-income families and those at highest risk of trauma is much lower than other groups.

Recognizing this issue, the American Psychology Association writes: "It is imperative that we improve efforts around early recognition of mental health needs among children and adolescents and foster greater awareness of early warning signs. Early identification of mental health problems needs to be encouraged in preschool, childcare, K-12 education, health, child welfare, juvenile justice and substance use settings. Staff in these settings require additional training and technical assistance to understand the early warning signs of mental health problems, what to do about them and where to make referrals for further assistance."

The One in Five Minds campaign, sponsored by Clarity Child Guidance Center, is on the fore front of this issue and has reached thousands of families through online education at 1in5minds.org and through multiple events in the past 5 years.

State of Texas Funding for Children's Mental Health

While Texas spending on children's mental health has nearly doubled between 2009 and 2013 to reach $40 per capita[8], it still lags behind most other US States which spend on average $119 per capita. During last sessions, the legislature increased the Behavioral Health spending significantly as a result of the Four Price Select Committee Report and Recommendations.

Despite these improvements, funding remains a major issue for providers like Clarity CGC. There is a lot of pressure on payers to cut costs while still providing parity. It results in low reimbursement rates and shorter stays or denied days which put a lot of financial pressure on hospitals.

[7] The Mental Health Landscape of Texas: Key Finding from 2015 survey
[8] Source: Henry Kaiser Family Foundation State Mental Health Agency (SMHA) Per Capita Mental Health Services Expenditures

Funding is not only an issue for children in low income families. The parity requirement brought by ACA insured an increase of funding for families who have public insurance. However, while private insurances are required to provide parity if they offer a mental health coverage, they are not required to offer a mental health plan. Further, the rates they pay providers are often much lower than Medicaid rates and insufficient to cover the costs of critical services.

For instance, the Government Accountability Office reported[9] in 2013 that: "an annual average of 6.2 percent of noninstitutionalized children in Medicaid nationwide and 4.8 percent of privately insured children took one or more psychotropic medications, according to GAO's analysis of 2007-2009 data from the Department of Health and Human Services' (HHS) Medical Expenditure Panel Survey (MEPS). MEPS data also showed that children in Medicaid took antipsychotic medications (a type of psychotropic medication that can help some children but has a risk of serious side effects) at a relatively low rate--1.3 percent of children--but that the rate for children in Medicaid was over twice the rate for privately insured children, which was 0.5 percent."

Outpatient Treatment

In 2015, there were 2,052 actively licensed psychiatrists providing direct patient care in Texas[10]. This number represented a 21.6% increase since 2010 and a 39.1% increase since 2004. Relative to population growth, the size of the psychiatrist workforce has improved by 12.7% over the past ten years. Despite these improvements, Texas still had fewer psychiatrists than the national average and the majority of the state was federally-designated as a Mental Health Professional Shortage Area. Also, within 10 years, 60% of the current Texas Psychiatric workforce will be at or past retirement age.

Thanks to the efforts of UT Health and other local institutions, the number of child and adolescent psychiatrists in Bexar County has grown from 7.53 for every 100,000 to almost 15 today. However, this masks a critical lack of services in neighboring counties and especially the continued scarcity in rural areas and in South Texas.

[9] CHILDREN'S MENTAL HEALTH: Concerns Remain about Appropriate Services for Children in Medicaid and Foster Care GAO-13-15: Published: Dec 10, 2012. Publicly Released: Jan 9, 2013.
[10] Health Professions Resource Center, Trends Distribution and Demographics, Statewide Health Coordinating Council, June 2016.

In addition, only half of Texas psychiatrists accept private insurance (compared with nearly 90 percent of other physician types), and only 21 percent of Texas psychiatrists will accept Medicaid patients, according to the Texas Medical Association[11].

For providers like Clarity CGG, the reimbursement rates of outpatient services for Medicaid patients is below cost of services, which limits their ability to expand services.

Emergency Room "Boarding"

Another unintended consequence of the lack of care in our community is the increase of emergency room (ER) visits by children and teens with an MEB diagnosis. This is the most expensive and ineffective option for the children of our community.

An ER setting is particularly not suited for such patients. Diagnosis and intervention must wait for a specialist's arrival following an initial general physician's evaluation. ER staff may be undertrained in mental health treatment resulting in more complications. The emergency setting is likely to extend the problems as it is not offering the nurturing, calming setting required for such patients.

According to a study published in the February 2012 Journal of the American Academy of Child & Adolescent Psychiatry, "a substantial proportion of young Medicaid beneficiaries who present to ERs with deliberate self-harm are discharged to the community and do not receive emergency mental health assessments or follow-up outpatient mental health care". The article is based on a study of over 3,000 cases of youth 10-19 admitted to ER for self harm:

- 73% of the youth in the study were discharged in the community
- 39% of the discharged patients received an assessment in the ER
- 43% received follow-up outpatient mental healthcare

Data provided by Healthcare Access San Antonio (HASA), the local Health Information Exchange, reveals a high number of ER visits for mental health in three Bexar County Health Systems between July 2013 and June 2014[12]. It reported 457 ER visits for children 0 to 12 and 1,448 for the 13 to 17 year old group. Among the older group, the length of stay analysis showed that 82% of them spent more than an hour in the ER. The median stay was 4 hours.

[11] Quoted by Hogg Foundation Blog article : http://hogg.utexas.edu/the-shame-of-texas

[12] The data is comprised of ER admissions to Baptist Health System (BHS), Methodist Health System (MHS) and Christus Santa Rosa (CSR). The data compares admissions for a primary diagnosis of mental health versus all admissions and includes length of stay (LOS) information. There has been some discussion amongst various groups that HASA data may be incomplete, or contain only unfunded patients. If that is indeed correct, then the numbers being shared in this report are low and would only rise if funded patients were included.

Overall 48% were discharged before 3 hours, but 34% stayed between 4 and 7 hours and 18% stayed over 8 hours.

Acute Treatment – More beds but shorter stays

There is an overall shortage of psychiatric beds in Texas. The total capacity is at 4,855 while the need is estimated at 5,425 and the projection for 2024 is 6,033, including State funded beds and private funded beds[13].

In 2010 Methodist Healthcare Ministries estimated that there was a deficit of 21 child and adolescent psychiatric beds in Bexar County based on occupancy rates at local psychiatric hospitals. Since then, the following happened:

- Clarity added 14 inpatient beds
- Other privately-funded hospitals also added beds (Nix, Laurel Ridge, and San Antonio Behavioral Hospital)
- San Antonio State Hospital (SASH) practically closed their 30 youth beds for a while and recently reopened 12 (designated for teen girls).

The total number of beds is now at 291, compared to 164 in 2014. Despite this significant increase in capacity the needs are still high and the community still experiences shortages at times. There is State funding earmarked to increase SASH capacity in the next 2 years.

Exhibit 12

Number of Children Acute Care Beds in Bexar County in 2018

Organization	Acute	Crisis observation
Memorial Hermann		
Clarity CGC	66	6
Laurel Ridge	40-60	0
The Nix	31	
San Antonio Behavioral Healthcare	122	
SA State Hospital	12	
CHCS		16 (14 for respite)
Total 2018	**291**	**20**

[13] Analysis for the Ten-Year Plan for the Provision of Services to Persons Served by State Psychiatric Hospitals (SPHs) Consulting Services for DSHS Rider 83 RFP No. 529-14-0066 November 2014

Health Outcomes and Factors

Ripple Effects of Non-Treatment

Absence of treatment harms children and their families and often leads to more trauma:

- Nationally, 50 percent of children with serious emotional disturbances drop out of high school, as do 30 percent of all students with disabilities. High school attrition rates in Bexar County, which compares the number of students who start in 9th grade with how many finish 4 years later, is 37% compared to 27% on average for Texas. (Source: Texans Care for Children, 2009 report.)
- A 2005 national study showed that youth with a major depressive episode were about twice as likely to start using alcohol or an illicit drug as youth who had not experienced a major depressive episode in the past year. Between 2014 and 2016, past month use of marijuana increased across all grade levels with 12th grade students showing the most significant increase of 11.0 from 11.1 percent in 2014 to 22.1 percent in 2016[14]. The 2016 Texas School Survey of Substance Use asked students "About how many of your close friends use tobacco, alcohol or marijuana". The findings of students' perceptions for their friends use[15]:
    - One in three (31.1%) perceive their friends use tobacco.
    - One in two (51.3%) perceive their friends use alcohol.
    - Almost one in two (43.2%) of their friends use marijuana, higher than tobacco.
    - The gap between the perception of friends that use alcohol (35.5%) and marijuana (31.7%) are closest for 8th grade students.
    - Alcohol (74.1%) is perceived to be used the most followed by marijuana (65.4%) and then tobacco (54.4%) across all grades.
- Between one half and three fourths of youth in the juvenile justice system nationally are estimated to have a diagnosable mental health disorder according to the Texans Care for Children, 2009 report. The population in juvenile facilities in Bexar County has grown by 39% between 2000 and 2010.

Observations

The following quote from the book The Premature Demise of Public Child and Adolescent Inpatient Psychiatric Beds by authors Dr. Jeffrey Geller and Dr. Kathleen Biebel summarizes the situation we are experiencing.

[14] Regional Needs Assessment REGION 8 PREVENTION RESOURCE CENTER, Sept. 2018.
[15] From the San Antonio Council on Alcohol and Drug Awareness

"The expectation that the range of interventions offered by inpatient facilities would be effectively replaced by community based services has not been fulfilled". This error has led to "children and adolescent with serious emotional disturbance being 'warehoused' in juvenile detention centers, stuck in emergency rooms, inappropriately placed in child welfare."

Health Care Resources

Other Mental Health Care Facilities and Providers

The Bexar County Mental Health Consortium publishes the resources available to the community and specifies children's resources, which are noted in Exhibit 13.

Exhibit 13

Source: Bexar County Mental Health 2016 Publication of Resources

Organization	Non-profit	Assessments	Case Management	Outpatient Therapy (with Therapist, Psychologist or Psychiatrist)	Partial Hospital	Acute Care Hospitalization
Any Baby Can	X		X			
Baptist Child & Family Services	X		X	X		
Blossom Center for Children	X	X				
Catholic Charities	X	X	X	X		
Center for Health Care Services	X	X	X	X		
Centro Med	X	X		X		
Children Hospital of San Antonio	X	X		X		
Children's Bereavement Center	X	X		X		
Childsafe	X	X	X	X		
Clarity CGC	X	X	X	X	X	X
CommuniCare Health	X	X	X	X		
Excel… Rise Above the Rest	X		X			
Laurel Ridge Treatment Center		X	X	X (IOP)	X	X
Nix Hospital		X	X	X (IOP)		X
Pathways Youth & Family Services	X	X	X	X		
Presa Community Center	X	X	X	X		
Rape Crisis Center for Children & Adults	X	X	X	X		
Roy Mass' Youth Alternatives	X	X	X	X		
San Antonio Behavioral Hospital		X	X		X	X
San Antonio Youth Mental Health Assoc	X		X			
San Antonio Youth Mental Health Assoc.	X		X			
St. Peter St. Joseph Children's Home	X		X	X		
Unversity Health System San Antonio	X	X	X	X		

Observations

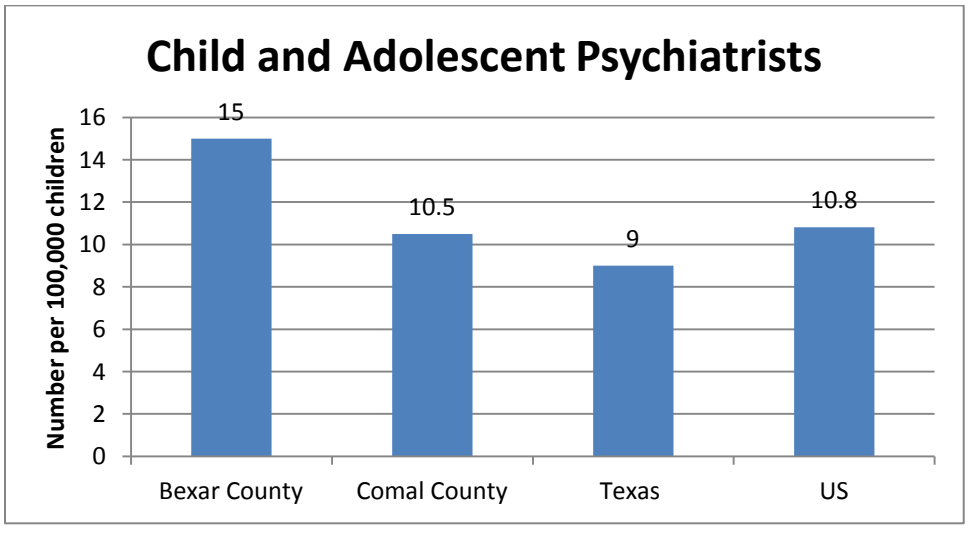
With so few providers in our community, it is difficult to think of fellow nonprofits and the two for-profit entities as "competition". The two largest providers of outpatient therapy are Clarity CGC with over 30,000 therapy and psychiatry visits annually and the Center for Healthcare Services. The two largest providers of acute inpatient care are Clarity CGC, with over 16,000 inpatient days annually and Laurel Ridge, who treats both adults and children and have the capability to flex beds to either population, based on need. Rural access in counties adjacent to Bexar are not listed because there are literally no acute care services and few outpatient services available, forcing this population to access care in the San Antonio area.

Demand for Mental Health Care

As noted, there are significant delays in obtaining an outpatient therapy appointment and a lack of beds for acute care in our community. Not only are there not enough facilities to accommodate demand, but there is a shortage of child and adolescent psychiatrists. Clarity CGC is proud to be affiliated with UT Health San Antonio, where residents and fellows from the Division of Child and Adolescent Psychiatry receive their training onsite at our campus. This affiliation has helped Bexar County to improve upon its per capita rates of providers and we're now above the US and Texas. However, Bexar County is surrounded with counties with very few psychiatrists, and as noted above, many physicians do not take insurance.

Exhibit 14

The supply of Mental Health Professional in Texas 2015



Source: American Academy of Child and Adolescent Psychiatry, https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx

Surveys

Survey Responses - Parents

As noted on page 3, a survey of parents and professionals was conducted in the fall of 2016 to ascertain stakeholder feedback. A common issue with hospitals is the realization that the patient is the customer; therefore their feedback is crucial to strategic planning. Since our patients are minors, parents and legal guardians become their voice.

The first need identified in the parent survey is education-based. About 20% of parents had no idea where they would send a child suffering from mental health problems, and 42% would send them to a general hospital. It shows a lack of familiarity with the field which is not a surprise. However, thanks to increased efforts of awareness, the number of parents who would take the child to a mental health facility increased from 13% in 2014 to 33% in 2016. More and more families are coming directly to Clarity CGC for help and over one third of our crisis assessments are from parent "walk-ins."

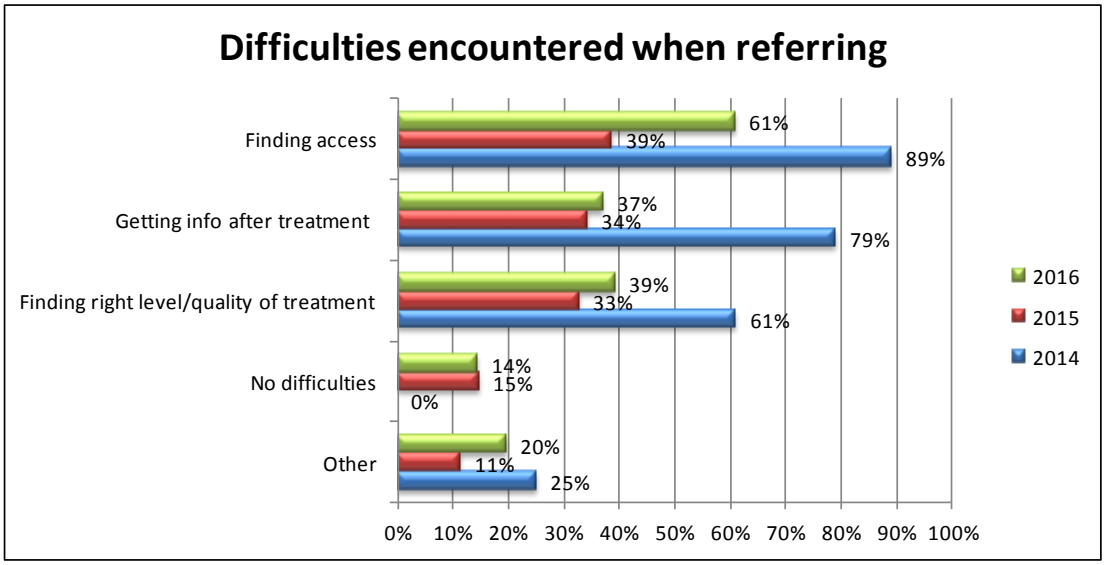
Parents were also asked if they had anything to add concerning mental health facilities or professionals in San Antonio. Out of 170 answers, 37 made positive comments about the facilities and services available, 40 expressed the need for more facilities or some specific level of service, 30 said more outreach or advertising was needed, 22 didn't have any comments because they didn't know anyone close who needed this kind of help, 11 thought the quality of care should be improved, and 11 commented about the cost of these services

Sample comments regarding the lack of services in San Antonio from parent respondents are as noted:

- *WE NEED MORE FOR CHILDREN AND TEENS. THERE ARE ONLY A FEW THAT I KNOW OF. THEY ARE NOT ACCEPTING LOW AND MEDICAID PATIENT OR THERE IS A FOUR TO SIX MONTH WAIT.*
- *IT IS ALMOST IMPOSSIBLE TO GET A CHILD PSYCHIATRIST IN SAN ANTONIO.*
- *PERSONALLY, I THINK THERE IS A LOT OF CHILDREN THAT ARE UNDER OR MISDIAGNOSED AND NOT ENOUGH HELP FOR CHILDREN AND SCHOOL DISTRICTS DO NOT HAVE ENOUGH SUPPORT FOR CHILDREN. NOT ENOUGH SUPPORT PROVIDED.*
- *SAN ANTONIO IS VERY LACKING IN PSYCHIATRIST THAT ACCEPT MEDICAID ESPECIALLY FOR CHILDREN. CLARITY'S WAITING LIST IS 6 MONTHS LONG TO GET IN TO SEE A PSYCHIATRIST THERE ARE NOT MANY OPTIONS FOR KIDS*
- *There is a major shortage of psychiatrists who treat children and accept insurance.*
- *They are very limited for counseling services for children with Medicaid who do not live in Bexar County. I had to search for months to get my daughter psychological services. Ended up going to a psychologist in Hays County. Only Dr. that would accept her Medicaid. Still cannot find a psychiatrist that will do her medication and accept her medicaid.*

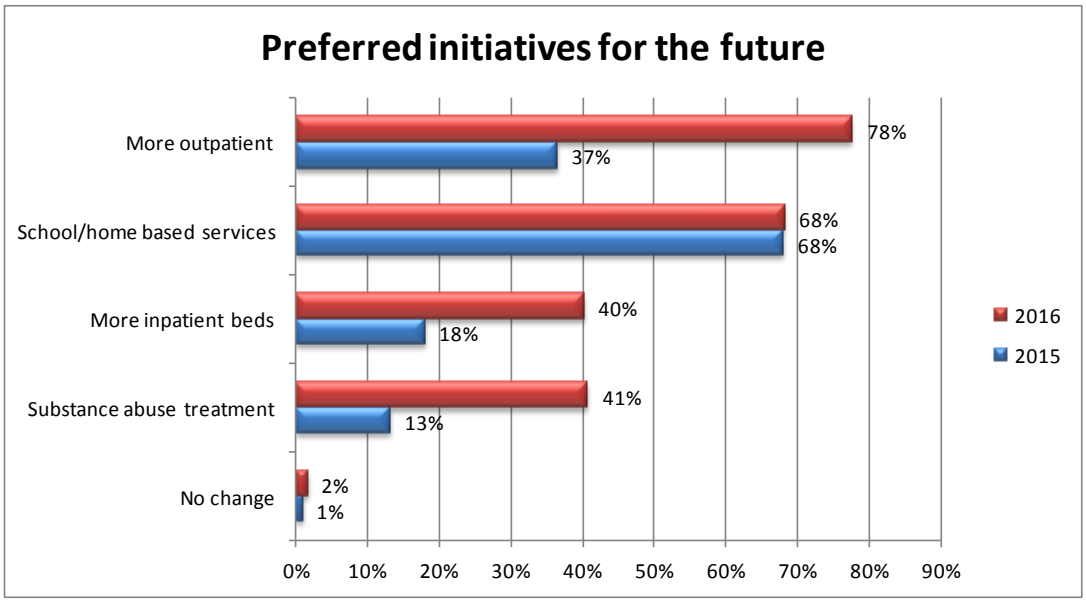
Survey Responses – Professionals

We asked professional respondents for feedback about the referral process and what difficulties they experience in trying to get children to a psychiatric facility. While the issue of access went down in 2015 because SABH's arrival created more access, this issue came back up to 61% (89% the first year.) It is closely followed by the difficulty to find the right level of treatment (39%) and then the lack of follow-up after treatment (37%.) 14% of the respondents say they have no difficulties.



We then asked professionals what would be the most beneficial initiative for children with mental health problems in our area. Multiple answers were possible. Here is the response in order of preference, along with a visual representation:

1. Increase the availability of outpatient clinical services (78%)
2. School/Home based services (68%)
3. Increase the number of psychiatric inpatient beds (40%)
4. Substance abuse treatment (41%)
5. Only 2% said no changes were needed.



Professionals also had an opportunity to comment on the topic of mental health. Of the 52 comments:

- 17 suggested an increase in capacity, especially more psychiatrists,
- 7 mentioned the lack of Medicaid providers and difficulties for low-income families to get help,
- 7 talked about how school based services or better collaboration with schools were needed,
- 7 mentioned an improvement of services, especially outpatient services, as well as the need for long-term inpatient to help kids who go in and out of acute.

Sample comments regarding the lack of services in San Antonio from professionals are as noted:

- *We are stretched so thin in my school district that I feel that we cannot properly identify and prevent mental health issues in our children.*
- *Many youth in the Juvenile Probation system who are not criminogenic are sent to residential placement along with other, more risky youth, because they have severe mental health needs that place them at risk to themselves or others but no one will take them due to their criminal histories or hold onto them long enough for them to make long-term change.*

- *Huge gap from discharge to outpatient psychiatrist and parents run out of the Rx, can't get more, and child goes untreated. Leads to spiral downward and in some cases, as though child never admitted (no benefit ultimately). Need to bridge this gap.*
- *Increase the number of psychiatrists in the area.*
- *Make it easier and attractive for psychiatrists to participate in Medicaid*
- *More character building and service oriented empowerment programs in our community for pre-youth/middle school aged youth.*
- *Provide home based services and services in neighborhoods and communities that allow for/require family participation. Eliminate need for families to drive/bus across town for services. Include families in treatment rather than visiting schools to fix the child. Collaboration between agencies to share space in different parts of town. Utilize grant funds to prevent immediate medical diagnosis and focus on behaviors and functioning, reducing the diagnosing and labeling of children unnecessarily.*
- *We need long-term residential behavioral healthcare and it should be accessible right out of crisis stabilization. The lack of continuous primary care integrated with behavioral health is the main resource needing to be identified and rectified.*

Key Findings

A summary of themes and key findings provided by document reviews of key stakeholders reports and the parent/professionals surveys revealed the following (specifically related to mental health):

- Lack of funding to meet community mental health care needs, including low public and private reimbursements for these services.
- Lack of medical providers specialized in the child and adolescent treatment and especially taking Medicaid or CHIP.
- Lack of care coordination among different providers and especially to identify and treat early onset of psychosis.
- Lack of access through patient-facing organizations like schools.
- Increased complexity of patients in crisis including co-morbidity, drug addiction, autism.
- Lack of long-term residential care providers for complex patients.
- Increased need for crisis services including stabilization and follow-up.
- Local hospitals have eliminated psychiatric acute care services for children, creating an emergency room bottleneck.
- Gaps in levels of care – community is missing an after school intensive outpatient program and respite care for mentally ill children and their families when school is not in session.

- Significant delays in outpatient care and acute inpatient care due to lack of resources, both personnel and facilities.
- Significant stigma that prevents conversations at the parent, family and neighborhood levels.
- Lack of "pathways" or access points for parents and legal guardians to navigate the disconnected care models, or to follow-up on care.

Prioritization of Identified Health Needs

Clarity CGC has been the premier resource for children's mental health care in South Texas. Much work remains to be done and steps are being taken by Clarity CGC Leadership and its Board of Directors to close as many gaps as is feasible. In evaluating the results of our document research as well as survey respondents, we ranked the opportunities identified in the following manner:

- Does the opportunity align with our values, our mission and our vision?
- Is it a core competency currently? If not, is it a complementary core competency that strengthens our value proposition?
- Is there another organization or entity that would be better served to address the opportunity versus Clarity CGC?
- Is there a viable funding stream for sustainability purposes?
- Does the opportunity impact improvements in other areas of need, if implemented?
- What are the benefits in quantifiable terms of implementing the opportunity?

Clarity Child Guidance Center's leadership evaluated the opportunities revealed in the Community Health Needs Assessment and with the guidance of the Board of Directors, developed a strategic plan to address gaps in the community. Items prioritized were the following:

1. Continue investing in development to enable systemic and repeatable funding streams to our existing business model of billing insurance companies.

2. Explore methods to increase access to care, knowing that a severe shortage of psychiatrists and other mental health professionals has been an ongoing societal issue.

3. Expand levels of care and types of care in the community.

    a. Deployment of neighborhood-based clinics over a period of several years to expand access to mental health care, alleviating wait times for initial care and transportation issues.

i. Expand traditional longer-term outpatient therapy to include a brief psychotherapy model.

ii. Include medication management at the clinic, when feasible.

iii. Offer day treatment (partial hospitalization) when feasible.

b. Deploy brief therapy options beyond the neighborhood clinics.

c. Evaluate non-medical based levels of care, such as intensive outpatient, respite beds, etc.

d. Evaluate addition of substance abuse services and support.

e. Evaluate home and school based partnerships for services.

4. Deepen the relationships and outreach related to One in Five Minds, Clarity CGC's signature campaign to end the stigma of mental illness.

5. Implement care coordination to create more effective utilization of health services for children at high-risk.

From our last published CHNA in 2015, we have implemented the following initiatives:

- Opening of a Crisis Assessment Center on our main campus which includes six observation beds for extended assessments and crisis stabilization (November 2015) and 24-hour staffing.
- Implementation of a telepsychiatry relationship with a Houston-based organization to add additional psychiatry support to our assessment and admitting processes.
- We also added several nurse practitioners to continue addressing the severe psychiatrist shortage.